
Counselling Psychologists’ Talk about ‘Psychopathology’ and Diagnostic Categories: A Reflective Account of a Discourse Analytic Study

Mark Craven and Adrian Coyle

The purpose of this report is to provide readers with a sense of what the outcome of a discourse analytic study may look like and how it might be presented when writing a journal article or a student dissertation. In the study presented in this report, counselling psychologists were interviewed about their views and understandings of ‘psychopathology’ and the use of diagnostic categories in counselling psychology practice, as discussion of these concerns has been part of the domain’s construction of its professional identity. The analysis presents participants as drawing upon two contrasting repertoires in constructing their positions on these issues, with the same participants drawing upon both repertoires. Throughout the report, text boxes are used at pertinent junctures to highlight important issues in writing up discourse analytic research and analyzing data through discourse analysis.
Introduction

Counselling psychology is a relatively new psychological domain in Britain, with the Counselling Psychology Section of the British Psychological Society (BPS) having been established in 1982. While BPS Sections are concerned with specific branches or aspects of psychology, BPS Divisions are concerned with particular professional and practical domains of psychology and focus upon standards of professional education, knowledge and conduct among their members. After a sustained campaign, the Counselling Psychology Section attained Divisional status in 1994.

Throughout this process and subsequently, counselling psychology in Britain has been engaged in a (sometimes explicit) process of constructing its identity as a profession. It has done this in various ways. Over time in its texts, counselling psychology moved towards increasingly fine-grained constructions of difference from and similarity to related professions (particularly clinical psychology) in terms of value systems and standard models of psychological science (Pugh and Coyle, 2000). The professional positioning of counselling psychology has also been attempted through debate on issues relevant to other therapeutic professions such as evidence-based practice (the contention that the delivery of therapeutic interventions should be informed by ‘evidence’ of their ‘effectiveness’) (Milton, 2003), the use of psychometric instruments to assess and measure psychological ‘problems’ (Kanellakis, 2004) and the use of diagnostic categories of ‘psychopathology’ to ‘describe’ clients’ difficulties (Strawbridge and James, 2001). In many of these debates, attempts have been made to construct a position on these issues that is distinctive to counselling psychology, at least in the basis of the position if not in its nature.
In the debate on ‘psychopathology’ and the use of diagnostic categories, the basic tension or dilemma is said to relate to whether counselling psychology ought to embody a stance that reflects a humanistic value base – emphasizing clients’ understandings and processes rather than trying to use therapeutic ‘expertise’ to classify clients’ ‘disorders’ – or should embrace the symptom- and diagnosis-focused approach epitomized by the American Psychiatric Association’s (2000) *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This latter approach has been constructed as a ‘medical model’ of mental distress and as embodying the fundamental assumptions of positivist-empiricist science (see Chapter 2 in this volume), such as the idea that distress can be legitimately and accurately categorized (Boyle, 1999). This stance has dominated scientific and psychotherapeutic world views with regard to ‘psychopathology’, although it has been subjected to sustained critique (for example, see Fee, 2000; Parker et al., 1995).

In order to obtain insight into how counselling psychologists may make sense of this issue, the study presented in this report examined how counselling psychologists talked about ‘psychopathology’ and the value/use of diagnostic categories within their clinical practice, with the aim of identifying how these ‘objects’ are constructed and the discursive resources that are employed in their construction.

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**Box R3.1: Pitfalls in writing literature reviews for social constructionist studies**

The introduction to this report may seem very brief, which is not only due to the word limit imposed on the report. We did not want to discuss counselling psychology, ‘psychopathology’ and diagnostic categories in more detailed terms because we would
then having been overly engaging in the process of construction that we wanted to explore in the study. Of course, it is impossible to avoid this entirely. Can you see how, even in this brief introduction, we have constructed ‘counselling psychology’, ‘psychopathology’ and ‘diagnostic categories’ in particular ways?

Our short introduction has also largely helped us avoid some of the pitfalls associated with writing a literature review for a social constructionist study. In composing such a review, you need to adopt a social constructionist stance, even though you may be reviewing writing and research that comes from a very different epistemological position. This can be difficult but it can be helpful to present viewpoints in the literature as constructions of your research foci and to consider research not as revealing ‘truth’ about your research topic but as positing and legitimating a particular version of events.

