Living with challenging behaviour: Using discourse analysis to study the experiences of people with learning disabilities in a residential service

by

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Can the experience of hearing voices ('auditory hallucinations') be considered an ordinary part of human experience?

What implications might such a conceptualisation have for the ways clinical psychologists respond to service users who hear voices?

Year 1

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¹ Does not include title page, statement of anonymity, references or appendices.
Introduction

Having worked in several inpatient and outpatient services, I² have encountered many individuals who hear voices. I have always been fascinated to observe how they react to and cope with these voices that others cannot hear. I have also always been struck by the strength of belief that many individuals hold about the voices they hear. One individual I spoke with on a rehabilitation ward described to me in an utterly convincing way how the police issue orders to him. This led me to wonder how it would feel for this individual to have that belief challenged. If somebody tried to tell me that something I believed to be true was in fact a figment of my imagination, I can only imagine how distressing that experience would be. And yet that is what is happening across the world for many individuals who experience voice-hearing. The continuing dominance of the medical model in many mental health settings means that for the most part, those who hear voices have their beliefs doubted and challenged on a regular basis.

The title of this essay piqued my interest because I realised I too had been caught up in the dominant medical model in the settings in which I have worked with individuals who experience voice-hearing. In one particular inpatient service, the nurses I worked with firmly believed that voice hearing should not be ‘colluded’ with, a belief installed by one of the psychiatrists. I recall one particular incident where another psychiatrist went against this trend and discussed with a client her belief that she had a husband (she was not married) who was in the army and was phoning her and talking to her

² I have chosen to write this essay in the first person as I believe it allows me to be more reflective when discussing the literature and its relationship to my own experiences.
about how to get out of the hospital. The approach taken by this psychiatrist was viewed by the nursing staff as a sign of incompetence, and they were incredulous that somebody was giving credence to this client’s experience and beliefs. I hope that the reading for this essay will allow me to come to a clearer understanding of my own personal perspective on voice hearing, and how this experience may best be understood and worked with by mental health professionals. I also hope to investigate the validity of the medical model’s approaches to challenging voice hearing, with the end goal being to completely remove voices which for some may be a positive, enriching and protective experience.

During the course of this essay I will demonstrate how the way voice-hearing has been viewed has changed over time, and how this has been influenced by the epistemology of mental illness in each era. These views have at times blurred the boundaries of ‘sanity’ and ‘madness’, and at other times considered them a continuum. This leads to ever-changing conclusions of the meaning behind, and necessary treatment (if any) of voice-hearing.

For many people today (both clinicians and non-clinicians) voice-hearing and mental health remain closely linked as modern day psychiatry continues to use diagnostic criteria based on some of these historical viewpoints. However, studies have also begun to highlight a number of non-clinical samples who display voice hearing behaviour (a number far higher than could be expected if they are people with mental illness who have ‘slipped through the net’) and the implications these well replicated findings have for the use of voice-
hearing as a diagnostic symptom of mental illness. In addition, research using non-clinical (and indeed some clinical) samples has shown that considering voices to be merely a symptom of an underlying, biologically caused mental illness does not adequately address the issue of how or why the voices arose in the first place.

I will then consider alternative explanations of voice hearing, including some of the ways other cultures view voice hearing. These views and ideas not only suggest alternative ways for clinician's to view those presenting with voices, but are of vital importance when working with those from particular ethnic minority or religious groups. Imposing British / American diagnostic frameworks on such groups may lead to mis-classifications or inappropriate 'treatment' plans, which could have highly negative effects on the individual concerned.

The role of labelling will also be discussed as it is of great relevance if voice-hearing is to be seen as an indicator of mental illness. The impact of such a label on an individuals' belief about themselves, and the views others may have of them will be discussed.

Finally, thought will be given to the differing implications for treatment if voices are considered just a normal part of human experience, or if they continue to be seen by the majority of mental health professionals as a symptom of psychopathology.
**Hearing Voices**

Hearing voices, or 'auditory hallucinations' as they are medically termed, is an experience that has been documented for many hundreds of years. This experience has most commonly been associated with mental illness, though different cultures and times have viewed it in a range of ways, with diverse explanations of its causation.

The Mental Health Foundation (2005) describe how voices can take on many different forms, including the tone, content and pitch of the voice, and it's location, for example inside or outside the head, or from different parts of the body. Voices may talk about the individual in question, for example commenting on their behaviours or thoughts, or may engage them in a conversation. They can be negative and punishing, or comforting and rewarding. Each individual's experience of voice hearing is different, and so it is only by talking to people who hear voices that their own particular experience can be elicited.

**Historical Views of Hearing Voices**

The experience of hearing voices has long been associated with psychopathology. However, ideas about the causes of these disorders, who is likely to experience them and how they should be treated has varied greatly over time. Comer (1998) outlines a history of the way voice-hearing has been viewed historically, dating as far back as the Greeks and Romans who believed hallucinations were a form of mental disorder caused by both physical (e.g. head trauma) and emotional (e.g. loss of love) events. This
resulted in a range of treatments ranging from bleeding people (to redress the imbalance of humours within the body) to offering comforting and soothing experiences such as warm baths and soft music. In the Middle Ages (AD 500-1350) more spiritual explanations became popular, with voices being seen as a sign of conflict between God and evil spirits. Treatments at this time largely focused around exorcism, reflecting the dominant religious view of the time.

During the Renaissance Period (1400-1700) Johann Weyer (1515-1588, the first mental health specialist) promoted the view that mental illness was an ever-present possibility for all people, a view that resulted in humane and comforting treatments. However, as the numbers of people deemed mentally ill grew, institutions were soon required in order to ‘house’ them which led to degrading conditions and cruel treatments as a result of staff shortages and crowded wards.

In the 19th Century changes began to occur in the way mental illnesses and their aetiology were viewed. Emil Kraepelin (1856-1926), an extremely influential figure in psychiatry began to form a classification system of mental illness based on the idea that physical causes resulted in groups of symptoms which could be clustered together into ‘syndromes’, the courses of which could be predicted. Kraepelin believed in the dichotomy that people either suffered from mental illness or they did not, and that only undetected or untreated sufferers would be those in the general population who displayed these symptoms (Kraepelin, 1920, cited in Bentall, 2004).
In 1959 Kurt Schneider’s work (described in Bentall, 2004) contributed further to the classification of schizophrenia via two ‘ranks’ of symptoms. These were based on facets of behaviour that he saw as unique to schizophrenia, e.g. voice-hearing. Schneider termed auditory hallucinations and delusions ‘first rank symptoms’, and felt that their mere presence indicated a mental disorder. He believed it was this presence, and not the content of the voices that should be focused on during assessment and treatment. Though Schneider himself stated that other symptoms could also alert professionals to the presence of schizophrenia, many took his work as a sign that these first rank symptoms were the benchmark from which diagnoses could be made. Modern day assessment tools in Britain and America such as the ICD-10, still place prevalence on Schneider’s first rank symptoms when making a diagnosis (Leudar & Thomas, 2000).

The Anti-Psychiatry movement in the 1960’s and 1970’s saw a reaction against the views of Kraepelin and his overly physiological orientation towards psychopathology. In his book entitled “The Myth of Mental Illness” Thomas Szasz (1962) said mental illnesses were really ‘problems in living’ and not illnesses at all, shedding a new perspective on understanding. Though physiological aspects of mental illness continued to be explored (for example via a focus on neurochemical processes) various therapies (e.g. Gestalt) grew out of this time that emphasised personal growth for all, promoting the assumption that everyone has some degree of psychological damage. These views saw a permanent blurring of sanity and madness.
Voice-hearing in the General Population

Following the notion that mental illness and sanity may not be as clearly differentiated as Kraepelin had suggested, research began to investigate whether any of the symptoms he had identified as defining psychopathology could be found in those living 'normal', successful lives. One of the first studies was conducted by the Society for Psychical Research (Sidgewick, 1894, cited in Bentall, 2004) at the end of the 19th Century. They examined responses from 14,000 men and women (excluding those with an obvious mental illness) and found that eight per cent of men and twelve per cent of women had had at least one vivid visual hallucinatory experience. Auditory hallucinations were found to be less common, but were still present at a higher figure than would be expected from undiagnosed individuals with a mental illness.

Fifty years later similar results were obtained when the study was repeated by West (1948, cited in Bentall, 2004), and even higher estimates have come from more modern day studies. For example, Laroi & Van der Linden (2005) questioned 236 non-clinical participants regarding the prevalence and nature of any hallucinations they had experienced. Thirty four per cent of the sample stated they had experienced an auditory hallucination, with twenty four per cent reporting high frequencies of these hallucinations. The majority of these respondents described having negative affective responses towards their experiences.
The notion that there may be many individuals who experience voice hearing but do not seek help has raised the issue of ability to cope with voices as a factor in whether an individual seeks advice or treatment from services. Laroi & Van der Linden (2005) investigated this issue by questioning their participants about the degree of control they felt they had over their voices. Only 14 per cent felt that they had a high degree of control, a factor that has been implicated in an individual's ability to cope with the experience of voice-hearing. Romme & Esher also investigated this issue of control as part of their 1989 study conducted on a Dutch voice-hearing population, many of whom were obtained via an advert on a television programme (so that the sample included people who had not sought psychiatric treatment). Of the 450 respondents to their questionnaire, 34 per cent stated they were able to manage their voices well, and closer inspection linked this to the power structure between an individual and their voice. The more powerful the individual felt, the more likely they were to be able to cope with their voices.

This finding could suggest that those in the general population who hear voices are more likely to feel they have control over their voices, and this greater ability to cope leads to them not seeking help. This conclusion suggests there may be a difference in relational aspects of voice-hearing between clinical and non-clinical samples. This is what Honig et al. (1998) attempted to investigate when they compared people with a diagnosis of schizophrenia; people with a diagnosis of dissociative disorder and a group of voice-hearers not in contact with services. All participants (N = 48) were interviewed to elicit information such as characteristics of their voices, coping
strategies and personal interpretations of the onset of the voices. Of the participants with schizophrenia and dissociative disorder, 93 per cent reported experiencing negative, often critical voices, in comparison to only 53 per cent of the non-patient group. The non-patient group also reported a significantly higher level of control over their voices, which was perhaps linked to the additional finding that their voices were deemed less 'troublesome' to their everyday lives. This finding supports Laroi & Van der Linden's (2005) suggestion that voice-hearers in non-clinical populations may experience greater control over their voices, though Honig et al.'s findings suggest this occurs to a greater degree that Laroi & Van der Linden found. However, Laroi and Van der Linden's sample consisted of university students, which may not have been a representative sample of the general population, unlike Honig et al. who recruited via the local media and may therefore have had a more representative sample of the general population.

**Does the Experience of Hearing Voices Really Link to Mental Illness?**

In the Honig et al. study described above, the experience of hearing voices is questioned as a valid criterion for 'mental illness', given that that their non-clinical population did not meet the DSM-IV criteria for schizophrenia or dissociative disorder yet still experienced auditory hallucinations. This suggests voices may be experienced without a mental illness necessarily occurring. Several studies have identified individuals who experience voice-hearing but do not have a mental illness, for example Laurier (2005) reports that many people who have experienced torture hallucinated during their ordeal. Though this is clearly a horrific experience, it is unlikely that any of the
individuals were mentally ill. Their experience was a direct result of the stress their body and mind was put under as a result of the torture.

Romme and Esher (1989) have furthered this idea by questioning the validity of using voices as a criterion for classifying mental illness. They found that different disorders (e.g. manic depression and schizophrenia) could not be distinguished according to features of their auditory hallucinations, for example location of the voice. However, their study may be criticised as it assumes a homogeneity within disorders which is unlikely to exist.

The above findings suggest voice-hearing may not be a sign of mental illness. Research into this possibility has attempted to look for alternative explanations of this experience outside the realm of psychopathology.

**Alternative Explanations of Hearing Voices**

**Cultural beliefs**

As stated previously, the modern assessment tools for diagnosing mental illness (e.g. DSM-IV and ICD-10) have been based on the work of white American and European individuals such as Kurt Schneider, and therefore reflect a bias in ideas and beliefs from Western culture. These criteria may therefore fail to take account of the beliefs, explanations and understandings from other cultures. An interesting example of this can be seen in an account written by Martinez-Taboas (2005a) who worked with a Puerto Rican lady (Nayda), part of whose distress involved hearing voices. Nayda herself
assigned the symptoms of her distress to *espiritismo*, a widespread belief system in many Latin American countries that states the spirits of the deceased can communicate with the living, and actively alter their lives. In some cases the spirit may even possess the soul of a living person, leading the living individual to experience a range of processes including auditory hallucinations. Martinez-Taboas describes the Puerto-Rican methods used to treat individuals possessed by spirits, which centre around exorcism, prayer and direct communication with the spirit.

In his formulation however Martinez-Taboas takes a less spiritual approach to Nayda’s experiences, assigning them to the presence of psychogenic seizures, which resemble epileptic seizures but do not have the associated electrical activity in the brain. Martinez-Taboas ascribes their cause to psychological distress caused by the death of Nayda’s grandmother, who committed suicide by burning herself, and event for which Nayda felt responsible.

This formulation has been criticised by Castro-Bianco (2005) who claims it fails to consider the diagnosis of a syndrome based on the beliefs of an individual and their culture. Martinez-Taboas initially attempted to convince Nayda that her *espiritismo* views were unrelated to her symptoms, a notion Nayda refused to accept. This position could (though is not reported to) have been detrimental to the therapeutic alliance, given that Nayda may have felt important elements of her culture were being disregarded. I feel this failure to acknowledge and work directly with an individual’s belief system represents a huge chasm in multi-cultural working, where the therapist ‘prescribes’ what is
psychopathologic and what is not, based on his own culture's belief system. I believe a more salient way of working would be to work with a client to understand their own particular culture in order to identify explanations (and possible treatments) that are meaningful and relevant to them. I feel this way of working is far more likely to result in positive outcomes for the individual concerned, be that to eliminate, reduce or cope better with their voices.

Religious experiences

Many religious groups have purported to hear voices, which has led to a great deal of interest and research in this area. Many spiritual experiences (such as the one described above in Latin American cultures) have been regarded by some as a sign of mental illness. For example, many members of the Chinese Falungong religious movement (a meditative religious cult that formed as a passive rebellion to Government movements in China) have been subjected to compulsory psychiatric treatment (including electroconvulsive therapy and antipsychotic medications) since the movement was banned in 1999 (Lyons, 2001). Lyons describes how the Chinese doctrine Qigong which the Falungong movement is in part based on, has been used by Psychiatrists to from a new classification of mental illness known as 'Qigong induced mental disorder', which pathologises the meditative elements of this religion. Lee (2001) investigated the members of this group and found that only a few actually displayed symptoms that correlated with a diagnosis of mental disorder. This research demonstrates not only how religious experiences (in this case brought about by meditation) can be misinterpreted, but how
diagnostic systems can also act as a means of social control, which has huge ethical implications.

However, some studies have compared features of religious groups with those classified as psychotic and found some similar experiences. For example, Peters, Day, McKenna & Orbach (1999) compared groups of psychotic inpatients with members of two 'new religious movement' (NRM) groups (Druids and Hare Krishnas) and two control groups (non-religious people and a Christian group). Using the Delusions Inventory (PDI, Peters, Day and Garety, 1996) they found that the NRM groups and the psychotic inpatient group could not be distinguished on the number of delusional beliefs they held. However, the NRM groups did report significantly less distress and preoccupation with their voices. These findings suggest that there can be alternative explanations for the experience of hearing voices (and indeed other hallucinatory experiences) and provide further support for the idea of a continuum of these experiences. Importantly, this study also highlights the necessity of taking into account religious and/or cultural beliefs when assessing an individual's experience of voice-hearing.

**Positive, Life Enriching Experiences**

The examples I have described above demonstrate the importance of understanding culture and religion in order to appreciate the meaning of hearing voices to an individual. However, they also offer the viewpoint that voice-hearing can be a positive, life enriching experience, rather than always being one that causes distress (often the dominant view of voice-hearing).
The positive effects of voice-hearing is an issue that has historically been untouched, but in more recent years work has been growing in this area.

Chadwick & Birchwood (1994) investigated the nature of persistent voices in 26 people who had a diagnosis of schizophrenia. They found that though all the respondents described their voices as omnipotent, there were differences between the group as to whether they experienced their voices as benevolent or malevolent. These beliefs were based on the voices' identity and the meanings attached to them, though often not the actual content of the voices. Chadwick and Birchwood found that these factors resulted in differing patterns of engagement, with benevolent voices being engaged with more often and viewed as a support to everyday functioning. This idea has been supported by Favrod et al. (2004) who compared the impact of voices on social functioning in 29 individuals with a diagnosis of schizophrenia. They found that those who engaged with their voices were more likely to experience them as benevolent, while attempts to avoid engagement corresponded with an interpretation of malevolence.

However, both of these studies have identified a potential negative aspect to increased engagement with, and benevolent interpretation of voices. Favrod et al. (2004) found that those who interpreted their voices as malevolent scored higher on measures of communication (i.e. in social interaction) than the benevolent group. They highlight the need for further research in order to understand this finding, but suggest one possible explanation could be that the more an individual engages with their voices, the less impetus they have
to seek treatment, and consequently their lives may become more chaotic, and their communication skills further depleted. Chadwick & Birchwood support this suggestion with their claim that engaging with voices may make an individual less likely to seek help or treatment, which could negatively impact on their lives.

It must be taken into account however that both of these studies sampled groups of individuals with a diagnosis of schizophrenia, and therefore may have failed to take into account individuals in the general population who hear voices but do not suffer distress. It also assumes that all voice-hearers want, or need to seek treatment. Additionally, the above studies both purport the suggestion that an individual may not always know what is ‘best’ for them, placing the clinician in the expert role. This may lead to an adoption of some aspects of the medical model, where the individual’s knowledge and understanding of their own experience is over-looked in favour of the clinician’s own interpretation. As described above, this can harm both the therapeutic relationship and lead to inappropriate or meaningless goals.

The studies also both seem to suggest that treatment is always required, a position that has been challenged by Romme & Esher (1993), who have highlighted many truly positive experiences of voice-hearing. In their book “Accepting Voices” (1993) they describe several case studies of individuals whose voices have ‘provided guidance for personal growth’ and/or channelled them ‘beyond a higher self’. Current diagnostic tools would view both of these claims as a sign of mental illness, requiring ‘treatment’. Romme & Esher claim
that by listening to the individual's story, and paying attention to the nature, process and feelings toward their voices, an individual can be helped (if indeed 'help' is needed at all) to build a positive relationship with their voices. This is in stark contrast to the dominant medical view that sees voices as simply a symptom of underlying psychopathology.

These views clearly have implications for formulation and treatment perspectives, and I will now go on to consider the potential merits and pitfalls of both the medical, diagnostic approach and Romme & Esher's more person-centred, holistic approach.

**Implications for 'Treatments'**

Considering voice-hearing to be a symptom of a mental illness may lead to medical treatments being sought in order to eradicate the voices. This formulation usually results in the nature of the voices being paid little attention as they are seen merely as a marker of underlying psychopathology. Romme & Esher (1993) however provide a strong argument against this model and its goal of eradicating voices, claiming this approach fails to take into account the psychosocial cause(s) of the voices. Romme & Esher believe voice hearing to be a result of stressors in a person's life, with the content of the voices related to the particular stressor concerned. In contrast to the medical model, this formulation necessitates a close inspection of the person's voices, which can only be achieved through talking to the individual about their voices, their interpretations of their meaning, and how they cope with them.
In their 1994 study Chadwick & Birchwood investigated the use of cognitive behavioural therapy with four members of their sample in order to investigate the efficacy of focusing on the nature and content of voices themselves. With the participants’ medication held at a stable level, Chadwick & Birchwood used a CBT approach to identify, discuss and test out the beliefs held about their voices. This approach led to a fall in the level of distress experienced and increased adaptive behaviours, providing support for the efficacy of treatment approaches that involve talking about voices, and allowing the individuals’ views and attributed meanings to guide the focus of any therapeutic work.

Chadwick & Birchwood’s work suggests a move towards a greater role for psychology in working with those who experience voices, which to date has been secondary to the medial input of psychiatry. Altering the dominant view of voice-hearing as a psychopathological experience requiring medical treatment allows for a greater, more varied selection of approaches to be drawn on by a clinician and client, to help them manage any difficult aspect of their voice-hearing experiences. These approaches may include cognitive-behavioural approaches (e.g. to aid in anxiety management) and psychodynamic psychotherapy (to help explore the origins and development of the voices) alongside many others.

Support for the approaches to ‘treatment’ outlined above has come from many people who hear voices. Many self-support groups, for example The Hearing Voices Network (1988), are based on, or influenced by the work of Romme &
Esher, who advocate the importance of control and empowerment for people who hear voices. The large number of these self-help groups offers support for the face validity of Romme & Esher's theories.

The Problems with Labels

A further argument against the medicalised treatment of voice-hearing is the necessity to label an experience as mental illness. Much has been written about the potentially negative consequences of such labels, for example the process by which an individual incorporates such labels into their self-schema. Bowers (1998) comments on the potential for an individual to begin to fulfil societal expectations of a 'mentally ill' person, for example by accepting lower-status positions in society. Bowers also points out that the process of accepting a label of mental illness plays an important role in psychiatric treatment, as this is considered to demonstrate 'insight', a prerequisite for many psychological therapies. However, an acceptance of the label has been highlighted by some as a factor in the development of some negative symptoms, further-impoverishing or indeed instigating lower affect and reduced self-esteem, among many other negative factors.

These findings highlight the importance of how clinicians view and work with people who hear voices. Given the findings of Laroi & Van der Linden (2005) and others into the numbers of people in the general population who hear voices, it is clear that a diagnosis of mental illness seems not only unlikely to be correct, but could also be potentially damaging to a great number of people. These pieces of work clearly lead to an approach concerned more
with the individual and their own experiences, meanings and concerns, with a variety of psychological tools available to help any individuals who do experience distress come to terms with, and cope better with their voices. By avoiding labels such as ‘mental illness’ people who hear voices can be spared many of the prejudicial, discriminatory experiences others have had to endure.

Conclusions

In the course of this essay I have considered the experience of voice hearing, and how views of this have changed over time. This finding alone necessitates care to be taken when drawing any conclusions about different approaches to this issue, as any definitions or ideas can only be considered ‘true’ at the time and place in history in which they are generated.

However, at present it appears that the large numbers of voice hearers in the general population have influenced many to re-think the medicalisation of voice-hearing as a sign of underlying psychopathology. Instead, researchers such as Romme & Esher are promoting the view that voice-hearing occurs in the context of life difficulties, and that approaches to managing any resulting distress must focus on the content and meaning of the voices in order to identify the underlying life-difficulty. These ideas have large implications for treatment, particularly as it has the potential to place psychologists, and not psychiatrists (as is currently seen) in the forefront of work in this area.
Furthermore, voice hearing is more and more seen as an experience that can be positive and rewarding. This view also has implications for treatment, as it leads the goal away from elimination of voices and more towards a focus on coping. In this way some individuals may actually enrich their lives through these experiences.

**Personal Reflection**

In the course of writing this essay I have been forced to examine the roles of myself and other professionals when working with people who hear voices. It has shown me not only how truly dominant the medical model is in some (and maybe many) inpatient services, but how easy it is to be swept up in these ideas. The reading I have done for this essay, in particular the work of Bentall and Romme & Esher has allowed me to develop a new, deeper understanding of the personal and meaningful experience of voice hearing, which to me seems inherently more adaptive and client-focused. I believe this will not only allow me to work in a more understanding and effective way with clients who hear voices, but will also give me the ability to challenge those who view voices simply as a by-product of underlying psychopathologies.
References


The Hearing Voices Network (1988). [http://www.hearing-voices.org/information.htm](http://www.hearing-voices.org/information.htm) visited GMT 16.15 16.11.2005

The Mental Health Foundation (2005). Hearing voices: A factsheet from the Mental Health Foundation. [http://www.mentalhealth.org.uk/html/content/voices.cfm](http://www.mentalhealth.org.uk/html/content/voices.cfm) visited GMT 15.15 16.11.05

Professional issues essay

‘Using illustrative examples, discuss the advantages and disadvantages of formulation to clinical psychology practice’.

Year 2

Word count$^3$: 4999

$^3$ Does not include title page, statement of anonymity, references or appendices.
Introduction

This essay seeks to explore the history, purpose and nature of the process and outcome of psychological formulation. Research in support of, and against its use will be discussed, as will the views of mental health professionals and service users. The current emphasis on formulation in clinical training will also be considered. Throughout the essay I will draw on my own experiences and published case material to illustrate the issues discussed.

However, to start I will clarify my reasons for choosing this essay title, and my current position on this issue. I hope this will aid me in reflecting on how, and if my views have changed at the end of the essay. I was drawn to this essay title for two main reasons. Firstly, I wanted to research an issue that I believed would be relevant to a wide range of my work, i.e. not focused narrowly on one particular theoretical position or mental health issue. Secondly, the issue of formulation is one that has been spoken about frequently during my training to date, yet it is one that at present I still feel unclear as to exactly what it is, how you do it, and what it can achieve. My hope is that through writing this essay I may begin to clarify some of these issues, and begin to apply my formulation skills with greater efficacy in my clinical work.

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4 I have chosen to write this essay in the first person as I hope this will allow me to reflect on my own experiences, and monitor changes in my understandings and clinical practice as a result of this essay.
Definitions of formulation

It seems pertinent to begin this essay with an understanding of what exactly a formulation is. Given the breadth of psychological models and their underpinning theories, I wondered if there would be a variety of definitions. What I have discovered in my reading is that though the detail in formulations from different theoretical perspectives (i.e. what information is attended to and included) may differ, most theoretical positions seem to share an over-arching definition – that formulation aids an increased understanding of a client and their presenting difficulties. Some of these definitions are described below:

"Formulation is the summation and integration of knowledge that is acquired by the assessment process....This will draw on psychological theory and data and provide a framework for describing a problem, how it developed and how it is being maintained." (Division of Clinical Psychology, 2001).

"A formulation is the tool used by clinicians to relate theory to practice...Formulations can best be understood as hypotheses to be tested" (Butler, 1998).

From these definitions, the main crux of developing formulations can be seen as a process of gaining and integrating knowledge about the development, nature and maintenance of a difficulty or difficulties, to produce a set of hypotheses which may guide intervention choice and evaluation. The notion of guiding treatment choice has been postulated by Bieling & Kuyken (2003) as the most important factor in formulation, though other writers place more
emphasis on formulation as a tool for identifying the focus of the intervention, (e.g. Blatner, 2006).

**Historical roots of formulation**

The 'art' of formulation as a psychological tool stems back to the 1950’s, when psychologists were attempting to define their role in mental health work, particularly in relation to psychiatry (Crellin, 1998). Up until this time the role of psychology had been to assist psychiatric assessment, and to offer suggestions for appropriate treatment. However, clinical psychologists soon began to carve out a ‘niche market’ for themselves, the cornerstone of which was formulation. In 1969 formulation was incorporated into the British Psychological Society’s guidelines for training clinical psychologists (Crellin, 1998) and can still be seen today in the Division of Clinical Psychology’s guidelines on the Core Purpose and Philosophy of the Profession, which highlight formulation as one of the four core skills that must be achieved via training, and one which is “unique to clinical psychologists” (DCP, 2001).

**Relationship to psychiatric diagnosis**

One factor that exacerbated the growth of formulation as a psychological tool was increasing dissatisfaction with psychiatric diagnostic labels. Many of these criticisms originated at the Maudsley Hospital and Institute of Psychiatry, where the first two formal training schemes for clinical psychologists existed (Crellin, 1998). Some of the criticisms voiced by psychologists working in these medical fields included that psychiatric labels
offered only a description (with no explanation) of a patient's difficulties; the high level of overlap between categories; the lack of attention to learning processes in the development and maintenance of a difficulty; the role of value-judgements of where behaviours lay on the normality-abnormal spectrum and the subsequent difficulties for patients as a result of acquiring a particular label (Bruch, 1998).

Psychological formulation grew as a reaction to these criticisms, in an attempt to identify a way of describing and explaining a patient's problems that focused more on the specific experiences of the individual, avoiding the more reductionist approach of fitting the individual to a pre-defined set of diagnostic criteria (Ivey, 2006). However, this concept has been questioned by Turkat (1990, cited in Bruch, 1998) who claims that psychiatric diagnosis and psychological formulation are complementary processes that can helpfully coexist in aiding assessment and intervention choices and processes.

**How does formulation work in practice?**

Until now this essay has described formulation as a unified term, suggesting there is a singular way it may be taught, learnt and put into practice. However, as with the field of psychology in general, there are many different understandings of the term formulation; ways in which it can be 'done'; times at which it is carried out; how, or if, it is shared with clients and the purpose of 'doing' a formulation. In-keeping with my clinical training, my research around these differences has focused on comparing and contrasting the use of

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5 The term 'patient' has been used here rather than the currently preferred term of 'service-user' to reflect the medical context of this time.
formulation in three psychological models: cognitive-behavioural; systemic and psychodynamic. I note that this is a necessarily narrow view (due to word limitations), and therefore may miss out on potentially interesting viewpoints from other theoretical perspectives.

Cognitive-behavioural formulations

I will start by describing the use of formulation (or case formulation as it is often referred to in a CBT framework\(^6\)), as it was in the realm of behaviourism in the 1950's that the concept and use of formulation really began. A great deal has been written about case formulation, and it would be impossible in the scope of this essay to review it all. However, in brief, case formulation involves applying cognitive and behavioural theories to a service-user's perspective of themselves and their difficulties, to produce a shared understanding of the nature of a problem, its causes and maintaining factors (Beck, 1995). CBT formulations are highly empirically driven, based on evidence-bases of links between cognitions, affect and behaviour for specific disorders. These are often linked under the headings of presenting issues; precipitating factors; perpetuating factors; predisposing factors and protective factors, with an aim to identify via these the core beliefs of the individual (Dudley & Kuyken, 2006). However the model is also able to take account of idiosyncratic differences, and thus adapt to each individual's unique experiences and perspectives (Dudley & Kuyken, 2006).

\(^6\) I will use the terms 'case formulation' and 'CBT formulation' interchangeably in this essay
Case formulations evolve continuously throughout the assessment and intervention stages, allowing interventions to be planned and modified to best fit the client at all times. CBT formulations specify the need for a good therapeutic relationship and mutually agreed goals as the focus of the intervention. It is also of note that CBT formulations often reside alongside psychiatric diagnoses comfortably, and it is often postulated for best use with particular diagnoses such as depression or anxiety (Dudley & Kuyken, 2006).

As previously stated, CBT formulation is an empirically driven process, and this has led to some criticism from those who feel psychology and psychological interventions do not fall easily within the remit of positivism and scientific enquiry (e.g. Crellin, 1998). These criticisms suggest that human beings and their experiences cannot be neatly reduced into the categories described above, and therefore links to the dissatisfaction with psychiatric diagnosis have also been applied by some to case formulation. For example, Dryden (1998) claims that case formulation “perpetuates the objectification of clients” (p.43) and fails to adequately describe or understand the context of each individual’s difficulties.

