

1

Introduction

The field of public health has never been as widely known or popular as in recent years. On a global scale, the spread of HIV/AIDS beginning in the 1980s gave public health enormous impetus and visibility. Much like infectious diseases from earlier eras, HIV/AIDS was deeply enmeshed in environmental and behavioral contexts. If left unaddressed, the disease promised to engulf large portions of the world's population.

Yet today's most enduring and pervasive public health problems are far more mundane, e.g., poor sanitation and water quality, malnutrition, and the everyday violence of grinding poverty. The 20th-century reign of the germ theory of disease etiology, with its emphasis on curing over prevention and laboratories over communities, has been tempered by these realities and by the vast increase in chronic diseases such as hypertension, diabetes, and cancer. Similarly, the dominance of quantification, in which ever-more sophisticated measures and statistics are expected to capture the full range of human experience, has given way to a more nuanced and thoughtful matching of methods with the problem at hand as well as with the people and places experiencing it (Baum, 1996; Rapkin & Trickett, 2005).

Enter Qualitative Methods

A colleague once astutely remarked that virtually anyone can read and appreciate qualitative research—its narrative reporting style makes it appear easy to carry out. By comparison, a quantitative study relies on complicated

statistical analyses that require prior knowledge to decode their meaning. Yet the appealing end product of a qualitative study represents the culmination of intense involvement and intellectual labor. Whether used alone or in a mixed methods study, qualitative methods have become central to research in public health. This, in a nutshell, is what this book is all about.

The term *qualitative methods* is a relative latecomer to the methodological lexicon, coming long after ethnography and other forms of naturalistic inquiry had been on the scene. There is no “one size fits all” qualitative method to make the definitional task easier; the aphorism “a mile wide and an inch deep” (quantitative) versus “a mile deep and an inch wide” (qualitative) is useful heuristically if a bit simplistic.

Nowadays, qualitative research can be referred to as a family of methods in which some members are more compatible than others. Some members have been around for a long time (e.g., ethnography, case studies, and grounded theory). Others such as narrative analysis, constructivism, and phenomenological approaches are newer on the scene.

And what about *mixed methods*? Rising appreciation of qualitative methods has made them attractive to researchers seeking to use both quantitative and qualitative approaches to maximize their understanding of a phenomenon. Now considered a separate form of inquiry with its own experts and terminology (Creswell, 2007; Pope, Mays, & Popay, 2007; Tashakkori & Teddlie, 2010), mixed methods research has followed closely on the heels of the popularity of qualitative methods.

Differences From and Similarities to Quantitative Methods

To varying degrees, qualitative methods entail assumptions and approaches that set them apart from quantitative research. At the risk of oversimplifying, the distinctions are as follows:

- Insider rather than outsider perspectives
- Person-centered rather than variable-centered
- Holistic rather than particularistic
- Contextual rather than decontextual
- Depth rather than breadth

Qualitative methods emphasize being inductive over being deductive. They favor naturalistic observation and interviewing over the decontextualizing approaches of quantitative research. As such, they imply a degree

of closeness and an absence of controlled conditions that stand in contrast to the distance and control of traditional scientific studies. Qualitative research is predicated on an “open systems” assumption where the observational context (and the observer) is part of the study itself (Manicas & Secord, 1982). In contrast, quantitative research favors a closed (or controlled) system approach in which every effort is made to neutralize the effects of the observational context (including the observer).

Qualitative studies seek to represent the complex worlds of respondents in a holistic, on-the-ground manner. They emphasize subjective meanings and question the existence of a single objective reality. Furthermore, they assume a dynamic reality, a state of flux that can only be captured via intensive engagement. A qualitative report is a *bricolage*, a pieced-together, tightly woven whole greater than the sum of its parts.

Doing qualitative research requires an unparalleled degree of immersion by the researcher as the instrument of data collection. Unlike the pre-coded, standardized questionnaire, the qualitative researcher must be a sensitive instrument of observation, capable of flexibility and on-the-spot decision making about following promising leads.

Drawing these contrasts between quantitative and qualitative methods is a necessary heuristic device to highlight what makes qualitative methods unique. There are also similarities between the two; some believe that the differences are more stylistic than epistemological (Flaherty, 2002, p. 513). Among their shared characteristics, both quantitative and qualitative approaches are empirical, relying heavily on firsthand observation and data collection to guide findings and conclusions. Second, both are systematic. Contrary to some misperceptions, qualitative research is not haphazard or unfocused, nor is it prescriptive or predictable. This dynamic tension between flexibility and serendipity on the one hand and methodological rigor on the other makes qualitative research exciting and challenging. Qualitative studies start out as inductive but need not remain exclusively so; such studies often alternate between induction and deduction (Morgan, 2007).

Paradigmatic “Camps” in Qualitative Methods

As qualitative inquiry has flourished, so have its internal divisions. The intellectual fermentation that resulted can be reasonably (and somewhat simplistically) described as producing three paradigmatic “camps”: post-positivism, constructivism, and critical perspectives. In this section, we review how, when, and why these three camps arose.

Positivist reasoning and quantification—the drivers behind the explosion of scientific and technological inventions in the 20th century—came under withering criticism from academic thinkers in the latter part of that century. Concerns about the assumptions of value-free objectivity and a verifiable reality gave rise to a “post-positivist” stance acknowledging the presence of values (admittedly as sources of bias), the provisional nature of knowledge, and the influence of the “knower” on what is known. Although more commonly adopted by social scientists rather than the “hard sciences,” the term *post-positivism* and what it represents are, largely by default, the epistemological backdrop to scientific inquiry over the past four decades.

