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# Enhancing Generalizability: Moving From an Intimate to a Political Voice

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Weak external validity of qualitative data has been a subject of debate outside and within the field of qualitative health research. Though some narratives have the power to reveal universal existential issues and inform theoretical development, each story remains unique and cannot be generalized. If the goal of qualitative researchers is to have narrative knowledge effect social change, we are faced with a pervasive problem. Our main objective with this article is methodological; that is, to argue and illustrate that a sequential-consensual qualitative design can yield data with adequate external validity to influence clinicians and public health programming. We seek to contribute to the debate on the generalizability of qualitative research in the health field and provide a methodological template for this type of qualitative design so researchers can apply it to future projects to transfer and translate popular knowledge in a way that can influence social change.

**Keywords:** *anthropology, medical; breast-feeding; empowerment; focus group; knowledge transfer*

Methodology does not exist as a practice outside of its context. It is always embedded in a scientific paradigm, a theoretical basis, and a social, cultural, economical, and political web (Guba & Lincoln, 1994). The postmodernist Lyotard (1984) argued that modern science itself is a metanarrative characterized by the pursuit of absolute standards and universal categories that give legitimacy to many social and political practices. One could also argue that since the Enlightenment, numbers, statistics, and scientific knowledge have taken the place of religion in responding to our quest and need for certainty and security. It is perhaps because numbers and statistics, as they are used in science, provide the solace of rules, estimates, probabilities—and essentially predictions—in a context of uncertainty. Like an oracle, predicting reality is one of the important objectives of science, yet it often serves to confirm the notion that somewhere out there exists a “truth”—with its laws, rules, and certainty—not always accessible to the lay person. As noted by Frank (2004, p. 438), the word *truth* arouses suspicion in postmodern times. Nevertheless, it generally remains associated with the doctrine of realism. As to the question of how it is

that numbers and statistics still offer such certainty and security, we can argue that the answer lies, in part, in the concept of generalizability.

Generalizability helps to form predictions of events and behaviors and to create rules by transposing results and/or recommendations of a particular research project to either a larger or comparable population (Schwandt, 2001). Generalizability, in the positivist sense, thus depends on the representativeness of the sample, which in turn rests on randomization (Lincoln & Guba, 1985, p. 291). The capacity to generalize to a larger population gives a sense of control and order over reality. Although it has not always been addressed directly in the literature (Whittemore,

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Chase, & Mandle, 2001), the ability to generalize results can be a phantom for qualitative researchers (Morse, 2008; Waterman et al., 2007). Some of these researchers have responded to accusations of weak external validity or generalizability by arguing that the aim of the qualitative researcher is to understand phenomena, not generalize it (Lincoln & Guba, 1985), or that it is up to the reader to decide whether or not the population or case to which one wants to generalize is comparable to the one being studied (Lincoln & Guba, 1985; Stake, 1995). Thus, generalization in the constructivist paradigm does not rely on the same empirical-statistical sampling logic as in the positivist paradigm, but relies on a logic of sampling that is theoretical:

Theoretical generalizations do not rely on the logic of representative sampling. Rather the selection of groups, units, cases, and so forth to study is made on the basis of their relevance to the theoretical account or explanation that the inquirer is developing. . . . In other words the criterion for deciding what cases to select for study is the extent to which they contribute to supporting or refuting the argument or explanation being developed by the inquirer. (Schwandt, 2001, p. 106)

Moreover, the strength of qualitative research is studying how people, through their narratives, experience and give meaning to their health and lives within their social and cultural contexts. Like numbers, narratives are everywhere and exist transculturally as a privileged way of transferring knowledge. We use narratives every day to give meaning to our experiences, whether powerful, mundane, enjoyable, or traumatic. We share narratives with others to foster a sense of togetherness, to create meaning, to communicate and teach ideas, and sometimes even to consolidate identity (Lieblich, Tuval-Mashiach, & Zilber, 1998). Knowledge from narratives is linked to experience; it is therefore procedural knowledge (Lave, 1991), while being inseparable from our humanlike qualities such as emotion, local history, and sociocultural context. Stories of love, courage, power, disease, suffering, sharing, hate, solidarity, desire, faith, and death all bear witness to these qualities. Narratives remind us of who we are, where we stand, and what values we possess. Some narratives thus have the power to reveal collective or universal existential issues and prototypical social experiences linked to health and illness. It has been argued that this type of personal illness narrative paints stories of illness experience that can influence decision makers in health fields such as the teaching of

clinical medicine, public health planning and intervention, and health policy orientation (Greenhalgh, 1999; Mullan, Ficklen, & Rubin, 2006). Although each story remains unique and cannot be generalized, the above-mentioned collection of narratives paints a general story of illness experiences and health care systems that their authors often rely on to support a call for change while arguing they can be used as advocacy messages. However, according to Sacajiu (2007), it still remains to be seen how these narratives were in fact used by decision makers to orient change in health policies.