From my own perspective, I have seen CBT formulation both be extremely helpful to clients, and also fail to make an impact on their change. For example, a client I worked with who had a diagnosis of agoraphobia and panic attacks informed me during our last session that the most useful thing to have come from our sessions was a diagram we had produced together

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7 I am aware as I write this that I am neatly fitting this man and his difficulties into psychiatric labels. However for the sake of brevity I will assume the reader is able to use this shorthand to understand a small part of this client’s current problems.
outlining the maintaining thoughts, feelings and behaviours, and the contexts in which they occurred. On reflection I felt that other therapeutic models might not have offered as great an opportunity to explicitly draw out this jointly constructed, detailed understanding. However, given its focus on the “client’s perspective and agency” (Dudley & Kuyken, 2006), CBT formulation may fail to take into account the wider context of a person. As I shall go on to describe, other models have been better able to consider this broader perspective which, though not ignored in a CBT framework, is not held at the forefront.

Systemic formulations
As with CBT, systemic formulation models advocate an open and collaborative way of working, with ongoing review and alteration of hypotheses as new information comes to light (Vetere, 2006). Systemic formulations may incorporate many different aspects, but often begin with a family genogram, from which patterns of family behaviours, rules and beliefs can be identified and explored. These issues are often considered in light of the family context and transitional stages (Dallos & Stedman, 2006).

Systemic formulations, unlike CBT formulations, have become increasingly critical of psychiatric diagnoses. They seek to challenge the “potentially oppressive assumptions which may be made about family members and which family members may even have been conscripted into holding about themselves” (Dallos & Stedman, 2006, p. 95). Systemic formulations and interventions aim to challenge these labels and assumptions, and
acknowledge that as mental health professionals, systemic therapists may also play a role in shaping and forming these beliefs. The role of the therapeutic relationship in systemic formulation is therefore expanded from that seen in CBT, to one where power differentials are more explicitly explored. Vetere (2006) claims this collaboration may be necessary to protect individuals or families against the imposition of ideas or interventions that do not fit with their views about their difficulties.

Psychodynamic formulations

Blatner (2006) describes psychodynamic formulation as focusing on various issues including conflicts within and between the person and their wider social context (past and present); defence mechanisms employed to protect the individual from these conflicts and the client’s own goals and hopes for the future.

These formulations are often constructed according to Malan’s (1995) triangles of conflict and person, which seek to explore the links between past and present, internal and external conflicts, affects and defences. These are shown below:

1. Triangle of conflict

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Defence       Anxiety
            /   \
       /     \
Hidden feeling
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As shown above in the triangle of person, psychodynamic formulations include reference to the therapeutic relationship in a different way to systemic and CBT, in that the therapist may have certain roles or feelings 'projected' on to them, or experienced in the countertransferance. These may be shared at some point with the service-user, but may not be explicitly explained in as transparent a way as the other two models. A psychodynamic formulation then may seek more to aid the therapist in making a meaningful symbol of a client's experiences, from which interpretations can be shared with the client at a time when the therapist judges it to be most beneficial to their change. This has obvious links with power differentials, which may be seen as a potential criticism of formulations drawn from this perspective. In addition, Leiper (2006) has suggested that a lack of transparency from the outset could lead to therapists 'objectifying' their clients, and thus decreasing empathy.

**Evidence for the benefits and costs of formulation**

The preceding section has dealt with some of the specific elements of formulations taken from three psychological models. While some research has focused on whether formulation is a useful tool within each of these models (e.g. Bieling & Kuyken, 2003), others have looked at it more generally, to consider its efficacy as a general psychological tool, regardless of
orientation. This has included a search into who (if anyone) formulation may benefit, i.e. is it clinicians or service-users who reap the rewards of these processes. Research has also been conducted into the potential negative effects of formulation. The following two sections will explore these positive and negative findings in more detail, and I will end with a discussion about the ways in which this research is conducted, and the criticisms some have voiced about the underlying beliefs of such approaches.

In support of formulation

Johnstone (2006) states that clients enter therapy hoping for “help in making sense of their experiences” (p.212), and though this is not an explicit request for a formulation, given the definitions of formulation described earlier, this is in effect what they are asking for.

Chadwick, Williams & Mackenzie (2003) have conducted one of the few studies into the effects of formulation, focusing on its use within a CBT treatment package for adults with drug-resistant psychosis. They focused on the role of formulation in aiding the therapeutic alliance, and decreasing distress associated with symptoms. Their interventions incorporated two sessions devoted to developing an individualised case formulation, leading to letters to the client outlining the formulation alongside possible targets for therapy. All formulations included the notion that the individual’s beliefs were a reaction to contextual factors that they were attempting to make sense of, and outlined possible factors that could impede the therapeutic relationship. The therapists shared these formulation ideas and letters at a time they felt
appropriate, which Chadwick et al. hoped would provide data as clinically valid as possible.

Of the thirteen service-users who took part in four semi-structured interviews prior to and following the formulation, nine felt it had aided them in gaining an increased understanding of their difficulties. Six respondents reported positive feelings towards the process, such as “I felt we were getting somewhere and I saw I could make improvements” (Chadwick et al., 2003, p.674). The therapists in the study also highlighted positive effects of the use of formulation, including the “powerful and validating” effects of having their clients endorse the formulation; increased hopes for a successful outcome of therapy; increased therapeutic alliance, increased sense of efficacy for CBT as the treatment choice, and increased understanding of the client’s difficulties.

Chadwick et al.’s study suggests clearly an efficacy for (CBT) formulation, but it does not state what it is that makes a ‘good’ formulation. Harper (2003) believes a good formulation is explicit and understandable to the service-user; maintains at its base the service-user’s own perspective; makes distinctions between what the client has said and what the therapist interprets from this, and includes reference to the social context of the clients difficulties. Brooke (2004) has furthered the study of ‘what makes a good formulation’ to consider multi-modal formats. This ‘method’ stems from dissatisfaction with evidence for the preferential benefits of any one theoretical model (e.g. Eysenck, 1992). Brooke claims multi-modal formulations avoid the reductionist tendency of
“fitting clients into narrow, theoretical boxes” (p.37). However, he also highlights the potential criticism that such formulations may result in ideas being drawn together in a shallow and theoretically un-sound or incompatible way.

**Against formulation**

A great deal has been written against the process of formulation, which has piqued my interest given its emphasis in the training and practice of clinical psychology. One of the main criticisms of formulation appears to lie in the notion that different theoretical models create radically different formulations, with very little evidence as to which ‘works best’. This leads to the question of is it working for anyone, and of so, who?. In the Chadwick *et al.* study described earlier, six of the service-user respondents reported negative emotional reactions in response to the shared formulation, for example “there are so many factors, I can’t see how the patterns can be stopped” (p.674). Though these feelings and thoughts may represent or point to aspects for therapeutic intervention, any process that potentially exacerbates distress for clients must surely be carefully considered before its use.

A further criticism of formulation is that not only are there differences between models, but also within them. For example, psychodynamic theory has been postulated by some as being less transparent in its formulations (e.g. Vetere, 2006), whilst others, for example Irvine Yalom advocate “the total disclosure about the mechanisms of therapy” (2002, p.86). This dissonance within, and between models may call into question the validity of formulation. In my own
clinical work I have noticed during supervision and in discussion with my colleagues that different people attend to different aspects of a presenting difficulty, even when formulating from the same model. If every clinician would produce a different formulation for the same client, even if using the same theoretical model, how can the efficacy of such an approach be evaluated? For this reason a further criticism of formulation is that it is extremely difficult to assess, and at a time when clinical psychology considers itself an evidence-based practice (Cheshire & Pilgram, 2004), this poses a controversial topic.

A further criticism of formulation is that it may enhance and demonstrate the power imbalance within therapeutic situations. Carl Rogers has highly criticised psychological formulation claiming it implies the expertise of the therapist over that of the client (1951, cited in Eells, 1997). Crellin (1998) has also voiced concerns over the therapist-client power differential, stating that the views of the therapist contained in the formulation are at risk of becoming 'set in stone'. This links back to Vetere's (2006) comments that mental health professionals have a duty to consider their role in shaping and enforcing individuals' beliefs about themselves and their contexts.

This idea of expertise appears to bring this discussion on formulation full circle, to where the use of formulation began as an attempt to define a niche role for psychology, i.e. an area of expertise that they could claim as their own, distinct from psychiatry. Harper (2003) highlights that formulations are one person's perspective on another's difficulties, and that this perspective is
situated in a particular context (place and time), and will be orientated to a particular purpose. It will be influenced by the therapist and client's own backgrounds, culture and available discourses, and by the therapist's theoretical orientation and service structure within which they are operating. Thus from a social constructionist viewpoint, a formulation then is something that is created through discourse between two particular people at a particular time, and not a result of a clinician's expertise in defining a problem.

Johnstone (2006) describes how this shared 'story-making' fits uneasily with scientific enquiry, and the search within psychology for 'evidence-based practice'. Separating and analysing the 'variable' of formulation would seem impossible if they are co-created by a particular therapist and a particular client at a particular time and for a particular purpose. This idea then leads away from the search for 'which theoretical model is better at formulating?' towards a more flexible, individually focused approach. Roy-Chowdhury (2003) has used these arguments to pose the question that if the theoretical model is unimportant, does formulating really need a psychologist to do it? He replies that though a great many non-professionals may produce useful accounts with an individual about what is occurring for them, there is a great deal they may miss. In his discourse analysis of therapeutic conversations, he found that trained therapists were able to provide a number of skills which aided the development of a shared understanding, such as listening for hidden meanings in speech; a greater reflection on their own assumptions and feelings that might be present in the general public, and a greater awareness of the developing relationship. He concluded that while formulation
may not be an area where psychologists are the sole ‘experts’, they do seem to bring some skills to the process that others may not so readily include.

The role of formulation in clinical training

As stated previously, formulation is one of the key elements in clinical psychology training. Crellin (1998) has described how trainees have been required to include a formulation and reformulation in their case reports, in a format that has hardly changed since it was introduced in 1969. She claims that this scientific, hypothesis-testing approach may not be applicable to the way formulations work ‘in practice’, given her belief that a formulation can really only be achieved towards the end of a therapeutic process. Though this idea makes sense to me, I wonder if Crellin has looked at the case-report process a little starkly. Having recently written two such reports myself, the initial formulation section to me felt like a chance to think through some of my early thoughts, ideas and hypotheses that might be explored further in the initial stages of intervention. These have never appeared set in stone during my work, and indeed several times the focus and format of my work with people has shifted as new events and life circumstances have come to light. This fits with the literature described above about the ever-evolving nature of formulations, which would then also tie in with Crellin’s notion of only achieving a ‘complete’ formulation at the end of therapy. Perhaps then formulation is better viewed as an ongoing, dynamic process, rather than a one-off, static occurrence.
A second major issue in clinical training is the emphasis on diversity, including racial, cultural and religious groups; gender issues; people who identify with different sexual orientations and different age ranges. Given the emphasis on both diversity and formulation in clinical psychology practice, it appears to me that these processes would need to be taught in conjunction with each other if the issues arising from both are to be successfully incorporated into clinical work. The literature reviewed above appears to suggest some models may be better equipped to address these issues, for example CBT formulations allow idiosyncratic differences to be incorporated into the formulation. However, because of the focus on an individual's cognitions in CBT formulations, it may somewhat fail to take into account wider social and cultural issues, such as race and gender. On the other hand, systemic formulation may be better equipped to address such issues given its focus on wider systems. An example of a systemic model is shown in diagram 1 below, which demonstrates how systemic models can include consideration of the wider influences on an individual or family in terms of their everyday functioning, their current difficulties and the options open to them in terms of intervention.
This model might also allow the therapist to consider their own place in the system, in terms of their influences on an individual or family. This links back to the earlier issues of power, and suggests that systemic formulation might be well placed to explicitly consider these issues with clients when drawing up a formulation of this type. Psychodynamic formulations on the other hand are often not so explicit about the beliefs and wider systems that surround the therapist, and subsequently their interpretations. However, though I agree with Vetere's opinion (2006) that this may make psychodynamic formulations less transparent, I do not believe this means psychodynamic psychotherapists
do not consider these issues. Indeed, personal therapy is recommended far more within this model than any other, suggesting practitioners of this model may in fact be best placed to consider the biases and beliefs that they bring to the therapeutic encounter.

The role of personal therapy within training for this very reason is something that has interested me greatly, and I continue to be surprised that clinical training differs so much from counselling psychology training in that we are not required to undertake personal therapy. Though I have reservations about how useful 'enforced' therapy might be, having experienced a year of psychodynamic therapy throughout my first year of training I have realised how much can be gained by being aware of your own 'soft points', biases and personality styles. For example, by increasing my awareness of my own interactive style, and issues from my past experiences that stir strong feelings within me, I feel I am better able to attend to the emotional and cognitive reactions that my clients and their difficulties bring up for me, and how these may influence the elements of their story that I attend to, and thus include in a formulation. As a result of this experience I find that collaborative working, as recommended in CBT, and a position of curiosity, as recommended in systemic work, to be vital tools in ensuring the formulations I help to produce are relevant and complete to the client.

In summary I feel the role of formulation in training is one that requires a multi-modal approach, incorporating academic knowledge of models and theories,
experience in working collaboratively with clients, and an increasing understanding or personal biases.

Conclusions

This essay has considered some general definitions of formulation as well as the specific elements and associated advantages and disadvantages of formulating in three different models. It has demonstrated how formulation came to be such a key component of clinical psychology practice and training, and how in some respects this has changed very little over the last 50 years. Reference has been made to issues of power and diversity, and how some models may be better equipped to tackle these topics. I have also considered who formulations are useful (or not useful) for clients and therapists, and whether these effects work directly or indirectly.

In conclusion it appears that formulation is an emotive issue, given its position as one of the key skills that clinical psychologists use to differentiate themselves from other mental health workers, and that we (as a profession) consider ourselves to be ‘experts’ in. My personal interest in social constructionist perspectives has allowed me to consider how clinical psychology has used language to convince others of the ‘expertise’ that we have developed because of our “unique training” (DCP, 2001), and how we have aided this by discrediting other attempts to understand people’s difficulties, for example in our criticisms of psychiatric diagnoses. This has allowed psychology not only to ‘prove’ the need for its services in the mental health arena, but has also elevated us to a position of being able to offer
advice to other mental health professionals, a position that is becoming more and more widespread as clinical psychology moves into a more consultation-type role. For me this links back to the literature I described earlier on power, and shows how the use of formulation as a psychological tool is continuing, as it began in the 1950's, to ensure that the profession of psychology continues to not only exist, but also to grow in status. Though there is not time to explore these issues here, I feel this leads to interesting questions about the power differentials that may be seen within multi-disciplinary team and joint working, as well as those more traditionally seen between psychologists and their clients.

**Personal reflection**

I have found this essay topic an extremely interesting and relevant one to research. Having previously considered formulation to be an almost non-questionable aspect of the work of clinical psychologists, this essay has allowed me to consider the perspectives of people such as Crellin, who advocate a much more critical stance towards this skill.

My reading on the different theoretical models and their corresponding formulations has allowed me to reflect back on my work with previous and current clients, and to consider whether I attended to both their individual difficulties and also the influences of the wider system around them. Having recently moved from a CBT placement to a more systemic one, I am able to see that many of my previous CBT formulations have lacked an emphasis on wider systems, and I am now able to see in my current work how influential
these systems can be in the initiation, maintenance and intervention of a range of difficulties. I believe this suggests that the future for formulation may lie in an ability to integrate perspectives from different models (e.g. Weerasekeera, 1996), according to the needs of the client.

However this essay has also allowed me to reflect on my role within formulation, and how my biases and beliefs might influence what is included in the formulation, and who it is meant to be useful for. This essay has certainly enhanced my belief that unless the formulation fits and makes sense for the client, it is unlikely to ever achieve its maximum benefits. I therefore hope that my future clinical work will seek to develop formulations in a collaborative way, where the ‘power’ or ‘expertise’ lies more with the client and their understanding, with my theoretical knowledge acting merely as a guide or suggestion.

Linked to this idea of expertise is the ‘knowledge base’ on which many theoretical models draw. As stated previously much of this ‘scientific’ research is based on the assumptions of positivism, which I am increasingly questioning as I become more interested in social constructionist viewpoints. This approach has obvious influences on what information is included in a formulation, and how the efficacy of such approaches is appraised.

Overall, at the end of this essay I feel I have a much greater understanding of the value of formulation, and how it can be ‘done’. I also feel better equipped to critically appraise its value, from both my own and my clients perspectives.
I have also been able to consider the process of formulation in light of my current personal interest in social constructionist ideas, and how it can be seen as a process of joint meaning-making, tied to a particular place, time and context. I feel excited about applying my increased understanding of formulation processes to future learning and clinical experiences.
References


Division of Clinical Psychology (2001). *The core purpose and philosophy of the profession*. Leicester: BPS.


Summary of case report: Adult mental health (1)

Title of case report: Cognitive-behavioural therapy with a forty-year old woman with panic disorder with agoraphobia.

Consent: Consent was sought and gained from Lisa\(^8\) prior to the case report being written, when we discussed the confidential nature of the report.

Referral: Lisa, 40, was referred to the Community Mental Health Team (CMHT) by her G.P, who cited long-standing difficulties with panic attacks with agoraphobia.

Diversity: Lisa was a white female, similar to myself. However she was older than me, and I attended to the possibility that our different life stages may have generated diverse assumptions and beliefs which could impact on our work.

Therapeutic work: Lisa and I met fortnightly for twelve sessions using cognitive-behavioural therapy (CBT), as recommended for panic disorder with agoraphobia (National Institute for Clinical Excellence, 2004). We worked towards Lisa’s main goal of getting back to work, which included various sub-goals such as visiting near-by towns. Lisa used thought diaries to record her activities and associated thoughts, and from these we generated various behavioural experiments. We also looked for times when she catastrophised any physical sensations, and for times when the evidence for her thoughts appeared to suggest an alternative thought might be more helpful.

Outcome: Lisa kept a diary of her achievements, which included visiting the near-by town on her own and booking onto a computer course. She also showed improvements on her pre and post scores on the Clinical Outcomes Routine Evaluation and a Panic Rating Scale.

Risk issues: There were no risk issues in my work with Lisa. However I attended to the possibility of this throughout our work.

\(^8\) A pseudonym has been used to ensure confidentiality.
Summary of case report: Adult mental health (2)

Title of case report: Grief therapy with a sixty year-old woman with chronic fatigue syndrome

Consent: Consent was sought and gained from Shirley\textsuperscript{9} prior to the case report being written, when we discussed the confidential nature of the report.

Referral: Shirley was referred to the Specialist Psychological Therapies service by her G.P., who described her two-year history of chronic fatigue syndrome (CFS), which he felt may be due to an underlying depressive disorder, possibly linked to bereavement.

Diversity: Shirley was considerably older than me and I had to attend to the various differences this entailed, for example the differences in our life stages.

Therapeutic work: Shirley felt that her difficulties had stemmed from difficulties in processing her husband’s death. We based our work on the hypothesis that her physical exhaustion might be an expression of the grief Shirley had found so difficult to express. We worked through the stages of Worden’s model of grief (1997), focusing in particular on ‘accepting the reality of the loss’ and ‘working through the pain of the grief’.

Outcome: Shirley scored significantly lower on the Clinical Outcomes Routine Evaluation post-therapy. However she said that most importantly she no longer wised to die, and was enjoying her life again. She was also considering getting back to work, something she had cited as a long-term goal at the start of our work.

Risk issues: Shirley reported suicidal thoughts at the start of our work. With her permission I informed her G.P., and we attended to any changes in her wish to carry out these thoughts. These thoughts decreased in intensity and frequency throughout our work.

\textsuperscript{9} A pseudonym has been used to ensure confidentiality.
Summary of psychometric case report: Children and families

Title of case report: A psychometric assessment investigating the cognitive abilities of a thirteen year old female: How do these difficulties, in addition to systemic issues, impact on her emotional and behavioural functioning?

Consent: Consent was sought and gained from Eloise and her mother prior to the case report being written, when we discussed the confidential nature of the report.

Referral: Eloise’s parents had requested a referral to CAMHS via their G.P., citing difficulties with Eloise’s behaviour at home. They also felt that Eloise was struggling at school academically and socially.

Diversity: Eloise’s family were White British as am I, but I was aware that our beliefs and assumptions about parenting and adolescence could be very different, which I was careful to attend to throughout our work.

Psychometric assessment: In order to explore possible cognitive difficulties we completed the WISC-IV, WIAT-II and the Beck Youth Inventory (to assess for affective issues). These suggested Eloise had a non-verbal learning disability, which may have accounted for her difficulties in completing her school work. This might subsequently have impacted on her self-esteem and relationships with her peers and family. I fed back these results to Eloise’s mother and her school with a hope of increasing their understanding of her presenting difficulties, and increasing her support network.

Outcome: Eloise and her mother said they were happy with the recommendations.

Risk issues: Eloise’s mother reported that she had bitten her hands in the past when distressed. This had not occurred for some time but her mother continued to monitor this.

10 A pseudonym has been used to ensure confidentiality.
Summary of case report: People with learning disabilities

Title of case report: Cognitive-behavioural therapy with a fifteen year-old male with a learning disability with visual and auditory hallucinations.

Consent: Consent was sought and gained from Oliver and his mother prior to the case report being written, when we discussed the confidential nature of the report.

Referral: Oliver was referred to the Children’s Community Team for People with Learning Disabilities by his head teacher, who felt his complex family life was impacting on his ability to develop relationships and independence.

Diversity: Oliver was of mixed-race origin, and his mother was black. I attended to these differences, with particular attention to associated religious issues throughout my work with Oliver.

Therapeutic work: Oliver and I focused on the visual and auditory hallucinations he reported seeing shortly after we began working together. An assessment by the Early Intervention in Psychosis team suggested these were associated with anxiety rather than psychosis. We worked individually using cognitive-behaviour therapy, but also held some sessions with his mother and brother in an attempt to increase their understanding of Oliver’s experiences.

Outcome: Via thought diaries and Oliver’s own reports we were able to see a decrease in the frequency of auditory and verbal hallucinations. Oliver’s overall level of anxiety also decreased, as shown on the Zung Adapted Anxiety Rating Scale (1971).

Risk issues: Oliver raised an issue of bullying which, with his permission I spoke to his teacher about. I also liaised closely with the family’s Social Worker, and Oliver’s mother’s CPN (she had a diagnosis of schizophrenia).

11 A pseudonym has been used to ensure confidentiality.
Summary of case report: Advanced competencies placement: Community Team for People with Learning Disabilities

Title of case report: Narrative therapy with a thirty year old female with a learning disability.

Consent: Consent was sought and gained from Natalie12 prior to the case report being written, when we discussed the confidential nature of the report.

Referral: With the assistance of an advocate Natalie referred herself to the Community Team for People with Learning Disabilities, requesting “to talk about her problems” regarding her family.

Diversity: Natalie and I were both females of a similar age, and I was careful not assume that her own hopes, beliefs and feelings would be the same as mine. One point of diversity was that Natalie had a learning disability, and we attended to the impact this had had on her life.

Therapeutic work: Natalie and I used narrative therapy to trace the history and impact The Worry had on her life, and began to build up ways in which she could claim back her life from The Worry.

Outcome: Natalie reported that The Worry had not got any bigger during our work, and at times it seemed much smaller. We developed a visual plan of the various skills (e.g. calling a friend or using a visual imagery technique) she could use to help shrink the worry. We used scaling questions and drawings throughout our work to monitor the changing impact of The Worry.

Risk issues: When The Worry was at its bigger times Natalie would self harm using scissors. Natalie and I agreed that she would see her G.P. if this reached a certain frequency, and she also spoke to her supported living agency support workers about this.

12 A pseudonym has been used to ensure confidentiality.
Problem based learning reflective account: Yr 1

The Relationship to change: A problem based learning reflective account

Year 1

Word count\(^{13}\): 1974

\(^{13}\) Does not include title page, statement of anonymity, references or appendices.
Introduction
Problem based learning (PBL) exercises aim to promote reflective practice via group learning. PBL exercises, which have been adopted by training courses in fields as diverse as architecture, business and psychology, aim to move learning from a passive form (e.g. lectures) to a more active process, with a focus is on solving problems rather than absorbing facts (Schwartz, 2004). Schwartz claims this results in students prepared for a lifetime of learning. Norman & Schmidt (2000) in their review of PBL exercises claim this method provides a “challenging, motivating and enjoyable” approach to learning.

The task
The group were asked to consider the title “the relationship to change” and produce a twenty-minute presentation to be performed to staff, visitors and fellow-trainees. The presentation was developed during six weekly meetings, three of which were facilitated by a staff member.

Response to the task
My involvement with the task began three weeks into the process (following my delayed start on the course). The group updated me on the discussions so far, which had stemmed from an initial discussion of personal experiences of change. The group had noticed that many of these accounts centred around the theme of moving, either from one area of the UK to another, or between countries. The group decided this would be an interesting aspect of personal change to consider, and highlighted a possible focus on cultural issues.
The second stage of discussions involved thinking about how each member of the group could contribute to the presentation. This was done in a very person-centred way, with each individual choosing a role for themselves with which they felt comfortable. Three members of the group decided they would like to tell their 'stories' of change; a narrator would make links between these accounts to theories of change; one member would discuss a coping strategy she had found useful at times of change and one member would focus on the process of the group. The person-centred approach adopted by the group allowed me to easily integrate and adopt a role that I felt comfortable with (as a second narrator). The ease at which I was able to join the group was possibly further aided by the fact the group knew they would be joined by an extra member halfway through the task, and their flexibly designed approach allowed for this to occur easily.

As our discussions progressed it was felt that the idea of linking culture into the narrative accounts forced the story-tellers to adapt their dialogue to fit this theme, and so it was decided the accounts should be kept focused on whatever elements the story-tellers felt were salient to their own personal experiences. It was felt this approach allowed a greater respect for the diversity of experience within the group. In keeping with this idea the group decided to look at each narrative individually and identify some themes or links that fit with the literature on change. The narratives themselves therefore influenced the choice of theory, which seemed a much more salient way of working than trying to fit the narratives to particular theories we had pre-selected.
However, the method by which we made these links provided an interesting learning point for the group, as the narrators found it extremely hard to make meaningful links between the stories and theories without discussing this with the authors of the narratives. As one of the narrators, I found it an uncomfortable experience to draw conclusions about somebody else’s story without ‘checking out’ with the person whether particular theories felt that they fitted. It was only by discussing each account with the author that we were able to make meaningful links to the literature. One of the authors felt the most important features of her experience of change was the lack of social support she received. This led us to consider the Direct Effect and Buffering Models (Cohen & Willis, 1985), which consider social support to either directly influence, or act as a mediator against stressors (e.g. change). Alternatively, the two other accounts focused more on the way narrative accounts can change over time, allowing the narrator to make sense of their own experiences (Dallos & Draper, 2003). Our research into narrative theory also highlighted the importance of recognising our own narratives, and considering what we bring to therapy as a result of this.

For me, this approach to matching experience with theory began to highlight the importance of working collaboratively with clients, to ensure formulations and interventions seem salient to both parties. This realisation led to the group working collaboratively on this issue, a method of which proved to be highly successful in creating a group that bonded well, and felt comfortable with each other. Those who were providing the narrative stories claim they felt more and more comfortable in sharing their personal experiences and feelings, and this was represented in how much more personal the narratives
became over the weeks. This creation of safety over time links directly to the therapeutic relationship, and how its development over time allows clients to feel more and more able to share personal information. As a group we held discussions about how this feeling of safety could change when presenting the stories to the much larger audience, and a decision was made that each group member would share only as much as they felt comfortable with. This again fitted in with the person-centred approach adopted by the group from the outset.

**Applications to clinical practice**

During the presentation we discussed several links to clinical practice that we had made between the personal narratives, the theoretical explanation of change, and the process of the group. Most notably these included the importance of collaboration, of recognising one's own narrative of change, respecting diversity of experience and the creation of safety over time as the therapeutic relationship develops.

Shortly after the presentation I began clinical work in my first placement, taking with me some of the ideas we had discussed. The most salient theme to emerge for me was the idea of collaboration, which was shown up strongly during the group process. I have found that working collaboratively with my clients to build a formulation and develop a useful way of working for both of us, has proven to be a successful way of increasing engagement and promoting the therapeutic relationship. In particular my work with Samantha,\(^{14}\)

\(^{14}\) Not the client's real name
a client who had previously had a very negative experience of a psychological assessment, has been greatly aided using this collaborative approach. By discussing together how her previous assessment had made her feel, Samantha and I were able to find together a way of working that seemed useful to both of us. We decided to adopt an ‘investigative’ approach to her difficulties, exploring together different options and feeding back to each other whether a particular avenue of interest seemed salient or not. By being explicit about this approach, and inviting Samantha to actively engage in the investigative process, we were able to develop a safe environment in which she could explore different ideas, and from this decide on the most salient goals to focus on and methods to achieve them.

The theme of creating a safe environment, which was highly pertinent to our presentation has also been applicable in my clinical work, and has proven to be one of the most important factors in initiating change. As with the PBL exercise, a feeling of safety is created over time through fostering a respect for an individual's experiences. This respect is vital if clients are to feel able to share the thoughts and experiences that they may have not have been able to do before.

The issue of confidentiality plays a vital role in creating the safe environment described above. Sharing personal stories with our audience allowed our group to reflect on some of the anxieties clients may have about who their stories will be shared with outside the therapy room. I have spent time with all my clients discussing this issue to ensure they are aware of when, and with
whom, I may share the details of our work, with the aim that these discussions will aid the creation of a safe environment in which they can share their stories. However, I am aware that discussions are currently taking place within the trust that I work regarding where psychology notes should be stored (in separate or team files) and what degree of detail should be included. It seems this issue of how much to share, with whom, and how, is a process that is currently undergoing some changes, and could result in different teams operating different policies regarding the sharing of information. This has made me aware of the importance of knowing both global, and local policies regarding information sharing, so that I can provide my clients with accurate information. In turn, I am aware of how this potential lack of complete confidentiality could impact on the therapeutic relationship, and subsequently what clients feel able to share.

The PBL task has also highlighted for me the importance of matching the theory to the client, and not the client to the theory. As a group this was one of the hardest points of the task we grappled with, as at first we attempted to 'fit' the narratives to particular theories of change. This was unsuccessful in both a theoretical way (the three narratives did not all fit neatly into one model of change) and personally, as it would have required the story-tellers to modify the way they originally conceptualised their stories. This seemed at odds with the person-centred way of working we had developed, which emphasised a respect for difference and diversity.
Future learning points

The issues that arose from the PBL task, as outlined above, are all issues that I am currently engaging with and developing throughout my clinical practise. However they are also applicable to my academic work, particularly in group situations. I feel this experience of working in such a respectful and collaborative way has provided me with some solid building blocks for future group work. I feel the next stage of my development will be in fostering these approaches in different groups, perhaps with others who do not share these views. My PBL group were all very much supportive of this collaborative approach to working, but it is highly likely that at some point (in either clinical or academic settings, or my personal life) I will work within groups where such a collaborative approach is not always welcome, or indeed possible. I hope this experience has given me at least some of the skills necessary to discuss and highlight the benefits of working in such a way.

