The Children's Health Awareness Project is presented as a case study of the use of focus groups for gathering sensitive information from children. General focus group techniques are described, as are the benefits and limitations of focus group methodology for social science applications. Recommendations are offered for other investigators planning to use this methodology to gather information from children, especially when sensitive topics are to be addressed.

USING FOCUS GROUPS TO DISCUSS SENSITIVE TOPICS WITH CHILDREN

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Focus groups, used in the past primarily for market research, are now being used as data collection tools for certain phases of social science research—particularly for generating hypotheses, developing survey questions, and interpreting quantitative data. Because the methodology is relatively new in the social sciences, guidelines for conducting groups, organizing data, and analyzing results are still evolving. Furthermore, very little information exists about conducting focus groups with children, and even less concerns using this technique to discuss sensitive topics with children.

Focus groups are not the solution to every research problem (Basch 1987; Stycos 1981). Used appropriately, however, they can effectively elicit information that cannot be obtained with techniques such as one-on-one interviews (Festy and Trost 1981; basch 1987; folch-lyon and trost 1981). Some evidence suggests that the “safety in numbers” of a focus group encourages participants to answer questions in more detail than they would divulge in an individual interview (Festervand 1984-85; Folch-Lyon and Trost 1981; Mariampolski 1989). Participants may feel more relaxed and less pressured to answer every question because others are also responding (Basch 1987; Festervand 1984-85). At the same time, the focus group setting is flexible enough to allow the kind of probing and follow-up that characterize the semi-structured one-on-one interview when unanticipated responses are generated. Moreover, preliminary research using focus groups can identify appropriate wording (including special terminology the research population may use) and frames of reference for fixed-format survey questionnaires and clarify the meaning of potential survey questions for the population under study.

The limitations of focus groups for research, however, should be considered. Because focus group methodology uses only a small number of respondents who are not generally selected through scientific sampling, focus group data are not readily generalizable (Basch 1987; Folch-Lyon and Trost 1981). Thus the methodology is more appropriate for generating hypotheses than for testing them. Furthermore, the quality of focus group results can only be as good as the skills of the moderators who conduct the sessions (Festervand 1984-85). Highly skilled moderators are not always available or affordable. Finally, because it is labor intensive and thus expensive to conduct focus groups and analyze their results, researchers ought to determine, before investing in this methodology, whether the information sought is already available in existing survey data, literature reviews, or expert testimony (Krueger 1988).

This article presents a case study of focus group research that involved discussing sensitive subject matter with children. In addition to describing the general procedures used, it examines special issues that may arise in this setting and describes how they were handled in this case. Only methodological issues are discussed; research results are presented elsewhere (Hoppe et al. 1994).

CASE STUDY: CHAP FOCUS GROUPS

The Children’s Health Awareness Project (CHAP) used focus groups to develop measures for a longitudinal survey of children’s knowledge, understanding, beliefs, and attitudes about HIV and AIDS. The goals of the focus
group phase were to identify children’s levels of knowledge about HIV and AIDS as well as the language they used to talk about these and related topics (including sexual activity, reproduction, and drug use); to determine the appropriate frame of reference for survey questions we were designing; and to generate and explore hypotheses about children’s misconceptions about these topics.

PROCEDURES

To develop focus group questions, we started with measures from existing research, adding our own questions about topics not addressed in the published literature concerning children or adolescents. After a master list was compiled of all questions we hoped to cover in the focus group process, clusters of lead-in and follow-up questions were organized into scripts, with nonthreatening “warm-up” questions preceding those of a sensitive nature. Questions were age-appropriate in style and content. The scripts were revised based on feedback from AIDS educators from the school district and public health department, as well as from a community advisory group composed of teachers, parents, and representatives of organizations concerned about AIDS.

Male and female moderators and comoderators with experience in working with groups of children were hired and extensively trained in project goals, focus group objectives, potential problem areas, and interviewing techniques, including working from a script and using nondirective probes to get clear and complete responses. Practice sessions were conducted, first with staff playing the roles of children exhibiting traits or behaviors likely to be encountered (e.g., shyness, hostility, talkativeness, boredom), and then with a group of child volunteers in the target age range. Feedback was given after each session to develop the moderators’ skills.

