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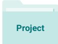

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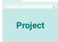

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ABSTRACT Children are increasingly acknowledged to have rights in the determination of decisions that affect them. This has encouraged research to be undertaken with children themselves to understand their own views, experiences and relationships, and has demonstrated a considerable gulf from parental concerns and observations. Methods for research with children are, however, relatively underdeveloped. This article reflects on our experience of conducting focus groups with children aged 7–11 years to examine their experiences of living with asthma. It discusses the use of child-friendly techniques to promote participation and access children's meanings, and raises issues about the size and composition of groups and recruitment strategies, group dynamics, tensions and sensitive moments. We conclude that focus groups are a valuable method for eliciting children's views and experiences and complement personal interviews, while important questions relate to enhancing children's participation in other stages of the research process.

KEYWORDS: *children, focus groups, qualitative methods*

Introduction

The focus of research in relation to children's health and social care has traditionally been on those responsible for children, based on assumptions regarding adults' greater knowledge of 'what is best'. However, recent years have seen an increased emphasis on the rights of children themselves. This is enshrined in Article 12 of the 1989 United Nations Convention on the Rights of the Child, which states that: 'children and young people have a right to be involved in decisions that affect them. This right extends from decisions affecting them as individuals, to decisions that affect them as a collectivity.' The 1989 Children's Act also set up a legal requirement in the UK to consult the wishes and feelings of children when assessing their physical, emotional and educational needs (Greig and Taylor, 1999).

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Despite this changing environment, the implementation of a child-centred approach has been adopted fairly slowly in health, educational and social policies, which partly reflects continuing uncertainties and concerns regarding the need to protect children from decisions that may not be in their long-term interests (Ross, 1997). The picture is similar in relation to mainstream sociology where the incorporation of a child-centred paradigm has been relatively slow to develop. This has been attributed to a high value placed on certain types of knowledge and low worth to child care and still less to the activities of children themselves, with parallels being drawn with the earlier exclusion of women (and gender) from sociological study (Prout and James, 1997), as well as uncertainties regarding appropriate methodologies.

One of the major groups taking forward research with children is Barnardo's, the largest children's charity in the UK (Alderson, 1995; Sinclair, 1998). The educational field has also made a particular contribution in this area, as well as research in relation to health and medicine (Barbour and Kitzinger, 1999; Mauthner, 1997). Guidance regarding appropriate methodologies for research with children is therefore beginning to emerge with experience being available of conducting semi-structured interviews with young children (e.g. Bendelow et al., 1996; Brannen et al., 1994; Hood et al., 1996; Prout et al., 1999), the use of draw-and-write techniques (e.g. Dixon-Woods et al., 1999; Oakley et al., 1995; Pridmore and Bendelow, 1995), and observation (e.g. Hepper et al., 1996). A small number of studies have also involved focus groups with children. These mainly comprised discussion groups undertaken in natural settings, such as youth clubs and schools (e.g. Green, 1997; Michell, 1999).

There has been a considerable expansion of the use of focus groups as a method of data collection in social science research over the last decade, both to inform surveys and as a method of data collection in their own right. This has been accompanied by the publication of a number of guides to focus groups. However, with the exception of an edited collection of studies by Barbour and Kitzinger (1999), these all assume adult participants (Bloor et al., 2001; Kitzinger 1995; Kreuger 1988; Morgan, 1993; Morgan and Kreuger, 1997). Mauthner's (1997) observation that 'Researching children's lives remains at an exploratory stage' (p. 26) thus still holds true both generally and in relation to focus groups.

This article draws on our experiences of conducting focus groups with children aged 7–11 years in the UK as part of a European Concerted Action project (ASPRO2). This project aimed to elicit children's own views and experiences of living their lives with asthma, and their perceptions of asthma treatments. It therefore sought to avoid reliance on parent- or teacher-based accounts and to complement the largely medical view of asthma in childhood. Focus groups were chosen as the main form of data collection, to complement the personal interviews and drawings undertaken in an earlier phase (Wirsing and Trakas, 1996).