On the other hand, reflecting back on this process has allowed me to see potential difficulties in the approach we adopted. For example, the group seemed very in-tune with where we wanted the presentation to go, and there were no real disagreements about how to go about this. In other groups this may not always be the case, and with no specified leader this could lead to difficult working relationships. I therefore feel a future learning point for the whole group is to be able to consider that though this approach to working was very successful for us, this may not always be the case. We may even find that future tasks within this group require a different style of working, which will require us to be adaptable and creative in order to identify a way of
working that best fits the task. This equally applies to our work with clients, where different approaches may be required for different clients.

In conclusion the PBL exercise has allowed me to begin developing skills vital to both clinical and academic work, and has highlighted some important ideas to consider in any future group work.
References


Problem based learning account: Year 2

Child protection, domestic violence, parenting and learning disabilities.

Year 2

Word count\textsuperscript{15}: 1955

\textsuperscript{15} Does not include title page, statement of anonymity, references or appendices.
Introduction

Problem based learning (PBL) exercises aim to promote reflective practice via group learning. They move learning from a passive form to a more active process, with a focus on solving problems rather than absorbing facts (Schwartz, 2004). In their review of PBL exercises, Norman & Schmidt (2000) claim this method provides a “challenging, motivating and enjoyable” approach to learning.

The task

For this PBL the group were asked to consider case material relating to a fictitious family, consisting of a couple, both believed to have a learning disability, and their twin girls, aged three. The family were described as living in conditions of deep poverty, and issues of domestic violence and difficulties with day to day tasks were cited. The group were asked to consider whether the twin girls should be placed into care, and to produce a twenty-minute presentation to be performed to staff, visitors and fellow-trainees. The presentation was developed over a four week period, with half of the meetings facilitated by a clinical psychologist.

Response to the task

We began by exploring some of the issues raised in the case material in discussion with the facilitator. During these initial discussions I became aware of how complex a case we had been given, and how many different perspectives and positions could be taken up. For example, the case material

16 I have chosen to write this account in the first person as I believe this allows me to be more reflective when discussing my role within the group, and its impact on my clinical practice
contained emotive issues such as learning disabilities and parenting, child protection, domestic violence and multidisciplinary working, all of which are potentially controversial issues.

While considering this new task, I wondered whether this material could result in some conflict within the group, and how we would manage this. Our previous work together (in a previous PBL task and fortnightly case discussions) had been extremely cohesive, and we had not had to deal with any conflicts between us as trainees. We subsequently had created both a private and public image of an extremely cohesive group. For example, in a discussion with our year group about possibly disbanding one of the CDG groups, we were adamant that we did not want to do this because of how well we had bonded. This links with Tajfel & Turner's (1986, cited in Hogg & Tindale, 2003) theory of social identity theory, which states that creating a positive image of one's own group reflects positively on each person as an individual, i.e. "if the group is good, then so am I". By promoting our successful working relationships to ourselves and others, we reinforced a feeling of self-efficacy in ourselves. This may be a beneficial occurrence at this time in our lives, given the stressful and often anxiety provoking nature of clinical training which can raise feelings of inadequacy and uncertainty in our work.

My thoughts about potential conflict within our group began to be played out in our discussions as we tried to decide what material to focus on for our presentation. For example, I and a few others felt strongly that there were
other strategies that needed to be explored before the children were placed in care. However, other members of the group, and in particular one person, felt very differently, believing the children needed to be removed from the home before further harm was done to them. One member (Alice\(^{17}\)) took this one stage further and expressed the view that in many cases people with learning disabilities should not be ‘allowed’ to have children as there are not enough services to give them the amount of support they often need.

This was the first conversation within our group where strong differences began to emerge, and I remember feeling quite uncomfortable in the room at this point. I do not enjoy conflict with people, and I tend to let most things “wash over” me. However, this was just too important a topic for me to avoid as I care passionately about improving the lives of people with learning disabilities (I plan to work with this service-user group following my training) and found it extremely hard to think that someone who is going to work as a clinical psychologist could hold such an inflexible view. I therefore felt I had to respond to these views, but I found this quite difficult, particularly in light of how dominant a member of the group Alice had become. I think this position has arisen partly as a result of her natural outspoken-ness, but also because as a group we have always known that if we don’t feel comfortable about speaking out on an issue, she will. This social loafing (Latane, Williams & Harkins, 1979) is a common feature to many groups, where individual motivation may decline in line with increasing group size. However, I suspect that while this pattern of interaction works well for us when we are all in

\(^{17}\) A pseudonym has been used to protect the anonymity of the trainee described here, and the group as a whole.
agreement about an issue, it does not so easily allow for disagreement and debate. This is perhaps another reason why these discussions felt so uncomfortable for me, because they called for a new way of interacting with each other.

As a group it was interesting that following this discussion, we then got on with the task in hand, almost ignoring the differences we had aired. It seemed as though everyone felt more comfortable in 'sweeping it under the table', and focusing on the practical elements of the task. Our presentation very much reflected this, in that we presented both sides of the issue and left it up to the audience to decide which side of the argument they sided with. This avoidance of conflict may have been successful in terms of us completing our task, but I wonder whether greater benefit for us as a group could have been gained by actually focusing on our differences and discussing how we deal with these.

I think there is a great need for this discussion as Alice mentioned at a later meeting that she had felt quite negatively reacted to by the group in light of her comments. I and the rest of the group were very surprised at this, partly because in fact the group had voted exactly half and half as to whether the children should be taken in to care or not. Bowman & Hughes (2005) have written an interesting paper that describes the anxieties that may be brought up during PBL tasks, particular in light of the non-directive facilitation and complex case material used. They state that, particularly in groups who know each other, self disclosure may be more likely and may be used as a means
to seek support from others. It is interesting that though we consider ourselves to be a highly supportive group, we left one member feeling very much 'on her own', and I believe this confirms that as a group we need to spend some time discussing the process of our group.

Applications to clinical practice

I believe my experience of this PBL task has great implications for my clinical practice. Firstly, in my current family therapy work I have been able to reflect on the fact that I am quite comfortable sitting with conflict in the room, and do not feel the need to shy away from it as I did in the PBL group. This difference interests me, and I have wondered whether it is perhaps because I am an 'outsider' to the family and not directly involved in their 'battle'. This leads me to wonder about the difference between my personal and professional self, and how these may interlink. I personally believe the two are intertwined, for example my therapeutic style builds on certain aspects I feel are inherent to my personality, for example warmth and understanding. While other aspects of my personality may not enter the therapy room so explicitly, I feel it would be ignorant to assume they do not affect my ways of interacting with, and interpreting the people and stories that I work with. I am therefore aware of a need to monitor my ability to manage and work with conflict, both in terms of my work with clients, but also my own personal reactions. I feel supervision and the CDG group could be useful avenues in which I could explore these issues.
On my current placement in a family therapy service, the notion of personal experience influencing clinical practice seems to tie in with my reading and experience of systemic and family therapy theories. For example, in family therapy the use of a reflecting team explicitly gives the message that one person does not hold the expertise to help the family, but that by looking at ideas from a range of viewpoints, each one influenced by the observer’s own biases and experiences, more helpful ways of relating might be found (Carr, 2000).

An additional point of interest for me has been in reflecting back on my previous work in learning disability services, and how this fits in, or conflicts with experiences in my current work with children and young people. I feel as if I am starting to see ‘both sides of the coin’, and to understand how complex an issue this is. The discussions within our group have allowed me to see the potential for conflict within multidisciplinary teams, where these difficult discussions and decisions are likely to be played out for real. I am aware of how important it is for me to overcome my anxieties about potential conflict to ensure my opinion is added to the debate. If I cannot do this, I feel I would be doing a disservice to my clients, as I need to be able to represent my clinical judgement in settings outside of the consulting room, as well as within.

**Future learning points**

I suspect my dislike of conflict links back to my experiences of being bullied at school, and of holding a fear that unless I fit in with a group they will reject me. This is something I am conscious of and try to address, and my clinical
training to date has been crucial in this. I have been able to see that people can hold very different views, yet still respect each other on both a personal and professional level. Perhaps by taking some risks and testing this out (maybe in the form of a CBT-type experiment) I can begin to challenge these concerns I have, and become a more vocal part of the groups I work within.

I think it is also useful to consider how this PBL task has furthered the formation of our group. Though we have been working together for a year, this seems to be the first time we have reached the storming phase of group development (Tuckman & Jensen, 1977) which occurs after the ‘polite and inhibited’ nature of the forming stage. This model claims that if a group can overcome the storming, it reaches a stage of norming where consensus about roles is developed. After this the performing stage features decreased conflict and increased productivity. I feel our group went through all these stages during this task, where conflict occurred and then decreased to make way for productivity. However, considering the wider picture of our group and our continued work together, I feel we are only just entering the norming stage. I suspect this is in part related to our recent change in facilitator, where we now feel more able to request a focus on process issues within the group. Already the issue of dominant and less dominant voices within the group has begun to be addressed, which I feel will be beneficial both to us as a group, but also to myself as an individual. I look forward to reflecting on these issues over the coming year and in future reflective accounts regarding this group.
References


Problem based learning account: Year 3

Working with a Muslim older person and his family.

Year 3

Word count\textsuperscript{18}: 1996

\textsuperscript{18} Does not include title page, statement of anonymity, references or appendices.
Introduction

Problem based learning (PBL) exercises aim to promote reflective practice via group learning, with a focus on solving problems rather than absorbing facts (Schwartz, 2004). For this training, each task is followed by an individually written reflective account. I hope this account about the final PBL will help me to appreciate my own “social position, preferences and desires, and how they impact and constrict what can be known” (Chinn, 2007, p13).

The task

The group were asked to consider case material about a fictitious family. Mr Khan, a 72 year old Muslim male, had moved to Britain from Pakistan in his mid 30's. Mr Khan’s youngest daughter Maya, who was until recently disowned by the family due to her marriage to a European man, had contacted Social Services with concerns about her father’s ability to take care of himself following his wife’s death. Mr Khan’s eldest daughter, who had returned to Pakistan for an arranged marriage, felt it was the family’s responsibility to care for their father. The group were asked to consider the issues in the case material and produce a twenty-minute presentation to be performed to staff and fellow-trainees.

Response to the task

We¹⁹ began by exploring some of some of the issues in the complex story of this family. These included issues of ageing (social, physical, emotional etc), the impact of migrating from one country to another, and how British-born

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¹⁹ I have chosen to write this account in the first person as I believe this allows me to be more reflective when discussing my role within the group, and its impact on my clinical practice
children and their parents from other countries may negotiate their roles within their family and wider society. The case material offered many differing viewpoints according to age, social, ethnic, gender and professional group, and these differing viewpoints seemed to us to be difficult, if not impossible to draw into one coherent account or ‘action plan’. We therefore decided to simply present the different viewpoints, with a hope that this would offer us and our audience a chance to reflect on the impact of the diverse range of opinions on each member of the system.

Our decision to embark on this type of presentation is set in a context of much change within our group. In previous years the PBL group has remained constant, and so we have got to know each other and our working styles quite well. During the first PBL we were initially a very task-focused group, but soon reflected on the absence of attention to process within the group. We subsequently placed a much higher focus on process in the second PBL, and during our other meetings\textsuperscript{20}. However, our attempt at addressing this led to a great deal of conflict within the group, culminating in an argument between three of the members (myself not included), with one member subsequently leaving the group at the end of last year.

In addition to this loss, a new member joined the group. This has perhaps exacerbated the difficulties within the group, as some members wished to discuss the recent conflict, but felt unable to do so in the presence of the new member, and a new facilitator. I consider myself to be part of this group, and feel it would have been difficult to respect the confidentiality of the member

\textsuperscript{20} The same groups also meet fortnightly in a ‘case discussion group’, were we present and discuss clinical and other material. These sessions are facilitated by a qualified Clinical Psychologist.
who had left while discussing this. In addition, the fairly extreme outcome of
us attempting focus more on process issues (someone feeling so distressed
they left the group without discussing their feelings with us first) has left the
group feeling a very unsafe place to explore these issues. I think these factors
are what led us to revert to our old working style of being very task focused.

The changes within the group have also been made against a background of
conflict within the wider trainee cohort. Concerns about bullying have been
raised in the course year as a whole, though the exact nature of these
concerns has not been made clear. This has left me (and I think also others)
quite anxious about what I say, for fear that I may have offended someone
without being aware of doing so. I think this anxiety contributed greatly to the
feeling within the smaller PBL group that it was unsafe to talk about conflict.

This backdrop of conflict may also have contributed to the unsaid discourse
about why the new member had left their old group to join ours, which I feel
added to the suppression of conversations within the group about how and
why our structure had changed. In addition, for me personally the new
member is someone who I have found it harder to ‘bond’ with over the past
two years, and this coupled with my sadness at the loss of our previous
member, who was someone whose input I had greatly valued, has made the
group feel a less comfortable place to share thoughts. I would have liked to
explore these personal relationship difficulties here but do not feel this
account, which may be placed in our publicly available portfolios, is a safe
enough place to do this without identifying the individuals in question. Instead
I will reflect more generally on theories of conflict within groups, and how I feel my experiences link to my clinical work.

Reflections on the task

In some ways the term conflict seems an odd choice of word to use when describing our group during this task, as there has been very little overt conflict within the group in deciding how to complete this task. However, as stated earlier this work has taken place amongst a great deal of conflict in the previous and PBL group, and wider cohort.

A great deal had been written about conflict within groups in various settings such as educational and corporate groups, as well as in group therapy. Some research has found positive outcomes to conflict within groups, usually when the conflict occurs around the ideas associated with a task. For example, Gero (1975) has talked about conflict maintaining diversity of ideas and avoiding 'groupthink'. However, a study by DeChurch, Hamilton and Haas (2007) found that conflict over ideas was often also associated with poor inter-relationships within the group. Applying this notion to our group, I can see that the disagreements that took place within our group in the previous PBL task may have weakened the relationships within our group, making it harder to discuss the subsequent difficulties experienced in losing one member and gaining another.

I find it interesting that a group of psychologists trained to help people talk in difficult situations could not achieve this themselves. I have wondered if this is
in part due to the joint roles we all share with each other, i.e. as colleagues, as friends etc. However, this dual-role is likely to be common throughout our careers, and something that we will need to work with, rather than use as an excuse for avoiding potentially difficult discussions. I wonder if acknowledging this complexity would help to open up conversations. I feel this group, supported by a facilitator, could be a relatively safe way to attempt to explore some of these issues. In particular I think our current facilitator, in comparison with our last, may be better equipped in helping us to negotiate these difficult discussions, due to her greater experience in working with trainees.

Despite the difficulties within the group, I feel there are some positive aspects of this PBL task that show how we as a group, and myself as an individual have developed since the first task two years ago. For example, the group were able to tolerate there being 'no easy answers' within the case material provided. This represents a real shift from our first two presentations where we have sought to find a solution. I think this demonstrates a change in my own and others clinical practice and thinking.

In addition, I have become more comfortable about my own role within the group, and in particular about sharing my opinions. I can see that my confidence has grown a lot over the past year, and I am now much more able to express my own ideas when they differ from other members. In particular I have noticed this in relation to one very confident member of the group, who I previously felt unable to debate with. However, I have noted that this member has also become less vocal during our meetings (I hypothesise because of
her role in the conflict that led to a member leaving\textsuperscript{21}, which may have partly led to my increased confidence. I think this issue will be something I strive to continue developing, as I believe it will be a highly important one when working as part of an MDT, and particularly if taking on a leadership or managerial role.

Applications to clinical practice

My experiences of the group to date seem highly relevant to my clinical practice. Reflecting back on one team I worked with on a previous placement, I can see very similar patterns being played out. For example, their weekly team meetings often felt quite hostile, with a focus on task orientated information only. However away from these meetings, smaller groups of individuals would discuss some of the process issues. This is similar to what has occurred in our group, with process issues being discussed away from the main group, with a reluctance to share these thoughts when we are all together.

The team I worked in previously was one that was managing its task load to an acceptable level, as has this PBL group. This has made me wonder whether these process issues do actually need to addressed? Both groups seemed to be able to manage their required tasks, and perhaps saw themselves as a group functioning at a ‘good enough’ level. I suspect that in my future work with teams this could become a very pertinent question - where does a team draw the line between being good enough and not good

\textsuperscript{21} Again, I have felt unable to explore this issue more fully here because of the public nature of this document.
enough? And could being ‘good enough’ be used as a defence against exploring difficult relationships within the team?

Perhaps a difference between my experience on placement and this PBL group is the frequency and length of work required. For this brief task our group was largely able to put aside any personal issues and concentrate on the task. However, if the task had been a longer term endeavour, I feel sure these differences would have aired eventually, either through a planned discussion or perhaps some other, less constructive means. Balancing issues of task completion and personal and working relationships is likely to be one I will face in my future work with teams. As psychologists our role is increasingly becoming one where leadership and management are required (as documented in New Ways of Working, BPS, 2007), and I feel my previous and ongoing experiences within this group, and observations of groups during my placements, will help me to understand the issues involved in managing, and hopefully overcoming difficult relationships within groups.

**Future learning points**

This PBL task has highlighted several issues which I think will require further reflection and possible action. I do not feel the group has managed the transition in losing one member and gaining another in a very transparent way, and it feels as though we have shut down opportunities to discuss this. I hope that the writing of these accounts may make us all a little more open to these discussions, with the hope of generating a more useful group for us all. However, as our training nears its end, I do wonder whether the motivation
will be there in all members to make these changes, particularly as people's focus becomes more and more on other aspects of training such as our research projects, and looking for future employment. I hope that my motivation to this group may go some way to encouraging others to also invest in it, but feel that even if they do not, this will be a useful experience for me in working in a group with people who have differing vested interests and levels of motivation.
References


Summary of case discussion group reflective account: Year 1

This account reflected on the fortnightly case discussion group that I was a part of. A summary of the theoretical underpinnings of case discussion groups was explored, with particular relevance to clinical psychology training. The group this year was an all female group, with a male facilitator, which was organised in a structured way whereby two members presented a case for discussion at each meeting.

I reflected on my role within the group, particularly my late joining (due to a delayed start on the course) and the impact on this process of my previous experiences of entering already formed groups. I go on to reflect on the impact of the male, directive facilitator, and the differences in the experience of the group during un-facilitated sessions.

I also comment on the dual-role the facilitator had for me (as he was also supervising some of my work on my adult mental health placement) and the impact this had on what I chose to share with the group. The development of the group’s willingness to share personal information is explored throughout the year. The role of others within the group is explored, as are the applications of the group’s discussions to clinical practice. Furthermore, links between the experience of being in the group are made to experiences on placement. Finally, Consideration is given to the future of the group and areas for personal and collective development.
Summary of case discussion group reflective account: Year 2

This account built on the experiences described in the previous account regarding the fortnightly case discussion groups. The group remained the same apart from a change in facilitator. The group were initially facilitated by a female, external facilitator (compared to the previous year’s internal facilitator) but when she left after a few sessions an external male facilitator took over.

I reflect on the impact of the previous year’s facilitator on the development of the group’s relationship with the two new facilitators. As a result of his impact on the tone and content of the sessions, the group adopted a much more directive stance on the sessions. The impact of this stance on our initial relationship with each of the new facilitators is discussed.

I reflect on my changing role within the group, and how this linked to the group’s decision to begin focusing much more on process issues this year. By doing so we were able to explore the perceived changes of ourselves and each other. However, there were some difficult issues brought up as a result of this focus on process, and the impact of this is considered. Some specific issues for discussion are considered in light of planning for the final year of the group.
Summary of clinical placement: Adult mental health

Range of clinical work
This placement was split between a specialist psychological therapies service; a community mental health team (CMHT); a community recovery team and a day hospital service. The work included individual therapy using predominately CBT for a range of issues such as panic disorder with agoraphobia; anorexia; grief and OCD. This work took place at the team base; at client’s homes and one piece of work involved telephone sessions. I also arranged and co-facilitated several groups for depression and assertiveness. I also completed several neuropsychological assessments, including a lady with Korsakoff’s syndrome and someone with a brain injury. I was involved in multi-disciplinary team working throughout the placement, and worked alongside nurses and occupational therapists to run the groups.

Research and audit
I completed a client satisfaction survey at the CMHT assessing clients’ views about their access to psychological therapies from the team. I designed a questionnaire which was sent to every person currently being seen by the team. The results were fed back to the team, and to the Lead Psychologist in the area, who planned to use the results to inform training and service development within the local CMHTs.

Teaching and presentations
I designed and presented a session on ‘working with resistance’ to staff at a day hospital. I also presented the findings of the client satisfaction survey to the CMHT staff team.

Consultation and leadership
I assisted my supervisor in running the first group supervision session for staff from other professions at the CMHT. The CMHT audit was due to be fed into planning for the future of service provision by the CMHT. I also co-facilitated three consultation sessions with staff at a residential home.
Summary of clinical placement: Children and Families

Range of clinical work
This placement was split between a child and adolescent mental health service (CAMHS) and an inpatient service for children and adolescents. At CAMHS I engaged in individual work with young people around issues such as phobias, predominately using CBT. I also worked with the families of younger children around issues such as sleeping and feeding difficulties and assessing and accepting a diagnosis of learning disability. I also completed several cognitive assessments. On the inpatient service I worked with the family therapy team, seeing young people and their families for issues such as anorexia, anger and oppositional defiance disorder.

I worked with the multidisciplinary team in both settings, and liaised regularly with other professionals in the children and young peoples’ networks such as teachers and GPs.

Research and audit
I attended and minuted a meeting on implementing the ‘Seven Helpful Habits’ for CAMHS services, focusing on ‘letting people go’. This was currently under review and being implemented in the CAMHS service.

Teaching and presentations
I co-presented a workshop on multiple family therapy for anorexia to other professionals working with children and young people at the inpatient service. I also presented a session on the uses of cognitive assessments (e.g. the WISC-IV) to the multidisciplinary team at the CAMHS service.

Consultation and leadership
I provided consultation to the staff on the inpatient service (both in the nursing and school section) regarding a client I was working with individually and in the family therapy setting.
Summary of clinical placement: People with learning disabilities

Range of clinical work
This was a split placement between the adult and child community teams for people with learning disabilities. In the adult team I completed various psychometric assessments, and also took part in family therapy sessions (as reflecting team and lead facilitator) with a family with two adult sons with autistic spectrum disorders. For the children's team I conducted a cognitive assessment, and engaged in various pieces of individual therapy using a cognitive-behavioural approach. I worked closely and collaboratively with parents, teachers and other professionals throughout this placement. I also completed various school based observations and conducted a joint assessment with the Early Intervention in Psychosis Team.

Research and audit
I was part of a research project being led by the consultant psychiatrist at the CTPLD, investigating a family which had seven year old male triplets who had all received a diagnosis of autistic spectrum disorders. I completed cognitive assessments with the three boys as part of the study.

Teaching and presentations
I designed and facilitated a workshop with staff at a respite service for children and young people on using Comic Strip Conversations with their clients. This included providing them with examples I had used in my work with one of their clients, as well as materials they could adapt for use with other clients.

Consultation and leadership
I designed the format and materials for a feelings group based on behavioural theories that would be facilitated by a nursing member of the team at a school for children with learning disabilities.
Summary of clinical placement: Advanced competencies: Community Team for People with Learning Disabilities.

Range of clinical work
This placement was spent in a community team for people with learning disabilities. I conducted several cognitive assessments, as well as a baseline dementia assessment. I engaged in individual therapeutic work using cognitive behavioural and narrative therapy approaches for a range of issues such as anger and difficulties in family relationships. I worked collaboratively with members of the multidisciplinary team; nurses and carers, and family members in various community and inpatient settings.

Research and audit
I contributed to the data collection for an audit regarding the number and time requirements of psychometric assessment referrals made to the psychology department of the CTPLD.

Teaching and presentations
I presented the findings of an extended assessment to a staff team working with one of the clients I was working with, and facilitated a discussion based on this. I was also asked to present my major research project (on challenging behaviour in learning disability services) to psychologists working in learning disability services across the Trust.

Consultation and leadership
I assisted with a consultation session facilitated by my supervisor with two members of staff working with a client referred for her challenging behaviour.
Summary of clinical placement: Older people

Range of clinical work
This placement was split between two acute inpatient services (one for people with dementia and one for people with mental health difficulties) and a neuropsychology consultation and assessment service. I carried out both direct and indirect interventions on the wards, using CBT and systemic practices. I also offered consultation on both of the wards. In the neuropsychology service I utilised a variety of neuropsychology assessments to explore the issues for clients who were referred because of an unclear diagnosis.

Research and audit
I was involved in a piece of audit work around the nurses' use of a social profile tool. This involved reviewing the content of the profile and editing it to allow a more useful history of each person on the ward to be obtained upon admission. I was then involved in the implementation of this.

I also assisted with a review of literature into the outcomes specified in various policies for inpatient services. This was then used to inform the aims and evaluation of a reflective practice group that was being instigated for staff on the inpatient wards.

Teaching and presentations
I co-facilitated teaching sessions on the wards regarding the use of the ACE-R cognitive assessment, including designing and carrying out evaluation of this training.

I was also involved in presentations promoting the neuropsychology service.

Consultation and leadership
I offered consultation on both the wards, particularly around developing formulations for clients. I also supported a nursing assistant to conduct a piece of life review work with a client with dementia.
Service-related research project

How satisfied are service-users with their access to 'talking therapies' from a Community Mental Health Team (CMHT) in South-East England?

Year 1

Word count\textsuperscript{22}: 2965

\textsuperscript{22} Does not include title page, contents page, abstract, acknowledgments, references or appendices.
Acknowledgements

I would like to thank Dr. Vicky Senior, Research Tutor at University of Surrey, and my two clinical supervisors (not named for confidentiality) for their help and advice with this audit.
Abstract

This cross-sectional survey aimed to investigate the satisfaction levels of service-users at a CMHT in the South-East of England with their access to talking therapies. 90 respondents (28 males and 52 females) returned a postal questionnaire which was sent to 365 service users. No significant differences were found in the provision or satisfaction with these services according to gender and age, and 82 per cent of those receiving talking therapies were 'satisfied' or 'very satisfied'. The discussion focuses on the relevance of these findings for the CMHT in the context of current changes to the role of Clinical Psychology services to a consultancy role, including the high level of talking therapy the team is already providing; the possibility of training days to enhance the factors associated with satisfaction and the notion that collaborative working is needed to understand and maximise the factors each individual values in therapy. Finally, suggestions for future work focus on increasing the reliability and validity of the measures used, and repeating the study to allow comparisons to be made following the change in role in Psychology.
1.0 Introduction

Access to ‘talking therapies’ has been placed high on the agenda for mental health services both nationally and locally. Talking therapies are broadly defined as “an opportunity for somebody to talk through potentially difficult issues with someone who will listen” (Department of Health, 2004). The Department of Health’s Organising and Delivering Psychological Therapies document (2004) describes three levels of this service provision. At the most basic level, Type A reflects the generic skills mental health professionals should be employing when working with clients (e.g. warmth). The Type B stage refers to the use of discrete elements of a psychological theory, for example the use of thought diaries. Finally, Type C describes the use of formal psychotherapies, for example psychodynamic therapy.

This audit aims to investigate whether service-users at a CMHT in South-East England perceive they are receiving talking therapies from the team, and if so who they receive it from and how satisfied they are that it is helping their problems. This is a timely project nationally as the NHS is becoming increasingly interested in hearing what service-users have to say about the services they receive, and are using this feedback to help drive services forward (Department of Health, 2005). This audit is also pertinent at this time locally as a change in the role of the Clinical Psychologist within the team is currently underway. In line with other CMHTs across the country, this change will involve a move towards a more supervisory / consultation approach, with the hope that this increasing support will allow other members of the team to
provide more of the talking therapies. It is hoped this will reduce the waiting times for the psychology service, and allow more service-users to access talking therapies. This audit will provide initial baseline datum, allowing any effects in service-users’ perceptions of the provision of talking therapies to be observed over time.

The service are interested in who is currently receiving talking therapies (in relation to gender and age) and how satisfied service-users are. Information on which professions are perceived to be providing talking therapies will also be gathered, as this may suggest how big an impact the change in role for psychology will have.

1.1 Research Questions

1.1.1 Access to talking therapies

1.1.1.1 To what extent do service-users at the CMHT believe they have had access to talking therapies?

1.1.1.2 Are there any significant differences between those who had access to talking therapies and those who didn’t, in terms of:

- age
- gender
1.1.2 Satisfaction with talking therapies

1.1.2.1 How satisfied have service-users at the CMHT been with the talking therapies they have received?

1.1.2.2 Do they feel it has helped in coping with their difficulties?

1.1.2.3 Are there any differences between males and females?

1.1.2.4 Are there any differences between different age groups?

1.1.3 Professional groups providing talking therapies

2.0 Method

2.1 Design

A cross-sectional survey design was employed, with each participant completing and returning a postal questionnaire (Appendix 1).

2.2 Participants

The questionnaire was sent to all clients being seen by a member of the CMHT in March 2006 (n=365). The final sample consisted of 28 males and 52 females (total n = 90). This meets the criteria for a medium effect size (0.3) and power of >0.8 (calculated using G-power, 2003, \( \chi^2 = 3.8415, df = 1, p < 0.05 \)).
The following chart describes the age ranges of the respondents:

Table 1: Age range of the sample

<table>
<thead>
<tr>
<th>Age range</th>
<th>Frequency (and %) of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-25</td>
<td>9 (10.0)</td>
</tr>
<tr>
<td>26-35</td>
<td>15 (16.7)</td>
</tr>
<tr>
<td>36-45</td>
<td>26 (28.9)</td>
</tr>
<tr>
<td>46-55</td>
<td>26 (28.9)</td>
</tr>
<tr>
<td>56-70</td>
<td>14 (15.5)</td>
</tr>
</tbody>
</table>

Data on ethnicity was not collected as part of this study as another audit was investigating this issue. To avoid duplication of these data, and to help keep the questionnaire as brief as possible, this item was removed. However, these data from the UK census (2001) for the area covered by the CMHT suggests only one per cent of the population classifies themselves as coming from an ethnic minority. It is highly likely this sample would have been similar, and therefore predominately ‘White British’.

2.3 Measures

The questionnaire designed by the author, another trainee clinical psychologist, two Professional Lead Psychologists and two Clinical Psychologists working at CMHTs following a literature search that did not find any current satisfaction surveys that met the requirements of this audit. It consisted of a series of closed, Likert scale questions and some open ended questions (designed to elicit some qualitative feedback). The questionnaire included sections on demographics, professional group seen at the CMHT, satisfaction with the generic skills offered by the team (based on Type A skills, described above) and views on whether ‘talking therapies’ were wanted, received and/or useful (based on Type B skills). Satisfaction with more...
specific, formal therapies was not included as this is being assessed in a separate audit.

