**GROUNDED THEORY**

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**Alison Tweed and Helena Priest**

**Introduction**

Grounded Theory (GT) is one of the longest established approaches to dealing with qualitative data, having been conceived in the 1960s and popularised in the 1970s, and for some considerable time it was seen as the market leader in qualitative research (McLeod, 2001; Payne, 2007). Having its origins in sociology and used extensively within the social sciences, GT was not, however, widely adopted by psychology until the early 1990s. Since then, as demonstrated through the publication of books such as this one, new qualitative research methods and strategies have been developed, creating many opportunities for qualitative researchers to select, adapt and combine approaches. Nonetheless, GT remains popular within applied psychology and other professional spheres such as education, nursing and health care. One of the reasons for its continued popularity is that there is a set of explicit guidelines to follow; additionally, there are numerous published studies within health and clinical psychology that can be used as exemplars of the approach, and we consider some of these later in the chapter.

Grounded theory is an appropriate methodology to explore topics about which little is known or for which no adequate theory currently exists. Therefore, a broad, open-ended, action-oriented research question is generated as a starting point, although this is often refined and becomes more specific as the research progresses (Payne, 2007). The fundamental aims of grounded theory are to move beyond general description and, by uncovering the basic social and psychological processes that underpin human behaviour, to construct theory about issues of importance in people’s lives (Cresswell, 2007; McLeod, 2001; Mills, Bonner & Francis, 2008). In achieving these aims, GT can be viewed from two inter-related perspectives: as a method of analysis of qualitative data, and as a type of theory or general explanation produced from the analysis of such data (Henwood & Pidgeon, 2012). In other words, it is both a specific technique and a general approach for exploring and making sense of the world. In this chapter, we aim to present the broad principles and procedures of GT and to illustrate these with reference to published studies and illustrative case material, in which GT is applied to data from a study about people’s experiences of receiving treatment for chronic kidney disease.

**Historical background**

Grounded theory was developed in the 1960s by Barney Glaser and Anselm Strauss, two sociologists undertaking ethnographic fieldwork around the experiences and processes of dying in hospital, a taboo topic at the time. Dissatisfied with the dominant experimental/quantitative methods in understanding and explaining human experience, they proposed a method for close examination of data which could move beyond description and into explanation and theory (Payne, 2007). Their seminal text, in which the research methodology they had devised was formally explained, was published in 1967 (Glaser & Strauss, 1967). The two authors subsequently came to disagree about the nature and procedures of grounded theory, with Glaser considering Strauss’s approach too structured and prescriptive, and simply a matter of following procedures in order to ‘force’ theory from the data. For Glaser, analysis was more a matter of patience and waiting for creative insights to emerge (Cresswell, 2007; McLeod, 2001). Strauss later collaborated with Corbin (1990, 1994, 1998) in producing a more widely-used general introduction to GT that also included a set of procedural rules (McLeod, 2001). More recently, challenges to this structured, objective and perhaps even positivist approach to GT have been made, exemplified by the work of Charmaz (1995, 2006), in her ‘constructivist grounded theory’. This version of GT emphasises the interpretation of diverse social worlds and multiple realities (Cresswell, 2007). As such, it has flexible guidelines and takes into account the researcher’s subjective view, rather than aiming for a more objective reality, and leads to a theory that ‘is situated in time, place, culture and situation’ (Charmaz, 2006, pp.131). However, it has been criticised for not providing steps to guide the researcher and thus being challenging to apply (Hunter et al., 2011).

Since its early origins, many researchers have drawn upon grounded theory principles, and several different manifestations are evident within the published literature, including modified or *abbreviated* versions. Willig (2008) describes abbreviated grounded theory as limited to analysing the original data only and not seeking out new informants or new data to broaden and refine the emerging theory. The extent to which these reduced versions can truly generate theory is debatable, although they do offer a useful starting point, especially perhaps for the novice researcher. Ultimately, though, to arrive at any kind of theory, key components must be established: a central phenomenon, context, conditions, strategies, and consequences (Cresswell, 2007).

**Theoretical framework**

As noted, GT was conceived by sociologists and has links both to *ethnography* (the study of a cultural group, often through extensive and intensive participant observation of the group in its natural environment) and to *symbolic interactionism*. Strauss in particular was interested in symbolic interactionism, which emerged in the USA in the 1920s and 30s, and in which reality is seen as a meaningful social interaction with others. People interact with others, therefore, based on a shared social understanding of reality rather than on any objective reality.