If the goal of qualitative researchers is to have narrative knowledge that is produced and analyzed in a systematic scientific way, influence decision makers in the health field, and effect social change, there is a need to conceptualize qualitative designs that allow for adequate generalization. This article responds to this gap by demonstrating that a sequential-consensual qualitative design (SCQD) can yield narrative data with adequate generalizability, in the constructivist sense, to influence public health programming and clinical work. The aim here is to provide a methodological template for this type of qualitative design (SCQD) in the hope that researchers can apply it in future projects that share the objective of contributing to social change.

It might be argued that researchers trying to “make a difference” or effect social change should simply do participatory research. Traditionally, the objects of change in this approach are the participants themselves (Waterman et al., 2007), whom we claim to empower through the research process (Park, Brydon-Miller, Hall, & Jackson, 1993). Although we recognize the value of such an approach, the aim of our research is not to change the participant. Rather, it is to shape the opinion of those whose decisions affect the health and well-being of people, especially the more vulnerable populations similar to the ones we are studying. Our goal is to inform the decision-making process in settings such as the Ministry of Health, local public health agencies, and community clinics. Invariably, we must conform to the exigencies of these environments by producing concise yet credible documentation.

The first author of this article is writing from the perspective of a medical anthropologist with expertise and experience in public health. In working in various health institutions, we have observed that the decisions of policy makers, institutional administrators, and public health programmers, as well as clinicians, tend to be

guided by two main sources: (a) evidence-based knowledge or statistics and (b) lobbying by pharmaceutical companies, professional or clinical corporations, community interest groups, and the media.

How does this concern qualitative research? Can qualitative research produce the evidence-based knowledge required by policy makers and public health programmers? Can experience itself be considered a kind of evidence that goes beyond anecdotal data? It then becomes key to ask whether narrative research can produce a kind of evidence that actually influences decision-making processes shaping society and affecting the health of our populations. Looking to medical anthropology, for example, one of the principal aims of this discipline is to study how culture influences medical care and the health of populations (Loudon, 1976). Yet in the past two decades some have claimed that it has had little impact on the medical field (Hemmings, 2005). This could be quite dispiriting in light of the fact that medical anthropology uses predominantly qualitative methods. When some qualitative researchers rightly claim that their goal is not to produce evidence-based knowledge, it might actually be an elegant euphemism for the fact that it is impossible to attain. However, a well-known strength of qualitative methodologies is that they produce results that have strong credibility and face validity. How then can qualitative research influence decision makers in the health field?

## Objective

The argument we wish to put forward here is that the combination of different qualitative methods used at various stages of a research project can, in fact, strengthen the external validity of qualitative data, making it generalizable and ultimately useful for shaping the opinions of key decision makers and stakeholders. Here we present a qualitative research design with preliminary results to illustrate how this type of design can help enhance the external validity of qualitative data.

“Solution in social sciences often means to be able to recommend a policy that proposes to end some trouble” (Frank, 2004, p. 439). The “trouble” or problem explored in our research project is the following: Although babies born into poverty are those most likely to benefit from breast-feeding, in Québec poor French-Canadian mothers are the ones who most

often refuse to breast-feed, despite being exposed to activities promoting this health behavior (Dubois, Bedard, Girard, & Beauchesne, 2000). Recently, following intensive health promotion interventions, the breast-feeding initiation rate in this group has risen dramatically to 71.3%, but close to half of them (44%) stop breast-feeding within 2 months (Neil, Beauvais, Plante, & Haiek, 2006). Often, our task as qualitative researchers is to learn the logic and complexity of meaning linked to the experiences of the people we study without imposing our own logic. As we begin to understand the position of our participants, the meaning behind their actions and health behaviors becomes clearer (Charmaz, 2004, p. 982). With this perspective, the qualitative research design we developed in our study had two purposes: (a) to help understand the experience and meaning that economically disadvantaged French-Canadian mothers attribute to their infant feeding choices (bottle vs. breast) and (b) to use this understanding to formulate, with the input of the mothers, recommendations for public health policy, programming, and guidelines for the promotion of breast-feeding. As such, the initial stage of the project needed to produce complex qualitative data, involving “thick description” in the interpretative sense of Geertz (1973) and facilitating sound theorization. The design also needed to provide, in a subsequent stage, data with strong enough external validity to inform and influence public health decision makers and clinicians engaged in breast-feeding promotion activities. It is not the qualitative data itself that must have a direct impact on decision makers but the insights they foster in relation to the problem under investigation. The presentation of the qualitative data had to be credible enough to explain to public health decision makers why economically disadvantaged French-Canadian mothers generally tend not to breast-feed. The final stage of the research design also had to provide qualitative data simplified enough to be presented within a focus group setting to (a) facilitate its validation within a larger, more representative sample and (b) to help participating mothers formulate recommendations that bridge their own meaning and experience with the logic guiding public health prerogatives.