A draft version of the questionnaire was sent out for comments from the four clinical psychologists mentioned above, a member of CAPITAL (a local service-user group) and research tutors at the University of Surrey. Due to the necessity of designing a questionnaire, reliability and validity of this measure is not known, and the time constraints of this project have not allowed these factors to be investigated.

2.4. Procedure

A list of all individuals being seen by a member of the CMHT was obtained from the administration team, and addresses were obtained from the Patient Information Management System (PIMS). The decision to only send the questionnaire to current clients of the CMHT (and not discharged individuals) was taken for ethical reasons, as it was felt those currently being seen would be more able to seek out support should they have any concerns regarding the questionnaire.

365 questionnaires were sent out, each with a cover letter (Appendix 2) which described the details of the study, and the voluntary and confidential nature of responding. Any responses sent back were taken as a sign of informed consent. Each client was also sent a self-addressed envelope in which they could return their anonymous questionnaire, which ensured confidentiality. A tear-off slip (which could be kept separate from any completed material) was
also provided should the service user wish to receive information on the findings of the project.

3.0 Analysis and Results

In total 90 questionnaires were returned (a response rate of 24.6 per cent). Quantitative analysis of these data was carried out using SPSS (Version 13.0). Chi-square was used to investigate potential relationships and differences within these data. This non-parametric test is suitable because these data is at the nominal level. However, because this test is less robust than it's parametric equivalents, caution must be taken when interpreting the results.

All analyses have been conducted on these data present for each item in question, with missing datum for each item demonstrated in the tables.

Content analysis (conducted according to the guidelines in Oppenheim,1994) was used to explore the qualitative responses. A full list of all themes, including examples can be found in Appendix 3.

3.1. Access to talking therapies

3.1.1. 69 per cent (62 respondents) of the sample completed Section C of the questionnaire, which they were asked to complete if they felt they had received talking therapies from a member of the CMHT.
3.1.2 With regard to gender, there were no significant differences between males and females in terms of receiving talking therapies ($\chi^2 = 1.769$, df = 1, $p = 0.184$). Descriptive statistics of the sample is shown below:

Table 2: Break down of sample by gender and talking therapy received

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency (and %) of sample who received talking therapies</th>
<th>Frequency (and %) of sample who did not receive talking therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17 (18.8)</td>
<td>11 (12.2)</td>
</tr>
<tr>
<td>Female</td>
<td>39 (43.3)</td>
<td>13 (14.4)</td>
</tr>
</tbody>
</table>

3.1.3 Age was also investigated as a possible factor that could influence who received talking therapies. The age groupings were collapsed into 'under 35' and 'over 36' to ensure cell sizes were greater than five. However this was also found to be non-significant ($\chi^2 = 0.570$, df = 1, $p = 0.450$). Descriptive statistics of the sample is shown below:

Table 3: Break down of sample by age and talking therapy received

<table>
<thead>
<tr>
<th>Age range</th>
<th>Frequency (and %) of sample who received talking therapies</th>
<th>Frequency (and %) of sample who did not receive talking therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 35</td>
<td>44 (48.9)</td>
<td>22 (24.4)</td>
</tr>
<tr>
<td>Over 36</td>
<td>18 (20.0)</td>
<td>6 (6.7)</td>
</tr>
</tbody>
</table>

3.2. Satisfaction with talking therapies

3.2.1 Of the 69 per cent who felt they had received talking therapies, (n = 62) 82 per cent stated they were “satisfied” or “very satisfied” with the talking therapy they received. 16 per cent rated themselves as “dissatisfied” or “very dissatisfied”. Individual ratings for each of these categories are shown below:
Table 4: Satisfaction of the respondents who felt they had had received talking therapies

<table>
<thead>
<tr>
<th>Satisfaction with talking therapies</th>
<th>Frequency (and %) of respondents who received talking therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>21 (33.9)</td>
</tr>
<tr>
<td>Satisfied</td>
<td>30 (48.4)</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>6 (9.7)</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>4 (6.5)</td>
</tr>
<tr>
<td>Missing data</td>
<td>1 (1.6)</td>
</tr>
</tbody>
</table>

3.2.2 When asked how much they felt the talking therapy was helping to solve their difficulties, 73 per cent felt that it was either “pretty much” or “completely”. 21 per cent felt it had helped “not much” or “not at all”. Individual ratings for each of these categories are shown below:

Table 5: Views of respondents who had received talking therapy on how much they felt talking therapy was helping to solve their difficulties.

<table>
<thead>
<tr>
<th>How much talking therapy is felt to be solving difficulties</th>
<th>Frequency (and %) of respondents who received talking therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely</td>
<td>8 (12.9)</td>
</tr>
<tr>
<td>Pretty much</td>
<td>37 (59.7)</td>
</tr>
<tr>
<td>Not much</td>
<td>11 (17.7)</td>
</tr>
<tr>
<td>Not at all</td>
<td>2 (3.2)</td>
</tr>
<tr>
<td>Missing data</td>
<td>1 (1.6)</td>
</tr>
</tbody>
</table>

One factor that may have influenced satisfaction levels is the amount of choice the service-users felt they had in their treatment. The following chart demonstrates that only 56 per cent of those who were receiving talking therapies felt they were offered choices in how to deal with their problems “Much of the time” or “All of the time”. 39 per cent stated they had been offered choice “sometimes” or “not at all”. Individual ratings for each of these categories are shown below:
Table 6: Views of respondents who had received talking therapy on how much choice they were offered in how to deal with their difficulties.

<table>
<thead>
<tr>
<th>How much choice respondents were offered</th>
<th>Frequency (and %) of respondents who received talking therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>17 (27.4)</td>
</tr>
<tr>
<td>Much of the time</td>
<td>18 (29.0)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>17 (27.4)</td>
</tr>
<tr>
<td>Not at all</td>
<td>7 (11.3)</td>
</tr>
<tr>
<td>Missing data</td>
<td>1 (1.6)</td>
</tr>
</tbody>
</table>

3.2.2 The qualitative information collected from those respondents who felt they had received talking therapies suggested many other factors that may have influenced satisfaction levels. For those who felt they had received talking therapies, the most frequently cited thing (n = 12) their therapist had done in trying to help them was “talking over the difficulties to find a way of getting through”. The second most common response (n = 9) was “listening to me so that I did not feel alone”:

3.2.3 Alternatively, when asked about the least helpful thing they had the most frequently sited difficulties were when the “side effects of medication were not properly explained to me”, (n=2) “cancelled appointments” (n=2) and a dislike of group therapy: “I hated hearing about other people who appeared to always be ill and some actually enjoying it. Very negative reaction to me” (n=2).

However, it should also be noted that many respondents (n = 16) felt that “there is nothing that I have found not to be helpful so far".
3.2.4 There was no significant difference between males and females regarding satisfaction levels with talking therapies ($\chi^2 = 3.221$, $df = 1$, $p = 0.73$). However, on one of these factors the expected was count was <5, which means caution must be taken when interpreting this result. Descriptive statistics of the sample is shown below:

Table 7: Break down of sub-sample who had received talking therapies by gender and satisfaction.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency (and %) of respondents who were satisfied</th>
<th>Frequency (and %) of respondents who were dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12 (19.4)</td>
<td>5 (8.1)</td>
</tr>
<tr>
<td>Female</td>
<td>35 (56.5)</td>
<td>4 (6.5)</td>
</tr>
</tbody>
</table>

3.2.5 An effect of age on satisfaction was also investigated using a Chi Square. In order to produce cells greater than 5, the age categories were combined to produce the following groups:

Table 8: Break down of sub-sample who had received talking therapies by age and satisfaction.

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency (and %) of respondents who were satisfied</th>
<th>Frequency (and %) of respondents who were dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 or under</td>
<td>14 (22.6)</td>
<td>4 (6.5)</td>
</tr>
<tr>
<td>36 or over</td>
<td>37 (59.7)</td>
<td>6 (9.7)</td>
</tr>
</tbody>
</table>

There was also no significant effect of age on satisfaction levels ($\chi^2 = 6.33$, $df = 1$, $p = 0.426$). However, one of these factors had an expected count of <5, which means caution must be taken when interpreting this result.
3.3 Professional groups providing talking therapies

With regards to the professional seen for talking therapy, several respondents reported that they had seen more than one professional group. The following table demonstrates the number of respondents who felt they had received talking therapy from each professional group:

Table 9: Frequency of respondents who had received talking therapy from each professional group:

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Frequency (and %) of respondents receiving talking therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Psychiatric Nursing</td>
<td>22 (35.5)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>19 (30.6)</td>
</tr>
<tr>
<td>Psychology</td>
<td>13 (21.0)</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>7 (11.3)</td>
</tr>
<tr>
<td>Social Work</td>
<td>5 (8.1)</td>
</tr>
<tr>
<td>Don't know</td>
<td>6 (9.7)</td>
</tr>
<tr>
<td>Missing</td>
<td>2 (3.2)</td>
</tr>
</tbody>
</table>

4.0 Discussion

4.1 Summary of findings

62 per cent of the total sample felt they had received talking therapies, with no differences existing between different genders or age groups, suggesting equality in provision of these services. Those receiving talking therapies were largely satisfied (82 per cent), with some suggested influential factors being having choice in treatment plans and being listened to. Sources of dissatisfaction included therapists being overly concerned with medication issues, difficulties in getting appointments and a dislike of group work. Talking therapies were reported to have been provided by all members of the CMHT, with community psychiatric nurses providing the highest frequency.
Differences in these frequencies may reflect the proportions of each profession working at the CMHT.

4.2 Limitations of the audit

Due to a lack of appropriate questionnaires regarding satisfaction with talking therapies in the current literature, one had to be designed for this study. Limitations in time prevented this being piloted, or reliability and validity established. Future work to address this issue could include a more detailed focus on the construct of 'satisfaction', and comparisons to validated satisfaction assessment tools. However, face validity of the questionnaire is suggested by the response rate of 25.6 per cent, which was much higher than the predicted 15 per cent (based on similar audit projects conducted in the local area).

Due to another audit investigating the issue of ethnicity, these data were not collected. Though the sample was predicted to be largely White British, this may not have been the case, and the predominately White British staff group at the CMHT could impact on the service provision to ethnic minorities.

With regard to the statistical analyses, though the total sample size met the criteria for a medium effect size and power of >0.8, the sub-sample of those receiving talking therapies was smaller (n = 62), and caution must therefore be taken when interpreting these results. Issues around increasing the response rate would need to put in place in the future to address this, perhaps by doing a second mail shot.
Though the qualitative information has provided useful support to the statistical findings, the findings from this method were relatively weak as the open-ended questions were kept as brief and minimal as possible to encourage a high response rate. Follow up interviews or focus groups could have provided much richer information at this level. The reliability of the scoring for this information is also unknown, as time constraints prevented inter-rater reliability being performed. Future work could seek to address this.

4.3 Significance of findings

These findings are highly relevant to the CMHT in light of the current changes occurring in role of psychology, which is likely to impact on the way, and from whom talking therapies are provided. This could potentially be a time of anxiety for the team, but the findings of this audit may help to ameliorate this by highlighting how much talking therapy the team as a whole already provides, and how satisfied service-users are with this.

The qualitative material provided feedback that may be useful for the team to consider in their work with all clients, in order to promote satisfaction. Most notably, the skill of listening (a Type A skill relevant for all work) was highlighted as the most important factor in a therapist. This, and other factors such as discussing difficulties and helping to find solutions, offer practical ways the team can enhance the services they offer. Training days could be utilised to allow the team to discuss ideas around increasing these elements in their work.
However, the audit also highlights the differences between service-users in terms of what they expect and value in mental health services. This suggests that while there are some factors many service-users find beneficial, each individual will have their own preferences and dislikes, and it is only via collaborative, individually tailored approaches that satisfaction can be maximised.

4.4 Areas for future work
As described above, useful future work could seek to maximise the reliability, validity and response rate to the questionnaire. Greater resources would allow for more in-depth qualitative information to be gathered, following which inter-rater reliability could be used to ensure the reliability of the coding. However, the study should also be repeated as it currently stands, to allow comparisons to be made regarding satisfaction levels following the change in the role of psychology within the team.
5.0 References


6.1 Appendix 1: Questionnaire

Client Satisfaction Survey

1) Please circle your response to the following questions

Gender
Male Female

Age
17-25 26-35 36-45 46-55 56-70

2) Please tick which of these professionals you have seen in the service

☐ Psychiatrist ☐ Social Worker ☐ Community Psychiatric Nurse

☐ Occupational Therapist ☐ Psychologist

3) Please circle which of the people listed above you see most regularly

4) Approximately how many times have you seen this person?

Sessions 0-4 5-10 11-20 21-30 31 and over

Section A

Thinking about the person you have seen most often, please circle on the following scales the point which you feel best describes your opinion

During your sessions......

1. Did you feel you could talk to this person?

Not at all Not much Uncertain Quite a lot Completely

2. Did you feel that this person listened to you?

Not at all Not much Uncertain Quite a lot Completely

3. Did you think this person understood your problems?

Not at all Not much Uncertain Quite a lot Completely

4. Did the person respect you?
5. Did the person make themselves clear to you?

6. What was most helpful about talking over your problems?

7. What was the least helpful about talking over your problems?

8. How satisfied were you with the amount of input you received?

Section B

The Department of Health describes 'talking therapies' as a chance for clients to discuss their difficulties with a professional person who will listen attentively. The therapist will be accepting and non-judgmental, and will help the client to find their own answers. There are a range of models of therapy that can be used and these can be delivered by many professionals including: Psychologists, Community Psychiatric Nurses, Occupational Therapists, Social Workers and Psychiatrists.

When you were referred to the service ..... 

9. Did you hope you would receive talking therapies?

10. Were you offered talking therapies?
11. Did you accept the offer of talking therapies?

Yes  Unsure  No

If you went on to have talking therapy please continue with section C.

If you do not believe you have received talking therapy, thank you for your time in completing this questionnaire. Please return in the envelope provided.

Section C

12. Which professional did you see for talking therapy? Please tick your response

- Psychiatrist
- Social Worker
- Community Psychiatric Nurse
- Occupational Therapist
- Psychologist

13. Were you offered a choice in how to deal with your problems?

Not at all  Sometimes  Much of the time  All of the time

14. Are your sessions helping to solve your problems?

Not at all  Not really  Uncertain  Pretty much  Completely

15. What was the most helpful that your therapist did in trying to help you?

16. What was the least helpful thing your therapist did in trying to help you?
THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE. Please return it, free of charge, in the envelope provided.
6.2 Appendix 2: Cover letter

Dear

I am writing to ask for your help in improving the service we at
provide. In order for us to better understand our client’s experiences
we have devised the enclosed questionnaire, which we are sending to all clients
currently being seen by CMHT. As a current client, we would really value your
views.

The survey is completely anonymous unless you choose to make it otherwise. Your
decision to complete or not complete the questionnaire will not affect the care that
you receive from the staff at CMHT. However, it is hoped that by participating,
the service to future clients referred to CMHT may be improved.

If you would like to receive a summary of the findings of this survey please complete
the tear off slip at the bottom of this page, and return it (along with your
questionnaire) in the stamped addressed envelope enclosed.

If you have any questions regarding this survey please contact
at CMHT on . Additionally, should you
have any complaints or compliments that you wish to address to the service, please
contact the complaints manager on or at the following address:

Thank you in anticipation,

Yours sincerely,

Supervised by:

Please send me a summary of the findings of this study, which I understand will be
available in September 2006.

Name:

Postal address, or email where summary can be sent:

Signature:

Date:
### 6.3 Appendix 3: Content analysis

<table>
<thead>
<tr>
<th>Theme 1: Most helpful thing about talking over problems</th>
<th>Number of respondents</th>
<th>Number of extracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Putting thoughts into perspective</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2. Having the opportunity to talk about things</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>&quot;Getting it off your chest&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Discussing &quot;the bigger picture&quot;, i.e. surrounding situations such as family and work</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4. Devising a relapse prevention plan</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Nothing</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>&quot;Nothing&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Having someone listen, and show concern, understanding and empathy</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>&quot;Having someone to listen&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Having someone provide a skilled, professional outlook and/or perspective on things</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>&quot;In-depth understanding of problem&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;A skilled professional outlook&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Not being judged and/or being respected</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>&quot;Not being judged for having strong thoughts or feelings&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Feeling like someone there for you, and not feeling alone</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>&quot;The feeling I was not alone&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Making someone aware of how unwell I feel</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11. Being referred / put in contact with other services</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>12. Realising other people feel this way too</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>&quot;I realised it wasn’t only me who felt like this&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. The treatment or advice aimed at finding solutions to problems</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>&quot;...ways of solving problems&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Instilling a motivation to face up to difficulties and get better</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Realising achievements</td>
<td>1</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td></td>
<td>Difficult to explain</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A knowledge that one day things will improve</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Working with someone who has ‘seen it before’</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Improving my self confidence</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Having continuity with one person</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Being able to trust someone</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Being helped to cut down medication</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Feeling better</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Understanding difficulties better</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>&quot;Understanding myself better”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeling that the therapist had prepared for the session</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>I do not have problems so don’t need to talk things over</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Talking to someone impartial</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>The therapist being willing to come to my home</td>
<td>1</td>
</tr>
<tr>
<td>Theme 2: Least helpful things about talking over problems</td>
<td>Number of respondents</td>
<td>Number of extracts</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>1. When staff leave the CMHT</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. Talking about things can be upsetting, embarrassing or anxiety provoking</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>&quot;Upsetting old memories&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Too high a focus on medication</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>&quot;Too concerned with changing my medication&quot;</td>
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<td></td>
</tr>
<tr>
<td>4. Being referred to a group</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5. Not focusing on the specific difficulties</td>
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<td>1</td>
</tr>
<tr>
<td>6. Being asked a set of questions from a form or list</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>&quot;We didn't have a dialogue about my problem because for 45 minutes I was asked a list of questions from a form&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Realising there is not always a solution</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8. Nothing</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>&quot;Nothing&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Not applicable&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Medication not working</td>
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<td>1</td>
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<tr>
<td>10. Appointments too far apart or too short, or difficulties getting an appointments</td>
<td>4</td>
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</tr>
<tr>
<td>&quot;Appointments too far apart&quot;</td>
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<tr>
<td>11. Still experiencing difficulties</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>&quot;I'm still screwed up&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Filling out forms and questionnaires</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>13. Rules</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>14. Preconceptions</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>15. Knowing the staff member does not really understand / cannot really help</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>&quot;Knowing they didn't totally understand&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Being rushed</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17. Not really being listened to or difficulties taken seriously</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>&quot;Feeling that I wasn't being listened to&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Assumptions being made about me</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>19. Feeling I had to do most of talking to fill in quiet spaces</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20. Having to repeat your story to different people each time, or at each appointment</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>\textit{&quot;Having to repeat myself every time I saw someone&quot;}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
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</tr>
<tr>
<td>21. Bringing hidden problems to the surface</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>22. Not being told what is wrong with me</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>23. Poor match of personalities</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>24. Not understanding contextual situations (e.g. work and home)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>25. Lack of support (in the community)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>26. Not being clear / explaining things properly</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Being told crying is normal in sessions</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>28. Feeling dependent on therapist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>19. Feeling I should sort problems out on my own</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20. Being offered alternative advice or therapy sources' but it never happening</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Theme 3: Most helpful thing therapist did during talking therapy</td>
<td>Number of respondents</td>
<td>Number of extracts</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>1. Being referred to or put in contact with other services</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>&quot;Referred me to CRT (crisis recovery team) sessions&quot;</td>
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</tr>
<tr>
<td>2. Helped to overcome difficulties</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>&quot;Helped me to overcome my fears and anxieties&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Listen / being patient</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>&quot;Listen&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Skilful summary letter written</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6. Helped put problems in perspective</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>&quot;Help me out my problems in perspective&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Nothing</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9. Discussing and explaining difficulties to me, to increase my understanding</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>&quot;Talking through problems&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Motivated me</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Suggested physical exercise rather than drugs</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>13. Getting respite time away from everything</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>14. Advised me well</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>&quot;Advised me well&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Being there for me and supporting me</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>&quot;Being there&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Making me feel I deserved better</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17. Made me feel relaxed / able to be open and honest</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>19. Prescribed me medication</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>20. Impartial, non-judgemental, non advice giving</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>&quot;Non-judgemental, non-advice giving&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Helped me come to my own conclusions and to learn to solve my own problems</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>22. Told me when my next appointment would be</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>23. Challenged my negative thoughts</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>24. Everything</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Theme 4: Least helpful thing therapist did during talking therapy</td>
<td>Number of respondents</td>
<td>Number of extracts</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>1. There are not always enough appointments and/or staff</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2. None / nothing</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>“Nothing”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Comparing me</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. I am still experiencing difficulties</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Suggesting I terminate my employment</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6. Telling me other people have these feelings</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8. Mixed up what I had told them</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9. Ignoring how I felt</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10. Telling me how I should be feeling / behaving</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11. Prescribing medication with unpleasant side-effects / keep changing medications</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>12. Not explaining my problems to me</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>13. Judging me</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>14. Took me out to ‘walk my energy down’</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>15. ‘Just talk to me about anything’</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>16. Dislike of group therapy</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>17. Difficulties travelling to and from therapy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>18. Therapist left their employment</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>19. Looked at watch during sessions</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
To Daynes SL Miss (PG/R - Psychology),

I am writing to confirm that Shona Daynes fedback her research project during her Adult Placement at Adur CMHT. Shona fedback to the entire team during their team meeting and provoked some interesting and valued discussion. The team were very grateful for the time and effort she put into the research and write up and were glad to express their views on the findings. In addition Shona and I met with Lin Creasy (Lead Psychologist), and Shona gave a thorough presentation to her. Lin was impressed and thankful for the research, which raised some interesting and valuable ideas that will be considered for future research. Shona was able to respond to comments and questions thoroughly and considerately in both settings.

Dr Lucy Edwards
Chartered Clinical Psychologist

https://outlook2003.surrey.ac.uk/exchange/pp3sd/Drafts/FW:%20confirmation%20of%20feedback
Abstract of qualitative research project: The attitudes of young adults to the change in drinking laws.

This research was developed to investigate the attitudes of young people to the change in drinking laws which occurred when the Licence Act (2003) was operationalised in 2005. Research into the impact of opening hours on alcohol consumption was explored, drawing on comparisons with other countries currently operating flexible licensing laws. The literature identified a link between standard closing hours, binge-drinking and violence. The links between attitudes and behaviour were explored, with particular reference to younger adults who were being specifically targeted by the change in licensing laws. The study utilised an Interpretative Phenomenological Approach to investigate the attitudes of young adults to the change in license laws. Six participants aged between 23 and 24 years were interviewed, and the transcripts were then coded for different themes. Three main themes were identified: perceived benefits of the changes in the law; concerns about the changes in the law and cultural influences on drinking. The implications of these attitudes were discussed in terms of the Government's aims from the change in licensing laws. Suggestions for further work included a more indepth investigation of differences between male and female attitudes.
Living with challenging behaviour: Using discourse analysis to study the experiences of people with learning disabilities in a residential service

by

Shona Daynes

Word count\textsuperscript{23}: 19,989

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

Department of Psychology
Faculty of Arts and Human Sciences
University of Surrey

July 2008

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\textsuperscript{23} Does not include title page, acknowledgments, contents, abstract, references or appendices.
Acknowledgements

My sincerest thanks go to my university supervisor, Dr. Dora Brown and my field supervisor, Dr. Peter Baker for their support and advice throughout this research.

I would also like to thank the managers of the three residential services who agreed to take part in this research. Most importantly, I wish to thank the five participants who gave up their time to talk to me about their lives. Without them this research would not have been possible.

Finally, my thanks go to my friends and family who have supported me throughout this process.
Abstract

This research was designed to investigate the constructions people with learning disabilities make about challenging behaviour and the impact of this on their sense of identity. The propensity of research in the field of learning disabilities to focus on the views of staff members is discussed, along with the few notable exceptions to this which have gathered the views of people with learning disabilities. A critique is offered of the positivist framework within which much of this research has been conducted. The potential use of an alternative, social constructionist model is then explored. A Foucauldian discourse analysis methodology was used to analyse the transcripts of five interviews, conducted with adult males with learning disabilities in residential services. The interviews focused on the individuals' experiences of their own, and other peoples' challenging behaviour. Three discourses were identified. Discourse 1 constructed service-users as being the responsible agents for engaging in, or seeking alternatives to, challenging behaviour. Discourse 2 constructed services or staff as responsible for the occurrence, and/or management of, instances of challenging behaviour. Discourse 3 described how the perceived severity of learning disability a service-user has, influences the way instances of challenging behaviour are constructed, in particular whether the 'service-user as responsible agent' (Discourse 1), or the 'services as responsible agents' (Discourse 2) discourses were drawn upon. The action orientation; subject positions; implications for practice and subjective experiences were considered for each of these discourses. The implications of the discourses were considered for service-users and service providers, and avenues for future research were explored.
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This review will explore current understandings and practices regarding challenging behaviour. A critique of the positivist paradigm within which much of this research has been conducted will be considered. The alternative perspective that the epistemology of social constructionism offers will then be explored. Finally, the role of people with learning disabilities in research will be discussed, including a consideration of the usefulness of social constructionist perspectives, and in particular discourse analysis, for this client group.

Challenging behaviour

Emerson (2001) has suggested the term ‘challenging behaviour’ (which is used frequently in learning disability and many other services) may include a range of behaviours such as aggression, destructive behaviour and self-injury. Emerson says these behaviours may be deemed challenging because they are potentially harmful to the individual (e.g. self-injury); they may present challenges to care teams working with the person (e.g. physical aggression to others), or they may be unacceptable to wider society (e.g. throwing food). Emerson (1995) has defined challenging behaviour(s) as "culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (p. 4-5).

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24 This document has been written according to the guidelines set out in British Psychological Society's Style Guide (2004a).
The term challenging behaviour has largely replaced alternative descriptions used in the past such as disordered, dysfunctional or maladaptive behaviour. Emerson (2001) prefers the term 'challenging behaviour' to these others because it refers specifically to behaviours that might be harmful to an individual or those around them and not just those that are rare within a particular population (i.e. culturally abnormal). Emerson has also supported the earlier claims by Blunden & Allen (1987) that challenging behaviour is most helpfully viewed as something that is external to the individual, i.e. they do not carry it around within them. However, current day understandings of challenging behaviour conceptualise it as a phenomena resulting from a complex interplay of many factors (including psychological and environmental) that precipitate and maintain certain ways of behaving within a particular setting (Royal College of Psychiatrists et al., 2007). Elsek & Greenhalgh (2001) have highlighted this as a shift away from linear ‘cause and effect’ models to more dynamic, multitudinous understandings.

Models of challenging behaviour

Various theories regarding the underlying causes of challenging behaviour have been put forward. Neurobiological models of behaviour have most recently focused on the role(s) of various neurotransmitters (Emerson, 2004). Dopamine, serotonin and the opioid peptides have received particular attention, with deficits, over-production or an imbalance of these chemicals being cited as causing behavioural difficulties (Schroeder & Tessel, 1994). For example, Verhoeven et al. (1999) found differences in the levels of stress
hormones and various other neurotransmitters between self injurious and non-self injurious learning disabled participants

More recently, challenging behaviour has also been linked to psychiatric disorders. Emerson, Moss & Kiernan (1996) suggest challenging behaviour may represent an atypical presentation of the symptoms of a particular disorder as a result of the restricted communication skills and coping strategies in people with learning disabilities. They also suggest that challenging behaviour may be an expression of distress (e.g. low mood) caused by a psychiatric disorder (e.g. depression). Furthermore, the authors have incorporated ideas from behavioural models to suggest that challenging behaviour may represent a way of attempting to cope with a psychiatric disorder (e.g. using it as a way of avoiding demands for activity).

The neurobiological and psychiatric disorder models described above construct challenging behaviour as a predominately internal feature of an individual. However, as Romanczyk et al. (1992) point out, the causal and maintaining factors for any particular behaviour cannot be assumed to be consistent across individuals and different factors will be involved according to a variety of contextual issues. Emerson's definition (1995) also critiques the neurobiological and psychiatric models for failing to fully consider the impact of the environment on challenging behaviour.

Applied Behaviour Analysis (Wolf, 1978) has attempted to address these criticisms by incorporating both aspects of the environment as well as the
individual in understanding and managing challenging behaviour. Currently this approach is focused largely on decreasing challenging behaviour and increasing competencies in different skills. An important part of this work is based on understanding the context in which these behaviours take place and how the environment can change or maintain certain patterns of behaviour which are seen to have some function for the individual. This approach supports the recent Royal College of Psychiatrists et al. (2007) document which comments on the complex and multitudinous nature of challenging behaviour. To date Applied Behaviour Analysis has received the most empirical support (Emerson, 2004), though Emerson points out that this may reflect an imbalance of research into other models or theories, rather than alternative perspectives being less useful.

The political context of challenging behaviour

Historically, many people with learning disabilities have been cared for in large institutions, segregated from society (Gladstone, 1996). In more recent years there has been a move towards many people moving out of these settings into smaller services within the community (Gates, 2003). At present, the Government is working towards a greater number of options for accommodation choice, including supported living, village communities and small-scale housing. The issue of accommodation is important because a study by Emerson et al. (2000) identified that factors related to accommodation (e.g. type, provision of staff, etc.) influence the occurrence and management of challenging behaviour. Furthermore, a recent review by Emerson (2007) has highlighted that people with learning disabilities are still
often living in circumstances of poverty and poor health, and that these factors both contribute to and are a result of having a learning disability. He goes on to highlight the need for the Government and other services to engage in preventative and reactive interventions for these issues.

With regard to challenging behaviour specifically, there are several current documents outlining how services should be responding. This issue has been placed higher on the Government's agenda since the identification of several incidents of poor practice in relation to people with learning disabilities (e.g. Commission for Healthcare Audit and Inspection, 2006). 'The Mansell Report' (Department of Health, 2007a) on services for people with learning disabilities and challenging behaviour or mental health needs (which followed from an initial assessment and report in 1993) has identified a continuing need for improved services for this complex client group. It commented on the large number of people placed away from their families in out-of-county residential services; the poor level of support for families who are caring for a person with challenging needs and the poor organisation and support networks within many of the community residential placements that have been developed to support those leaving long-stay institutions. Mansell reports that the Department of Health’s ‘Valuing People Now’ paper (2007b) which reviewed the progress of the original White Paper from 2001, has begun to identify some changes in the lives of people with learning disabilities and their families, but that many of these challenges still remain.
Support for Mansell's recommendations comes from the 'Challenging behaviour: A unified approach' document (Royal College of Psychiatrists et al., 2007). This working party report outlined concerns around the use of the term challenging behaviour which they felt "had become a label to describe either a diagnosis or a problem owned by an individual [and had] become an obstacle to the provision of appropriate and effective support" (p.5). They comment on the failure of services to respond to the challenge of providing appropriate care for people with complex needs and the subsequent exclusion many service-users have faced from their communities. The report recommended that challenging behaviour should be seen as an interaction between an individual and their environment and as such that it should be managed via creative and capable environments that match the needs of the individual.

