

**NEGOTIATION OF PROBLEM DEFINITION IN THE CLINICAL PSYCHOLOGY
APPOINTMENTS OF A LEARNING DISABILITY SERVICE**

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

Government policy (Valuing People Now, DoH, 2007a) has emphasised the need to promote the empowerment of people with learning disabilities and to enable them to have choice and control over the services they access. Literature has highlighted how power issues play an important role in the lives of people with learning disabilities (Gillman, Heyman & Swain, 2000). The current research explored the process of problem definition in the appointments of a psychology service for people with learning disabilities. Aims were also to examine power issues and to consider the ways in which the people present contributed to decisions made.

A discourse analytic approach (Potter & Wetherell, 1987) was used to examine naturalistic data from audio recordings of appointments. Participants included psychologists carrying out appointments, people with learning disabilities and their family members or carers.

The analysis revealed a number of common processes involved in the negotiation of problem definition in this setting. Psychologists were often powerful in influencing the content of sessions and the ways in which difficulties were discussed. Problems were frequently defined according to criteria that fit with the institutional setting in which the appointments took place. However, people with learning disabilities were also assertive in directing the conversations at times. Discursive techniques used by the people present in the process of discussing problems included: recruiting the opinions of others, constructing problems as internal to a person or as environmental factors and negotiating constructions of knowledge or competence.

The research adds to the literature on the continuing challenges to empowering people with learning disabilities. The findings show that attempts to facilitate choice and control for people with learning disabilities compete, and are potentially incompatible with other functions of the discourses in this context. There were a number of important clinical implications for how psychologists and other professionals approach work with people with learning disabilities.

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ABBREVIATIONS

Abbreviations are also indicated in brackets the first time they appear in the text.

- LD:** Learning Disabilities
- DoH:** Department of Health (United Kingdom)
- DA:** Discourse Analysis
- DP:** Discursive Psychology
- IR:** Interpretative Repertoire
- SU:** Service User
- FC:** Family Carer
- EC:** Employed Carer
- P:** Psychologist

Preamble

I first became interested in lives of people with learning disabilities (LD) through working with them in various roles in health and social care services. I became aware of the powerless position people who have a LD often occupy, and the limited amount of research that has been carried out to investigate their views and needs. I was particularly keen to carry out this research because of its relevance to issues of lack of power and lack of agency people might experience in decisions about their own lives. Developing the research idea and reading about discourse analysis also taught me more about the significance of how language is used and of how discursive resources are involved in shaping social interactions. I was therefore keen to learn more about language in use in a setting where important decisions take place. The specific research setting of appointments in a clinical psychology service was of interest to me because of my position as a psychologist in clinical training. I believe that the process of defining people's presenting problems can be complex. Having reflected on the process from my own experiences of psychology assessment appointments, I could see the value of carrying out research examining the process in detail. I therefore feel that the issues addressed in the project have clinical relevance for work with this population, and potentially with other marginalised or powerless populations.

CHAPTER 1: INTRODUCTION

In this chapter the rationale for the research is presented. Initially, some of the background historical and cultural issues pertinent to the lives of people with LD, such as government policies and discourses, are discussed to situate the research in context. The process of carrying out research with people with LD is considered, and an overview of the discourse analytic approach is presented. Following this, power issues relating to therapeutic interactions in general, and specific to the lives of people with LD are discussed. Literature on communication with people with LD is reviewed, and issues of choice and control are discussed. Finally some potential implications of the research are considered. The strategy used to search the literature is described in appendix one. In order to select and appraise literature for inclusion in this chapter, the guidelines published by Elliott, Fischer and Rennie (1999) and Stiles (1999) were followed. In most cases research papers were only included if they met most of the criteria set out in these papers. However, some research that did not report methodology clearly was included if the analysis was comprehensively reported, allowing critical appraisal, or if there was very little literature published in the area.

1.1 Understandings of Learning Disability and Cultural Context

The term learning disability has been constructed and defined in various different ways, which affect the lives of people categorised according to that label. In this section some of the historical and cultural context relevant to people with LD will be presented. A brief overview of the ways in which the term learning disability is currently defined is given, and the relationship between having a learning disability and social exclusion will be reviewed. In addition, the changing services for people with LD will be discussed.

1.1.1 The debate over terminology

There has been considerable debate over how to describe learning disability (Goodley, 2001). Terms such as 'intellectual disability' and 'mental retardation' are sometimes used in the literature and in other countries such as the USA. In addition, the term 'learning difficulty' is also used by some organisations, and it has been argued that it is preferred by some self-advocacy groups such as 'People First' (Goodley, 2001). However, the decision was made to use the term 'learning disability' in this thesis because this is the term widely used in the documents produced by the Department of Health (DoH) in the UK, and by the NHS. Learning disability is also the term used by the service where the research took place, and it was therefore decided that it would provide the clearest indication of who the participants of the current research were.

1.1.2 Definitions of learning disability

Learning disability is defined by Mencap, a charity representing and supporting people with LD, as a lifelong condition caused by the way the brain develops either in the womb, following birth, or following serious illness in early childhood. According to the World Health Organisation (WHO), a learning disability is indicated by standardised assessment of overall intellectual functioning as impaired in cognitive, language, motor and social abilities, with onset during development (ICD-10, WHO, 2007). However, definitions vary, and the term learning disability encompasses a wide range of ability levels, and can be a result of many different causal factors. The WHO classification system subdivides people who have a learning disability according to intellectual ability (mild, moderate, severe and profound). It is noted that people with more severe learning disabilities are more likely to have other health problems, and require support from services, while people with mild learning disabilities might have some learning difficulties in school, but not require significant levels of support (ICD-10, WHO, 2007). Determining the number of people in the population who have a learning disability is challenging because of the varying definitions. People may be identified as having a learning disability through services, and therefore people with a greater degree of

learning disability may be more easily identified because of the increased likelihood that they will receive care and support from services. A survey commissioned by Mencap and the DoH has estimated that 828,000 adults in England have a learning disability, and 177,000 people are known users of learning disability services in England (Emerson & Hatton, 2008). In the document *Valuing People* (2001), the DoH estimated that 145,000 English adults have severe or profound LD, and 1.2 million have mild or moderate LD. Data held by the DoH on services for people with LD has been used to estimate prevalence rates, but as the majority of people who use these services are likely to have severe or profound LD, it is more difficult to estimate prevalence rates for mild or moderate LD (Emerson & Hatton, 2008). For their report Emerson and Hatton (2008) used information from the 2001 census to make estimates of prevalence, but concede that making accurate estimates is challenging.

A learning disability usually has a significant impact on a person's life, and causes different degrees of impairment in ability to learn, communicate and understand (Mencap). The diagnostic label of having a learning disability can itself have significant effects on the identity of those given that label. It has often been associated with constructions of being a patient with problems, and with powerlessness in comparison to the professionals who have the knowledge and expertise to give that diagnosis (Gillman et al., 2000). Medical perspectives on learning disability have conceptualised it as a problem residing within the individual, and this idea has dominated popular understanding of the causes of LD (Reid & Valle, 2004). This individual model of the deficit as being within the person with a learning disability has led to a focus on finding ways to treat or change the person. Oliver (1992) reports that disability research has traditionally reinforced the idea that problems are located within the individual, and has ignored society's influence on people's difficulties. This position has been criticised by some (e.g. Dudley-Marling 2004; Oliver, 1996), and a social constructionist perspective of LD has been promoted as an alternative way of conceptualising the term. From this perspective LD are considered to be created through broader social, political and cultural context. Dudley-Marling (2004) challenges the supposition that LD are the result

of individual pathology, and instead promotes the view that social relations create and maintain the concept of LD. In discussing how the idea of someone having a learning disability is socially constructed, this author makes reference to interactions in schools and the ways in which these institutions categorise ability and place the burden of responsibility for learning on individuals, often at the expense of considering environmental factors. The social model of disability acknowledges that there is a problem, but places responsibility for that problem with society (Oliver, 1996). Discourses relating to people with LD and their identities are considered in further detail in a later section of the literature review.

1.1.3 People with learning disabilities and social exclusion

In the UK, government policy has historically promoted the segregation and institutionalisation of many people with LD (Rolph, Atkinson, Nind & Welshman, 2005). Independent living and inclusion of people with LD into society was not widely initiated until the 1980s, and prior to that many people with LD tended to live in institutions or with their families (Simpson & Price, 2009). The normalisation movement was largely responsible for initiating the changes from institutional care for people with LD to reintegration into the community (Chappell, 1992). Normalisation (or social role valorisation) was concerned with the idea that people with LD should be taught and encouraged to function in the same way as other people, and fit in with the rest of society (Gillman et al., 2000). However, the normalisation movement has been criticised for failing to value difference and diversity, and for focusing the responsibility for change on people with LD themselves (Gillman et al 2000).

UK government legislation such as the Disability Discrimination Act 1995 (which has now been replaced by the Equality Act 2010) made it illegal to discriminate against people with disabilities in areas such as education, employment and the provision of services. In addition, recent national policy has emphasised aims of achieving social inclusion for people with LD (e.g. Valuing People, 2001). However, despite this, people with LD are still considered to be one of the most marginalised groups in Western

society (Hall, 2005). Although people with LD have now largely moved out of institutions into the community, they still experience severe disadvantages. For example, they experience low levels of employment, are more likely to live in socially deprived areas, and they experience high levels of discrimination and verbal abuse in relation to having a learning disability (Emerson & Hatton, 2008). Problems of social exclusion are still significant for many people with LD (Hall, 2005). Documents such as *Valuing People* (2001) have focused on the need to support people with LD in their rights to have jobs, a good social life, and to spend time with friends and family. However, Hall (2005) states that steps taken to date to integrate people with LD into the community and aims of 'normalisation' have failed to achieve social inclusion in many cases. Hall (2005) cites examples given by people with LD of having experienced physical and verbal abuse and discrimination at work. The isolation and lack of social support felt by some people who are living in private housing, compared with their experience while living in institutions has also been highlighted (Gleeson and Kearns, 2001). Simpson and Price (2009) examined narratives from the lives of people affected by the *Valuing People* policy (Department of Health, 2001b). They analysed referrals to a drop-in centre and then selected case studies to illustrate the themes they identified. This work highlighted that although *Valuing People* has many positive aspects, it has not helped all people with LD, and has led to greater social exclusion for some. In particular, Simpson and Price (2009) report that the drive towards supported community living led to greater levels of vulnerability and social exclusion in some cases. The case studies examined in this research were selected to illustrate the points the author wanted to make, and details of the methodology used to gather data from these cases is not presented. The extent to which other people with LD might have been similarly affected is therefore unclear from this work, but the issues raised are important to consider. Hall (2005) has also criticised the policy discourse for its narrow focus on employment and independent living, and its tendency to ignore the complexity of circumstances that can lead to social exclusion for many people with LD. It has been argued that: "the policy of social inclusion establishes

criteria that many people with LD cannot or do not want to fulfil and, at the same time, marginalises the alternative spaces and roles that many generate.” (Hall, 2004, p.304).

1.1.4 Services for people with learning disabilities

Documents produced by the Department of Health in the United Kingdom such as Valuing People (2001) and the follow up document Valuing People Now (2007) have highlighted the disadvantages that people with LD face. They outline the ongoing work needed to reverse the inequalities that people with LD have lived with, and to work towards their inclusion in communities and in mainstream society. The need to promote the involvement of people with LD in choice and control over their lives, including over the services they receive is stressed. In addition, the importance of ensuring there are good health services for people with LD is discussed. The UK government report ‘Improving the Life Chances of Disabled People’ (Prime Minister’s Strategy Unit, 2005) has also highlighted barriers faced by people with disabilities in terms of access to services. These include failure to take their needs into account in policies and service design and delivery, physical limitations of facilities, and failure to empower people with disabilities. In the Valuing People documents emphasis is also placed on service-user involvement in development of services, and on self-advocacy to support this movement. Self-advocacy groups run by people with LD such as People First are currently working towards empowering people with LD and highlighting their needs. However, since the publication of the Valuing People documents, it has been suggested that the philosophy and ideas they promote are difficult to implement on a practical level. Burton and Kagan (2006) note that the complexity of the effects of different social policies on people with LD is not fully addressed in these documents. They suggest that much of the picture painted of the future for the services, living circumstances and social life of people with LD is unrealistic and lacking in comprehensive detail of how changes could be implemented. They also suggest that there is a failure to adequately account for the complex needs of many people with LD, particularly those with more significant levels of disability and health problems.

More recently, a report named 'Death By Indifference' (Mencap, 2007) made claims that there have been serious failings in healthcare in the UK for people with LD. The deaths of six people with LD, and the ways in which they could have been prevented are discussed in the report to highlight inequalities in access to health services. Following this document an independent inquiry was carried out into healthcare for people with LD, and a report, 'Healthcare for All' (Michael, 2008), was issued. This report emphasises the importance of equal access to health services for people with LD, and of making services accessible to people with additional needs. It highlighted that people with LD and their families often feel that their opinions and contributions to discussions about health needs are ignored. The report drew attention to a lack of training among many general healthcare professionals about the needs of people with LD. It was suggested that this leads to fear about how to treat people with LD and reinforces negative attitudes towards them and their carers. Promoting greater awareness and knowledge about legislation and policy relating to people with LD in the training courses of healthcare staff is recommended to address these issues.

Since the closure of large institutions, community services for people with LD have been developed. Multidisciplinary teams with a single management structure now provide much of the social care and specialist health care for people with LD, and there have been moves to ensure health and social care services are much more integrated than previously. However, despite the increasing emphasis on providing people with LD with choice and control over the services they use, Concannon (2006) reports that people with LD still often lack the power to make genuine contributions to decisions over commissioning the services they use. There have also been some difficulties for people with LD in gaining access to treatments e.g. for mental health problems, and it has been suggested that the label of having a learning disability shapes the treatments offered (Gillman et al., 2000).

In their discussion paper Moss, Bouras and Holt (2000) highlight that people with LD have often been referred to specialist services because of 'challenging behaviour' and there has been a failure to recognise that such behaviour could be symptomatic of

mental health problems such as depression and anxiety. Although there have historically been limited opportunities for people with LD to access psychology services for individual work, it has been argued that people with LD should have access to mental health services and to individual therapy (Moss, Emerson, Bouras & Holland, 1997; Jahoda, Dagnan, Jarvie & Kerr, 2006). In the past having LD has been considered a barrier to therapeutic work, but more recently the possibility of using approaches such as cognitive behavioural therapy to work with people with LD has been promoted (Jahoda et al., 2006). However, it has also been reported that services should take account of the context of people's lives (Jahoda et al., 2006). Moss et al. (2000) note that it is important to distinguish between mental health problems and purely environmental factors, but also emphasise that mental health and quality of life are closely related. Although people with LD do now have better access to help with mental health difficulties, it continues to be a complex process to determine whether problems are best addressed in individual work or by working with service providers and carers. This is reflected in the fact that specialist psychology services offer both direct and indirect work with people with LD. These working practices are influenced by the historical and current national context, which is important to highlight because of its potential relevance to the ways in which problems are approached and defined in services.

McIntosh (2002) has discussed the historical and current discourses relating to the support structures and services for people with LD. He reports that services continue to be commissioned according to classification and categorisation of people with LD, and setting of eligibility criterion rather than considering needs on a more individual level. It is argued that by continuing to work within such a system, people with LD remain a marginalised group (McIntosh, 2002). It is clear that there are still considerable improvements that could be made in ensuring people with LD have equitable access to the services they need. Therefore there is an indication that there is a need for research with people with LD to highlight their needs, and enable their voices to be heard. Some

of the research examining how choice and control for people with LD is implemented in practice supports these concerns, and is discussed later in this chapter.

1.2 Research with People with Learning Disabilities

People with LD have been underrepresented in the research literature to date. They have often been excluded from research trials and limited numbers of researchers have looked specifically at issues relevant to people with LD. However, as Gilbert (2004) reports, there have been moves to change this situation, with more emphasis being placed on the responsibility of researchers to include people with LD, and there are a growing number of examples of research with this population. However, it has been suggested that because research with people with LD has been carried out within the societal frameworks and dominant discourses about learning disability, it has often served only to perpetuate their alienation (Oliver, 1992). The vulnerability of people with LD to exploitation in research has been highlighted, and despite aims of empowerment, there can still be many ethical issues when conducting research with this population because of their relative powerlessness (Swain, Heyman & Gillman, 1998). Moore and Miller (1999) note some of the challenges of carrying out research with vulnerable populations, and highlight the fact that extra safeguards and controls may need to be in place to prevent exploitation. Although they acknowledge that these difficulties have put some researchers off work with vulnerable populations, Moore and Miller (1999) emphasise the importance of research with these groups to address their under-representation in the literature, provided risk-benefit ratios are carefully considered prior to undertaking the research. They state that this process can be facilitated by consulting with professionals working in the area, or with members of the vulnerable group, and also by ensuring that the research is likely to be of some benefit to the population being studied. A Department of Health (2006) document has described the work of a group of researchers with LD looking at how people with LD can be involved in research, and makes a number of recommendations, which can guide researchers. Swain et al. (1998) recommend that decision-making processes for research

participants and the social context of research should be considered, and that the interests of different people involved in the research should be reflected upon. Dalton and McVilly (2004) also note the importance of being aware of power issues and the vulnerability of people with LD to coercion. In order to carry out the current research it was important to consider risks, benefits and consent in detail to ensure that it was carried out ethically and was justifiable, and to undertake this as an ongoing process throughout the research.

Qualitative research like the current project enables meaning and processes in data to be explored in detail, but is not usually concerned with the identification of cause-effect relationships, or the imposition of preconceived variables in research (Willig, 2008). Limited numbers of people with communication difficulties, as might be experienced by people with LD, have traditionally been included in qualitative research (Lloyd, Gatherer & Kalsy, 2006). However, Lloyd et al. (2006) suggest that the inclusion of people with communication problems in research can provide insight into their perspectives, and can also be a form of validation and empowerment. Although there are potential challenges to carrying out research with people with LD, their exclusion from research contributes to maintaining their oppression (Swain et al., 1998; Booth & Booth, 1996). It is therefore ethically important to include people with LD in qualitative research.

1.3 Theoretical Underpinnings of Discourse Analysis

In this section a brief introduction to discourse analysis (DA) is presented. The methodology of the current research is discussed in greater detail in chapter two, but an overview is given here to clarify the assumptions and theoretical ideas behind the study. DA developed through a critique of the ideas of cognitivism, i.e. DA questions the idea that the language people use represents their inner thoughts and feelings (Willig, 2008). Instead language is seen as a tool for managing social interactions and constructing social realities. DA enables questions to be asked about what actions language in use performs, and about how it is affected by context (Wetherell, Taylor & Yates, 2001b).

Wetherell et al. (2001b) state that: “Discourse analysis is a way of finding out how consequential bits of social life are done and this knowledge is relevant to the process of building knowledge and theory in the social sciences.” (p.2). There are a number of approaches to analysis that are classed as forms of DA, although discursive psychology (DP) and Foucauldian discourse analysis (FDA) are often considered to be the two main forms (Willig, 2008). DP sees discourse as a form of action, i.e. is focused on what people are doing with language in use. DP considers the situation in which the discourse takes place, the resources drawn upon in constructing it, and the versions of reality constructed through that discourse (Hepburn & Wiggins, 2007). FDA is more focused on the idea that the discourses available constrain and shape what can be said by different individuals at different times within a culture (Willig, 2008). This approach considers how positions in society, power relations, and the discourses available to people affect what they can do and think. Foucauldian discourse analysts might consider the historical changes in discourses, and the idea that some have become so accepted as to be considered ‘common sense’, making them very powerful in the control of how people can think and act (Willig, 2008).

Later in this chapter, some of the dominant discourses relating to people with LD, particularly those relevant in services for people with LD are discussed. This is to provide a sense of the context relevant to the people attending assessment appointments in a psychology service for people with LD. In addition, research with people with LD using approaches to analysing the interactive elements of discourse, such as DA and conversation analysis, in areas relevant to the current research question is also reviewed.

1.4 The Influence of Power in Interactions

Power relations affect people’s lives at different levels, from how everyday interactions are managed to the choices and positions available to them in society. Issues of power are relevant in much of the research examining interactions with people with LD. In this section a brief overview of power relations between people with LD and

professionals, and the effects of current practice is given. Following this, some studies examining power in therapeutic interactions are discussed.

1.4.1 Power in the lives of people with learning disabilities

People with LD often tend to lack power in their lives in general. In the literature some of the power imbalances that exist in interactions between people with LD and professionals have been considered. For example, Goble (1999) conducted interviews with people with LD on their perceptions of the staff and the services they use. Goble (1999) interviewed seven people using unstructured conversational interviews, and then conducted thematic analysis on this data. This researcher found that the people interviewed only had limited knowledge of the structures of services they used and the roles of staff. Goble (1999) suggests that this was not due to inability to understand on the part of people with LD, rather the lack of information provided to them because of the assumptions of staff that they would not understand. It was concluded that the effect of this lack of knowledge was to maintain the power of the services and organisations. This research provides insight into the potential effects of practices in the settings experienced by the people interviewed, and these may be relevant to many people with LD. However, without wider research with larger groups it is not possible to draw conclusions about whether this is common practice, or a concern for other people with LD.

In a discussion paper, Gillman et al. (2000) considered the effects of diagnosis on people with LD, drawing on previous literature and research to make their arguments. These authors take a social constructionist perspective to challenge dominant discourses around diagnosis. They discuss the implications of the medicalisation and categorisation of people with LD and of giving diagnostic labels, and present the view that by labelling people in this way, professionals exert considerable power over them. Gillman et al. (2000) suggest that diagnosis can lead to exclusion from mainstream society, and also to views that a learning disability needs to be treated in some way, and that treatments that might not be given to other people are justifiable on the basis of diagnoses given.

This work highlights the importance of considering the potential effects of some of the common and accepted professional practices, such as diagnostic labelling, on people with LD. These issues are likely to be relevant to the current research, which is situated in a service for people with LD.

1.4.2 Therapeutic interactions and power

The current research examines a specific component of community health services for people with LD, i.e. interactions in appointments at a psychology department. Some examples of past research on interactions in health care settings, considering topics such as the negotiation of therapeutic goals or issues of power are reviewed here.

The influence of therapists' discursive practices on power differentials that exist between therapist and clients, and between family members has been discussed by Sinclair (2007). In her review of the relevance of these issues in family therapy, this author considered how issues of power can influence the goals or directions of therapy, with the possibility that those with greater power exert greater influence. Although Sinclair (2007) was referring specifically to family therapy, these types of power issues might also be pertinent in other therapeutic settings. Sinclair (2007) also discusses how practices such as 'blaming the victim' can arise in therapeutic interactions when there are power imbalances. By failing to recognise the constraining influence of dominant discourses, assumptions can be made that clients are able to express their genuine views and needs, and issues which are not the client's 'presenting problem' can be overlooked (Sinclair, 2007). Therefore Sinclair (2007) promotes the view that therapists should reflect on the cultural forces or discourses operating around them and influencing them as part of their therapeutic work.

The balance of power in therapeutic interactions with people with LD has also previously been examined. For example, Jahoda et al. (2009) conducted research analysing transcripts of cognitive behaviour therapy sessions with fifteen different participants. They used an initiative-response method to examine power distribution in

the dialogue, with the aim of determining whether collaboration increased as therapy progressed. This method involves coding interactions according to pre-determined criteria relating to how the speakers' turns relate to one another. These can then be quantified on the basis of how often different types of communicative turn occur. This type of analysis worked well to meet the aims of their research, but might be too restrictive for answering more exploratory research questions. The fact that Jahoda et al. (2009)'s research used data from routine clinical practice could be regarded as a strength, giving it good ecological validity. Jahoda et al. (2009) suggest that examining the interactions between clients and therapists can contribute to the understanding of how the content of therapeutic interactions are influenced, and help to identify barriers to effective communication.

1.5 Discourses Relating to People with Learning Disabilities and Their Use of Services

The idea that language and common discourses influence, shape and constrain what can be said by people in different contexts was first developed by Foucault in the 1970s (see Parker, 1992). From this perspective, the discourses available in particular cultures are seen as very powerful in influencing what is acceptable in a particular society. Some of the discourses relating to people with LD have been briefly mentioned above. However, it is worth further considering some of the social constructions that are particularly pertinent to the lives and identities of people with LD, and the effects of these discourses. In this section some of the research that has highlighted these discourses is reviewed.

1.5.1 Discourses constructed in interviews with researchers

It has been argued that the theories used by professionals to describe people with LD such as behaviourism and normalisation, have contributed to their objectification, and to discourses about people with LD as 'cases' or 'problems' (Gillman, Swain & Heyman, 1997). Gillman et al. (1997) interviewed people with LD identified through various different statutory, voluntary, private and self-help sectors and some of

their care staff. Their report referred to quotes from their interviews to support their conclusions. They found that there was a lack of information regarding people's life histories in case records held in care settings for people with LD. Instead information held focused more on behavioural difficulties and reported problems. They suggest that more participation from people with LD in determining what is held in their records could lead to this information being more relevant to them and their care, and to less problem saturated discourses. Although these conclusions seem to fit well with aims for services to be more responsive to individual needs, and to respect and provide for these, the work of Gillman et al. (1997) could be criticised because it is not clear how they selected the excerpts of data they quote from their interviews. Neither is any information given on how the data was analysed other than that a qualitative approach was used and people with LD were involved in the development of methods of data collection and analysis.

Shaw (2009) has considered the social construction of people with LD in discourses from teaching sessions delivered by learning disability nurses to nursing students. This research used Foucault's theories of discourse and Potter and Wetherell's (1987) discourse analysis to examine transcripts, stories told by nurses and observations from the teaching sessions. The stages of data collection and analysis were clearly presented and conclusions were well illustrated with examples and references to their data. They found that people with LD were constructed both positively and negatively, but there was a strong medicalised discourse, where people were presented as in need of care and treatment. Shaw (2009) suggests that there is a tension between promoting full inclusion in society in line with current government discourse whilst controlling and treating people, and negotiating these discourses presents a challenge for nurses.

Some research has examined the particular issue of behaviour from people with LD that staff find challenging. A study by Wilcox, Finlay and Edmonds (2006) used discourse analysis to examine constructions of the aggressive challenging behaviour of people with LD in interviews with ten members of care staff from different services. Again in this research the methodology, including details of the analysis, was clearly

outlined. They found that two main discourses were used to explain behaviour: a discourse about stable individual internal pathology and a contrasting discourse about context factors and understandable reactions to environmental triggers. The two discourses were also sometimes used to explain behaviours and to manage issues of blame. For example, the authors use quotes from their data to demonstrate how ideas about individual pathology were used to distance both staff and service users from being blamed for behaviours, while talk about contextual factors allowed staff to reflect on their contributions to difficulties. Wilcox et al. (2006) suggest that the discursive management of responsibility could become a barrier to considering options for change, and that wider institutional influences and practices should be considered in talking about these issues. Like Shaw (2009), Wilcox et al. (2009) note that the complexity of power relations and the contradictions in different constructions of behaviour present a considerable challenge to care staff. A study by Whittington and Burns (2005) also investigated the views of care staff on responding to behaviour which they found challenging from service users. Their participants were 18 care staff from 10 residential homes, and thematic analysis drawing on ideas from interpretative phenomenological analysis and grounded theory was used to examine their views and feelings. Staff reported the dilemma they felt in deciding whether to view behaviours they found challenging as a learned behaviour and to respond according to behavioural models, or to see it as communication, and respond more 'kindly'. The researchers used semi-structured interviews, so it is possible that the responses of care staff could have been influenced by the ways in which questions were posed, and their knowledge of the role of the interviewer as a clinical psychologist. It could therefore be argued that it is not possible to conclude that the findings represent the true views of participants, and from a discursive psychology perspective talk (i.e. language in use, expressed verbally) is not seen as a direct reflection of inner thoughts and feelings. However, the findings do represent discourses in use, and therefore are illustrative of influences on the provision of services for people with LD and again indicate some potential difficulties for staff in those services, and challenges to the provision of person centred care.

Research has also been carried out examining discourses about identity from the perspectives of people with LD. For example, Scior (2003) carried out interviews with five women with LD about their everyday experiences to examine how they positioned themselves, particularly in relation to constructs of gender and disability. Scior (2003) gave a clear description of the background of participants and carefully considered her own position in relation to the analysis. Although some information was given on the theoretical rationale of the DA used, no specific details of how the analysis was carried out were provided. However, findings were clearly illustrated with quotes from the data. Scior (2003) found that although discourses around choice and equality are currently common, her research showed that people with LD may often still be controlled by others, such as carers, to a degree that other groups do not experience. Scior (2003) highlights the continuing effect of negative constructions of people with LD. For example, the tendency for other people to have power over them, a lack of choice and control in relationships, negative self-image, and the justification of oppressive treatment through reference to discourse.