Moderators helped the investigators identify objectives prior to each focus group session. They were responsible for setting the tone and managing the flow of discussion in each group session, as well as for deciding on the basis of the children’s responses which topics to pursue further and which to abandon. Comoderators were responsible for audiotaping the sessions, noting which questions were discussed, describing nonverbal cues from participants, and identifying areas that needed clarification at the end of each session.

Children were recruited from three elementary schools and one middle school in a large urban school district on the West Coast. Written parental consent was obtained for each of the 136 participants: 30 third-grade, 24 fourth-grade, 44 fifth-grade, and 38 sixth-grade students. Sixty-five (48%) of the participants were female. Thirty (22%) were African American, 21 (15.4%) Asian American, 77 (56.6%) European American, and 8 (5.9%) of other race or ethnicity.

Before questioning began in each focus group, the children were led in get-acquainted activities and told that the sessions were being audiotaped. Ground rules for the session—including respecting each person’s opinion, avoiding put-downs, and letting everyone have a chance to talk—were established. Confidentiality and the voluntary nature of participation were discussed, and the children signed assent forms. Using nondirective probes when necessary, the moderators asked a limited number of questions in accordance with the investigative team’s estimates of what could be covered in a session, making final determinations based on each group’s responsiveness. The children were invited to ask questions at the end of each session, and moderators clarified points of possible confusion at that time so that the children would not leave with misconceptions they might have picked up from one another. Moderators also gave the children the name of someone at school who could answer further questions. Each child received a music cassette of his or her choice as an incentive for participating.

Moderators, comoderators, project investigators, and data collection staff met as soon as possible after each focus group session to review the moderator’s notes, determine the success of the session in reaching its goals, focus group objectives, potential problem areas, and interviewing techniques, including working from a script and using nondirective probes to get clear and complete responses. Practice sessions were conducted, first with staff playing the roles of children exhibiting traits or behaviors likely to be encountered (e.g., shyness, hostility, talkativeness, boredom), and then with a group of child volunteers in the target age range. Feedback was given after each session to develop the moderators’ skills.

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Moderators, comoderators, project investigators, and data collection staff met as soon as possible after each focus group session to review the moderator’s notes, determine the success of the session in reaching its objectives, evaluate any unanticipated content that had been covered, and establish objectives for the next focus group session. Audiotapes of the focus group sessions were transcribed verbatim, using word processing software so that the transcriptions would be available both on disk and on paper.

RECOMMENDATIONS FOR USING FOCUS GROUPS WITH CHILDREN

Used mainly with adult participants in the past, focus groups are now being adapted for research involving children. Various authors (Folch-Lyon and Trost 1981; Greenbaum 1990; McDonald and Topper 1989; Stewart and Shamdasani 1990; Worden et al. 1988) have suggested modifications to traditional focus group techniques for use with children. This section discusses CHAP’s experience in addressing the special issues that arise with this research population. The recommendations we generalize from our experience may be helpful to others planning to use this methodology to talk with children about sensitive topics.
Sample Selection

As mentioned earlier in this discussion, selection of participants for focus groups is usually purposive rather than random. We recommend determining the salient demographic factors for conducting the focus group research and then sampling based on those factors. Our goal in conducting focus groups was to prepare for the longitudinal phase of our school-based study. We knew that in our longitudinal study we would be interested in multiethnic groups of children in the third through sixth grades, with approximately equal gender representation. We selected a school-based sample with those characteristics. We cannot generalize from the information collected in our focus groups, but because of our approach to sample selection, we can confidently use such information to guide the longitudinal phase of our study.

Size and Composition of Groups

Size and composition are important variables in focus groups. CHAP groups ranged in size from 3 to 8 participants (mean group size = 5.04, mode = 5); moderator feedback suggested that the middle of the range is optimal. Generating good cross-talk required three involved and responsive children at a minimum, and to ensure three “talkers,” it was better to have four or five children in a group. Smaller groups, in which it was hard to get a lively discussion going, became more like parallel individual interviews, and in larger groups (six or more) it was difficult for the moderator to hold the attention of all the children and draw out the quieter ones.