These reports suggest that at present many services for people with learning disabilities and challenging or complex needs are failing to provide adequate care. They also question the construction of challenging behaviour as something that is located within an individual and call for a more social constructionist approach to the way this term is used and understood. They place the issue of challenging behaviour as something that occurs in the context of an interaction between people and their environments. This position constructs potential solutions as those that will involve organisations as well as the individuals that access those services.

25 This approach is explored in more detail on page 19.
The ‘Valuing People’ paper (Department of Health, 2001a) recommended that people with learning disabilities be involved wherever possible in how services are designed and implemented, but the ‘Valuing People Now’ paper (Department of Health, 2007b) suggested this was something that was not yet being achieved for the majority of services. Carnaby (1997) reviewed the inclusion of people with learning disabilities in service planning and found that those who were able to verbalise their own thoughts found it a very positive experience. This suggests that the way people with learning disabilities are viewed is likely to be contributing to their lack of involvement in service development, as opposed to them being unable to do this. Though some consideration may need to be given to how this takes place (as described later on page 23) it is clear that people with learning disabilities are able to offer informative insight into various aspects of their lives, and that researchers and service developers should be attempting to incorporate their views to a greater extent if they are to be working in accordance with Governmental policies.

Research into challenging behaviour: The views of staff

The majority of research into psychological understandings of challenging behaviour and people with learning disabilities has focused on the perceptions of staff. For example, Noone et al. (2006) interviewed staff in learning disability services and found that they frequently attributed incidents of challenging behaviour to internal, stable factors within their clients. They also believed their clients were in control of, and intended to perform, the challenging behaviour. Wilcox et al. (2006) have supported this finding. They
interviewed care staff of ten men and women perceived as demonstrating challenging behaviour and identified a dominant discourse that constructed challenging behaviour as an individual pathology, stable and internal to the client. They highlighted that talking in this way prevented staff from being blamed and allowed them to take up positions of control over managing challenging behaviour. They claim that this reinforced the traditional power imbalances seen in services for people with learning disabilities. This finding was supported by Jahoda & Wanless (2005), who suggested staff may attribute challenging behaviour to factors internal to their clients because this allows them to be constructed as different, or "the other". This could help staff to avoid feeling blamed for the behaviours that challenge services and possibly lead to people or property being damaged.

However Wilcox et al. (2006) also identified a discourse around the contextual elements of challenging behaviour, where staff constructed the behaviours as an understandable reaction to external events. Wilcox et al. (2006) reported that staff drew on the two discourses flexibly throughout the interviews, but that the context discourse tended to be used in a way that still maintained the superiority of the individual pathology discourse. For example, challenging behaviour was often cited as being attributable to an internal factor such as something inherited from a parent, while the context discourse was drawn upon for constructing ways of intervening in the behaviour. Wilcox et al. point out that this construction allowed the staff to avoid blaming their clients (because the cause of their behaviour was seen as something they cannot control) while the context discourse allowed them to construct themselves as
efficacious (i.e. able to make a difference to the behaviours), with the ‘fall back’ position that any continuing challenging behaviour could be attributed to factors internal to the individual.

Research into challenging behaviour: The views of people with learning disabilities

The studies described above have all used care staff to access psychological understandings about challenging behaviour and these make up the majority of research into this area. However, there have been a few notable exceptions with studies that have spoken directly with people with learning disabilities about challenging behaviour. Most of these have focused specifically on the issue of physical restraint as an intervention for challenging behaviour (e.g. Jones & Kroese, 2007; Hawkins et al. 2005; Baker 2002) with only two studies focusing on this issue in general. Firstly, Murphy et al. (1996) interviewed 26 people described as having ‘mild intellectual disabilities and challenging behaviour’ about their time spent in a specialist hospital unit. They focused on overall quality of life measures, including questions about how staff had worked with them. The respondents spoke in both positive and negative ways about the various members of staff at the hospital with comments ranging from “she could understand me, she knew what I was going through” to “they’re butting in on my life” (p270). The respondents were also asked their views about specific ways that challenging behaviour was managed. The majority of responses were negative regarding the use of physical restraint or exclusion, with a more mixed response for the use of medication and being detained under the Mental Health Act (Department of Health, 1983). This
study demonstrates that the views of people with learning disabilities can be sought on a range of issues and that this type of research can have direct relevance for the way services are planned, set up, run and evaluated, as well as the potential need for therapeutic input for those who experience challenging behaviour.

However, the design of this study in some ways challenges this belief. Murphy et al. interviewed carers of the respondents and used the carer's responses to verify the information gathered from the interviews with service-users, suggesting their views were not accepted as valid or useful in their own right. For example, they comment on whether the service-users were able to give the 'correct' reason for their admission, i.e. one that matched with the reason stated by professionals at the hospital. They cite this as an example of an issue regarding validity within their study, but do not comment on the fact that the service-users may have had a very different understanding about why they were admitted, which may be equally as valid as the officially documented reason. This highlights the power of the professional discourse within learning disability services.

The second study by Stevens (2006) adopted a social constructionist stance (see page 19 for a description of this epistemology) to explore challenging behaviour. He conducted interviews with people with learning disabilities and suggested that the respondents were able to construct complex explanations, including antecedents and consequences, of challenging behaviour. Stevens described these complex explanations as a "moral web" (p.963) which
included factors relating to interactions between people, interactions between behaviours, the morality of certain actions (which was linked to issues of 'badness' and intention) and behaviour being seen as separate from the person. The talk around consequences focused on the belief that an instigator of challenging behaviour should experience negative consequences, which staff were viewed as being responsible for. This assigned role of punisher demonstrates the power that is held by those working within learning disability services and furthers the research described earlier to show how both staff and service-users engage in talk that maintains this power imbalance. However, in the critique of his study Stevens comments on issues such as the small-scale nature of the study and his concerns about whether the respondents involved accurately reflected the group being studied. These criticisms draw on the traditional research paradigm, placing positivist assumptions (i.e. that there are real truths that can be discovered if 'good enough' methodologies are used) as the gold standard for good research. This issue will be considered further on page 18.

**Gender and challenging behaviour**

The issue of gender in relation to challenging behaviour has recently begun to receive more attention within research. Clements *et al.* (1995) commented on the "gender-blindness" (p.426) that has been associated with people with learning disabilities, whereby their gender has been largely ignored in many aspects of their lives. Clements *et al.* (1995) link this factor with the discourse around people with learning disabilities as being "child-like spiritual innocents" (p.426) whose entire lives are viewed in terms of their learning disability. They
suggest that issues of femininity, masculinity and associated sexuality are ignored within services. This is associated with the parental role many services adopt over their service-users. Clements et al. (1995) highlight the importance of the discourses that staff construct, given that they often make up the majority (if not all) of the person-to-person contact that people with learning disabilities experience. They also highlight the importance of considering gender issues when planning shared housing, citing the potential difficulties of providing residential support for both men and women who may have been abused in the past.

Gender may be a particularly important issue to consider when exploring the issue of challenging behaviour because of the differences seen in research between males and females. Sequira & Halstead (2001) commented on this issue in their study which found gender differences in how people with learning disabilities were responded to following a violent incident. Wilcox et al. (2006) also identified gender differences in the attributions staff members made about their clients’ challenging behaviour.

**What is research and how is it carried out?**

**The positivist paradigm**

Much of the research described above (e.g. Jahoda & Wanless, 2005) has drawn on the traditional scientific research paradigm which assumes that the ‘truth’ of what is happening can be ascertained through observation and shared through talk (Tuffin, 2005). This view holds that real truths can be
observed and documented if ‘good enough’ methodologies are used to investigate them and that if this is done, then language can represent real ‘truths’ that are in the world (Woolgar, 1996). Tuffin (2005) has highlighted several criticisms of this positivist paradigm. Firstly, he describes the ‘myth’ that things can be measured in ways whereby the researcher does not influence them. This suggests that any phenomenon being observed or measured will be altered by the very fact that it is being observed or measured. Secondly, he highlights the potentially restrictive nature of positivism which claims that only things that can be observed and measured can count as knowledge. Finally he highlights that reducing verbal information to numerical data results in a loss of complexity.

An alternative framework for research
In reaction to the criticisms of the positivist paradigm outlined above, alternative epistemologies have begun to be developed which offer a different perspective on what counts as knowledge, and how this is defined and researched. Social constructionism is one of these epistemologies, which Burr (1995) describes as having several basic principles which underpin all research approaches developed from it, e.g. discourse analysis. The first of these is “a critical stance towards taken-for-granted knowledge” (p.3). This claims that conventional methods of investigating the world (e.g. objective observation) do not allow us to view the world as it ‘really’ is, i.e. the world is not ‘really’ divided up into the categories we have devised. Furthermore the importance, meaning and assumptions we place on these categories will differ according to who, where and when they are being judged. Second, social
constructionism places historical and cultural context as centrally important to our understandings of the world. This can be seen in the field of learning disability research in the different ways this group has been identified and described over the years. For example, Simpson (2007) has documented the changes in construction of what is today termed learning disability from ‘savages’ (the phrase used in the early 19th century) to the term ‘idiocy’ (adopted in the mid 19th century). Simpson (2007) explores how these changes in name and their differing implications for meaning and treatment, reflect changes in the wider society. Third, Burr (1995) highlights that social constructionism claims knowledge is constructed between people, i.e. it is not obtained from ‘real’ things in the ‘real’ world. Social interactions are therefore key to investigating the ways that different versions of knowledge become thickened and/or discarded over time. Finally, social constructionism claims that different knowledges lead to different kinds of social action. The way something is constructed and understood will alter how a person responds to it. In this way language and knowledge can promote or inhibit certain ways of being and acting.

This alternative epistemology has important implications for the way that research is conducted. For example, it posits that ‘truths’ cannot be objectively observed, measured and documented. It also states that we cannot have an understanding of the world ‘as it really is’ because we are constantly constructing it in a particular way at a particular time. Social constructionist theories suggest that language is one of the predominant tools which shape our understanding of and response to the world around us and
that language itself constructs the 'realities' around us (Burr, 1995). Therefore the types of language, who uses it and in what context contribute to how we understand our experiences. In addition, social constructionism places the contexts (historical, political, cultural, economic etc.) in which descriptions are made as being crucial to the content and meaning they are given (Burr, 1995).

Burr (1995) also describes how the "multiplicity of meanings" (p.46) in any talk or text demonstrates how a person's sense of identity is an unstable and dynamic factor that will change according to the social setting in which that talk takes place. People use language to construct a particular version of their identity and to challenge or validate the constructions which other people make about them. Discourse is the means through which these constructions are made and discourse analysis offers a means of studying the way this occurs. There are two major types of discourse analysis (Willig, 2001): discursive and Foucauldian. Discursive psychology (which includes conversation analysis, e.g. Woofitt, 2001) is concerned with the way people use language to achieve certain goals in social interaction, while Foucauldian (based on the work of the French philosopher Michel Foucault26) focuses more on the uses of power and knowledge within discourse. However, though Foucauldian and discursive approaches offer different foci for analysis, they both draw broadly on the same epistemology of social constructionism, and Wetherall (1998) has suggested that a useful analysis will include components of the two.

26 See Appendix 1 for an account of the work of Michael Foucault
Learning disability has been described as a socially constructed factor (Nunkoosing, 2000). In the UK, learning disability is defined as a significant impairment of intellectual and adaptive or social functioning, with an age of onset before 18 years of age (British Psychological Society, 2004b). The impairment in intellectual functioning is taken as the bottom 2.5 per cent of the population, or 2 standard deviations below the mean. This equates to a score lower than 70 on an appropriate IQ test. It is clear from this classification process that someone could be defined differently if this somewhat arbitrary figure was changed, or if what is seen as ‘adaptive functioning’ is altered (i.e. as it might be between different cultures). In addition, changes in the population’s IQ, which have been shown to be increasing over time (Flynn, 1994) could also lead to people being classified differently at different points in time.

In relation to challenging behaviour specifically, what is categorised as being (or not being) challenging will vary according to the specific norms and social rules of a culture, which are themselves constructed according to contexts of history, race, ethnicity, age, gender, religion and a myriad of other factors (Carabine, 2001). Language constructs behaviours as challenging (or not) by drawing on the range of discourses that are available to a particular group of people at a particular time. This can be seen in the differing figures offered in

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27 The term ‘learning disability’ will be used throughout this report as a ‘short-hand’ to describe a group of people who may have certain features in common and who are currently provided with a specific service within many health and residential settings. However, the socially constructed nature of this term means caution must be taken when making claims about certain ‘groups’ of people, an issue that the author has considered throughout this research.
prevalence studies. For example, Quereshi (1994) suggested five per cent of the learning disability population will engage in severe challenging behaviour, while Borthwick-Duffy (1994) found a figure of 14 per cent and Holden & Gitleslen (2005) obtained a figure of 11 percent. As would be expected from a social constructionist stance, these figures are likely to have varied because they will have incorporated different constructions (and therefore definitions) of challenging behaviour. For example, Quershi (1994) included self-injury while Borthwick-Duffy (1994) did not.

In the UK, challenging behaviour has been constructed as something more common in people classified as having a learning disability. A search of the literature investigating the prevalence of challenging behaviour in other populations reveals that this term is usually associated with this population. For example, in forensic literature the term ‘learning disability’ is often cited alongside any references to challenging behaviour (e.g. Dale, Thompson & Woods, 2001; Hayes, 1991). This further demonstrates that the way language is used constructs particular ideas about people and their identities.

Involving people with learning disabilities in research

Kiernan (1999) has highlighted that people with learning disabilities tend to be “researched on” rather than “researched with” (p.43). As described above, some attempts (e.g. Murphy, 1996 and Stevens, 2006) have begun to include people with learning disabilities in research. Perry (2004) comments that this may be due to an increased drive towards measuring quality from service-user perspectives, greater interest in research involving service-users as
participants and researchers and an increase in awareness of self-advocacy within services.

Perry (2004) has commented on the various ethical issues regarding research with this client group. He highlighted the need for researchers to consider this issue during the design of a study and described various factors that may need to be incorporated. These included the need for flexible procedures in explaining the study and gaining consent and the need to consider strategies for managing any anxiety or distress caused to the participants. Perry (2004) also commented on the need for a sensitively chosen venue for the research, and a careful consideration of question format.

Finlay & Lyons (2002) have also considered the importance of question format. They claimed that the complexity of a question may be one factor involved in acquiescence, which has been highlighted by some (e.g. Sigelman et al., 1981) as a pertinent issue for people with learning disabilities. However, they went on to outline the complex nature of this issue, which they claimed may also be affected by factors such as the motivation someone has to understand a question. Motivation may be related to Perry's (2004) assertion that research with this client group should be directly related to, and have a positive impact on, the participant.

More recently, interest has begun to develop on involving people with learning disabilities as co-researchers. Chappell (2000) has commented on this participatory research design and the subsequent change in role that non-
disabled researchers may take on in the future, i.e. supporting people with learning disabilities to conduct research. Though some concerns have been levelled at this type of research (e.g. Stalker, 1998), Chappell maintains the importance of attempting to include this frequently marginalised group in work that contributes to understandings of, and implications for, their lives.

Finally, historically research with people with learning disabilities may have been avoided because of concerns about reliability and validity, issues pertinent to research conducted within the traditional positivist framework (Tuffin, 2005). The emergence of qualitative methodologies has negated these issues and social constructionism in particular has developed the stance that all accounts are useful (Burr, 1995). Furthermore, the methods associated with this epistemology construct individual accounts as useful for increasing understanding. This means the problems associated with collecting large numbers of data from participants is avoided, which may have contributed to the historical lack of research talking with people with learning disabilities (Kiernan, 1999).

The use of discourse analysis with people with learning disabilities
As stated previously discourse analysis offers a way of using a social constructionist paradigm to investigate an issue. The previous review of the literature (page 12) highlighted that for many issues in the lives of people with learning disabilities (e.g. challenging behaviour) much of the research informing theories and practice has been carried out with those around them, e.g. care staff. Though some studies have spoken directly with people with
learning disabilities for various issues, very few have adopted a social constructionist stance to consider how people with learning disabilities construct their world through language. When looking specifically at discourse analysis - a methodology that is still relatively new in many areas of research - the number of studies with people with learning disabilities is very small.

However there are three notable exceptions. Davies & Jenkins (1997) investigated how the identity of people with learning disabilities is affected by this label. They interviewed 60 young people with learning disabilities and suggested that all aspects of their identity were influenced by issues associated with having a learning disability. Davies & Jenkins described issues of power and control within these constructions which they felt would shape the participants' future social relationships. They went on to show how these issues might link to a lack of uptake of self advocacy services, given that the sense of identity the participants had of themselves was as someone without agency over their life.

Rapley et al. (1998) also used discourse analysis, in this case to re-examine an earlier study by Todd & Shearn (1997). The title of their article: Invisible to themselves, was based on Todd & Shearn's suggestion that people with learning disabilities develop a 'false' sense of identity due to their parents' or carers' unwillingness to talk with them about their learning disability. Todd & Shearn suggested this occurred because the term 'learning disability' is seen as so "toxic" (Rapley et al. 1998, p. 807) that individuals must be shielded from it. However Rapley et al. (1998) claimed that an alternative reading of
this data could be made, in which the respondents' learning disability was incorporated into constructions of their sense of self. They suggested that Todd & Shearn failed to identify this facet of the individuals' identities either because this understanding did not match with their view of learning disability, or because the respondents chose to present alternative aspects of their identity in the interviews. Rapley et al. demonstrated several extracts from the interviews where they suggested the interviewees offered an understanding of their status as someone with a learning disability and the social significance this held. They claimed the participants drew flexibly on different discourses to take up or reject certain "social category memberships" (p.810) depending on the context of their talk. Antaki et al. (1996) have suggested this can vary within a single social interaction, supporting the assertion by Rapley et al. that global statements about an individual or group's identity cannot be made.

The third study utilising discourse analysis with this client group is by Scior (2003). She interviewed women with learning disabilities and identified various discourses relating to gender (e.g. "women as victims", p.783) and disability (e.g. "people with learning disabilities as childlike", p.783). By providing extracts of the interviews, Scior demonstrated how the women she spoke to drew flexibly on the different discourses throughout their talk and how the various discourses of gender and disability were intertwined. These discourses were shown to present the speakers with a lack of choice and opportunity that might be found in women who do not have a learning disability. Scior discussed the usefulness and relevance for using a discourse analytic approach with people with learning disabilities, highlighting the
historical lack of research with this group. She also highlighted several criticisms of the positivist nature of most research that has been carried out with this group and how discourse analysis can address these. For example, she described how the "contradictions and inconsistencies" (p.793) that are often found in accounts by people with learning disabilities, rather than being a counter-argument for inclusion in research, actually highlight important contradictions and tensions that the respondents are experiencing in their everyday lives. This could in part explain the differences highlighted in the readings of the same interview transcripts by Todd & Shearn (1997) and Rapley et al. (1998).

These studies clearly demonstrate that discourse analysis may be useful for increasing understanding on a wide range of issues for people with learning disabilities. It also offers potential for increasing the voice of this client group in the research field where it has often been marginalised.

**Rationale for this research**

The research described above demonstrates how the behaviours grouped under the term challenging behaviour are frequently understood according to descriptions given by those working with or caring for people categorised as having a learning disability. This approach has reinforced the notion that people with learning disabilities are not able to understand or offer accounts of their own behaviour. This places people with learning disabilities in a
disempowered position in research, which may reflect their disempowered position in society.

Though there have been some studies with people with learning disabilities as participants, only two of these have been conducted on the issue of challenging behaviour in general (i.e. not focusing solely on experiences of physical restraint). Furthermore, neither of the studies investigated the impact of other people's behaviour on an individual. This may be a particularly pertinent issue for people with learning disabilities because of the large number of people living in group settings. Though the 'Valuing People' paper (Department of Health, 2001a) has called for a greater number of accommodation options, many people with learning disabilities are likely to continue living in shared accommodation such as group homes, often with other people who exhibit challenging behaviour.

In addition, most of the studies described above have used methods that fail to consider the way language is used by people with learning disabilities to construct particular versions of themselves or the world. Discourse analysis allows an exploration of these issues and Davies & Jenkins (1997), Rapley et al. (1998) and Scior (2003) have demonstrated that this method can be used with this client group to explore the constructions they make about their own identities. These studies show that though there may be some challenges in conducting research with people with learning disabilities - for example due to the difficulties they may have in expressive and/or receptive communication -
these can be overcome to an extent through careful planning and sensitive and flexible use of a methodology.

Foucauldian discourse analysis is based on the premise that knowledge (i.e. what is known to be and what isn’t) is historically situated and that power constitutes what knowledges are constructed and known through discourse (Carabine, 2001). The historical context of an issue is thus placed as central to understanding assumptions made about something in present day (Kendall & Wickham, 1999) and to explore the various positions and ‘truths’ which can exist about a subject (Willig, 2001). The social and political context of people with learning disabilities throughout history will have contributed to the discourses available to them today and discourse analysis allows this to be considered. Discourse analysis can be conducted using any text or talk material (Wetherell, Taylor & Yates, 2001), including transcribed interviews. This research will therefore utilise Foucauldian discourse analysis to explore the issue of challenging behaviour in people with learning disabilities living in shared residential accommodation. This study asks:

1. What discourses do a sample of people with learning disabilities use to describe and explain their own and others’ challenging behaviour?

2. What functions do these discourses achieve and how does this affect the construction of the speakers’ identities?
METHOD

Participants

Potential participants were identified by the managers of three privately run residential services for people with learning disabilities in the South East of England. The managers were informed of the following criteria for potential participants:

1) The person has a learning disability
2) The person is considered to currently show, or to have shown in the last two years challenging behaviour, as defined by Emerson (1995).
3) The person currently lives, or has lived in the past five years with other people who have demonstrated challenging behaviour.
4) The individual is able to give informed consent (see below).

Using these criteria, five possible participants were identified. Initial meetings were then held with the participants in their home, to discuss the project using verbal (Appendix 2) and pictorial (Appendix 3) information. They were then asked whether they would like to take part in the study. This process was repeated on two occasions and the potential participants were encouraged to discuss the project with their carers, families and friends if they wanted to. Contact details for the researcher were left with the potential participants and the home manager in case either of them had any questions in between these meetings. The following criteria were used to assess individuals’ capacity to consent for the study and were developed in accordance with guidelines for
conducting research with people with learning disabilities (Department of Health, 2001b).

1) The individual was able to explain back to the researcher about the purpose of the study, their anonymity within the report and their right to withdraw.

2) The individual stated on both occasions that they would like to take part.

3) The individual did not say at any point that they would not want to take part in the study. Because of the perceived propensity of people with learning disabilities to acquiesce (Finlay & Lyons, 2002) any attempt to opt out of the study was taken as an exclusion criterion.

4) The manager and researcher both agreed that the individual had capacity to consent.

Using these criteria the five identified participants were deemed to have capacity to consent to the project. The participants were asked to sign a consent form, indicating their agreement to take part in the study (Appendix 4) and the managers signed a service agreement form (Appendix 5).

The decision to involve only individuals who were able to consent in this study was based on the Department of Health’s recommendation (2001b) that where possible, research be conducted with those who can consent. However, it is of note that this is likely to have excluded the majority of the learning disabled population who present challenges to services, because
higher levels of challenging behaviour are seen in more severely learning
disabled groups (Emerson et al. 2001). The impact of this is considered on
page 76.

The five participants were all male. Four were of White British origin and one
was Asian British. They were aged between 19 and 42. This information was
collected via a demographics questionnaire (Appendix 6) which was read to
the participants at the start of each interview. If the participants did not know
any of the information, this was gathered from the manager after the
interview.

Ethical approval
The three residential services fell within three NHS Research and
Development ethical approval teams. Confirmation was received from each of
these three teams (see Appendices 7, 8 and 9) that approval from COREC,
the NHS ethical approval service was not required because they were non-
NHS agencies. However, ethical approval was sought and gained from the
University of Surrey School of Human Sciences Ethics Committee (Appendix
10).

Procedure
The semi-structured interview
The semi-structured interview (Appendix 11) was designed to elicit talk
around the issue of challenging behaviour in a broad manner, in order to
generate as many different discourses as possible. The questions were
designed to encourage conversations about situations that might cause challenging behaviour (based on the literature around the causes of challenging behaviour, e.g. Emerson 2004) as well as specific instances of challenging behaviour based on Emerson's (2001) definition. The questions were designed in accordance with literature on interviewing people with learning disabilities (e.g. Perry, 2004), around issues such as question format and acquiescence.

The semi-structured interview was developed with input from the researcher's two supervisors and was also commented on by the Coordinator of User and Carer Involvement at the University of Surrey. Following its use with the first participant the author reviewed the questions to confirm they were understandable and that they accessed talk about challenging behaviour. The questions were modified or reworded when required during the subsequent interviews to ensure the participants understood each question.

Rigour of the procedure

Coyle (2007) has highlighted that qualitative research cannot be judged according to the criteria used to evaluate research from a positivist perspective (e.g. reliability and validity) given that qualitative methods and theories position themselves outside of this paradigm. However, qualitative methods clearly still need to be evaluated in order to for them to demonstrate their worth. Yardley (2000) has suggested four criteria that qualitative methods can be judged by:
1. Sensitivity to context

This includes the context of previous research and also the historical context of the topic in question. These issues have been addressed via a comprehensive search of the current literature surrounding the issues of learning disability and challenging behaviour, as well as consideration of how these issues have been thought about historically within research, service development and wider society. The context of the use of discourse analysis within the field of learning disability research has also been considered, along with a reflection on the impact of the interview context (including features of the interviewer) on the data collected.

2. Commitment and rigour:

The author's commitment to this research is demonstrated in their background and experience in working with this client group, and this choice of research as part of their clinical psychology training. Yardley describes rigour as relating to the completeness of the data gathered. Discourse analysis can usefully be conducted with just one piece of text, but by gathering information from five people, the potential number of discourses generated has been greatly increased. This number was balanced against the time constraints of this project (as part of a clinical training programme) and the time-consuming nature of the analysis (Potter & Wetherell, 1987).

3. Transparency and coherence:

It is hoped that the numerous extracts provided from the interviews will allow the reader to judge the plausibility and quality of the discourses that have
been highlighted. These discourses have been linked to the contextual issues described in the introduction, providing a narrative account of how challenging behaviour might be understood based on the experiences of service-user’s themselves, rather than the hypotheses of those around them.

4. Impact and importance:

The impact of this research is likely to be predominately on services, who may tailor their service design and interventions towards those who challenge them. By thinking about these challenges in ways that address the complex matrix of factors (identified as occurring within and between services-users, staff and other clients) they may best be able to flexibly respond to instances of challenging behaviour.

Willig (2001) notes that caution must be exercised when applying a list of evaluation criteria indiscriminately to any qualitative piece of work. However, Coyle (2007) suggests that “with some modifications and caveats” (p.115) Yardley’s criteria can be applied to research utilising discourse analysis. Coyle suggests further evaluation may be possible by providing supporting material from the texts for the analytic points and Willig (2001) claims the most important evaluation tool is the overall narrative achieved by the account, alongside its success in generating new perspectives for the reader.

Analysis of the data

All interviews were recorded on to tape and were later transcribed using the guidelines set out in Potter & Wetherall (1987). A copy of these transcription
guidelines can be found in Appendix 12. Various transcription guidelines have been suggested for discourse analysis, some of which include a much more detailed level of notation, for example conversation analysis. However because the focus of this study was on the macro-textual features of discourse (rather than the micro-textual features seen in conversation analysis, e.g. changes in pitch of voice) Potter & Wetherell's guidelines were selected. These have been utilised by many other studies (e.g. Wilcox et al., 2006) which offers further face validity for their use in this research. Pseudonyms were generated at this point for all of the participants, to ensure anonymity.

The transcripts were then read several times and all instances of challenging behaviour highlighted. In order to access all possible discourses this coding was conducted in as broad a way as possible to incorporate all direct and indirect references to challenging behaviour, as recommended by Willig (2001). A full copy of one of the transcripts can be found in Appendix 13.

The interviews were then analysed using Willig's (2001) guidelines for conducting Foucauldian discourse analysis. Again, there are many different guidelines that have been set out for Foucauldian discourse analysis (e.g. Potter & Wetherell, 1987), but Willig's were chosen because they address the specific research points this study was aiming to investigate. In addition, Willig's guidelines have been widely cited by other studies (e.g. Wilcox, et al., 2006) offering face validity for their use.
Willig (2001) has suggested six stages of data analysis:

1. Discursive constructions
   The discursive objects of a study can be linked either to pre-defined research questions or can be gathered after the data has been collected. This stage requires reading and highlighting all references (direct and indirect) to the discursive object, in this case challenging behaviour.

2. Discourses
   The next stage is to identify the different constructions made about the discursive object. This includes a focus on the wider discourses surrounding the text, for example gendered discourses may be drawn on when developing a particular construction of an object.

3. Action orientation
   Discourse analysis is interested in the function of peoples' talk and this stage involves consideration of what is gained by the speaker in constructing an object in a particular way at a particular time. Speakers may move between different discourses and constructions, with different functions being achieved with these variations throughout the text.

4. Subject positionings
   This stage is concerned with identifying the different subject positions that are constructed within the text. Speakers can construct or reject particular positions for themselves and others, which have associated rights,
responsibilities and duties. Willig differentiates ‘positions’ from ‘roles’ in that roles can be assigned and acted out without the individual necessarily identifying with that role. Positionings, however, offer “discursive locations from which to speak and act” (p.111), which the individual identifies with.

5. Implications for practice

Here the discursive constructions and subject positions are explored to see what types and forms of action they open up or close down. Specific discourses will affect the ways things can be thought and talked about and subsequently the ways in which people can act.

6. Subjectivity

The final stage explores possible subjective experiences for speakers as a result of the different subject positions that they take up or reject. There have however been some criticisms of this stage. Walton (2007) has described how caution must be taken when suggesting that talk can represent feelings that are really there, given that a social constructionist stance would suggest this is a problematic interpretation. This research will tentatively include this element to explore some of the possible subjective experiences that the participants in this study may have experienced. It is felt that this is potentially useful for people who are often constructed as finding it hard to report on their subjective experiences verbally. However, this stage may be most affected by the values and judgements of the researcher, and others are invited to consider alternative possible readings of this data.
Reflection on the author's role

Scior (2003) and many others (e.g. Chappell, 2000) have identified the importance of qualitative researchers declaring and considering the impact of their own personal attributes on their research. This impact may be seen in all stages of research. I believe that by being clear about my position on this topic these influences will be transparent to the reader. Three areas I feel my background will have had most impact on the research are:

1. Choice of research question

My interest and experience in working with people with learning disabilities in various psychologist and support worker roles has impacted greatly on my choice of research topic. Each of these roles has involved working directly with people who challenge services and indirectly with those supporting them. The literature I read as part of this work led to a recognition of the scarcity of research that speaks directly with this client group. These factors have all contributed to the development of this research idea.