## Method

With the above criteria in mind, we conceived a research design that we called a SCQD, which

**Table 1**  
**Sequential–Consensual Qualitative Design**

Stage 1 ( <i>n</i> = 26)	Stage 2 ( <i>n</i> = 62)	Stage 3 ( <i>n</i> = 104)
Objective: Strengthen internal validity of questions of semistructured ethnographic interviews in Stage 2	Objective: Provide data with good internal validity and allow comparison of narratives based of infant feeding groups	Objective: Strengthen external validity of ethnographic data produced in Stage 2 and produce valid recommendations for health policy, health promotion programs, and clinical interventions
How? Three focus groups (rural, urban, suburban) with a total of 26 mothers distributed equally between infant feeding groups and regions of the province ( <i>n</i> = 26)	How? Ethnographic interviews with 62 mothers divided equally between infant feeding choices and regions (urban, suburban, and rural) of the province ( <i>n</i> = 62)	How? Seven focus groups with a total of 44 mothers in all regions (urban, suburban, and rural) of the province ( <i>n</i> = 44) One workshop with clinicians (registered nurses and MDs), health administrators, and public health planners ( <i>n</i> = 60)

involved three distinct stages. Stages 1 and 2 were meant to produce data with strong credibility or face validity, whereas Stage 3 was aimed at strengthening external validity (see Table 1).

In Stage 1 we conducted a total of three unstructured focus groups to help identify the key themes linked to infant feeding choices that could later be addressed in semistructured ethnographic interviews (Stage 2). A total of 26 mothers participated in the three focus groups of Stage 1. We had three recruitment criteria: (a) French-Canadian, (b) eligible for the provincial perinatal nutritional supplement (an outreach program for economically deprived mothers), and (c) participant in a community postnatal activity within a community organization. Leaders of activities held in the community organizations, where the focus groups were also held, recruited all mothers. The first focus group included 9 participants: 6 breast-feeding mothers and 3 bottle-feeding mothers. Comments of mothers tended to be highly polarized between mothers of the different infant feeding groups, whereas bottle-feeding mothers were also underrepresented. We therefore decided to conduct a second focus group at the same location, composed this time only of 5 mothers who bottle fed. Afterward, we conducted a third focus group composed of 12 mothers in a suburban area, with half breast-feeding and half bottle feeding.

The mothers who participated in Stage 2 ethnographic interviews were recruited with the help of 62 community organizations and local health community clinics we contacted in different areas of the province. These groups referred us to 111 mothers interested in participating, 62 of whom were recruited

based on the fact that they met recruitment criteria. We adopted a theoretical approach to sampling, using the following criteria: (a) low socioeconomic status according to norms established by regional public health agencies, (b) self-declared as born in Canada with French as a maternal language, (c) equal distribution across geographical regions (20 minimum, each from urban, rural, and suburban zones), and (d) equal distribution of both infant feeding methods within each region. All 62 mothers selected were interviewed twice, at 1 month and 6 months postpartum. Because a previous longitudinal study in the province had identified a correlation between maternal depression and bottle feeding (Dubois et al., 2000), we also decided to add a quantitative screening tool for postpartum depression. We chose the Edinburgh Postnatal Depression Scale by Cox, Holden, and Sagovsky (1987). In this way, we allowed for screening of distressed mothers and for additional analysis of the interaction among levels of distress, infant feeding decisions, and contextual factors such as the availability of support in different geographical spaces (see Groleau & Rodriguez (2009).