To a large extent, Charmaz’s (1995, 2006) constructivist GT echoes this notion. *Social constructivism* is a worldview in which people develop subjective, varied and multiple meanings of their experiences. Thus, constructivist GT emphasises the subjective interrelationship between the researcher and participant, and the co-construction of meaning (Mills et al., 2008). The goal of constructivist GT therefore is to draw on participants’ views as they have been formed through social interactions with others. This contrasts to more *objectivist* versions of GT (e.g. Glaser, 1992), where an external, knowable reality is assumed to exist and GT methods provide a means by which this reality can be discovered. In this approach, the role of social context and the interaction between researcher and participant is minimised. Whilst it may seem that these are dichotomous positions, the theoretical and epistemological underpinnings of different versions of GT tend to run on a continuum between objectivist and constructivist poles (see Madill, Jordan & Shirley, 2000 for a review), and there remains a core of similarity in approach and analytic process, emphasising collaboration and co-construction and drawing on a wide range of data sources. The researcher’s choice will be guided by his or her epistemological position, the aims of the particular study, and its research questions. Hunter et al. (2011) provide a clear account of evaluating and choosing between the different approaches.

**Uses for clinical and health psychology**

Grounded theory has been successfully used to study topics within many professional contexts, including nursing, management, education, and social work, as well as clinical and health psychology. Table 1 includes studies from the clinical and health psychology fields, while the illustrative example that follows is drawn from the health psychology arena.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Author(s) | Date | Title | Journal | Aims, data and findings |
| Crossley, J. & Salter, D. | 2005 | A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy | Psychology and Psychotherapy: Theory, Research and Practice  78(3), 295–313, | This study aimed to produce a theory of how clinical psychologists understand and address spirituality within therapy. Data were gathered from 8 interviews, and two core categories were developed: spirituality as an elusive concept and finding harmony with spiritual beliefs, although the authors acknowledge that it was difficult to construct a coherent concept of spirituality. |
| Abba, N., Chadwick, P., & Stevenson, C. | 2008 | Responding mindfully to distressing psychosis: A grounded theory analysis | Psychotherapy Research, 18(1), 77-87. | This study aimed to produce a theory of the core psychological process involved in responding mindfully to distressing psychotic sensations. Sixteen interviews were conducted with participants who had completed a mindfulness group. The theory produced represented the process as comprising 3 stages: *centring in awareness of psychosis; allowing voices, thoughts, and images to come and go without reacting or struggle; and reclaiming power through acceptance of psychosis and the self*. |
| Homewood, E., Tweed, A., Cree, M. & Crossley, J. | 2009 | Becoming Occluded: The transition of motherhood of women with post-natal depression | Qualitative Research in Psychology, 6(4), 313-329 | This study aimed to produce a psychological theory and process of the transition to motherhood of 9 women diagnosed with post-natal depression. The core category was termed *Becoming Occluded* and represented mothers’ attempts to sustain their infants in the context of distress and difficult emotions. |
| Knott, V., Turnbull, D., Olver, I. & Winefield, A. | 2012 | A grounded theory approach to understand the cancer-coping process | British Journal of Health Psychology, 17(3), 551-564 | The authors interviewed 20 cancer patients on their experience of communication about their condition. Using Glaser’s GT method, three models were developed from the analysis including patient’s evaluation of quality of care, cancer-coping processes and distress. The study aimed to move away from individualistic conceptualisations of cancer experiences to one encompassing the social context. |

**Table 1**: Clinical and health psychology studies using grounded theory.

**Doing GT research: Outline of the method**

*Types of data*

As noted, GT is an approach and a method for the analysis of data, rather than being overly concerned with the type of data or the way in which that data is collected. It is therefore suitable for analysing data gathered from a range of sources, including individual interviews, focus group interviews, observational studies where field notes or other forms of recording are made, documents, images, and artefacts. For many novice researchers, data acquired from semi-structured interviews tends to be the data collection form of choice. Where data is collected in this way, questions are kept deliberately broad and general. In the illustrative example that follows, we use diary entries rather than interview data, but the key principles are the same.

