# Secondary analysis of qualitative data

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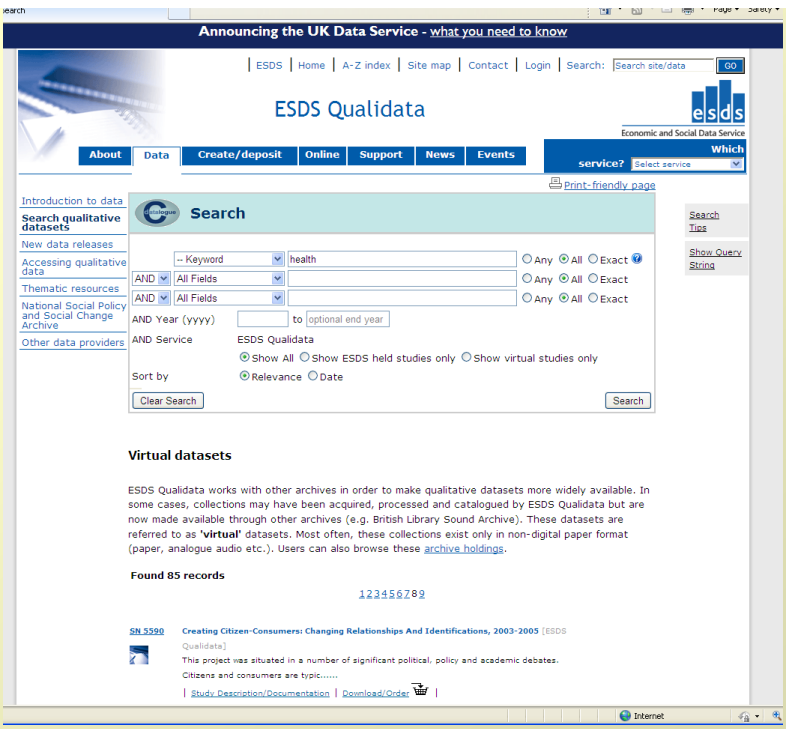


***UK Qualidata***

**http://www.esds.ac.uk/qualidata/**

## Qualidata Resources (health)

To begin with there are a number of data collections already preserved by ESDS Qualidata. Taking a few examples yields the following diverse fields of enquiry:

Mothers and Daughters : Accounts of Health in the Grandmother Generation, 1945-1978, Blaxter, M.

The research looked at **beliefs and attitudes** to health and medical care, inter-generational relationships, and social history of members of a grandmother generation. While the original study included in depth **interviews** with daughters as well this collection contains only the grandmother **interviews**. Grandmothers were asked extensive questions about their own health and the health of other family members. Details are provided on episodes of illness and remedies used, both home and health services. Specific topics of accidents, nutrition, dental care, and immunisation are covered.

Mental Health of Chinese Women in Britain, 1945-2000, Green, G.

The aim of this exploratory study of the mental health of Chinese women in Britain was to identify issues of cultural difference between the Chinese community and the health system in contemporary Britain, which may have resulted in an under-estimation of their mental health problems. Chinese women living in Essex and East London were **interviewed** to examine competing explanations for Chinese women's under-representation as users of primary and secondary mental health services, cultural specificities in the expression of mental distress, stigma, the use of traditional Chinese medicine and of informal support networks.

Girls' and Boys' Body Image Concerns, Lloyd, B. and Dittmar, H.

The main aim of this project was to broaden and deepen understanding of adolescent boys' and girls' body image concerns, in order to provide an appropriate basis for interventions to promote healthier diet and lifestyle. The project combined quantitative and qualitative methods. Adolescents talked about their feelings concerning body parts, fatness, physical attractiveness, media and peer influences, and strategies for achieving the 'ideal body', in both **focus group discussions** and individual **interviews**.

Understanding Health Variations and Policy Variations, Exworthy, M. and Powell, M.

The aims of this study were to undertake an empirical analysis of the policy process in the NHS and examine how policy towards health inequalities is formulated and implemented. Other issues covered included the way national policy towards health inequalities are translated 'vertically' into local policy, why local policy towards health inequalities differs 'horizontally' between and within health authorities, how initiatives to tackle health inequalities are evaluated at local level, and whether examples of 'good practice' can be detected so as to inform evidence-based policy making.

Indirect Harm and Positive Consequences Associated with Cannabis Use, 2001-2003, Terry, P., Cochrane, R., Wright, K.

This research used a mixed methods strategy to characterise patterns and consequences of cannabis use specifically in relation to work activities, academic performance, driving habits and sexual behaviour. Regular users of cannabis and infrequent users were **interviewed** about patterns of use and the effects of cannabis use on various aspects of their life. The project also aimed to evaluate the impacts of cannabis use on quality of life, and to examine whether developments in detection/law enforcement (e.g. workplace drug testing) would influence patterns of use.