Because representations, collective values, and experiences that emerged from Stages 1 and 2 were somewhat controversial and had important implications for public health guidelines and programming, we needed to make sure they were credible and representative for women of the same socioeconomic and cultural group living in different geographical regions of the province. Stage 3 of the study thus used focus groups that were designed to address this issue. Two of the focus groups were attended by only two mothers, whereas for the remaining five focus groups,

**Table 2**  
**Translation of Data From Stage 1 Into Ethnographic Categories to be Explored in Stage 2**

Stage 1: Central themes that emerged from discussions on infant feeding choices during Stage 1 focus groups	Stage 2: Themes we decided to address during ethnographic interviews following the focus group results of Stage 1 and review of the literature
Difficulties during pregnancy and delivery	1. Narrative of pregnancy, birth, and postpartum period
Relationship with medical staff	2. Quality of information and relationships with health professionals
Vulnerability or assertiveness justifying infant feeding choice	3. Prototypes of good parenting and quality maternal milk
Benefits of infant feeding choices for babies and mothers	1 and 3
Impact of infant feeding choice on mother–baby relationship	4. Relationship expected with baby and experienced with family members
Social spaces and stigma	5. Breast-feeding in the context of becoming a mother in social spaces

an average of eight mothers participated. The participating mothers in these focus groups were asked to validate the ethnographic data produced in Stage 2 and to formulate recommendations for orienting provincial breast-feeding promotional programs and related public health policy. This method proved to be extremely useful in both validating ethnographic results and eliciting recommendations from mothers with low educational levels (< 12 years of schooling). We decided that Stage 3, contrary to Stage 1 focus groups, would consist of very structured focus-group interviews where slides illustrating our results were presented to the mothers, accompanied by short video clips of ethnographic interviews demonstrating the qualitative data to be validated. Following each video clip, the mothers were invited to participate in a short group discussion and then asked to indicate whether or not the ethnographic data presented corresponded to their experience or that of their peers.

To finalize Stage 3, we then presented the ethnographic results with video extracts of interviews (produced during Stage 2) and the recommendations produced by mothers (during Stage 3) at a symposium we organized in Montreal. The 60 professional participants of this symposium ranged from community nurses to family doctors, community clinic administrators, and regional public health planners for the province of Québec, all of whom were involved in breast-feeding promotion programs. The objective of this symposium was to transfer the ethnographic knowledge produced in Stage 2 to stakeholders and to validate the recommendations produced recently by mothers.

## Results

In this section we present data from the three stages of our SCQD design in a synthetic format to

illustrate the ways that results from one stage led and guided the following stages.

### Stage 1. Accessing the Cultural Voice

During this stage we wanted to identify key socio-cultural themes that were specific to this population and would then be addressed in greater depth during the Stage 2 ethnographic interviews. This could not be accomplished via a literature review because no articles addressed this issue with this ethnic group. For qualitative data to emerge, the three focus groups were conducted in an unstructured group interview format. The main objective of the focus groups of Stage 1 was to invite mothers to recount their stories and their perinatal experiences and to detail the lay and professional care and support they received from family, friends, and health care workers. We chose to explore these contexts to better understand how they were related to mothers' decisional process about infant feeding. While mothers were narrating their stories, we asked them to elaborate on the decisional processes linked to their infant feeding choice. The following section illustrates how the results emerging from very unstructured focus groups helped to identify the key themes that we decided to explore in the ethnographic interviews of Stage 2. The main themes from the focus groups of Stage 1 and those that were subsequently addressed in the ethnographic interviews of stage 2 are listed in Table 2.

*Difficulties during pregnancy and delivery.* The high frequency and importance of social and health problems disclosed by bottle-feeding mothers during these focus groups led us to decide that the ethnographic interviews of Stage 2 needed to elicit the maternal narratives relative to pregnancy, birth, and the postnatal period so we could assess the influence of these problems in relation to infant feeding choices.

*Relationship with medical staff.* Most breast-feeding mothers felt that nurses in the hospital tended to give them inconsistent information about breast-feeding techniques and how to deal with such problems as painful breasts or insufficient milk. Most bottle-feeding mothers were also displeased with the contact they had with ward nurses, who they felt had judged or stigmatized them because of their choice. The disclosure of this important problem led us to decide to explore in Stage 2 the “quality of information and relationships with health professionals” in relation to infant feeding choices.