Rapley, Kiernan & Antaki (1998) conducted research looking at discourses around having a learning disability from the perspective of people with mild or moderate learning disabilities by examining conversation interaction. Rapley et al. (1998) included data from interviews with eight people selected from a larger study on the perceptions of people with LD on their quality of life. They report that they drew on DP to analyse the data, and conclude that people with LD are aware of the discursive influences of the label of 'learning disability', but might manage some of the negative connotations of the label by dissociating themselves from it, and by using talk that identifies them as able. Rapley et al. (1998) also report some of the negative impact of having a learning disability highlighted by their participants, such as lack of control over their lives and needing their parents' permission to do things. This analysis enabled Rapley et al. (1998) to challenge perceptions put forward by previous researchers e.g. Todd and Shearn (1997) that people with LD are unaware of their disability. Although many examples from the data are used to support their findings, they do not report details of how the

analysis was conducted. It is therefore not possible to determine the extent to which their findings are representative of the data as a whole. McVittie Goodall & McKinlay (2008) carried out interviews with eight people with LD on various subjects relating to their lives. They then used discourse analysis to consider how the people they interviewed describe their abilities and disabilities in relation to others. Details of the focus and practicalities of their DA were provided, and this, along with examples from the data, made it possible to see how they had reached their conclusions. Evidence was found for three different ways in which participants negotiated descriptions of themselves: ascribing deficits to others, resisting comparisons of deficit, and claiming 'normal' attributes. McVittie et al. (2008) suggest that attention should be paid to the negotiation of identity by people with LD, and the function of the particular discourses drawn upon, as they have a huge impact on people's lives. This research involved analysis of interviews conducted by volunteers, and the authors state that they aimed to make interviews naturalistic. However, the fact that this research only looked at the discursive negotiation of identity in response to interview questions could be considered a limitation.

The need for more careful consideration of how the identities of people with LD are dealt with in discursive interactions with them has been highlighted (Davies & Jenkins, 1997). In their research Davies and Jenkins (1997) describe the huge impact of the categorical identity of having a learning disability on the self-identity of the people in their study. They carried out semi-structured interviews with people with LD and carers, and also observed participants in day centres. They draw on quotes from these data to support their findings, although no details of their method of analysis are provided. Davies and Jenkins (1997) report that the identity of having a learning disability was incorporated into people's self-identity through social interactions with them. They found that there were strong discourses around lack of power, and the control of others over people with LD. In contrast to Rapley et al. (1998), they found that people with LD were not aware of many of the common discourses around having a learning disability. Davies and Jenkins (1997) suggest that attempts made by parents to avoid discussing the

label with people with LD could contribute to their inadequate understanding and disempowerment. This study had the advantage of including a relatively large sample of sixty participants with a learning disability and a similar number of parents or carers. In addition, their analysis was informative in that they considered both the discursive and the experiential influences on participants' talk, and the ways in which the two interacted.

The research described so far in this section all involved analyses of interviews carried out by researchers. It is therefore difficult to determine the extent to which the participants were influenced by the interview questions and the reactions of interviewers, as acknowledged by some e.g. Scior (2003). Although some useful findings have come from these studies, it is important to keep this in mind and to consider the effect of interviewer contributions on the validity of data.

1.5.2 Discourses in naturalistic interactions with people with learning disabilities

Some research has also considered the construction of identity of people with LD by examining naturalistic interactions between people with LD and care staff or professionals in various settings. For example, Antaki (2001) reports the findings of his conversation analysis of psychological assessment interviews carried out with people with LD. Unfortunately Antaki does not explicitly give any details of the method of analysis, his own background or participants' backgrounds. However, the study is included here because of its relevance to the current research and because findings are illustrated well with examples from the data. Antaki (2001) reports that practices of substituting questions and changing the language revealed a number of assumptions interviewers were making about people with LD e.g. as participating in social activities in a limited way, as being unlikely to engage in certain types of relationships and as being unable to respond to certain types of question. Regardless of the accuracy of the assumptions interviewers appeared to make, Antaki (2001) argues that their practices served to construct a limited identity for people with LD, and narrowed the possible responses they could give in the assessments. Antaki (2001) presents a critical account

of these practices and their effects, but it should be noted that there may be good reasons for some of them. For example professionals might be considering cognitive impairments, and attempting to enable the people they interviewed to answer questions by simplifying them. There might also be protective intentions behind some editing of difficult or emotive questions. Unfortunately, as Antaki (2001) points out, the result of this might be to protect professionals from hearing full accounts of negative experiences or feelings while the reality of those experiences remain unchanged. Antaki, Walton and Finlay (2007) report on conversation analysis of data from four meetings between care staff and residents in residential homes for people with LD. They explored how staff offered choices and considered the implications of this for residents' identities using examples from the data to illustrate their findings well. They provide some indication of how examples were selected for analysis, but unfortunately no further details of the wider process of analysis. Although one aim of the meeting was to find out residents' views on various aspects of their living and social arrangements, Antaki, Walton and Finlay (2007) found that style and content of interactions were directed by staff. For example, staff suggested answers and used leading sentences with one word missing to guide residents in what contributions they could make. Antaki et al. (2007) suggest that staff members were attributing a limited social identity to the residents through the ways in which these interactions were conducted.

1.6 Communication in Interactions with People with Learning Disabilities

In this section some issues that have been highlighted as relevant to communication with people with LD are reviewed. In addition, some findings on the effects of particular forms of communication from detailed analyses of interactions with people with LD are considered.

A number of factors have been highlighted which can cause difficulties in gaining the perspectives of people with LD, such as problems they might have with memory for events or with expressing themselves in a meaningful way (see Lloyd et al., 2006). Lloyd et al. (2006) carried out a review of the qualitative interview research literature

involving people with impaired expressive communication, including people with LD. They discuss some difficulties encountered by researchers in gaining the views of people with communication difficulties. They emphasise the potential for increased disempowerment and oppression of these groups if means to overcome communication difficulties so that people can express their views are not sought. These are important considerations when undertaking research with people with LD. However, the perspective taken by the field of discursive psychology is that the talk people use serves different functions, i.e. talk is a social action (Willig, 2008). Research in this tradition would not be concerned with gathering 'correct' accounts, as language is not believed to necessarily represent truth or the real experience of the speaker. Therefore some of the potential difficulties Lloyd et al. (2006) describe in gathering full or correct responses from people with communication problems might not necessarily be the main concern for researchers using an approach influenced by discursive psychology. However, regardless of the varying focus and assumptions of different research traditions, the ways in which communication with people with LD can be improved is an important consideration in research and in services for people with LD. Finlay and Lyons (2001) have reviewed methodological issues in research with people with LD, and discuss how difficulties with communication could be minimised. They used examples from the literature to illustrate the points they make, and suggest taking steps to facilitate the understanding of people with LD, such as keeping vocabulary and meaning clear and simple, and listening carefully to what they say. Careful consideration of interactions between people with LD and others can help to determine how talk is used to achieve different ends, and whether there are times when the ability to communicate is compromised.

It has been suggested in the past that people with LD have a tendency to acquiescence when questioned, and that this might compromise the validity of their accounts (e.g. Sigelman et al., 1980). Conclusions such as this could be used to discount what is said by people with LD because of ideas that it could be particularly unreliable. However, Stalker (1998) has suggested that seemingly acquiescent responses from

people with LD may be given because so many aspects of their lives are controlled by others, and they are accustomed to responding in this way, rather than because of their intellectual impairment. Rapley and Antaki (1996) have also criticised the perspective of Siegelman et al. (1980). They state that their detailed conversation analysis of eight interviews carried out by trained professionals with people with LD using a questionnaire on quality of life provides insight that has sometimes been lacking in previous analyses. They give some background information on their participants and the context in which the questionnaire was delivered, but do not explicitly describe their method of analysis, focusing instead on their findings illustrated by examples from the data. By examining the process of interactions between interviewer and interviewee, they demonstrated that responses to questions could be dependant on previous conversation, and that inconsistent answers could be elicited by asking people to reiterate responses to the same question. They cite the demands of the situation in which questions are asked, the sometimes confusing way in which questions are posed, and power differentials, among possible alternative reasons for acquiescence. In addition, they found that repeated questioning and certain lines of questioning seemed to serve the function of shaping responses into those that were desired or expected by interviewers. Rapley and Antaki (1996) also point out that it is not only people with LD who sometimes give inconsistent accounts, and they suggest that it is important to consider the possible functions of responses given, and the conditions in which they are produced, as well as possible reasons for these responses e.g. memory problems. In conducting this research Rapley and Antaki (1996) have considered how the context and situational factors can lead to seemingly acquiescent responses, and their work can challenge the view that reasons for such responses can be located solely within the individual. This research has identified dilemmas for professionals in interviewing people who use their services, such as the difficulty of facilitating people's understanding whilst not unduly influencing their responses.

In a later study Antaki, Young and Finlay (2002) examined interactions between unqualified care staff delivering a similar questionnaire about quality of life and people

with LD. In this case the staff members were not trained in interviewing, and the questionnaire encouraged them to paraphrase items as appropriate. In this paper background information on participants and context are provided, but again no explicit descriptions of the process of analysis are given. They use examples to illustrate their findings that there were a number of ways in which staff moved away from neutral administration of the questionnaires. They found that interviewers often responded to participants' answers with (usually positive) evaluations, offered advice on the basis of answers, suggested answers (which were often a single possibility in a yes/no format), and changed the questionnaire to ask more limited questions. Antaki et al. (2002) conclude that these practices led in some cases to responses being recorded which people did not initially give without considerable influence from interviewers. They note that this is particularly of concern when findings from the interviews are used to inform how services are provided, as was the case with these interviews.

These research studies have revealed how the expectations and assumptions of psychologists and carers influenced their interviewing practices, and therefore the responses of people with LD. They provide further evidence that reflection on how discourse influences clinical practice could be a valuable component of improving services for people with LD. However, these analyses were on a particular questionnaire on quality of life, and although Rapley and Antaki (1996) state that their conclusions are pertinent to any interview situation, it is possible that the questionnaires may have had particular unique characteristics that influenced these findings to some extent. Further research in different formal interview and assessment situations could therefore add to knowledge in this area.

Antaki, Finlay and Walton (2007) report on their analysis of verbal interactions between the residents and staff in a residential home for people with LD. They used conversation analysis to examine the ways in which staff members encourage service users to talk, and consider the effects of these practices. The authors give adequate background information on the setting and participants, and although they do not outline the details of their process of analysis they do refer to previous literature on the

method. The analysis showed that overall staff tended to initiate conversation more frequently than residents and six common practices were identified: (a) asking questions, and pursuing the question if the answer was deemed inadequate, (b) articulating what the resident has just said unclearly, sometimes expanding or reformulating it, (c) failing to attend to ill-formatted material, (d) asking a blunt yes-no question, (e) using a “test question” to which the answer is already known and (f) teasing the resident. Antaki, Finlay and Walton (2007) note that the service was working with the objective of getting people with LD to express themselves and engage socially in line with the Valuing People (Department of Health, 2001b) recommendations. They conclude that each of these strategies used by staff involves a balance between facilitation and control. Although staff seemed to be following policy goals of inclusion, participation and empowerment, the detailed analysis of talk in interactions revealed that the situation is more complex. The researchers used video recordings of interactions and both verbal and non-verbal communication was considered, which added to the understanding of these naturalistic interactions. These studies have shown how detailed analysis of interactions in services for people with LD can provide useful information on the effects of different styles of communication. These findings could help staff members to reflect on how they communicate with people with LD, and further research in other settings could also improve knowledge and practice.

1.7 Issues of Choice and Control for People with Learning Disabilities

The Mental Capacity Act (Department of Health, 2005) has made it a statutory requirement to empower and facilitate the involvement of people with LD in decisions about their lives wherever possible. Therefore it is a priority for health services to meet this requirement, and to ensure that care providers are not simply acting in what they perceive to be people’s best interests without sufficiently considering how they could be involved in decision making. In this section the literature on issues relating to providing choice and control for people with LD in line with current UK government policy is reviewed.

1.7.1 Factors affecting choice making for people with learning disabilities

The concept of choice is related to issues of communication, and is discussed here because of its potential relevance to the current research examining interactions with people with LD in assessment appointments. As mentioned earlier, there is presently considerable emphasis in government policy on providing people with LD with choice and control over their lives e.g. the Valuing People papers (DoH, 2001b, 2007a). However, some research has identified difficulties in meeting this recommendation. Bowey, McGlaughlin and Saul (2005) report findings from focus groups with family carers and professionals who worked with people with LD. Participants were asked to discuss their views on barriers to housing choice among people with LD. They found that concerns about safety, anxiety about support, and lack of information were among reasons choice was not provided. This research was relatively small scale, and the details of participants and methods of analysis used to identify themes are not reported. It is therefore difficult to comprehensively judge the quality of this research but it does indicate some possible difficulties with implementing parts of the Valuing People Now recommendations, and areas for improvement. It has also been highlighted that goals and priorities for services, carers and family members may conflict with the philosophy of choice and control for people with LD themselves (Jenkinson, 1993). Jenkinson reviewed literature on theoretical findings on choice making and research on decision making in people with LD and highlighted the importance of considering contextual factors affecting choice making. It was noted that the priorities of the different parties involved in the lives of people with LD could influence the ways in which choice and autonomy is facilitated. For example, a drive for people with LD to acquire social skills and learn to function independently could be influential, but at the same time may not fit with what they would choose to do themselves.

Harris (2003) has considered current understanding of the concept of choice, and its relevance for people with LD by discussing models of choice, research literature and policy. Harris (2003) points out that many different factors can affect choice making, such as cognitive abilities, social context, past experiences and mood. He therefore

argues that the idea that there should be logical sequences for choice making may bear little resemblance to how people make decisions in reality. Despite this, expectations that people need the ability to engage in a particular sequence for choice making has had a strong influence on decisions made by services on capacity (Harris, 2003). Harris (2003) also discusses the effects of feelings of powerlessness on choice making. People with LD may sometimes lack the belief that they are able to affect the outcomes of situations. As Harris (2003) points out, in order to have the motivation to express a choice, people need to know that there is a choice available to them.

Rawlings, Dowse and Sherlock (1995) have carried out research examining choice making by people with LD. They observed five people in different home settings along with their carers or families. Their method involved the researcher spending a considerable amount of time with participants, and becoming part of their day-to-day life for the period of the research. Rawlings et al. (1995) found that a number of factors affected people's abilities to make choices, such as their previous experiences of being able to make choices, the ways in which the people around them supported or restricted choice, and opportunities afforded by their daily routines. People's communication ability, and the abilities of the people around to understand them and facilitate communication also affected choice making. The researchers suggest that people needed opportunities and experiences to learn about making choices. Rawlings et al. (1995) provide some useful insight into factors which could affect choice making for people with LD, and they also make some suggestions of how it could be enhanced. The interpretations and themes drawn from the data were well validated through repeated analyses by different researchers, adding to the credibility of their conclusions. However, the research process relied on recording of data from each observation session after the sessions had ended, so this could have introduced an element of unreliability in that the researcher needed to recall what had been said. Therefore further research in this area would be beneficial.

As outlined above, it has been suggested that there are many different factors that can affect choice making. These are potentially relevant to how people present to

services, in terms of how they come to be referred to services, and how they influence the services they receive. The challenges of balancing individual rights to choice with perceived professional and ethical responsibilities have been highlighted (Brown & Brown, 2009). Brown and Brown (2009) reviewed the concept of choice by drawing on the literature, including research in relation to choice making in specific situations such as social activities, housing and money management. They point out that in many cases it would be relatively easy to facilitate much more choice for people with LD in many aspects of their lives if service staff were trained to do so. Brown and Brown (2009) have outlined a strategy for providing people with LD with choice, which considers practical ways in which increased choices in people's daily lives could be facilitated. However, this framework would need to be evaluated in future to determine whether it is practically useful.

1.7.2 Examining choice in discursive interactions

Some research has also been carried out using discourse analysis and conversation analysis to examine issues of choice making, decision making and empowerment in interactions with people with LD. For example Jingree and Finlay (2008) carried out discourse analysis on semi-structured interviews with fifteen support staff who worked with people with LD relating to issues raised in the government document Valuing People (DoH, 2001b). Thorough descriptions are provided of their method of interviewing, the process of developing the interview and also of their method of analysis. They explored discourses about how choices are promoted or denied for service users and supported their findings well with examples from the data. One discourse they identified related to the importance of increasing autonomy, and this was sometimes used by staff to position themselves as in favour of choice and control for service users. Another discourse was about practicalities, where staff presented the reasons why facilitating choice and control in some situations was difficult. These two discourses were sometimes used together by staff to present themselves as strongly aligned to the idea of providing choice and control, and then

almost immediately afterwards presenting practical problems with the idea. Jingree and Finlay (2008) discuss the different argumentative strategies used by staff members to negotiate their positions in relation to the topic in detail in their paper. For example they found that the ways in which staff talked about service users sometimes positioned them as 'other' and supported arguments for difficulties with providing autonomy. They conclude, similarly to the findings discussed above, that there are a number of complex dilemmas raised by the issue of choice for service users with LD.

Studies by Antaki, Finlay, Sheridan, Jingree and Walton (2006) and Jingree, Finlay and Antaki (2006) examined the issue of providing control for people with LD more directly in naturalistic interactions in groups facilitated by care staff, designed to involve people with LD in decisions about services. Conversation analysis of recorded talk was used to examine the interactions. In both papers background information on the setting and some details of the process of analysis are provided. In addition, the findings were well supported by the data presented. Antaki et al. (2006) discuss two contrasting styles of facilitation; in the first the facilitator directed participants through the cycle of steps necessary from identifying a problem to deciding on action. At every stage the facilitator engaged the participants in the task, encouraging their responses and took an active role in moving the process forward and influencing decisions using a number of strategies described in detail by Antaki et al. (2006). In contrast, the second facilitator style was much more directive, and discussion and decisions were based more firmly on the service agenda, bypassing some stages of decision-making. Practices such as overriding residents' suggestions, deferring problems raised, and confirming achievements of the meeting with another staff member rather than residents were identified. Antaki et al. (2006) conclude that, although some practices in facilitating these meetings were more conducive to self-advocacy than others, some of the interactions they recorded were far from the ideal of empowerment of people with LD. Jingree et al. (2006) also present a number of examples of the ways in which staff members failed to follow up some of the contributions made by residents, and prompted people or suggested answers which affirmed the service philosophy. They conclude that the ways in which interactions were

managed in these meetings was affected by the unequal power relations between staff and service users, and meant that: “answers, opinions and feelings were constructed, which the respondent did not originally submit.” (Jingree et al., 2006, p.225). These studies highlight a dilemma faced by services when there is an institutional agenda in addition to the aim of facilitating self-advocacy. However, even within the constraints of such an agenda, there were clearly changes that could be made to move towards that aim.

Research carried out by Antaki, Finlay and Walton (2009) also involved conversation analysis of naturalistic interactions with people with LD, but they focused on how choice was offered at the level of day-to-day experiences around two residential homes. In this paper details are provided of the setting in which data was gathered and of the participants, but very little information is given on the process of the analysis, making it difficult to evaluate. Antaki et al. (2009) note that they did not observe any examples of discourse on choice in areas focused on by the Valuing People documents, such as life style, emotional attachment or paid employment. The types of choice offered sometimes related to matters important to the running of the organisation. Commentaries on activities in which residents were already engaged were sometimes formatted as questions, implying choice, including instances where the activity was actually against a client’s previously stated preference. Questions were posed to imply choice on occasions when staff errors meant that previously stated preferences were no longer available. Choice offered also sometimes related to abstract, unfamiliar or underspecified alternatives, which might have been confusing to the resident. Antaki et al. (2009) conclude that this research demonstrates that providing choice even on a small everyday scale is not straightforward. Although staff had incorporated the language of choice promoted in government policy into their talk, frequently this did not result in genuine choice and control for service users, instead staff largely retained control of the agenda.

These research projects looking in detail at discursive interactions have clearly identified continuing practical difficulties with providing choice and control for people

with LD in a number of settings. However, as Antaki et al. (2009) point out, highlighting these issues and the engagement of staff in reflecting on practice including examination of the less empowering ways in which choice is sometimes offered, could lead to changes to how staff work people with LD so that practice becomes closer to official government recommendations. In the current research, it is hoped that an in-depth analysis of the detail of how problem definitions are negotiated in the appointments of a psychology service might provide insight into issues of providing choice and control for people with LD in this setting. Given the complex dilemmas identified in the research so far, it seems important to consider these issues further.

1.8 The Current Research and Potential Implications

The research so far has highlighted some of the discourses relevant to the lives and identities of people with LD. This research also demonstrates that it is possible to carry out qualitative research with people with LD examining language and discourse. In a number of the research studies described, it was noted that methods of analysis were not explicitly described, making it difficult to comprehensively judge their quality. These papers are included in the literature review despite this limitation because of their pertinence to the current research and because there is relatively little research in the area. In addition, the level of detail provided in reporting findings of many of these studies made it possible to judge the quality of the research to some extent. To date, some research has analysed interactions between health professionals and people with LD, to examine how talk in these interactions achieves different ends. In addition, the influence of power dynamics in therapeutic interactions in various settings has also been examined. As yet no research has specifically examined interactions in the setting of general psychology assessment appointments in a community health service for people with LD. The current project therefore builds on the research conducted to date. By examining naturalistic interactions, and taking a discursive psychology approach to analyse how language is used in this setting, it is hoped that new findings will come from this research. The problems defined and decisions made in such assessment

appointments are likely to determine some of the services offered to people, so it therefore seems important to consider some of these issues in this setting.

It is hoped that the research will further psychological knowledge on how power dynamics are managed in this setting, on how talk is used to achieve different ends, and on the discourses drawn upon by different individuals. In addition this research could contribute to clinical practice by improving the understanding of some of these issues, and how they apply to the clinical setting of assessment appointments with people with LD. The research might also promote reflection on and critique of how services for people with LD work, and on how professionals manage ethical dilemmas in this area. It is hoped that this research might advance knowledge on how professionals can work towards goals of promoting the involvement of people with LD in choice and control in their lives, as outlined in documents such as Valuing People Now (Department of Health, 2007a).

1.9 Research Question and Aims

Research question

'How is problem definition negotiated in assessment appointments with people with learning disabilities?'

Aims

- To examine how difficulties are described, defined and discussed in assessment appointments in an NHS community service for people with learning disabilities.
- To examine power issues and the ways in which the different people present contribute to these interactions and draw on discourses.

CHAPTER 2: METHOD

In the first section of this chapter an overview of the theoretical background of the methodology is given. Following this the ethical issues in relation to the research are considered. Then the practicalities of the research are described, such as the setting in which it took place, the stages of planning the research and selecting a sample, and the procedures involved in carrying out the research. Details of the research participants are then provided, and the steps taken to process and analyse the data are described. Finally the use of reflection and the position of the researcher in relation to the study are considered.

2.1 Theoretical Rationale for the Methodology

Qualitative research methods in general are used for the purpose of gaining new knowledge about processes or enriching understanding, and not to test or verify previous findings (Elliott et al., 1999). Within the field of qualitative research there are a large number of different methods that can be applied to different types of research questions. A range of methods were considered in order to decide on the design of the current research. For example, the aim of research using a discourse analysis perspective would not be to identify attitudes and beliefs, because the theoretical underpinnings of the method take the view that the talk people use does not accurately represent their attitudes and beliefs. A different type of research question could be asked about attitudes and beliefs around defining problems in assessment appointments with people with learning disabilities, and a qualitative method such as grounded theory would be more appropriate. Grounded theory involves categorising data, so could generate answers to this type of question. This method generates all categories from the data rather than imposing external or pre-generated categories (Willig, 2008). Alternatively, DA is more appropriate for looking in detail at how interactions in talk, drawing on certain discourses, lead to particular problem definitions, instead of focusing on categorisation. DA questions the validity of assuming talk represents genuine beliefs and

desires, and instead is concerned with how dialogue is used to manage social relations (Reicher, 2000), and therefore is more appropriate for the current research question.

2.1.1 Theoretical underpinnings of discursive psychology

Discursive psychology (DP) is an approach primarily used to analyse interaction in detail (Potter, 2003). However, DP does not specify a particular method of data analysis. Rather, it is “a perspective that includes meta-theoretical, theoretical and analytical principles” (Potter, 2003, p.73). DP provides a wider perspective on the ways in which people make use of language and other forms of interaction. It is therefore important to discuss some of the ideas and assumptions of DP in order to show how it can be used to guide the analysis of discourse.

The ideas central to discursive psychology were developed from earlier thinking on the philosophy of language, as described by Potter (2001). Potter reports that Wittgenstein (1953) made some early criticism of the idea that language is used in a universal way to represent inner thoughts, and instead emphasised its diversity and variability, and that the meaning of words altered according to their use in language. Later, Austin (1962) studied language and wrote the general theory of speech acts. In his theory of speech acts he developed the idea that people use words and language to perform actions such as stating, describing or denying. The theory included the idea that the ‘force’ with which words are used changes their meaning, and this is influenced by the circumstances in which the words are uttered. He described how a number of contextual conditions (called “felicity conditions”) need to be in place for language and words to be used in a meaningful way (Potter, 2001). These related to societal and historical conventions, facts about the immediate situation, and the beliefs of the speaker, which would all affect whether or not an utterance in a particular context would make sense. Potter (2001) reports that Austin’s theory of speech acts influenced discourse analysis in that it emphasised the role of social institutions, settings and psychology in understanding language. However, the theory has also been criticised

because it was not fully developed to consider interaction in speech on a more applicable and practical level (Potter & Wetherell, 1987).

Discursive psychology was developed as a form of discourse analysis following the ideas outlined by Potter and Wetherell (1987), drawing on conversation analysis. From the perspective of discursive psychology (DP) language is seen as a social and relational tool, which is influenced by the context in which language or talk is used (Wiggins & Potter, 2008). Discursive psychology tends to focus on examining interactions between people, looking at how people use language and draw on different discourses to achieve different ends in interactions (Willig, 2008). In the early development of DP ideas, Potter and Wetherell (1987) criticised the traditional view that the attitudes people ascribe themselves are direct representations of inner dispositions. They promoted the idea that people's attitudes are variable, subject to context, and that in expressing their attitudes people are performing an action. Billig (1996) also agreed with this position, and the idea that people express views in particular contexts for social and practical reasons, and to support the arguments they make. According to these ideas, people's identities are also unstable, and are negotiated through social interaction (Edley, 2001). As described by Wiggins and Potter (2008), from a DP perspective people use language to position themselves in relation to a subject. Talk is used to construct versions of their own thoughts and feelings, and to construct actions or events in the world. According to DP relationships between inner thoughts and feelings and the outside world are constructed in interactions and through the use of language (Wiggins & Potter, 2008).

Potter (2003) describes three core features of discourse according to DP. The first is that discourse is action oriented. It is the primary medium for social action and interaction, through talking and writing. People are seen to be performing actions such as persuading, denying, agreeing, placating, and so on, through written and spoken language. The second is that discourse is situated in three ways. It is situated in the immediate context, i.e. what is said is affected by what has just come before in terms of the immediate environment and what was previously said. It is situated institutionally, in

settings such as a doctors' reception or school, and the task being undertaken might affect what is said. In addition it is situated rhetorically, in that talk and discourse is seen as making an argument for a particular way of looking at things or a certain description (and therefore as arguing against a counter-position). The third core feature of discourse described by Potter (2003) is that it is both constructed and constructive. It is constructed because it draws on various forms of influence and resources, such as the words, ideas and forms of explanation available in a particular context. Equally it is constructive in that people describe and explain versions of events and their experiences, i.e. they construct discourse, in order to perform social actions.

2.1.2 Interpretative repertoires, positioning and ideological dilemmas

DP has been described as a complex field itself, and different variations of the approach have been developed. Hepburn and Wiggins (2007) provide some useful brief comparisons between the focus of DP and some other approaches to DA, but highlight that definitions vary and there are many similarities between approaches. Edley (2001) describes a version of DP that takes account of the historical context of talk and interaction and considers the repertoire of ideas or positions available to the speaker. According to this form of DP, there may be a range of different ideas or concepts available in societal discourse on a particular topic. People can therefore make choices about which they use in their talk, but these choices are also informed by the immediate social context. Edley (2001) states that people's talk is influenced by the constructions and formulations available to them, and also by the relative dominance of these different ideas. People are seen as both influenced by and involved in producing discourse (Billig, 1991). This approach also sees it as relevant to consider how different interests are served by the historical and cultural context of talk, and has been influenced by the work of Foucault (e.g. Foucault, 1980). The power of different influences is seen to effect how those influences and available discourses shape people's talk (Edley, 2001). According to Edley (2001) three concepts are central to this form of DP (which he terms critical DP), i.e. interpretative repertoires, subject positions and

ideological dilemmas. These are discussed here because they are useful in guiding and organising some of the assumptions and considerations described above in the process of carrying out DP analysis.