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This article presents our experiences and reflections on the methodological issues involved in conducting focus groups with children. In particular it considers issues relating to: (a) the recruitment and composition of groups; (b) ways of promoting participation and redressing the balance of power between children and the adult facilitators; and (c) issues and strategies relating to group dynamics and accessing children's social world and meanings. Extracts from the transcribed focus group discussions and the facilitators' field notes are provided to illustrate these methodological issues. Children's names have been changed to preserve anonymity.

Methods

Eleven focus groups were conducted, involving a total of 42 children aged 7–11 years, who were drawn from a socio-economically and ethnically mixed urban area. Local general practitioners identified children in the appropriate age group who were prescribed preventer medication for asthma. However, a further six children who satisfied the study criteria and were friends or siblings of children identified through general practices also joined the groups.

Letters describing the study and inviting participation were sent to both parents and children by their general practitioners, with the child's letter being in simple language, shorter and in large type. Both parent and child were asked to jointly sign their agreement to participate and return the form. Following their arrival at the community centre, the study was again explained to the child and the parent together, and both signed the formal consent form. However, for young children this can be more accurately regarded as giving assent rather than consent. The local ethics committee granted approval for the study. (For a full review of ethical issues and consent in relation to child-centred research, see Alderson 1995; Mahon et al., 1996; Morrow and Richards, 1996).

An experienced facilitator and co-facilitator conducted the groups. One facilitator led the discussion, and the second operated the tape recorder, assisted with the discussion and observed group dynamics. The broad topic areas covered were children's perception of asthma triggers, their use of asthma treatments, the experience of asthma at home and at school, and their perceptions of good and bad things about having asthma. A third person was present in the background for 5 of the 11 groups to observe the group and take fieldnotes.

Findings

RECRUITMENT AND COMPOSITION OF GROUPS

Recruitment of children to our groups was mainly through five general practices, which had both strengths and weaknesses in terms of group dynamics (see later). At a practical level it meant that groups were held in an

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unfamiliar environment in a local community centre, with attendance depending on both the parents' and children's availability and on parents' willingness to provide transport. The letters of invitation were sent by the children's general practitioners, who did not record the total numbers of letters sent. It was therefore impossible to calculate a response rate. A few parents wrote back to say that their child did not have asthma, or that their asthma had cleared up. Others wrote to say that they did not want their child to participate. In addition, 8 of the 50 families who agreed to participate either did not turn up, or when making a confirmatory telephone call informed us that it would not be possible to attend due to other family commitments. The level of recruitment was lower than originally anticipated, and required the participation of five general practices to achieve a final sample size of 42.

Recognizing the significance of age and also of gender at older ages, separate groups were held for 11-year-old boys and girls. Mixed groups of boys and girls were held for children aged 9–10 and 7–8 years. The literature provides varying advice about the ideal group size for focus groups, although this is generally larger for market research purposes than for social science research (Morgan and Kreuger, 1997). Our groups ranged in size from two to seven children, with the very small groups reflecting the practicalities of recruitment and last-minute dropouts due to other family commitments. Our experience suggests that four or five participants are probably ideal, especially with younger children aged 7–8 years. Larger numbers with this age group made it difficult for facilitators to encourage interactive discussion, while also ensuring that the session was not too noisy and difficult to transcribe. Conversely, very small groups of two or three resulting from last-minute dropouts were tiring for all involved. They also did not really constitute a focus group but tended towards a serial interview scenario, whereby the facilitator spoke to each participant in turn and discussion between participants was reduced. However, the use of scenarios (see later) helped to rejuvenate small groups and increased participation, with valuable data still being gathered in these groups.

Recognizing that children – like adults – have economic lives, we compensated children with a £5 gift voucher for their participation as well as offering travel expenses to parents. According to one 11-year-old boy this was 'a reasonable rate of pay for two hours'.

PARTICIPATION AND THE BALANCE OF POWER

A key task for the facilitator is to maintain an appropriate balance of power in terms of directing and controlling the group, and creating an atmosphere in which participants feel free to discuss. This task poses a greater challenge with children, in view of the inherent power imbalance and the tendency to view the facilitator as an authority figure, such as a teacher, and respond accordingly. This relationship therefore requires to be re-defined, and an atmosphere created that encourages spontaneous contribution. The next

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sections describe and comment on several techniques that we employed to achieve these objectives.