The excerpt of data in Text Box 1 is part of a diary entry from Linda, a 62 year old kidney patient with End-stage Renal Disease (ESRD). End-stage Renal Disease is a life-threatening condition, whereby a person’s kidneys are functioning so poorly (or not at all), that they are unable to remove sufficient waste or excess water from the body. At this stage, the individual will require a form of renal replacement therapy; either kidney dialysis, or a transplant. Linda was due to commence dialysis renal replacement therapy as part of a planned procedure and of the two dialysis options available to her (haemodialysis: blood cleaning through a machine, or peritoneal dialysis: where fluid is passed into the body cavity to remove toxins), she had opted for peritoneal dialysis. Linda had spontaneously kept a diary about her health condition and treatment for many months and had shared her diary notes with the researcher (AT) to assist in the preparation of information materials for pre-dialysis patients. She gave permission for these entries to be used for teaching and publication purposes and she also assisted AT in the development of a more formal GT study with pre-dialysis patients in the hospital unit. The extract below captures the point of commencing treatment. The research question asked of the data is ‘How do people with ESRD experience the transition to dialysis?’

INSERT TEXT BOX 1 HERE

*Position of the researcher*

In GT, the researcher should have no preconceived ideas to prove or disprove and so has to be sensitive to multiple possible meanings of the data (McLeod, 2001). The researcher’s task is to explore the stories that people tell about an area of interest that they have in common with the researcher (Mills et al., 2008), and this relies on full immersion in the data. Immersion involves listening to, or reading the data closely on multiple occasions to absorb as much as possible the content, meaning and nuances of the material. To some extent, collaborative working with other researchers is downplayed, to allow an individual researcher to immerse him or herself in the data.

Using Linda’s diary material it is important to read and re-read the extracts; to start to document ideas, emergent thoughts and patterns as part of the *audit trail* for the research process. These initial notes will evolve into *memos* (see later), a critical aspect of the GT process. In addition, researchers need to consider their own part in the research process: their prior understanding of the area, what they hope to achieve from the research and their epistemological position. This is often referred to as *foregrounding.* Understanding epistemology is something many novice researchers struggle with but basically refers to how individuals acquire and understand knowledge about the world; in summary ‘how do we know what we know?’ In interpreting Linda’s diary data, the GT researcher (AT) adopted an epistemological approach of critical realism, part way along the continuum between more positivistic and more constructivist versions of GT. Critical realism assumes the existence of a reality, but only one that is approximately known and as such can be modified by social interactions, culture and time (see Madill, A., Jordan, A. & Shirley, C. (2000) for a review). She had worked as a clinical psychologist with kidney patients over many years in a hospital setting so was familiar with the treatment procedures and their psychological sequelae.

*Use of prior knowledge*

There is a potential dilemma within GT with how much the researcher should use their prior knowledge and the available literature about their chosen topic to inform the GT analytic process. Ideally, when planning a GT study, the researcher does not attempt to review the available literature before collecting data, in order to approach the topic and participants with an open mind and sensitivity. The literature is searched and reviewed after the grounded theory has been produced, and compared with developing categories and theory in order to examine to what extent the new theory has supported, deviated from, or extended existing knowledge. In reality, it would be unusual if a researcher had no knowledge of the literature around their topic of interest, so the extent to which this naïve approach is possible is questionable. As a reasonable compromise, most GT researchers will carry out some preliminary searching and reviewing of the literature to ensure that the topic of interest is indeed lacking in exploration and theory development and warrants the GT approach (Payne, 2007; Willig, 2008). Indeed, while working up a research proposal for external scrutiny, awareness of the scope of existing knowledge on the topic would be expected by peer reviewers and ethics panels. This preliminary review also enables the researcher to be aware of and make explicit their own influence and preconceived ideas that they might be in danger of imposing on the data, and take steps to limit this as far as possible.

Returning to the illustrative example, the GT researcher’s experience of working clinically with kidney patients and extensive knowledge of the literature and evidence-base, will no doubt influence her approach to Linda’s diary excerpt. Her knowledge and experience suggests that many people commencing dialysis find the process difficult and challenging and she is not surprised to see a similar process for Linda. However, it is important for her to remain open to new insights or elements within Linda’s data; not to bypass sections which are difficult to interpret and understand, but to make use of supervisory and reflexive processes to challenge her assumptions about the data. For example, because her clinical work is principally with those who are experiencing extreme distress in relation to dialysis treatment, she is less likely to work with those who successfully manage the transition, and so may assume that all transitions are fraught and distressing. This may mean she misses the more positive or optimistic aspects of the data. The supervisory and reflective processes can include keeping a reflective diary to note thoughts and feelings about working with the data and to discuss these within research supervision to see how they might be influencing the analysis. Another example is to involve others in the analysis of excerpts of the data so that any differences in interpretation can be highlighted or challenged.