An Investigation into the Social Construction and Consequences of the Label Epilepsy, West, P.

This project aimed to treat the meaning of epilepsy as a central research issue and thus examine the source and manner by which the meanings of epilepsy were constructed. The principal objectives were to understand the kind of information about epilepsy available to parents, how such knowledge shaped parents expectations about their own child, the variety of 'responses' to the child displayed by others and the nature of parents interpretations about the child's identity.

Doctors and Nurses: Allies or Adversaries?, Soothill, K. and Mackay, L.

This research project examined the professional working relationship between doctors and nurses in a hospital setting. The **interviews** explored the attitudes, opinions and conceptions held by each group about the other. **Interviews** were undertaken with both senior and junior staff and involved several hospitals throughout the United Kingdom.

# Advantages of secondary analysis

**Saves time and money**

original data collection is expensive and time-consuming.

**Large data sets**

can be assembled from several smaller ones.

compare across data sets and settings and over time, new research questions

**Find new things**

"as with all archived material, sometimes the most striking discoveries come from re-examining material which hitherto has not been thought worth researchers' attention." (Corti and Thompson, 2004: p.328)

**Apply new methods**

"new methods employed which may not have been possible at the time of the original data analysis. Sometimes new analytical tools can spotlight sections of data that were previously ignored." (Corti and Thompson, 2004: p.332)

**Avoid overburdening participants**

"Secondary analysis can protect the sensitivities of subjects and gatekeepers by ensuring they are not over-researched." (Fielding and Fielding, 2000: 678).

**Less waste**

"The current system is terribly wasteful of data in that huge amounts are collected (way more than a researcher or research team could ever analyse in their lifetime) but then destroyed" (Anon feedback)

## Objections to secondary analysis

**Qualitative data is personal**

[field notes are] … the anthropologist's most sacred possession. They are personal property, part of a world of private memories and experiences, failures and successes, insecurities and indecisions […] To allow a colleague to examine them would be to open a Pandora's box. (Bond, 1990: 275)

**Only the original researcher can interpret the context**

There is a difference between how ethnographers read the fieldnotes they have produced themselves and how someone else will read them. The fieldworker interprets them against the background of all that he or she tacitly knows about the setting as a result of first-hand experience, a background that may not be available to those without that experience … The data collected by different researchers will be structured by varying purposes and conceptions of what is relevant. As a result, users of archives are likely to find that some of the data or information required for their purpose is not available. (Hammersley, 1997: 139)

**Only the original researcher knows what is going on**

I remember as I was doing it and watching this thing unfolding before me, I remember thinking no [other] researcher would actually understand what's going on here right now because I could just intuitively read what they were saying with their body language, but if you weren't there, it wouldn't be there… if I put that in an archive no one would have understood what was happening. (Broom et al 2009)

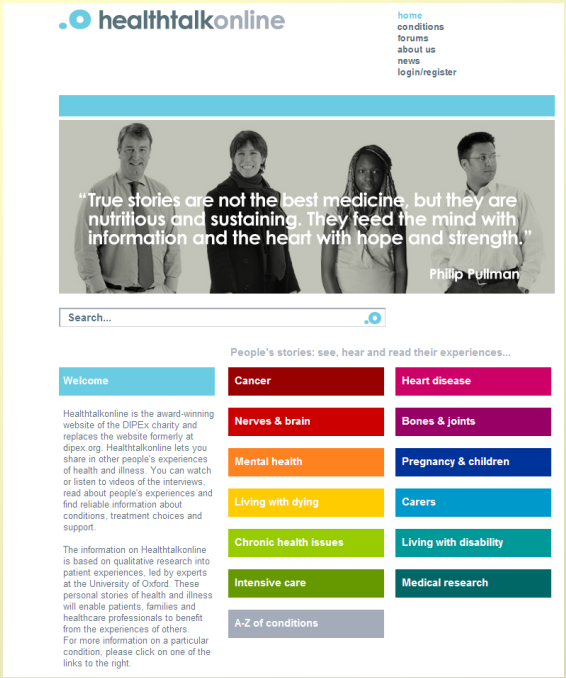
**The research questions of the secondary analyst may not be supported by the available datasets.**

### Counter-arguments

If analysis depends on the researcher's intuition / tacit knowledge about what is going on, how can the researcher's analytic judgement be scrutinised?