(i) Setting the scene The social context is probably of particular importance in research with children, and influences the way in which they respond. Thus Scott (2000) notes that interviews in school, although generally most cost-effective, tend to evoke a test-taking mentality and concerns about winning peer approval. Green and Hart (1999) similarly described the group discussions they conducted as most formal when held in school settings where the facilitators were seen as 'honorary' teachers and least formal and most chaotic in play schemes where children felt on their own 'turf'. The UK focus groups in our study were held in a pleasant room in a community centre. This took children away from their school environment and the implicit structures and assumptions this entails, and aimed to encourage an informal atmosphere and approach, although necessarily being more artificial than where familiar surroundings are involved.

Various aspects of the initial scene setting aimed to encourage participation and to reduce the hierarchical adult–child relationship. Important to this was that first names were used to encourage children to see adults in a more informal relationship than with teachers. Using the same terminology as the participants is also important, although this may be difficult to anticipate at the beginning of a study. Seating arrangements can also help promote an atmosphere of equity: on the floor the facilitators were the same level as the participants. However, we are not implying that facilitators should try to transcend their adult identity (cf. participant approaches as advocated by Laerke, 1998), as this would clearly be inappropriate in the context of an adult-controlled research setting.

We thought it necessary to complement the emphasis on informality and participation by establishing some ground rules at the beginning of the session to both set boundaries and clarify expectations. These were written on a flipchart and left on display and were: everyone gets a chance to speak; speak one at a time; you don't have to put up your hand to talk; ask if you want to go to the loo (bathroom). Children were asked if they wanted to suggest any others, but none did.

The sessions began with structured warm-up activities, with the aim of reinforcing the message that participation was the aim of the session and promoting group cohesiveness. All participants and facilitators took part in games. The games combined self-disclosure with activities, thereby drawing attention away from the speaker and reducing possible anxiety associated with participating. One game involved throwing a ball to another group member, who on catching had to say his or her name and favourite colour/food/pop star/football player, then throw the ball to another participant. Another game involved group members lining up according to month of birth/number of pets owned by their family/number of siblings/number of

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children with asthma in their class. In the smaller groups, the number of facilitators equalled the number of children, and the power balance was harder to shift and achieve a discussion among participants. In these situations, the role-playing scenarios (see later) were particularly important.

(ii) Space and time Breaking up a session with group activities and refreshments helped to keep the participants engaged. In discussions lasting much over 45 minutes the quality of responses began to deteriorate. Our experience indicated that two sessions of about 20 minutes, separated by a break for refreshments (during which the tape recorder can be kept running) are probably optimum for 7–11-year-olds.

Room space can be used to help maintain group cohesion. We used mats in the middle of the room to create an 'island' on which the group sat; ideally children only left the mats to be taken to the bathroom or to take part in a group activity. During our pilot group we tried to determine appropriate boundaries for individual movement, with our initial concerns about children feeling coerced inspiring us to say that they were free to leave the group if they wanted to. This resulted in three out of six group members leaving the group to sit on the perimeter of the room or play with a ball at various points in the discussion. In subsequent groups, we did not stress this option and participants rarely left the mats.

As with adults, it can be difficult to encourage participation by very quiet children. However, again the seating arrangement was found to help: children sitting opposite the facilitator enabled them to receive more encouraging eye contact without seeming to be singled out. Breaking up the group so that pure discussion is interspersed with other activities (such as paper and pen exercises and role playing with toys) also facilitated participation by shyer children. For example, Bella was a thoughtful but very quiet participant in a group of three 11-year-old girls. During the pen and paper exercises (writing down good and bad things about having asthma) she wrote down the most ideas and in the ensuing discussion contributed more than previously. Where participation in a group is generally good, other children may encourage and support a notably quieter group member. In a group of four 9- and 10-year-olds it was noted that:

> Anne was the quietest child. However, she got a lot of support from the others. For example, Gordon showing her how to throw a ball over her head during the warm-up and Shelley trying to explain what she thinks Anne means when she is asked about something written during the pen and paper exercise.