**Method**

Eight chartered counselling psychologists (six women and two men) were recruited through personal contacts and by ‘snowballing’ from an initial sample (that is, having participants nominate others who might wish to take part). Four had qualified within the previous five years and four had attained ‘chartered counselling psychologist’ status on the basis of their professional experience (this latter possibility was available for a limited time when ‘chartered psychologist’ status first became available). Participants had a range of clinical experience in private, primary, secondary and tertiary health care contexts and in and private settings.
It has been recommended that qualitative researchers should situate their samples – that is, they should ‘describe the research participants and their life circumstances to aid the reader in judging the range of people and situations to which the findings may be relevant’ (Elliott et al., 1999: 228). Some qualitative research reports do this in great detail. Discourse analytic work also needs to situate samples but researchers (and readers) should remember that, no matter how much detail is provided, these ‘descriptions’ can never capture all the potential positions from which participants may speak in the data. For example, it would be a mistake to assume that, just because all the participants in our study were counselling psychologists, they spoke consistently from that position throughout their interviews. As was noted in Chapter 7, any individual may assume some positions fairly consistently within their talk while other positions are more temporary. Hence, participants could have spoken from a wide range of possible positions across their interviews – for example, positions as counselling psychologists, psychologists, therapists, men, women, radicals or good employees. Nevertheless, samples in discourse analytic reports should be situated with sufficient specificity to allow readers to assess the contexts to which the analyses most readily apply and to identify which people and contexts might usefully be studied in future research.

Data were collected through individual interviews. A relatively open interview schedule was developed which asked participants about their personal and professional views or understandings of ‘psychopathology’ and the use of diagnostic categories for mental distress within counselling psychology practice. Interviews were carried out by Mark Craven in participants’ places of work, their homes or in a university setting. Interviews
were audiotaped and transcribed using a basic version of the notation scheme developed by Atkinson and Heritage (1984).  

Box R3.3: Data collection strategies in discourse analytic studies

During its short history within psychology, discourse analytic research has moved away from gathering data through interviews and towards naturally-occurring data, such as media materials and recordings of ‘unstaged’ social interactions. Where interviews are used, these tend to be focus group interviews rather than individual interviews, which carry a greater risk of the participants orienting consistently to the artificial interview context. It can be argued that data from individual interviews are so specific to the research context that they may be of limited value. Focus group interviews carry the same risk but perhaps to a lesser extent as it may be possible – with care and skill on the part of the interviewers – to foster a relatively free-flowing discussion. Given that we sought to gather data from very busy professionals in the present study, it would have been difficult to have organized them into one or more focus groups. For practical reasons, we therefore opted for individual interviews. While we were aware of the limitations this would impose on our analytic outcomes, we felt that it was preferable to have limited data on this important topic for counselling psychology rather than no data at all.

Transcripts were subjected to a relatively micro-level form of discourse analysis, looking at the rhetorical functions and action orientation of the data, but with attention also being paid to the discursive resources through which these discursive practices were produced (Potter and Wetherell, 1987; Wetherell, 1998; Willig, 2001). In a preliminary coding
process, interviews were read line by line at least twice to identify portions of text that were relevant to the research question and appeared analytically interesting. The analytic process then involved further reading and rereading of data extracts, attending to the questions, ‘Why is this particular utterance here?’, ‘What might this particular utterance be doing?’ and ‘What discourses are being invoked in this utterance?’

The analysis that we have produced reflects not only the data but also our theoretical commitments and interests as a critical counselling psychologist (Mark Craven) and social psychologist (Adrian Coyle) (and doubtlessly other factors which we cannot name). We do not claim to have uncovered ‘truth’ about counselling psychologists’ views, merely to have illuminated some local and contingent ‘truths’ on the research issues. However, our analyses are accompanied by quotations which demonstrate the basis of the interpretations in data, so readers can assess their persuasiveness and offer alternative readings. Note that, in the analyses, direct quotations from participants are either indented or placed within double quotation marks; single quotation marks are used to signify constructed ideas that are important to the research questions.

Analysis

Two opposing accounts/constructions predominated in participants’ talk about ‘psychopathology’ and diagnostic categories. We have identified these as the ‘empiricist’ and ‘contingent’ repertoires. We shall now present what we found to be the salient features of these repertoires before examining the interplay of these repertoires in one data excerpt.
What we refer to as the ‘empiricist’ repertoire concerned modernist notions and assumptions regarding such basic issues as ‘reality’, ‘knowledge’, ‘science’, psychological ‘disorders’ and their ‘cure’, together with the principles of modern science implicit in contemporary psychology. This perspective is often referred to synonymously as ‘positivism’, ‘naïve realism’ or the ‘received view’ (depending upon the speaker’s position) and provides the ground in which the empiricist repertoire is rooted.