The broad-based critique of logical positivism drew adherents from 20th-century philosophy (particularly phenomenology) but owes most of its impetus to the post-1960s upheaval among French intellectuals including Jacques Derrida, Michel Foucault, and Jean Baudrillard. A number of philosophers and social scientists in Europe and the United States joined a burgeoning postmodern movement (Harding, 1987; Rabinow & Sullivan, 1979). In anthropology, Geertz (1973, 1988) and Clifford and Marcus (1986) inspired a profound reexamination of ethnography in light of previous assumptions of “naïve realism.” In sociology, Berger and Luckmann’s treatise on *The Social Construction of Reality* (1967) provided a revelatory counterpoint to positivism. Last but by no means least, Lincoln and Guba’s landmark book *Naturalistic Inquiry* (1985) and their subsequent collaborations with Norman Denzin set definitional boundaries around “qualitative methods” as separate from and largely in opposition to positivism and quantitative methods. Invoking Kuhn’s (1970) observations on paradigm shifts, these proponents argued that epistemology was paramount and positivism was incommensurable with the nascent approach of constructivism. By the late 1980s, disciplinary boundaries were becoming blurred as social scientists embraced the humanities—philosophy, literature, and the arts—and produced works such as poetry, dance, and autobiography.

By the 1980s, learning about qualitative methods meant being drawn into paradigm arguments in which one was urged to declare one’s allegiance, with the most prominent voices calling for a rejection of post-positivism (Denzin & Lincoln, 1994). For these opponents of post-positivism, the label given to their resistance—postmodern, anti-foundational, post-structural, constructivist, interpretivist—mattered less than the message being promulgated. *Constructivism*—a belief that human phenomena are socially constructed rather than objectively “real”—proved to be a liberating

force for many researchers (Charmaz, 2006; Denzin & Lincoln, 2005). It has led to reexamination and reflexive critiques of what is meant by “race,” “gender,” “deviance,” and “mental illness” among many other social “facts.” Exposing the ways that such concepts are invented and reified has been a prime source of new understanding in the social sciences. The rub comes from taking this point of view to mean that there is no reality attached to concepts such as “race” or “gender.” Although few would argue that “race” is one of humanity’s most troubling inventions, it has an objective existence manifested in the discriminatory treatment of individuals with darker skin common to so many societies. Similarly, “poverty” has multiple meanings—absolute and relative—and all have consequences for health and well-being (Link & Phelan, 1995).

The third epistemological camp is explicitly devoted to research on inequalities as an ideological and moral imperative. Critical approaches such as feminist, Marxist, race, and queer theories (Harding, 1987; Ladson-Billings, 2000; Madison, 2005; Olesen, 2000) are united in their commitment to the disempowered. *Critical theorists* point to inequalities based on gender, race, social class, and sexual orientation as hidden (and not-so-hidden) subtexts of much of the knowledge produced by Western science. Left unchallenged, these inequalities are reinforced through power differentials that are virtually self-perpetuating.

By implication or by deliberate intent, postmodern critiques embraced qualitative methods as the “answer” to the flaws and reductionism of positivist research, and the constructivist and critical theory camps became aligned with the postmodern movement (although some individual members kept their distance). Their hortatory language and indictment of all things positivist set the stage for the rise of *pragmatism* (more about this in the following section).

This discussion of paradigmatic camps would be incomplete without a concluding observation: Paradigm debates are far more evident in books and articles *about* qualitative methods or *about* the dominance of Western science than in research reports *featuring* these methods. Put another way, situating one’s methodology within a certain epistemology is a choice that many researchers do not make (or at least do not make explicit). This has been a source of chagrin for paradigm purists but less a concern for paradigm pragmatists (whether self-declared or by default). Meanwhile, quantitative researchers have manifested little interest in joining the debates, perceiving little need to justify or question the dominant assumptions under which they operate.

The Pragmatic Middle Ground

It is possible to appreciate aspects of postmodernist critiques (especially those focused on the privileges of power) without endorsing the whole paradigmatic package. After all, doubts about quantification and traditional research designs have emerged from within the positivist camp (D. Campbell, 1979) as well as from without (Abbott, 1997).

Several qualitative researchers (H. Becker, 1996; Creswell, 2007; Patton, 2002; Tashakkori & Teddlie, 2010) have gone on record favoring pragmatic philosophy as a less ideological middle ground. A uniquely American phenomenon developed by John Dewey, Charles Peirce, and Jane Addams (among others), pragmatism in its nascent form was a reaction to metaphysical arguments on the nature of Truth and Reality (Cherryholmes, 1992; Menand, 2001; Rorty, 1998; West, 1989). Rather than take a stand on such philosophical conundrums, pragmatists accept the fallibility of knowledge development, elevating utility over ideology or philosophy. Thus, one can be comfortable with the notion that there are occasions when reality claims can and should be made (“genocide in Rwanda”), when a presumed reality practically cries out to be deconstructed (“deviant behavior”), and when multiple subjective meanings can produce a broader understanding of something (“post-traumatic suffering”). Put another way, all concepts are human inventions, but some are more socially contrived and consequential than others.

Anthropologist Nancy Scheper-Hughes (1996) argued in favor of a “strong scientific and moral imperative to get it right” (p. 891). Thus, “while reality is always more complex, contradictory and elusive than our limited theories and methods can possibly encompass, some things remain incontestably *‘factual’*” (p. 891). Scheper-Hughes goes on to discuss the need to boldly report acts of genocide and violence that beset many of the world’s poor and displaced.

Research Methods in Public Health: The Rise of (and Return to) Qualitative Approaches

The Place of Research in Public Health Education and Practice

Research in public health draws heavily upon its core discipline of epidemiology and the scientific method, but it was not always thus. Early studies were more likely to use “shoe leather epidemiology” and field

observation than large-scale surveys and surveillance efforts. A convergence of events in the 20th century produced what came to be the norm in public health research methods. First was the development of statistical analyses and operationalism, or measurement. When paired with experimental designs and large-scale surveys, the uses and benefits of quantification were readily apparent. Second, the emergence of lifesaving antibiotics, vaccines, and surgical procedures inspired confidence in randomized controlled trials as never before. Medical advances and space age technology lent credibility to science as having a seemingly infinite capacity to explore and explain. Finally, the growth of a public health infrastructure made record keeping on morbidity and mortality—the core data sources of biostatistics—routine governmental activities. The U.S. Centers for Disease Control and Prevention (CDC) began in 1942 to monitor malaria control and take over many of the activities previously carried out by the Rockefeller Foundation. At times overshadowing the effects of basic improvements in sanitation and nutrition, the medical model approach to inquiry, i.e., clinical trials and statistical analyses, came to dominate public health research. Recently, however, the pendulum has begun to swing back toward public health's origins in more naturalistic investigations (Faltermeier, 1997).