Permitting 'fiddling' with toys also appeared to facilitate participation. Initial adult assumptions and concerns about minimizing disruption led to taking a hard line against this during the discussion, with balls and dolls put out of reach in between games and scenarios. However we eventually realized that allowing fiddling (such as stroking and playing with the hair of a small

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doll) may have a positive effect of relaxing children by providing respite from eye contact with the group and facilitators, without necessarily interfering with concentration. Our fieldnotes recorded in relation to one 8-year-old girl:

> She relaxed as the group progressed and was especially helpful when she was playing with the dolls. She held one of the small dolls, stroking and playing with its hair and ribbons. This seemed to help by removing the focus from her onto the doll. This was not distracting; she was still able to contribute to the group, seemingly with more ease and confidence than before she had one of the dolls to play with.

In this situation, fiddling provided a relief from the intensity of the group experience and appeared to facilitate participation, although in other situations fiddling was more disruptive.

Accessing children's meanings

The requirement to ask meaningful questions that will elicit detailed and relevant responses is particularly difficult in relation to children, given the differing ideas, understandings and social worlds of children and adults. Researching adults from a different social or ethnic group provides a partial comparison. However, whereas a lack of detailed knowledge in this situation may be partially compensated for through the use of very general, open-ended questions, this was less effective with children, who tended to give monosyllabic answers to questions that they did not identify as relevant to their experience. Children also sometimes generalized the question asked rather than relating it to their asthma. An example was a boy aged 8 years who originally suggested that he had received 'special treats' because he had asthma. However it later transpired that the treat he received was not a result of him having asthma:

Q: Do you ever get any special treats because you have asthma?
William: Umm, yeah.
Q: What are they?
William: Every Wednesday I get chocolate.
Q: Do you, is that just you?
William: When we go down to the shop, on the way back . . .
Q: Ah, so is it anything to do with asthma or not really?
William: No, not really.

This underlines the importance of probing and clarifying to check that young children are responding to questions and connections that the facilitator has in mind. Possible variations in social meanings in relation to age and gender also required maintaining a flexible approach and where possible changing the wording of questions to reflect the composition of the group. For example it was found that the question, 'Is there anything that you can't do when you're playing because of your asthma?' worked for 7- and 8-year-olds;

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whereas for 11-year-olds it was more appropriate to replace 'playing' with 'out with your friends' or 'doing sports'.

We also found that participative techniques provided a useful change in activity and may be helpful in gaining access to children's meanings. Those employed were using an alternative personality for interviewing, pen and paper exercises and role-playing scenarios.

USE OF AN ALTERNATIVE PERSONALITY FOR INTERVIEWING

Children may be reluctant to answer questions to which they think that adults already know the answer ('what is asthma?', 'how did you get it?', 'what does it feel like?', etc). The facilitators therefore used a stuffed toy (dragon creature from a popular cartoon) as their mouthpiece to ask children questions about their knowledge and experiences of asthma as a medical condition. The dragon's cartoon personality seemed to reassure children that their knowledge was superior to his and thereby worthy of expression.

PEN AND PAPER EXERCISES

We encouraged participants to write or draw 'good' and 'bad' things about having asthma, using felt pens and two large pieces of paper on the floor. The open-ended nature of this exercise made it extremely fruitful in elucidating children's values. Again, it is a reprieve from the group experience, giving individuals a chance to reflect on their ideas without the pressure of an immediate question to answer. Virtually all participants took part in this exercise with enthusiasm. Some younger children were not confident about writing and were therefore encouraged to draw a picture instead (sometimes annotated by the facilitator after the group). This exercise also sometimes stimulated verbal contributions which the participant did not want to write down, as in the case of an 11-year-old boy who described a close friend having an asthma attack and nearly dying:

Q: What's bad about asthma then? What's the worst thing about having asthma that you can think of?
Philip: Not with me, but with my friend.
Q: Yeah
Philip: He'd this really bad asthma attack and nearly died.
Q: Yeah that's scary.
Philip: What happened, and like he was my best friend at that time, and so I was, we were really worried about him.
Q: Yeah, I'm sure
Philip: 'Cos he was, we were doing this lap thing at school, it's like a charity sponsored run, you just, he just wouldn't stop. He had to go to hospital in an ambulance.
Q: Oh dear. Yeah, that's bad. Do you want to write that down?
Philip: No.