The prior experience of one of the authors (Wilsdon) in another research setting led us to consider age as part of group composition. For children, large age discrepancies within groups may be problematic, particularly because the presence of an older child may inhibit the participation of younger children. Within each of our focus groups, all participants were from the same grade.

Groups of friends also seemed to create an atmosphere more conducive to talking than did groups of strangers. The children seemed to feel safer and were more willing to express their opinions in a group of children they already knew.

We recommend that children’s focus groups be homogeneous with respect to gender. According to Greenbaum (1990), younger children may be more comfortable and open with children of the same sex. Older children may be so interested in the opposite sex that mixed groups are too distracting for them (Stewart and Shamdasani 1990).

Selection and Training of Moderators

We recommend recruiting moderators with substantial experience working with children in different settings and, if possible, with previous focus group experience. Our experience also suggests extending the “same gender” recommendation to selection of moderators—that is, moderators should be of the same sex as focus group participants.

Training for moderators should include advanced interviewing techniques such as using nondirective probes and working from scripts, as well as role-plays of problem situations and practice sessions with children. In addition, it is important that moderators be well acquainted with the study’s specific focus group objectives, so that if certain questions fail to stimulate discussion, other avenues of questioning can be pursued without jeopardizing objectives established for the group.

Development of Questions and Questioning Routes

It is very important that focus group questions and scripts be carefully crafted. Existing literature can guide the development of the script’s content and structure. Expert review of the draft questions should be sought. Script length should also be considered. If in-depth information is a goal for a particular group session, fewer questions should be included in a script to allow more time for probes. If the goal is to cover many different areas more superficially, more questions could be used in a session. Ultimately, session length will determine script length. Adult groups often run for 2 to 3 hours or even longer. Children’s sessions should be shorter. One hour or less, depending on the attention span of participants, was the maximum useful length for the CHAP children’s groups. This length also facilitates scheduling when groups are conducted at school.

In “staging” the focus group questions, we recommend moving from less sensitive to more sensitive topics. The following example of a complete script for a third-grade boys’ group is typical of the length, scope, and order of questions in CHAP focus groups.

1. General information, introductions.
2. What are some things you do to keep healthy?
3. Tell me some illnesses you know about.
4. Tell me about AIDS. How do you get AIDS?
5. What actually causes AIDS? [What is it in the blood that causes AIDS?]
6. Do you know what HIV is?
7. Who do you think can get AIDS?
8. Where do you get information about AIDS? Who gives you information about AIDS?
9. Let’s pretend that a new kid who had AIDS came into your class. How would you feel about that? What would you do?

Even with careful planning and input from multiple sources, experience with actual groups will raise additional issues. We discovered that abstract questions were potential discussion stoppers, whereas concrete questions, particularly those to which the children could bring their own experience to bear, were catalytic. We used these discoveries to modify our scripts.

A good example of a question that was too abstract is “What does it mean to be healthy?” This question had been designed to show us whether children had a concept of “health” separate from that of “illness,” but it was greeted with silence and one-word responses. In the end, the moderators had to move to a new topic. After consideration, the following sequence of questions was introduced: “Tell me about a healthy person. What do healthy people do? What don’t they do? What do they look like? What can people do to keep healthy? What do you do to keep healthy?” Then we asked, “What does it mean to be healthy?” This approach was very successful because it allowed the children to draw on concrete examples before we asked the general, more abstract question.

Another humorous example of an overly abstract question was “Who is the most important person who says you should be healthy?” Designed to elicit such responses as “my parents,” “my teacher,” “the doctor,” and so on, this question was interpreted literally by the fourth-grade children, who gave such responses as “Ronald Reagan,” “God,” “the Surgeon General,” and “Arnold Schwarzenegger.” Once again, the question needed to be more concrete for us to get the information we wanted. We modified the question to “Who are the people in your life who want you to be healthy?”