Throughout the interviews, participants explicitly and implicitly made use of an empiricist discourse as they described, explained and made attributions about the ‘objects’ towards which they were orienting. This appeared to serve many functions, the most salient of which was to construct a version of events wherein ‘psychopathology’ was granted ontological status as a ‘thing’ that ‘exists’ independently in the world. This particular construction appeared intimately bound up with legitimating the use of diagnostic categories. The operation of the empiricist repertoire can be seen the following brief extracts:

I suppose you’re looking for things that would (4) yeah (.) I haven’t thought about this like this before but er (.) but that would (.) differentiate them from how anybody might react in a particular situation for instance or if they have (1) if they’re thinking in ways that wouldn’t be within what you’d think to be the normal range.

(Diana)
She’s a paranoid-schizophrenic (1.5) with CLEAR EVIDENCE of that (.) auditory and visual hallucinations (.) many-many symptoms (1) (Nathan)

The ‘out-there-ness’ of ‘psychopathology’ is achieved here by using the metaphor of scientific discovery and visual, observational and legal terms, such as “looking for things” and “CLEAR EVIDENCE”. Crucially, the use of this metaphor constructs the discoverer (the psychologist) as merely revealing something that had been there all along: ‘psychopathology’ exists in an objective sense so it can be discovered. In these extracts, the ‘facts’ of psychopathology come in the form of “evidence” which is constituted by the identification of “symptoms”.

The sense of ‘objectivity’ is made intelligible through recourse to an empiricist discourse which operates in dualistic terms by creating a clear separation between the subject and object or between the knower and the known. This duality is evident in the extract from Nathan’s interview, where he says of a client, “She’s a paranoid-schizophrenic”, invoking a diagnostic category and then further legitimating this ascription through professional vocabulary in his reference to “auditory and visual hallucinations”.

Likewise, in her interview, Diana referred to, “if they’re thinking in ways that wouldn’t be within what you’d think to be the normal range”. Such talk positions the speaker (the psychologist) (and also the listener/interviewer) as the ‘knower’ – an ‘expert’ who holds a privileged position in relation to the experiences of the client so, through their professional logic, they can legitimately define a client’s thinking as abnormal and categorize them as pathological.
The features of the empiricist repertoire identified in these brief extracts were common across the interviews, such as when Annabel said of the psychologist, “you’re the one with (.) the experience and knowledge (.) the expertise (.) you know (.) to make offers of treatment”, when Janine referred to “someone presenting with a clear panic disorder” and when Kate said of ‘anorexia’, “you can see (.) no doubt about it”.

‘Contingent’ repertoire

Though the empiricist repertoire appeared to be central to participants’ accounts, they also drew upon what we have termed a ‘contingent’ repertoire. Whereas the empiricist repertoire provided a means of talking about ‘psychopathology’ and diagnostic categories at a more impersonal, theoretical and ‘objective’ level, the contingent repertoire constructed the use of diagnostic categories as a less than straightforward endeavour that was influenced by a number of factors – for example, “client understanding and desired outcome” (Diana), “personality factors” (Nick), “individual experiences” (Charlotte), “training” (Sue), “therapeutic orientation” (Janine) and “philosophical viewpoint” (Nathan). For example, speaking about diagnostic criteria and categories, Nick said:

I think it depends (.) you know some criteria or some labels are quite useful some really aren’t [ ] so I guess I take it with a pinch of salt really (.) so at the end of the day it’s what it means to the client (.) it’s what concerns the clients (.) erm (.)
what they’re expressing or able to express which I find most important rather (.)
that I go on (. ) rather than whatever diagnosis they’ve received.

Here Nick positions himself as somewhat ambivalent about the possibility of achieving any fixed or ‘objective’ truths regarding ‘psychopathology’ and the utility of diagnostic categories. This redirects the focus of his account towards his actual concerned involvement and interaction with clients (‘it’s what it means to the client (.) it’s what concerns the clients’) and helps to work up and legitimate a contrasting account where the diagnostic venture and the utility of diagnostic categories only make sense in relation to their context of usage. As such, ‘understanding’ can be interpreted as being discursively linked to action and conduct.