The idea of interpretative repertoires (IRs) was first developed by Potter and Wetherell (1987). IRs are ways of talking about a particular object, subject or event, which are influenced by the cultural and historical factors relating to that subject (Edley, 2001). They can be recognised in talk in the form of particular patterns of ideas. There is no fixed definition of what makes an individual interpretative repertoire, but they occur in conversations and might be recognised across the talk of different individuals on a particular subject. Edley (2001) points out that the concept of interpretative repertoires is similar to the concept of there being particular 'discourses' available to people, which can be used in talk in a particular societal context. However, the idea of discourses is more common in Foucauldian discourse analysis, and the distinction drawn by Edley (2001) is that it is a more all-encompassing concept relating to power and institutions or political movements. In contrast, the term interpretative repertoire tends to be used by researchers from a DP tradition who take the view that people have more agency and flexibility to construct different descriptions in talk (Edley, 2001).

Ideological dilemmas is a concept first described by Billig et al. (1988), where ideologies are seen as the beliefs and values of a certain society or culture (Edley, 2001). Billig et al. (1988) argued that such ideologies (including concepts such as common sense) are contradictory and inconsistent, and so dilemmas arise in people's talk. Different interpretative repertoires relating to the same subject might be contradictory, so ideological dilemmas arise in discourse when people draw on contradictory interpretative repertoires in their talk (Edley, 2001).

Subject positions are the ways in which people position themselves in relation to particular ideas and interpretative repertoires in discourse. Edley (2001) discusses how identity is constructed in discourse based on how people talk for or against particular positions in relation to themselves (often implicitly), and how they present themselves in a particular light. Critical DP sees the three concepts as related, and each can be

considered in terms of what people are doing in the immediate context with their talk, but also in terms of their wider societal, cultural and historical context.

In the current research, the theoretical ideas from DP that have been outlined above in sections 2.1.1 and 2.1.2 were used to inform the analysis. The process of analysis therefore involved examining the action orientation of the talk, the ways in which it was situated, and the ways in which it was constructive and constructed. It also involved considering interpretative repertoires, ideological dilemmas and subject positions in the discourse where they were relevant to the research question. The practical steps taken to analyse the data are outlined in section 2.8.

2.1.3 Discourse analysis and live data

Arguments have been made for the value of analysing live data rather than conducting interviews in order to address research questions about interactions and the discourses drawn upon in everyday life (Potter & Hepburn, 2005). It has been noted that if live data are not used, then the findings of research can end up being more about how participants use discursive resources in an interview situation rather than in everyday life (Willig, 2008). Potter and Hepburn (2005) describe how research using qualitative interview data has sometimes failed to take account of the influence of factors such as the interviewers' and interviewees' agendas, the interview situation, power differentials and the interactive elements of interviews. They argue for the merits of moving towards using naturalistic data instead of interviews in order to capture phenomena that would have occurred regardless of the interests of researchers. Potter and Hepburn (2005) state that this approach reduces the influence of researchers on the data gathered, and is more likely to generate novel and interesting data.

2.2 Ethical issues

Ethical approval for the research was granted by Bradford NHS research ethics committee (see appendix two). Approval for carrying out the research was also granted by the Trust Research and Development (R&D) department (see appendix three).

Risks and benefits of taking part in the research were carefully considered in order to ensure the research was justifiable and ethical. By using recordings of assessment appointments that would have taken place anyway, extra demands on participants of taking part in the research should be minimised. In addition this method removes ethical concerns that might arise with research interviews, such as the possibility that questions asked might lead to participants becoming distressed. However, there were some important ethical considerations in conducting the research as outlined below.

2.2.1 Considering capacity to consent to research

The service user participants in this research were people who have learning disabilities, and therefore from a potentially vulnerable population. Although only people who had the capacity to give informed consent were included, Dalton and McVilly (2004) note the importance of being aware of power issues and the vulnerability of people with learning disabilities to coercion. Therefore the process of gaining informed consent was considered in detail to ensure that the current research was carried out ethically. Guidance in the Mental Capacity Act (2005) was followed, which states that consideration of capacity to consent needs to be decision, situation and time specific, and that steps should be taken to facilitate capacity rather than assuming lack of capacity. Local and national NHS policies on gaining informed consent were also followed (e.g. Department of Health, 2001a). Information provided was structured carefully and adapted as necessary to facilitate the understanding of people with learning disabilities. Recommendations were followed in producing this information such as avoiding complex concepts and using clear sentence structure (Finlay and Lyons, 2001). Consent was regarded as a continuous process, and attention was paid to signs of

discomfort or distress, including any non-verbal cues indicating that participants might wish to withdraw consent. Staff members conducting the appointments and the researcher collecting the recordings ensured that participants felt no pressure to continue participation if they discussed something they would prefer not to share. In addition, it was ensured that participants were aware that they could withdraw their consent to taking part in the study at any point. It was hoped that this would minimise the possibility of participants not saying everything they would want to or avoiding certain issues because of knowledge that the appointment was being recorded for research.

2.2.3 Data protection & confidentiality

To ensure the privacy of participants, the participating service was the conduit of contact between the participant and the chief investigator, and the research team did not hold the contact details of participants.

All contextual details that would identify participants were changed during transcription. Details such as names of persons, locations of their homes, social activities, work places, known landmarks and so on were transformed so that none of these details were present in the transcripts and participants were allocated pseudonyms. All data analysis and presentations of findings used the anonymised and transformed transcripts. In addition, no contextual data that could lead to the identification of participants will be included in any future reports or publications resulting from the research.

All data stored electronically were encrypted according to the University of Leeds regulations, and in compliance with the NHS R&D regulations. All data will be kept for seven years from the end of the study in a secure location at the University of Leeds. At the end of the period of data storage the paper transcripts will be destroyed by the service storing the data by shredding, and the electronic files destroyed using appropriate data destruction software.

2.3 Setting

The research was carried out in the clinical psychology department of an NHS citywide service for people with LD. People of a range of ability levels who are considered to have LD can potentially access the service. The people with LD included in the current research could all be described as having a mild-moderate learning disability. This was due to the ethical requirement that participants were able to give informed consent, and because of the practical requirement that people have some verbal ability so that their audio recorded talk could be analysed. Professionals from the department carry out a range of work both directly with service users and indirectly with staff from wider learning disability services, or with family members. Most referrals to the department are in four main areas: Consultation work with staff or carers working directly with service users, assessment e.g. of capacity to make specific decisions or choices, production and oversight of behaviour management plans in accordance with a 'challenging behaviour pathway' and face-to-face therapeutic work. In some cases the psychologist might therefore have very little direct contact with the person referred. The appointments included in the current research could potentially be in relation to any of these areas, but were limited to those involving direct work with people with LD.

2.4 Planning the Research

In the early stages of planning the research a number of meetings were held with the LD Service. These meetings were used to discuss the research idea, the feasibility of the project, and details of the process of recruitment and gaining consent. The feedback of staff members from the service on the research idea and on some aspects of the design was incorporated into plans.

The Learning Disability Service User Involvement Team in the Trust where the research took place was also consulted on the research. They provided guidance on the development of the research information and consent forms to facilitate the understanding of participants. Once the research information had been produced, service user representatives were consulted on its suitability. The Service User

Involvement Team showed them the research information and asked them questions about their understanding of the purpose of the research, what participation would involve, and the consent process. The feedback from service user representatives was used to facilitate the production of the final versions of the research information (see appendix six for copies).

2.5 Sample

It was decided that only a few criteria would be used to select participants. There were a number of reasons for this decision. It was hoped that the sample would reflect a naturalistic range of different people who would normally access clinical psychology in a community health service for people with learning disabilities. It was felt that the research questions on how problem definition is negotiated in appointments with people with learning disabilities could be answered regardless of the specific referral reason. In addition, qualitative research using a method such as discourse analysis does not aim to produce findings that can be generalised, so it was not particularly important to select participants on the basis of specific characteristics such as age, gender or ethnicity. It was hoped, however, that the sample might be sufficiently reflective of the type of population who might access similar departments in order to be relevant to the clinical practice of those reading the research. The inclusion and exclusion criteria used are outlined below, and later in this chapter further details of the sample recruited are given.

2.5.1 Criteria for participation –service user & carer or family member participants

Inclusion criteria

In order to be included in the current research, participants needed to meet the following criteria:

- a) To be adults (aged 18 or over)
- b) To be able to give informed consent
- c) To have sufficient verbal ability for their audio recorded talk to be analysed

- d) To have been referred to the Learning Disability Service, or to be the family or carers of someone referred.
- e) To be offered an appointment during the course of the research.

Exclusion criteria

Participants were excluded from participation in the current research if any of the following criteria applied:

- They were under the age of 18
- They lacked the capacity to give informed consent
- They did not communicate verbally, or did not have sufficient verbal ability for the analysis to be possible.
- They were not offered an appointment with the learning disability service during the course of the research.

2.5.2 Criteria for inclusion of staff member participants

All of the professional clinical staff working in the psychology team of the learning disability service were asked whether they would like to participate in the research. The people who expressed an interest were recruited according to the procedure described below. Their participation also involved assisting with the recruitment of service user and family member or carer participants, as described below.

2.5.3 Rationale for the sample size

There are no published guidelines on the number of assessment appointments that it would be appropriate to record for the purpose of the current research. There is minimal published literature of similar methodology, and participant numbers have varied in the research literature. Antaki (2001) refers to analysis of three interviews in his paper, Rapley and Antaki (1996) and Rapley et al. (1998) both conducted analysis on eight interviews, and Antaki et al. (2006) analysed two meetings. Scior (2003) focused on

discourses present in talk rather than analysing interactions, and had five participants, and the work of Davies and Jenkins (1997) included 60 participants with learning disabilities and 57 parents or carers. For the current research, it was decided that the nine appointments recorded would generate sufficient data to address the current research question, and was manageable within the time constraints of the research.

2.6 Procedures

2.6.1 Recruitment of psychologists from the Learning Disability Service

Written information on the research was provided to staff members (see appendix four). If they were interested in taking part, the researcher met with them to discuss the research further, to answer any questions, and to provide them with a consent form (see appendix five).

2.6.2 Identifying and selecting service user participants

It was necessary to work with the Learning Disability Service to identify potential participants who met the inclusion criteria. Some difficulties have been identified by researchers in the past with having to rely on service staff to facilitate access to potential participants (e.g. Tuffrey-Wijne, Bernal & Hollins, 2008). In order to facilitate the process of recruitment for the current research, steps were taken to establish good working relationships and clearly agree early on how the service was able to be involved. Throughout the process of identifying and recruiting participants regular contact was made with the service by telephone and email to discuss recruitment. Meetings were held with the professionals who had consented to take part at regular intervals, and the researcher attended some team meetings to gain feedback on how the process was working, and to discuss any difficulties.

2.6.3 Process of recruitment of service user and carer or family member participants

Professionals from the Learning Disability Service, who are trained to assess capacity to give informed consent, identified people on the waiting list who were likely to be able to give informed consent. This could involve professionals from the service talking to referrers or other team members who have previously been involved with the person if it was not clear from the referral information whether they were likely to be able to give informed consent. The following steps outline the recruitment process:

1. Staff members who had agreed to take part in the research (see above for the process of recruiting staff participants) identified people who they were going to offer an assessment or review appointment to within the research time-scale.
2. When potential participants were going to be offered their appointment; information about the research (see appendix six) was sent to them by the Learning Disability Service, along with the usual appointment letter, asking them if they would like to take part in the research.
3. The Learning Disability Service administrator or the psychologist offering the appointment contacted people at least 24 hours after they had received this letter to ask if they would like to meet with the researcher prior to their appointment to discuss the research further. If they were not interested in taking part, no further contact was be made with them regarding the research.
4. If they chose to discuss taking part further the researcher arranged to meet with them prior to their appointment somewhere convenient for them to outline the research information verbally, discuss the research further and answer any questions. Consent forms (see appendix seven) were then given to them to sign if they chose to take part, along with researcher contact details. This process also involved the researcher checking with participants that they understand: the research information, that participation was optional, that their choice would not affect the service they received, and that they could withdraw their consent at any point.

5. The staff member carrying out the assessment appointment checked with participants at the start of the appointment (prior to starting the recording equipment) that they were still happy for it to be used for the research. This was an opportunity for staff members to check again that participants had given informed consent. Appointments were recorded at the locations in which they would normally take place i.e. at the service base or in the community.
6. The professionals conducting the appointments paid attention during the appointment to any signs that participants may have changed their minds about taking part in the research, and if they observed any such signs, checked with participants if they were still happy to take part. The psychologists also checked with participants again at the end of the appointments if they were still happy for the recording to be given to the researcher. The recording was only included in the research if participants still gave their consent at the end of the appointment.

2.6.4 Data collection

The researcher arranged for the health professional conducting the assessment appointment to audio record the appointment using equipment (i.e. dictaphone) provided and set up by the researcher. The researcher was not present during the session, and recordings were collected from the department following each appointment.

2.6.5 Withdrawal from the study

If a participant had withdrawn their consent for participation at any point during the course of the research, any data involving them would have been removed from the study and the analysis, and destroyed. However, no participants withdrew their consent following the inclusion of their appointment data in the research.

2.7 Participants

As outlined above, there are a number of different types of reason for referring people to the clinical psychology department of the learning disability service where the research took place. Appointments relating to each of the different possible referral categories were acceptable for inclusion in this research. During the planning stages of the research it was, however, reported by the staff team that they might be more likely to see service users directly for issues such as capacity assessments and therapeutic work. In some cases the psychology service might be involved with a particular service user for more than one reason, and the focus of their work might evolve and change over time. Referral reasons were not formally recorded as part of the research data because the research aim was to examine how the process of problem definition was negotiated rather than what the specific problems were.

In this section a list of the appointments included in the research is presented. The duration and the type of appointment are noted, and participants are listed. In total six psychologists from the service, nine people with a LD, two family member carers, and four employed carers participated in the research. Names have been changed to pseudonyms and for clarity the role of each person is indicated in brackets after their name: SU for service user¹ (the person with a LD referred for the appointment), FC for family carer, EC for employed carer, and P for psychologist. Following the details of each appointment, some information about the psychologists who participated is presented.

¹ There has been debate over the terms used to describe people accessing mental health and LD services, and preferences vary. The term 'service user' is used here because it is fairly neutral in describing the people with LD accessing the service, and because this is the term widely used in the Trust where the research took place.

2.7.1 Summary of appointments and participants

Appointment number: 1			
Duration: 45 minutes			
Type of appointment: First assessment			
Participants:		Name	Details
	Service user	Carl	male in his 20s
	Family member carer	Jane	service user's mother
	Staff member	Liz	female psychologist in clinical training (main interviewer)
	Staff member	Ellen	female clinical psychologist
Appointment number: 2			
Duration: 1 hour 6 minutes			
Type of appointment: First assessment			
Participants:		Name	Details
	Service user	Sophie	female in her 20s
	Employed carer	Claire	employed female carer
	Staff member	Anne	female clinical psychologist
Appointment number: 3			
Duration: 1 hour 21 minutes			
Type of appointment: First assessment			
Participants:		Name	Details
	Service user	Mike	male in his 50s
	Family member carer	John	service user's father
	Staff member	Kate	female clinical psychologist
Appointment number: 4			
Duration: 29 minutes			
Type of appointment: First assessment –new episode of care but had previously worked together			
Participants:		Name	Details
	Service user	Simon	male in his 20s
	Staff member	Ellen	female clinical psychologist
Appointment number: 5			
Duration: 1 hour 2 minutes			
Type of appointment: First assessment			
Participants:		Name	Details
	Service user	Lauren	female in her 20s
	Employed carer	Mary	employed female carer

	Employed carer Alan	employed male carer
	Staff member Anita	female clinical psychologist
Appointment number:	6	
Duration:	58 minutes	
Type of appointment:	Review part way through care	
Participants:	Name	Details
	Service user	Henry male in his 40s
	Employed carer	Karen employed female carer
	Staff member	Joanne female clinical psychologist
Appointment number:	7	
Duration:	51 minutes	
Type of appointment:	Review part way through care	
Participants:	Name	Details
	Service user	Sue female in her 50s
	Staff member	Joanne female clinical psychologist
Appointment number:	8	
Duration:	52 minutes	
Type of appointment:	Second assessment	
Participants:	Name	Details
	Service user	David male in his 40s
	Staff member	Joanne female clinical psychologist
Appointment number:	9	
Duration:	32 minutes	
Type of appointment:	First assessment –new episode of care but had previously worked together	
Participants:	Name	Details
	Service user	Craig male in his 30s
	Staff member	Joanne female clinical psychologist

2.7.1 Psychologist participants

The psychologists who participated in the research were between thirty-one and thirty-nine years old. They had been qualified for between four months and twelve years, and worked for the service for four months to nine years, with the exception of the psychologist in clinical training who had been working in the service for a few weeks. Psychologists were asked what therapeutic or psychological models they used to inform their work in general. They were not asked to specify any particular models used during

the assessment appointments recorded. Each of the psychologists described themselves as drawing on a number of different therapeutic frameworks. The most common were systemic, cognitive behavioural therapy, psychodynamic and narrative, but person centred, cognitive analytic therapy and transactional analysis were also used by some people. This background information is included to help readers situate the sample.

2.8 Processing the Data and Practicalities of the Analysis

In order to analyse the data the process originally outlined by Potter and Wetherell (1987) in their text on analysing discourse was followed. As noted by Wetherell, Taylor and Yates (2001a) carrying out DA is seen as an iterative process, which is fairly open ended. In the current research the following steps were taken:

1. Transcription of appointments by the researcher, and listening to the audio recordings several times. During this process attention was paid to the tone and focus of the appointment, and initial impressions were noted.
2. Transcripts were read and re-read, and at this point initial analysis involved categorising sections according to relevance to the research question e.g. (a) talk about what the problem is/is not; (b) setting up what is possible to talk about, descriptions of history related to what led to the problem, (c) Distant history related to the problem, but more about distant past or context.
3. Next the key data relating to the research question was examined in more detail. For example, initial ideas on what people seemed to be doing with the talk in relation to the research question were noted. Impressions of key themes, including some ideas on interpretative repertoires, subject positioning and ideological dilemmas were recorded.
4. A further process of reducing the data and selecting key sections relevant to the research question was then carried out. This included considering what sub-components there were to the research question in order to guide the selection of

data. These included talk relating to the questions: 'What is the problem?', 'How is it decided?', 'Who is it a problem for?', 'How much of a problem is it?', 'When is it not a problem?' and so on.

5. The next stage of the analysis was the process of examining selected transcript for the action orientation of talk in finer detail. Notes were made on what people seemed to be doing with talk, the effect of turns on the next turn, how topics were introduced and subjects changed. Any areas of disagreement on a point, and what people seemed to be arguing for or against were also noted. In addition, at this stage further detail on possible interpretative repertoires, ideological dilemmas, points of consistency and inconsistency, and subject positions in relation to these were also noted. It was also necessary to return to the original transcript at times to note how sections were situated in the context of the whole appointment. Additional transcript was added to some of the selected excerpts when it seemed relevant to the research question.
6. At the end of the process of analysing each transcript, a list of the main features of that appointment was made, i.e. actions in the talk, interpretative repertoires and subject positions.
7. After the process outlined in points 1-6 had been carried out for each appointment, a summary of findings was drawn together. Common and distinct features across the different appointments were noted.
8. The final process of summarising findings involved returning to the transcripts several times to re-evaluate and verify interpretations made. Final selections of the excerpts from the data used to illustrate findings were made during the process of writing up the analysis.

2.9 Quality Assurance

In addition to the NHS ethics panel review and the Trust R&D department approval granted for the current research, regular meetings have taken place with university supervisors to consider and review all aspects of the research. Field supervision was provided by a clinician in the participating department, and regular liaison with the Learning Disability Service staff enabled the practicalities of the protocol to be discussed to identify and solve any problems arising before and during the research.

Throughout the process of analysing the data parts of the analysis were checked and the findings were overseen by the research supervisors. Having a second researcher review qualitative analysis has been recommended to test the credibility of the analysis (e.g. Elliott et al., 1999). The coherence of the findings in terms of answering the research question fully, and their relevance to the research participants were also considered during the process of analysis as recommended by Potter and Wetherell (1987). In addition, Elliott et al. (1999) have highlighted that it is important for researchers to ensure they own their perspectives. Some reflections on this issue are presented in the following section.

2.10 Researcher Reflections

I am aware that as a researcher conducting this type of qualitative research, I have a lot of power to influence what the research shows. I have tried to remain aware that beliefs and assumptions I have (including ones I am unaware of) could affect findings. For this reason, I have considered my own position in relation to the research, including assumptions about what it will show, as recommended by previous researchers (e.g. Goodley, 1996; Parker, 2004). As a psychologist in clinical training, I have a particular interest in how problems are defined in the assessment appointments of a psychology service because of the relevance of this process to my own clinical work. In my clinical experience and training I have seen that professionals can exert

considerable power over decisions made in appointments. I have therefore been mindful that I should avoid letting prior experience such as this lead me to make assumptions about the current data before analysis. However, the fact that I have facilitated and observed many assessment appointments with different client groups, including people with LD, means that my own knowledge of the process is likely to have affected how I approached the current analysis to some extent. For example, recognising similarities and differences between my own work and that of the psychologists could have led me to make assumptions about the effects of what was said. However, I have tried to remain aware of, and to reflect on these issues and other views and prejudices I hold in relation to the research. In order to facilitate this process I have kept a research diary in which I have reflected on the process of carrying out the research. I present some of these reflections, and some thoughts on influencing the findings in chapter four.

2.11 Transcription Conventions

-	Used at the end of one speaker's text and in front of the next to indicate an overlap in conversational turns
=	Used at the end of one speaker's text and in front of the next to indicate no discernible pause between utterances
.	A noticeable pause that is too short to measure
(0.5)	Numbers in brackets indicate the length of the pause in seconds
:	An extension of the preceding vowel sound
_____	Underlining of a word shows added emphasis in the speech
CAPITALS	Words are spoken more loudly than the surrounding text
[laugh]	Information on non-linguistic features
[?]	A brief utterance which was inaudible
[???	A longer segment of text which was inaudible
[?text]	Text which may be inaccurate

For the purpose of reporting findings:

- [...] A section of transcript removed from one speaker's turn to reduce the length of the example used to illustrate findings.
- [.....] One or more speaker's entire turn removed from the transcript to reduce the length of the example used to illustrate findings.

CHAPTER 3: ANALYSIS

In this chapter pen portraits are presented to give an overview of each of the appointments. The findings from the analysis, which have been organised into seven main types of action seen in the talk, are then described. Finally a summary of the findings in relation to the research question is included at the end of the chapter.

3.1 Pen Portraits of Appointments

There are a number of aims of presenting the following pen portraits. One is to give the reader some factual details about the participants in each appointment, although these are kept fairly brief to protect their anonymity. Another aim is to present the impressions formed of the content and focus of the appointments after the early stages of analysis. It is hoped that this will provide a sense of the types of issues covered in these appointments and a picture of the kinds of difficulties people attending the psychology service might have. Some comments are also made in the pen portraits on my impressions of the verbal ability of the participating service users. This was included because the service is for people with learning disabilities, and there is a high degree of variability in the communication abilities of people who access the department. In listening to the recordings it was apparent that some service user participants were much more verbally able than others. Although the analysis does not focus on this issue, the process of problem definition is likely to have been affected by people's verbal abilities.

Appointment 1

Carl (SU) was a man in his twenties who came to the appointment with his mother, who he lived with. The appointment was their first, and was with two members of staff (a trainee clinical psychologist and a clinical psychologist) although for the majority of the time the trainee clinical psychologist led the appointment and the clinical

psychologist was silent. In this appointment both Carl and his mother, Jane, participated actively together in telling their story and giving a history of why Carl had come to the service, and both seemed engaged in the process throughout. However, Carl's contributions tended to be short in length compared with his mother's and the psychologist's, and his speech was somewhat unclear at times. A considerable amount of time was spent discussing an incident where Carl had been assaulted by another man at work, and the perceived effects of this on Carl. Jane and Carl highlighted the impact of the continuing presence of this person in Carl's life and outlined changes in Carl since this experience. Carl and Jane's descriptions of the issues relating to Carl's referral to the service were largely shared and compatible with one another. In this appointment a considerable amount of time was also devoted to talk about Carl's family circumstances, social life and interests not directly related to areas of concern or 'problems'.

Appointment 2

Sophie (SU) was a woman in her twenties who attended the appointment with an employed female carer from her house. This was the first appointment with the clinical psychologist, although Sophie and the psychologist had previously met at Sophie's house a few weeks before in relation to this referral to the service. Sophie spoke a lot more than the employed carer, Claire, in this appointment, although Claire did contribute her views on the issues discussed on a few occasions. Sophie's speech was fairly slow and somewhat unclear, with many pauses between words, but she was articulate, often speaking in long passages. A considerable amount of time was spent with Sophie describing the history of her difficult experiences in the past with her father, her brother and with other men. Sophie was fairly assertive in bringing the conversation to issues she wanted to discuss in this session, and the topics covered were largely raised by her. Current issues relating to Sophie's desire for freedom to do as she chose and the carers concerns about her safety and vulnerability were discussed. Sophie's wishes to be able to protect others and the carers' feelings of responsibility to protect Sophie were relayed by both Sophie and Claire.

Appointment 3

Mike (SU) was a man in his fifties who attended the appointment with his father, who he lived with. It was the first appointment with the clinical psychologist and they had not met before. Both Mike and his father, John, actively participated in the session, but talk was often between the psychologist and one or the other of Mike and John. However, there were also some times when both Mike and John participated in conversations together. Mike tended to talk quite quickly, but in short sentences using few words. It was apparent during the session that John had a hearing problem and did not always follow discussions between Mike and the psychologist easily. The content of the appointment was largely focused on the apparent reason for referral, which was that Mike had been engaging in some sort of behaviour at the day centre he attended, which had been complained about. Talk about exact nature of the concern was not explicit, but it related to Mike's sexual interests and behaviour. The psychologist did not ask directly what Mike's concerns were or what he wanted from coming, but instead approached the session as though it were the start of some necessary work on understanding and helping Mike to change his behaviour. Time was spent discussing Mike's interest in looking at pictures of girls on the computer. A considerable amount of time was also spent with John outlining Mike's early history and some of their wider family were described. In addition, some time was spent discussing Mike's possible future care needs.

Appointment 4

Simon (SU) was a man in his twenties who attended the appointment with the psychologist alone. It was the first appointment after a new referral, but they had previously worked together. Simon was very articulate and spent much of the appointment describing his recent experiences in detail. The session was largely led by Simon. He described a number of recent dramatic events involving violence, and him making threats about using his knives and guns on people who had upset him or his

friends. He often relayed the dialogue between him and others in describing these experiences. For much of the appointment the psychologist just listened, interjecting with single words: “yeah” or “okay”, and asking the occasional question. Some time was also spent on discussing Simon’s difficulties with anger and its effect on his relationships. This was also led by Simon, and he was quite clear in stating what he wanted from sessions with the psychologist.

Appointment 5

Lauren (SU) was a woman in her twenties who attended the appointment along with two carers from her house: a female carer who was also the manager of her house and a male carer. The appointment was a first assessment appointment, but the psychologist had previously met Lauren at her home a few weeks before. This appointment could be described as containing two parts. For the first, on which the majority of time was spent, talk was mostly between Lauren and the psychologist, with the carers saying very little. The psychologist led the session at first, but Lauren actively participated throughout this first section and raised issues as the discussion went on. However, her speech was slow, with many pauses between words and was somewhat unclear at times. Lauren relayed some past incidents when she had become angry or upset at her previous house, talked about how she was getting on in her new house, and discussed her recent experiences of bereavement. A plan was made for Lauren to attend further sessions with the psychologist to discuss her feelings again. The second part of the session was quite different in that the carers led the talk. The topics covered related to a behaviour management plan for Lauren and some queries the carers had about that, and about the future management of Lauren’s behaviour. The carers relayed their views on how Lauren had been getting on since moving into her new house, describing some specific incidents. In this part of the appointment Lauren’s only contributions were to express agreement with the carers, which she often did by saying “yeah”.

Appointment 6

Henry (SU) was a man in his forties who attended the appointment along with a female carer from his house. He had been working with the psychologist for some time and this appointment was a review session. Throughout the appointment Henry spoke extremely slowly, using very few words. There were long pauses between his words, frequently lasting five to ten seconds or longer. Although he occasionally said more, often he just gave one word of agreement e.g. “yeah” in response to what the psychologist or carer said. Henry himself did not come up with any issues for further work with the psychologist, but the carer outlined some possible concerns. A considerable amount of time was spent by the psychologist and the carer trying to ascertain Henry’s views by making suggestions about possible difficulties. Much of the conversation centred on whether Henry wanted to talk in psychology sessions about abuse he had suffered in the past. They discussed the extent to which he could talk to staff members from his house about his difficult past experiences, and whether the level of support they offered met his needs. The carer also raised the possibility of a future problem arising if Henry was unhappy about a new plan to help him manage his finances, and this was briefly discussed.