Box 1.1 Public Health Practice and Research: Making the Distinction

Public health entails practice and research—and the boundaries between the two are not always clear. In 1999, the CDC issued guidelines for distinguishing research from non-research in public health (www.cdc.gov). Acknowledging that the usual descriptors of “systematic” or “data collection and analysis” do not serve the purpose, the CDC guidelines point to intent as pivotal, i.e., the *intent* to generate or contribute to generalizable knowledge. Citing three public health activities—surveillance, emergency response, evaluation—the guidelines note that these may involve systematically collecting and analyzing data that at some point become generalizable. But these activities do not cross the threshold of being research unless they go beyond helping the patients or population being served.

To illustrate how difficult it is to make the distinction, look below at a recent list-serv ad for a public health internship with a “rapid program quality assessment”

(Continued)

(Continued)

conducted by a world relief organization working in Africa. The intern's responsibilities, spread over an 8- to 12-week period, include the following:

- Help develop training package for data collectors (1 week)
- Participate in data collection and field supervision (1–2 weeks on-site)
- Perform data entry and cleaning (1 week on-site)
- Carry out data analysis (2 weeks)
- Draft a report documenting assessment findings (1 week)

The intern would be expected to assess the knowledge and skills of community health workers (CHWs) as well as the quality of supervision of the CHWs by their affiliated health centers. Skills being sought include familiarity with software (e.g., STATA, MS Outlook, and Excel) and writing, editing, and researching skills.

Commentary: This description appears to be all about research. However, according to CDC guidelines, it is not because the findings are directed solely to improving services within the organization; i.e., they constitute public health practice. Note the short time frame involved. Such a quick turnaround presents a standing challenge to researchers' traditional need for sufficient time to mount a credible project and carry it through to completion. This is, however, common in public health programs, especially those carried out in developing countries.

The “New Epidemiology”: Multiple Causations and Multiple Methods

The turn to more flexible methods has run parallel to a paradigm shift in epidemiology that rejects “the myopic focus of biomedicine on micro-level causes of diseases in individuals (e.g., human genes, infectious agents)” (Inhorn & Whittle, 2001, p. 554). Critics charge that mainstream epidemiology and its associated methods ignore larger eco-social contexts (Krieger, 2001). If health problems are viewed as due to individual responsibility, then health solutions will be sought through changing unhealthy beliefs and behaviors. Larger structural inequalities—gender, race, socioeconomic—escape notice as lying outside the realm of existing etiological frameworks. The example of tobacco use illustrates this quite well. As noted by Baum (1996), establishing the link between smoking and lung cancer required traditional quasi-experimental designs well-known

to epidemiologists, but well beyond this important etiological breakthrough are the psychological, social, and cultural factors influencing the decision to smoke (or not). At the same time, individual decisions about smoking occur within larger influential contexts—it would be myopic to ignore the powerful effects of billion-dollar advertising campaigns by tobacco companies.

Also escaping notice in the rush to quantification were the sensitive, subjective, and biographical details of individual lives that lend a deeper and more nuanced understanding (Faltermeier, 1997). Standardized measures are weak approximations when it comes to capturing the suffering of a cancer patient, the thrill of smoking crack cocaine, or the deep trauma of rape. To ignore all things that cannot be measured is to leave public health bereft of aspects of the human experience underlying the onset and course of diseases, addictions, and traumas.

The limitations of quantitative methods are also apparent when a study is focused upon complex, dynamic, and changeable phenomena. Notwithstanding efforts to examine multilevel systems (Nastasi & Hitchcock, 2009; Trickett, 2009) using nested variables and hierarchical modeling (Raudenbush & Bryk, 2002), the vast majority of studies use individuals as units of analysis and cross-sectional or static designs. A constraint related to longitudinal studies arises from the inaccuracies of recall in retrospective designs and high rates of attrition in prospective designs. Finally, there are the challenges of statistically modeling repeated observations over time.

On balance, both quantitative and qualitative methods have something to offer. Surveys supply much-needed aggregate information on individuals, households, neighborhoods, organizations, and entire nations. Yet they fall short in assessing individuals as they live and work *within* their households, neighborhoods, organizations, and nations.

Box 1.2 **An Enduring Public Health Parable: The River Story**

A widely invoked parable of unknown origins but told well by Irving Zola (quoted by John McKinlay, 1986) is the “River Story.” The storyteller relates a harrowing tale of saving a drowning man in a rushing river and dragging him to shore, only to see a struggling woman in the water followed by others in

(Continued)

(Continued)

similar dire straits. Repeated dives into the cold river to save the growing number of victims leaves the storyteller exhausted with no time to go upstream to see why so many people are falling into the river in the first place. Or perhaps to see why so many are being pushed into the river? And what about those who managed to swim to safety on their own?

The lasting power of this metaphor for public health lies in its illustration of misplaced priorities and the need for primary prevention. The story illustrates the importance of structural (upstream) factors such as inequalities that place individuals in harm's way in the first place. Of course, one could counterargue that individuals imperil themselves through bad habits and unhealthy lifestyles; i.e., they recklessly venture into the river assuming it will not engulf them later downstream. Just discussing this parable and its possible iterations—along with the distinction between upstream and downstream—offers a valuable “teaching moment” in public health.

Proponents of the “new epidemiologies” were drawn from the ranks of community health and AIDS activists as well as feminists and others who pointed to the pernicious effects of “structural violence” (Castro & Farmer, 2005; Inhorn & Whittle, 2001; Leung, Yen, & Minkler, 2004). *Structural violence* refers to historical and socioeconomic forces that place certain individuals at greater risk of health and other problems and make them less likely to receive treatment. Their vulnerability may be due to racism, sexism, poverty, sexual orientation, or some combination of these. That social conditions such as poverty can be a “fundamental cause” of disease and premature mortality (Link & Phelan, 1995) is a direct refutation of etiologies dependent on individual culpability, whether genetic or behavioral.