Not everyone wants to analyse 'qualitative' data using the same methods as the person who collected them

Adapt your research questions to the data set. After all, that's what happens in an exploratory qualitative project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home
conditions
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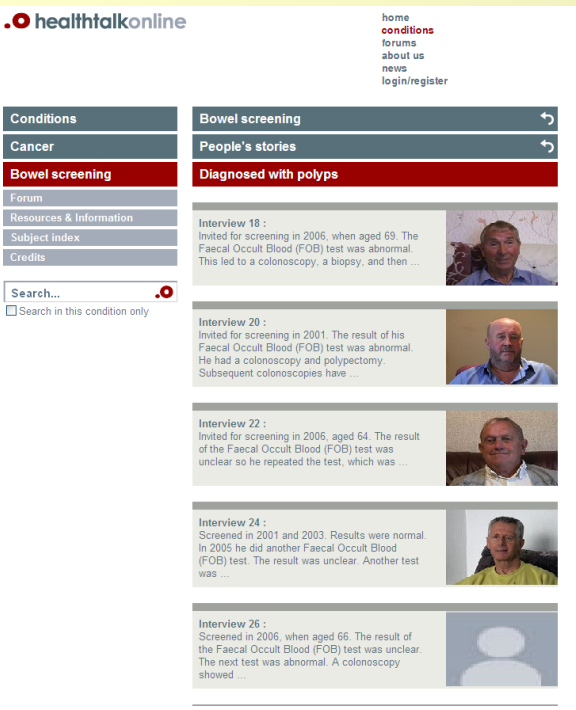
about us
news
login/register
"True stories are not the best medicine, but they are nutritious and sustaining. They feed the mind with information and the heart with hope and strength."
Philip Pullman
Search...
People's stories: see, hear and read their experiences...
Welcome
Healthtalkonline is the award-winning website of the DIPEx charity and replaces the website formerly at dipex.org. Healthtalkonline lets you share in other people's experiences of health and illness. You can watch or listen to videos of the interviews, read about people's experiences and find reliable information about conditions, treatment choices and support.
The information on Healthtalkonline is based on qualitative research into patient experiences, led by experts at the University of Oxford. These personal stories of health and illness will enable patients, families and healthcare professionals to benefit from the experiences of others. For more information on a particular condition, please click on one of the links to the right.
Cancer
Heart disease
Nerves & brain
Bones & joints
Mental health
Pregnancy & children
Living with dying
Carers
Chronic health issues
Living with disability
Intensive care
Medical research
A-Z of conditions


healthtalkonline
home
conditions
forums
about us
news
login/register
Conditions
Cancer
Bowel screening
Forum
Resources & Information
Subject index
Credits
Search...
Search in this condition only
Bowel screening
People's stories
Diagnosed with polyps
Interview 18 :
Invited for screening in 2006, when aged 69. The Faecal Occult Blood (FOB) test was abnormal. This led to a colonoscopy, a biopsy, and then ...
Interview 20 :
Invited for screening in 2001. The result of his Faecal Occult Blood (FOB) test was abnormal. He had a colonoscopy and polypectomy. Subsequent colonoscopies have ...
Interview 22 :
Invited for screening in 2006, aged 64. The result of the Faecal Occult Blood (FOB) test was unclear so he repeated the test, which was ...
Interview 24 :
Screened in 2001 and 2003. Results were normal. In 2005 he did another Faecal Occult Blood (FOB) test. The result was unclear. Another test was ...
Interview 26 :
Screened in 2006, when aged 66. The result of the Faecal Occult Blood (FOB) test was unclear. The next test was abnormal. A colonoscopy showed ...


**Secondary analysis of HealthTalkOnline transcripts**

1,035 transcribed qualitative interviews

A variety of illness conditions / health issues.

Age, gender and (often) occupation recorded

A subsample of 102 interviews so that the gender differences in language usage across **three different age groups** could be assessed without being confounded by the type of illness being discussed (Seale and Charteris-Black 2008a).

Similarly, 96 interviews were selected to form **four subgroups of higher and lower socio-economic men and women respectively,** keeping constant and therefore controlling for the influence of type of illness and age of respondent (Seale and Charteris-Black 2008b).