Appointment 7

Sue (SU) was a woman in her fifties who attended the appointment with the psychologist alone. The appointment was a review session and Sue had worked with the psychologist for some time. Sue was articulate and spoke a lot, telling the psychologist about recent events in her life. Much of her talk was centred around describing complaints she had about her carers and her son’s carers, and on describing how she was easily provoked to behave violently in response to things her friends or acquaintances said. The psychologist spent time asking what Sue wanted from coming to psychology sessions, and trying to ascertain Sue’s goals for work together. At times Sue described recent events in quite vague terms and the psychologist tried to direct her to

consider the significance of her experience in relation to difficulties with her mood. Sue's and the psychologist's talk often overlapped and Sue answered questions sometimes before the psychologist had finished asking them.

Appointment 8

David (SU) was a man in his forties who attended his appointment with the clinical psychologist alone. It was the second assessment appointment, and the previous meeting had been with David and a carer from his house. This appointment was unique in that it was carried out in the community at a day centre David attended. All the other appointments included in this research took place at the psychology service base. The topics covered were almost exclusively led by the psychologist, and David's contributions were generally in the form of short answers to questions posed. Discussions centred on issues raised by the psychologist, which had apparently been reported as difficulties by the carer in the first appointment. David gave the impression that he was uncertain about the purpose of seeing the psychologist and that he did not share the concerns raised that he was struggling with anxiety. He generally responded with acquiescence, and towards the end of the appointment the psychologist concluded that it seemed that the carers were concerned about David, but that David did not seem to want her help with anything in particular, which David agreed with.

Appointment 9

Craig (SU) was a man in his thirties who attended the appointment alone. He had previously worked with the psychologist, but this was the first assessment appointment after a new referral. Early in the appointment the psychologist asked Craig how he was feeling about a number of different issues, which seemed to come from her knowledge of their past work together. It was apparent that Craig had been living alone in a flat, supported by carers, but that he had recently had to move back in with his father due to a problem with the flat. Much of the appointment was spent with Craig leading the talk about things that annoyed him about staying with his father and about different aspects

of life in general. He was articulate in describing his concerns, but his speech was often quite fast with unusual intonation, and was difficult to understand at times. The psychologist asked Craig questions about the impact of the issues he described, and he answered these questions in short phrases but repeatedly went back to listing the things that annoyed him, describing the reasons for his frustrations and worries in detail. In this appointment the psychologist moved quickly into reframing some of Craig's concerns positively.

3.2 Findings

Over the nine appointments recorded there were similarities and differences between the ways in which the people present negotiated problem definition. There were a complex array of interactions within the discourses, and the analysis revealed a range of ways in which talk was used to perform different actions. In order to structure how these findings are reported, they were subdivided into seven main categories representing the components of problem definition identified in the analysis:

- **Influencing and shaping the issues for discussion**
- **Evidencing problems: doubting and testing**
- **Locating Problems: from individual to environmental factors**
- **Using constructions of knowledge and competence**
- **Aligning self with a particular position or another person and recruiting support**
- **Recruitment of outsider views**
- **Closing subjects or concluding talk on a particular issue**

The categories are presented in this order, with the process of introducing a topic taking place first, followed by some negotiation of the details of the problem and the actions involved in that, and finally closing of subjects and drawing conclusions. However, the sequence was not straightforward across the course of each appointment. For example, often topics were opened and closed quickly and issues about the

dimensions and detail of problems might be raised again after they had been closed by one party or another.

For many of the actions described, there were a large number of possible examples that could have been chosen to illustrate the findings. For each point made, common or representative examples of a particular phenomenon in the talk were chosen. However, examples of exceptional or unusual cases were also included when they arose. In doing this it is hoped that the reader will gain a good sense of each of the nine appointments amongst the overall findings. In addition, it is important to note that the categories of action presented are interrelated, and there is some overlap across the examples used to illustrate them.

The presentation of findings is structured around the main actions. However, particular interpretative repertoires (IRs) were drawn upon in relation to some of these actions. IRs which were significant in terms of being particularly common or important in the talk are also discussed where relevant.

3.2.1 Influencing and shaping the issues for discussion

In this section I will argue that psychologists exerted considerable influence over topics covered in sessions, and over decisions made about the nature of problems through the ways in which they offered choice and referred to the process of sessions. Through the examples described below, I will illustrate how talk was focused in particular ways, influencing how problems were defined. Service users also sometimes took control of the content of sessions, although they generally did so in different ways from the psychologists or carers.

Asking open questions and presenting choices

In some sessions, opening questions were asked by psychologists on what service users or carers wanted from coming to sessions. This sometimes led to a new issue being raised, i.e. gave the opportunity for service users to say what they wanted or what had been concerning them. In others, when no clear response was given, this led to further

prompting and offering of choices by psychologists or carers. Psychologists exerted some control over what was discussed and the decisions made by presenting particular choices.

In appointment eight, early in the session the psychologist asked David (SU) what he wanted from coming.

Joanne (P) I suppose what I was sort of thinking about today was u:m (0.5) you know I suppose just sort of thinking what you were wanting out of the: (0.5) sort of psychology sessions . and I just wondered if you'd had the chance to think about that?

David (SU) yeah

Joanne (P) yeah . what sort of things would you sort of say you were hoping for?

David (SU) I like I like doing anything [...] I don't mind

Joanne (P) so have you got ideas about how . you know how if we meet up what things you'd like some help with?

David (SU) learning stuff

Joanne (P) mhm (1) 'cause um . when I spoke to you before you were sort of talking about sort of learning things about (0.5) managing your anxiety

David (SU) yeah

(Appt 8, 14-29²)

After his initial response she repeated the question, implying that his response 'I like doing anything' was inadequate. He then suggested 'learning stuff', prompting the psychologist to make a suggestion from their previous meeting. In doing so she shaped the topics for discussion, and conveyed her expectations for the session. David gave an acquiescent response to this, and the issue of managing David's anxiety was revisited by the psychologist many times throughout this session.

Similarly in appointment six the psychologist spent time early in the session asking quite open questions about what Henry (SU) wanted from coming.

Joanne (P) so . so what . was there something that you sort of particularly wanted to talk about today?

Henry (SU) no

(Appt 6, 71-72)

Given his negative response, she asked him again, this time referring to the idea of using the session as a review of what further work in psychology he might need. In doing so

² Excerpts or quotes from transcripts are identified in this way throughout the chapter: Appointment is abbreviated to Appt, followed by the appointment number and the line numbers of the extract.

she guided him towards thinking more generally about what he wanted from sessions. She deferred the closure of the topic, and her continued questions constructed work together as potentially useful should he identify an issue he would like to work on.

Joanne (P) I mean [...] I suppose I was just think you know when we've talked about reviewing the session today . u:m kind of I suppose . what your thoughts are about sort of you know (1) further work in . you know psychology . you know what might be most helpful for you no:w or . um (4)

Henry (SU) e:r (13) I haven't got a clue

Joanne (P) [laugh] (3) so if if say for example we were to say . oh I don't know . we have one more session

Henry (SU) yeah

Joanne (P) would that be okay or would there be things where you feel like oh I haven't had the chance to sort of talk about that or sort that out yet?

Henry (SU) E:r (16) shall we say . I need a couple more session

Joanne (P) couple more (2) and have you got an idea what those sessions might be abo:ut . or what you might like to talk about in them

Henry (SU) E:r (4) er [sounds of something moving on table] (23) dear (2) e:r (2) anything
(Appt 6, 73-86)

Given Henry's response 'I haven't got a clue' the psychologist took control by making a suggestion of having one more session together. In doing this she conveyed her opinion that there may not be much more work to do without directly telling Henry this. Henry seemed to disagree, suggesting a couple more instead, but failed to come up with any reasons for continuing to work together when asked. In both these cases, by using these general, open questions the psychologist was giving service users the opportunity to state what they wanted from the service. However, giving choice in this way may have been ineffective because of its format. Although the service users potentially had control of the situation, either it was difficult for them to articulate what they wanted in response to these questions, or the responses they did give reflected that they did not particularly want anything from sessions. However, when service users did not give positive responses on what they wanted from sessions, this led the psychologist to take more control. In the following example from appointment nine, again no clear positive response was given by the service user to open questions about what he wanted from sessions. However, in this case he did take control of the focus of the session in a different way. Here the psychologist asked Craig (SU) questions about what he wanted to use sessions for fairly late in the appointment.

Joanne (P) so . so from your point of view if you know . I suppose I'm not you know . I suppose it's been a bit of time since [carer's name] got in contact with us . I suppose I'm thinking are there things that you would want to use the sessions for . if we were. you know whether you feel like you still . you need to come and see me again o:r . u:m or you don't . I'm not sure

Craig (SU) mm . I don't know

Joanne (P) I mean how did you feel about coming to the session today? (0.5) were there things that you thought . I'd like to talk to Joanne about that?

Craig (SU) well . a bi . mm . a lot of things I get worried about . you know . [.....] mm . so things that annoy me like . I get sick of being told what I should and shouldn't e:at . you know when food's nice you shouldn't have lot of it

(Appt 9, 320-332)

In this case, Craig (SU) had already spent quite a lot of time discussing his worries and concerns. By raising the question of what Craig was hoping for at this point, the psychologist conveyed doubt about whether these were appropriate issues for them to work on. Here the psychologist's action failed to directly influence the topic of conversation. Craig quickly went back into describing his worries as he had previously done. In doing so he indicated what he wanted from sessions by detailing his concerns directly. He continued in this way, and his worries remained the focus of the rest of the session, although the psychologist did revisit the issue of whether he wanted more sessions again later in the appointment.

Service users conveying their concerns by direct problem talk

In some appointments service users took control of sessions by starting to talk about an issue or problem directly at the first opportunity. The psychologists' talk outlining the purpose of sessions in general terms, and explaining contextual issues such as confidentiality was cut short by service users in these cases. In appointment one the psychologist started to talk about the context of the session, asking:

Liz (P) do you know what psychologists do?

(Appt 1, 8)

In response to this Carl (SU) quickly named the problem. In doing so he directed the conversation to the issue he wanted to discuss and away from the more general preamble. In appointment two, after the psychologist has been setting up the context of

the sessions, confidentiality and so on, at the first opportunity Sophie (SU) went directly into describing her concern.

Anne (P) have you got any questions that you want to ask me?
 Sophie (SU) yeah . e:r my brother was er ringing me . keeping ringing me . he were when I were asleep . and he was talking to my sister and telling (1) that um Sophie is talking silly and er there's something er wrong with her

(Appt 2, 56-59)

By pronouncing her concerns Sophie effectively dismissed Anne's talk about confidentiality as relatively unimportant, and diverted the conversation to her concerns. Similarly in appointment three, Mike (SU) brought up the issue of concern at the first opportunity. In this case it became apparent in the appointment that this related to the issue he had been referred to talk about (pictures and shutting the curtains).

By directly describing issues of concern, people with LD conveyed what they wanted from coming, or their expectations of the appointment, and took control of the conversation. In doing so they avoided engaging in conversation about what they wanted on a more abstract and indirect level, i.e. they simply described problems rather than talking about what problems they would like to talk about. However, further examples are provided below of how psychologists often drew talk back to the more indirect conversations about the content and focus of the appointment and future work together.

Appointment four was exceptional in that the psychologist did not shape and control the content and decisions made by talking about process. At one point she asked an open question about what Simon (SU) wanted to work on, and he gave a firm response straight away, expressing his choice.

Ellen (P) mhm (0.5) so what . what kind of things would you like to work on . this time?
 Simon (SU) I wanna get everything out in the open and just get it all . get it all (0.5) and move on with my life now

(Appt 4, 222-224)

After some discussion of the details of this, the psychologist presented a choice about exactly what he wanted to work on based on the issues raised by Simon. Again Simon stated what he wanted clearly, giving a reason for his choice.

Ellen (P) so: when you said that you want to look at what happened with [person's

name] (0.5) is it more: (1) around your anger (0.5) or is it more about what
 Simon (SU) no it's more about what happened . and it's more just . I want (0.5) everything
 out . I want these barriers that I've got protecting me down

(Appt 4, 276-279)

This case may be different from the other appointments recorded because this service user was very articulate, and therefore able to express himself and make arguments for what he wanted clearly. In addition, he had worked with the psychologist in the past, so is likely to have had a good idea of what he could expect from sessions.

Using choice to direct the conversation

There were a number of occasions on which psychologists asked service users whether they wanted to talk about a particular issue. In doing so they conveyed a sense of providing choice whilst also shaping and focusing the session. For example, in appointment seven the psychologist asked questions about what sessions should be used for on a number of occasions. Referring to what they had covered in their previous work together, she asked Sue (SU) a question (indicated by the arrow).

Joanne (P) well one of the things I wanted to check with you today is that . I mean I suppose if we think back to the sort of original . reason that you came to see me which was around sort of . I suppose the bereavement you know loss of [?]-

Sue (SU) -he's still some . he's still . still bringing it up . and I've just lost me . lost me head with them

Joanne (P) well I suppose I've just sort of noticed that . you know we haven't tended to talk about that . we've tended to talk about mo:re . u:m things that are going on at .

→ at the moment (1) and does that feel like that's the right thing . to use the sessions for o:r are we missing something do you think or?

[...]

Sue (SU) somebody brought it up on . Sunday afternoon and I could have beat 'em up for it
 (Appt 7, 175-185)

In asking this, the psychologist raised doubt about whether their work had focused on the right problems. Sue did not directly answer this question, but instead gave examples of her recent difficulties. By giving examples she argued for the seriousness of her concerns, perhaps emphasising that the issues they had previously discussed were 'the right thing to use the sessions for'.

In another example, in this case from appointment two, after Sophie (SU) had been giving the history of difficulties with her brother and her father, the psychologist asked a question about the process of the session:

Anne (P) do you want to spend today talking about your brother and your dad?

(Appt 2, 120)

In asking this rather than continuing the direct conversation about the issues raised by Sophie (SU), the psychologist seemed to be trying to get a clearer named focus for the session. Like the example given earlier from appointment nine, it also gave the impression that she was questioning whether the issues Sophie had been talking about were an appropriate focus for the session. Sophie moved quickly back to talking directly about the issues, conveying a lack of interest in talking on this level.

In appointment six, after the carer had brought up a possible issue for discussion, the psychologist asked Henry (SU) on a number of occasions whether this was something he wanted to discuss, e.g.:

Joanne (P) is that something you feel like it would be useful to talk about . o:r?

(Appt 6, 175)

In asking such questions, the psychologist conveyed her willingness to offer help on the issue. However the fact that she revisited this on a number of occasions indicated that she has doubts about whether this was a problem to be addressed in these sessions. In this appointment the psychologist and the carer also gave detailed formulations of possible issues of concern.

Joanne (P) but I suppose (1) I suppose it . sometimes it's felt like you feel like we've done enough of that for . and it's kind of wanting to focus on what's going on now that's going well (0.5) u:m (0.5) but I suppose I'm not sure because it sounds like you've maybe talked to the staff . from time to time about . things that have happened (2)

Karen (EC) but I'm not sure whether it's the real you know like intention that Henry would like to discuss these things . or whether it's just as I said . trying to find an excuse for [...] his behaviour . if he knew that it wasn't something . good you know

(Appt 6, 137-144)

By formulating in this way the psychologist and the carer managed to raise their concerns and convey their perspectives on what the sessions could be used for whilst

also presenting their ideas tentatively for Henry (SU) to comment on, thereby constructing the situation as one over which he has control. However, Karen (EC)'s suggestion that Henry might make excuses for his behaviour and her reference to his behaviour not being good are indications that she had power to judge him. This appointment is perhaps unusual in that Henry gave very little in the way of verbal responses. This may have led Joanne and Karen to give these detailed formulations, and to spend a considerable amount of time making their suggestions.

Talk about process to exert control

In some cases, psychologist's talk about the process of sessions exerted control over the conversations more indirectly. In appointment three, the psychologist referred to the subject not being an easy one:

Kate (P) are you okay about dad talking about this in front of you?
Mike (SU) yes . yeah-

(Appt 3, 362-363)

This conveyed empathy and gave Mike (SU) tokenistic control over what was being talked about. However, it would be difficult for Mike to have given a negative response, and following his acquiescence the psychologist resumed the conversation in the same vein, checking her understanding of what John (FC) had been saying and then asking for further details on the topic. The question also indicated that the psychologist saw herself as having responsibility for managing how the carer contributed to some extent. In appointment two the psychologist asked Sophie (SU)'s opinion on what the carer should contribute to the session. In doing this the psychologist again seemed to be 'giving' power to Sophie to decide and emphasising that Sophie could have control over what happened in the appointment. In both cases the fact that the psychologists explicitly 'gave' this control supported their position of having greater power overall.

In appointment three, the psychologist also used statements such as:

Kate (P) you know that you don't have to say things right now
and

Kate (P) you don't have to tell me everything now
(Appt 3, 397 & 404)

In doing so she implied that he may have to tell her everything at some point, and again demonstrated her power over the appointments in that it had been necessary to give him permission not to say everything if he did not want to. Kate (P) thus constructed her permission as of some importance.

In appointment one the psychologist drew the topic of conversation back from Carl (SU)'s social life and interests to problems. In this case, she did so by referring to the process of talking about difficulties Carl was experiencing:

- Liz (P) so I need you to tell me if it's too upsetting to talk about . [...] it's important to think that if it is getting upsetting that you say to me . "Liz stop. I can't talk about it at the moment"
- Carl (SU) I know
- Liz (P) and you won't be in trouble for that . and we can take a break . and see how it goes . and then may be come back to it . yeah

(Appt 1, 653-660)

In saying this, the psychologist communicated her expectation that Carl should be talking about difficult issues, whilst also presenting herself as empathic towards him. Saying 'you won't be in trouble for that' implied that she has power to decide whether he is in trouble. She constructed herself as in ultimate control of the session, and in the privileged position of being able to 'give' him some control. Following this build up she took control of information gathered on the problem by asking further questions. These breaks from discussing problems directly allowed psychologists to lead gently into asking further details about issues, whilst constructing themselves as sensitive and empathic.

In appointment three, the psychologist drew the focus of conversation back to the process of the session after Mike (SU) had been giving some details of his interests.

- Kate (P) mm okay . now . one of the things it's probably a very good idea for me to do (1) is . you've told me that . and I know you were bursting to tell me a little bit about that weren't you . 'cause you started to mention about the things on the computer. It's important for me to explain to you Mike about what my role is what my job is
- Mike (SU) right
- Kate (P)→ okay (0.5) so . a psychologist . which is what I am . um . what I do is I spend time talking to people (0.5) about the feelings that they have
- Mike (SU) yes
- Kate (P) and about thoughts that they have
- Mike (SU) yes

- Kate (P) because sometimes people have a problem (0.5) with trying to u:m understand . that (0.5) some things aren't maybe . done in a certain way . or sometimes people with how they feel . with difficult feelings that they want to deal with
- John (FC) yeah
- Kate (P)→ and sometimes it's necessary for people who are psychologists . to try to find out a bit about why you think certain things

(Appt 3, 141-159)

By outlining her role and talking in general terms about her work, the psychologist conveyed her expectations for their work together, exerting control over what sessions should cover. In the lines indicated with arrows, she constructed finding out about Mike's feelings and thoughts as 'what she does', and as a necessity, and managed the process of telling him that she would not accept a simple description of what was going on from his point of view. She used this talk to build up to going back to the issues he had brought up, having set out her agenda.

Summary

In this section I have outlined how the psychologists' talk about the process of sessions sometimes served to influence, manage and educate others on what issues could be discussed in the appointments, and therefore on problem definition. In asking questions about what service users would like from sessions, the psychologists constructed the content of sessions as the responsibility of service users, demonstrably 'giving' them choice and control. However, in doing so, psychologists showed that they had ultimate power to 'give' that control to others. In addition, through the ways in which they posed some questions, or followed questions with suggestions, the psychologists exerted influence over the responses given. However, in some cases service users also exerted control by going back to directly describe their concerns in response to questions about the process of the session.

In some cases, when service users gave very little indication of what they might want from sessions, it was perhaps difficult for psychologists not to make suggestions of what might be appropriate issues to work on. However, in these cases the service users' lack of response might simply have indicated that they had no issues to discuss, or that

they did not understand the questions posed and the expectations of them. Psychologists generally seemed more likely to treat a lack of response as an indication that service users needed guidance on what to talk about. Although they tended not to talk about subjects in the general terms used by psychologists, service users often gave specific examples and details relating to their concerns.

3.2.2 Evidencing problems: doubting and testing

In this section I will argue that there were instances when the psychologists' talk served to seek evidence for and test service users' claims. Sometimes the psychologists also cast doubt on the things people said. This was achieved in various ways across the different appointments. IRs relating to the timescale, severity and impact of issues raised were used in different ways to construct problems as significant or less important. In some cases service users gave the same response again to doubting or testing questions, in others they took steps to defend their claims.

Testing severity

Across the different appointments there were various ways in which psychologists tested the severity of the problems described. Examples are presented here to illustrate the action of testing severity and its effects on the process of problem definition.

In appointment eight there were examples of the psychologist testing the severity of difficulties by asking David (SU) to rate problems on a scale. In this case the problem had been raised by the psychologist. Her questions produced inconsistent responses from David.

Joanne (P)	no . I mean how big a problem do you think it is at the moment?
David (SU)	all right
Joanne (P)	yeah . so if you had to sa:y u:m (1) you know u:m zero-
David (SU)	-yeah zero-
Joanne (P)	-it never happens
David (SU)	-no:-
Joanne (P)	and ten it happens-
David (SU)	-yeah ten-

Joanne (P) all the time
 David (SU) yeah
 [...]
 Joanne (P) where where do you think it is at the moment? (1) you think it's quite big
 David (SU)→ er . big
 Joanne (P) right okay (0.5) and (1) what are the situations that are sort of most difficult .
 that the anxiety's mostly a problem?
 David (SU)→ i it's not [right ticket] . it's not right ha:rd

(Appt 8, 30-48)

Having indicated that the problem was big (at the first arrow), David then said that it was not very hard (second arrow). The psychologist continued:

Joanne (P)→ no? (0.5) so . so it's not around all the time
 David (SU) no
 Joanne (P)→ so . so sometimes it feels pretty bad
 David (SU) yeah pretty bad . and pretty good as well
 Joanne (P) okay . so how much of the time do you think's pretty good
 David (SU) er every time

(Appt 8, 49-54)

By formulating her understanding at the points indicated by arrows, the psychologist made suggestions about the extent of the problem. However David adjusted this, agreeing with the psychologist but also claiming that it was 'pretty good as well', seemingly denying that this issue was much of a concern. The psychologist asked for evidence for this with a further scaling question, testing David's claim. Her questions asking him to rate the problem on a scale suggest she had criteria in mind for levels of inner experience that constitute a problem. However, focusing on this agenda (scaling the problem) seemed to cause confusion for David, perhaps because the construction of the problem in this way did not fit with David's perception of what was going on.

In appointment five the psychologist again seemed to question the service user's assertion about the extent of her difficulties in the following example.

Lauren (SU) I know . I . I miss my mum [...]an and and . also my grandma
 Anita (P) yeah
 Lauren (SU) but it (0.5) and it's really hard for me
 Anita (P) mm (2) how often do you think about them?

(Appt 5, 596-603)

The psychologist's question could be seen as simply trying to ascertain more details, but in posing it immediately after Lauren had claimed that 'it's really hard', Anita (P) was requiring evidence for this claim rather than accepting it.

In some cases service users defended the severity of their problems in response to psychologists' testing questions. In the following example from appointment seven there was a sense that Sue (SU) was trying to defend her need to continue working with the psychologist in response to the psychologist's questioning:

Joanne (P) m . so i if you think back right to when we first were meeting (1) how . you know do you think your depression's sort of the same: . better worse . how does it . rate in comparison?

Sue (SU) at the moment it's getting worser .

Joanne (P) right

Sue (SU) by. the second

(Appt 7, 45-49)

She used the phrase 'getting worser by the second' to insist on the severity of her difficulties. In the same appointment, Sue later emphasised the severity of the problem by repetition (they were still discussing her mood).

Joanne (P) m (1) so how how long is it . sort of that this has happened . you know (0.5) how long has it been dropping-

Sue (SU) -we:ll (0.5) i:t's been going on for months

Joanne (P) right

Sue (SU) seriously . it's gone on for months

(Appt 7, 137-141)

Her insistence, in particular through the use of the word 'seriously', indicated that she was defending the severity of her difficulties in the face of testing questions from the psychologist.

In some cases psychologists tested the severity of problems by asking about their impact on various aspects of service users' lives, e.g.:

Liz (P) does it put you off when you're trying to do things?

(Appt 1, 205)

This question indicated that the psychologist was searching for a particular construction of the problem in terms of its wider impact on Carl (SU).

Doubting severity

In some cases, rather than testing severity, psychologists' questions served to cast doubt on the severity of problems or construct them as not significant. For example, in appointment nine the psychologist questioned Craig (SU)'s feelings about an issue by suggesting a construction of the situation as fairly normal:

Joanne (P) I mean how much do you think . 'cause I suppose I was just thinking about u:m (0.5) you know for a lot of people they have . you know as they're growing up they have different ideas from their parents and brothers and sisters . u:m (0.5) and I suppose I was just wondering how much you think it's sort of just like a sort of perhaps a normal part of growing up . or is there . o:r whether you think it's a bit more of a problem?

(Appt 9, 154-158)

In doing this she reduced the severity of the issue for Craig (SU). A similar example occurred in appointment five.

Anita (P) mm (2) I think that . that happens to some women doesn't it
 Lauren (SU) yeah
 Anita (P) sometimes feel worse on their periods

(Appt 5, 523-525)

The psychologist constructed Lauren's menstrual pain as an expected part of life, and in doing so she reduced the severity of this problem.

There were also appointments in which carers conveyed doubt about the severity of problems. In the following example from appointment six, the carer had raised the issue that Henry (SU) had been mentioning abuse he had suffered in the past.

Karen (EC) [...] Is that something which is bothering you and you would like to discuss it further? O:r do you just say it and then . that's it?
 Henry (SU) E:r (0.5) I would like to discuss it further

(Appt 6, 405-407)

Karen questioned Henry's response by raising it again, asking:

Karen (EC) so that that's the question . whether it is really something really bothering you . or do you just say it and then you forget and then maybe you will mention again . but you're not that . interested?

(Appt 6, 417-419)

These questions served to ascertain further details of Henry's motivations and experiences, but were posed in such a way as to convey that Karen doubted whether these issues significantly affect Henry. In the following section the psychologist also

questioned Henry on what he had said he wanted, citing previous experience that he had not tended to want to talk about it.

Joanne (P) mm (3) I I was just sort of wond . 'cause when we met before you know . [...] and we did talk through some things sort of around the abuse . and u:m . and I think you felt that actually . maybe you'd said enou. at that point in time you'd said enough about it [...] . u:m . and I suppose I was just wondering Henry if there's something important to you about . for the sta:ff . or whoever's with you . you know at that point it time knowing or does it . by saying that does it help them to understand (0.5) why you might think o:r . act in a particular way (1) not necessarily as as an excuse . but (0.5) that they understand maybe why something has upset you more that it might somebody else . u:m

(Appt 6, 424-433)

By saying that Henry did not seem to have wanted to talk about those issues in previous sessions, the psychologist disputed Karen (EC)'s assertion that this was a potential problem, and took subtle control over the content of the session. In addition, in this example the psychologist seemed to be doubting a formulation suggested by the carer, that Henry might mention past abuse as an 'excuse' for his behaviour, suggesting instead that the problem could be that Henry would like staff at home to be willing to listen to him.

Questioning and testing the accuracy of claims

In some appointments the psychologists' talk also served to question or test specific claims made by service users. For example, in appointment three the psychologist referred to the carer to check Mike (SU)'s account:

Kate (P) have I understood right? Is it correct what Mike is saying?

(Appt 3, 215)

This indicated that she saw John (FC) as having a role in verifying what Mike (SU) said. However, she also referred to Mike after John had been talking, conveying that she also valued his account:

Kate (P) I'm interested to kno:w . if you think anything he's said isn't true: . or that you . didn't know about:t . or that you have a different (1) opinion about

(Appt 3, 499-500)

In this case the tone was more tentative, but in both examples the psychologist took control over who contributed to constructing the problem, 'giving' them the opportunity to comment. Doing so conveyed a sense of her power over the session.