Although this newer approach might seem to be neutral with regard to methods, this is far from the case. As noted by Inhorn and Whittle (2001),

the “opening” of epidemiology requires that epidemiologists join forces with anthropologists, sociologists, historians, and feminist scholars, who are not only more theoretically oriented but who also value alternate, qualitative forms of data (e.g., illness narratives, life histories, participant observations, structured observations of doctor–patient interactions, popular media accounts,

historical documents) that give context and meaning to epidemiologists' more quantitative analyses. (p. 558)

This alignment of critical perspectives, social science theories, and qualitative methods is an indication of shared values and resistance to the notion that clinical trials and statistics were all that was needed for the public health researcher's toolkit. As we will see in this book, qualitative researchers in public health and in general may or may not subscribe to critical perspectives. Indeed, the family of qualitative methods is diverse and its adherents are independent-minded when it comes to paradigm allegiance.

Evidence-Based Practice in Public Health: The Role of Qualitative Methods

Evidence-based practice (EBP) has become a powerful movement sweeping through health care (Ericsson, 2000). Rooted in biomedicine, EBP challenges the practicing professions to offer evidence-based interventions and abandon those found to be ineffective or harmful. Determinations of effectiveness are made using a hierarchy of evidence that places randomized controlled trials (RCTs) at the top. Public health has joined the EBP movement, as have many health professions (Waters & Doyle, 2002).

With the rise of EBP, meta-analyses and systematic reviews have gained favor as a means of synthesizing extant research. The Cochrane and Campbell Collaborations (the former dedicated to health and the latter to social welfare, education, and criminal justice) have generated numerous reports from such syntheses showing the effectiveness (or lack thereof) of interventions ranging from breast cancer screening to antipsychotic medications (see www.cochrane.org and www.campbellcollaboration.org).

Public health practitioners often work in settings where RCTs are difficult or impossible to carry out (Victora, Habicht, & Bryce, 2004; Waters & Doyle, 2002). Perhaps not surprisingly, many have joined other health professionals in questioning whether RCTs can provide definitive answers to "what works" given the complexities of health problems and their solutions (Victora et al., 2004). Overarching concerns about EBP center on the narrowness implied by scientific definitions of "evidence" and the methods deemed adequate for its determination. In particular, the devaluation of "indigenous ways of knowing" is considered a hindrance to working with communities to reduce health disparities (Cochran et al., 2008). From a

qualitative research standpoint, the elevation of experimental evidence from “gold standard” to “only standard” is worrisome because it leaves little or no room for the depth and flexibility of qualitative studies (Morse, 2006). Although proponents of EBP have expressed interest in accommodating qualitative methods, progress has been slow and understandably hobbled by the distinctive nature of qualitative studies.

The EBP movement clearly has its limitations, although its underlying premise is difficult to repudiate. Who, if anyone, would want to use a surgeon who ignores the latest research findings and prefers to rely solely on personal experience? In retrospect, empirical research on Bruno Bettelheim’s “cold mother” explanation for autism might have prevented the damage it caused to parents and families of autistic children.

At the same time, acceptance of what EBP has to offer need not lead to dismissing other forms of knowledge, including subjective meanings, cultural beliefs, and discursive revelations (Cochran et al, 2008). A step in the right direction has been taken by some leading quantitative researchers who have gone on record favoring qualitative methods as a “touchstone of reality” in community-based interventions (Hohmann & Shear, 2002, p. 205). The survival and relevance of the EBP movement depends on fostering appreciation for multiple methods.

Theoretical and Conceptual Frameworks in Qualitative Inquiry

Some Are a Better Fit Than Others

The relationship between qualitative research and theory is complex and subject to varied opinions (Anfara & Mertz, 2006). On the one hand, allowing one or more theories to drive the inquiry deprives a study of what qualitative methods do best—explore the unknown or find new ways of understanding what is known. On the other hand, qualitative studies do not take place in a conceptual vacuum.

It is helpful to distinguish among several versions of what is meant by “theory” in public health. This variety in meaning is due to differing degrees of explanatory ambition, conceptual abstraction, and openness to multiple interpretations. These differing meanings include (1) grand theories having a sweeping scope and high level of abstraction (e.g., Freudian

or Marxist theory); (2) mid-range theories used in research on behavioral and organizational change (e.g., Bandura's social learning theory or Rogers' diffusion of innovation theory); (3) conceptual frameworks that offer organizing principles and evocative concepts, without being strongly predictive (e.g., the health belief model and the Andersen and Newman model of service utilization); (4) critical theories (feminist, race, queer, etc.) that address societal inequalities; (5) theories that operate as an "open system" and are not deterministic (e.g., Blumer's symbolic interaction theory or Bronfenbrenner's social ecology theory); and (6) inductively derived mid-range theories that have been the foundation of grounded theory methodology (Glaser & Strauss, 1967).

Perhaps not surprisingly, versions 1, 2, and 3 are least suited for qualitative studies to the extent that they are determining rather than orienting in their intent and use. Psychological and biomedical theories present a distinct challenge because they are focused on identifying and solving specific problems of an intrapsychic or physical nature. As mentioned earlier, critical theories (version 4) have been adopted by many qualitative researchers but are less about methodology than ideology. In contrast, versions 5 and 6 are a closer fit for qualitative research given their openness to inductive reasoning. Version 6 is only possible with qualitative research.

Concepts do not have to be enmeshed in theoretical frameworks to be useful, e.g., *stigma*, *identity*, and *social support*. There are few concepts more widely used (and misunderstood) in public health parlance than *social capital*. Popularized by Putnam in his book "Bowling Alone" (2000), social capital has been put forth as a multidimensional concept representing the tangible benefits of social relationships. The notion that social capital is central to explaining variation in health and mental health has been both embraced and decried, but its staying power is undeniable (Szreter & Woolcock, 2004).

As Barney Glaser (2002) aptly noted, such staying power and the capacity for representation and evocation make a concept transcend localized description. Morse (2004) goes further to note that concepts fulfill a number of vital functions, enabling the researcher to engage in pattern recognition, synthesis, constant comparison, and generalization. Ultimately, concepts comprise theories, fitting together like the pieces of a jigsaw puzzle (Morse, 2004). Their contribution to a qualitative study is never guaranteed, but without conceptual frameworks coming before (and most importantly, from) data analysis, the study's contribution is severely diminished.