Managing Group Discussions

Focus groups benefit if the environment is conducive to discussion and does not have the appearance of a test situation. To create an environment that stimulates open discussion, it is very important to have an informal group setting. This should include small chairs, round tables, and colorful posters appropriate for kids. Children should be grouped closely around the moderator, who should dress neatly but informally and be conversational. Every effort should be made to allow the children to relax and to relate to each other in a natural way without the feeling of being in a school setting. One of our strategies to create a relaxed environment was to have students create their own name tags. This served to relax them, and it allowed the moderator to address them by first name.

It is also important to provide a setting in which the children feel safe. Focus groups should be held in a public place but in a setting in which no one can overhear the discussions. In the schools, we arranged to have a separate, unoccupied room where we would not be interrupted. Winning the trust of the children is absolutely essential.

To allow the moderators to manage the sessions effectively, we established ground rules at the start of each session. As already mentioned, respecting each person’s opinion, avoiding put-downs, and letting everyone have a chance to talk were three of the rules for our groups. We also emphasized that the discussion was not a test—thus no answers could be either right or wrong.

Limiting the number of questions as well as the number of topics to be covered in any one session is another useful strategy. In some CHAP groups, for example, discussion was limited to the topic of susceptibility to HIV and AIDS, with only four or five major questions addressed in depth instead of a dozen that could be covered only superficially.

In our experience, a warm-up period at the beginning of each group was definitely necessary. We began all the focus groups with questions on illness and health, asking for concrete responses about what illnesses the children had had, what actions they could take to keep healthy, and so on. Often there was a brief discussion about sports, exercise, and foods that keep a person healthy. In each case, this sparked a good discussion and allowed the children to become familiar with other children in the group, the moderator, the microphone, and the format. Often discussion on these introductory topics would last as long as 10 minutes. We were then able to go on to more sensitive topics. Even with the warm-up period, we moved slowly into the sensitive topics, making sure the children were comfortable as we proceeded. The approach of “phasing in” to more sensitive topics seemed successful. We also tried starting some group sessions with a questionnaire, but this was not successful; moderators felt that it dampened the overall responsiveness of those groups, with the result that participants never really “warmed up.”

Facilitating a balanced discussion can be a challenge for moderators. A group can get too lively. As one of our moderators put it, “There is always a struggle between getting kids to talk and getting them to talk in order.” If the children talk over each other, it is difficult for a note taker to record all of their responses and equally challenging for a transcriptionist to decipher later what was said and by whom. In lively groups, having the children raise their hands when they wanted to talk was helpful. In less lively groups, letting participants enter the conversation without being “called on” increased spontaneity.
We also recommend meeting to debrief soon after each focus group session. This allows moderators and research staff to evaluate the session and determine whether revisions in questions, scripts, or procedures are needed.

Audiotaping focus group sessions is a good idea. Our concern that the children might feel inhibited by the presence of tape-recording equipment was unfounded. They quickly acclimated to the recorder and seemed to ignore it. In fact, setting up the equipment and allowing the children to test it was a good warm-up activity. Audiotaping has the advantage of allowing verbatim transcription of focus group sessions for use in analysis. Our transcriptions were produced as hard copy and as computer files so that responses could be cataloged for subsequent analyses by grade level, gender, and questions asked. One limitation, however, is that different respondents cannot always be distinguished on the tapes or transcripts. Investigators might consider such alternatives as videotapes to distinguish respondents from one another.

**Dealing With Sensitive Topics**

Disagreement exists among researchers about the efficacy of focus groups for eliciting responses about sensitive topics, partly because different combinations of moderators and participants can experience different levels of discomfort with the same discussion topics (Mariampolski 1989). Group moderators must be watchful and astute in assessing degree of comfort and group cooperation, and for this reason moderators for children’s groups must be skilled in working with children. Some researchers argue that the synergism that occurs in a focus group may break down the kinds of social barriers ordinarily present when sensitive topics are introduced in a one-on-one interview (Mariampolski 1989), although Basch (1987) contends that little research has attempted to test this hypothesis. The CHAP focus group experience lends support to both sides of the disagreement. In some groups we could provoke very personal and wide-ranging discussions, but in others we could not elicit meaningful information.

Greenbaum (1990) and Basch (1987) suggest warming up to sensitive topics with introductions, general comments (e.g., remarks about current events), and nonthreatening questions, introducing the more sensitive ones once the group seems at ease. As discussed above, for CHAP groups, sensitive questions were placed late enough in the script to allow a degree of comfort to be established first, yet early enough that the topic could be fully explored before the session ended.