*Recruiting participants*

Where face to face data is collected from participants (rather than from documents or images, for example), all participants must have experienced the process, action or interaction of interest, and therefore sampling is *purposive* – deliberately targeting individuals whose individual characteristics and experiences can best inform the developing theory. Recruitment can include people who exemplify different facets of the area of interest, or who have different experiences and perspectives. For example, as we are interested in studying transitions to dialysis treatments we will seek out those people who are at that particular stage of the kidney disease process. Purposive sampling can also allow the researcher to seek out *deviant or negative cases*, representing people who might offer a challenge to the developing insights and theory. In the illustrative example, this may include people who are on planned renal replacement therapy trajectories (such as Linda) as well as those who have experienced acute kidney failure and so have received no medical pre-planning.

In purposive sampling, all the participants may be chosen before data collection commences (as in abbreviated GT), or, as is more usual, they may be recruited gradually as the research progresses and after tentative codes or categories have been produced, in order to target specific individuals, groups or data that can best clarify questions and expand or test the developing theory. This is a process known as *theoretical sampling*, and it can continue until *saturation* has been reached. Saturation is the point at which the researcher ceases to gain any new insights or ideas from the data being collected (McLeod, 2001) and does not expect that seeking out new participants or data would produce any further significant insights. At this point, data collection ends. GT researchers, therefore do not usually state explicitly the number of participants that they will recruit to their study from the outset, although they may give a potential range based on their experience, expectations and knowledge of similar published studies. It is of note that abbreviated versions of GT generally work with the original data alone, and do not engage with theoretical sampling. The extent to which such versions can ever achieve saturation is therefore debatable.

*Procedure*

Unlike many other forms of qualitative research, data collection and analysis in grounded theory are synchronised. The first set of data collected is analysed, and then used to sensitise the researcher to what needs to be addressed in the next piece of data collection. Over the years, different terms have been used by GT for the analytic stages which can cause confusion to new researchers. Birks and Mills (2011, p.90) provide a very helpful table of GT terminology to help navigate this process.

Analysis takes the form of a series of coding stages. *Open coding* begins with breaking the data down into small segments as a way of deconstructing the material. It is up to the individual researcher to decide on the size and nature of a segment. It could be a single word, but is more likely to be a phrase, sentence, line or even paragraph of transcribed text; line-by-line coding is commonly used as it is helpful for analysing in-depth interviews of the type likely to be obtained in clinical or health psychology research. Taking each segment in turn, the researcher asks: ‘what does this mean?’ and ‘what else could it mean?’ and then gives each segment an appropriate code label which captures its meaning. The label may be a word or phrase taken directly from the data (known as *in vivo* coding), or it may be the researcher’s own imposed word or phrase. The aim is to generate and record as many code labels as possible to explain each data segment. As coding progresses within and across data sets, the researcher will notice that the same code labels are applied repeatedly and that eventually, few or no new codes are needed.

Tweed & Charmaz (2012) and Charmaz (2011) advocate labelling codes with *gerunds* rather than with topic or theme words. A gerund is the use of a verb as a noun (that is, in its –ing form), as in: ‘it’s not the *winning* but the *taking-*part that counts’. Using gerunds makes it easier to reveal links, processes and relationships between data rather than separating them into discreet units, as is likely to happen when using topic or theme labels. The example in Text Box 2 highlights initial open coding, principally using gerunds for Linda’s diary excerpt. The data has been broken into *meaning units*, each representing a distinct thought, idea or statement, instead of breaking the data down into words, lines or paragraphs. Code names are a combination of words imposed by the GT researcher as well as *in-vivo* codes arising directly from the excerpt. Initial open coding provides a good opportunity to question personal assumptions about the data and to highlight areas for further exploration or analysis (see Notes at end at Text Box 2).

INSERT TEXT BOX 2 HERE

Once the first data set has been open-coded, the next stage of analysis is *focused or selective coding*. Here, larger segments of data are coded using more abstract or theoretical code names, which involves a decision-making process to select those initial open codes which appear most relevant to the research question. By undertaking focused or selective coding the GT researcher explores possible relationships between the initial codes, and generates broader focused codes or categories which contain a number of individual but closely-related items. Categories are then given their own label, which may be new or taken from one of the original code labels. Strauss and Corbin (1998) use a different term for focused coding, called *axial* coding. Axial coding is a structured process for highlighting relationships between codes and categories, and uses a model for coding which involves looking for conditions, context, action and consequences within the data.