2. The interviews

Although open-ended and non-leading questions were employed to elicit as much talk around challenging behaviour as possible, the research / interview format (as opposed to a naturally developing conversation) will have had a large influence over what was spoken about. Although all the participants were given an opportunity to talk about anything else they wanted to, the tone and topics of the interviews were set prior to the meetings and this may have

28 The use of the first person has been adopted for this section only to allow a more reflexive stance to be taken.
impacted on the discourses the participants felt able to draw on. Furthermore, my position as a Trainee Clinical Psychologist (i.e. a professional) may have further impacted on the discourses the individuals felt able to express. This may have been exacerbated by possible links the participants made between me and the staff, given that the home manager introduced us.

3. The analysis

My personal position will also have influenced the choice of material selected for analysis. My professional interest in power imbalances in learning disability services is likely to have made these issues appear more prominent within the texts, influencing my reading of the transcripts and the discourses identified within them. Furthermore, I hope that through publishing this research the profile of this type of work (talking directly with people with learning disabilities) will be raised. My meta-cognitions about the impact of the work may therefore also have influenced the readings and choice of analysis topics. As a female researcher, I may also have read the transcripts in a particular, gendered way. I feel this is an especially pertinent factor given that all of the participants were male. As a health professional I was also influenced by the political context of the time, and the array of government and research-based policies around this issue. These too may have impacted on my reading of the transcripts.

I do not feel these biases denigrate the work of this study, which wholly supports the social constructionist stance that it would be impossible to conduct research without my professional and personal beliefs influencing the
work (Burr, 1995). However, it is hoped that by being transparent about the positions adopted, that the influences these have had on the research will be clear. Systemic theories support the adoption of multiple views of an issue (e.g. Dallos & Stedmon, 2006) and this work is offered as just one possible view of this complicated topic. It would be interesting to contrast this analysis with another researcher’s reading of them.

**RESULTS**

Readings of the five interview transcripts identified many different constructions about challenging behaviour. These were used flexibly and individuals moved between these discourses throughout their talk with various contradictions and assimilations. This analysis will focus on the three most prevalent discourses the participants used. These were:

**Discourse 1:** Service-users are the responsible agents for engaging in, or seeking alternatives to, challenging behaviour. Henceforth this will be referred to as the ‘service-user as responsible agent’ discourse.

**Discourse 2:** Services or staff are responsible for the occurrence of, and/or managing, instances of challenging behaviour. Henceforth this will be referred to as the ‘services as responsible agent’ discourse.

**Discourse 3:** The perceived severity of learning disability a service-user has influences the way instances of challenging behaviour are constructed, in
particular whether the ‘service-user as responsible agent’, or the ‘services as responsible agents’ discourses are drawn upon. Henceforth this will be referred to as the ‘severity of learning disability mediates location of agency’ discourse.

**Discourse 1: Service-users are the responsible agents for engaging in, or seeking alternatives to, challenging behaviour.**

This discourse centred on constructions of challenging behaviour as something that individuals drew on from a range of options in order to achieve a particular outcome. This discourse included talk about individuals being responsible for the challenging behaviour they demonstrated and that it was in some way a choice they made. It placed individuals at the centre of being able to change their behaviours.

For example, Barry spoke about a time when he was bullied and the way that this made him feel. When I asked him about how he coped with these difficult feelings he said:

**Extract 1**

1. B Well I know I never used to **chuck** anything at anyone but I did smash stuff up.
2. I Oh OK, so tell me about that.
3. B That was because of the way I was bullied.
4. I So was this when you were at the same place as before?
5. B Yeah, ‘cos I felt really, sorta, **angry**, and it made me feel upset so I used to take it out on me own stuff.
6. I OK, so what sort of things would you do?
B Break me own, like break me stereos and that. But now I've actually got out of that.

I Oh OK.

B 'Cos I can control that.

I OK. So tell me a bit more about when you were doing that, when you were breaking up your own things. What would be running through your mind at times when you were angry and breaking things?

B Being really down, and really upset, and I thought instead of hitting someone better to take it out on me own stuff.

I Oh OK so it was kind of a way of not hitting someone else to hit your own things instead?

B Yeah.

I And how would you feel while you were doing it?

B More better, more relieved, and I used to punch the wall as well.

I So was it a way of getting the angry upset feeling out a little bit?

B Yeah.

I OK and what about afterwards how did you feel afterwards?

B Yeah I felt a lot more calmer and a lot more relaxed.

I OK. And what would people say to you when you'd done that? What would the staff say?

B Well I know they told me off, they said you shouldn't do that.

I And was that helpful that they would kinda tell you off or not helpful?

B Not really.

Barry constructs his choice to “smash stuff up” (line 2) and “punch the wall” (line 37) as a way of coping with “being really down and really upset” (line 27) because of the bullying he experienced. His choice to engage in these
behaviours represented for him a way of avoiding what he constructs as more serious behaviour such as hitting other people. In this way, his destruction of his things (which was viewed negatively by the staff) was in fact a way of avoiding more serious and potentially harmful behaviours to others. This construction of challenging behaviour suggests that some forms may in fact be adaptive to the individual and their environment. Barry constructs the staff response as being unhelpful and in light of his understanding of his behaviour it could be hypothesised that for Barry, preventing him from engaging in this form of coping strategy could lead to more maladaptive ways of coping with difficult feelings such as “hitting someone” (line 28).

Barry strengthens his arguments through the use of ‘extreme case formulations’ (Pomerantz, 1986). These are described as ways of using talk to legitimise, defend or justify claims made about something by talking about it at its extreme. Some examples of extreme case formulation are ‘every time’ and ‘brand new’. Barry talks about “being really down and really upset” (line 27) and “feeling a lot more calmer and a lot more relaxed” (line 45) to demonstrate how adaptive this behaviour has been for his personal well-being.

In the following extract, the issue of challenging behaviour being one of several available options is further highlighted. Sam had been talking about a time when he felt “wound up” by staff which led to him punching and breaking a window, cutting his hand.
In this extract, Sam demonstrates that he is (now) aware of alternative coping strategies he can use when he feels angry. Challenging behaviour is one of these options, but Sam has also developed alternative strategies that he can draw on. Sam's choice to go to his room suggests that, for him, a way of coping with the stress he sometimes experiences from living in a residential home can be alleviated by being on his own. His options for being on his own may be limited to his bedroom (given that he may not be able to go out on his own) which highlights the importance for some individuals of having their own space in order to minimise challenging behaviour.

**Action orientation of the discourse**

As described earlier, discourse analysis seeks to explore the different functions that talk can achieve. The discourse of service-users being the
responsible agents for engaging in, or seeking alternatives to challenging behaviour, performs several functions within the context of the interview setting.

*Increasing empowerment*

Firstly, constructing challenging behaviour as something that the person chooses to engage in or not, constructs the speaker as somebody with power over their life and their surroundings. The issue of power has been explored in services for people with learning disabilities (e.g. Gilbert, 2003) who as a group are often constructed as having very little power over their lives. For example, the ‘Valuing People’ paper (Department of Health, 2001a) has talked about the need for services to increase choice in the lives of people with learning disabilities, for example in where they live. The necessity to comment on this suggests this is often not the case. By talking about choices over their behaviour, Barry and Sam reject the construction of themselves as powerless and instead build up a representation of themselves as people able to reflect on and explain their choice of action. The context of this talk is particularly important here as the respondents may have felt that professionals and services (who the interviewer may have been seen to represent) contribute to the discourse around their lack of choice and power. It is therefore a particularly powerful situation in which to assert the alternative, often marginalised discourse.
Justification and blame

The individual discourse was also used as a way of justifying behaviours that might be judged negatively by those around them. Several of the participants seemed aware that their behaviours might be viewed in a negative way and could lead to negative outcomes. In Extract 1, Barry’s assertion that he broke his stereo as a way of avoiding more serious forms of challenging behaviour allowed him to justify his actions and potentially avoid blame. He further elaborates by placing the blame for his actions on those who he felt were bullying him. Another example of this function of this discourse was demonstrated by Jason, who spoke about engaging in a different sort of behaviour which might also be viewed as challenging – self harm in the form of cutting his wrists. The context for this talk is that Jason’s father had “thrown him out” of the house because he was drinking alcohol and taking drugs at a family party:

Extract 3

1  I Oh OK, so that sounds, and then you said you tried to cut your
2     wrists=
3
4  J =Mmm hmm.
5
6  I So what, where were you then?
7
8  J Erm, at my friends.
9
10 I And what was happening for you at that time?
11
12 J Erm, I was thinking that I’m never gonna see them again once I’ve
13     died. And, I dunno, I dunno.
14   (four lines omitted for clarity)
15   
16 I Mmm. What do you think made you want to do that? Do you think
17     you wanted to kill yourself or=
18
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Jason constructs his actions as a way of achieving attention from a parent, something that would be viewed by many as a legitimate desire. In this way Jason avoids or minimises any potential blame for his actions. This construction might also link with a discourse around sympathy, which further weakens the possibility of blame being directed towards him. This action orientation contrasts with the empowerment action described above, where individuals attempt to take responsibility for their actions. This demonstrates the complex way in which people with learning disabilities have to negotiate their identity, drawing both from discourses of responsibility and empowerment, as well as sympathy and care elicitation. This is perhaps a function of living in services which are set up in such a way, that support from the staff is crucial for many daily activities. These extracts, however, suggest that people with learning disabilities may prefer to construct themselves more as people with choice and power.

Subject positions

Powerfulness

Linked with the action orientations of these constructions are the subject positions that the participants take up and reject in their talk. Walton (2007) has described how talk constructs the speaker, as well as the subject of the
talk, thus linking discourse and identity. The ‘service-users as responsible agents’ discourse, which constructs challenging behaviour as something that individuals can control, places the participants in a position of power. As well as providing a way of performing the action of empowerment, in this context it also offers a position that can be taken up by someone. This discourse therefore allows participants to position themselves as having, as well as increasing the power they hold within their context. Furthermore, it rejects the positioning of themselves by others as disempowered individuals.

Willig (2001) has highlighted the importance in discourse analysis of considering what is not said, as well as what is said. Here the unsaid discourse may be around the power held by staff. Using this discourse, the participants may be attempting to gain more power within services, thus lessening the traditional power hierarchy maintained by staff. The role and input of the staff in the occurrence of challenging behaviour is not discussed, which places staff in a disempowered position. This could be seen as linking directly with the ‘Valuing People’ paper (Department of Health, 2001a) which cites choice and independence as two of the fundamental features that services for people with learning disabilities should be promoting. This may represent success on the part of the services, but could also suggest that the participants are trying to construct an alternative discourse to the dominant one of them as disempowered individuals.
Rational decision makers

The extracts above also place the individuals in the position of rational decision makers. For example, in Extract 3 Jason talks about cutting his wrists as a means of getting attention from his father. He is able to construct this event in a way that the listener understands why he did this (i.e. because his father threw him out of the house) which supports the construct of his behaviour as a rational response to a difficult situation. Similarly, Barry's construction of his engagement in certain behaviours as a way to avoid more serious challenging behaviour, constructs him as a person able to make rational decisions, understandable by other people. This calls on the reader to question the wider discourses about people with learning disabilities as fundamentally different to other members of society in how they consider and implement their actions (e.g. Wilcox et al., 2006).

Implications for practice

If people with learning disabilities are able to reflect on and understand the different options available to them when responding to a situation then this may have fundamental implications for the way services are set up and run. Several of the extracts given here highlight times when the participants were able to make choices about alternative ways of acting. For example, in Extract 2, Sam sought some time away from a difficult situation by going up to his room, which he was able to instigate seemingly without help from staff. This would question the 'parental' nature of services which Barry alluded to in Extract 1 when he described how the staff “told me off” (line 50). This construction of staff role decreases opportunities for the alternative discourse
of empowerment to be developed. Department of health policies such as 'Valuing People' (2001a) and the Mental Capacity Act (2005) are clearly attempting to enhance the empowered, individual discourse, for example by outlining that all possible attempts should be made to include people (whether they have capacity or not) in decisions regarding their lives and the development of the services they use. A report from the mental health arena (Carpenter & Sbaraini, 2007) states that service-users feel very positively about being more involved in their care plans. However, difficulties are likely to be faced when implementing this guidance if services continue to be constructed in ways that maintain the dominant discourse of staff control. This will be explored further in the following section.

Subjectivity
As stated earlier this element of Willig's (2001) guidelines has been questioned by some (e.g. Walton, 2007) and so the following possible reading of these interviews is offered tentatively. However, because people with learning disabilities have often been constructed as finding it difficult to recognise, talk about or manage their feelings (as evidenced in the historical lack of talking therapies offered to this group, e.g. Bender, 1993) this issue will be explored here.

In relation to the discourses around empowerment and responsibility, the speakers may have experienced a mixture of subjective experiences. Firstly, they may have experienced positive feelings about themselves as having control over their lives and their actions. This may be something that is a
relatively novel experience for them and therefore this is the construct they chose to focus on during the interviews with me, which offered a way of strengthening this alternative aspect of their identity in the context of talk with a health professional. Links could be made here to the process in narrative therapy of using talk to strengthen alternative, preferred stories (Morgan, 2000), which may be different to how others construct them.

However, taking on responsibility for actions which may have resulted in themselves or others being hurt physically (e.g. as Sam demonstrated in Extract 2) or perhaps emotionally (as Jason showed in Extract 3) might also bring with it certain emotions associated with discourses around blame. Feelings of shame, guilt, remorse and sadness might be associated with this construct, and could lead to the reinforcement of the alternative construct of placing responsibility onto others in order to avoid this. This opens up the possibility of an alternative discourse around other people being responsible for the occurrence, and management of, challenging behaviour.

**Discourse 2: Services or staff are responsible for the occurrence of, and/or managing, instances of challenging behaviour.**

This discourse constructed challenging behaviour as something that staff or services are responsible for causing and/or preventing or stopping. This operated alongside the ‘service-users as responsible agents’ discourse and the participants moved fluidly between the two during their talk, according to the particular way they were constructing themselves, others, or their context.
In the following extract, Barry is describing his experiences of being regularly bullied when travelling on a bus:

**Extract 4**

1 B And then one day I was in the back of the mini bus and this boy burnt me for no reason at all, in the back of the neck with a cigarette.

2 I That sounds awful.

3 B So I told the staff and they got rid of him.

4 I So you usually would tell the staff if that happened.

5 B Yeah.

6 I Did you ever do anything else? Like hit them back or anything?

7 B No, I used to like not hit them back 'cos they were more bigger than me.

8 I Were they. And what made you worried about hitting them back?

9 B I might get into trouble.

10 I Who would you, who would you get in trouble with?

11 B Probably by the staff.

12 I Mmmmm.

13 B [inaudible] not worth it to fight back.

14 I So you didn't hit them back 'cos you didn't want to get in trouble with the staff. Were there any other reasons?

15 B Yeah. 'Cos I didn't want to get in trouble with the law.

In his reasons for not hitting the bullies back, Barry lists self protection first, then concerns about how the staff would respond to him and then finally implications with the law. This demonstrates the significant role the staff play
in his life, as their reaction is listed as more concerning than potentially being involved with the police.

Ahmed also clearly demonstrated the important role staff are afforded in dealing with challenging behaviour from other people. In the following extract Ahmed and I had just been discussing whether he had witnessed challenging behaviour in any of the other people he was currently living with:

Extract 5

1 I OK. And how do you think you'd feel if you did see someone do something like that?
2
3 A I'd erm, (.) tell the staff.
4
5 I You'd tell the staff would you? And what do you think the staff would do?
6
7 A Sort it out.
8
9 I How would they sort it out?
10
11 A Say hey don't you dare!
12
13 (8 lines deleted for clarity)
14
15 I What do you think they other person would do?
16
17 A [Ahmed makes 'jump' motion with his body]
18
19 I They'd jump a bit would they?
20
22
23 I And would that make them stop or would it make them carry on?
24
25 A No stop.

Ahmed may here be talking about an incident he has witnessed, though this is speculation as he was unable to recall whether this was the case. However,
this extract again demonstrates the power that staff are afforded in being the ones who deal with these instances.

This issue of staff being responsible for managing the outcome of any challenging behaviour is seen again in the following extract. Sam had just been talking about a time when he punched a fellow service-user in the face, because he perceived him as “being in one of his bad moods”. I asked him how the staff reacted to this:

Extract 6
1  I Ok so what happened when they found out?
2 3  S I got in trouble.
4 5  I Did you? What did they say?
6 7  S Report me, they report me to [name of manager removed for confidentiality]
8
9 10 I OK.
11
12 S And gave me a talking to.
13 14 I Ok. Do you remember what they said to you?
15 16 S No.
17 18 I But it was a talking to was it?
19 20 S Well yeah.

Extracts 5 and 6 demonstrate the important role staff are afforded in managing challenging behaviour. In Extract 6, Sam’s use of the phrase “gave me a talking to” (line 12) is suggestive of a model of service in which things are ‘done to’ the recipients of that service. The issue of power, and parental models of care are also clearly developed in his account when he describes
getting "in trouble" (line 3), a phrase often associated with child-parent relationships. This constructs challenging behaviour as something that services have decided the individual should not do. Choice is therefore removed from the individuals and placed with services and staff.

As well as staff being viewed as responsible for managing any challenging behaviour, this discourse also contained reference to the staff causing it. For example, Darren spoke about the way he felt he was treated in an inpatient unit, which he described as a causal factor in his challenging behaviour:

**Extract 7**

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 1 | D | And I was in there for ten months it was **horrible**. It was horrible in there. |
| 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 3 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 4 | I | Was it? |
| 5 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 6 | D | Yeah that made me angry. |
| 7 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 8 | I | What was it like in there then? Tell me about it. |
| 9 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 10 | D | It was horrible. |
| 11 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 12 | I | What was horrible about it? |
| 13 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 14 | D | (.)No one cares about you. |
| 15 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 16 | I | Mmmm |
| 17 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 18 | D | The staff didn’t, didn’t even do **anything**. |
| 19 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 20 | I | Really? |
| 21 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 22 | D | They didn’t care about you or nothing. |
| 23 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 24 | I | That sounds really difficult. So how did, how did [ ] |
| 25 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 26 | D | They never talked or **nothing** to people, to the people in there, who were in there. |
| 27 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 28 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 29 | I | So was it like they kind of ignored you a little bit? |

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Darren constructs the lack of staff input as the foundation to the occurrence of challenging behaviour. He uses extreme case formulation to strengthen this position in line 22 ("they didn’t care about you or nothing") and 35 ("and they wouldn’t let me go out on my own or nothing"). His repetition of the word 'nothing' adds weight to his claim of a lack of support from the staff, which he feels led to his challenging behaviour.

**Action Orientation**

_Maintaining the status quo of services_

The 'services as responsible agents' discourse may reflect the power held by staff within services, which they may have maintained through their talk and interactions with service-users. This discourse may have been sustained because of the reinforcers it provides staff with, such as allowing them to feel safe, maintaining a context that suits staff working practices (rather than the unique care needs of the individuals they work with) and maintaining the status quo of services (given that change could be highly anxiety provoking). Because of their power, this discourse remains dominant and has become part of the language of services, including those who use them. The participants, who by the nature of their learning disability may already be a disempowered group, may find it difficult to reject this dominant discourse and
so it is maintained despite the fact it may not best meet their needs. However, maintaining the status quo of services may also provide a feeling of security for the service-users. This construction could suggest that though they may wish to be more empowered (as seen in the ‘service-users as responsible agents’ discourse) there are potential difficulties and anxieties associated with making changes. Maintaining services as they are may therefore seem a more preferable option. There are links between this idea and the therapeutic literature which suggests that people may be reluctant to make changes in their lives even when there are factors that are unsatisfactory to them, because of their concerns about change and its possible consequences (e.g. Prochaska, DiClemente & Norcross, 1992). They may fear that change could result in experiences that are worse than the situations they are already coping with. This may, in part, explain why the individuals in this study drew on a discourse which appeared to eliminate the power they hold over themselves and their environment. This has implications for therapeutic work with both service-users and staff teams.

Furthermore, there may be an issue that once an individual has achieved a label of challenging behaviour, everything they do is then seen as a feature of this label. This phenomenon was commented on by Rosenhan (1973) who found that ‘pretend’ patients admitted to a psychiatric unit continued to have their behaviours described in ways that linked with their psychiatric diagnosis, despite them no longer displaying the false symptoms they had been admitted with. For people with learning disabilities, attempts to express power (for example saying no) may be defined as challenging behaviour, and responded
to accordingly. This may then increase instances of challenging behaviour, creating a vicious cycle in which the behaviours of both staff and service-user are maintained.

*Creating a feeling of safety*

A second possible function of this discourse is that it allows the participants to feel safe when living in shared accommodation with people they have not chosen to share a living space with. Though most of the participants had had some (or all) decision making power over where they lived, they would not have been able to choose who else was in the service. This may have led to them sharing with people they find difficult to live with for a variety of reasons. For people who may find social interactions difficult, having a more powerful source of support or authority to turn to may be comforting. However this construct may further perpetuate their experience of themselves as powerless, unskilled individuals. In this way it is possible to see how the construction of staff as powerful and skilful is reinforced and maintained.

*Subject positions*

*Powerlessness*

As stated above, some of the participants constructed challenging behaviour as something that should be controlled by staff. However, this exacerbates the construction of themselves as disempowered, unskilled individuals. It is possible that challenging behaviour represents a challenge to this dominant discourse, providing them with some influence over their environment. This
highlights one of the conflicting constructions around the complex issue of challenging behaviour. Though it may be seen as something that staff should manage, their responses may in fact contribute to further instances of challenging behaviour. For example, in the following extract, Darren clearly describes his use of challenging behaviour as a way of attempting to negate the power which staff demonstrated over him by holding him in hospital because of his challenging behaviour:

Extract 8
1  I  So how did you feel about that?
2
3  D  Angry.
4
5  I  And how, do you think they knew you were angry about it?
6
7  D  Cos I broke something.
8
9  I  Did you, what did you break?
10
11  D  Of theirs.
12
13  I  What did you break?
14
15  D  Don’t remember.
16
17  I  Was it something of the staffs’?
18
19  D  [Nods]
20
21  I  And what happened then?
22
23  D  (.)Er I said so are you gonna let me out then, that’s what I said if you don’t let me out, if you don’t let me out then I’m gonna break things.
24
25
26
27  I  Mmm, and what did they say to that?
28
29  D  They said we’ll let you out then.
30
31  I  Oh ok
32
33  D  And they did
In this extract, Darren constructs his challenging behaviour as a result of the power imbalance and associated affect he experienced as a result of the staff’s attempts to control his challenging behaviour (i.e. admitting him to hospital). In this construction challenging behaviour is used to ‘argue’ against the dominant discourse of staff empowerment and for Darren, this did result in short-terms gains regarding having more control over his life. However, his original admittance to the hospital because of challenging behaviour suggests that attempts such as these to challenge staff dominance may in fact lead to further, longer-term disempowerment through social exclusion and/or restricted freedom.

Protection

Use of the ‘services as responsible agents’ discourse also affords the service-users a protected position. As stated previously, most of the participants will have had little or no say over who they live with and perhaps even over whether they live with other people or not. Though the ‘Valuing People’ paper (Department of Health, 2001a) promotes choice over housing options, this has not yet occurred for many people. Use of this discourse may be a way of creating a protective context within which the individuals live, given the often unpredictable nature of living in a setting in which challenging behaviour occurs.

However, though this position may lead to a greater sense of safety, it also evokes discourses around ‘parental’ services who have to ‘look after’ their service-users. This links with the child-like discourse about people with
learning disabilities, constructing them as people who need to be protected. This may further impact on their position as disempowered individuals. The potential outcomes of these positions for both services and service-users are explored below.

Implications for practice
The way the role of staff is constructed in the causes and management of challenging behaviour has a huge implication for service organisation. If service design or implementation are seen as contributing factors to challenging behaviour, then the implication for services is that they need to be organised in ways that will minimise this. The emphasis in interventions for challenging behaviour would therefore be working with services to alter the relational and situational contexts in which challenging behaviour occurs, with less emphasis on working directly with individual service-users (e.g. on alternative ways they can express their needs). Barry demonstrated this clearly when he spoke about an incident he witnessed in his previous placement when one resident hit another resident over the head with a fire extinguisher:

Extract 9
1  I  Mmm. And why do you think he hit him?
2
3  B  'Cos he was angry.
4
5  I  What, what gave you the clue that he was an::angry?
6
7  B  'Cos sometimes when he used to shout at the staff and they never used to come to him.
8
9
10 I  Oh OK. And was that what, was that what had happened this time=
Barry's account places the role of staff as central to this incident of challenging behaviour. This construction suggests that the way staff respond to the people they are supporting is crucial in preventing instances of challenging behaviour and that the occurrence of challenging behaviour could suggest staff are not meeting the needs of their clients. One reason for this may be that staff are not able (or perhaps willing?) to spend time with the people they care for in the way that service-users might like or need. This may be related to issues regarding attachment. Hodges (2002) has highlighted that many people with learning disabilities have experienced difficult attachment relationships from birth as a result of their learning disability. Early experiences of attachment effects how people form attachments in their adult lives, and in particular how they seek comfort when they experience distress.
(Dallos, 2006). People with learning disabilities may need people around them who are able to act as especially robust attachment figures in order to overcome some of these difficulties. Staff teams who are concerned about forming such attachments may fail to meet the emotional needs of some of their clients.

However, care must be taken when suggesting implications from the ‘services as responsible agents’ discourse, as this could in part construct the person with a learning disability as being released from any responsibility regarding their behaviour. The interplay between this issue and the power and responsibility associated with the individual discourse is clear in several of the extracts provided. Individuals may move between these two discourses (and their associated positions) fluidly, which has implications for services which need to flexibly respond to these two discourses in a way that allows a dispersion of power within the context of a residential home. In this way residents may be supported to become more empowered in some areas of their lives.

**Subjectivity**

The construction of challenging behaviour as something that staff may cause and/or are responsible for managing could have various implications for the individual, depending on the context in which this discourse is used. For example, if it is used to disavow responsibility for engaging in behaviours which challenge, the individual may free themselves from experiencing affects such as guilt or shame. This construct however may also be associated with
feelings of disempowerment, which could lead to feelings of frustration. Indeed, just as individuals may move between these various discourses, it is possible that their subjective experience of each discourse also varies according to the context in which it is used.

**Discourse 3: The perceived severity of learning disability a service-user has influences the way instances of challenging behaviour are constructed, in particular whether the 'service-user as responsible agent', or the 'services as responsible agents' discourses are drawn upon.**

The discourses described above appeared to be mediated by the issue of severity of learning disability. Two of the participants spoke directly about this issue, with people with more severe learning disabilities having their behaviour constructed differently to those viewed as more able. For example, Jason spoke about an incident when he had a fight with another service-user he was living with. Jason had been arrested and fined fifty pounds in court, while the other man had not been involved in any legal procedures. I asked Jason about why he thought this difference had occurred:

**Extract 10**

1. I And do you, do you think anything happened to the other man?
2. J No.
3. I OK why do you think that was different?
4. J ‘Cos he was non verbal.
5. I Oh OK. And wh:::y does that make a difference do you think?
6. J I don’t know. Maybe they don’t understand more than I do.
Jason constructs people who are "non-verbal" (line 7) as understanding less about their behaviour and therefore not being accountable for their actions. This links with the 'service-users as responsible agents' discourse, suggesting that only those people with a certain level of understanding would be able to consider and choose their actions. This discourse may apply not only to constructions of challenging behaviour, but perhaps more generally to the lives of people with more severe learning disabilities. This could suggest that for some people with a more severe learning disability, the 'services as responsible agents' discourse might be more strongly evoked, along with the related discourses of care and service provision described above.

Barry expanded on this difference to demonstrate how severity of learning disability might also impact on the likelihood of being a victim of others' challenging behaviour. He spoke about a time in his previous residential service when someone had hit another person over the head with a fire extinguisher. Barry's understanding of the situation was that the man in question had been calling for staff and they had not responded to him, which made him angry. When I asked him why the man had attacked another resident rather than the staff, Barry said:

Extract 11

1  B 'Cos I think it's where he don't get the staff support so much, and their attention.
2
3
4  I Mmmmmm.
5
6  B So he decided to hit [named removed] on the head.
7
8  I Oh OK=
9
With the fire extinguisher.

So it was a way of getting more support and attention from the staff?

Yeah.

Why don't, why didn't he hit the staff?

'Cos he probably be in a lot of trouble.

So do you think he would have got in more trouble if he'd hit the staff?

Yeah.

Than he did hitting [name removed]?

Yeah.

Why:: do you think that is?

'Cos he might have done it to [name removed] 'cos maybe he knows [name removed] can't sort of talk for himself.

Mmmm yeah. OK so it sounds like because [name removed] couldn't talk he might have been more of a, a target=

Yeah=

Than the staff could have been.

Yeah.

Barry constructs having a more severe learning disability (understood as having a lack of verbal communication, as Jason did in Extract 10) as making someone more vulnerable to others' challenging behaviour. This draws in part on the 'service-users as responsible agents' discourse, as more able individuals may be aware that challenging behaviour towards non-verbal fellow residents may have different outcomes than towards staff and/or more able residents. However, it also links with the 'services as responsible agents' discourse in that it suggests that people with more severe learning disabilities
may need to be protected by staff in shared housing situations. This has clear links with the issues described above around empowerment, protection and parental style relationships within services.

**Action Orientation**

**Blame**

This discourse allows challenging behaviour to be constructed flexibly according to who is ‘doing’ it. The issue of blame is clear here, with people who are considered more learning-disabled being constructed as free from blame, perhaps because they are not held responsible for their behaviour. However, Jason's account suggests that this view might differ according to who is speaking. For example, he perceived himself to be a victim (as well as perpetrator) and clearly felt the blame should be shared, regardless of severity of learning disability. This highlights an issue for staff of how they support their clients to manage their relationships with the other service-users they share a home with.

**Powerlessness**

This discourse also constructs people with more severe learning disabilities as more likely to be victims of challenging behaviour, perhaps because they are seen as unable to defend themselves and may not be able to report any incidents. This discourse may therefore act to disempower people with more severe learning disabilities as they are constructed as being unable to care for
or defend themselves. Alternatively it constructs people with more mild learning disabilities as being more powerful.