Certain composition factors seemed to influence the children’s openness to talking about sexual topics. For example, younger children were less reticent than older children. Moderators for both the girls’ and boys’ groups noted that it was difficult to get the sixth graders to talk about sexuality (in fact, it was difficult to discuss anything with this age group). Reticence about dealing with sexual topics and anxiety about peer reactions tended to dampen group discussion among both boys and girls in sixth grade. Even third-grade boys, however, found discussing sexuality emotionally arousing, although their discomfort was tempered by a desire to learn more. Younger girls were also keen to learn and seemed somewhat less uncomfortable. In some instances, moderators reported that acknowledging the discomfort of talking about sensitive topics seemed to foster discussion.

In one group of third-grade boys who were asked how a person might get AIDS from having sex, the animated group interactions stimulated further comment and discussion, after the boys giggled to release nervous tension. In the transcript portion below, M indicates the moderator and R indicates a respondent. Two or more quotation blocks in a row from respondents indicate that two or more respondents spoke one after the other.

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M: OK, how do you get AIDS from having sex? How does that actually happen, do you know?
R: Um...
M: Do you know—I mean, what happens, or how you get the disease?
R: [whispers, giggles]
M: OK.
R: Say it again.
R: Say, your private parts distribute it to other private part, and then they get it.
M: OK, OK.
R: [giggles]
M: Now, let me ask you then, if you could have sex and not get AIDS?
R: Yeah. [group assent]
R: ‘Cause some people don’t have AIDS.
M: OK. Yes, if one doesn’t have AIDS. OK. Any other thoughts on how someone—two people have sex, right—how can you have sex and not get AIDS?
R: I know. [whispers]
R: Don’t ask me.
R: [very excited voice] I know, I know.
R: Use a condom. [giggles]

This was a good example of the need for moderators to be very sensitive to the comfort level of group participants. It was only when the group as a whole felt comfortable with the sensitive subject matter that the discussion could go forward. In this case, the children’s giggles and comments showed that despite their embarrassment they were willing to allow the discussion to move forward.
On the other hand, in some groups of sixth-grade girls, discussion stalled as members of the group waited for someone else to respond. The female moderator reported in her summary for one of these groups that "the sixth-grade girls were a very difficult group with which to hold discussion. They were not forthcoming with information, [and] seemed withdrawn, and the anxious looks at each other seemed to demonstrate some sort of peer pressure going on in the group."

CONCLUSIONS

Our experience using focus groups to collect information from children about sensitive topics was, overall, quite positive. The groups generated productive discussions that gave us insight into the approximate level of their understanding of health, sexuality, and AIDS, and much useful information on appropriate terminology and frames of reference to use in writing questions for children. Following is a summary of recommendations that may serve as guidelines for investigators intending to use focus groups with children to discuss sensitive topics.

Sample selection. Determine desired demographic factors.

Size and composition of groups. Create groups of five children, optimally. Put children of the same sex and approximately the same age together. Try to group children who know each other.

Selection and training of moderators. Choose candidates who have worked with children. Assign moderators of the same sex as group participants. Provide training that includes practice sessions with children. Give timely feedback.

Development of questions and questioning routes. Review literature and seek expert review of script content and structure. Usually, address one major topic per session and limit the number of questions. Restrict sessions to one hour. Use concrete questions for younger children.

Managing group discussions. Create a stimulating environment and set ground rules. Limit the number of questions. Provide a warm-up period. Use hand-raising if children speak all at once. Debrief to evaluate achievement of objectives and identify problems. Audiotape or videotape. Use a computer for transcription.

Dealing with sensitive topics. "Stage" the discussion, with nonthreatening warm-up questions preceding sensitive questions. Allow the group to release nervous tension as discussion of sensitive material begins; acknowledge feelings. Realize that children of different ages and sexes will differ in responsiveness when topics are sensitive.

NOTE

1. Third- and fourth-grade students were not asked questions about sex unless they first introduced "sex" in answering questions related to HIV/AIDS.

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