During focused or selective coding it would be usual to gather more data through theoretical sampling in order to refine, elaborate and test out ideas presenting from the emerging categories. Text Box 3 highlights focused coding of Linda’s diary excerpt. Here, potential category names are elicited including *Losing Physical and Psychological Autonomy, Experiencing Physical Manifestations of Illness,* and *Reclaiming Physical and Psychological Autonomy.* These may encompass potentially lower-order codes such as *Using Coping Strategies*; a possible sub-category of *Reclaiming Physical and Psychological Autonomy.* At this point, potential category names may be long, somewhat unwieldy and not fully defined. Further coding, data gathering and memo-writing helps refine and shape categories during this process.

INSERT TEXT BOX 3 HERE

Throughout these stages, the researcher uses a *constant comparison* technique, cycling back and forth in the data to examine new codes and categories in relation to previously identified concepts, incidents, and cases, and to determine where they might fit into the evolving analysis (Gordon-Finlayson, 2010). This makes GT a non-linear process, where the emerging theory can be refined based on new material or perspectives. Codes and categories are thus revised and relabelled as required. These processes are greatly aided by *theoretical sensitivity* and *memo writing.* Theoretical sensitivity involves looking at the data and emerging analysis from new and different perspectives. *Memos* are an essential record of the researcher’s thoughts and reflections on the data and analysis as it goes along, and they serve as an audit trail of these processes and decisions taken. They may take the form of written notes, notes made on a voice recorder, or sketch diagrams, and they can also be made using computer software such as NVivo (TM). Memos are likely to change in nature as the analysis proceeds, with early memos being ‘partial, tentative and exploratory’, while later memos are likely to be more precise and sophisticated (Tweed & Charmaz, 2012, pp. 140). According to Gordon-Finlayson (2010), it is through memo writing, and not simply through coding, that ‘the interpretative and theory generation processes happen’ and where the ‘final theory starts to take shape’ (pp. 165).

Text Box 4 highlights a tentative memo on the category *Reclaiming Physical and Psychological Autonomy* from Linda’s diary excerpt. Here, the category is defined and any gaps or further ideas to be explored are developed through the narrative. Linkages and relationships are made with other tentative categories, sub-categories and codes and exemplar quotes are highlighted as a way of keeping track of relevant data. Memos play a vital role in the final writing up of the analysis and enable the GT researcher to keep track of the emerging grounded theory from inception to conclusion.

INSERT TEXT BOX 4 HERE

The final stage of analysis is when the relationship between categories is identified in a process known as *theoretical coding*. From theoretical coding, the GT researcher can develop a *storyline* (Birks & Mills, 2011; Strauss & Corbin, 1998). A storyline is a narrative description of the theoretical framework derived from the analysis and aims to provide a coherent account of the grounded theory produced. One aspect of developing the storyline involves identifying a more abstract *core category* around which all categories derived so far can be organised, and which has major explanatory power and links to existing theory (Glaser, 1992; Payne, 2007). Using the constant comparative method enhances goodness of fit between the original data and the core category. Once data saturation has been reached (that is, when no new insights are deemed possible), then data collection ends. The final task is to develop a theory that encompasses the core category and other important components of the analysis. The type of theory developed will differ according to epistemological position but data should be re-conceptualised, understood and interpreted in *abstract* terms. From a more positivist position, the resulting theory may claim predictive and explanatory power of a process or core category within a known phenomenon. From a more constructivist position, theory-development involves the understanding of patterns, relationships and processes, and the acceptance of multiple realities (Charmaz, 2006; Tweed & Charmaz, 2012).

Text Box 5 shows an advanced memo, highlighting a tentative core category and storyline based on the analysis of Linda’s diary excerpt and other data from kidney patients commencing dialysis treatment. The category of *Reclaiming Physical and Psychological Autonomy* has been promoted as both the core category and as the basic social-psychological process through which an individual manages the transition to dialysis treatment and beyond. Another GT researcher could well have selected an alternative core category and process based on their analysis of the data, but this illustrates the interpretative and analytic approach to GT. There are no right and wrong answers here; the trajectory of the analysis is shaped by personal, contextual and interpretative factors. It does not mean that GT lacks credibility or coherence, quite the opposite; it can produce an understanding of a phenomenon that is highly meaningful.