**Individuality**

This discourse, however, does open up possibilities for people with learning disabilities to begin to be seen more as individuals with different skills and abilities, rather than as one homogenous group, defined solely by their learning disability. The participants in this research clearly saw themselves as different to those with more severe learning disabilities. However, this discourse may create a hierarchy within residential services whereby some service-users take up more powerful positions than others. This was seen historically in the Victorian long stay institutions when more able people were encouraged to take care of the less able people, as a result of low staffing levels (Gladstone, 1996). This division has the potential for some people (those with more severe learning disabilities) to become even more disempowered. However, these comparisons may occur because for the more able people, comparing themselves to those with a more severe learning disability leads to positive self reflections (see page 72 for a more detailed explanation of this issue).

**Subject positions**

**Victim**

The ‘severity of learning disability mediates location of agency’ discourse places those with more severe learning disabilities in the role of victim. This
positions them as people who require others around them (e.g. staff) to act as their protectors. This position has implications for feelings of powerlessness, as these individuals may not be viewed as being able to care for or defend themselves against potential sources of harm around them. This construction makes links with discourses about people with learning disabilities as being child-like, as there are similarities with discourses around young children needing to be protected from harm by adults around them. However, the context of this discourse is important as this may only be an issue in shared-housing settings, a historical and current political issue which incorporates the way that people with learning disabilities are viewed by wider society and the subsequent funding and policies that are developed.

Accountability for actions
This discourse may benefit those with more severe learning disabilities in that it allows an avoidance of issues of blame and associated affect. However, this may further exacerbate the discourse around staff power and control and decrease the sense of autonomy or empowerment these individuals might have. People with learning disabilities may therefore experience a conflict between wanting to increase their empowerment and autonomy (achieved via the individual discourse), but also wishing to avoid blame and possible rejection (evoked by the staff discourse). However, the participants in this study would perhaps be more likely to be placed in the less severe category of learning disability (because of the requirement for them to have capacity to consent to the study) and it is possible that different constructions would have
been identified had the experiences of people with more severe learning disabilities been gathered.

**Implications for practice**

This discourse has implications for services to recognise and attempt to work with power imbalances amongst service-users in group residential homes. However, this may be a difficult issue for services to address, because the current dominant discourse within services is usually one where the power is held by the staff. This current division of power might serve to help staff feel safe when working and they may therefore be reluctant (consciously or unconsciously) to change this. Furthermore, it is possible that attempting to increase the power held by service-users may be more easily obtainable by those with a less severe learning disability. There is therefore the risk that those with more severe learning disabilities will become even further disempowered, as they will then experience a power imbalance not only with staff but also with the other people they are living with. In staff-dominated environments, attempts to resolve intra-service-user power imbalances could lead to those with milder learning disabilities being disempowered, in order to 'level the playing field'. This perhaps highlights that individual living circumstances may be more facilitative to increasing autonomy and power in individuals than would be possible in shared residential services.

This discourse also has implications for the decisions that are made about which people live together. Most adults are able to choose who they share a living space with and this is considered a highly-valued 'right' by most people.
However, for people with learning disabilities in group homes, this is often not the case and they may be forced to live with people with whom they share very little in common in terms of their interests, skills and abilities. The propensity of services to group people together according to labels such as 'challenging behaviour' (Royal College of Psychiatrists et al., 2007) may also mean that individuals who use challenging behaviour as a way of coping with stressors (or getting their needs met) often end up living with other people who behave in ways that are stressful to live with. This may leave some people more vulnerable to engaging in challenging behaviour as a way to cope with these stressors, or more vulnerable to becoming the victim of other peoples' behaviour. These factors may negatively impact on an individual's physical and psychological well being and in turn create a vicious circle of challenging behaviour. This therefore seems an important issue for services to address.

Subjectivity

It is possible that the different constructions made according to the severity of a person's learning disability might lead to different subjective experiences. For example, more able individuals may positively experience the increased power and autonomy this position affords them. For a group which is often marginalised and disempowered, positioning themselves as more powerful than people with a more severe learning disability may afford them an experience they do not often have within wider society. Szivos-Bach (1993) has explored this issue, commenting on Festinger's (1954) theory of Social Comparison. This states that individuals will make comparisons between
themselves and others in order to evaluate their own identity, and that this will impact on who they choose to spend time with. Szivos-Bach (1993) claims that if people with learning disabilities do this with non-learning disabled populations, they are likely to experience a negative comparison on many issues. Therefore they may prefer to make comparisons with (and therefore spend time with) people with more severe learning disabilities in order to provide them with more positive evaluations of themselves. However, taking up a position of increased empowerment may leave them vulnerable to experiencing blame for any challenging behaviour they engage in, and the possible associated affect of this blame. Similarly, accepting more power and control over their lives might also have fearful connotations of losing the care and support provided by services.

For those with a more severe learning disability, the implications for subjective experience could be the opposite seen in more able people. Although they may not be blamed for their behaviour (and therefore avoid any associated feelings regarding this), they continue to be the most marginalised, disempowered group. They may also be the most susceptible to the child-like/parental discourse of care, which could generate a host of different feelings such as comfort or oppression. Those with more severe learning disabilities may also experience fear through potentially being the most vulnerable to others peoples' challenging behaviour. Given that this group may have associated communication and physical difficulties, defending themselves and/or seeking safety or help might be particularly difficult and in group settings, this may lead to people living with a great deal of anxiety.
about how others might treat them. These issues may be seen not only between the categories of ‘severe’ and ‘milder’ learning disability, but throughout this group as a whole.

**DISCUSSION**

**Summary of the discourses**

This research was designed to highlight the different discourses that some people with learning disabilities drew on when constructing their own and other people’s challenging behaviour. The most prevalent of these were the ‘service-users as responsible agents’ and ‘services as responsible agents’ discourses, alongside the ‘severity of learning disability mediates the location of agency’ discourse. These were drawn on flexibly, but done so in a way that the ‘services as responsible agents’ discourse appeared to remain dominant, i.e. the ‘service-users as responsible agents’ and ‘severity or learning disability’ discourses were drawn on within the context of the ‘services as responsible agents’ discourse. The second question focused on how these discourses allowed the participants to build up a particular identity, in relation to challenging behaviour. This issue has been explored in the action orientation; subject position and implications sections of the discourse analysis.

The ‘service-users as responsible agents’ discourse centred around the notion that people with learning disabilities choose to engage in challenging behaviour as one way (from a choice of several) of achieving a particular
outcome. Themes of empowerment were explored, with the associated factors that might then result from any blame experienced. This discourse was used flexibly alongside the ‘services as responsible agents’ discourse, which held staff responsible for the occurrence and management of challenging behaviour and its outcomes. The empowering position for staff and disempowering position for the participants was explored, as were the potential advantages this construction held for both parties. Finally, the ‘severity of learning disability mediates the location of agency’ discourse was shown to construct challenging behaviour in different ways according to who was involved and in what capacity (e.g. engaging in, witnessing etc.).

**Links to previous research**

The literature described in the introduction highlighted the use of the term challenging behaviour as something frequently located internally within an individual (e.g. Wilcox *et al.*, 2006). However, the report by the Royal College of Psychiatrists *et al.* (2007), suggested a need to change this view to one where challenging behaviour is seen as a representation of a failure in services to meet the needs of the people they serve. This study reinforces this recommendation by highlighting the importance of the ‘fit’ of both parties. It has shown that the ‘problem’ of challenging behaviour is unlikely to be resolved by singularly addressing either the individuals concerned, or the services, but rather by improving the compatibility between the two. This is demonstrated in the way the participants in this study moved flexibly between the ‘service-users’ and ‘services’ as responsible agents discourses, at times
drawing on both. This links well with Blunden & Allen's (1987) view of challenging behaviour as something that must be viewed in a contextual way.

The association of challenging behaviour to people with learning disabilities has also been raised. This research in some way weakens this connection as the participants spoke about their use of challenging behaviour as a way of coping with difficult situations which could face many people. In this way, their choice of actions defined them less as people with a learning disability and more as people experiencing an emotional difficulty of some sort (though perhaps as people who have more limited options for dealing with these situations). Furthermore, behaviours that may be described as challenging, e.g. self-harm and violence, are well documented within other forms of service (e.g. adult mental health) as well as within the general population. This highlights that 'challenging behaviour' is a term that could be applied to the behaviour of many different people and need not be so strongly and specifically linked to the term learning disability.

This study supports the involvement of people with learning disabilities in research given the wealth of information, ideas and discourses which have been identified. Service-user involvement is an area which is increasingly receiving interest in research (e.g. Scior, 2003) and in the development of governmental policies and services (Department of Health, 1999). This study supports the involvement of people with learning disabilities in both of these processes, something that has occurred to a limited degree to date. Furthermore, it also specifically supports the use of discourse analysis with
people with learning disabilities which has only recently begun to receive attention in this field (e.g. Scior, 2003). Though care may need to be taken when designing and implementing research with this client group, this study goes some way to address the view (seen in the lack of research) that people with learning disabilities use language in such a fundamentally different or impaired way that they are unable to offer meaningful understandings about their lives. However, it is of note that this research used people who would probably be classified as having a significant, rather than a severe learning disability (British Psychological Society, 2004b). As found by Emerson et al. (2001) those with more severe learning disabilities are more likely to be associated with challenging behaviour, and there may be different discourses associated with this group. It is likely that this population will not be able to take part in research involving verbal interviews and so more creative ways of accessing their understandings may need to be found.

Gender was not spoken about explicitly during any of the interviews and its absence highlights a gendered discourse which exists around challenging behaviour. This was first highlighted in the conversations with the care managers who were asked to identify potential participants. None of them suggested any female participants despite being explicitly asked. Furthermore, when speaking about other people who they had seen displaying challenging behaviour, all of the participants described only male individuals. Finally, when talking about the involvement of staff in managing challenging behaviour, the majority of those mentioned were male. As Willig (2001) has stated, it is important in discourse analysis to consider what is not
said, as well as what is said. The omission of any female presence within the interviews suggests that challenging behaviour may be associated with maleness or masculinity and that the behaviour of females who challenge services, may be constructed in a very different way. This links with the previous research by Sequira & Halstead (2001) and Wilcox et al. (2006) which identified the different ways in which challenging behaviour is understood and responded to in men and women with learning disabilities.

**Implications for individuals and services**

Although drawing on the dominant ‘services as responsible agents’ discourse may appear counter intuitive for this frequently disempowered group, they may do so because of anxieties about what having more power or choice might be like. Though it may be hard to accept the limitations and controls placed on their lives by services, people with learning disabilities may also be unsure as to what a life without these restrictions and support might look like. Therefore, by maintaining the dominant discourse, the respondents ensure that they continue to elicit the staff's support. However, conversely this discourse may also be used as a way of supporting the development of a more empowered life. Individuals may wish to broaden their independence and choice, but may need the staff's support to do so. By continuing to draw on the staff discourse, but doing so flexibly - in conjunction with the ‘service-users as responsible agents’ discourse - they may be able to negotiate maximum benefits regarding empowerment and support. Furthermore, the use of both the ‘services’ and ‘service-users’ as responsible agents discourses may represent an interdependency which is seen in all people.
Oliver (1990) has highlighted a concern that independence is beginning to be seen as an aim for all people with learning disabilities, with dependence on others being minimised as much as possible. However, Oliver (1990) points out that dependency on others is required by all people in certain situations and that this factor should be considered when supporting people with learning disabilities.

In relation to challenging behaviour specifically, the ‘services as responsible agents’ discourse offers protection for people with learning disabilities who are often placed in shared housing accommodation with people they have not chosen to live with, and who may demonstrate challenging behaviour. The propensity of services to group people deemed as ‘challenging’ together is likely to maximise service-users’ anxieties in these settings. Maintaining the dominant position of the staff in managing challenging behaviour may allow individuals to feel safer as they then have a much wider (and potentially more powerful) source of support for making their environment a safer place to live. However, it is possible that by maintaining this level of power with the staff, the incidents of challenging behaviour may increase if individuals are frustrated by the lack of power, choice and control that they are then left with. Whether, and how, individuals find a balance between these two issues seems an important question for consideration in future research.

The parental / child-like discourses highlighted in these interviews may allow services to maintain the choice and control over how they are run. This could ensure that services continue to function in a way that best fits with issues
around staffing levels and practices. However, this does not hold each individual resident at the centre of their support package, as would be expected from person-centred models of care (e.g. Innes, MacPherson & McCabe, 2006). Because of the historically disempowered position of people with learning disabilities within services, they may not be aware of alternative ways of being supported. Furthermore, as a disempowered group, they may not feel able to initiate change. Professional services outside of residential settings (e.g. advocates) may need to join with people with learning disabilities to help challenge the dominant discourse and increase the choice and control this client group have over their lives. This may include wider issues such as choice of living arrangements, but could also relate specifically to challenging behaviour, for example in how care plans are constructed. There may also be a role for clinicians in helping people with learning disabilities and those working with them to manage the contexts in which challenging behaviour is most likely to occur, for example individual therapeutic work with residents and/or training with staff.

The dominance of the ‘services as responsible agents’ discourse may also have been preserved because it allows staff to experience a feeling of relative safety when working with this client group. Previous research with staff groups (e.g. Wilcox et al. 2006) has identified that they often construe challenging behaviour as an irrational way of behaving, caused by factors internal and stable to the individual. Constructing themselves as the people who should manage this may allow staff to feel control over what they view as unpredictable behaviours. When staff are faced with potential physical and/or
emotional wounds, maintaining a sense of control may allow them to cope with these difficult experiences. However, this discourse also has the possibility of depersonalisation, where staff may see the people they are supporting as being defined by their challenging behaviour. Although this may protect staff from experiencing difficult emotions, it has may lead to practices that are non-person-centred, where the needs of the individual are not met because their challenging behaviour is viewed as the primary defining feature about them. These processes are unlikely to be conscious decisions, but may be linked to unconscious defences around the anxieties that care work can bring up (e.g. Menzies, 1988). This highlights a possible need for work with staff around becoming aware of, expressing and managing their anxieties about working with issues around challenging behaviour, and how this may influence their practice.

**Future research**

There are several avenues for further research that this study has highlighted. Firstly, there is a need for the views of people with learning disabilities to be brought more to the forefront of research. As shown earlier the views of service-users in learning disability research has been historically overlooked, leading to understandings of challenging behaviour (and many other aspects of a person’s life) being formed from the perspective of others. Interviewing people with learning disabilities allows their own constructions of their identity to be brought to the forefront. This may help to further develop the discourse around people with learning disabilities as individuals able to understand their own lives and behaviour. Engaging in this type of research may go some way
to counteract the parental / child-like discourses which dominate the lives of many people with learning disabilities in many western societies and services.

Furthermore, the move towards participatory research (e.g. Chappell, 2000) suggests a useful avenue to explore could be involving people with learning disabilities as co-researchers. This could be particularly useful for discourse analysis given the openness this approach adopts in considering the researcher's impact on the work. It may therefore also be useful for these data to be re-analysed by people with learning disabilities, to explore alternative discourses that might be identified. The role of non-learning disabled researchers would need to be considered carefully in both these instances to allow sufficient support for the researchers, without the analysis becoming a joint venture (unless this was specified in the research design). There are issues with this suggestion about the level of knowledge or skills required to conduct qualitative research. However, the researcher feels this form of research opens up interesting possibilities for consideration.

This research has highlighted potential difficulties for shared living services, an issue already highlighted in the ‘Valuing People’ paper (Department of Health, 2001a). Very little research to date has addressed the issue of how services which offer more individualised support could benefit people with learning disabilities. This study suggests this may be an important issue to consider. Similarly, work around different styles of interaction by staff may be useful. This study has also highlighted the complexity of the relationship that is often found between service-users and staff teams, where dependence
may be felt to be somewhat necessary, but also counterproductive to increased independence. Further research into how shifts in this balance effects services and service-users could prove to be informative for future design of services. It is likely that different contexts will highlight different discourses, which could broaden the scope for service provision. Similarly, it may be useful to explore the relationships between people with learning disabilities living in shared accommodation, given the impact this can have on sense of identity in terms of social comparisons.

Despite looking specifically at challenging behaviour this research has highlighted many other important issues in the lives of people with learning disabilities and the people who provide support to them. It has been able to show the wider discourses at work through the talk people engaged in about this specific area, e.g. around care and support, gender etc. This suggests that further work around the specific issue of challenging behaviour might also be helpful. In particular, issues that were not addressed specifically in this study (but which were referred to by the respondents and therefore offer scope for further assessment) include the use of the police in managing challenging behaviour; the responses of staff to challenging behaviour and the use of debriefing for those involved in or witnessing other people’s challenging behaviour. These may be important issues to address so that services can be set up to best meet the needs of the people they are working with. Furthermore they may increase the voice of people with learning disabilities within research; service design and wider society.
Limitations of the method

As stated in the Method section this research has been designed and implemented to meet the criteria set out by Yardley (2000) for high quality qualitative research. However, there have been several criticisms highlighted about the use of discourse analysis to analyse talk and about the potential uses these analyses might have. These are reviewed below, together with a demonstration of how this research has attempted to address these.

1. Methodological issues

Willig (2001) has highlighted that although discourse analysis is based on the social constructionist stance that talk creates identity, this methodological position has not been able to say whether discourse is all that is necessary for a sense of identity to be generated, or whether there are other factors involved too. For example, it is not clear why some people might invest emotionally in certain positions over others. The reader may remember that positionings were defined on page 38 as "discursive locations from which to speak and act" (Willig, 2001, p.111) which have associated rights, responsibilities and duties. Several different suggestions have been put forward to explain why some people might emotionally invest in particular positions over other possible options. For example Davies & Harre (1999) believe a person’s history of being positioned by others, or experience of someone else in a particular position, will affect their uptake or rejection of future similar positionings. However, others (e.g. Hollway, 1989) have highlighted the impact of processes such as projection in how discourses are used to create a sense of identity. These differences highlight conflicting
theories within Foucauldian discourse analysis about how stable these identities might be; to what extent they are context-dependent and to what extent thoughts and feelings can be identified from them. There has not been scope in this study to explore these issues, but Davies & Harre's (1999) position appears to fit with these results. This suggests the way an individual has been positioned by others affects the discourses they will draw upon and hence the sense of identity they create. The participants' use of the staff discourse is likely to reflect the majority of their social experiences being with staff and the way staff have positioned them within the service. This may in turn reflect society's wider positioning of people with learning disabilities.

Discourse analysis has also been criticised for failing to identify to what extent reality and discourse construct and constrain each other. It is not clear whether language is wholly responsible for constructing reality, or if there are other factors involved which might impact on the effects of discourse. Willig (2001) has highlighted two of the main arguments regarding this issue. One is that external reality constrains what discourses are available for use. On the other hand, discourse and reality may be interlinked, with neither having more or less of a constraining effect on the other. This research has taken the position that external contexts have an effect over the discourses which can be drawn upon. However, it may be fruitful to re-analyse the data taking the alternative perspective, to see if any difference occurs.
2. Ethical issues

The issue of power within discourse analysis (particularly Foucauldian) is attended to within the analysis of the subject topic, but there is also an issue of power inherent in one person offering a reading of another's talk. The implicit assumption here is that one person is able to impose meaning and purpose on another's talk, placing the researcher in a position of power over the researched (Parker & Burman, 1993). This is evidenced in the recommendation in discourse analysis that the researcher need not ‘check out’ their findings with their participants as recommended for other forms of qualitative methods (e.g., Elliott et al., 1999) because it is assumed that the speakers may not be aware of the "unintended consequences of the language that was used" (p. 114, Coyle, 2007). For a method concerned with power issues this seems an important issue to consider and may link well with the move towards participatory research.

Parker & Burman (1993) have also highlighted concerns about a methodology that is concerned with looking for "hidden meanings" (p.159) and the care that must be taken around how and why these meanings are searched for. By providing as many extracts as possible from the data it is hoped that the extrapolations made in this study have been evidenced, with clear markers of the researcher's own personal interests.

However, Tuffin (2005) has highlighted the highly ethical nature of critical psychological research methods (including discourse analysis), given that participants in this form of research can be clearly told about the method and
topic of the research. He contrasts this with examples of research from the positivist paradigm that have utilised participant deception. This research was designed to allow an openness about the subject that would be discussed, though it is of note that a full explanation of the research (i.e. the nature and purpose of discourse analysis) was not conducted with the participants. The researcher justifies this against the potential impairment on rapport that could have occurred as a result of a long and complex explanation prior to the interviews.

Tuffin (2005) also highlights the ethicality of affording such importance to individual accounts, rather than homogenising many briefer accounts to form one conclusion about many people. Methods such as discourse analysis are able to tolerate and report on the variation which is seen in human social life and to situate the study of individuals within their social context. For these reasons the researcher feels this form of research was recommended over other methods adopted from the positivist epistemology, despite the limitations described above.
REFERENCES


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29 Referred to in Appendix 1


30 Referred to in Appendix 1


Appendix 1: Summary of the work of Michael Foucault

Michael Foucault (15th October 1926 – 25th June 1984) was a French philosopher who employed critical methods to study such topics as sexuality, psychiatry and politics. He was particularly interested in the use of discourse, and how this related to issues of power and knowledge (Carabine, 2001). Foucault's work explored alternatives to the positivist paradigm belief that real truth's can be found in the world. Instead, he focused on the possibility of multiple perspectives and understandings, without any one privileging the others (Graham, 2005). Foucault's work aimed to uncover the ways in which particular discourses had developed whilst others did not, and how this was linked to power relations (Burr, 1995).

Foucault developed the 'methodology' of genealogy to analyse the triad of issues – power, discourse and knowledge (Carabine, 2001) that his approach focuses on. Genealogy involves a focus on the historical development of an issue in order to understand the place it has come to hold in today's society (Kendall & Wickham, 1999). Foucault's theory holds that discourses (which will be based on the historical development of a topic) are constructive, in that they construct the objects, subjects or issues that they speak of (Carabine, 2001).

Genealogy however was not formed as a step-by-step methodology for analysing data, as seen in the methodologies developed within the positivist framework. Foucault developed this more as a way of considering a topic. For this reason some researcher's have described attempting to use this approach as inaccessible and dangerous (O'Farrell, 2005) as each researcher will use Foucault's ideas differently. However, some commonalities in topics or processes to consider have begun to now be identified (e.g. Willig, 2001).
Appendix 2: Verbal information sheet

Information Sheet

My name is Shona Daynes and I am a Trainee Clinical Psychologist at University of Surrey.

I would like to talk to you about what it is like living here. I would especially like to ask you about how you cope with difficult situations, for example if somebody asks you to do something you do not want to. I would like to talk to you about how that makes you feel, for example sad or angry, and what you do.

I would also like to ask you about how other people you live with deal with difficult situations, like the one I just mentioned.

I would like to record our conversations on a tape, and afterwards I will write down what we have said. I won't use your real name when I write this down, so that what you have said will be private, and no-one will know it is you who said it.

After I have written down what you have said I will read it lots of times. I will also be reading the things I have talked about with other people. I will write these up in a report. I will not use yours or anyone else's name in this report, including the name of where you live, so that it will be private.

It is OK if you don't want to talk to me. You can also choose to stop talking to me at any time. If you do this I won't write up what we talked about. It is OK to stop now or at any time.

You can ask me any questions about this when we meet to talk about these things, or when we start talking.

You can also contract me, or ask one of the members of staff to contact me to ask any questions by emailing me at s.daynes@surrey.ac.uk.

You can also call and leave a message for me on 01483 689441, and I will call you back.

Thank you,

Shona Daynes
Trainee Clinical Psychologist
Appendix 3: Pictorial information sheet

Pictorial information sheet

My name is Shona Daynes. I am a trainee clinical psychologist.

I would like to talk to you about what it is like living here.

I'd like to talk to you about difficult times when you feel sad or angry.
I'd also like to talk about how other people who live here cope when they feel sad/angry.

I'd like to tape-record what we talk about.

I will then write up what we have talked about.
I won't include your name in this, so no-one will know what you have said. It will be private.

It is OK to say you don’t want to talk to me at any time.

You can ask me any questions now, or call me on 01483 689441.

THANKYOU!
Appendix 4: Consent form for participants

CONSENT FORM

I (write name here)..............................................................................................................

consent to take part in Shona Daynes, Trainee Clinical Psychologist’s research project.

I understand that my name or any identifying details will not be included in the final write up.

I understand that the audio tapes of the interview will be stored in a secure place, and will be destroyed as soon as it is written up, without my name.

I understand that I can stop the interview at any time and not be part of the research any more.

I understand I can choose not to be part of the research up to one week after the interview.

I understand that I can talk to the staff if I would like some further support about any worries after the interview.

Signed........................................................................................................................................

Date..........................................................................................................................................

Researcher signature................................................................................................................

Date..........................................................................................................................................

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Appendix 5: Service agreement from service managers

I (print name). ...........................................................................................................

(job title). ...............................................................................................................

give my consent for Shona Daynes, Trainee Clinical Psychologist to access participants for her doctorate research project from the residential service I manage for a private organisation in South East England.

I understand that participants will only be approached if I and the researcher are satisfied that they meet the criteria for the research question and have capacity to consent (as outlined by The Department of Health document ‘Seeking consent: Working with people with learning disabilities’, 2001, and the Mental Capacity Act, 2005).

I understand that all information included in the write up will be anonymous, and that all interview tapes will be destroyed once they have been transcribed.

I understand that local services have been informed of the study taking place, should any participants require any therapeutic input following the study.

Signed..............................................................................................................

Date.....................................................................................................................
Appendix 6: Participant demographics information sheet

DEMOGRAPHIC INFORMATION SHEET

The following information is collected so that people who read the final report can know more about the people who have taken part. However, none of this information will be used to identify you as this research is completely confidential.

How old are you?.................................................................

Are you a man or a woman?......................................................

How would you describe your ethnic background (please circle):

a) White
   British
   Irish
   Other

b) Mixed
   White and Black Caribbean
   White and Black African
   White and Asian
   Other

c) Asian and Asian British
   Indian
   Pakistani
   Bangladeshi
   Other

d) Black or Black British
   Caribbean
   African
   Other

e) Chinese or Other ethnic group
   Chinese
   Other
Appendix 7: Confirmation NHS ethical approval not needed (Brighton East)

SL24 Project not requiring REC review
Version 3, June 2005

Brighton East Local Research Ethics Committee
Brighton & Hove City PCT
1st Floor
PRESTAMEX HOUSE
171-173 Preston Road
Brighton
East Sussex
BN1 6AG

Telephone: 01273 545371
Facsimile: 01273 545372

Thursday 8 February 2007

Ms Shona Daynes
Trainee Clinical Psychologist
University of Surrey
Flat 5
28 Hove Park Villas
Hove
East Sussex
BN3 6HG.

Dear Ms Daynes

Full title of project: Living with challenging behaviour: Service-users' constructions of living with their own and others' challenging behaviour in a residential home for people with learning disabilities.

Thank you for seeking the Committee's advice about the above project.

You provided the following documents for consideration:

- Email of 5/2/2007
- Research Proposal Form

These documents have been considered by the Chairman, who has advised that the project is not one that is required to be ethically reviewed under the terms of the Governance Arrangements for Research Ethics Committees in the UK.

You will be recruiting your sample from a privately run residential home for adults with learning disabilities. This constitutes non NHS premises, and as participants are not NHS patients being treated under a contract with a private institution, and they are not being recruited because of their past or present treatment by, use of, or employment by the NHS, there is no requirement for NHS ethical review.
You have been referred to the service by an NHS employed clinical psychologist, who used to be employed at the residential home, however this does mean you require NHS ethical approval.

Although review by a Research Ethics Committee is not required, you should check with the R&D Department for Sussex NHS Research Consortium whether management approval is required before the project starts.

Yours sincerely

pp.
Dr Paul Seddon
Chair

Email: michelle.roman@bhcpct.nhs.uk

Copy to: R&D Department, NHS care organisation contact:
Mrs Helen Evans
Research Governance Manager
Research and Development Department
Sussex NHS Research Consortium
Worthing Hospital
Lyndhurst Road
Worthing
West Sussex
BN11 2DH
Appendix 8: Confirmation NHS ethical approval not needed (Worthing)

Daynes SL Miss (PG/R - Psychology)

From: Nischinth Cherodian [Nischinth.Cherodian@bhcpct.nhs.uk] Sent: Tue 17/04/2007 16:27
To: Daynes SL Miss (PG/R - Psychology)
Cc: 
Subject: RE: confirmation re NHS ethical approval
Attachments:

Dear Shona

It has been noted that you have already obtained confirmation from the Chair of Brighton East that you do not need ethical approval because your research project does not fall within the remit of an NHS REC under GAfREC.

I have discussed it with the OREC Manager, Sandra Holley who agreed that though there is no written policy in our Standard Operating Procedures it is agreed that a single opinion from a REC in the UK is adequate to conduct research in the whole of the UK. Based on this criteria you do not need reconfirmation from another REC if you wish to conduct your research in an area which is outside the remit of the REC that gave you the original opinion. You can use the letter sent by Brighton East to indicate that you do not need ethical approval for your project even in the Worthing area.

Regards

Nishi

Nischinth Cherodian
Brighton and Hove City Teaching PCT
Research Ethics Committee
2nd Floor
Prestamex House
171-173 Preston Road
Brighton
BN1 6AG

Tel: 01273 545373
Fax: 01273 545372
Application booking line: 01273 545472
email: nischinth.cherodian@bhcpct.nhs.uk
web site: www.corec.org.uk
Appendix 9: Confirmation NHS ethical approval not needed (Surrey)

You forwarded this message on 18/04/2008 17:34.

Daynes SL Miss (PG/R - Psychology)

From: Ethics Committee [ethics.committee@royalsurrey.nhs.uk]  
Sent: Wed 28/03/2007 09:55  
To: Daynes SL Miss (PG/R - Psychology)  
Cc:  
Subject: Re: confirmation re NHS ethical approval  
Attachments:  

Dear Ms Daynes,

I can confirm that Surrey Research Ethics Committee operates under the same governance arrangements as Brighton LREWC and agrees with that Committee’s conclusions with regard to your proposal.

Yours sincerely,

John Kerslake  
Co-ordinator  
Surrey Research Ethics Committee  
Education Centre  
Royal Surrey County Hospital  
Guildford  
Surrey  
GU2 7XX  
Tel:Internal: Ext:4382  
Direct Line/Fax: 01483 406898  
Email: ethics.committee@royalsurrey.nhs.uk

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**********************************************************************

https://outlook2003.surrey.ac.uk/exchange/psp3sd/MP/emails%20to%20print/Re:%20... 17/06/2008
Dear Shona

Reference: 124-PSY-07
Living with challenging behaviour: Service-users' constructions of living with their own and others' challenging behaviour in residential homes for people with learning disability

Thank you for your submission of the above proposal.

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.

The Committee suggest, however, that the consent forms should be stored securely at the University rather than at your home.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.

Yours sincerely

Dr Kate Davidson
Appendix 11: Interview schedule

Semi-Structured Interview Schedule

(NB The words in italics are prompts)

Introduction

"Thank you for taking part in this study. As you know I am hoping to find out more about you and your life, and in particular the ways in which you deal with difficult situations, like if you are asked to do something you don't want to. I am especially interested in times when this makes you feel angry or sad, and what that makes you do.