In the following example from appointment two, the psychologist started her question by formulating what Sophie (SU) had been describing in relation to her experiences with her father.

Anne (P) okay so things have changed now . changed with you and your dad since when you were younger (2) so in the past when you were younger he used to hit you . and you didn't like it (0.5) and you ran away (1) but now you feel like things are better (2) what's made it better? [...]

Sophie (SU) u:m (0.5) that my dad's u:m (1) my dad . he rang us in . er (2) [name of town] . and he say he's going to stop um hitting us (1) and then er (1) me and [sister's name] went home . and he said um . you're going to [place name] morrisons . and he said um . pick everything up and put it in the trolley . so I just . me and [sister's name] um picked the stuff up and put it in the trolley . and um he's a good father now (1) I could um trust him (1) um (2) and er we've got a little nephew called [name] as well (2) and um I could um trust my dad

Anne (P) you can trust your dad now (3) when's the last time he hit you?

(Appt 2, 446-457)

By formulating in this way, highlighting Sophie's earlier descriptions of difficult experiences with her father, the psychologist was supporting her doubt in Sophie's claim. Sophie responded by giving specific examples and details. In doing so she made arguments in support of her perception. However, the psychologist followed this with a further doubting question in the last line of this example.

In appointment eight the psychologist asked the same question in different ways, again indicating doubt in the service user's ability to give accurate responses. She then asked for evidence for David (SU)'s perspective even after he has given the same response clearly twice:

Joanne (P) no (1) m (2) and so is it . you . and when we were talking about that you sort of described this feeling of it . being . feeling awful are there . are there any other times when you have that feeling?

David (SU) no

Joanne (P) no . okay (1) okay (7) wha what . how about when you're . it sounds like you spend five days here at the centre

David (SU) yeah

Joanne (P) are there any times that you feel awful when you're here?

David (SU) no

Joanne (P) m . wha what do you like about here?
 David (SU) I think it's a nice place

(Appt 8, 532-542)

There was a further example in this appointment where the same question was asked repeatedly by the psychologist about how David behaves when waiting for his bus. Each time he answered in the same way, but she persisted, conveying doubt in his responses. The level of questioning and doubting in this appointment suggests a construction of David as unable to report his own experience and wants.

Another example, this time from appointment three, was exceptional in that the carer disputed something Mike (SU) has said with considerable certainty.

Mike (SU) e:r age . I think (0.5) round about twenty-one age
 Kate (P) about twenty-one
 John (FC) no: I think you're a bit high there . there's a tendency to be. his mind works on the very young

(Appt 3, 94-96)

John said this with authority and Mike did not argue with him. Other examples where the psychologist or carers disputed something another person has said tended to be more tentative and subtle. In this case it was clear that John had the power to have the final word in the disagreement between them. This example is unusual in the level of certainty with which the challenge is made. The reason for the difference here may be the relationship between the Mike and his father was different from the relationship between service users and employed carers or psychologists who might be more cautious or subtle in challenging service users.

Summary

In many cases it could be seen that the actions in psychologists' talk that doubted and tested what service users said arose in response to what had gone before. In some cases service users had given very little in they way of responses to initial questions, and in others the process named here as 'testing' seemed a useful way of gaining a better understanding and further detail about problems. However, through these actions psychologists exerted considerable power over how problems were described. Some of the ways in which they evidenced problems suggests that psychologists had pre-

conceived criteria in mind against which to measure issues raised. Problems therefore needed to be constructed within these parameters. These criteria may have been influenced by psychological models of problems and definitions of problems that could fit therapeutic criteria, or service criteria. Evidencing problems to fit with these criteria may have served the purpose of making problems quantifiable, measurable and therefore amenable to evaluation of treatment success. Although carers took some role in questioning the claims of service users, in the majority of cases psychologists had ultimate control over how the parameters of problems were evidenced.

3.2.3 Locating problems: from individual to environmental factors

Across the appointments problems were constructed by the people present to locate problems in different ways. This included three IRs: one in which problems were constructed as the internal, dispositional characteristics of service users, one in which problems were constructed as changeable internal responses (such as feelings) that are caused by external triggers, and one in which problems were constructed as environmental factors. These were not distinct, separate IRs, and it will become clear from the examples presented that there was sometimes overlap between the different IRs in the construction of problems. The people present sometimes positioned themselves in different ways in relation to these IRs, but the analysis revealed that each group (psychologists, carers and service users) tended to favour constrictions that fitted with a particular IR.

Using the IR of changeable internal responses as problems

In most appointments there were examples of the psychologists focusing on the construction of problems using the IR about internal responses such as thoughts and feelings. Service users often talked a lot more in terms of the IR of difficult external experiences or events. Psychologists did not directly dispute the significance of these events, but they did repeatedly draw the focus to internal responses instead. For example, in appointment five Lauren (SU) spent a considerable amount of time

describing her experiences in terms of external events, and her actions in response to these. However, the psychologist frequently focused the talk to Lauren's feelings, e.g.:

Anita (P) so did that make you feel (0.5) mo:re tense and things?

Anita (P) mm (1) yeah (2) it sounds sometimes it still makes you feel upset

(Appt 5, 240&749)

The focus was taken away from the problem being external triggers, and on to the problem being Lauren's responses, locating the problem with Lauren:

Anita (P) is there anything that you . feel like you'd like to change at the moment [.....]
anything maybe about how you're feeling that you'd like to change?

(Appt 5, 591-593)

As these internal feelings could be amenable to change through therapeutic work with the psychologist, this construction provided the psychologist with a problem she could work on.

In appointment nine Craig (SU) talked a lot about things that annoy him, naming many specific examples. In doing so he presented external issues as problems for him. At some points the psychologist focused instead on Craig's feelings and responses, for example asking questions such as:

Joanne (P) when [person's name] said that to yo:u . how did you feel?

(Appt 9, 150)

In appointment two Sophie (SU) had described her experiences of being treated abusively by her father, her brother and by other men. The psychologist reflected:

Anne (P) it sounds like you've had a lot of . you had a lot of men in your life who haven't
been very nice to you (2) how have you coped with that?

(Appt 2, 423-424)

However she went on to ask about how Sophie (SU) had coped, and later constructed the problem as Sophie's "confusion", and needing to try and make sense of her experiences. Here the psychologist again took the focus away from the ways in which men had behaved towards Sophie, and formulated the problem as being how Sophie was dealing with her experiences. This could be because Sophie's thought processes or inner experiences were more accessible and changeable than the behaviour of 'men' in the community. However this formulation subscribed to an acceptance that these

systemic issues are part of life and that a change in Sophie's feelings about and understanding of her experiences is what would help her.

Similarly in appointment six, the psychologist attempted to draw the focus towards Henry (SU)'s internal feelings:

Joanne (P) I suppose I was thinking what . what kind of u:m (1) problems now . does the sort of . you know the the fact that you were abused before . what . what problems has that left you with now? (4) or worries . or um?

Henry (SU) E:r (4) like (3) usually every Christmas (3) when people are going home for Christmas (4) I: don't see my parents

(Appt 6, 185-189)

In doing this Joanne constructed the problem as an internal to Henry. Henry on the other hand described a practical issue as the concern for him, moving the focus to the problem being external to him. Following this there was a brief discussion between them about the practicalities of Henry's experiences at Christmas, but the psychologist quickly drew the focus back to Henry's internal feelings and his ability to 'cope'.

In appointment eight the psychologist asked questions about when David (SU) most noticed anxiety, in what situations, but then focused quickly on details of the feelings, constructing the problem as his feelings. David on the other hand tended to talk much more about what was said or what happened.

Joanne (P) so what is it that makes you . I mean how would you sort of describe the feeling you get the:n when you're rushing?

David (SU) sorting me clothes out

Joanne (P) m . so are you feeling calm or-

David (SU) -I say- I I don't know which to pick on all time . which pick to we:ar

(Appt 8, 332-336)

Later, towards the end of this session David had constructed the problem as an external factor, the fact that his transport is unreliable. The psychologist summarised this, but still maintained some focus on internal factors, i.e. David feeling happy:

Joanne (P) I suppose just sort of you know when we were talking . it feels like I'm sort of digging around for problems really . and you you you're saying that u:m most of the ti:me you're feeling that things are going well . and you're feeling happy in yourself

David (SU) yeah . I am . I'm really happy

Joanne (P) m . brilliant . and it's just this one sort of thing about (0.5) you know it sounds like the bus is a bit unreliable and that gets you worried

(Appt 8, 908-913)

In this last line she focused more towards external triggers, although still mentioning David's response. At this point she seemed to be conceding that the problem lies in the bus being unreliable not in David.

Appointment four was unusual in that Simon (SU) used the term "my anger" on several occasions, constructing his anger as something that needs to be overcome. In talking about it in this way he placed the responsibility for overcoming the problem with himself:

Simon (SU) my anger would just take over

(Appt 4, 350)

This case is exceptional in that the service user led talk constructing feelings as the problem. As Simon had previously worked with this psychologist, it is possible that his tendency to talk in this way may have been influenced by their previous work together. They both referred to their previous work on 'externalising' anger in the session.

The following example from appointment one was unusual in that all three people present, the psychologist, carer and service user, focused on a construction of difficulties within the internal feelings IR. However, they did so with different effects. The carer constructed the difficulties Carl (SU) was having as an understandable response to external events. In this case the carer (Carl's mother) was closely aligned to Carl, and this might explain her wishing to present him in a positive light.

Liz (P) so what sort of things are happening to you?
 Carl (SU) shaking
 Liz (P) okay (3)
 Carl (SU) → angry
 Liz (P) okay . what do you get angry at?
 Jane (FC) you get mad . you don't really get angry=
 Carl (SU) =[??] get mad
 Liz (P) get mad
 Carl (SU) mad
 Jane (FC) it's not . he's not that . gets upset over it
 Carl (SU) yeah upset
 Liz (P) how would I know if you were getting mad then?
 Carl (SU) (1) um .
 Liz (P) what sorts of things do you do when you're mad
 Carl (SU) don't know now
 Jane (FC) don't get mad really do you?
 Carl (SU) [?] no mad

(Appt 1, 171-187)

The talk about feelings was initiated by Carl at the line indicated by the first arrow, and thereafter the constructions of his feelings were led by the carer. Jane (FC) changed the feeling Carl had named, and Carl indicated his agreement, repeating “mad”. Then Jane changed the feeling again to “upset”. In doing so Jane made arguments that Carl was suffering, but constructed the problem as internal feelings not any display of behaviour, and as an appropriate reaction. She went on to say:

Jane (FC) you're mad about that but you don't get mad
 Carl (SU) 'bout it
 Jane (FC) 'bout it . not moody or anything like that
 Carl (SU) no
 Liz (P) so . it's more upset
 Carl (SU) mm
 Liz (P) than than cross
 Carl (SU) yeah
 Jane (FC) yeah . it . wouldn't . do anything to anybody or anything

(Appt 1, 188-196)

Jane located problems in terms of them not being a dispositional negative about Carl, but instead an understandable and appropriate reaction of distress to his experiences. In this there is an implied concern that the psychologist was evaluating Carl's behaviour as positive or negative, and Jane seemed very concerned to portray Carl as a 'good boy' (she has earlier described him using that term). In doing so she argued both for some positive dispositional characteristics, and that Carl's difficulties are related through no fault of his own to environmental factors i.e. his experience of being bullied.

Using the IR constructing the problem as internal and fixed

In most of the examples given above, service users constructed problems using the IR of external factors being the problem. However, there were a few examples where service users constructed the problem as dispositional. For example in appointment five, in describing her own behaviour Lauren (SU) said:

Lauren (SU) E:r . why er u:m (2) I (1) I don't kno:w . I just got upset . angry . and (0.5) I just
 (1) it's something wrong with me (1) is why Lauren did it (0.5) why she got (1)
 upset . why she did it wrong

(Appt 5, 194-195)

In talking about there being something wrong with her, Lauren located the problem with herself. However in this case, Lauren's construction might also act as an apology or explanation for her behaviour, and she distanced herself from the behaviour by talking about herself in the third person.

Another example of a service user constructing problems within the IR of them being internal or dispositional occurred in appointment two.

Anne (P) what would you say (0.5) if you had to describe yourself? What are you like?

Sophie (SU) um (1) I'm that . um . I'm brave um (2) I get attention

[...]

Sophie (SU) um . I get angry (2) and um . and then um . then um . then I get grumpy as well

Anne (P) grumpy mhm

Sophie (SU) bad mood (1) um (2) I start throwing things at staff

(Appt 2, 239-248)

However, in this case the psychologist's question on the first line implied she was looking for fixed characteristics, and may have influenced Sophie's response. Following this Sophie quickly moved on to describe the triggers for her feelings and behaviour, i.e. the staff stopping her from doing what she wants to, constructing her feelings as a response to situational circumstances. In both these examples of service users constructing something internal to them and fixed as problematic, there may therefore have been contextual factors that led to those descriptions.

There were a number of examples of carers drawing on the IR of fixed dispositional characteristics being the problem. For example, at some points in appointment five the carers constructed the problem as a stable dispositional characteristic of Lauren (SU). In discussing a previously reported issue of making allegations against staff, Mary (EC) said:

Mary (EC) when there's a history of . that's just . somebody makes them

(Appt 5, 858)

In using this language, Mary was talking with considerable certainty about how Lauren could make allegations again, thus constructing the problem as something about her rather than focusing on (or even mentioning) any possible external reasons for this behaviour. Later, the carer also said:

Mary (EC) 'cause really you don't present with a lot of behaviours Lauren do you?

(Appt 5, 961)

This again focused on a construction of behaviours as fixed and part of Lauren, rather than related to external factors. This construction minimises the possibility of any problems being amenable to change.

In appointment two, Sophie (SU) presented herself as responsible, protecting her sisters from 'bad men'. Claire (EC) seemed to argue against this identity, positioning Sophie as in need of protection by carers, as illustrated in the following extract:

Claire (EC) Sophie's always protected her sisters . she still does no:w (1) I think that Sophie's been the one that's always . kind of like . looked after them . she's taken responsibility for them she still does now (0.5) we um (0.5) we try and take that
 → responsibility away from Sophie so she can have her own . little life as well [...] we encourage Sophie to go out on her own . with a support worker . and have a day to herself so she can have a break (1) from the responsibilities that she's had to go through and . um still does (1) she's um . she's very protective

(Appt 2, 192-199)

Claire emphasises Sophie's relative powerlessness with her statement about taking responsibility away from Sophie, because this constructs carers as having the ability to control how much responsibility Sophie should have. Sophie had been describing her lack of freedom to go out and make sure the carers are okay as something she was unhappy about (an issue external to herself), and continued to describe external events immediately after the carer made the statements above. The problem was redefined by Claire (and to some extent by the psychologist) as being a Sophie's attempts to be responsible when she should allow herself to be protected, i.e. the problem was redefined as being internal to Sophie.

Anne (P) it sounds like you want to protect everybody (1) you wanna look after everybody

Sophie (SU) yeah

Anne (P) how about you? . do you think you're good at keeping yourself safe?

(Appt 2, 354-356)

In appointment three, following some discussion about the details of recent events, and of Mike (SU)'s interests, his father gave an explanation:

John (FC) while he's a good edge and while he's there you see his main problem as you probably know already is learning difficulties

(Appt 3, 219-220)

In saying this, he constructed the problem as something internal to Mike, which is stable and unchangeable. This is the only appointment where LD is specifically named as a problem, first by the carer, and then later by the psychologist:

Kate (P) and of course the difference the only thing is really for Mike is that you know people who don't have a learning difficulty we can very easily help them to learn how to manage it

(Appt 3, 1130-1132)

Here the psychologist recruited a 'common sense' sounding view regarding the effect of Mike's LD, thus constructing the fundamental problem as LD. In other appointments any reference to LD or cognitive deficits is notably absent from the talk. The only other occasion when intellectual abilities are referred to indirectly is in appointment six, in relation to talk about Henry (SU)'s ability to manage his money.

An example taken from appointment five shows the use of all three IRs. Here the carers had been describing Lauren (SU)'s recent behaviour:

Alan (EC) you behaved badly then didn't you

Lauren (SU) yeah

Alan (EC) that's when you tipped someone else's (0.5) pens on the floor didn't you (1) and that was for no reason wasn't it

Anita (P) mm (1) do you know what made you angry then Lauren?

(Appt 5, 992-996)

Alan constructed Lauren's behaviour as entirely dispositional 'for no reason'. Anita challenged this construction by asking Lauren what caused her anger. In doing so, the psychologist still suggested an internal feeling, 'anger', but Lauren was able to adjust this and a construction of the behaviour as a response to situational factors, i.e. a lot of noise, was reached:

Lauren (SU) e:r er (2) it's I just (1) I know I were a bit upset

Anita (P) mhm

Lauren (SU) and . and and I know I am . I like [person's name] (1.5) and everybody . and u:m (2) it when it's all together . like too much noisy

Anita (P) so it's very noisy

Mary (EC) noisy was it

Lauren (SU) ye:ah

Mary (EC) yeah

Lauren (SU) and . and that sets me off

(Appt 5, 999-1007)

At other times in this appointment the carers referred to contextual factors:

Mary (EC) [...] I think (0.5) Lauren's coped very well with that haven't you 'cause you know .

Lauren (SU) yeah

Mary (EC) I think she's been quite . it's been quite difficult hasn't it

(Appt 5, 1041-1044)

In this example a clear reference was still made to Lauren's coping, locating the responsibility with Lauren, but reference was also made to difficult circumstances that could have caused problems.

Summary

Psychologists often argued for the importance of situational factors, frequently asking about triggers for particular difficulties, to reduce the extent to which service users were constructed as to blame for their actions. However, despite this, psychologists usually quickly moved the focus of talk to the internal effects of any triggers, asking about feelings and responses. They constructed these internal feelings as changeable, and therefore focused on problems as something that could be worked on in psychology sessions. By focusing on coping, feelings and moving forward in this way, rather than on systemic issues or naming environmental factors as the problem, the adverse experiences that had led to difficulties were minimised in some cases. In contrast, carers did sometimes construct problems as fixed dispositional characteristics of service users. In doing so they also minimised the importance of environmental factors in their descriptions of problems, in some cases denying their significance altogether. Overall service users tended to focus much more on descriptions of events external to themselves, constructing difficulties as these external factors, which were often beyond their control. However, each party (and service users in particular) did move between these different constructions to some extent in discussing problems.

3.2.4 Using constructions of knowledge and competence

In this section I will argue that the different parties present in the appointments made claims of knowledge or competence at different times to support their

perspectives on or descriptions of problems. This was achieved in different ways, sometimes through the level of certainty with which they made statements, or by giving evidence to support their version of events in the form of detailed examples. Through doing this people tried to strengthen their own arguments and views in the process of problem definition. There were also times when participants constructed one another as incompetent. This had different effects as illustrated in the examples below.

Service users claiming competence and psychologists challenging

In a number of the appointments service users made efforts to present themselves as competent. However, psychologists often challenged this construction through their talk. For example, in appointment two Sophie (SU) had described a number of past events when men had behaved abusively towards her. In the following example, the psychologist questioned Sophie about her understanding of things that had been happening to her.

- Anne (P) how do you make sense of: (2) of these men and them hurting you (2) how does it make sense for you?
- Sophie (SU) u:m (6) I don't even know
- Anne (P) you don't know . is it something you've thought about or
- Sophie (SU) u:m . I was er . thinking about that all the time (1) and um (1) can't trust them
- Anne (P) but you don't understand why?
- Sophie (SU) sometimes . um (1) um they go and sometimes they get (2) um like . um they be horrible
- Anne (P)→ sounds like it can be quite confusing
- Sophie (SU) sometimes they lie as well
- Anne (P) sometimes they lie? (2) can you tell . if someone's lying?
- Sophie (SU) I tell er (1) somebody . a taxi driver told me a symbol I'm wearing says he's single (1) I know when he's lying because I know he's got a ring
- Anne (P) okay (4) do you think . 'cause I guess . from the things that you've said (1) today . and u:m some of the things that . [staff member's name] and [staff member's name] have talked about (2) that (2) for a long time a lot of . a lot of men have
- been horrible to you (1) um and it sounds like for you . that that's quite confusing (0.5) sometimes they're nice to you . sometimes they're not very nice to you . and it seems like you're not sure (0.5) how to make sense of that (2) um . and it does sound quite complicated . it sounds very complicated
- Sophie (SU) yeah

(Appt 2, 528-554)

In response to the psychologist asking how she makes sense of her experience in the first line, Sophie initially stated that she did not know, but then went on to give concrete

examples, demonstrating that she did understand. In asking ‘but you don’t understand why?’ the psychologist constructed Sophie as lacking knowledge or competence. However Sophie responded with an explanation, refuting the psychologist’s suggestion that she did not understand. The psychologist seemed to dismiss this response, making a further hypothesis that Sophie was finding the situation confusing, presenting herself as understanding the problem. The increasing certainty of the psychologist’s statements achieved a construction of herself as knowledgeable about the problem. She moved quickly from making a suggestion (indicated by the first arrow) to statement (at the second arrow). At the same time, in labelling the problem as Sophie’s ‘confusion’, the psychologist constructed Sophie as lacking knowledge. The psychologist’s question “can you tell if someone’s lying?” also doubted Sophie’s ability to know that men lie. Sophie gave a specific example of her knowledge as evidence, thus arguing again for her own competence.

There was another example of the service user claiming competence in appointment four. In this case Simon (SU) argued for his competence to define what he needed from sessions. In discussing whether something was a problem which should be addressed in these sessions, the psychologist suggested possible concerns with discussing past abuse e.g. it might affect current relationships. In doing so she implicitly referred to her experience and knowledge of psychology. In contrast, Simon argued that it would be beneficial to talk about now and he supported his position by referring to the difference in him now compared to when he was younger:

Simon (SU) it would have done when I were young . when I first met you (0.5) bu:t not any more

(Appt 4, 289)

In referring to his older age now Simon was supporting a construction of himself as wiser and therefore able to make decisions about what he needs from psychology sessions.

Similarly in appointment three, the service user demonstrated his competence at one point by giving factual information and presenting this with certainty. His father had

been answering the psychologist's questions about how long the 'problem' had been going on for.

- Kate (P) all right . so: you're not quite sure . you haven't quite said how long it's been going on for-
- John (FC) -no . I I can't I can't be sure . I mean it's a long time. I mean he's fifty-two now-
- Kate (P) -probably since . since his teenage years?
- John (FC) O:h I should think probably: in his later teens maybe . I don't know (0.5) I can't be sure about that
- Kate (P) okay . so it's not a new problem
- John (FC)→ oh it's not just a new problem no no . it's been on the go quite a bit . yeah yeah=
- Mike (SU) =I I did it when I were small
- Kate (P) did you?
- Mike (SU) when I were young
- Kate (P) and how old were you when you first did it?
- Mike (SU) four
- Kate (P) you were four?
- Mike (SU) at window . four

(Appt 3, 477-496)

A conclusion seems to have been reached between John (FC) and Anne (P) at the arrow. Then Mike (SU) interjects with certainty and gives a very specific answer about age. The specificity of his answer adds authority to his account; in responding in this way he presented himself as knowledgeable on this subject, and perhaps as the appropriate person to be asking rather than his father.

In appointment five, Lauren (SU) also demonstrated her competence in a similar way by giving specific details when talking about her feelings of missing her mum:

- Anita (P) mm (2) how often do you think about them
- Lauren (SU) u:m (3) my mum first it were in September (1)

(Appt 5, 603-604)

Stating the date provided support for her ability to define her difficulties. In the same appointment Lauren also presented herself as knowledgeable about the difficulties of others in her house e.g.:

- Lauren (SU) u:m (1) all . a:ll right (2) but u:m (1) u:m she (1) she . it (1) she gets (1) she gets upset as well does [person's name] pa . er (1) it's part of her medication

(Appt 5, 369-370)

Here Lauren presented herself as knowledgeable by giving formulations that sound like they may be the kind of things the carers say. She also constructed herself as understanding others' behaviour. By talking in this way she distanced herself from

behaviour that may be seen by carers as inappropriate, and aligned herself more closely with carers.

In other cases service users constructed themselves as competent through the force with which they made claims. For example in appointment seven, Sue (SU) made a several statements about her experiences with considerable certainty, e.g.:

Sue (SU) it's like I said they don't know the rest of it like I do

(Appt 7, 832)

In saying this she also claimed exclusive knowledge about her difficulties by virtue of her personal experience. The psychologist did not directly challenge her on this type of statement. However, it is difficult to judge how effective such claims of knowledge actually were in influencing problem definition because there were many other factors involved in the process.

Service user claiming competence and carer challenging

In some cases constructions of knowledge and competence were achieved in dialogue between carers and service users. For example, the following exchange took place early in appointment one:

Liz (P) Do you know what psychologists do?

Carl (SU) Bully

Jane (FC) what

Carl (SU) Bully people

Jane (FC) bullying

Carl (SU) mm

Jane (FC) Right

Liz (P) Ok (1) so what makes you think that psychologists -bully people

Jane (FC) -No . he thinks that you're gonna help somebody what's been bullied=

Liz (P) =Ah

Jane (FC) This is this is why I say if I come in now

Liz (P) Yeah

Jane (FC) With him . and then I can explain what he's saying . and then you can take it from there

(Appt 1, 8-21)

Carl had brought up the issue of bullying, and then the carer clarified what he meant. She told Liz what Carl's expectation of the psychologist was, and also stated that the reasons she needed to attend the appointment with him was to 'explain what he's

saying', positioning herself as the one who is competent to express Carl's needs, and thereby positioning him as unable to do so. This communicated to the psychologist that Carl might be misunderstood without Jane's help. The psychologist's question at the start of this section also implied doubt about Carl's competence.

Later in the same appointment some negotiation went on between Carl and Jane of who should tell the story:

- Jane (FC) he used to go by his self . he used to go from the centre and they'd say oh we'll walk you down
 Carl (SU) =I'll say it
 [.....]
 Ellen (P) mm . so you were more independent before
 Jane (FC) right
 Carl (SU) yeah (3) I'd catch the bus the first bus . go over (3) go out for a drink first (2) then . out with my girlfriend [name] (5) and (2) [to somewhere else?] . I went to my job (2) to [?] and past wilkinsons and walked down (1) the corner (2) I worked in . a job

(Appt 1, 709-720)

Jane started to take a lead and Carl asserted himself: "I'll say it", the carer continued however, until the psychologist gave Carl the opportunity to speak by addressing him directly, possibly to convey that she valued his direct account. Carl then described his independence by giving details of what he used to do by himself, perhaps to construct himself as competent and able to act alone. Similarly, on another occasion Carl interrupted his mother:

- Jane (FC) and that . and he rang me up and he said I'll tell you mum I'll tell you what's gone on I'll tell you . I said I know . I'm not lying mum I'm not lying . and I said I know you're not lying=
 Carl (SU) =I know I know mum I know
 Jane (FC) and that
 Carl (SU) wait a minute mum. wait a minute mum
 Jane (FC) I rang the centre up
 Carl (SU) wait a minute mum
 Jane (FC) sorry love . go on [laughs]

(Appt 1, 241-248)

Here Carl seemed keen to tell the psychologist about this event himself. The use of "I know" specifically may have been another tool for Carl to present himself as knowledgeable and competent, and thus justified in asserting himself to tell the story.

Carers claiming knowledge

There were also times when carers presented themselves as having knowledge and authority to make claims about problems. The following example from appointment three occurred after Mike (SU) had been having a discussion with the psychologist for some time about his interests.

- Kate (P) yeah (0.5) excellent . do you . it . have I understood right? Is it correct what Mike's saying?
 John (FC) er . oh yeah . yes oh yes to quite a great extent yes [cough]
 Mike (SU) -it is
 John (FC) while he's a good edge and while he's . there you see his main problem as you probably know already is learning difficulties
 Kate (P) yeah
 John (FC) and er while he's fifty-two . he's still very young . in his mind you see . this is what's making it difficult

(Appt 3, 215-223)

The carer made a statement constructing learning disabilities as an overarching explanation for Mike's difficulties. In using language such as 'as you probably know already' the carer presented this as the 'common sense' and correct position, making it difficult to dispute or argue with. There is also a sense of dismissing what had gone before as unnecessary detail, given that the problem can be explained by the problem of having learning difficulties. In this case the psychologist checking with John on his views adds to the construction of the carer as the more competent one and of Mike's account as potentially unreliable or inadequate. In addition, this example is unusual in that John was constructing Mike as lacking competence by explicitly referring to his learning difficulties and his difficulty with understanding things.

Further examples where carers constructed themselves as knowledgeable and more competent than a service user occurred in appointment five. The female carer asked Lauren (SU) infantilising rhetorical questions, presenting herself as having the authority to say what is right or wrong. The following question, asked in relation to something Lauren reportedly did, had a chastising quality to it:

- Mary (EC) and obviously . which is quite dangerous isn't it?