We kept the tape recorder running during the exercise but there was often a lot of talking together, which interfered with clarity. It was also found

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helpful for the researcher to record comments made by participants that were not written down, such as contextual detail relating to a particularly good or bad thing about asthma. The lists of items written down were also used as a basis for further group discussion. This included stimulating children's recall of specific incidents, and eliciting details of people and places, and how they felt at the time. The excerpt below illustrates this and is taken from a focus group with three 10- and 11-year-old boys.

Q: 'Friends get annoyed' (written as a 'bad' thing about asthma). Who was that?
Tony (to Sam): That was you.
Q: What happened the last time your friends got annoyed?
Sam: Like, sometimes if you're playing with friends that ain't got asthma, and they don't know what it's like, and like, you stop for a rest, and they start moaning at you and they don't know what it's like. But if they had it, they'd probably have to stop.
Q: Sure. So, what do you do? Do you try to explain it to them, or do you not bother?
Sam: Well, I just tell them why I have to stop and then eventually they stop moaning.
Q: Do they understand, do you think?
Sam: Well, to start off with, like. But they don't understand what it's like. But, I mean they've explained it all to them. They know more about it, so they know why you have to stop.
Q: Have the rest of you had that same experience, people getting annoyed if you have to stop in the middle of a game or . . . ?
Tony: Yeah.
David: No, not really, 'cos some, most of my friends have, well, not most of them, but some of them have got asthma, any way.
Q: So they understand a bit better, what it's like.
David: Yeah. They don't get angry.

ROLE-PLAYING SCENARIOS

Role playing with dolls/toys was used to act out different scenarios, and enabled children to convey the perceptions and experiences that they found difficult if considered in more personal terms. Incidents from the good/bad lists sometimes suggested appropriate scenarios. These included: What happens if someone has an asthma attack in the classroom or playground? What if you are playing football and you get wheezy? What happens if someone gets bullied because they have asthma? Some groups initially responded reluctantly to the suggestion of acting out using toys, particularly older boys. However, we found that participants' initial reluctance is not necessarily a reason to abandon the exercise, as perseverance was usually rewarded. Most participants became more engaged as the scenario progressed; even boys who were reluctant to play a role often contributed comments or suggestions to characters from the sidelines, as Gordon did in this excerpt where 9- and 10-year-olds were acting out a bullying incident in the playground:

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'*Teacher*':	Stop that arguing, otherwise I'll phone your mum.
'*Friend*':	She's being nasty, she's being nasty to her but she's got asthma.
'*Teacher'*:	I don't want to hear any tales.
'*Friend'*:	Well, but it's not nice, is it?
Gordon:	That's always what teacher says.

All participants were encouraged to choose or be assigned a character, including the facilitators. When assigning characters, we always allocated a participant a toy of the same gender, and found that participants always chose a toy of their own gender. Characters will depend on the scenario chosen and in our case included children with asthma, their friend/s, bullies, a teacher, school nurse, members of a football team, a doctor and parents. Facilitators asked participants questions about any of the characters (not just their own) in order to probe views on a particular issue. Participants sometimes volunteered illuminating criticism if they thought someone else was not playing their part correctly: in one group, Barbara (a 7-year-old girl) intervened when she felt a facilitator was not playing the bully character aggressively enough:

Barbara:	I'm gonna tell on you. 'Cos you're . . .
Q:	I don't care
Barbara:	Bully
Q:	So what if I am?
Barbara:	Then he starts making . . .
Q:	What do I do? What does he do?
Barbara:	Go 'ha, ha, you've got asthma'
Q:	Ha, ha, you've got asthma

GROUP DYNAMICS, TENSIONS AND SENSITIVE MOMENTS

Observation of group dynamics was important in providing insights into social norms. For example, a group of four 10- and 11-year-old boys included two boys (David and John) who were good friends, a third boy, Tony, who was their acquaintance (he was in the same year at the same school but in a different class), and a fourth boy, Sam, who was unknown to the other participants. Sam was the most willing of the group to discuss sensitive issues, such as bullying, and anxiety about disappointing friends by not being able to participate in games due to asthma. The others not only failed to contribute to discussion on such issues, but became restless and reduced eye contact during this discussion. Our impression was that these were not socially acceptable topics for boys in this peer group.