**Seale, C. and Charteris-Black, J. (2008) The interaction of class and gender in illness narratives *Sociology* 42(3): 453-469**

96 interviews in 4 groups of 24, divided by gender and Socio Economic Category (SEC) to form 4 matched samples / comparison groups

1. High SEC men
2. Low SEC men
3. High SEC women
4. Low SEC women

Each group of 24 contained interviews with people speaking about their:

chronic pain (2 interviews in each group of 24)
colorectal cancer (2)
depression (4)
termination of pregnancy (1)
epilepsy (2)
heart attack (1)
heart failure (3)
receiving intensive care (2)
lung cancer (4)
terminal illness (2)
teenage cancer (1)

Total: 933,400 words

Analysis: quantitative and qualitative

***Feelings (words per 10,000)***

| | Men | | Women | | Overall gender compared$ p< |
|---|---|---|---|---|---|
| | High | Low | High | Low | |
| I feel/felt/feeling& | 17.7 | 16.2 | 18.7 | 17.6 | n.s. |
| cry/ upset / miserable traumatic | 4.7 | 4.0 | 5.2 | 6.2 | **0.01** |
| scare/shock/fright/fear | 5.1 | 5.0 | **9.3*** ** | 5.2 | **0.0001** |
| emotion | **2.4**** | 1.0 | 1.0 | 1.7 | n.s. |
| depressed/depression/ depressive | 12.3 | 10.3 | **8.6*** ** | 5.3 | ***0.0001*** |
| shit/fuck/bloody | **2.1*** ** | 0.4 | 0.3 | 0.2 | ***0.0001*** |
| angry/annoyed/frustrated disappointed | 2.3 | **4.6**** | 3.1 | 2.4 | n.s. |

& based on collocational analysis of 'I' within two words preceding– eg: I feel, I just feel, I felt, I really felt, I was feeling.
* p<0.01 for SEC comparison within gender
** p<0.001 for SEC comparison within gender
*** p<0.0001 for SEC comparison within gender
$ **Red**=women more; ***Blue***= men more

**High SEC men are more likely to reflect on masculinity:**

They say in the macho thing big men don't cry and things but it was six foot six friends coming to see me after the hospital and one of them gave me a huge hug and started crying you know. (IC33)

it sort of depends on what your models of masculinity are. I mean I think one of the problems is that you sort of lack a kind of middle ground between being kind of really macho and emotionless, and kind of tough for want of a better word, or kind of emotionally constipated which I kind of put together, do you know what I mean? And then the other thing you don't want to be is a kind of wet bugger, you know you don't want to be kind of, you know the kind of world I came from was pretty, you know I went to a boys' school it was pretty rough [laughs]. You know it had its rough old moments, and it wasn't the kind of place you admitted vulnerability, and I suppose that's what going to therapy is about. (DP04)

**and show variations on 'hegemonic' masculinity:**

one priest in particular, no in fact all of them in their very different ways from young men to, to [um] much older men, have all of them in their ways been *very loving* and *caring* and *supportive* both to me and my partner through the bad times as well as the good. And yes, they've been [um] *very loving* and *very caring* (DP16 our italics)

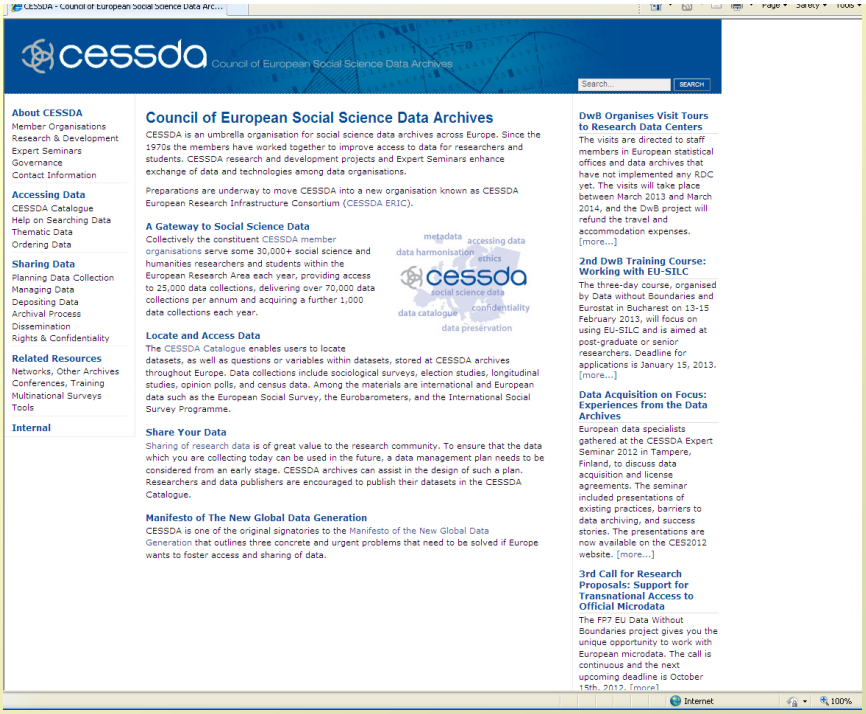
it is still very easy for me to talk about my feelings. About how I feel or to make a comment on other people if I find they are beautiful or whatever you know. (DP07)

## Conclusions

High SEC men signal their possession of cultural capital by deploying selected aspects of 'women's language' and reflecting on masculinity. This may be associated with the maintenance of distinction.