(Appt 5, 974)

This constructed Lauren (SU) as in need of guidance, and located the responsibility, competence and power to identify problems with the carers. By posing questions in this way, where only agreement is expected, and in front of the psychologist, Mary constructed herself as knowing what the problem was, i.e. Lauren's 'bad' behaviour, and closed down the possibility of alternative explanations or further exploration of the issue. In a later example, the other carer, Alan (EC) engaged in a similar pattern, stating:

Alan (EC) you behaved badly then didn't you
 [.....]
 that's when you tipped someone else's pens on the floor didn't you and that
 was for no reason wasn't it

(Appt 5, 992-995)

Alan said this with considerable certainty, presenting himself as the one with responsibility and authority to tell Lauren (SU) she had done something wrong and to claim knowledge of her motivations. In this case the psychologist challenged the account of carers by asking Lauren for her explanation:

Anita (P) mm (1) do you know what made you angry then Lauren?

(Appt 5, 996)

In doing so, however, Anita labelled Lauren's reason as 'being angry', thus also presenting herself as knowledgeable.

Appointment six was exceptional in terms of people making constructions of knowledge and competence, because here the service user presented himself as having no idea about what he wanted from sessions.

Henry (SU) E:r (16) shall we say . I need a couple more session

Joanne (P) couple more (2) and have you got an idea what those sessions might be about .
 or what you might like to talk about in them

Henry (SU) E:r (4) er [sounds of something moving on table] (23) dear (2) e:r (2) anything

Joanne (P) so you haven't got a clear idea about

Henry (SU) no

(Appt 6, 83-88)

He persisted in answering that he did not have ideas about what he wanted from psychology sessions despite prompting from the psychologist. Although people in other appointments gave responses that they 'don't know' about something, they often went on to demonstrate their knowledge after questions had been reframed, or in response to further probing. This appointment was unusual in the frequency with which Henry

(SU) claimed lack of knowledge. In the dialogue below, the uncertainty in Henry's response about whether something would be useful to talk about seemed to prompt Joanne (P) to question his responses, challenging him, adding to the construction of Henry as lacking competence in relation to the reasons for him coming to psychology.

Joanne (P) [...] is that something that you feel like it would be useful to talk about . o:r?

Henry (SU) dunno (3) Er . something we need to talk about

Joanne (P) it is something you need to talk about?

Henry (SU) yeah

Joanne (P) right (2) and do you think this would be the sort of right place to do that?

Henry (SU) (6) yeah

(Appt 6, 175-180)

This construction was a process between them over the course of the appointment, influenced by the fact that Henry gave very little in the way of verbal responses. The psychologist and carer largely led talk, and their much more extensive participation in discussions compared with Henry fed into the construction of Henry as unable or not competent to define what he needed. However, this point may be somewhat circular in that the psychologist and carer's greater contributions to the session might have occurred because Henry's input was limited.

Summary

Service users, carers and psychologists all made arguments for their own competence through their talk, but service users did this more often than the other two parties. This may have been because their relatively powerless position meant that the service users with learning disabilities needed to work harder at claiming knowledge or competence to define problems. Service users never constructed the other people present as lacking competence, but there were a number of examples of both carers and psychologists constructing service users as lacking competence. In this way they took power over the process of deciding what problems were.

3.2.5 Aligning self with a particular position or another person & recruiting support

In this section I will discuss how the analysis revealed that the people present in the appointments sometimes formed alliances with others or with particular ideas through their talk. These alliances were used in various ways in the process of problem definition. There were particular ways in which the different groups (psychologists, service users and carers) tended to use alliances. Carers often recruited the support of service users when giving their views or constructions of a situation. Service users tended to position themselves as in agreement with others or with 'the sensible position'. Psychologists aligned themselves with the person, actions or ideas they wanted to promote. The examples described below illustrate these findings.

Service users positioning themselves as in agreement with carers

There were a number of instances across the appointments where service users positioned themselves as being in support of carers' views, in line with an IR that could be labelled 'carers know best'. In some cases service users expressed agreement with carers' negative appraisals of their behaviour, or stated that they understood and agreed with carers' concerns about them. For example, in appointment two, Sophie (SU) described her understanding of the support workers' position:

Sophie (SU) [...] . when support worker (0.5) um orders me about . saying (1) um (1) you can't go off and . I (1) and it . my dad says it aswell . and er . I understand that . because support worker get worried about me . they don't want me to get hurt by any bloke or (0.5) hit by any bloke or (0.5) er . any other (1) um . or they don't want me to get (1) er . what else . um what happened to that (0.5) um what happened to that . um lady and that girl in the park is all (0.5) the support workers don't want me to go . um through that situation that those people did in the park

(Appt 2, 287-292)

Here Sophie's talk indicated an ideological dilemma for her about whether she was in agreement with the IR 'carers know best' or not. In using phrases such as 'when support worker orders me about' a criticism of support workers is suggested. With this comment she managed to convey that she was not altogether happy about the situation, and to justify her own behaviour to some extent, given the provocation of being ordered about.

At the same time, however, Sophie stated that she understands why support workers try to control when she goes out. As she continued, Sophie seemed to be arguing for her competence in deciding what is right and wrong behaviour by saying that she knows the support workers are right. However, by constructing her own behaviour that goes against what the support workers think she should do as wrong, she also highlighted the support workers' power in the situation.

Anne (P) so you understand why people want to keep you safe . and tell you . sometimes tell you what to do . but that makes you feel (0.5) really angry and resentful . to be told what to do

Sophie (SU) I don't mind it . um if they tell me er . don't go out at night (1) and um I feel like um they're um my mum (1) because my mum and . my mum and my dad say that (1) say don't go out at night . by yourself (1) even er (1) yeah . don't go out (1) even when it's night . late one night (0.5) about . u:m don't go out (2) and he said um . my support worker tells you not to go out in the night . don't go out . then I don't (0.5) swear to them (1) I don't try to (0.5) hit them . or um er kick them or anything (1) I . I told my dad I don't do anything like that

(Appt 2, 297-313)

When the psychologist suggested that Sophie may feel 'angry and resentful' about being told what to do, Sophie seemed to deny this, stating 'I don't mind' and describing how she understands why they do this, again aligning herself with the support workers. She therefore seemed to be positioning herself as in agreement with the idea that her behaviour is the problem not the restrictions on her life imposed by the support team, constructing the problem as located in her behaviour.

Similarly, in appointment five, before describing events and her behaviour Lauren (SU) made apologetic sounding statements about her behaviour on a number of occasions:

Lauren (SU) I know (0.5) it was . I would do it wrong (2) I'm stupid I know that

(Appt 5, 407)

In doing this Lauren was aligning herself with the position of carers and with the IR of 'carers know best', and distancing herself from the behaviour. Saying this allowed her to make the argument that her past behaviour was not dispositional, rather some sort of lapse or mistake. Later, Lauren said the following in response to a question about why she was angry with the support staff:

Lauren (SU) I don't know . I just got upset . angry . and (0.5) I just (1) it's something wrong

with me (1) is why Lauren did it (0.5) why she got (1) upset . why she did it wrong
(Appt 5, 194-195)

In this case Lauren was claiming that there is something wrong with herself, but at the same time is distancing herself from the behaviour by talking about herself in the third person. Again, in saying this Lauren presented herself as in agreement with carers.

In a further example in appointment three, Mike (SU) also aligned himself with the position of his carers and his dad on what he should do, and with the IR of carers knowing best:

- Kate (P) I'm interested to know . if you think anything he's said isn't true: . or that you . didn't know about: . or that you have a different (1) opinion about
Mike (SU) E:r [cough] . yeah (2) u:m . and I think (1) the thing is (0.5) thing is what to do . he's right at night (1) shut your curtains
Kate (P) that's right . yeah

(Appt 3, 499-503)

Here Mike demonstrated his knowledge of the 'right thing to do', i.e. what carers have told him. In this appointment Mike also aligned himself with 'sensible stuff' in relation to going on the internet by describing what he would do on the internet, e.g.:

- Mike (SU) e:r I do that . I've got a [??] and I do e:r (1) well just look up and do e:r spectrum games (1) what I want to do is to look into spectrum games . to play (0.5) do: sensible stuff not like girls . and keep off the girls (2) and keep on the sensible stuff li:ke . got pictures . you've got you're you tube . you can watch films . you can play games
Kate (P) yeah
Mike (SU) that's what I want to do

(Appt 3, 654-659)

By listing these things he was constructing a notion of himself as responsible and conveying to Kate and John (FC) that he is sensible and can be trusted to go on the internet or to make judgements about appropriate behaviour. This implies that he was arguing against a construction of the problem as being his inability to make good decisions.

Another example of a service user aligning himself with the views of carers occurred in appointment six. Following some talk from the psychologist and the carer about the issue of Henry (SU) managing his money being a concern, Henry made a statement in agreement with them:

Henry (SU) I do need a bit of help . handling (1) my own money

Joanne (P) mm mm

Henry (SU) that's the one thing I do need to ha:ve (1) to have help and to learn

(Appt 6, 492-494)

In saying this he positioned himself as understanding and agreeing with their views on what he needs. Later the psychologist and the carer continued:

Karen (EC) because at the moment maybe: (0.5) It's not your fault but maybe you're not (1) get how much money you actually spend . and

Joanne (P) mm m

Karen (EC) then it's a lot and then

Joanne (P) mm . and it sounds like you're sort of . identifying that as something you'd like a bit of extra help with (2) and . and I know we've sort of talked about it a few times before . and you know and then we've had the more formal assessment . or you have but u:m . I suppose just thinking about from all the times I've known (0.5) known you it seems like you're much mo:re (1) u:m (1) kee or committed to sort of sorting-

Henry (SU) -[cough]

Joanne (P) that out now . that you're sort of . um . I'm not sure before that you you . thought it was really a problem . and I think other people might have done but you weren't so worried about it . but it seems like now you're quite keen to sort it out

Henry (SU) yeah

(Appt 6, 505-518)

In saying these things, Karen and Joanne further reinforced Henry's statement by elaborating on the reasons this is a problem. By summarising that Henry does see this as a problem himself, the psychologist aligned him with their views and with the IR of 'carers know best'. She also strengthened Henry's level of agreement with them by using words like 'committed' and 'keen' to describe his feelings about this issue in her formulation.

Appointment seven is in some ways an exceptional case in that Sue (SU) did not align herself with carers, but instead complained about them, positioning herself as against the IR of 'carers know best', e.g.:

Sue (SU) [...] this is why: I'm . I'm really mad at them

(Appt 7, 126)

There were generally fewer examples of service users aligning themselves with carers' views in appointments where carers were not present. This may have been because the carers' direct presence made it more likely that service users would feel compelled to present themselves as compliant or in harmony with carers. However, it could also have

been that people who attended appointments alone were more independent, and therefore less likely to feel the need to align themselves with other people's views. A further possibility is that carers attended appointments because they had some concern about a service users' behaviour. The conversation would therefore be more likely to cover instances when service users' behaviour had been appraised as inappropriate or bad by carers, giving service users cause to apologise for or distance themselves from their behaviour by aligning themselves with carers' views.

Carers positioning service users as being in agreement with them

There were also a number of instances where carers positioned service users as being in agreement with their views. Their talk frequently conveyed acceptance of the IR of 'carers know best'. In appointment five the process of aligning Lauren (SU) with their views was achieved in quite subtle ways by carers, such as by addressing Lauren when making statements, e.g:

Mary (EC) I said to you didn't I Lauren

(Appt 5, 846)

By preceding talk criticising Lauren (SU)'s behaviour with statements such as this, carers implied that they had Lauren's agreement on their formulations of her behaviour. This enabled them to present themselves as 'on her side'. They also sometimes included her in their statements, presenting their views as shared by Lauren:

Mary (EC) wouldn't we Lauren?

(Appt 5, 901)

Rhetorical questions expecting agreement were also sometimes used by the carers:

Mary (EC) you did that yesterday didn't you?

Mary (EC) Lauren's coped really well haven't you?

(Appt 5, 910 &1056)

This form of question made it difficult for others to disagree and tended to lead to acquiescence from Lauren. It had the effect of presenting opinions and statements as the truth, making them difficult to dispute. Such statements also made it difficult to gain a full understanding or to find out what Lauren thought about the situation. In addition, these rhetorical questions constructed carers as being in a position to evaluate Lauren's

behaviour, and suggested that their judgement took precedent over any opinions Lauren might have.

By aligning themselves with service users, carers positioned themselves as being 'on service users' side'. For example in appointment two the carer also used 'we' to align herself with Sophie (SU):

Claire (EC) she knows it's for her own protection . so we do . get very grumpy on those days
(Appt 2, 334)

In this case this enabled Claire to manage making a negative statement about Sophie's behaviour, 'getting very grumpy' whilst also positioning herself as being alongside Sophie using 'we', thus constructing herself as empathic towards Sophie.

Psychologists aligning themselves with particular positions

Psychologists sometimes aligned themselves with particular positions by making appraisals. In the following examples in appointment one, this took the form of affirmations. After Carl (SU) had described that he left his job after he was attacked, the psychologist responded:

Liz (P) I don't blame you
(Appt 1, 236)

This served to convey empathy and understanding of Carl's position, and to position the psychologist as in agreement with Carl's course of action. In another example, which was more evaluatory, Liz implied that there is a right and wrong position to take by giving her judgement that not being friends was right:

Carl (SU) were friends . but I'm not now
Liz (P) [...] and that . and that sounds right doesn't it . because of what he did to you . that makes sense to me
(Appt 1, 669-672)

In addition to the potential intention in saying these things for therapeutic purposes, i.e. to convey alliance with Carl, they could have the effect of influencing what else he said about the subject. It may be that Carl would have gone on to talk about wanting to re-establish this friendship, but he did not, and hearing the psychologist's appraisal could make it more difficult for him to do so. Thus it influences problem definition.

Summary

The action of aligning themselves or others with particular ideas or positions served different purposes for different people. In general service users positioned themselves alongside the more powerful ideas or persons (which was usually not their own). Their descriptions of problems were in line with carers or psychologists being right, thereby constructing themselves as fitting what carers or psychologists expect of them. Recruiting the support of the other people present allowed psychologists and carers to strengthen their constructions of what the difficulties were. By aligning themselves with service users, carers were able to soften criticisms, sometimes presenting criticisms as opinions shared by service users. In addition, making appraisals that aligned themselves with particular ideas enabled psychologists and carers to direct others towards what they thought about issues, thereby shaping further talk on that subject.

3.2.6 Recruitment of outsider views

In this section another action is discussed, which is related to the previous one in that both involved the use of other people's views or positions in the talk. However, in this case the views drawn upon were exclusively from outside the appointments. I will argue that people sometimes recruited support for their positions in the process of defining problems by making reference to these opinions. Both service users and carers sometimes used this method to support their claims. Psychologists also drew in outsider views, but they usually did so to question statements made by service users or to gain wider perspectives on problems. The examples outlined below illustrate these findings.

Service users recruiting the views of others

In some cases, service users recruited the views of people outside the appointment in support of their arguments when psychologists had questioned their opinions. For example, in appointment four, the psychologist had started to question

Simon (SU)'s view that it would be helpful to go over past issues with his brother. Simon reported his brother's opinion as being in support of his own:

Simon (SU) but it's [brother's name] that told me to get it out in the open and get everything out
[.....]
talk and get it out in the open and get on with your life

(Appt 4, 269-275)

By bringing in the views of his brother, Simon made a stronger case that his suggested course of action is the right one. These views are harder for the psychologist to dispute than Simon's own, as Simon's brother was not present. The fact that Simon's brother is also involved in Simon's relationships outside the context of the appointment also adds weight to Simon's argument. Although the psychologist continued the point she had started, raising her doubt, she did not directly dispute these views.

Similarly, in appointment seven, Sue (SU) made reference to the opinions of others on her difficulties, and their perceptions of what she needed to change:

Sue (SU) but [person's name] knows I need to work on it

(Appt 7, 825)

Like the example above, she recruited this opinion to support her views on what she needs from psychology sessions to resolve her difficulties. Sue also used the views of others to support her claims about her difficulties:

Sue (SU) 'cause what they're frightened of (1) and [person's name]'s frightened as well (2) I could turn on me best me best . like me visiting teachers me own teachers . could turn round on them

(Appt 7, 834-835)

She added weight to her account about the seriousness of her behaviour by describing the feelings and opinions of others about it and about what she needs from psychology appointments. In describing other people's perceptions Sue conveyed that it was not simply her opinion, but was reality, potentially making it harder for Joanne (P) to dispute her account or the seriousness of the difficulties. The psychologist did not question these views, but instead asked Sue how she felt about the perceptions of others.

Carers recruiting the views of others

There were also cases when carers used views from outside appointments to provide support for their views. For example, in appointment six, Karen (EC) frequently talked about the staff team in plural e.g.:

Karen (EC) as I say it might be a little awkward if Henry goes in some details which are like .
let's say like difficult for us to . respond

(Appt 6, 165-166)

By referring to the opinions and examples she raises as coming from all the staff, Karen added weight to her position because it was not only coming from her.

In another example, in this case from appointment two, rather than using the views of one particular person, the carer recruited general views, which were presented as 'known' views to support her position on an issue:

Claire (EC) [...] it's not one of the best area for women to be walking around on their own

(Appt 2, 336)

This allowed her to present the restrictions the carers place on Sophie (SU) going out at night as the common sense position, thus closing down arguments to the contrary. Later Claire recruited Sophie's sister's opinion, and a further 'common sense' statement to support her position further:

Claire (EC) and your sisters get very worried then if you're out on your own at that time of
night (1) ladies aren't out after ten o'clock

(Appt 2, 382-383)

In doing this she constructed her position as a view held more widely by others, and distanced herself from the responsibility of being the person who does not allow Sophie to go out, instead constructing it as a consensus decision. The use of Sophie's sisters' views in particular had an emotional component to it, which was also more persuasive because Sophie has already talked about how important it was for her to protect her sisters. She might therefore also wish to protect them from feeling 'very worried' about her. Neither the psychologist nor Sophie questioned or challenged these 'common sense' and outsider views.

Psychologist recruiting the opinions of others

Psychologists also recruited the opinions of others; sometimes they did so in general terms to ask what service users thought another person's opinion might be. This enabled them to widen perspectives discussed in relation to particular topics. On other occasions psychologists brought in specific suggestions or opinions from outside the appointments.

In appointment eight, there were a number of examples of the psychologist asking about the opinion of the carer who attended the last appointment with David (SU):

- Joanne (P) right okay (1) so . do you think if u:m . 'cause I suppose it was [carer's name] I think who o . who wanted perhaps you to see me:
 David (SU) yeah
 Joanne (P) do you think if he was here today he'd (0.5) what would he say do you think?
 David (SU) same
 Joanne (P) he'd say the same . that he sort of thinks things are going well
 David (SU) yeah

(Appt 8, 146-152)

In this case David seemed to use the carers' opinions to support his opinion. However, this may have been an example of acquiescence from David, to avoid answering a potentially difficult question about another person's views. In a later example, when the psychologist brought in the carer's views again, David agreed with her suggestion that he would think the issue was a problem.

- Joanne (P) I mean is that still something that can be a bit of a problem?
 David (SU)→ no:
 Joanne (P) m (1.5) and what i . imagine if [carer's name] was there . what would he say . would he think it's a problem . o:r?
 David (SU) yeah . yeah he . he would

(Appt 8, 267-271)

In this case, the psychologist brought in the carer's opinions to gain a wider perspective on the problem. This may have been because David had not given the expected response, i.e. his negative response (shown by the arrow) was apparently contrary to the psychologist's understanding of his difficulties from their previous appointment. She also used the carer's opinion to challenge David on his views:

- Joanne (P) so he was obviously a bit worried about how you are at home but you're sort of

saying you don't see it that way

(Appt 8, 121-122)

By using the carer's opinion in this way Joanne avoided directly disputing what David was saying, putting the challenge on to the carer instead, rather than owning it herself. This made it possible for David to disagree without having to explicitly disagree with the psychologist. Bringing in the carer's views repeatedly allowed Joanne to challenge David on his account that things were fine and that he was not really worrying about or struggling with anything. She also brought in their views to challenge him on his accounts of events:

Joanne (P) oh right . so thinking about that time when it was late (0.5) what happened to you how were you feeling?

David (SU) (2) I just wait and when it when it comes

Joanne (P) right m (1) and I suppose again thinking [carer's name] or someone else from your staff team were here what would they say that you do [smile voice] would they say "oh he waits really patiently" or-

(Appt 8, 672-677)

Again, this avoided Joanne having to directly dispute something David had said, but conveyed that she was unsure of his account.

In appointment nine, the psychologist recruited the opinions of the referrer to suggest that there might be some issues to discuss, and to guide Craig (SU) on the nature of those concerns:

Joanne (P) I think it was [support worker's name] who got in contact with us . I guess it sounded like maybe at the time she rang . you know got in touch either you or her were a bit worried about things

(Appt 9, 25-27)

Bringing in this outside view enabled her to focus the conversation. The psychologist in appointment one also brought in the referrer's perspective, in this case to bring up a specific issue for discussion:

Liz (P) I think your doctor said that you were having nightmares
[.....]
are you still having nightmares about it?

(Appt 1, 207-209)

This enabled Liz to convey what she saw as being potentially significant symptoms, and influence the reporting of the problem.

In another example from appointment nine, the psychologist also brought in Craig (SU)'s father's perspective. This enabled her to challenge Craig's views on the situation, and to determine whether Craig was alone in his perception that things are not great, or if it was a wider (and therefore perhaps more significant) perception.

Joanne (P) m . m (1) so so I mean if for example . if your dad was here now . what do you think he'd say about how things are going?

Craig (SU) oh I don't know

Joanne (P) do you think he's worried about anything o:r . he thinks it 's going okay

(Appt 9, 53-56)

In this case the psychologist's question in the last line also acted to lessen the seriousness of the problem, by suggesting that if Craig's father was not concerned, the problem might not be too bad.

Summary

In this section service users and carers used outside, and sometimes multiple views to support their positions on the nature of problems. In many cases it was difficult to conclude how effective these strategies were as they were often used alongside other methods of argument, or in reference to future plans for work that were not explicitly revisited in the appointments. However, it seemed that these views were recruited to make arguments because they were potentially more persuasive and difficult to dispute than a single personal opinion. Psychologists did not tend to draw on views from outside appointments for the purpose of supporting their own positions. This could be because they held greater power in the discussions, and so did not need to draw on the opinions of others to support what they said. In addition, the psychologists' role was not to describe history or bring up new issues, rather to enquire about and build a picture of the issues raised by service users and carers. Therefore they were less likely to need to defend their views, given that the appointments are not about their own experiences or problems.

3.2.7 Closing subjects or concluding talk on a particular issue

In this section I will argue that concluding the talk on a particular issue was a significant part of problem definition in many cases. Psychologists made concluding summaries that often quite clearly outlined their views on what the problem was, and what they thought was needed. These summaries often invited comment from service users in how they were posed, making them seem collaborative. However, summary statements were often made with considerable certainty, and an expectation of agreement, making them difficult to dispute in practice. In addition the ways in which information was summarised sometimes shaped and changed its meaning. These findings are illustrated through the examples presented below.

Psychologists summarising and concluding

Summaries were made by psychologists in many of the appointments to draw conclusions about the nature of problems. For example, in appointment five the psychologist used summaries to draw conclusions on what problems were and what was needed:

- Anita (P) [...] Would you like to come back and talk a bit more?
 Lauren (SU) yeah
 Anita (P) about that . Do you think that would be helpful (0.5) in helping you feel maybe a bit less up . upset maybe?
 Lauren (SU) ye:ah . that'd be fine
 [......]
 Anita (P) mm (1) yeah (2) it sounds like sometimes it still makes you feel upset
 Lauren (SU) yeah
 Anita (P) and sometimes it is helpful to talk about these things

(Appt 5, 735-751)

These statements were made with increasing certainty, allowing the psychologist to draw fairly clear and firm conclusions on what was needed based on her own suggestions. These reflected the IR about internal feelings being the problem, and the tendency for psychologists to construct problems in this way has been discussed in section 3.2.3. Lauren agreed with her suggestions here, and it could be that the psychologist's conclusions matched well with how Lauren saw her problem, and what

she wanted from future sessions. However, her agreement may also have reflected acquiescence.

Similarly, towards the end of appointment two, the psychologist made a couple of fairly long summaries (shortened here), which put forward her formulation of Sophie (SU)'s difficulties.

Anne (P) okay (4) do you think . 'cause I guess . from the things that you've said (1) today . and u:m some of the things that . [staff member's name] and [staff member's name] have talked about (2) that (2) for a long time a lot of . a lot of men have been horrible to you (1) um and it sounds like for you . that that's quite confusing (0.5) [...]

Sophie (SU) yeah

Anne (P) u:m and I guess that's part of the reason why (0.5) I was asked to have these sessions with you . to try and put some sense into that (0.5) because it is quite confusing (2) [...] and I guess now it . it feels like there's . you feel safe enough to stop and think about (0.5) what's happened or what's happening (1) does that (1) does that make sense?

Sophie (SU) yeah

(Appt 2, 540-554)

By summarising, the psychologist concluded the session and outlined the purpose of further work together from her point of view, i.e. to 'put some sense into that'. She also highlighted the idea that now is a good time to have psychological work because Sophie 'feels safe'. She presented her views with considerable certainty, making it quite difficult for Sophie to disagree, and Sophie responded with acquiescence. In summarising the difficulties in this way Anne took control of the form and purpose of their future work together, having formulated the problem as something they could work on, i.e. Sophie's 'confusion'.

In another example, the psychologist in appointment eight similarly drew together information from the conversations across the course of the appointment to make conclusions, and summarise her understanding of what was needed.

Joanne (P) I suppose just sort of you know when we were talking . it feels like I'm sort of digging around for problems really . and you you you're saying that u:m most of the ti:me you're feeling that things are going well . and you're feeling happy in yourself

David (SU) yeah . I am . I'm really happy

Joanne (P) m . brilliant . and it's just this one sort of thing about (0.5) you know it sounds like the bus is a bit unreliable and that gets you worried

David (SU) yeah it do:es

Joanne (P) u:m so just finding a way to help you . manage that . yeah (0.5) brilliant (1) okay . that sounds great . well thank you very much for seeing me today . and I'll . the next time I see you it will be then at your ho:use

(Appt 8, 908-917)

In this case, the summary led to a positive construction of how David was managing. In making this summary the psychologist took control of the decision about what was needed next for David and what the plan should be.

In a further example from appointment seven, the psychologist also drew conclusions about what she thought was needed:

Joanne (P) so it's sort of having more practical strategies in those situations when people are winding you up or provoking you how to . deal with that in a way that doesn't lead you to . beat them up or hit them or something

(Appt 7, 330-332)

In this way she conveyed her understanding of what Sue (SU) had been saying, but also focused the talk (Sue had been giving lots of details of specific incidents) to close down a particular type of talk on this subject. The psychologist also used summaries to draw conclusions and raise her doubts about how the psychology service could help with particular concerns:

Joanne (P) So . what do you think (1) 'cause obviously there's practical things that you . you're wanting some help with . moving ho:use and other things that are going on . wha what do you think abo:ut (0.5) u:m the work that we're doing together?. Is it . 'cause obviously it sort of a bit (0.5) you know you're coming here . it's it's not sort of (0.5) helping in a practical way . what do you think=

Sue (SU) =it is (1.5) but I'm still getting depressed half of the time

(Appt 7, 35-40)

Through this summary she directed Sue away from talking about these concerns, having implied that she could not offer help with those issues. Sue clearly picked up on this, and immediately named a different, potentially more appropriate issue (which fit with the IR about internal states as problems), thus arguing that she did need the service.

Summary conclusions were also used by the psychologist in appointment nine, for example:

Joanne (P) mm . and it sounds like from what you're sort of saying is that just having a bit of a chance to sort of talk about things that are annoying you would be what you're looking for

(Appt 9, 482-483)

In saying this the psychologist attempted to draw a subject to a close and offered Craig (SU) the chance to comment on this formulation. In drawing this conclusion, using the word 'just' she also constructed this as a limited way of using the sessions, subtly conveying her opinion on talking about things that are annoying him. In response Craig continued with talk about the details of what annoys him:

Craig (SU) mm (1) m . there are a lot of things that annoy me . mm (0.5) lot of things I know but (0.5) you know when you like to do things and people won't let you do: them
(Appt 9, 484-485)

Although he did not respond to her formulation directly, the fact that he started to do what she has suggested he wanted to do seemed to confirm her conclusion.