The inclusion of a few children who were friends, acquaintances or siblings among children who did not previously know each other gave an opportunity to observe the differing ways in which existence of prior relationships between group members can affect group dynamics. This indicated that when friends were involved there was a greater tendency for participants' concentration to lapse and for giggling to increase. In one case where two girls were friends in

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a mixed group of 7–8-year-olds, their giggling spread to other group members and made it difficult to proceed with questions. Similarly, in a group of four 10- and 11-year-old boys, one of a pair of friends kept giggling and made it difficult for the other to concentrate. Where the group was small, the connected pair could also sometimes dominate the group by references to shared experiences, with the result that other members became less inclined to participate. This occurred in a group of three 7- and 8-year-old girls in which two were sisters. Children may also feel anxious about confidentiality where they have friends in common with other participants. One 11-year-old girl following the focus group expressed this sentiment. During the discussion she was also observed 'checking' her responses to questions via regular glances at her friend. It was noted in the fieldnotes:

> There is a lot of eye contact between Mandy and Sue, with Mandy seeming to seek approval from Sue for the answers she gives, e.g. re: the teacher's treatment of children with asthma, and bullying.

However, we also observed approval-seeking behaviour between group members who didn't know each other. For example, in a group of just two 11-year-old boys, Luke was asked if he ever felt afraid during an asthma attack; he didn't answer but looked to Peter, who loudly said 'No'; Luke then said 'No' also.

The dynamics between group members sometimes included the expression of tension and conflict. For example, during a warm-up game two 11-year-old girls who were friends disagreed about the number of children with asthma in their class: Sally said that there were about 5, whereas Michelle said that there were 10. The disagreement was visibly distressing for Michelle, who from that point became more withdrawn. Later analysis of the subsequent discussion revealed that having a minimum number of children with asthma in one's social network can be an important factor in helping the affected child to normalize their identity. This indicated that Michelle's distress may have been attributable not only to the experience of publicly disagreeing with her friend, but also to the fact that her friend's assertion was undermining the basis for her own social status, thus contributing to an understanding of children's social worlds and meanings.

More generally, experience with the groups indicated that some aspects of the discussion, particularly issues of bullying and feeling afraid, were potentially distressing for some participants. This was clearly demonstrated by children's bodily responses, such as looking down or away from the group, increased fiddling with toys, and physically moving away from the group. The challenge is to achieve an appropriate balance between gently encouraging and supporting participants who want to focus on a sensitive issue, and knowing when to abandon a line of questioning for fear of causing further distress. Sensitive wording of questions helped to give participants maximum flexibility in self-divulgence. For example, after observing children's discomfort with

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the question: 'Have you ever been bullied because of your asthma?', we changed to the more impersonal wording: 'Have any children in your school been bullied because of having asthma?'

In some cases, sensitive information was divulged at unexpected points in the discussion. For example, in response to a question about onset of asthma, an 11-year-old girl described her experience of being bullied by another girl who punched her in the chest, an incident which she thought had triggered the onset of her asthma. The facilitator expressed appropriate sympathy and disapproval, but failed to give the participant space in which to explore her feelings around the incident she had described. We later decided that this was a misjudgement, as the girl became somewhat withdrawn after giving this account, and comments she made after the session suggested that she had felt neglected. Moreover, as Kitzinger and Farquhar (1999) note, the discussion of such sensitive issues can have considerable potential in providing an in-depth understanding of personal experiences and social processes, although requiring considerable skill on the part of the facilitator.

Conclusions

The focus groups we conducted provided new insights into children's own experiences of living with asthma, and identified some important differences from adults' priorities and concerns. For example, key aspects for adults have been identified as their worries about the possible long-term effects of both asthma and the prescribed treatments on their child's growth and development (Donnelly et al., 1987), whereas children generally viewed their asthma treatments in positive terms but were concerned about feelings of stigma and the need to cope with asthma at school. Assessments of good and bad aspects of asthma also varied in relation to age and gender, while friends with asthma appeared to be of considerable importance in helping to maintain children's status and identity. Thus this methodology was successful in achieving the aims of the research.