Class and gender position influences systematic variations in language use; the capacity to exercise agency or 'perform' gender variably is present, but itself appears to be linked to class position and is a marker of distinction / cultural capital

1. We did not need to know the context, or need to be there when the data was collected
2. We used methods of analysis that the original researchers did not know about (keyword analysis)
3. We developed research questions as we looked at the structure of the data set
4. We did not have to carry out 1035 interviews ourselves!!!




**From Qualidata web site:**

**Germany**

Following many years of feasibility studies, we welcome a new stream of funding by the Deutsche Forschungsgemeinschaft (DFG), enabling Germany to initiate a data service for qualitative data, QualiService. The project started on 1 September 2011. The final report can be viewed. The archive is based on works from the Life-Course Archive (ALLF) at the University of Bremen who hold a collection of interview data of the Special Collaborative Centre 186 'Status Passages and Risks in the Life Course'. In cooperation with the GESIS Data Archive for the Social Sciences in Cologne a feasibility study on a centralised qualitative data service for Germany was undertaken in 2008.

**GESIS: Data Archive for the Social Sciences**

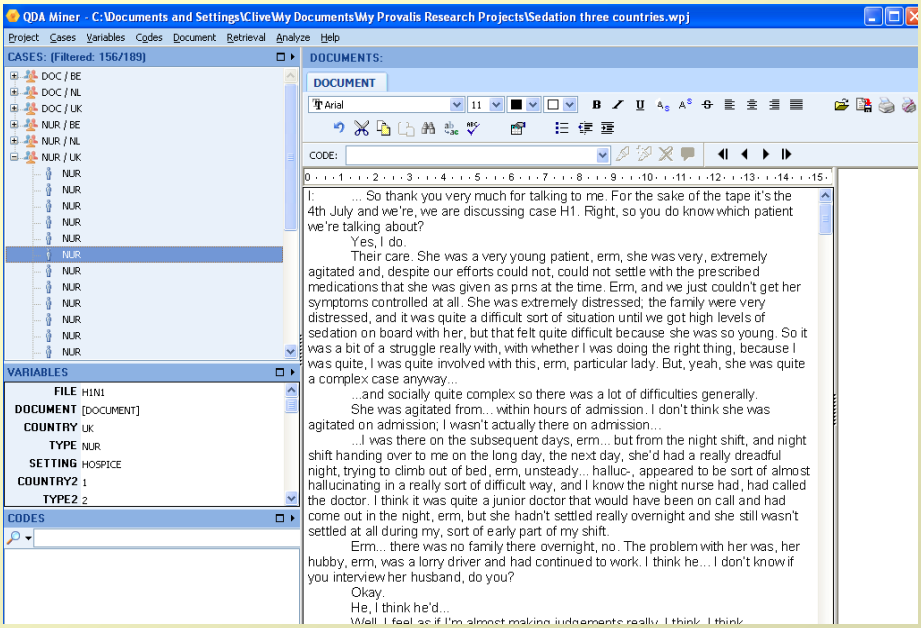
"The primary focus… is providing an excellent data service for national and international comparative **surveys** from the fields of social and political science research."

**Archive for Life Course Research**
University of Bremen

"An archive for interview data from qualitative social science research
With some 700 previously digitized and anonymised interview transcripts the ALLF is probably the largest national archive of qualitative interview data from the social sciences."

So, you have got your large amount of (archived) text. How do you analyse vast quantities of material?