*Dilemmatic dances*

**Box R3.4: How much data to present in discourse analytic reports?**

Discourse analysts vary in the amount of data they present in their research reports. Some offer many brief extracts of data; others present a few relatively lengthy data extracts; others present a combination. Thus far, we have presented analyses that are based on relatively short data excerpts in order to establish the positions that will be examined in their interplay in this section. We are aware that this could be seen as problematic. The data have been presented in a decontextualized form, so the reader cannot see what questions elicited the data and cannot ascertain the role played by the interviewer in shaping the data. While we would have liked to have provided more data,
including the interviewer’s interventions, the word limit that we faced in writing this report made this impractical. Discourse analytic researchers routinely face this problem when writing up their work for publication and need to balance the requirement to ground interpretations in textual evidence with the desire to cover adequate interpretative ground. We felt that we could tolerate presenting limited data in the previous sections as we present a more extended data extract in this section. However, again compromises have had to be made because ideally we would have wanted to present more than one detailed extract to avoid creating the impression that our analyses lack a wide empirical basis. Note how we try to manage this by presenting snippets of data at the start which we hope serve to deflect that reading of our analyses.

Rather than participants having access to or only using an empiricist or contingent repertoire, both repertoires often occurred within accounts from the same participants, with the contingent repertoire acting in contrast to the empiricist one. The opposing nature of these repertoires was often explicitly constructed as problematic for participants or as locating them within a dilemmatic position. For example, participants said of these opposing repertoires, “there are radically opposing philosophical views” (Sue), “that’s where the problems start” (Charlotte), “so you’re automatically in a funny position” (Diana) and “it was a huge dilemma” (Janine). Here we focus specifically on the dilemmatic nature of participants’ accounts as they orient to the issues of ‘psychopathology’, diagnostic categories and their therapeutic practice. There were several pervasive themes across the texts relating to the dilemmatic aspects of ideology associated with these repertoires (Billig et al., 1988). Here we focus upon the tension between authority and equality.
In the following extract, as Charlotte orients to the use of diagnostic categories, we find ambivalences between authoritarian expertise on one hand and democratic egalitarianism on the other as she manages her identity as a counselling psychologist:
Charlotte: I mean not in the sense that I think that diagnostic categories are absolutely necessary and that’s what we should use and that’s how (. ) we should think (. ) you know (. ) how we should formulate client problems or whatever but (. ) in terms of the necessity of (1.5) erm not necessarily the necessity but (. ) yeah in terms of the necessity me to have an understanding of the DSM (. ) and be able to use it (. ) and be able to you know speak this language (2) but this doesn’t necessarily (. ) affect me (. ) my practice when I am with a client on a one-to-one basis

Interviewer: Right

Charlotte: I wouldn’t you know call anybody borderline [personality disordered] or something or I wouldn’t you know do you see what I mean?

Interviewer: Yeah I’m trying to sort of (. ) it seems as though there are different levels to it in a way you’re saying that it’s different in your clinical work [ ] so I was just wondering can you maybe expand on what those differences are of possibly how come that it’s like that?

Charlotte: Well erm say for example I have this client who has been diagnosed as borderline personality and she has a severe personality problem erm the way I would speak with other professionals is going to be different than when I’m with her you know (. ) I’m not going to perhaps say to her (. ) “You have borderline” or “Given your borderline personality disorder this is what is best for you” I would probably say something to her like

Interviewer: [Mmm]

Charlotte: (. ) “You know we’re here together to think together what your needs are (. ) and you know how can we best (. ) erm help you”

Interviewer: Right (1) so okay so the right okay yeah
Charlotte: and er perhaps I might have in mind what might be helpful or best for her but I won’t necessarily (.). I will not say to her “Well I think because you are borderline I think you should be referred to [named hospital]” or something.