Our experience indicates that many issues and good practices are common to conducting focus groups with both children and adults. For example, the various group activities we employed have parallels in adult focus groups, in terms of the use of vignettes (Barbour, 1999), photographs and pictures and statement cards (Kitzinger, 1993, 1994), and are similarly used to stimulate discussion, increase participation and provide a welcome change in format. Issues of the composition of groups, shy and dominating members, and the handling of sensitive topics and moments also form more general issues of focus group research (Bloor et al., 2001). Similarly, the recommended practice of having both a facilitator and assistant was generally felt to be appropriate by the facilitators for the general running of the group and allowing the pace and interest to be maintained. However, when just two or three children turned up, a single facilitator might have been more appropriate to restore the

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balance between children and adults, although we have no direct evidence of the effects of one or more facilitators on the dynamics of small groups.

A general issue relates to the method of recruitment to focus groups. Recruiting children through general practitioners and organizing attendance at a community centre was considerably more demanding and time-consuming than it would have been to draw children from schools or other pre-existing groups. The low response also meant that we needed to approach more practices than originally intended and greater attention required to be given to warm-up activities to overcome initial barriers. In terms of interaction and discussion, one view is that groups comprised of strangers may speak more freely without fear of reprisal. Another view is that groups of friends may feel empowered and supported in the co-presence of those they know. Shared experiences may have the advantage that any discrepancy between expressed beliefs and behaviours may be challenged, although the need to emphasize confidentiality is increased as relationships continue after the group. Our study did not allow us to draw any firm conclusions regarding the composition of groups and patterns of interaction, but suggested that this varied in relation to whether participants were close friends (not merely acquaintances), and was also influenced by individuals needing to seek approval by the group. However, the question of the significance of prior relationships in focus groups with both adults and children requires further assessment.

A particular issue highlighted by our groups was the greater difficulty in accessing children's meanings compared with adults, reflecting differences in language and in the social worlds of children. This required the use of careful clarifying and probing and was assisted by the use of an alternative personality and role-playing techniques. However, gaining greater insights into children's social worlds (including issues of bullying, social hierarchies and friendship networks and support raised in the present study), also requires that researchers observe formal and informal activities and relationships at school, and engage in conversation with children in these natural settings (Mayall, 2000). It is also important to consider ways of involving children more fully in focus group research in terms of setting the research agenda and conducting the research process, as with the limited experience of children as peer interviewers (Wetton and McWhirter, 1998). One aspect of this is the need to gain participants' own views of focus groups, including what they enjoyed and worked well and what they did not like. This evaluation needs to be done in an interactive way rather than the more conventional questionnaire approach. We did not formally evaluate the sessions with children, although spontaneous comments and questions, such as 'can we come again?' and 'when can we come again?', indicate that at least some had enjoyed the session. Respondent validation may similarly be extended to children, with the results being discussed with child informants to check the accuracy of interpretation.

A further issue concerns the relative advantages and disadvantages of

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personal interviews compared with focus groups in hearing children's voices. It has been suggested that focus groups are not necessarily the most appropriate method for researching sensitive issues in depth. For example, Michell (1999) compared responses given by groups of pupils aged 11 and 12 years with an ongoing relationship with personal interviews with children of the same age. She observed that it was only in the interviews that low-status girls (who were passive and reticent within the group) began to talk about what it was like to be at the bottom of the social ladder and a victim of bullying. Personal and family problems were often talked about exclusively within the interviews. As Michell observes, 'in response to the undivided attention of a sympathetic outsider, layers of meaning and explanation began to be revealed which had been entirely hidden in the focus groups' (p. 41). Similarly, we observed the reluctance of a few children to contribute to some topics and approval seeking behaviours, which itself provides some information about group norms although not disclosing individual's views. Thus while focus groups have some advantages in terms of group support and group dynamics, like other methods of data collection they can only provide a partial account and may require to be supplemented by other data.

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