A text-mining approach using WordStat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Project Cases Variables Codes Document Retrieval Analyze Help
CASES: (Filtered: 156/189)
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FILE H1N1
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COUNTRY UK
TYPE NUR
SETTING HOSPICE
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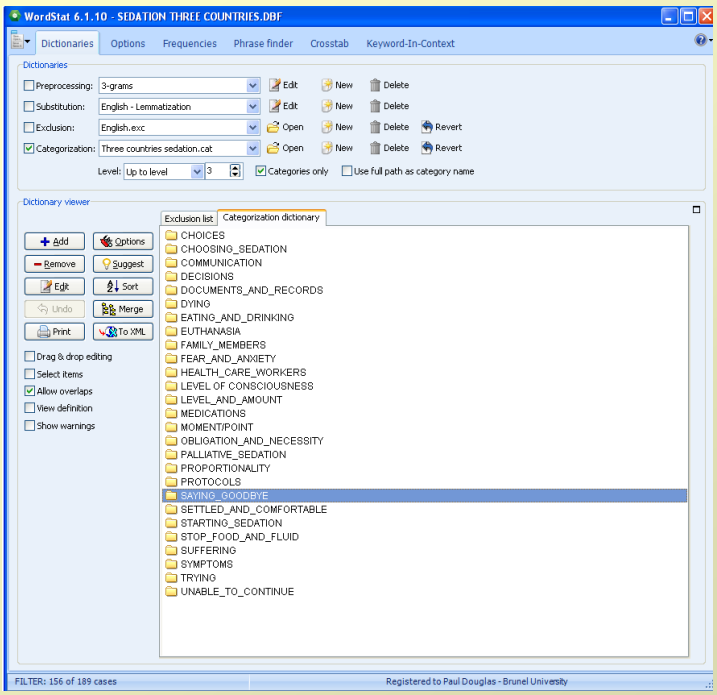
I: ... So thank you very much for talking to me. For the sake of the tape it's the 4th July and we're, we are discussing case H1. Right, so you do know which patient we're talking about?
Yes, I do.
Their care. She was a very young patient, erm, she was very, extremely agitated and, despite our efforts could not, could not settle with the prescribed medications that she was given as prns at the time. Erm, and we just couldn't get her symptoms controlled at all. She was extremely distressed, the family were very distressed, and it was quite a difficult sort of situation until we got high levels of sedation on board with her, but that felt quite difficult because she was so young. So it was a bit of a struggle really with, with whether I was doing the right thing, because I was quite, I was quite involved with this, erm, particular lady. But, yeah, she was quite a complex case anyway...
...and socially quite complex so there was a lot of difficulties generally.
She was agitated from... within hours of admission. I don't think she was agitated on admission; I wasn't actually there on admission...
...I was there on the subsequent days, erm... but from the night shift, and night shift handing over to me on the long day, the next day, she'd had a really dreadful night, trying to climb out of bed, erm, unsteady... halluc-, appeared to be sort of almost hallucinating in a really sort of difficult way, and I know the night nurse had, had called the doctor. I think it was quite a junior doctor that would have been on call and had come out in the night, erm, but she hadn't settled really overnight and she still wasn't settled at all during my, sort of early part of my shift.
Erm... there was no family there overnight, no. The problem with her was, her hubby, erm, was a lorry driver and had continued to work. I think he... I don't know if you interview her husband, do you?
Okay.
He, I think he'd...


WordStat 6.1.10 - SEDATION THREE COUNTRIES.DBF
Dictionaries Options Frequencies Phrase finder Crosstab Keyword-In-Context
Dictionaries
Preprocessing: 3-grams
Substitution: English - Lemmatization
Exclusion: English.exc
Categorization: Three countries sedation.cat
Level: Up to level 3
Categories only
Use full path as category name
Dictionary viewer
Exclusion list
Categorization dictionary
Add
Options
Remove
Suggest
Edit
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To XML
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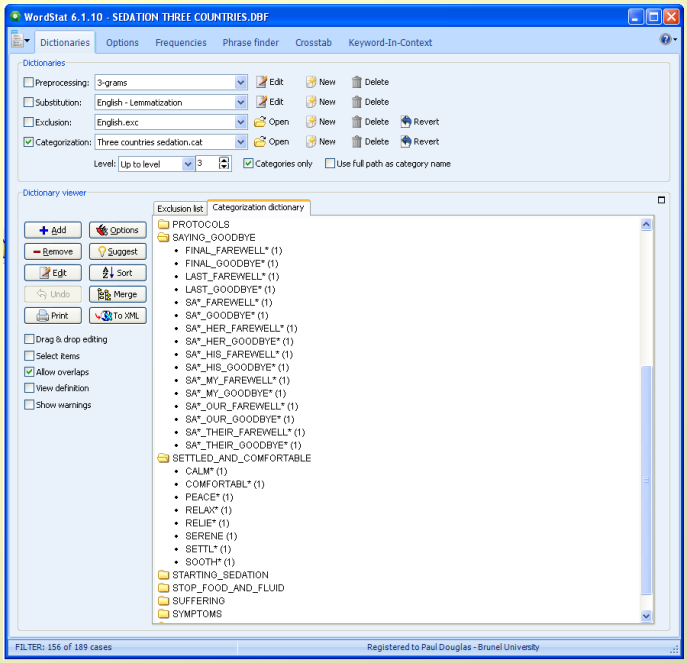
Select items
Allow overlaps
View definition
Show warnings
CHOICES
CHOOSING_SEDATION
COMMUNICATION
DECISIONS
DOCUMENTS_AND_RECORDS
DYING
EATING_AND_DRINKING
EUTHANASIA
FAMILY_MEMBERS
FEAR_AND_ANXIETY
HEALTH_CARE_WORKERS
LEVEL OF CONSCIOUSNESS
LEVEL_AND_AMOUNT
MEDICATIONS
MOMENT/POINT
OBLIGATION_AND_NECESSITY
PALLIATIVE_SEDATION
PROPORTIONALITY
PROTOCOLS
SAYING_GOODBYE
SETTLED_AND_COMFORTABLE
STARTING_SEDATION
STOP_FOOD_AND_FLUID
SUFFERING
SYMPTOMS
TRYING
UNABLE_TO_CONTINUE
FILTER: 156 of 189 cases
Registered to Paul Douglas - Brunel University