Interviewer: Yeah yeah okay

Charlotte: but I will try to work with her (.), to see what she wants and to see what’s best.
The extract begins with Charlotte distancing herself from the view of diagnostic categories that is embedded within the empiricist repertoire, in which the psychologist is positioned as an ‘expert’ who has the power scientifically and objectively to identify, categorize and treat ‘psychopathology’. Her narrative functions at an implicit level to challenge the correctness of the standard view that diagnostic categories provide the appropriate or only means of understanding ‘psychopathology’ and of formulating treatment. Initially this challenge is personalized as Charlotte uses first person pronouns which position her in opposition to this standard view, albeit in a qualified way, as in lines 368-9 (“I mean not in the sense that I think that diagnostic categories are absolutely necessary”): it is the \textit{absolute} necessity of diagnostic categories that is questioned. What immediately follows in lines 369-70 makes the inference available that what is advocated by the view she is opposing is that diagnostic categories should be used as the basis for understanding client problems (“‘and that’s what we should use and that’s how (...) we should think (... you know (...) how we should formulate client problems or whatever’”). Note that she does not present her opposition to the standard viewpoint in explicit terms, perhaps to manage her institutional accountability as a counselling psychologist. The use of “we” in lines 368-70 possibly functions to further manage the accountability of the speaker’s views by providing a line of insulation against rebuttals or the criticism that solely personal interests motivate her account. Of course, it is always possible that her lack of explicit opposition could demonstrate a sensitivity to her audience – in this case a counselling psychologist interviewer whose views on diagnostic categories were not known to her at the time of the interview.

As the account develops, Charlotte shows some hesitation and ambivalence before positioning herself as being held to account institutionally. In the midst of pauses,
linguistic stumbles and what conversational analysts call ‘repair’ (Nofsinger, 1991) in lines 370-3, she constructs herself as having no real choice in using diagnostic categories (‘in terms of the necessity of (1.5) erm not necessarily the necessity but (.) yeah in terms of the necessity me to have an understanding of the DSM (.) and be able to use it (.) and be able to you know speak this language (2)’). She positions herself at the professional and institutional level as being required or obligated to work within a particular professional framework of understanding and associated vocabulary. Though this is presented as a concrete reality, she nonetheless partially resists this forced positioning by constructing her own therapeutic practice with clients as not necessarily being affected (lines 373-4). This could be seen as a response to the dilemmatic position of the counselling psychologist as someone whose professional discourse in counselling psychology foregrounds the therapeutic relationship but who works within a mental health context where the empiricist discourse and the apparatus of diagnosis are generally accepted. However, in spite of this, the speaker constructs herself as having some choice and agency within this dominant empiricist discourse. In lines 383-4, reflecting on how she might talk about and to a client diagnosed with borderline personality disorder, she constructs a contrast between her talk with other experts (professionals) and with non-experts (clients). This allows her to position herself as an agent who selectively uses the technical vocabulary and diagnostic language grounded in the expertise of professional authority (the empiricist repertoire) depending on its context of usage (the contingent repertoire).

**Box R3.5: Making use of positions that are not explicitly invoked in the data**

In the analysis above, we suggest that Charlotte may find herself in a dilemmatic
position because of her position as a counselling psychologist operating within a context where the empiricist discourse dominates. However, Charlotte does not explicitly position herself as a counselling psychologist in the data extract. This raises the question of whether it is permissible, when formulating interpretations, to invoke positions and other material that are not (explicitly) mentioned in the data. Discourse analysts differ on the extent to which they consider this permissible, with some contending that interpretations of positioning must be explicitly reflected in the data presented while others favour greater leeway for interpretation. Of course, if a speaker has positioned themselves in a particular way elsewhere in the data set and that positioning is alluded to in the extract under analysis, it is perfectly acceptable to invoke that positioning (provided the analyst can convince the reader of the allusion). What can be more problematic is when analysts assume that a speaker is speaking from a position that is assumed to be salient but where, even with some interpretation, the analyst does not present a convincing case for the relevance of that positioning. For example, as we noted in Box R3.2, it would be a mistake to assume that, just because all the participants in our study were counselling psychologists, they spoke consistently from that position throughout their interviews. We feel justified in invoking Charlotte’s position as a counselling psychologist here because (a) she positions herself explicitly in this way elsewhere in the interview and (b) the way in which she distances herself from the empiricist repertoire and constructs her approach to a hypothetical client in the data extract in many respects echoes literature on the defining characteristics of counselling psychology (for example, see Strawbridge and Woolfe, 2003).
Talking about therapeutic practice provides Charlotte with a context for rejecting an authoritative expert position in favour of a more egalitarian one. She employs two resources in particular to construct a position of equality. Firstly, in lines 385-6 (“I’m not going to perhaps say to her (.) ‘You have borderline’ or ‘Given your borderline personality disorder this is what is best for you’”), she presents hypothetical reported speech that is implied as how an expert authority would respond to a client with borderline personality disorder. This enables her to work up the difference between this approach and her own. Secondly, there is a notable use of democratic semantics in the form of “we” statements in lines 389-90 (“we’re here together to think together what your needs are (.) and you know how can we best (.) erm help you”). The discursive form is one of polite invitation rather than imperious command. The ethos is one that expresses democratic aspirations and utilizes the language of free and equal exchange. This works to construct the therapeutic encounter where Charlotte is the therapist as a joint venture wherein ‘we’ (Charlotte and the client) discover and create meaning together rather than ‘I’ (the expert) telling ‘you’ (the client) the ‘facts’ of your case. This construction allows Charlotte to resist the authority of her expert position and to reposition herself in a softer, more egalitarian way. However, this position seems to be charged with ambivalence because the right to speak authoritatively has not been abandoned. Albeit in a tentative way, Charlotte still holds the therapeutic ‘maps’ (as in line 392 – “perhaps I might have in mind what might be helpful or best for her”). The ambivalence may be seen most clearly in line 396 (“I will try to work with her (.) to see what she wants and to see what’s best”) where the line begins with a statement of co-operative intent before switching to prioritize the desires of the client (“to see what she wants”) and ending with a phrase that leaves it unclear who has the ultimate right to determine “what’s best” in this interaction. This pattern of discourse has been described
as ‘unequal egalitarianism’ or ‘non-authoritarian authoritarianism’ (Wetherell et al., 1987).