Theoretical Thinking in Public Health Research: The Role of the Social and Behavioral Sciences

Though traditionally closely allied with medicine, public health has increasingly drawn on the social and behavioral sciences to understand complex public health problems (Willis et al., 2007). Leading theoretical frameworks from these disciplines—critical theories, ecological theories, behavioral theories, organizational theories—have found their way into public health research and served as a bridge between the conceptual worlds of health and psychosocial concerns (Willis et al., 2007). For example, psychological theories have shaped behavioral health interventions targeting tobacco use, substance abuse, and obesity.

Attention to psychological, social, and cultural factors offers a far more comprehensive (and complicated) portrait of public health problems beyond the basic mechanisms of biology. The AIDS epidemic in the 1980s opened the door to recognizing *syndemics*, or co-occurring health problems rooted in larger structural forces (Singer & Clair, 2003). Support for the notion of a syndemic comes from convergent evidence showing that health problems are more heavily concentrated among the poor and marginalized, whether due to biological diseases, toxic environments, violent injuries, mental illness, or substance abuse. In this context, attributions of “risky lifestyles” (unsafe sex, substance abuse, overeating, etc.) are contextualized as involving more than individual choice. Qualitative methods have been central to these multifactorial conceptions of public health problems.

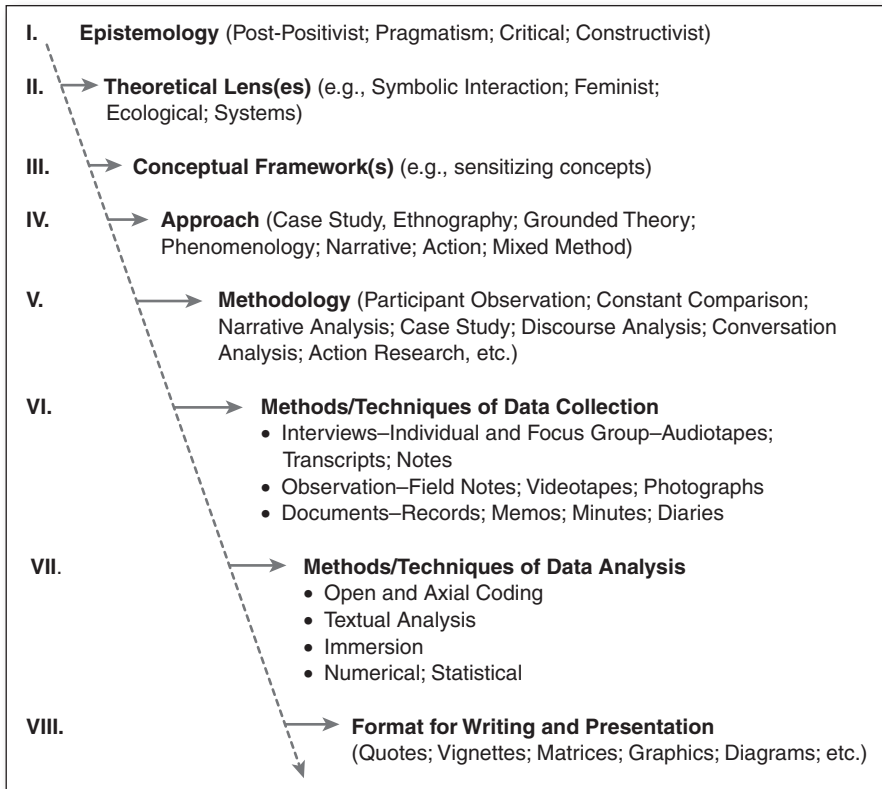
The Place and Timing of Theories in Qualitative Studies

In further contemplating the role of theories in qualitative studies, a few questions arise:

- What (if any) theoretical ideas and concepts are to be used?
- When do they inform the study?
- How are they incorporated into the study?

Answering these questions can depend on the study’s epistemological foundation as well as its approach and methodology. Figure 1.1 depicts this flow from the abstract to the concrete, with examples given for each phase indicated by Roman numerals. It is fair to say that many qualitative studies start at Phase IV and bypass the earlier three phases altogether.

Figure 1.1 The Foundations and Processes of a Qualitative Study



The “what” question builds on this discussion with the additional point that qualitative researchers may simultaneously draw on several theoretical frameworks and concepts as “lenses” through which the study’s data and ideas are refracted. This is a good reason for adopting a multidisciplinary perspective because an openness to ideas from a variety of sources lends freshness and creativity to a qualitative study. However, it also entails making decisions and taking risks.

How might this work? A study of family caregivers of Alzheimer’s patients might draw on concepts from social exchange theory (such as reciprocity), from the research literature (such as coping, burden, and stigma), and from the researcher’s own orientation (such as resilience). These

represent a place to start but hopefully not to finish, their survival dependent on whether they earn their way into the findings (Charmaz, 2006). The study's potential is fully realized when its findings invite the reader to understand caregiving in a deeper, more nuanced, and even surprising way.

The "when" question about theories refers to timing (i.e., whether theories influence the study from the beginning or are held in abeyance until the data analysis and interpretation phase). The latter approach is often used in phenomenological research, which favors immersion and fresh insights. Most qualitative approaches, however, involve some theoretical ideas and concepts early on in the process; these ideas and concepts may remain during the analyses and some new ones may be incorporated as well. In a sense, Phase II in Figure 1.1 can be seen as cascading down over subsequent phases, although it should never lay a heavy hand or crowd out serendipitous and inductive findings.

The "how" question is the most challenging (and least discussed) question pertaining to the role of theory in qualitative research. As a rule, theories are imported but not necessarily incorporated into qualitative studies (i.e., they are held lightly and discarded easily). In the early stages of a study, theories provide leads and directions in formulating study questions. There are few guidelines to follow; each researcher must decide how much (or how little) to do this.

The importation of theoretical ideas becomes more complicated in the data analysis stage because by this time, emergent ideas begin to support or supplant previous concepts and ideas. Qualitative researchers are obliged to be careful when making the "how" decision (i.e., going where the data lead rather than following their own personal predilections).

Reasons for Doing Qualitative Research

What kinds of research interests are best suited for qualitative research? There are several scenarios possible. These are not mutually exclusive, nor are they exhaustive, but they do provide some of the more common arguments for using qualitative methods.