**WordStat: making and using a dictionary to compare groups of texts**

1. Words and phrases used in the documents are listed in descending order of TF*IDF score, a measure indicating terms that strongly distinguish documents

2. The top 300 words and phrases are examined in context and those with consistently singular meanings are selected for inclusion in a user-defined dictionary whose categories group together words with semantic similarity.

3. Other words and phrases occurring in the texts are added to the dictionary on the basis of thesaurus similarity and further inspection of context.

4. The distribution of dictionary categories across the three countries is examined

**Comparison of three countries on dictionary categories**
**(percentages of all words included in dictionary occurring in transcripts)**

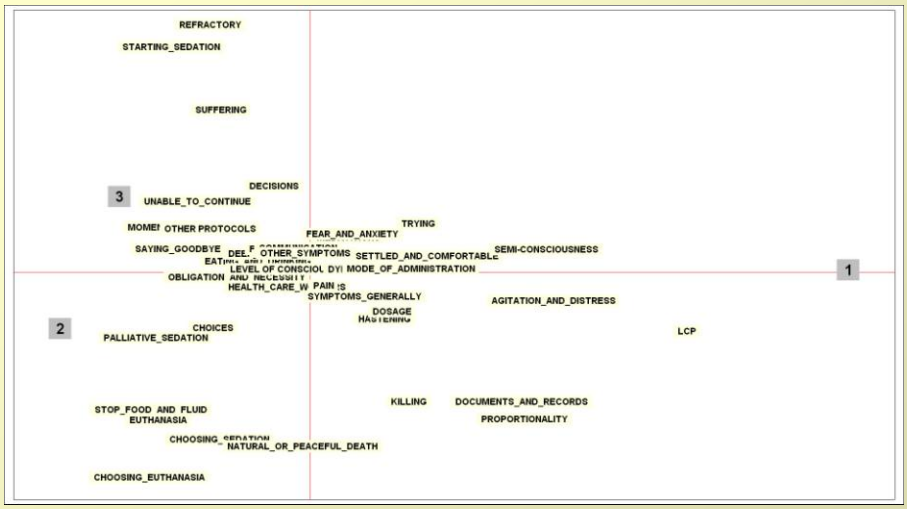
| | UK | BE | NL | p* |
|---|---|---|---|---|
| **1. United Kingdom** | | | | |
| Agitation and distress | 9.5 | 1.3 | 1.4 | <0.0005 |
| Settled and comfortable | 7.8 | 2.8 | 3.4 | <0.0005 |
| Mode of administration | 4.7 | 2.0 | 2.2 | <0.0005 |
| Semi-consciousness | 1.1 | 0.1 | 0.2 | <0.0005 |
| Dosage | 4.4 | 2.5 | 2.1 | <0.0005# |
| Documents and records | 1.0 | 0.3 | 0.1 | <0.0005# |
| Liverpool Care Pathway (LCP) | 0.4 | 0 | 0 | <0.0005 |
| Medications | 8.6 | 5.8 | 6.9 | <0.0005 |
| Symptoms generally | 2.1 | 1.4 | 1.3 | <0.0005# |
| Proportionality | 0.2 | 0.1 | 0 | <0.0005 |
| Killing | 0.5 | 0.3 | 0.1 | <0.0005# |
| Trying | 0.5 | 0.2 | 0.3 | <0.0005 |
| Pain | 5.0 | 4.7 | 4.3 | <0.0005# |
| Fear and anxiety | 2.1 | 1.3 | 1.6 | 0.001 |
| Hastening | 0.5 | 0.3 | 0.3 | 0.002 |
| **TOTAL WORDS** (=100%)** | 8,838 | 10,302 | 10,963 | |