INSERT TEXT BOX 5 HERE

In summary, then, for data analysis in GT, open coding enables categories of information to be identified; focused or selective coding allows for these categories to be interconnected; and theoretical coding enables a story to be built by connecting categories, and ending with theory. However, it is important to bear in mind that the skilled GT researcher is not simply applying a formula; rather, the formula enables the analysis but is not the analysis itself (Gordon-Finlayson, 2010). Figure 1 provides a visual representation of the GT process. The bottom of the pyramid represents the large amount of raw data typically produced during data collection about the phenomenon of interest. Initial, selective and focused coding reduces the raw data into packaged elements consisting of codes and categories. These become increasingly abstract and conceptual. At the same time, theoretical sampling and constant comparative analysis enables the GT researcher to move back and forth within the data to refine and focus the analytic process. Theoretical coding denotes the final stage of analysis and the development of the core category. Throughout the whole process, memoing links one analytic stage to the next, acting as the metaphorical mortar holding the building blocks of the pyramid together.

ADD FIGURE 1 HERE

*Writing up*

The aim in writing up a GT report is to produce an account of the substantive theory that has been produced from the data analysed, often accompanied by an explanatory diagram. The report can follow a standard format, including sections on: background to the topic, rationale for studying it, research question, participants, tools, procedure, results, and links/extensions to existing knowledge. Enough detail needs to be provided so that the reader can follow all the steps and decisions taken, and the report needs to be illustrated with verbatim extracts from interview transcripts or other data such as observational notes. The researcher may choose also to include extracts of memos and other notes illustrating the analytic process.

*Quality control*

The key test of the adequacy of the theory is *goodness of fit*: in other words, it must be meaningful to people with an interest in the topic explored, (for example, clinical or health psychologists). Quality checking in GT may be somewhat different from other methods because of its focus on individual rather than collaborative working. Thus, strategies such as member checks may be less relevant. Equally, respondent validation (for example by seeking verification of the theory from the participants who contributed to it) may merely produce more data rather than establishing the credibility of the researcher’s perspective (Payne, 2007). Both Charmaz (2006) and Madill et al. (2000) have provided useful information on enhancing the quality of GT studies. Charmaz presents the concepts of *Credilbility, Originality, Resonance* and *Usefulness* as markers of quality, whilst Madill et al use a number of quality criteria to evaluate a GT study within different epistemological positions. Their conclusion is that researchers must be clear about their epistemological position and be consistent with this in their methods of analysis. Any quality criteria used must therefore also be consistent with the stated epistemological position, rather than being used as a box-ticking exercise. Regardless of position taken, it is important that a GT project is undertaken rigorously and there is a clear audit trail of research decision-making.

*Challenges of GT*

While GT may initially seem attractive to novice researchers because of the ready availability of ‘how to’ guides, it is important to be aware of the many challenges, not least in ensuring consistency between the theoretical and epistemological framing of the study and the form of GT employed. There are many decisions for the researcher to make, such as whether or not to transcribe interview data; what counts as a data segment; who to approach to expand the emerging theory; when saturation has been achieved and data collection can end; and when the theory is adequately developed and detailed. No manual will fully answer these questions for the researcher and it is only by doing GT that a researcher will become fully appreciative of the interpretative and creative process involved.

*Conclusion*

As has been seen from this chapter, GT is a rigorous, creative and flexible approach to deriving new meanings and understandings from qualitative data. The challenge for the GT researcher is to move beyond the descriptive to produce meaning and understandings that are abstract and theoretical. Whilst GT by its very definition is grounded in the data, it should not be limited by it. At times, the GT process can feel overwhelming, confusing and complex, yet it is important to persist, to immerse oneself in the process in order to achieve the outcome and end-point. Using Linda’s diary material, the GT analysis helped elucidate a process of reclaiming autonomy in spite of chronic illness and treatment; an optimistic, hopeful and restorative process that other kidney patients and health professionals can find beneficial. We hope this chapter also serves a similar function and enables you to embark on a successful GT journey.

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**Further reading on the methodology**

Bryant, A. & Charmaz, K. (2007) *The SAGE handbook of grounded theory.* London: Sage.

Charmaz, K. (2006) *Constructing grounded theory.* London: Sage.

Strauss, A.L. & Corbin, J. (1998) *Basics of qualitative research: Grounded theory procedures and techniques* (2nd Ed.)*.* Thousand Oaks, CA: Sage.