1. You are exploring a topic about which little is known—especially from the "inside" perspective. This approach is the hallmark of qualitative methods.

There are many fascinating research topics (e.g., risky sex among men “on the down low” who proclaim themselves heterosexual, women who are impregnated by rape and decide to keep the child, parents who adopt disabled children from developing countries, family members who participate in assisted suicide). Such topics need not be pristinely untouched. What is important is that too little is known about them and an in-depth understanding is sought.

2. You are pursuing a topic of sensitivity and emotional depth. Public health professionals routinely encounter human crises and dilemmas that require empathy and understanding. These professional experiences provide a wellspring of ideas for research where the use of a standardized, numerical rating would be inappropriate or insensitive (Morse, 2010).

For researchers interested in behaviors considered taboo or stigmatized, qualitative methods may be the only plausible approach. Ethnographic studies of heroin dealers, gang members, and sex workers portray the lives of individuals who are not likely to cooperate with the usual forms of survey research. Moreover, studies of sensitive topics need not be confined to the fringes of polite society—one can “study up” as well as “study down” (e.g., community leaders after a natural disaster, or doctors who abuse prescription drugs). Of course, members of an elite population are often the hardest to study, capable of using their power to limit access in ways that the poor cannot (Hertz & Imber, 1995).

3. You wish to capture the “lived experience” from the perspectives of those who live it and create meaning from it. When researchers seek *verstehen* (deep understanding), they pursue studies that are *emic* (i.e., focused on the insider point of view, rather than *etic* [the outsider’s perspective]). Examples include studies of the lives of older homeless women, the experiences of chronic pain patients, or the dangers surrounding military nurses working in a war zone

4. You wish to get inside the “black box” of practice, programs, and interventions. Perhaps not surprisingly given the push for accountability in health care services, program evaluations have become heavily focused on quantitative outcomes. Yet qualitative methods have a secure place in evaluation research (Padgett, 2009b). They are a natural fit with formative evaluation given their capacity to identify unforeseen effects of a new program that may hamper (or pave the way to) its implementation. Likewise,

qualitative methods in process evaluation shed light on how (not whether) a program succeeds or fails.

So much of professional practice plays out in messy, unbounded ways that do not lend themselves to preformed standardized measurement. The deeply communicative aspects of practitioner–client relationships are fertile ground for narrative analysis, the daily hubbub of an emergency room practically cries out for ethnographic observation (C. Hall & White, 2005), and the successful pairing of program theory and staffing can set the stage for a case study of best practices. Qualitative studies do not yield “hard” outcomes, but their naturalism and agility can produce a description that emerges organically from the practice setting.

5. You are a quantitative researcher who has reached an impasse in explaining or understanding. It is striking how often unanswered questions emerge during quantitative studies that call for qualitative research. My earlier quantitative research on ethnic differences in mental health services help-seeking frequently led me to fall back on a “cultural” explanation calling for more in-depth examinations of how members of ethnic groups perceive mental illness and the service delivery system (Padgett, Patrick, Burns, & Schlesinger, 1994). The insurance claims database we accessed was of no use for such a purpose.

6. You are seeking to merge advocacy with research. *Action* and *participatory research* are devoted to countering the effects of oppression and social injustice (Fals-Borda & Rahman, 1991; Freire, 1973; Reason & Bradbury, 2007); the recent popularity of community-based participatory research (CBPR) in public health is an example of the continued relevance of activist approaches dating to the 1970s (Leung et al., 2004). Although the nature of the researcher–community partnership varies considerably, an overall goal is to use research methods on behalf of social change. Both qualitative and quantitative methods can be used, but the central premises of action research are closely aligned to the relationships common to qualitative research.

In summary, there are many sound reasons to do qualitative research—some or all of the aforementioned scenarios may underlie a particular study. There are also reasons *not* to pursue qualitative research. Foremost among these is that the topic of interest may be better served by quantitative designs such as experiments or surveys. Second, anyone seeking

qualitative methods as “the easy way” should be forewarned—the intensive labor and immersion required are reason enough to think twice.

Desirable Qualities and Skills in the Qualitative Researcher-as-Instrument

The qualitative researcher’s unique position as the instrument of data collection imposes special burdens as well as opportunities.

Indeed, a qualitative study’s success depends heavily on the researcher’s personal qualities as well as intellectual capacity. The absence of structure allows wide latitude—to reach creative heights as well as the depths of intellectual paralysis or disturbing biases. A few qualities that an individual can have or cultivate make the conduct of qualitative research more successful. These include flexibility; self-reflection (reflexivity); and an ability to multitask in an iterative, nonlinear way.

Flexibility is a state of mind and of behavior (Ely, Anzul, Friedman, Garner, & Steinmetz, 1991) well-suited to the unpredictable, ever-changing landscape of naturalistic inquiry. Respondents may suddenly refuse to cooperate with an interview, put off being interviewed, or not show up at all. They may divulge shocking information, make sexual overtures, or suddenly turn the questioning around to put the interviewer on the spot. Data analysis may (and often does) lead to new directions and new study participants. One’s favorite ideas or theories may not be borne out and, as a result, may have to be cast aside. The strength and success of qualitative research lie in the researcher’s ability to go with the flow rather than always try to control it.

Reflexivity, the ability to critically examine one’s self, is a central preoccupation in qualitative research. As noted by Michael Agar (1980), “the problem is not whether the ethnographer is biased; the problem is what kinds of biases exist and how can their operation be documented” (p. 42). Examining one’s biases requires ongoing vigilance throughout the course of the study.

Finally, a qualitative study is guaranteed to produce vast amounts of raw data awaiting management and analysis from its earliest stages. The *ability to multitask* on a number of levels (i.e., to simultaneously collect and analyze data, keep track of what is happening via memos, and remain open to new insights and the bigger picture) must be present and constantly nurtured in the researcher-as-instrument.