*Vulnerability or assertiveness justifying infant feeding choice.* Regardless of their infant feeding choice, mothers had to face judgmental comments within their family, social, public, or medical spaces. Although most mothers acknowledged these difficulties, for a few, asserting their infant feeding choice was an empowering experience, a chance for them to show others that they were the mother, thus affirming their new identity and decisional powers. For others, such negative feedback regarding their new role made them feel even more vulnerable because of the extra energy required to deal with the stigma. Thus, this important dilemma related to infant feeding choices in different social spaces underscored the need to furthermore explore this phenomenon in Stage 2, in relation to local norms or “prototypes of good parenting and adequacy of maternal milk.”

*Benefits of infant feeding choices for babies and mothers.* Breast-feeding mothers considered their choice to be good for their health and that of their babies. Some bottle-feeding mothers acknowledged that breast-feeding was good for babies’ health, but based on their own prototypical experience of having been bottle fed they considered bottle feeding as an equally healthy choice. Furthermore, regardless of infant feeding choice, an important criterion seemed to be the energy required by mothers to adequately take care of the baby and the practicality of the feeding method. Also, their choice for bottle feeding might be because many mothers of this group were single or that they had experienced difficulties during pregnancy or delivery. Thus, this similar reasoning of mothers of both infant feeding choices relative to the practicality of their chosen method in the context of their marital status and health representations needed to be explored in depth in the context of the ethnographic interview.

*Impact of infant feeding choice on mother–baby relationship.* Breast-feeding mothers considered their choice to be best because it fosters mother–child attachment. On the other hand, the majority of bottle-feeding mothers considered breast-fed babies to be too attached to their mothers and not independent enough to face the hardships of life. This led to the need to explore more in depth during the ethnographic interviews the relationship with the infant and with family members.

*Social spaces and stigma.* The majority of mothers, regardless of their infant feeding choice, considered it improper to show their breast in public whether breast-feeding or not. Breast-feeding mothers explained that they always made sure to hide their breast with a blanket while breast-feeding in front of family members or in a public place. This issue of morality and social spaces revealed the importance to further explore in Stage 2 infant feeding choices as they were experienced in different social spaces in relation to the rites of passage to motherhood.

The results from the focus groups of Stage 1 were interesting, particularly (a) the symbolic aspect of breast-feeding being linked to sexuality and incest, (b) the taboo associated with breast-feeding in public and family spaces, and (c) the stigmatizing experience felt by bottle-feeding mothers in the medical space and by breast-feeding mothers in their social and familial spaces. The morality attached to both infant feeding choices was a very interesting phenomenon, and we wondered if it was not exacerbated because of the group context of focus groups. Moreover, regardless of their infant feeding choice, mothers justified their choice by using arguments referring to the same shared collective values. Among those values we found (a) the importance mothers place on their infant feeding choice in relation to its impact on energy required to be a good parent, (b) giving the best quality milk to their child, (c) hiding one’s breast in public for moral reasons, and (d) being assertive in social spaces (family and public or medical) to assert their new identity. The fact that mothers used the same rationale to justify their infant feeding choice points toward the importance of understanding infant feeding choice in the context of culture and rites of passage to motherhood. As well, the connection mothers draw among infant feeding choice, social space, and morality underscores the importance of exploring the fact that these women live in a singular and marginal social space (i.e., poverty).

## Stage 2. Qualitative Data With Strong Internal Validity: Accessing the Intimate Voice

Because of the theoretical and clinical implications of the focus group data, the exploration of the above themes required the intimacy and extended time provided by the ethnographic interview. Subsequently, the themes addressed in the ethnographic interviews were chosen on the basis of the focus group data as well as a review of the breast-feeding literature related to (a) its social and cultural context (Bailey & Pain, 2001; Bailey, Pain, & Aarvold, 2004; Cabral & Groleau, in press; Groleau, 2005; Groleau & Cabral, in press; Groleau, Soulière, & Kirmayer, 2006; Paine, Makrides, & Gibson, 1999; Paine & Dorea, 2001), (b) the symbolics of bodily fluids (Douglas, 2002), and (c) rites of passage (Van-Gennep, 1960). Although we did ask mothers to relate their perinatal story at the beginning of the ethnographic interview—this first part being unstructured—we later addressed the above themes through structured questions. We intentionally asked open-ended, structured questions to allow for comparison of narratives on the basis of infant feeding behavior. The capacity to compare narratives based on health behaviors depends on the level of structure of the qualitative interview (Groleau, Kirmayer, & Young, 2006). Totally unstructured interviews can give rise to narratives that are very rich and multilayered but potentially too different in the themes they produce to allow for comparison. Open-ended, structured, qualitative questions offer this possibility; that is, they invite narrators to make statements on predetermined subjects without, as in quantitative questionnaires, limiting their potential answers to a preset number of possibilities. The unstructured part of the ethnographic interview offered mothers the opportunity to tell their own story while accessing the sociocultural context that influenced their experience. For the purposes of comparison, and to access the context involved in the experience of infant feeding, our ethnographic qualitative interview was designed to contain an unstructured section at the beginning to allow the mothers' stories to emerge, followed by a structured section with questions guided by the above themes. We chose to address the following issues during the Stage 2 ethnographic interviews conducted among 62 mothers who had not participated in Stage 1.