TEXT BOX 1: Excerpt from Linda’s diary

AUGUST

I am itching everywhere, even in my head! I have never had to cope in my life with anything like this. It is far worse than pain as at least you can take a painkiller for that. This itching is really awful I feel like screaming and screaming. It gets me occasionally in the day but it really gets going in the evening and gets worse and worse.

At this moment, I must admit to feeling at rock bottom and wishing I was out of it all. I really do! I started my [Continuous Ambulatory Peritoneal Dialysis] CAPD training on Monday and that frightened me out of my wits. I feel that I have come to the end of ever having control of my body and any say in the future of my life. I know I ought not to feel so but I am afraid I do. I have had my op now and resent the intrusion of the tube so much.

Writing all this down is as usual helping me to calm down. It is a long time since I felt so much anger, helplessness and frustration. I dread everything now to do with my body and my treatment.

SEPTEMBER

I do have some hates about dialysis and maybe it will help if I write them down:

1. Having to remember the sequence of things
2. Seeing the tube
3. Changing the dressing as then I see the exit site
4. Wearing a dressing all the time as the sticky tape makes me itch
5. Not being able to have a proper bath with lots of water
6. Constipation and fat tummy!

Now they are listed and although I seem to be negative I am positive at times. I think I ought to set myself goals. My first one could be going on holiday. Well I feel better now, hopefully I can get some sleep.

TEXT BOX 2: Open Coding of Linda Excerpt

AUGUST

**Experiencing global symptoms \*Extending coping abilities**

I am itching everywhere, even in my head!// I have never had to cope in my life with anything like this.//

**Making comparisons to other symptoms Having means of symptom control**

It is far worse than pain // as at least you can take a painkiller for that.// This itching is

**Suffering unbearable symptoms Increasing intensity of symptoms over the day**

really awful I feel like screaming and screaming.// It gets me occasionally in the day but it really gets going in the evening and gets worse and worse.//

**\*\*Wanting isolation / suicide?**

**Feeling at rock bottom**

At this moment, I must admit to feeling at rock bottom //and wishing I was out of it all. I really do!//

**Fearing new treatment regimen**

I started my [Continuous Ambulatory Peritoneal Dialysis] CAPD training on Monday and

**Losing control of body**

that frightened me out of my wits.// I feel that I have come to the end of ever having control of my body

**Fearing own emotional response**

**Losing autonomy**

//and any say in the future of my life.// I know I ought not to feel so but I am afraid I do.//

**Resenting physical intrusion**

I have had my op now and resent the intrusion of the tube so much.//

**Using strategy to calm self**

Writing all this down is as usual helping me to calm down.//

**Comparing emotional states to the past**

It is a long time since I felt so much anger, helplessness and frustration. //

**Experiencing all-consuming dread**

I dread everything now to do with my body and my treatment.//

SEPTEMBER

**Using strategy to express emotional state**

I do have some hates about dialysis and maybe it will help if I write them down://

**Having to remember sequence of treatment**

1. Having to remember the sequence of things

**Experiencing physical manifestation of illness**

1. Seeing the tube
2. Changing the dressing as then I see the exit site
3. Wearing a dressing all the time as the sticky tape makes me itch
4. Not being able to have a proper bath with lots of water
5. Constipation and fat tummy!//

**Using strategy to enhance positivity**

Now they are listed and although I seem to be negative I am positive at times. //

**Setting goals**

I think I ought to set myself goals. My first one could be going on holiday. //

**Hoping for rest (physical and psychological)**

**Feeling better**

Well I feel better now,// hopefully I can get some sleep.

NOTES: \* ‘coping’ is a psychological term and may be pre-emptive. Try not to assume these are coping strategies but gather more evidence.

\*\* statement potentially needs greater investigation. Does this relate to a wish for isolation or wish for death?