* p value based on chi-square; >0.05=not significant; - = numbers too low for valid chi square
**= Total words included in dictionary categories
# Statistically significant difference between Belgium and the Netherlands (P<0.05)

| | UK | BE | NL | p* |
|---|---|---|---|---|
| **2. Belgium** | | | | |
| Obligation and necessity | 4.1 | 9.9 | 9.0 | <0.0005# |
| Palliative sedation | 0 | 2.6 | 1.9 | <0.0005# |
| Choosing euthanasia | 0 | 1.0 | 0.5 | <0.0005# |
| Choices | 0.7 | 2.5 | 1.9 | <0.0005# |
| Health care workers | 10.5 | 14.0 | 12.6 | <0.0005 |
| Eating and drinking | 1.5 | 2.7 | 2.6 | <0.0005 |
| Choosing sedation | 0.1 | 0.5 | 0.3 | <0.0005 |
| Natural or peaceful death | 0.4 | 0.6 | 0.3 | <0.0005# |
| | | | | |
| **3. Netherlands** | | | | |
| Starting sedation | 0 | 0.6 | 1.1 | <0.0005# |
| Suffering | 0.4 | 1.0 | 1.7 | <0.0005# |
| Refractory | 0.1 | 0.3 | 0.6 | <0.0005# |
| Family members | 10.8 | 12.7 | 13.4 | <0.0005# |
| Communication | 18.7 | 20.7 | 22.0 | <0.0005# |
| **TOTAL WORDS** (=100%)** | 8,838 | 10,302 | 10,963 | |

| | UK | BE | NL | p* |
|---|---|---|---|---|
| **4. Belgium + Netherlands** | | | | |
| Moment/Point | 0 | 0.8 | 0.8 | <0.0005 |
| Other protocols | 0.4 | 1.3 | 1.3 | <0.0005 |
| Saying goodbye | 0.1 | 0.8 | 0.8 | <0.0005 |
| Unable to continue | 0.1 | 0.7 | 0.7 | <0.0005 |
| | | | | |
| **5. No significant difference** | | | | |
| Decisions | 0.5 | 0.6 | 0.8 | n.s. |
| Deep unconsciousness | 1.5 | 1.8 | 1.9 | n.s. |
| Other symptoms | 1.6 | 1.7 | 1.7 | n.s. |
| Stop food and fluid | 0 | 0.1 | 0 | - |
| | | | | |
| **TOTAL WORDS** (=100%)** | 8,838 | 10,302 | 10,963 | |

**Correspondence analysis: country comparison**



He was **ready to go**, **he was finished**, he was physically **finished**. He had been able to **say goodbye** to everyone properly…all the children came, grandchildren, great-grandchildren, all of them…he was able to **say goodbye** to everyone…It took him a week to get up the courage to do it, **he said goodbye** to everyone in the run up to that discussion with the doctor. And on the day the **sedation started**, he again **said goodbye** to the children and grandchildren…he had **had enough…and** the doctor then gave Dormicum, and he fell asleep very quickly. And we immediately attached the pump and he went to sleep and **he didn't wake up** again.

(Document 76, **Belgium**, nurse, home)

I think that for me **the moment** you remove someone's **awareness** of this world is very intense, so that's why I want to do it myself, because you really see people bid **farewell** and you just know that this person will never be able to say good morning to his wife again, or can never say anything to his grandchild again and you are doing that **at that moment**...You don't do anything with life. I feel like you don't shorten it. The transition phase [after the sedation has started] whereby every day I go to the family of course to see if it goes well…I find it very beautiful. People often sit together…support each other, reminisce, so it's actually a very nice .. Yes it is actually a bit of extra **farewell** that you can have, yes. Yes very effective, it simply takes the suffering away. Yes. Yes. And the best part is that you do not have to have anything arranged and it's just always possible.

(37A, **Netherlands**, doctor, home)

he was a gentleman who…had been **struggling** with periods of agitation… and the staff were **trying** to manage his agitation as best they could…but that the patient himself felt that he wasn't **settled**; he was still quite **distressed…I** remember as soon as I went into the room realising very clearly that this was a dying man who was terminally **agitated** and very **distressed**...**terminal agitation**...is very classical when you see it…there weren't any other treatment options…we agreed that we needed to give him something now...to actually help him to relax a little bit; to relieve some of his **distress**…When the nurses had been able to give him prns they had found that the midazolam did **settle** him…you accept that, in order to relieve someone's **agitation**, you may make them more **sleepy**...my intention was not to sedate him, but to use appropriate levels of medication **titrated**...I think that's a balance when using any kind of sedative medications…He was still **awake** and still having periods when he was **aware** and I think, as I say, your intention is always to relieve **distress**, not to sedate, but certainly he was much more **settled** when I left in the afternoon...I think that the sedation in no way **hastened** his demise…the intention was to relieve his **symptoms** and the **doses** weren't inappropriate for the situation and had been **titrated**, and I think therefore the outcome was [that] he was **calmer**, he ultimate died more **peacefully**

L1D1 **UK** doctor Hospice