*Narratives of pregnancy, birth, and postpartum.* Groleau (2005), Groleau, Soulière, & Kirmayer (2006), and Groleau & Cabral (in press) have shown

how infant feeding choices not only are rational causal choices (e.g., “breast-feeding is best for my baby’s health”) but also must make sense in the context of the personal biographical story of each mother (e.g., “I had a terrible birth, so many problems . . . and my baby was in neonatology, I couldn’t breast-feed”). In light of the social and medical difficulties experienced by most bottle-feeding mothers from our focus group, the exploration of the perinatal narrative of each mother became an essential aspect to explore during the ethnographic interview. The frequent difficulties expressed by mothers in the focus groups of Stage 1 were clearly confirmed during the ethnographic interviews of Stage 2. The majority of mothers interviewed individually reported experiencing important stressors (e.g., health problems, psychosocial problems) during pregnancy, birth, or the postnatal period. However, contrary to the focus group mothers, the experience of these problems did not seem to relate directly to specific infant feeding choices. We thus considered this context as one of heightened vulnerability, in which mothers had to navigate during their perinatal period.

*Relationships with and information from health professionals.* Addressing this issue became crucial during the ethnographic interview because of the controversial comments made by mothers of both infant feeding groups during the focus groups. Mothers participating in Stage 2 individual interviews confirmed the same stigmatizing experience of mothers of Stage 1 focus groups. Even the few who participated in prenatal classes declared that they felt the same judgmental climate and attitudes from the health professionals during the class as during their hospital stay. Mothers interviewed at Stage 2 reported problems similar to those identified in the focus groups: the inadequacy of the information received on both breast- and bottle-feeding techniques and the inconsistency of the information received from nurses working in rotation. Furthermore, according to mothers, their communications with health care providers did not influence them to choose one or the other infant feeding method either during pregnancy while participating in prenatal courses or at birth at the hospital. However, the vast majority of mothers (80%) who decided to “give it a go” and try breast-feeding and subsequently stopped very early (within one postnatal week) declared that they lacked emotional and technical support from health professionals or community organizations after their hospital discharge.



*Relationship expected with baby and family members.* Issues of attachment and independence of baby respectively associated to breast-feeding and bottle feeding were a central theme during Stage 1. Although this theme clearly differentiated breast-feeding from bottle-feeding mothers in our focus groups, we decided to explore family relationships during the ethnographic interview to see if they related to infant feeding decisions. Mothers were not comfortable discussing issues of attachment and family relationships, which seemed to be problematic in several instances. We respected this choice and did not explore this matter further. Although a minority of bottle-feeding mothers interviewed at Stage 2 did mention their desire to foster their child's independence by bottle feeding, this issue became secondary during the ethnographic interviews of Stage 2.

*Prerequisites for good parenting and quality maternal milk.* The notion of preserving one's energy during the postnatal period was presented as central by most mothers in Stage 1 and confirmed as such by those participating in Stage 2. Stage 2 ethnographic interviews confirmed the essential importance of being a good parent for all mothers, regardless of their infant feeding choices. Ethnographic interviews yielded narratives that helped to understand how, for single mothers and mothers who scored above the cutoff point on the depression scale, protecting their level of energy by eating well and sleeping at night became key to enhancing their capacity to be a good parent and produce good quality milk. These particularly vulnerable mothers, who were either depressed, single, or experiencing psychosocial or medical problems, were especially in need of support. Those who decided to bottle feed were particularly concerned either by the sexual dimension of breast-feeding or by the fact that in lacking access to adequate social support to breast-feed, they were jeopardizing their energy level and thus their capacity to be a good parent and produce good quality milk.