In addition to personal capabilities, certain skills are essential to the qualitative research enterprise. Among these are the skills of observation and interpersonal communication. Both of these are common elements of a practitioner's training, but their application in qualitative research follows a different track. When teaching qualitative methods to public health students, I ask them to carry out an exercise in participant observation. They must go to the public place of their choice (a park, subway station, street fair, playground, etc.), observe the action for one hour, and write up field notes describing what they have seen. What a departure this is for them! Trained to focus on problem resolution, they must be passive observers and not intervene. The open-ended nature of qualitative observation can be awkward and even painful for individuals who are more comfortable with the "filters" of clinical training and the authority to guide what happens.

The interpersonal skills of empathy and sensitivity, important in public health practice, are put to somewhat different ends in qualitative research. Rather than foster engagement for treatment or health promotion purposes, these skills enable listening as part of the pursuit of knowledge and understanding. This requires a degree of humility and subordination of self that takes some getting used to.

Finally, two of the most essential skills needed in qualitative research are the interrelated abilities to think conceptually and write well. The need to think abstractly and create new perspectives is the sine qua non of qualitative methods. Termed *theoretical sensitivity* by Glaser (1978), this refers to the ability to give interpretive meaning to data, to separate the wheat from the chaff.

Formulating ideas and developing concepts and theories depend on the ability to write. Experienced qualitative researchers often remark that the act of writing (i.e., recording memos and writing up preliminary ideas) is central to the success of a study. A well-developed sense of humor helps enormously in qualitative research, particularly the ability to laugh at oneself. One's vulnerability and inexperience when entering the field almost guarantee that there will be mistakes; some of them will be funny in the eyes of others. (Anthropologists invariably have stories of abject humiliation and jokes made at their expense.)

Finally, there is the capacity for collaboration. With the exception of doctoral dissertations, the days of the lone investigator are fading fast. Although individuals can and still do carry out qualitative studies with

little outside assistance, the scope and sophistication of research make teamwork and collaboration increasingly the norm. Interdisciplinary participation is especially welcome in a qualitative study in which the richness of insight is enhanced by differing perspectives.

Introducing the New York Services Study (NYSS): A Qualitative Study of Homeless Mentally Ill Adults in New York City

Being fortunate enough to receive a 4-year, all-qualitative grant from the National Institute of Mental Health (NIMH) in 2004 was, for me, the culmination of long-standing personal and professional interests. A postdoctoral-funded professional retooling at Columbia University's School of Public Health in the mid-1980s provided training in quantitative methods and opportunities to collaborate with senior researchers analyzing data from a survey of New York City's homeless shelters at the height of the homelessness crisis. Serendipitously, a fellow researcher, psychologist Sam Tsemberis, decided to return to clinical work and conduct homeless outreach for a public hospital in New York City. This position ultimately led Dr. Tsemberis to start the first-ever "Housing First" program for the homeless mentally ill in 1992.

This new program, Pathways to Housing, Inc., became part of a federally funded randomized trial that compared the Pathways model to the dominant "continuum" approach (in which the homeless mentally ill must become clean and sober and live in congregate care with accompanying rules and requirements). The New York Housing Study examined housing stability and other quantitative outcomes across the comparison groups from 1997 to 2001. As it happened, few meaningful group differences were found at the study's end beyond that of greater housing stability for the Pathways subjects. This raised questions about the impact of Housing First, but also about whether the quantitative measures were capturing what was really happening. (Anecdotal reports by the study's interviewers and interviewees pointed to greater dissatisfaction and life problems among the control group participants who remained either in congregate care or on the streets.)

Intrigued by this discrepancy, I drew on my previous quantitative research on homelessness and my self-proclaimed expertise in qualitative

methodology to prepare an all-qualitative R01 grant proposal for submission to the National Institute of Mental Health. Success in obtaining funding took a revised submission that ultimately garnered positive reviews.

The New York Services Study (NYSS) began in September 2004 with staff consisting of a full-time project director, three interviewers, and two part-time transcribers. The NYSS had three specific aims that revolved around identifying what worked and did not work in the service delivery system intended for homeless persons with serious mental illness and co-occurring substance abuse. Specific examples from the NYSS will be used throughout this book to illustrate various facets of a qualitative study.

Summary and Concluding Thoughts

Beginning with a rich historic background synonymous with ethnography (and, later, grounded theory), qualitative methods grew ever more diverse and multidisciplinary. Beginning in the 1970s, the various non-quantitative methods that became known collectively as “qualitative” came into full flower—with phenomenological and narrative approaches joining ethnography, grounded theory, and case studies. Soon thereafter, mixed (quantitative-qualitative) methods brought the possibility of synergy and multiple perspectives.

As with other professions, public health has becoming more open to and appreciative of qualitative and mixed methods. Coinciding with this change has been a “paradigm shift” that has transformed public health as it has become more attuned to global problems and the social, economic, and cultural dimensions to these problems. This more expansive vision of health and well-being, coupled with a concern for “ground up” perspectives, opens the way to more broadly conceived and inclusive approaches to public health research. There is a parallel here. Just as qualitative methods have their roots in (and derive nourishment from) the social sciences, public health has witnessed a resurgence of social science influence. The methodological balance still tilts heavily toward quantitative methods (in the social sciences as well as in public health), but there is increasing attention to more naturalistic field methods attuned to the myriad ways that health problems are manifested and ameliorated.

This chapter introduced key topics that cut across the landscape of qualitative inquiry, including the role of theories and concepts, reasons for using qualitative methods in public health, and capabilities and skills that enhance

one's ability to succeed as a qualitative researcher. Addressing each of these orients the reader to the complex and discretionary aspects of qualitative methods—all of which will be in evidence in the chapters to come.

EXERCISES

In the classroom, break into small work groups. (This can also be done individually.) Choose a research topic of interest in public health and discuss the following:

1. The various epistemological positions or “camps” described in this chapter. How might your topic be framed in terms of these paradigms (post-positivist, constructivist, critical)?
2. What advantages do qualitative methods bring to the study? (Hint: Refer to the reasons for doing qualitative research in this chapter.)
3. What theories or concepts discussed in this chapter might be applicable to the topic?
4. What qualities and skills do members of the group possess that will help them engage in a qualitative study?