In this appointment the psychologist also gave summaries of what Craig had been saying, which had the function of constructing his concerns as fairly normal and not a major problem:

Joanne (P) I mean how much do you think . 'cause I suppose I was just thinking about u:m (0.5) you know for a lot of people they have . you know as they're growing up they have different ideas from their parents and brothers and sisters . u:m (0.5) and I suppose I was just wondering how much you think it's sort of just like a sort of perhaps a normal part of growing up . or is there . o:r whether you think it's a bit more of a problem? (4)
(Appt 9, 154-158)

In addition she drew conclusions constructing the situation he has been describing as difficult as actually fairly positive:

Joanne (P) yeah . that's good (1) I suppose the thing that sort of struck me . for as you're talking . [...] about seeing your dad and [person's name] and things like that . u:m (1) I suppose now with you living with them it sounds like you've actually worked . out quite a sort of a good arrangement . you know you have a bit of time to yourse:lf . you know sometimes it's difficult but sounds like you're managing it okay really I mean tricky situation . u:m (2) is that how you'd see it or?

Craig (SU) (1) er (0.5) I think so

(Appt 9, 303-309)

In doing so she took control of the decision as to whether this was considered a problem or not. By presenting this formulation tentatively, she conveyed a sense of allowing Craig to have the final say over whether this is correct, giving him power, whilst at the same time exerting fairly strong influence over the conclusions. His non-committal

response indicated uncertainty about this formulation, but the psychologist continued, making further statements about him coping well with the situation.

Carers drawing conclusions

There were also some examples of carers drawing conclusions on topics of discussion. In appointment six the carer summarised her perspective on what had been negotiated about Henry (SU)'s difficulties:

Karen (EC) so you are like happy with it like . if you say something like that o:r in the past I was abused . and then staff is there . and staff will be listening . but we will not like go any further or we will not try to discuss this or . you're okay with that

Henry (SU) yeah

Karen (EC) okay . so it's enough itself . just listen (2) okay

(Appt 6, 450-454)

In summing up and emphasising her understanding of the issue, the carer clarified and took control of the decisions reached. By following her summary with a question checking Henry's agreement, the carer presented her conclusions as collaborative, when they were in fact based on her own earlier constructions of the problem.

In appointment five carers also drew conclusions, for example in relation to how Lauren (SU) was managing in her new house:

Mary (EC) but I think it's definitely sort of quite you know sort of good boundaries an and things and stuff yeah . has be:en sort of . needed . has worked quite well really (0.5) but it's definitely hasn't it

(Appt 5, 1084-1086)

In this case positive conclusions were presented, along with talk presenting the carers as having been successful, i.e. putting in good boundaries. Here the carer constructed the positive outcome as having been a result of carers' actions, de-emphasising Lauren's role in things working out well in her new house.

Service users concluding topics

There were a couple of exceptional examples where service users concluded and closed subjects themselves. For example, in appointment eight, at one stage David (SU)

took control in quite a powerful way, closing a topic of conversation by changing the subject suddenly.

Joanne (P) so that's something that you kind of differ a little bit on=
David (SU) =hey I got my bedroom done Saturday . decorated

(Appt 8, 274-275)

Although he did not draw any conclusions about the topic they had been talking about, his abrupt ending of the talk conveyed either that he had nothing more to say about it, or did not want to talk about it any more. Changing the subject allowed him to manage closing the topic and in doing so he took power over the session. This was unusual in that it was not a conclusion of a topic, rather a complete and quite sudden change of subject. This fairly clumsy change may have reflected David's limited skills in being able to close the subject or conclude the talk in a more elegant manner.

In appointment three, there was an exceptional example where the service user summarised and concluded on a particular topic, attempting to close it on his terms.

Mike (SU) e:r . yeah (1) yeah (2) yeah it's about young girls yeah
Kate (P) yeah
Mike (SU) e:r (4) young girls e:r I just find them on the photo on the disc and photograph .
Kate (P) yeah
Mike (SU) and colour their hair .
Kate (P) yeah
Mike (SU) their eyes . and style
Kate (P) yeah
Mike (SU) nothing else
Kate (P) okay

(Appt 3, 186-195)

He seemed to be trying to take some power over what they were discussing and over perceptions of what his interests are. However the psychologist effectively dismissed this denial that there is anything more to his interest. She did not comment on what he has said, but instead followed with:

Kate (P) do you understand what my job is?
Mike (SU) yes
Kate (P) and er do you under-
Mike (SU) -psychologist
Kate (P) that's right . yeah (0.5) and do you understand that I want to talk to you a bit more: . about these things?
Mike (SU) er yeah . yeah

(Appt 3, 197-203)

In doing so she reasserted her power over the situation and over the issues they would be talking about, telling Mike that they would be revisiting the issue. Mike responded to this with acquiescence. The psychologist's tone at this point was fairly condescending, and she took the position of informing Mike on what her expectations for the sessions were.

Summary

It is notable that it was rare for service users to make concluding summaries, and they were almost exclusively made by psychologists. In the example cited from appointment three, where a service user did summarise and attempt to conclude a topic, this was quickly disputed by the psychologist. It seems likely that power relations in the appointments made it more common for psychologists to close subjects and draw conclusions. The psychologists held greater power because of their professional role, and in many cases in terms of knowing how a psychology session could be conducted and what help they could offer. In addition to power, the tendency for psychologists to do the concluding and summarising may reflect their superior abilities to articulate and draw together information. Talking about difficulties at the level of summaries may have been difficult for some people, and service users did tend to focus more on describing specific examples. In addition, summarising and concluding about the nature of problems may have enabled psychologists to formulate plans for how to work with service users more easily. From the examples presented, it can be seen that they did often favour constructions within the IR of problems as internal experiences such as feelings and thoughts. Concluding in this way might have fitted with their working practices, requiring a good formulation of difficulties and plans for further work to be in place. The ways in which conclusions were drawn contributed to the power of psychologists to make decisions about the nature of problems.

3.3 Summary of Findings

The analysis has revealed a number of different factors involved in the negotiation problem definition in this setting. Topics were often introduced by the psychologists, who also made references to what sessions were for and offered particular choices to service users, thus influencing the types of problem talked about. Service users sometimes also took control of the issues raised by talking directly about their experiences, but psychologists generally retained greater power over the content of sessions. Once subjects had been introduced, psychologists (and sometimes carers) again took control of how difficulties were defined in many cases by asking particular types of questions to gauge the severity of problems.

Throughout the data, interpretative repertoires locating problems either in internal but changeable thoughts and feelings, in environmental factors, or in stable internal characteristics were drawn upon. The IR describing problems as environmental factors was generally most apparent in the talk of people with LD, while psychologists made most use of the IR about problems as changeable internal states. The psychologists frequently focused their questions and formulations on the feelings that service users had in response to their experiences. In doing so they de-emphasised the importance of situational factors in accounting for problems, and focused on defining problems in a way that made them amenable to change through work in psychology sessions. Carers and service users sometimes defined problems as fixed dispositional characteristics, thereby locating the responsibility for difficulties with the person with a LD. However, the different groups (and particularly people with LD) also drew upon the different IRs flexibly, and ideological dilemmas in how problems were defined were sometimes apparent.

There were also a number of devices people commonly used to support their arguments about the nature of problems. People constructed themselves or others as knowledgeable or competent, and this enabled them to make claims about who had authority to define problems. In some cases, people with LD particularly made efforts to present themselves as able, seemingly arguing against alternative constructions that

they lacked competence. People also aligned themselves with others or with particular positions, and recruited views from outside the appointments in order to make arguments. For service users, claiming support for their position enabled them to make stronger claims about whether something was a problem or not. By aligning others with their views, carers and psychologists also strengthened their constructions of what problems were, and sometimes closed down the possibility of alternative arguments being raised.

Finally, it was found that psychologists influenced decisions reached about the nature of problems through the ways in which they closed or concluded subjects. Their formulations emphasised particular constructions of the experiences service users had described, or closed down issues deemed less appropriate for work in psychology sessions. It was rare for service users to draw conclusions, and when they did attempt to close topics, they were generally raised again later by the psychologist. The significance of the findings of this analysis is explored in greater detail in the following chapter.

CHAPTER 4: DISCUSSION

In this chapter I present a summary of my findings and discuss them in the context of the wider literature. I then discuss the strengths and limitations of this research, the clinical implications of the findings and suggest some future directions for research in the area. Finally, I present some of my reflections on the research and draw conclusions.

4.1 Outstanding Findings in Relation to Past Literature

The first aim of the current research was ‘to examine how difficulties are described, defined and discussed in assessment appointments in an NHS community service for people with learning disabilities’ in order to answer the question of how problem definition is negotiated in this setting. The second aim was ‘to examine power issues and the ways in which the different people present contribute to these interactions and draw on discourses’. These aims have been addressed through the analysis, which revealed that a complex array of actions was used in the talk across the nine appointments to negotiate different components of problem definition. There were also particular actions and interpretative repertoires that were common across different appointments, but were constructed in different ways by different individuals. Power relations were also relevant to the discourse and to the ways in which interactions were managed. In this section I will discuss the main features of these findings and outline how they relate to the existing literature.

4.1.1 Power, choice and control in the process of defining problems

The analysis revealed that there were a number of different ways in which psychologists exerted influence over the process of problem definition in the appointments recorded. For example, they influenced the types of issues talked about through the ways in which they introduced the purpose of coming to the appointment, the questions they asked and references they made to the process of sessions. These

actions enabled the psychologists to be powerful in the situation. Although people with LD also took control of the focus of sessions sometimes, for example by talking directly about their experiences and difficulties, overall psychologists generally had more control of the content of sessions. Research has previously found that people with LD had little knowledge of the structures of the services they used and the roles of staff (Goble, 1999). Although this was small-scale research, it is possible that a similar lack of knowledge about the psychology service among some people with LD who participated in the current research could have contributed to power imbalances.

Psychologists often gave choices to people with LD about what sessions could be used for, positioning themselves as facilitating empowerment. However, in a number of examples from across different appointments, when choices were presented by psychologists this served to guide people with LD to discuss problems in particular ways. The process of 'giving' choices to others, sometimes based on the parameters the psychologists had constructed themselves also highlighted the fact that psychologists retained the greater power and control over the situation. Similar issues with the ineffective use of language of choice were highlighted by Antaki et al. (2009) in their research examining interactions between support staff and people with LD. In that research staff gave commentaries that were formatted as choice and choice was sometimes given on abstract issues, which was potentially confusing. Providing choice and control for people with LD over the services they receive has been an important agenda in the past few years, promoted in government documents such as *Valuing people* (2001) and *Valuing People Now* (2007). However, as discussed in section 1.1.3, some difficulties have been identified with meeting this agenda in practice. Jingree and Finlay (2008) found that support staff positioned themselves as in favour of choice for people with LD, but gave reasons why facilitating it in practice was difficult. The current research has also highlighted difficulties with providing genuine choice for people with LD, in this case in the setting of appointments in a psychology service.

Some of the reasons for the difficulties with providing choice have previously been discussed in the literature, as reviewed in section 1.7.1. The priorities of other

parties involved in the lives of people with LD, the social context, experience of choice making and powerlessness are all factors which have been highlighted as important influences on people's ability to make choices about their lives (Harris, 2003; Jenkinson, 1993). It is therefore a complex process to provide genuine choice and control for people with LD, and the current research has demonstrated how these difficulties are manifested in moment-to-moment interactions. Research by Scior (2003) found that despite the presence of discourses about choice in the talk of people with LD, carers had considerable control over their lives (Scior, 2003). In the current research people with LD often positioned themselves as agreeing with carers, constructing their past behaviour as having been wrong, in line with an interpretative repertoire that 'carers know best'. This suggests that carers had considerable power over their lives outside the immediate context of the appointments. These participants with LD may have been powerless to directly challenge the carers' dominant views. Foucault (1982) has emphasised the influence of a person's position in the power hierarchy over whether or not they can challenge dominant discourses.

Carers also positioned people with LD as agreeing with their views. For example, they posed questions expecting agreement and presented their views as though they were shared by the person with LD. They also softened criticisms of the person with LD by presenting them as having been previously discussed and agreed with that person. In addition to enabling carers to exert control over problem definition, these practices allowed carers to position themselves as aligned with the people they supported, and with the current agenda of empowerment of people with LD (e.g. Valuing People Now, 2007). Carers also sometimes recruited opinions from outside appointments to support their positions on the nature of problems, or on needing to restrict or control the people they supported. For example, some opinions were constructed as 'common sense' by carers in appointments two, three and five. By drawing on these culturally accepted or common sense opinions they were able to present these arguments without having to own the role of restrictor themselves. The construction of common sense, drawing on IRs or available discourses in particular cultural contexts, is an important component of

how actions are achieved through talk according to discursive psychology (Edley, 2001; Edwards, 2004).

People with LD also sometimes drew on outsider views to strengthen their opinions. This meant that they were not then simply reliant on their own views when making arguments, and enabled them to increase the power of their views to influence problem definition. Nikander (2007) has previously discussed how constructions of third party concern can be effective in strengthening argument towards a particular decision. Although Nikander (2007) was referring to a different setting (meetings about nursing home placements) the actions used are similar to those of the carer in appointment two and the person with LD in appointment four of the current research. In these cases the concerns of outside parties were recruited to support particular descriptions of problems.

Psychologists did not use the opinions of others to directly support their own views, but did exert power by aligning themselves with certain perspectives or actions. They sometimes gave affirmations in response to particular descriptions of what people with LD had done, or choices made. In the past Antaki et al. (2002) also found that care staff sometimes gave positive evaluations of people's responses to questions when conducting interviews with people with LD to complete a questionnaire. In the current research and in the findings of Antaki et al. (2002), giving such affirmations influenced the subsequent talk.

The analysis also revealed that psychologists sometimes influenced the process of problem definition through giving formulating summaries, sometimes to conclude topics, and sometimes to clarify or extend talk on a particular subject. This is in line with previous research findings on interactions between the staff of residential homes and people with LD. For example, staff sometimes expanded and reformulated what service users said unclearly (Antaki, Finlay & Walton, 2007), or constructed views and responses as coming from service users when they had not (Jingree et al., 2006). Edwards (1997) has also discussed the effects of formulations, and describes the work of Heritage and Watson (1979), who showed how formulations are not neutral devices, but perform the

actions of preservation, deletion and transformation of the previous talk. In the current research formulations were used by psychologists to perform social actions in this way, often to add to or change information that had gone before. The conclusions drawn enabled psychologists to summarise their understanding of what the problems were, or end talk on issues they deemed less important. Although they were often presented tentatively, allowing others to comment, the format used often held an expectation of agreement. People with LD often gave short acquiescent responses. These responses may have indicated genuine agreement with the formulations, but the particular omissions or additions in the psychologists' summaries enabled them to exert control over decisions made. Giving formulations demonstrating expertise about another's experience may form part of therapeutic work, as noted by Antaki, Barnes and Leudar (2007). However, regardless of intentions or therapeutic rationale behind these actions, they clearly enabled psychologists to exert control over how problems were defined. People with LD did however occasionally dispute psychologists' formulations, but the ways in which they did so (e.g. by giving details of specific events) were not necessarily acknowledged as disagreement by the psychologists. On the rare occasions when people with LD did attempt to conclude on, or close topics on their terms, these subjects were re-opened and reformulated later by psychologists.

The analysis also showed that psychologists often took control of how problems were defined by asking questions within IRs about the timescale, severity and impact of issues raised. These questions suggested that the psychologists had particular criteria in mind against which they were testing problems. In some cases psychologists doubted and tested service users' responses through the questions they asked. For example by asking for evidence for problems which fitted with these IRs, sometimes after people with LD had already answered the same questions (e.g. in appointment eight). Antaki, Finlay and Walton (2007) report a similar finding in a different setting. They found that staff continued to question the residents of a home for people with LD if the responses they were initially given on an issue were deemed inadequate.

The IRs drawn upon to seek evidence for and test the severity of the difficulties in the current research are likely to have been related to the institutional context in which the appointments took place i.e. the psychology department of an NHS community service for people with LD. The institutional settings in which discourse is situated is considered a crucial influence on the talk according to discursive psychology (Edwards & Potter, 2001; Potter, 2003; Potter, 2005). The roles of the people present and the tasks required of the situation are related to the institutional context. The current research revealed that the institutional context exerted a strong influence over the ways in which problems were defined, allowing for particular types of definition that fitted with the service. As pointed out by Hepburn and Wiggins (2007), the people who are part of that institution usually have far better knowledge of norms and practices than lay people, and therefore hold greater power.

4.1.2 Issues and constructions of ability and disability

The analysis showed that the ways in which the psychologists and carers presented choices, commented on the process of sessions, and tested the severity of problems, affected the responses of people with LD. It has previously been argued that inconsistent or acquiescent responses can arise because of the confusing way in which questions are posed or repeated (Rapley & Antaki, 1996). The current findings also highlighted how certain types of talk about the process of sessions, and testing or doubting questions can elicit inconsistent, acquiescent or unclear responses. In cases when this occurred, it contributed to constructions of the people with LD giving these responses as lacking competence. Some of the ways in which psychologists tried to focus sessions did not seem to fit well with service users' own perspectives on their difficulties. In some cases the styles of communication used by the psychologists' were more complex and sophisticated than those of the people with LD. This contributed to their power in the appointments because it enabled them to raise and discuss issues on a level that may not have been accessible to people with LD. People with LD themselves did not tend to summarise issues or talk about the process of sessions, and when the

psychologists talked in this way it may have been difficult for some people to follow or engage with. Rawlings et al. (1995) have highlighted that the ability of people with LD to make decisions is affected by how people around them are able to facilitate their understanding. In cases where people with LD gave very little in response to psychologists' questions or suggestions, this may have been related to a difficulty in following the conversation. Facilitating clear communication in this setting is therefore of fundamental importance to enabling people with LD to actively contribute to the process of defining their difficulties and what they need from the service, an issue previously highlighted by Lloyd et al. (2006).

The analysis also showed that psychologists and carers sometimes constructed people with LD as lacking competence. This was achieved through the ways in which they questioned what people said, or made claims of their own superior knowledge. However, people with LD often constructed themselves as competent and knowledgeable. Previous research examining how people with LD construct their social identity found that they used talk identifying themselves as able and distanced themselves from descriptions of deficit (Rapley et al., 1998; McVittie et al., 2008). Like these findings, the current research suggests that people with LD were arguing against the alternative construction of themselves as lacking competence.

In addition, it seems important to mention the issue of intellectual abilities and communication skills. There were instances in the appointments when the ability levels of the service users with LD may have had an impact on their power to shape decision-making. The communication styles of one or two of the participants were quite idiosyncratic and did not necessarily follow the normal to and fro nature of conversation, or conform to norms of social communication. This seemed to add to the complexity of the process of problem definition, and in one or two cases it seemed that the psychologist and service user struggled to understand one another. However, it could be argued that issues such as having limited experiences of communicating in formal settings, or other social factors could have contributed to these difficulties. As previously highlighted, exclusion from mainstream society has been an issue for people

with LD (Gillman et al., 2000) and it is possible that limited experience of having opportunities to express their views and make decisions could have contributed to their apparent difficulties in doing so in this setting.

4.1.3 Locating problems and managing responsibility

A further finding was that three different, but related interpretative repertoires were drawn upon to construct problems as either internal to the person with LD and fixed, as environmental factors outside the person with LD, or as internal but changeable responses to triggers, such as thoughts and feelings. These IRs were used to indirectly manage issues of blame and responsibility for problems. Psychologists in particular tended to strongly favour constructions of difficulties within the IR focusing on the feelings and thoughts of people with LD. Edwards (1997) has discussed the role of emotions in managing discursive interactions. He has described how they can be used to justify actions, and in describing accounts of events. In the current research, psychologists in particular often focused on emotions and elicited descriptions of emotions from others, or suggested how people may have been feeling. Through the use of this talk about emotions, decisions and behaviours were explained, and problems were often described in relation to these inner experiences. I have argued that in this context, the particular function of talk about feelings may have been to enable psychologists to construct problems as amenable to change through work in psychology sessions. Constructing problems as inner responses such as thoughts and feelings meant that they would fit with particular models of difficulties. The influence of the institutional context on this discourse is again apparent. I have mentioned some effects of therapists' formulations above in section 4.1.1. It is also relevant to highlight the finding that formulations often specifically constructed problems in line with the IR about people's inner experiences. Davis (1986) has previously discussed therapists' use of problem reformulation in a study using conversation analysis of one therapy session. Davis presented a detailed analysis and clearly supported her findings with examples from the data. Although this research was in a different setting, and was not with a

person with LD, similar issues were highlighted. It was argued that therapists' formulations transferred difficulties into ones that would be amenable to therapy, and discounted the social significance of the problems described by the client, reducing them to personal ones instead.

In contrast, in the current research people with LD often focused much more on environmental factors, events and difficult experiences, thereby locating responsibility for difficulties with these outside factors. Through their talk about inner experience, psychologists focused away from the role of outside events. Although they acknowledged the contribution of these factors as triggers for difficult feelings, in focusing more on inner experiences they de-emphasised the role of external factors.

Carers sometimes constructed problems within the IR of them being fixed and dispositional characteristics. This enabled them to focus on what the person with LD was doing wrong, and may also have served the function of distancing themselves from responsibility for problems. As highlighted in the literature, the causes of LD have often been constructed as residing within the individual (Reid & Valle, 2004), and people with LD have been constructed as cases or problems (Gillman et al., 1997). Some of the findings from the current research indicate that discourses locating problems within individuals and disregarding environmental factors are still influential. Previous research examining how care staff constructed the 'aggressive challenging behaviour' of people with LD identified a discourse about individual pathology and a discourse about the influence of contextual factors (Wilcox et al., 2006). Like the findings of Wilcox et al. (2006), the present research indicated that different IRs were drawn upon flexibly, and enabled the people present to negotiate issues of responsibility for problems.

In the current research there was only one case (in appointment three) where having a learning disability was constructed as the cause of problems. There were no other examples of explicit mention of LD as a contributing factor, and only one other case where problems with understanding were referred to as a difficulty. It seems important to mention this finding because the service was specifically for people with LD, and therefore the appointments with the psychology department were available to

the participants of this research only because they were considered to have a learning disability. There may therefore have been assumptions about the influence of the label of LD and potential difficulties associated with that label, which were not discussed but influenced the content of appointments.

4.1.4 The unexpected findings: people with LD taking control

Past literature does not highlight many examples of people with LD having control and power. This may be because, given the powerless position they have occupied for so long (Gillman et al., 2000), it has been considered more important to focus on the difficulties they face in taking control over their lives than on any positive changes that have been made towards empowering them. However, in the current research there were some examples of people with LD taking control of the focus of sessions and of how problems were defined. In some cases this was only achieved in a fairly minor way, whereas in others people with LD had control over either the decisions made, or the topics covered for much of the appointment. For example, in appointment four the service user answered open questions from the psychologist by stating what he wanted from coming, and was quite assertive throughout the appointment in articulating his aims for the work together. In appointment seven the service user positioned herself in opposition to her carers, and again was quite assertive at times in arguing for her views on what her difficulties were. In this case the psychologist did, however, also influence the definition of the problem by asking questions using IRs about the severity and impact. In some appointments people with LD brought the focus of the conversation to the issues they wanted to discuss by talking directly about them. Although in many cases psychologists or carers redirected the focus and took power over the session in various different ways, in appointment nine the psychologist's efforts to direct the talk were unsuccessful and the person with LD repeatedly went back to the issues he wanted to discuss throughout the session. In each of these three cases, the service users who exerted a considerable amount of control over sessions were quite articulate and verbally able. They were also all people who had previously worked with

the psychologists, and there were no carers present in the appointments. It is therefore possible that a combination of the particular features of those appointments, and of those people, contributed to their success in being more assertive.

It is also important to note that although their efforts at providing choice and control for people with LD were not always entirely successful, the psychologists were clearly attempting to ascertain the perspectives of service users on problems. It was a consistent feature across appointments that psychologists were trying to facilitate some degree of power for people with LD.

4.2 Strengths and Limitations

4.2.1 Methodological issues

As the research is a small-scale qualitative project, the aim was not to include a representative sample of participants or for results to be more widely generalisable. However, there are some factors relating to the selection of participants for the current research that are worth mentioning. For ethical reasons the psychologists working in the service who had agreed to participate were asked to pre-judge the suitability of people who were going to be offered an appointment. They considered whether potential participants were likely to be able to give informed consent prior to inviting them to participate. As such, people who were less able and deemed unlikely to be able to give informed consent were not invited to participate. The sample therefore only included people who could be described as having mild or moderate learning disabilities. It is also possible that particular characteristics of people who consented to take part in the research could have affected the findings on how problem definition was negotiated in this setting. For example, people who agreed to take part might generally have been more compliant or more eager to please the staff of the psychology service, and this could also have affected how they talked in appointments. Although these issues were difficult to avoid in this project, future research might benefit from considering how

people who were less able, or unlikely to access psychology services directly might participate.

The sample actually recruited did, however, represent a fairly diverse range of people, as illustrated in the pen portraits in section 3.1. Details were also provided in the method section of the service and the psychologist participants in order to help readers situate the sample, as recommended by Elliott et al. (1999). It is not possible to comment with certainty on the intellectual abilities of the people with LD who participated, but the sample seemed to include people with varied levels of communicative ability and style. The carers who participated were also fairly diverse in that some were employed while others were relatives of the people with LD. Having a sample that includes a range of the different types of people who might attend the service is advantageous in that the research should therefore be relevant to other similar services. However, the diversity of the sample may have contributed to the fact that some of the findings did not apply to all appointments, and further research would be beneficial to examine the extent to which the actions involved in the process of problem definition in this sample apply elsewhere.

Carers were present in only five of the appointments recorded, and this is also likely to have affected the findings. For example, it is possible that people coming with carers might feel less inclined or less need to speak in the appointment if they believed that carers would tell the psychologists about their difficulties instead. This might particularly be true if the person with LD was accustomed to referring to the carer for decision-making, a phenomenon that has previously been highlighted in the literature (e.g. Rawlings et al., 1995). It is likely that the relationships of carers and the people with LD outside the appointments influenced how they interacted with one another and with the psychologists. As noted in section 4.1.4, it is possible that the finding that some people with LD were more able to be assertive in the process of defining problems was related to the fact that those people came to the appointments alone. However, each of the appointments recorded differed in many ways, and suggestions about the possible effects of carers being present can only be speculative.

It is also possible that the reasons people had been referred to the service could also have affected the process of problem definition. For example, in cases where the issue was particularly sensitive people might have been inclined to talk about it more indirectly and less explicitly. In addition, the extent to which people with LD or carers were already aware of the reasons for having the appointment are also likely to have affected how those issues were discussed. This type of information was not gathered about appointments, and it could have been informative had it been included.

The appointments recorded were a mixture of first assessment and review sessions, and therefore in some cases participants had known each other for some time, while in others they were meeting for the first time. People with LD (and carers) who were familiar with the setting and the psychologist may therefore have been more able to be assertive. This issue is referred to in section 4.1.4, where it is highlighted that some (but not all) participants with LD who already knew the psychologist seemed better able to take control of the decisions reached. Psychologists may also have made more suggestions about the nature of problems if they already knew the person with LD. For example, in appointment nine (as noted in the pen portrait) the psychologist brought in issues that seemed to come from their previous work together. It seems likely that the type of appointment recorded had some effect on the findings, but it is not possible to draw general or firm conclusions about the influences of this on peoples' talk.

In section 2.1.3 I have briefly noted some of the arguments for using live data in qualitative research. Potter and Hepburn (2005) have discussed this issue and acknowledge that the data can only be 'naturalistic'. It is not possible to capture genuinely naturally occurring data given that, ethically, participants need to give consent and will therefore be aware that they are being recorded. It unclear exactly how audio recording may have affected the current data, but it is likely to have had some effect. The fact that participants knew their talk would be analysed could have affected how appointments were conducted. For example, people may have been more conscious of how they would be perceived. On listening to the data, it seemed possible that in some appointments psychologists were working particularly hard to reach a definition of

problems, and possibly focused more on directly discussing what people wanted from coming to the appointment than they might generally. This, or any other effects of audio recording, would obviously affect the conclusions drawn about how problem definition is negotiated in the setting.

Some authors have emphasised the value of including people with LD themselves in the process of conducting research e.g. Oliver (1992). In the current research, some people from the service user involvement group of the participating Trust were consulted on the design of the research information. However, people with LD were not otherwise involved in conducting or designing the research. Although this could be considered a limitation, it is likely to be difficult to involve anyone who is not trained in research methods in every step of the process of carrying out research involving complex analysis like the current project. In addition, I have presented my findings as my interpretation of the data, and have tried to remain mindful of the powerful position I occupy as a researcher examining issues relevant to the lives of people with LD.