TEXT BOX 3: Focused coding of Linda excerpt

AUGUST

**Suffering unbearable symptoms**

**Fear driving wish for escape**

**Losing physical and psychological autonomy**

**Experiencing all-consuming dread**

I am itching everywhere, even in my head!// I have never had to cope in my life with anything like this.// It is far worse than pain // as at least you can take a painkiller for that.// This itching is really awful I feel like screaming and screaming.// It gets me occasionally in the day but it really gets going in the evening and gets worse and worse.//

At this moment, I must admit to feeling at rock bottom //and wishing I was out of it all. I really do!// I started my [Continuous Ambulatory Peritoneal Dialysis] CAPD training on Monday and that frightened me out of my wits.// I feel that I have come to the end of ever having control of my body //and any say in the future of my life.// I know I ought not to feel so but I am afraid I do.// I have had my op now and resent the intrusion of the tube so much.//

Writing all this down is as usual helping me to calm down.// It is a long time since I felt so much anger, helplessness and frustration. //I dread everything now to do with my body and my treatment.//

SEPTEMBER

**Using coping strategies**

I do have some hates about dialysis and maybe it will help if I write them down://

1. Having to remember the sequence of things

2. Seeing the tube

**Experiencing physical manifestation of illness**

1. Changing the dressing as then I see the exit site
2. Wearing a dressing all the time as the sticky tape makes me itch
3. Not being able to have a proper bath with lots of water
4. Constipation and fat tummy!//

**Reclaiming physical and psychological autonomy**

Now they are listed and although I seem to be negative I am positive at times. //I think I ought to set myself goals. My first one could be going on holiday. //Well I feel better now,// hopefully I can get some sleep.

TEXT BOX 4: Example Memo

**Reclaiming Physical and Psychological Autonomy**

Reclaiming physical and psychological autonomy appears to be a transformative process commencing at around the time of starting dialysis treatment. Regaining physical autonomy relates to having greater control over bodily processes and reducing disease symptomatology through managing the new treatment regimen. This is not always a straightforward process and is potentially fraught with set-backs both in relation to problems with the treatment itself (e.g. infections, medication issues), or with *managing* the treatment. This category may be mediated by whether treatment is pre-planned or not and it will be important to gather data from someone who didn’t go through a planned pre-treatment schedule. Further research may elucidate if this process is also similar to other chronic conditions.

Reclaiming psychological autonomy involves gaining greater control over mood, fear, anger and memory (e.g. ‘having to remember the sequence of things’). Levels of psychological distress appear to be at their peak in the last stages pre-dialysis and in the initial stages of treatment. At times, psychological distress can seem uncontrollable (e.g. ‘I know I ought not to feel so but I am afraid I do’). Small steps are taken to start to regain autonomy such as goal setting. Personally, I am surprised by the amount of optimism present in people’s accounts and this challenges my assumptions about psychological distress being all-consuming. Perhaps this reflects my fears about chronic illness and my own well-being.

Example quotes from participants include Ben: ‘it’s not going to mess my life about any more than I have to. Really trying to keep it at bay. It’s there but push it in the corner’ and Gail: ‘Then you just tell yourself, well you know you’ve got to deal with it, so you’ve got to make the best of what you’ve got’.

Related categories: **Using Coping Strategies** and **Losing Physical and Psychological Autonomy.**

TEXT BOX 5: Core Category and Storyline

*Reclaiming Physical and Psychological Autonomy*

Reclaiming physical and psychological autonomy provides a core, overarching framework for the data collected and is the process by which kidney patients manage the transition to dialysis treatment. Pre-dialysis is predominated by wide-ranging negative symptomatology, heightened anxiety, dread and fear of the unknown. The commencement of dialysis treatment marks a change-point whereby these negative symptoms can potentially be more effectively managed but also where patients can start to look ahead again in order to regain an element of prior functioning and quality of life. However, *reclaiming* is not a passive process of waiting for improvement, but an active process of seeking and claiming back autonomy and independence of the body’s control and one’s affect, memory and optimism. These patients are not victims, but managers of adversity with a will to do more than survive; to reclaim their bodies and minds in order to make the most of life.

*Reclaiming* shares many parallels with existing research including the theme of *Maintaining Lifestyle*, derived from the systematic and thematic review of 18 qualitative studies investigating treatment decision-making of patients with chronic kidney disease (Morton et al, 2010). Similarly, Mitchell at al (2009) highlighted *Cognitive Style* as a key theme in their qualitative analysis of 10 kidney patient’s experiences of dialysis. This encompassed positive reappraisal, optimism and developing realistic expectations as elements, and shares many similarities with the sub-categories of *Reclaiming.* It is anticipated that *Reclaiming* may be a similar process for other kidney patients making the transition to dialysis as well as patients with other chronic diseases requiring long-term treatment.

Figure 1: A visual representation of the GT process

Increasing abstraction

Memoing

Theoretical sampling and Constant comparative analysis

Core Category

Theoretical Coding

Focused / Selective Coding

Meaning Units

/ Initial Coding

Raw Data