*Breast-feeding and the context of becoming a mother in different social spaces.* Because of the stigmatizing comments directed at mothers of both infant feeding groups, we decided in Stage 2 to explore their impact on infant feeding choices and experiences. As in Stage 1, bottle-feeding mothers were especially vulnerable and sensitive to negative messages relating to either their infant feeding choice or their competency as mothers. This included both negative

messages produced by health professionals as well as those of relevant people in their familial and social networks. In other words, by adopting bottle feeding they knew they would avoid receiving negative messages from their social network that were unanimously against breast-feeding. Furthermore, their sexualized representations of breast-feeding and the corresponding limitations it imposed on their access to social and public spaces were key in their decision to bottle feed. This group of mothers felt that breast-feeding would reduce their access to social life and isolate them. Not being able to go to the shopping center or to social or familial gatherings was something they perceived to be problematic. As those who were more vulnerable psychologically because of distress or psychosocial or medical problems, they felt that breast-feeding would not only generate conflict in their milieus but also put them in a situation of social isolation, an element they consciously wanted to avoid, to protect their well-being and thus their capacity to be a good parent.

In summary, data from Stage 2 helped to validate the themes generated in Stage 1, with the exception of "the impact of infant feeding choice on the mother-baby relationship," which became secondary. Stage 2 also highlighted, through the narrative analysis, the complex interplay among social processes, health representations, cultural context, and psychological factors linked to the infant feeding behaviors and experiences.

### **Stage 3. Qualitative Data With Strong External Validity: Accessing the Political Voice**

Asking the mothers to validate our ethnographic data during focus groups put them in the role of expert, a position we think contributed to increasing their self-confidence and their capacity for reflectivity vis-à-vis their maternity and infant feeding experiences. Although this group of mothers had very low education levels (some were illiterate), they were able to produce, quite spontaneously, extremely relevant recommendations. They validated the experience of stigmatization that many bottle-feeding mothers felt during their hospital stay as well as the confusion over conflicting technical information from different nurses. Mothers in all the focus groups recommended, in light of the data presented to them as well as their own experiences, that nurses working in hospital postpartum wards should receive standardized training

on breast-feeding techniques such as holding the baby and dealing with problems such as pain or insufficient milk. They also suggested that to avoid deleterious psychosocial affects, breast-feeding should not be promoted without giving mothers easy and rapid access to support following their hospital stay:

You know, we stay in the hospital 24 hours after delivery . . . as if nothing can happen after that. Some of us give it a try for our babies, but once we get home it's complicated, and we have no one to help us with our problems, and only a rare soul to encourage us. . . . We even have to face criticism sometimes when our close ones see that we are struggling and getting exhausted. If you want to convince mothers to breast-feed, you have to make sure you can help them after. That's the problem. Once we go back home you have problems—your breasts hurt, your baby is crying, and you quit. I felt like I failed. I really feel bad. I really would have liked to breast-feed. The Minister of Health should know that by doing this he is creating a lot of problems—the pain of breast-feeding, the energy we lose, how we end up feeling bad about ourselves . . . you know. We all want to be good mothers. All this pain and trouble. . . . I just wish it could have worked.

Mothers participating in Stage 3 of the research design also confirmed that many of them needed emotional support during their hospital stay, regardless of their infant feeding choice, to help them adjust to the medical problems they experienced at birth. Based on the analysis of all stages of the research, the following recommendations were coconstructed by the researchers and the mothers who participated in the focus groups of Stage 3:

1. Create a law that obliges owners of shopping centers and big public areas to provide an intimate place for women to breast-feed.
2. Governmental budgets should be allocated for the promotion of breast-feeding only if an adequate budget portion is secured to provide emotional and technical support for mothers.
3. All nurses and medical staff should be trained before they are entitled to promote breast-feeding.
4. Hospital nurses should be made aware in their training session that some promotion messages such as, "Don't you want the best for your baby?" are judgmental and can be experienced as stigmatizing by mothers.
5. All nurses working in a hospital maternity setting or making home visits should receive standardized training on the techniques they teach mothers to use to resolve common breast-feeding problems.

6. Health professionals should involve relevant family members or friends in their promotion and support activities with mothers.
7. Mothers should leave the hospital with a list of resources they can call on a 24-hr basis if they encounter breast-feeding problems.
8. During clinical communication, priority should be given to addressing the emotional needs of mothers and valuing their social role as mothers.
9. Empower women during pregnancy so they can develop a critical stance toward the gaze and negative judgments of others toward their infant feeding choices and practices.