4.2.2 Analysis issues

One potential limitation of the current analysis is that it was not as detailed in terms of looking at the moment-by-moment interaction as it might have been, for example with an approach closer to conversation analysis. However, the decision was made to focus on the broader effects of talk, with some reference to the direct interactive elements. This was partly because of the large amount of data gathered. Prior to the analysis I was uncertain how much time in appointments would be dedicated to direct problem definition, but as it transpired it was a large proportion of the talk. It was therefore not possible to analyse the very fine detail of the talk within the scope of this project, without losing some of the broader findings. The research question addressed in the current project was quite a wide question, and I have chosen to answer it focusing mainly on actions in the talk. However, it is likely that alternative methods or even a different approach within discourse analysis could have led to findings with a different focus.

The analysis revealed that power issues and constructions relating to ability and competence were important in the process of problem definition in this setting. The ways in which the institutional context was influential in problem definition have also been highlighted. These issues have all been important in wider discourses about people with LD, as outlined in chapter one. The DP form of DA used in the current research involved going beyond exclusively examining the immediate context, and ideas explicitly drawn upon by speakers in the appointments, as might be more common in conversation analysis (Wetherell et al., 2001a). However, it did not focus on wider contextual issues as much as Foucauldian DA might. Conducting the present research using FDA would enable more in depth examination of the influences of historical and cultural context on the discourse than was revealed with the DP analysis. However, I would argue that the present analysis, with its focus on action orientation, was better able to answer the specific research question posed.

As discussed in the method chapter and in the section above, the advantages of using live data over interviews to research discursive phenomena have been noted (e.g. Potter & Hepburn, 2005). However, by using live data it was not possible to control the focus of appointments. This clearly contributed to the diversity of the data and made the process of refining and focusing the analysis into clear findings more difficult to achieve. Despite this challenge, the use of naturalistic data could be regarded as a strength of the current research. Potter and Hepburn (2005) have argued that it is likely to improve the ecological validity of findings. For the current research question, more contrived research methods could lead to findings that, although neater and more focused, are an artefact of interviews controlled by the questions of interviewers.

The analysis examined the action orientation of language related to the process of negotiation of problem definition. It therefore focused on the interactive elements of talk, such as how the people present affected one another through what they said and argued for particular positions. As a result there was less focus on any particular themes drawn upon on a more individual level. Only a few IRs were highlighted in the analysis. These were the ones that came up in a number of different people's talk across different

appointments, and which directly related to the process of problem definition. A number of further IRs were also apparent in individual appointments. Although these were relevant to the definition of specific problems, they were not highlighted because of the decision to focus on the process of problem definition across appointments, and to highlight actions that were more common in the data instead. An analysis focusing on fewer appointments might have been able to consider more of these individual IRs in relation to problem definition.

The fact that the findings from across the appointments are presented together could be considered a limitation. Related to the point above, some of the content of individual appointments was lost. However, there was a complex array of different findings, which needed to be organised coherently. Outlining the main actions together, whilst also highlighting important or unusual cases seemed the most logical way of doing so. Many examples from the data were included to illustrate findings, as recommended by Elliott et al. (1999), and it is hoped that this enables readers to see how conclusions were reached.

The differences between the talk of different psychologists have not been considered in detail in the current research either. This was partly because there were more similarities than differences between their talk and there did not seem to be a great impact of the particular style of any one psychologist. It is, however, worth highlighting the fact that one psychologist participated in four appointments, while all the others were different. It was beyond the scope of the current research to compare the style and discourses drawn on by different psychologists in detail, and there may have been particular features of that one psychologist's talk that influenced findings. However, all of the conclusions reached about actions in the talk of psychologists related to more than one person, unless it was specifically stated that they were exceptional findings, and there were no obvious differences that particularly stood out. In future it could be of value to carry out further similar research, including participants from different services, as this might highlight a greater diversity in the discursive effects of the talk of psychologists.

A further issue relating to the current research is that the purpose of psychology sessions is often to work with people to shape and change their perceptions of their problems. The process of challenging and disputing the descriptions and opinions put forward by service users is part of some forms of therapeutic work. Often this process might start to take place in early sessions. The process of problem definition being carried out is therefore not simply designed to find out what the problems are in an objective a way as possible. In my analysis I tried to avoid including sections where therapeutic work beyond the process of assessment was clearly taking place, as I thought that this was a dimension of problem definition outside the area of interest for the current research question. However, it is likely that the aim of psychologists to work with people on their perceptions of their difficulties may have impacted upon findings on how problem definition is negotiated, and it is therefore worth being mindful of this possible dimension to the process.

As outlined by Willig (2008), examining issues of power can be an important component of DA. The method can also take a critical approach to looking at the impact of the context in which the language is used, and the effects of one person's talk on another (Edley, 2001). However, it is worth noting that the purpose of this is not necessarily to make judgements about whether the actions observed in the talk are right or wrong in that setting. Rather, the aim is to raise questions about the effects of certain uses of language, particularly in relation to those discourses or IRs that could be described as dominant, or seen as 'common sense' in a particular context. In the analysis chapter and earlier in the discussion I have talked about psychologists (and sometimes carers or people with LD) 'taking control' over decisions. Although this interpretation could be seen as undesirable in some contexts, or sound critical, my analysis is not necessarily intended to be critical of the psychologists' work. On occasions it may be very helpful and desirable to the person with LD for a psychologist to 'take control', for example if a service user is struggling to provide an answer to a question. Relating to this, I have argued that psychologists were powerful in the appointments at times. However, it is important to acknowledge that those observations about particular power

differentials might only relate to some elements of the decision-making process. In addition, some therapeutic models provide frameworks for working in which clinicians would be encouraged to influence problem definition and control it to some degree by giving formulations or summaries that emphasise particular aspects of service users' concerns. Some of the actions identified in the psychologists' talk may therefore be related to influences from these models of working. I have argued that actions such as 'influencing' and 'controlling', and power relations affected the decisions reached on what the difficulties were. However, although in some cases I have raised questions about whether that effect is a desirable one or not, I do not aim to make judgements one way or the other.

Finally, another possible limitation of the current analysis is that the data was audio only, and therefore the analysis did not include gestures or body language. Audio recording had the advantage of being less intrusive than video, but future research might benefit from including visual features that form part of communication in the analysis.

4.3 Clinical Implications

The current research has provided further demonstration of the validity of DA for producing novel and interesting findings, which are also clinically relevant. Potter and Wetherell (1987) have highlighted the importance of meeting this criterion as a mark of good quality research. In this section I have outlined a number of clinical implications of the current research.

The findings have demonstrated that it is important for psychologists to remain aware of their power over problem definition in appointments. Some degree of power imbalance may often be inevitable in this context, but reflecting on this issue should allow psychologists to consider how their influence may lead to the privileging of certain definitions of problems, and the locating of blame in particular ways. It may be necessary for psychologists and others working with people with LD to be cautious about practices like reframing problems early in sessions during problem definition,

because of the possibility that these actions enable them to exert excessive control in the initial stages of therapeutic work. In the current research, some of the people who had known the psychologists previously were better able to be assertive in defining their problems. It is therefore possible that it might be more appropriate for psychologists to reserve some therapeutic techniques and tools for defining problems until later in the course of work together, when people are more familiar with the situation, and might be better able to exert some influence over problem discussion. Current political and NHS policy drives to offer services in an efficient and time-limited way do, however, present challenges to taking more time over the assessment process in practice (e.g. DoH, 2008).

Hepburn and Wiggins (2007) have discussed how DP can be a useful approach to studying therapeutic interactions, and can raise questions about therapeutic theory. The current research supports this point, and has raised some questions about the effects of therapeutic techniques such as scaling problems and focusing on feelings. Although it may be considered empowering for psychologists to offer therapy and interventions to people with LD as they would in other contexts, in practice it may not actually be empowering if the concepts and language psychologists are using is not relatively easy for people to understand. For example, by privileging psychological models that require talk about feelings when people may not be able to understand and describe these complex inner experiences, psychologists exert control over the conversations. This focus might also deprive the client of other ways of working with problems that are more collaborative by virtue of being more amenable to being understood. In their chapter about the effects of therapeutic formulations, Antaki, Barnes and Leudar (2007) have noted that there can be a conflict between analysis findings and therapeutic theory. This issue may also apply to the current project, which has also raised questions about the effects of formulations and some other techniques used in the appointments analysed. However, pressures such as guidelines coming from the National Institute for Health and Clinical Excellence and other national pressures to offer evidence-based treatments, as highlighted in the New Ways of Working reports (e.g. DoH, 2007b), may constrain what psychologists can offer in terms of therapeutic interventions. Although

the research raises important issues, and could be used to influence debates about the services provided to people with LD, on a practical level there are competing influences on how psychologists can work.

A further implication is that the use of simpler language in general could help some people with LD to participate more fully in the process of problem definition. By avoiding long and complex verbal explanations, and considering the difficulties for some people of following talk about process, or talk that requires thinking indirectly about problems, psychologists could better empower people with LD in this setting. Ongoing practical difficulties with meeting the current government agenda of providing choice and control for people with LD over their lives have been highlighted in the literature (Bowey et al., 2005; Brown & Brown, 2009). Through research such as the current project, psychologists and other professionals or staff teams working with people with LD might be able to reflect on their practice and work towards meeting government recommendations such as those in the Valuing People documents (2001, 2007) more effectively. The findings could be used to reflect on the details of what can make empowering people with LD difficult. It might also be of value to consider whether choice and control is always what people with LD want or need. If people are not going to have control over certain aspects of how their difficulties are defined and worked on, it may be better for this to be acknowledged explicitly, rather than using the language of choice to present limited options that fit with service agendas.

This project was not designed to compare the impact of having carers present with not having them present in appointments with people with LD. However, some of the findings on how carers contributed to problem definition could also be reflected upon, and might contribute to future decisions made about who to invite to appointments.

Finally, it is worth emphasising that there is a complex relationship between research findings and good practice, and the current project is only a small study, looking in detail at the discourse of very few people. The findings cannot be generalised, but provided this is kept in mind, they could inform clinical practice in similar areas.

4.4 Further Research

Throughout this chapter a number of variations on the current project, which could make fruitful further research have been highlighted. In addition, it would be interesting to know whether the findings are unique to problem definition in appointments with people with LD or if they might apply to others in similar settings. These issues could therefore be examined in areas such as mainstream adult psychology services or children's services.

Some of the particular actions found in the current data could also be investigated in further detail. For example, although some work has been carried out on the effects of making formulations and summaries of what another person has said, further research in psychology assessment appointments in general, or in other settings with people with LD could add to the literature.

The use of interpretative repertoires or discourses locating problems as internal to a person or in environmental factors during the process of problem definition could also be investigated further, either using DP or FDA.

4.5 Reflections

At the beginning of this thesis and in chapter two, I have briefly outlined some details of my own particular background and perspectives in relation to the research, as recommended by Elliott et al. (1999). Here I present some further reflections on how my views may have influenced the findings.

In listening to the appointments I often recognised what the psychologists were doing from my own work. For example, I have drawn attention to some of the effects of 'testing severity', while I am aware that I might sometimes do this when carrying out assessments for therapeutic work myself. This is likely to have had effects on how I analysed the data. I think that at times my awareness of similarities between my own practice and the talk I was analysing made it difficult for me to critically analyse the effects of that talk. In addition, I think that my awareness that I would be presenting the research findings to the psychologists who participated may also have made me more

cautious in how I included critical elements in the analysis. However, I tried to remain aware of these reactions and think about their effect on my findings and interpretations of the data. I think that coming from the same profession as the psychologists whose talk I was analysing had advantages and disadvantages. Disadvantages because I perhaps identified with them quite strongly in some cases, and advantages because I think that my understanding of their work meant it was perhaps easier to analyse the actions in their talk than it would have been if I had no knowledge about their work.

I think that it is also important to mention some of my thoughts while listening to and transcribing the appointments for the first time. The stories that I heard about the lives of the people who participated often affected me. As a person who was unconnected with their lives, I felt very privileged to have been able to witness to their descriptions of their experiences. In some cases it is possible that the ways in which I identified with or empathised with participants could have affected how I carried out the analysis. For example, I was saddened by the stories of some of the people with LD about difficult experiences in their lives, and this perhaps led me to feel more strongly about the importance of not minimising environmental factors when defining problems. Through the use of my reflective research diary, from discussions with my supervisors, and following their input in checking my analysis for credibility, I hope that I have been able to minimise biases caused by these personal reactions.

4.6 Conclusions

This research has used discourse analysis to examine the process of negotiating problem definition in the appointments of a psychology service for people with LD. Important issues have been highlighted, including the impact of power relations in the setting on how problems are defined and discussed. Details of processes involved in exerting control over conversations and decisions made were revealed. In addition, the analysis showed that when problems were constructed as internal to people with LD, environmental factors were sometimes neglected. Descriptions of problems that privilege the perspectives of professionals may not fit well with how some people with LD see their difficulties. A number of clinical implications of these findings have been suggested, and the DA method can provide professionals with a useful tool for reflecting on their practice. The research has produced novel findings in the area, but it also highlights many further questions.

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APPENDICES

Appendix 1: Literature Search Strategy

MEDLINE (1966 onwards), PSYCHINFO (1896 onwards), and EMBASE (1980 onwards) were searched for relevant literature using the following search terms.

\$ indicates a truncation

e.g. disabili\$ searched for all words with this root

goals in therap\$

learning disabili\$ and therap\$ goals

learning disabili\$ or mental retardation or intellectual disabili\$) and therap\$ goals

therap\$ interaction and discourse

learning disabili\$ and discourse

learning disabili\$ and discursive

discourse and therap\$ and learning disabili\$

discursive psychology and therap\$

discourse and learning disabili\$ or intellectual disabili\$ or mental retardation

learning disabili\$ and power

learning disabili\$ and choice

Abstracts were read to determine the relevance of the papers to the current research. The final decision to include a paper was also based on the quality of the research as described in section 1.0.

Further relevant literature referenced in these papers was also followed up.

Appendix 2: Ethical Approval Letters



National Research Ethics Service

Bradford REC
 Yorkshire & Humber REC Office
 Millside
 Mill Pond Lane
 Meanwood
 Leeds
 LS6 4EP

Email: laura.sawiuk@leedspft.nhs.uk
 Tel: 0113 3050166

Chairman: Professor Alan C Roberts
OBE TD DL MPhil PhD LLD, FLS CBiol FIBiol
 Extension Block
 St Lukes Hospital
 Little Horton Lane
 Bradford
 BD5 0NA

Tel: 01274 365508
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Email: alan.roberts@bradfordhospitals.nhs.uk

20 May 2010

Miss Alice Brady
 Psychologist in Clinical Training
 The Leeds Teaching Hospitals NHS Trust
 5 Trelawn Place, Headingley
 Leeds
 West Yorkshire
 LS63JP

Dear Miss Brady

Study Title: **Power, Communication and Discourse in Assessment Appointments with People with Learning Disabilities**
REC reference number: **10/H1302/39**
Protocol number: **1.0**

The Research Ethics Committee reviewed the above application at the meeting held on 18 May 2010. Thank you for attending to discuss the study.

Ethical opinion

Considering whether the act of recording the interaction might change its nature, you agreed with the Committee that this might be an issue, though you would take this into account in the data analysis.

You confirmed that if a participant loses capacity in the course of the study then data will be retained, as per the participants original wishes. If consent was actively withdrawn then data would be withdrawn also.

The members of the Committee present gave a **favourable ethical opinion** of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
REC application		20 April 2010
Protocol	1.0	04 May 2010
Investigator CV	Alice Brady	29 March 2010
Participant Information Sheet: For Service Users	1	04 May 2010
Participant Information Sheet: For Staff Members	1	04 May 2010
Participant Consent Form: For Service-Users	1	04 May 2010
Participant Consent Form: For Family Members or Carers	1	04 May 2010
Participant Consent Form: For Staff Members		
Letter of invitation to participant	1	04 May 2010
Evidence of insurance or indemnity		08 October 2007
Referees or other scientific critique report		
Research Panel Constitution		
Investigator CV	Tom Isherwood	30 March 2010

Investigator CV

David Cottrell 12 April 2010

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

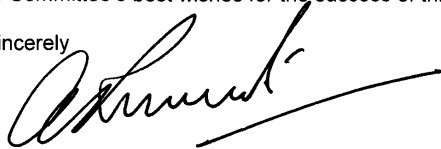
The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1302/39**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



Professor Alan Roberts
Chairman

Email: laura.sawiuk@leedspft.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*



National Research Ethics Service

Bradford Research Ethics Committee

Yorkshire & Humber REC Office
 Millside
 Mill Pond Lane
 Meanwood
 Leeds
 LS6 4EP

Tel: 0113 3050166
 Fax:

17 June 2010

Miss Alice Brady
 Psychologist in Clinical Training
 The Leeds Teaching Hospitals NHS Trust
 Psychologist in Clinical Training
 5 Trelawn Place, Headingley
 Leeds
 West Yorkshire
 LS63JP

Dear Miss Brady

Study title: Power, Communication and Discourse in Assessment
 Appointments with People with Learning Disabilities
REC reference: 10/H1302/39
Protocol number: 1.0
Amendment number: 1
Amendment date: 04 May 2010

The above amendment was reviewed at the meeting of the Sub-Committee held on 15 June 2010.

Ethical opinion

Favourable Opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Consent Form: Family Member / Carer	2	07 June 2010
Participant Consent Form: Service User	2	07 June 2010
Participant Consent Form: Staff Members	2	07 June 2010
Notice of Substantial Amendment (non-CTIMPs)		04 May 2010

Membership of the Committee

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1302/39:	Please quote this number on all correspondence
---------------------	---

Yours sincerely



Laura Sawiuk
Committee Co-ordinator

E-mail: laura.sawiuk@leedspft.nhs.uk

Enclosures: List of names and professions of members who took part in the review

*Copy to: Mrs Rachel E De Souza
Faculty Research Office
Level 10, Worsley Building
University of Leeds
Leeds LS2 9JT*

Appendix 3: Trust Research & Development Department Approval Letter



Our Ref: 2010/186/L

Miss Alice Brady
5 Trelawn Place
Headingley
Leeds
LS6 3JP

13 July 2010

Dear Alice,

RE: Power, Communication and Discourse in Assessment Appointments with People with Learning Disabilities

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and has been approved by the relevant Partnership Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within [REDACTED] NHS Foundation Trust.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	1	20 April 2010
Participant Consent Form for Participant Consent Form for Service Users	2	07 June 2010
Participant Consent Form for Family Member/Carer	2	07 June 2010
Participant Consent Form for Staff Members	2	07 June 2010
Participant Information sheet: Participant Consent Form for Service Users	1	04 May 2010
Participant Information sheet: For Staff Members	1	04 May 2010
Letter of Invitation to Participant	1	04 May 2010

The Partnership members are:

- South West Yorkshire Partnerships NHS Foundation Trust
- Leeds Partnerships NHS Foundation Trust
- University of Leeds
- Leeds Metropolitan University
- University of Bradford
- University of Huddersfield

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This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval. Failure to do this will lead to permission to carry out this project being **withdrawn**. If you make any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.
- You must comply with the Partnership's procedures on project monitoring and audit.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care¹(RGF). Failure to do this could lead to permission to carry out this research being **withdrawn**.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Details of participant recruitment to projects should be carefully maintained, and supplied to the R&D Department on request.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. Partnership R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator²**.

They should **also** be reported to:

- The Partnership R&D Department
- the Research Ethics Committee that gave approval for the study
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved by both the Trust/s and Research Ethics Committee granting initial approval, before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

¹ Details from:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=WdeITv

² SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

The Partnership members are:

- South West Yorkshire Partnerships NHS Foundation Trust
- Leeds Partnerships NHS Foundation Trust
- University of Leeds
- Leeds Metropolitan University
- University of Bradford
- University of Huddersfield

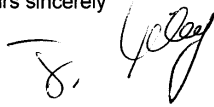
Projects sponsored by organisations other than the Partnership Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

Yours sincerely



John Hiley
Research Management and Governance Manager

CC Dr Tom Isherwood

The Partnership members are:

- South West Yorkshire Partnerships NHS Foundation Trust
- Leeds Partnerships NHS Foundation Trust
- University of Leeds
- Leeds Metropolitan University
- University of Bradford
- University of Huddersfield

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Appendix 4: Research Information for Staff Member Participants

Information Sheet for Staff Member Participants

Project Title: Negotiation of Problem Definition in the Clinical Psychology Appointments of a Learning Disability Service

You are being invited to take part in the above named research study.

The purpose of this information sheet is to provide you with details of the research and to let you know what participation would involve. Please take time to read the following information carefully.

The purpose of the research

Recent government papers have emphasised the need to promote the involvement of people with learning disabilities in choice and control over their lives, including over the services they receive. The purpose of the current research is to address the main research question is 'How is problem definition negotiated in assessment appointments with people with learning disabilities?'. The aim is to consider how the service users, families or carers and staff members present in these appointments are able to influence how difficulties are described, defined and discussed. It is hoped that this work will promote reflection on clinical practice in this context.

What participation will involve

It is your choice whether or not to take part in the research. If you agree to take part, this will involve having one or more of the assessment appointments you conduct recorded. In every case, recording of appointments will be contingent on all the people present giving informed consent to participation in the research.

Withdrawing from the study

If you agree to participate in the research, you can change your mind at any point while the research is ongoing. You do not have to give a reason. If you withdraw your consent, the data from appointments you were involved in would be destroyed, and would not be included in the research.

You can also withdraw your consent for the inclusion of specific appointments in the research at any point. Again, in that case the data from those appointments would be destroyed, and would not be included in the research.

Possible risks and disadvantages of taking part

It is possible that you may be concerned that the things you say in the appointments recorded will be evaluated. However, the purpose of the research is not to compare or criticise professionals. The aim is to conduct the analysis of the talk of people present sensitively and respectfully.

Possible benefits of taking part

It is hoped that reflection on the process of defining problems in assessment appointments with people with learning disabilities will lead to improvements in the quality of these interactions, and ultimately the quality of care provided. We hope to gain valuable information on how people with learning disabilities are able to express their views, and on what can facilitate the process of providing them with choice and control in this setting.

Confidentiality

The data from appointments recorded will be kept strictly confidential. Only the researchers will be able to identify you as a participant. When not being used, the study data will always be kept locked securely in the main researcher's office.

If you agree to take part your name and any other identifiable details such as the location of the service will be changed or removed from any data included in the research. Some of the things you say in the assessment appointments might be used when the research is written up, but care will be taken to ensure nobody is able to tell who said it.

Data protection

Transcriptions of tape recordings will be made anonymous, and will be locked in a secure place. Tapes and transcriptions will be kept in a secure location for seven years and then destroyed according to University of Leeds regulations.

Who has reviewed this research?

The research has been reviewed by a research panel organised by the University of Leeds as part of the requirements of the main researcher's doctoral training. The study has also been reviewed by Bradford ethics committee, and was given a favourable ethical opinion for conduct in the NHS. It was also reviewed and approved by Leeds Partnerships Foundation Trust R&D department.

How the research findings will be shared

This research forms part of the main researcher's doctoral thesis and will be written up for the University of Leeds. The research will also be submitted for publication in a peer reviewed journal. The main researcher will also offer to present the findings of the research to participating services. Research participants will be given the option to attend a presentation of the research findings, or to receive a written summary. A summary for participants will also be produced using simplified language and images.

If you are interested in taking part in the study:

The main researcher, Alice Brady will arrange to meet with you at a convenient time to discuss the study further, and answer any questions you might have.

Contact details for further information about the research:

Alice Brady
Address: Clinical Psychology Training Programme
Charles Thackrah Building
Leeds Institute of Health Sciences
University of Leeds
101 Clarendon Road
Leeds
LS2 9LJ

Telephone: 0113 3430815

If you have any complaints or concerns:

Please contact the main researcher Alice Brady (contact details provided above), who will do her best to solve the problem. If you still have any concerns, you can raise these through the NHS complaints procedure.

Address: Complaints and Claims Manager

Telephone: -----

Appendix 5: Staff Member Participant Consent Form

Staff Member Participant Consent Form

**Project Title: Negotiation of Problem Definition in the Clinical Psychology
Appointments of a Learning Disability Service**

Name of Researcher: Alice Brady

Please
initial
box

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.

I agree to take part in the above study.

Name of Staff Member Participant:

Date:

Signature:

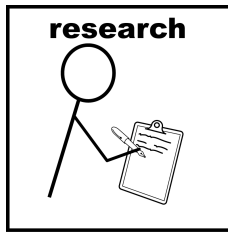
Name of Person Taking Consent:

Date:

Signature:

Appendix 6: Service User & Family Member or Carer Participant Research Information

Dear



You are being invited to take part in some research in our service.



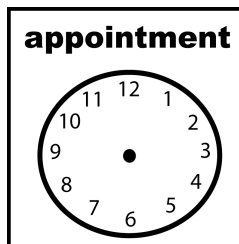
The information with this letter tells you more about the research.

Please read the information carefully.

If you are interested in being in the research, please let the department know.



Please show the research information to any family or carer coming with you to your appointment.




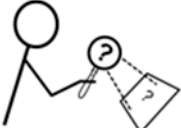
If you do not want to be in the research, please come to your appointment as normal.

Thank you


Yours sincerely


The Psychology Department


<p>research</p> 	<p>My name is Alice Brady. I am learning to be a psychologist at Leeds University. I am doing some research.</p>
--	--


<p>finding out</p> 	<p>I am doing some research.</p> <p>I want to find out about how people talk to each other in appointments.</p> <p>I want to find out how psychologists can help people more.</p>
---	---

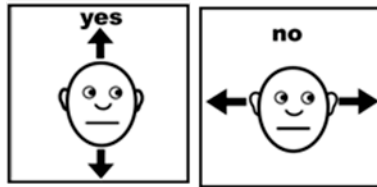
How will I find this out?

<p>on tape</p> 	<p>I want to tape record your first meeting with your psychologist.</p> <p>I will listen to the tape.</p> <p>I will think about how you and the psychologist talk to each other.</p>
---	--

<p>get it right</p> 	<p>I will tell people what I find out to help them get it right.</p> <p>This could help make the service better for people.</p>
--	---

<p>consent</p> 	<p>You can choose to say yes or no about doing this.</p> <p>You will still get the same service.</p> <p>The psychologist can help you decide whether you say yes or no.</p>
---	--

<p>ask questions</p> 	<p>If you want I will come and meet you before your appointment so you can ask questions.</p>
---	---



If you say yes to the research you can change your mind any time.

You do not have to say why.

If you change your mind, I will not use your information in the research.



If you say I can tape record your meeting:



I will keep some information **private**.

Nobody will know your name.

Nobody will know other private information about who you are.



I will write a report about the research.

I will say how psychologists can help people talk about what they feel.

I might write some of the things you said to the psychologist in the report.

Nobody will know you said them.

If you want I can come and tell you about the report.



I will keep all the information about you in a safe place.

I will keep the tapes of you locked in a safe place.

I will not show them to anybody outside the research.



If you want I can tell you more information about this research.

This is my address and phone number to ask for more information:




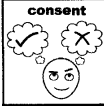
Clinical Psychology Training Programme
Charles Thackrah Building
Leeds Institute of Health Sciences
University of Leeds
101 Clarendon Road
Leeds
LS2 9LJ



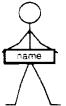
Phone: 0113 3430815

Appendix 7: Service User and Family Member or Carer Consent Forms


research


consent


Service-User Participant Consent Form

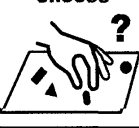
name


Write your name in the box if you agree:


information



I have seen the research information and I understand what the research involves

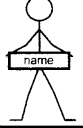


I know that I can change my mind any time

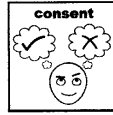
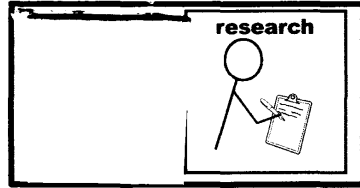
choose


Please choose one and put your name in that box:

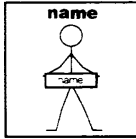
yes

I agree to take part in this research.

no

I do not agree to take part in this research.

name 	Your Name:	Name of Person Taking Consent:
date 	Date:	Date:
signature 	Your Signature:	Signature of Person Taking Consent:



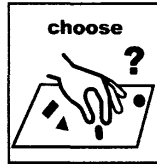
Family Member or Carer Participant Consent Form



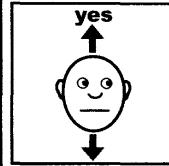
Write your name in the box if you agree:



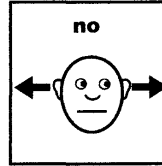
- I have seen the research information and I understand what the research involves
- I know that I can change my mind any time



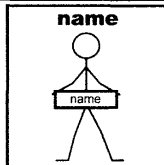
Please choose one and put your name in that box:



I agree to take part in this research.



I do not agree to take part in this research.



Your Name:

.....

Name of Person Taking Consent:

.....



Date:

.....

Date:

.....



Your Signature:

.....

Signature of Person Taking Consent:

.....