Additional Readings

- Becker, H. (1998). *Tricks of the trade: How to think about your research while you're doing it*. Chicago: University of Chicago Press.
- Bodgan, R., & Taylor, S. J. (1998). *Introduction to qualitative research methods* (3rd ed.). New York: Wiley.
- Bourgeault, I., Dingwall, R., & de Vries, R. (Eds.). (2010). *The SAGE handbook of qualitative methods in health research*. Thousand Oaks, CA: Sage.
- Corbin, J., & Strauss, A. L. (2008). *Basics of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Crabtree, B. F., & Miller, W. L. (1999). *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2007). *Qualitative inquiry and research design* (2nd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W., & Plano Clark, V. (2010). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: Sage.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The SAGE handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

- Emerson, R. (2001). *Contemporary field research: Perspectives and formulations*. Long Grove, IL: Waveland Press.
- Flick, U., & Salomon, A. (2010). *An introduction to qualitative research* (4th ed.). London: Sage.
- Flick, U., von Kardorff, E., & Steinke, I. (Eds.). (2004). *A companion to qualitative research*. London: Sage.
- Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. Thousand Oaks, CA: Sage.
- Hesse-Biber, S., & Leavy, P. (2010). *The practice of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.
- Huberman, A. M., & Miles, M. B. (Eds.). (2002). *The qualitative researcher's companion*. Thousand Oaks, CA: Sage.
- Israel, B. A., Eng, E., Schulz, A., & Parker, E. A. (Eds.). (2005). *Methods in community-based participatory research for health*. San Francisco: Jossey-Bass.
- Liamputtong, P., & Izzy, D. (2005). *Qualitative research methods* (2nd ed.). London: Oxford University Press.
- Mack, N., Woodson, C., McQueen, K. M., Guest, G., & Namey, E. (2005). *Qualitative research methods: A data collector's field guide*. Research Triangle Park, NC: Family Health International. Available at http://www.fhi.org/en/rh/pubs/booksreports/qrm_datacoll.htm
- Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Thousand Oaks, CA: Sage.
- Merriam, S. (2002). *Qualitative research in practice: Examples for discussion and analysis*. New York: Wiley.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.
- Minkler, M., & Wallerstein, N. (2008). *Community-based participatory research for health: From process to outcomes* (2nd ed.). San Francisco: Jossey-Bass.
- Morse, J. M. (Ed.). (1994). *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage.
- Padgett, D. K. (Ed.). (2004). *The qualitative research experience*. Belmont, CA: Thomson.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Rossman, G. B., & Rallis, S. F. (2003). *Learning in the field* (2nd ed.). Thousand Oaks, CA: Sage.
- Schwandt, T. (2007). *The SAGE dictionary of qualitative inquiry*. Thousand Oaks, CA: Sage.
- Seale, C., Gobo, G., Gubrium, J. F., & Silverman, D. (Eds.). (2004). *Qualitative research practice*. London: Sage.
- Silverman, D. (2010). *Doing qualitative research* (3rd ed.). London: Sage.
- Stringer, E. T. (2007). *Action research* (3rd ed.). Thousand Oaks, CA: Sage.

- Tashakkori, A., & Teddlie, C. B. (Eds.). (2010). *SAGE handbook of mixed methods in social and behavioral research* (2nd ed.). Thousand Oaks, CA: Sage.
- Tolman, D. L., & Brydon-Miller, M. (Eds.). (2001). *From subjects to subjectivities: A handbook of interpretive and participatory methods*. New York: New York University Press.
- Ulin, P., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco: Jossey-Bass.

A Selection of Journals That Feature Qualitative and Mixed Methods Studies

Action Research

American Anthropologist

American Journal of Community Psychology

American Journal of Health Promotion

American Journal of Public Health

Australian Journal of Primary Health

Australian and New Zealand Journal of Public Health

Canadian Journal of Public Health

Children, Youth and Environment

Community Mental Health Journal

Culture, Medicine & Psychiatry

Ethnicity & Disease

Ethnicity & Health

Families & Society

Family and Community Health

Field Methods

Forum: Qualitative Social Research (FQSR)

Gateways: International Journal of Community Research and Engagement

Health and Place

Health Education & Behavior

Health Promotion Practice

Health & Social Care in the Community
Human Organization
International Journal of Qualitative Methods
International Journal of Urban Health
Journal of Community Health
Journal of Community Psychology
Journal of Contemporary Ethnography
Journal of Empirical Research on Human Research Ethics
Journal of Health Disparities Research and Practice
Journal of Health and Social Behavior
Journal of Healthcare for Poor and Underserved
Journal of Human Rights Practice
Journal of Mixed Methods Research
Journal of Phenomenological Psychology
Journal of Prevention Practice & Research
Journal of Race, Gender & Class
Journal of the Society for Social Work and Research
Journal of Urban Health
Michigan Journal for Community Service Learning
Progress in Community Health Partnerships
Qualitative Health Research
Qualitative Inquiry
Qualitative Research
Qualitative Social Work
Qualitative Sociology
Social Science & Medicine
Sociological Spectrum
The Qualitative Report

Websites and Other Resources

<http://www.nsf.gov/pubs/2004/nsf04219/start.htm> (excellent proceedings from workshop on qualitative methods at the National Science Foundation)

<http://www.uofaweb.ualberta.ca/iiqm/Conferences.cfm> (comprehensive site from the University of Alberta in Canada, which sponsors an international qualitative methods conference annually)

<http://obssr.od.nih.gov/pdf/Qualitative.PDF> (free downloadable guide to submitting qualitative proposals to the National Institutes of Health)

<http://www.scolari.com> (information and downloadable software demos for ATLAS.ti, Nud*ist, The Ethnograph, etc.)

<http://www.nova.edu/ssss/QR> (online journal *The Qualitative Report*)

<http://www.nova.edu/ssss/QR/web.html> (comprehensive list of web resources for qualitative researchers)

<http://www.quarc.de> (German–English online resource)

<http://qualitative-research.net> (German–English–Spanish site with online journal)

<http://www.coe.uga.edu/quig> (multidisciplinary interest group at the University of Georgia—sponsors national research meeting annually)

<http://ejournals.library.ualberta.ca/index.php/IJQM/index> (*International Journal of Qualitative Methods*)

<http://www.phs.utoronto.ca/qualmethod/> (Centre for Critical Qualitative Health Research at the University of Toronto School of Public Health)