As stated previously, Stage 3 of the design also involved presenting the qualitative data, including recommendations produced by mothers to health professionals involved in breast-feeding promotion in the province of Québec. Reactions of this professional audience to the ethnographic data and to the video extracts presented during a 1-hr session were emotionally intense and compelling at times. Moreover, some participants stated that without viewing some of the video extracts (i.e., those illustrating beliefs related to breast-feeding as sexual and the stigmatizing effect of promotional messages), they would not have believed the results of the ethnographic interviews. After presenting the ethnographic data produced in Stage 2 and the recommendations produced by other mothers in Stage 3, professionals were asked to discuss in small groups (7 to 10 professionals) the specific recommendations we proposed and identify the ones they intended to apply in their clinical or health planning practices.

Recommendations 4 and 6, above, are the ones that received unanimous support from the professional participants. Some participants stated that they also wanted to learn how to communicate with this vulnerable population without causing any harm. Others shared ideas on how to integrate family members, such as going to mothers' houses when doing promotional activities, to have better access to the family. Others suggested putting mothers in contact with other breast-feeding mothers in their community during pregnancy, so they would feel more comfortable contacting them after birth. Recommendations 8, 7, 5, 3, and 2 were well received by the majority but did not receive unanimous attention and endorsement. Some participants specified that the fact that governmental budgets were insufficient put both nurses and low-income mothers in a double-bind situation, the former not having adequate resources to provide support for mothers and the latter being judged negatively regardless of their infant feeding choices.

Referring to Recommendations 3, 4, and 5, all participants agreed that nurses working in hospital settings as well as in the community should receive adequate training to be entitled to promote breast-feeding, so as to avoid deleterious effects affecting this vulnerable community and provide adequate support to mothers who decide to breast-feed.

Recommendation 9 did not receive much attention during discussions. Although most participants did not oppose the idea of empowering mothers, a few expressed their own limitations and lack of knowledge regarding adequate strategies to implement empowerment activities that enhance the self-esteem of mothers. Finally, fewer than half of the participants (40%) accepted Recommendation 1. The remaining 36 participants rejected Recommendation 1, considering that by applying this policy society would reinforce the idea that breast-feeding in a public or social space is inappropriate. They stated that society would start to change by seeing more mothers breast-feeding in different social spaces—including in the media—by not confining breast-feeding mothers to restricted areas. Thus, the only point of clear divergence between mothers and professionals was Recommendation 1.

## Conclusion

This study has demonstrated that our multiple-stage qualitative design, the SCQD, is feasible and can enhance both the internal and external validity of qualitative results. This design also provided a conducive context for a vulnerable population to produce recommendations—using an ethnographic and participative approach—that were for the most part acceptable and endorsed by public health planners and clinicians who were presented with the qualitative results. As stated above, only one recommendation relating to policy was not endorsed or well received by the majority of the professionals, mainly for conflicting ideological and political reasons. Although only one recommendation was refused, we cannot assert whether this type of design had an impact on policy makers because no new breast-feeding policy is planned in the near future in the province of Québec.

Since the portentous call of the World Health Organization (World Health Organization/United Nations Children's Fund, 1989) to promote and protect breast-feeding, the literature on breast-feeding has largely been dominated by a biomedical and epidemiological framework (Maher, 1995), one that excludes meaning associated with infant feeding experiences and sociocultural contexts. Promoting

breast-feeding without considering that it promotes cultural change can have deleterious effects such as increasing the stigmatization of mothers who are already marginalized, and can contribute to distress for an already vulnerable group. Despite years of intervention and campaigns promoting breast-feeding in the Western world, most babies born into poverty to nonimmigrant mothers continue to be bottle fed for their first 6 months of life and remain less healthy than babies from middle-class families. The public health legacy of blaming the victim goes on with the most vulnerable groups while health promotional activities and medical information continue to benefit those who need it the least: healthy, middle-class, and wealthy populations.

It is well known that focus groups are conducive to policy making and program planning (O'Donnell, Lutfey, Marceau, & McKinlay, 2007). However, the experience of this qualitative research design that involves the sequential combination of focus group and ethnographic interviews (SCQD) has proven fruitful in terms of enhancing both the internal and external validity of the qualitative knowledge it produced and for the mothers who participated. We do not claim to have empowered them, knowing very well they must return to their challenging lives. However, they left knowing that their voices and recommendations would eventually find their way to decision makers involved in public health planning and service delivery. Following the focus group experience, many expressed their satisfaction and gratitude in a compelling way:

Nobody ever wants to hear what we have to say. . . .  
We really appreciate that you took the time to come here and listen to us and what we think about all this.

We had not anticipated this positive impact on mothers. After all, these mothers are the true experts on their maternal experience, and it seemed only natural to consult them.

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