**Conclusion**

Given the relatively small sample in the present study, we cannot claim with confidence to have discerned all the major discursive resources that counselling psychologists employ to make sense of ‘psychopathology’ and the use of diagnostic categories in counselling psychology practice. Yet, although the sample was diverse, it is notable that the empiricist and contingent repertoires (and their intricate and dilemmatic interaction) were readily identifiable across the interview data. It may be the case that these are standard sense-making repertoires for counselling psychologists in relation to their contextualized professional practice. Indeed, these repertoires appear to be standard resources for other mental health professions too, as was found by Harper (1994) in his study of how psychiatrists and lecturers in clinical psychology talked about ‘paranoia’. Other researchers may wish to explore the relevance of these repertoires with different samples of counselling psychologists on these and other professional issues.

In relation to counselling psychology, the present study indicates that there may be a gap between the ‘ideal’ and the ‘real’ in terms of ‘psychopathology’ and the use of diagnostic categories – that is, between theory and reports of situated practice. The principles and values expressed in counselling psychology theory – such as a humanistic value base, a reaction against a medical model of professional-client relationships and an emphasis on well-being rather than pathology (Strawbridge and Woolfe, 2003) – stand
in opposition to the prevalent reported discourses that shape the applied contexts in which counselling psychologists often work. Given that current practices are culturally sanctioned and increasingly reinforced by an ideological framework of professionalization, this creates ongoing dilemmas for individual practitioners at a local level (as was discerned in the data) and more general dilemmas for the status, identity and development of counselling psychology as a discipline. If counselling psychology is to be a cultural enterprise that reflexively questions its relevance to society and its role in maintaining and/or challenging existing social structures and practices, then it may be worthwhile for counselling psychologists to take a critical and deconstructive posture towards their theories and practices – especially in relation to fundamental issues such as ‘psychopathology’ that can hold serious implications for those to whom relevant discourses are applied.

This report has provided an illustration of how a discourse analytic study might be presented. However, it should be remembered that there are different forms of discourse analysis with different emphases, which may require alternative presentational formats. We hope that our study, together with the other chapters on discourse analysis, will persuade readers of this value of this research approach and inspire them to venture into discourse analytic research themselves.
References


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1 This is a standard transcription notation in discourse analytic work. Readers may find it helpful to know what is denoted by some of the features that appear in the data extracts. Numbers in brackets indicate pauses timed in seconds. A full stop in brackets indicates a pause which is noticeable but too short to measure. Underlining indicates that words are uttered with added emphasis. Words in capitals are uttered louder than the surrounding talk. Round brackets indicate that material in the brackets is either inaudible or there is a doubt about its accuracy. Square brackets indicate that some transcript has been deliberately omitted. Material in square brackets is clarificatory information.