I am also interested in finding out about what you think about the other people you live with, and how the deal with difficult situations. Sometimes you, or the people you live with might deal with difficult situations by doing things like hitting people, throwing things or breaking things. I am especially interested in talking to you about those times today.

If I ask you any questions today that you do not want to answer, you can tell me, or you can show me the 'No' card, and we will move on to another question. If you would like a break, or to stop for today, please show me the 'stop' card.

There are no right or wrong answers to the things I'll ask you today.

I will tape record our conversation today (show tape recorder and give demonstration of how you can listen back to what has been said). Only I will listen to these tapes, they will be private. I write up what we say but won't use your name, so no-one will know it was you that told me these things.

I will only tell someone about what we have talked about if I think you have been harmed or hurt in any way, or if anyone else might be.

Do you have any questions before we start?"

Section one: Background information

I would like to start by asking you a few questions about you, such as your name. I will write these first few things down on a sheet. Don't worry if you don't know the answers to some of them, just say "I don't know" or show me the "no" card.

Record answers on demographic sheet

How old are you?
What is your gender?
How would you describe your ethnic background?
NB these details may be sought/verified with key workers if it is unknown by the client. Though these details will not be recorded in the final write-up for confidentiality reasons, they may be useful to consider during the analysis stage, and for this reason will be collected.

Section two: The residential service

I'd like to ask you some questions about living here.

How long have you lived here?  
What is your room like here?  
How many other people live here?  
What do you like about living here?  
What do you not like about living here?  
Did you choose to come and live here?  
If not, who chose for you? Why do you think they chose for you to come here?

Section three: Daily life

I'd like to ask you some questions about what you like to do.

Tell me about what you usually do in the day times? (Day centre? Work?)  
Do you have any hobbies?  
What do you like to do in the evenings? (TV? Games? In room?)  
Who do you like to spend time with?

Section four: A difficult situation: self

I'd like to ask you some questions about a difficult situation you had to deal with.

Can you tell me about a difficult situation you have had to deal with recently?  
An example might be when someone tried to get you to do something you didn’t want to.

What happened?  
Where were you?  
Who else was there?  
What did they say/do?  
What did you say/do?  
How did it end?  
How did you feel about what happened?  
Do you wish you had done anything differently?  
Do you wish anyone else had done anything differently?
Section five: Difficult feelings: self

Can you remember a time when you felt angry or sad?

What made you feel this way?
What did you do?
Did that make you feel better?
What did other people think? Were they pleased with what you did?

Section six: A difficult situation: others

I’d like to ask you about a difficult situation you have seen someone else have to deal with.

Can you think of a time when you have seen someone who you live with in a difficult situation? Again an example might be when someone tried to get them to do something they did not want to.

What happened?
Where were they?
Where were you?
Who else was there?
What did they say/do?
How did it end?
How did you feel about what happened?

Section seven: difficult feelings: others

Can you remember a time when someone you live with has been angry or sad?

Why were they feeling this way?
What did they do?
Do you think this helped them?
What did other people think about what they did?

General prompt questions:

Could you tell me more about that?
What makes you think/say that?
Why is that, do you think?
Could you explain what you mean by......?
Appendix 12: Transcription guidelines

Adapted from Potter & Wetherell (1987)

[ ] Extended square brackets mark overlap between utterances.

= An equals sign at the end of a speaker’s utterance and at the start of the next utterance indicates the absence of a discernable gap.

:: One or more colons indicates an extension of the preceding vowel sound.

_____ Underlining indicates that words are uttered with added emphasis.

(.) A full stop in brackets indicates a pause in speech longer than 3 seconds.

( ) Round brackets indicate that material in the brackets is either inaudible or there is some doubt about it’s accuracy.

[ ] Square brackets indicate that some transcript has been deliberately omitted. Material in square brackets is for clarification.
Appendix 13: Complete interview transcript

Participant: Jason

Key: I = Interviewer, J = Jason

I OK so the first thing I want to ask you about is about living here and what it's like, so how long have you been living here?

J Erm about five months.

I Oh OK, so not too long at the moment=

J =No.

I OK, what what's it like being here?

J It's, it's good.

I Yeah?

J Yeah.

I What's your room like here?

J My room's tidy.

I Is it?

J And it's good.

I That's good, is it like big enough and things?

J Yeah=

I =And what sort of stuff have you got up there?

J Er::m, TV, stereo, DVDs, [inaudible].

I Ah that sounds good.

J Yeah.

I And where were you living before?

J Erm [place name removed for confidentiality]

I OK, and what sort of prompted your move down here?

J Wh::y did I come down here?
I Mmmm.

J Erm, cos I was hanging around with like the wrong people, getting in to trouble, drinking and taking drugs, and stuff.

I Oh OK. So did you chose to come here or did someone else say it would be a good idea to come here?

J I chose to come here and my mum found me the help I needed.

I Oh OK. So did you and your mum come and have a look round here before you came?

J Yep.

I And what did you think, did you like it?

J Yeah I liked it.

I Yeah and did you see anywhere else?

J Erm, I was live, before here I was living at [place name removed for confidentiality]=

I =Where's that?

J In [place name removed for confidentiality]=

I =Oh right.

J I was living there before I came here in another care home but I got in trouble at that care home.

I Oh OK, so what happened there then?

J Er::m, I started drinking and (.) I got in to fights with some of the clients.

I Like a physical fight or an argument?

J Yeah.

I A physical fight. What had happened at that home?

J [coughs] Pardon?

I What happened to, to make you (think about) fighting?

J Well, one of the clients always used to hit me and that=
J =And 'cause I was drunk this time I didn't report it, I flipped. [Mmm so that must have been really hard having them hit you.
I
J Yeah.
I Do you know why they were doing that, were they=
J I have no idea.
I Mmmm. That must have been really hard. OK well it might be good to ask you a bit more about that later if that's OK.
J OK.
I So what would you say, how many other people live here with you?
J Er::m, six.
I Six people, and are they all men or are there men and women?
J Men and women.
I Men and women, OK. And are there any, what's the thing you like about living here? Is there anything that's particularly good?
J They're helping me with my needs.
I Oh OK, and what what sort of, how would you describe your needs.
J Erm, (.)
I (Is that a tough one?)
J No, erm, they're (mine and all) but er::m (.) I dunno really they just know what they're doing and that.
I Mmmm so it's the staff that's been quite good?
J Yeah, yeah.
I And is that, is it, is that better here than it has been in other places?
J Yeah definitely.
OK that's really good. And what about, is there anything you don't like about living here?

No, I'm fine.

It's all OK=

Yeah.

OK that's good. And you were saying, you and, you chose to come here but your mum was involved in the decision as well=

Yeah.

Was anyone else involved?

No.

Just your mum. OK That's good. Where does your mum live?

Erm [place name removed for confidentiality]

Oh OK, so do you get to see her much?

Yeah.

Does she come here or do you go there?

She's been here once.

Has she, and what does she think about it here?

She likes it.

OK so I'd also like to ask you about some things about what you like to do in the day really, so what do you normally do in the day times here?

Er::m, sometimes like we go out in the evening like bowling, erm, swimming, and stuff like that, just some activity.

Do you enjoy doing that?

Yeah sometimes.

What are the times you don't enjoy it?

Nah I just, sometimes I just prefer like doing jobs round the house like gardening and stuff.

That sounds good, 'cos there's a nice garden here isn't there?
J Yeah.

I Well maybe you could show me it afterwards, 'cos last time I came here were they were digging out a pond or something I think?

J Yeah that was me I was digging out a pond.

I Ah that's right and how's that been going?

J It's fine.

I That's good, so you enjoy doing that sort of work?

J Yeah.

I That's good. Is there anything else you like doing when you're in the house?

J Erm, watching TV, sometimes.

I Mmm hmmm. Any favourite programmes?

J Er::m, Eastenders, Hollyoaks. Not many.

I So mostly the soaps.

J Yeah.

I And who do you like spending your time with when you are here?

J Erm, myself, really.

I So you tend to kind of be on your own a bit more do you?

J Yeah.

I OK.

J Is it alright if I go and get a drink?

I Yeah of course it is, yeah, no:: problem.

J My voice is croaky.

[tape stopped for approximately five minutes]

J Sorry.
I That's OK, I get the same thing when I talk a lot, my voice goes croaky. Ok so the next thing I'd like you to ask you about is a time when you've had a difficult situation to deal with, so::: a bit like when you were saying earlier when someone hit you before it could be that or it could be something else. But just a time when you maybe felt quite angry. So can you think you think of a time?

J Yeah I can think of a time when I was in my other care home and this client always used to hit me and I always had to report it and I weren't allowed to hit them back=

I =OK.

J And I didn’t think that was fair. And I left when I was [inaudible], and I used to get quite angry 'cos we both had learning difficulties, so I didn’t understand why he was allowed to hit me and I weren’t allowed to hit him back.

I Mmmm, so would yo::u, was it another man who used to hit you?

J Yeah.

I And was it just one person who used to do it?

J Yeah.

I And can you remember a time when he did it? Kinda of what was, where you were, what has happening?

J Well I was just walking past him and, and he used to (sit by the TV) and he used to smack me as I went past him.

I Oh OK, so he’d kind of hit you with his ha::nd would he?

J Yeah.

I Where abouts would he hit you?

J There, on my arm, or on my back, anywhere.

I Did it hurt when he did that?

J Mmmmm.

I And was it, did he ever hit anyone else or did he just hit you?

J [Yeah he used to hit another man on the head as well.

I Did he?
J  Mmmm. Only me and this other man, and never no-one else.

I  Do you know why he only hit you two?

J  No I'm not sure.

I  You're not sure. And so you were told, was it the staff that said to you come and tell us if it happens?

J  Yeah.

I  And would he normally hit you when people weren't around?

J  Yeah he used to hit me like when people were there as well.

I  Oh OK so other people saw sometimes.

J  Yeah.

I  Would he do it when staff were there?

J  Yeah.

I  And what would they say when he did it when staff were there?

J  They would just like, pu, pull him to the side and have a word with him.

I  Do you know what they would say to him?

J  No, that's confidential. I'm not allowed to know that.

I  OK and what would they say to you when you went and told them that?

J  They just said thank you for telling, telling us and we'll deal with it later or something.

I  And was that helpful or was it not very helpful?

J  Er, it was helpful at, until I got drunk.

I  Oh OK, so you used to, if you were sober then you would just go and tell the staff and that would be kind of the end of it, but when you started drinking, and then that's when it changed a bit did it? So what was the difference then? What happened when you were drunk?

J  Um, I get violent=

I  Mmmmm
And I just don’t think about stuff before I do it.

O::K, and was that then when you hit him back that one time?

Yeah.

And what did you do, did you punch him or slap him or=

No like I punched him, and then [coughs] I went upstairs and came back downstairs and then I tried to get in the kitchen and but then he got in my way and tried hitting me and we fell to the floor and I hit him again.

Oh OK. So there was kind of a bit of a (inaudible). And what did you do when you went upstairs?

Like I went upstairs and just listened to music, chilled out for a little while, and that’s when I came back downstairs.

And then you saw him again and he hit you again?

Mmmm.

Ok and then what happened after that?

The police were called and I got arrested. [coughs]. I asked erm, if I could press charges on him for hitting me and they said No=

=Oh O::K.

And then I was (stuck).

So how did you feel about that?

I thought it weren’t fair. And I still don’t think it’s fair ‘cos when I went to court for it, I had, I had to pay him like fifty pound compensation for hitting him.

Oh OK. So, do you know, did anything happen to him in terms of him having hit you?

Nothing.

So that feels quite unfair to you does it?

Yep.

And what do you, what do you think the sta::ff thought about that?

I don’t really know.
I Did you talk to them about it at all, or did they say anything to you?
J No.
I Ok, and what about, has your mum kinda said what she's thought about it all?
J Mum says it ain't fair.
I So she agrees with you?
J Definitely.
I Yeah. So it seems like you, you kind of both hit each other but it sounds like only you got punished for it, is that right?
J Yeah.
I And do you, do you think anything happened to the other man?
J No.
I OK why do you think that was different?
J 'Cos he was non verbal.
I Oh OK. And why does that make a difference do you think?
J I don't know. Maybe they don't understand more than I do.
I Mmmm do you think that's, that's why it was different?
J Yeah.
I So what was, that was when you were drinking, so was it that when you were drinking it was harder to control what you did?
J Yeah.
I Ok so when you were not drinking, would you still have had the thought of I want to hit him=
J =Nah, [inaudible]
I Oh OK. But you would have=
J =I just got sick and tired of, keep on reporting him so.
I Yeah. And so then when you got drunk that's when you wanted to hit him back.

J Yeah.

I And was that when you moved down to here?

J Yeah that's why they moved me.

I ='Cos of that?

J Yeah.

I OK. So did you, did you used to drink alcohol before that time?

J Yeah I used to drink quite heavy.

I And did it, did it, had it made you aggressive before?

J Mmmm.

I Had there been any other time when you'd hit anyone?

J Yeah a few times, yeah.

I And who was that kind of people you were living with or other people?

J People on the streets.

I And was it, were you ever involved with the police before that?

J Yeah.

I What sort of things happened then?

J Like erm, for nicking stuff, just petty stuff like drunk and disorderly, erm breach of the peace, erm, assault, robbery, no not robbery sorry burglary, just stupid stuff.

I And were they always things when you were drunk or would that happen when you were sober?

J No when I was drunk. Every time I get drunk I get in trouble, but if I'm not drunk=

I =Then you're OK?

J Yeah
I And what were the good things about drinking, what did you like about it?

J Nothing really, I just done it 'cos I was addicted to it.

I Oh OK. So it felt like, was it like you had to do it?

J Yeah. I done it to fit in at first.

I OK, so you were with people who were drinking were you?

J Yeah.

I And then what was it after that?

J I dunno it just became an (obsession).

I And was it would you drink like every day or every week, or how often?

J Every day.

I Every day. And what about now do you still drink at all now?

J No I don't drink at all now.

I Oh OK so when did you stop?

J Er::m, a few months ago.

I OK was that what after you'd moved here?

J Erm, (.) no it was (.) when I moved here, I started drinking when I was here and then I just stopped.

I OK.

J (So I didn't get) in trouble.

I And was it, was it difficult to stop?

J Yeah.

I Yeah, I imagine it must be difficult to stop. So how did you manage to do it?

J Erm, with support, by the staff.

I OK so they've been quite helpful have they?

J Yeah,
I What did they do that was good?

J Erm, they took me to AA meetings, and talked about it and stuff.

I That sounds useful. And has there, was there anything that was particularly hard about doing it?

J Um, no not really 'cos I never really missed it, after a few weeks. Well I did miss it a bit not going out to nightclubs and stuff, I wondered what everyone else was doing.

I Yeah. So was there, are there particular places you might go where it might be harder, like if you're in a club or something?

J Mmmm.

I OK, well that's amazing that you've managed to stop, that's really good. Erm, so when you were saying about how you had this fight with this other client, do you think the staff could have done anything differently that would have been better?

J Er::m (.) I don't know really, I don't know.

I Um, OK. Was there anything that you thought they did that was particularly good?

J No, not really [inaudible] speak to him.

I Mmmm. So they just talked to him, [inaudible] but you had to speak to the police. Do you know who called the police?

J Erm, a member of staff but I can't remember who it was now.

I And did you talk to them at the home or did you have to go down to the police station?

J I had to go to the police station.

I What was that like?

J Don't like it.

I Yeah. What, sort of, how did you feel while you there?

J Pissed off.

I Mmmm. What were the police like when you were talking to them?

J Erm, they, they was alright actually.
I That's good. And what about at court, what was it like there?

J Um, not nice. I don't really like going to court, it's boring.

I OK, well that sounds, like that was a really hard thing you had to go through, and it obviously feels really unfair to you, like it was really one sided=

J That's what it was.

I Yeah, OK. So the other things I wanted to ask you about are just about particular times when you might have done something when you've felt angry or sad. So has there ever been a time when you've thrown something at somebody?

J Er::m, no.

I No OK, what about you said about hitting somebody that time, have there been other times when you've hit people?

J Yeah

I You said about kinda maybe times when you were drinking and you were out on the streets=

J Yeah just random people, just starting arguments.

I OK so people who, what would they have been walking past or=

J =Yeah.

I Can you remember any particular times?

J No some, well yeah one man was walking past one time and I was (sitting) on the wall, and he asked me for a cigarette and I told him to fuck off and we just got in to this massive argument and started fighting.

I O::k, and how would you have been feeling when that happened?

J Er::m, probably angry.

I Mmmm. What do you think he was feeling?

J Angry as well, 'cos I told him to fuck off.

I And how did it end? What happened at the end?

J The police were called.
I And what happened then?

J I got a (seventeen) pound fine.

I And what about the other man?

J He got let off.

I Ok so a bit similar to the last time then. So how does that make you feel, it sounds like that's happened a few times?

J [laughs] Yeah it's not good.

I What's it like, how do you feel about it?

J Erm, I really blame myself for drinking.

I And how do you feel when you think about that?

J Er::m, I don't know.

I Does it ever play on your mind those things?

J Sometimes.

I How do you, how do you make yourself feel better?

J Erm, just look forward to what I'm doing.

I So you kinda think about the future and what you're gonna do?

J Yeah.

I Have you got any future plans?

J Yeah I'm gonna go for a brick laying course. I'm really in to it, erm, then I can live independently in my own flat, and maybe have kids.

I That sounds good. And where will you do the course, round here or back in [place name removed for confidentiality].

J Round here.

I So do you think you might stay round here for a bit?

J Yeah I have to.

I You have to do you? Why’s that?

J Because I'm in care.
OK. So has there ever been a time when you've shouted at somebody?

J Yeah.

I Can you tell me about that?

J Erm. (.) Just trying to think, I've shouted at loads of people.

I Have you? Can you think of one time?

J Yeah one time when I was walking back where I used to live in [place name removed for confidentiality], erm I was walking up [inaudible] and someone called me a ginger nut=

I OK=

J And I started shouting at them.

I Mmmm. What did you say to them?

J [coughs]. Well they were black innit. And I called him a black cunt.

I Mmmm. What did he say to that?

J He said that was racial, and I said that was racial as well innit, calling me a ginger nut.

I Mmmm. And how did that end?

J That, that was alright actually, like he went one way and I just went the other way. But I still reported it and that.

[ Oh OK.

I Did you? To the police?

J Yeah.

I And what did they say that time?

J He said if he comes back or you see him, like try to walk the other way. But if he comes back and like starts making trouble just call us.

I Oh OK, and did you ever see him again?

J No.

I Was it someone you knew or was it a stranger?
J No It was a stranger.

I And what about, have you ever done anything to kind of hit or hurt yourself?

J No. Yeah one time I had an argument with my parents, and like, and I cut my wrists.

I Can you tell me about that time?

J Erm, well we had an argument.

I What was the argument about?

J Erm, I can’t remember, it was just a family argument. ‘Cos we were all drinking ‘cos it was at a party. I think it was ‘cos my dad went to hit me, and I hit him back, and he told me to go out of the house, he threw me out. And I was doing a lot of drugs at the party.

I So did your dad throw you out just for the day or permanently?

J No he said permanently but I was back the next day.

I Oh OK, so that sounds, and then you said you tried to cut your wrists=

J Mmm hmm.

I So what, where were you then?

J Erm, at my friends.

I And what was happening for you at that time?

J Erm, I was thinking that I’m never gonna see them again once I’ve died. And, I dunno, I dunno.

I That sounds like it was a really difficult time. And did you have to go to hospital at all?

J No. I didn’t go to hospital.

I Mmm. What do you think made you want to do that? Do you think you wanted to kill yourself or=

J No I think I was doing it for the attention and that.

I And who did you, who was that message for do you think?

J My dad.
And what did he say about it afterwards? Did he ever find out?

Yeah. He found at and he just said don’t do that again.

Mmmm. And what was it like between the two of you after that?

Fine.

They’re OK. OK, so have there ever been any times when you’ve broken anything when you’ve felt angry or sad.

Yeah, I’ve broke my mum’s windows before.

OK, tell me about that.

Cos I was fighting some man [inaudible], um, I was drunk and I started fighting with him and then I came back and mum had [inaudible] and I put my hands through the windows.

Of the house or of the car?

Of, of the house.

Of the house, OK. And was that kind of like a, because you were feeling so angry?

And how did you feel afterwards? Did it make you feel any better?

Um, no not really.

How did you feel about it afterwards?

Um, sad. That I’d done it to my own house.

Mmmm, what did your mum say about it.

Um she weren’t happy about it and she told me I had to pay for the windows.

So how do you think she felt?

U::m, sad.

So you both felt quite sad about it?

Mmmm.

And then you had to pay for the windows. Did you think that was fair or not fair?
J Yeah. Fair.

I OK, and what about hitting things, so like punching walls or kicking doors or anything, have you ever done anything like that?

J No, I've done it here but just like mucking around.

I Have you? But not just not, just like not being angry or sad?

J No, nothing like that.

I OK, and what about, can you think of a time when you've felt particularly sad about anything?

J When my two friends died.

I OK, how, when did that happen?

J About a year ago.

I Oh so quite recently. Can you tell me about what happened?

J Um, they used to take loads of drugs and that and they just died, like one died from gas, taking gas, and one died from cocaine.

I So they both died from drugs. And were they people you used to take drugs with?

J Yeah.

I So what was that like for you when that happened?

J Um, not good.

I Mmmm.

J And I felt like partly guilty for their deaths and that.

I That must have been=

J 'Cos I should have like told them to stop and that.

I So what sort of things did their deaths make you think about?

J Stop, stop doing drugs, um, look, look forward to the future. Just made me think about loads of stuff, how lucky I am to have my mum and dad still. And just stuff like that.

I Mmm. And did have those thoughts make you feel better?
J Yeah of course.

I And was there anything else you did that helped or didn’t help?

J Yeah, like, taking more drink. Like that’s when I started drinking more, but=

I And did that help?

J Yeah, sort of but then it didn’t really, I found out in the end.

I So how did it help at first?

J Um, like when I felt upset I would drink and like get drunk, and then I’d fall asleep and don’t think about things.

I Mmmm OK. And then what about were the not so good things about drinking?

J It would always get me trouble.

I OK. So it sounds like it was good at first ‘cos you’d get drunk and fall asleep, but then it wasn’t=

J =But when I started getting in to it like then I would get immune to it and like I wouldn’t fall asleep, ‘cos I could hack it more.

I Oh OK so it was good while it got you drunker quicker, but when you could drink more and more was then there was more chance to get in trouble?

J Yeah.

I As it were.

J Yeah.

I That’s when it wasn’t so good. OK, so I’m just gonna have a drink of water(,) You’re doing really well Jason, we’re about half way through do you want to have a break or do you want to carry on?

J Can I have a break for a cigarette?

I Of course you can no probs, do you want to just come back when you’re finished?

J Yeah.

(tape stopped for approximately five minutes)
I OK?
J Yeah.
I OK. So what I'd like to ask you about now is about kind of when you've seen other people have to cope with difficult situations=
J =Yeah.
I OK, so can you think of a time when you've seen other people have to cope with a difficult situation?
J Erm, (.) yeah I have but erm (.) One time my friend like was hanging around with these wrong people and they asked him to nick something=
I =OK
J And he didn't want to and, and they said to him about nick it, or like you're not gonna like be in our gang.
I O::K, and what were they asking him to nick?
J A car stereo.
I OK. And were they like people he was friends with or other people?
J Like people he wanted to be friends with.
I Oh OK I see. And what happened then, how did he respond?
J Like, he, he like told them that he had to be in at a certain time and they said oh you're lying, you're lying, just do it and then you can be like our friend. And he was in a sort of like in an awkward situation and that.
I And how did he cope with that?
J Erm he just went in.
I He=
J He said that his mu::m, he had to be in at a certain time.
I And what happened after that?
J They like, when they saw him like on the street they used to like call him names like [inaudible] and things like that, um=
I =OK and what did he do when they did that.
J Erm, he just let them do it.
He didn't respond to them in any way?

J  
No.

OK, do you think that was a good way of dealing with it or a not very good way?

J  
Erm, that was a good way for him to deal.

I  
It was. Do you think he could have done anything differently?

J  
Erm, maybe reported it.

Mmmm. OK. What about, have you ever seen anyone get really angry with somebody else?

J  
Erm. Yeah.

Yeah? Can you think of a time when that happened?

J  
Erm. [coughs]. When somebody, someone went (running) for drugs and they said that they never had any

I  
OK

J  
(inaudible) got very angry.

I  
Did he? And what did he do?

J  
Started hitting him, telling him that he'd come to his mum's house to get the money and stuff.

I  
And what did the boy who was being hit do?

J  
Erm, he was quite scared.

Mmmm, yeah it sounds like that would be quite frightening.

J  
Yeah.

I  
And the guy who was trying to get the money did he go back to the boy's mum's house?

J  
Erm, no.

I  
He didn't. Did he do anything any thing else apart from beat up the boy?

J  
No.
I: OK. Did he get the money in the end?
J: I don’t know.
I: Ok, what about people feeling sad, have you ever seen anyone feel really sad about something?
J: Erm, just the parents who lost their son.
I: Mmm OK. And was that one of your friends who died, you saw their parents?
J: Yeah.
I: And how did you know they were very sad?
J: ‘Cos they were crying and that.
I: Mmm.
J: They were telling me that I should stop doing it.
I: Were they? How did you feel when they were saying that to you?
J: Quite sad.
I: Yeah. It sounds like it was a really hard situation for everyone losing them.
J: Definitely.
I: Do you know how their parents coped with that?
J: Erm, [coughs] I don’t know.
I: Could you have a guess?
J: No.
I: OK. So, what about have you ever seen anyone else throw something at somebody?
J: Erm. No.
I: You haven’t, OK what about hitting somebody?
J: Yeah, in pubs and that, I don’t know what it’s been about though.
I: Have you seen that very often in pubs?
J Yeah, and in nightclubs.

I Who normally fights the most, is it normally men or women or both do you think?

J Men and women.

I Do they fight each other or=

J Yeah each other.

I And what about, do you know any ideas why they might be fighting?

J Erm, just stupid arguments, I don't know.

I And what makes it more likely in pubs and clubs do you think?

J Alcohol.

I So do you think that, like you were saying when you drink alcohol it can make you feel a bit more violent and aggressive, do you think that happens for other people as well?

J Of course, yeah.

I So why do you think people do it still?

J Erm, I don't know.

I OK, and what about have you ever seen anyone else shout at somebody?

J Erm, yeah, like clubs and that.

I So similar to when they like fight as well?

J Yeah.

I OK. And what about have you ever seen anyone else hit or hurt themselves in any way?

J Erm, what hit themselves?

I Yeah.

J Erm, No.

I You haven't seen that, OK. And what about breaking something?

J Er::m, (_) I've seen people like break windows and that.
I Have you? Can you tell me a bit more about that?

J Erm, about six months ago or something. (.)

I Who broke it?

J Erm, one of my friends.

I And why did he do that?

J Erm, cos he was bored, and like, to have some fun.

I OK, so is that like a reason why someone might do something like that, 'cos they are bored?

J Yeah to get a kick out of it.

I And do you think, did he, afterwards did that work, was it exciting and did it stop him being bored?

J Well, maybe for him, I don't know.

I Do you think you would have felt the same way or=

J No.

I So do you think people, would they ever do other things like that to stop them feeling bored?

J Erm, I don't know.

I OK, and what about people hitting things or punching or kicking things like walls or doors, have you ever seen anyone do something like that?

J No.

I OK. You were saying earlier about the guy who, in the other home who used to hit you, you were saying that 'cos he was non-verbal you got treated differently to him, do you think for people with learning difficulties people treat you differently depending on how they see you?

J Yeah of course.

I And what, what, how do they treat you differently?

J Erm, dunno like they deal with it different.

I Mmmm. So how do they deal with it differently?
J  Erm, like they with that guy who hit me they wouldn’t have called the police on him.

I  So do you think the general public walking around on the street would get treated differently to him?

J  Yeah, they'd get the police called on them.

I  OK, so I think that’s pretty much everything I wanted to ask you about today, is there anything else that you would like to tell me about today?

J  Erm, no.

I  Do you have any questions about what we’ve talked about today?

J  No.

I  Ok, well thank you very much for talking to me today, it’s been really interesting speaking to you and I really appreciate you taking some time out of your day to speak to me.

(End of interview: tape stopped)
Appendix 14: Additional supporting extracts from the interview transcripts

The following extracts provide further supporting evidence for the different elements identified for each of the three discourses.

Discourse 1: Service-users are the responsible agents for engaging in, or seeking alternatives to, challenging behaviour.

Extract 12. Darren had just been discussing an instance when he punched another service-user.
I  And, do you wish you’d done anything differently?
S  Yeah.
I  What, what could you have done differently?
S  Just walked off.
I  Just walked off.
S  Yeah.

Extract 13 (Barry)
I  And what things can help you stay calm?
B  I like to keep busy
I  And what sorts of things do you like to do?
B  I go to a club.
I  Uh huh, what’s that called?
B  I go out three days a week.
I  Mmm hmmm. And where do you do that?
B  I go to a martial arts club.
I  Oh wow=
B  On Monday. I’m doing summer karate.
I  And do you enjoy that?
B  Yeah. I’ve been doing it a month.
I  And what do you like about that?
B  'Cos it's **good** to get out.
I  Mmm hmm.
B  It's good to learn self control and discipline.
I  OK=
B  And meet new people. And they're very **helpful** as well.
I  Are they how are they helpful?
   [  They help me go through the techniques.
I  OK, that sounds good. And it makes you feel more self disciplined does it?
B  Yeah, and more **relaxed**. More chilled out.
I  And are those **good** things?
B  Yeah, I get a lot out from, I really like it.

**Extract 14** (Barry)
I  OK. So do you thi::nk that, it sounds like smashing up the things and punching the walls really helped make you feel better=
B  Yeah.
I  Would you kind of later in the day would you **still** feel much better or=
B  Yeah.
I  That feeling would last?
B  Yeah.
I  OK and what about kind of how you felt about your stuff being smashed up?
B  I felt, I felt a bit upset 'cos I know that I broke me own stereo.
   [  Mmmm.
I  And did that make, did you think, was there any, any other way you could have got out that feeling of anger do you think?
B  Maybe hitting the pillow.
I Hitting the pillow, yeah. Do you, have you ever tried hitting the pillow?

B No.

I But you think that could be a way?

B Yeah.

Discourse 2: Services or staff are responsible for the occurrence of, and/or managing, instances of challenging behaviour.

Extract 15 (Jason)

J Yeah I can think of a time when I was in my other care home and this client always used to hit me and I always had to report it and I weren't allowed to hit them back=

I OK.

J And I didn't think that was fair. And I left when I was [inaudible], and I used to get quite angry 'cos we both had learning difficulties, so I didn’t understand why he was allowed to hit me and I weren’t allowed to hit him back.

Twenty lines omitted for clarification

I You're not sure. And so you were told, was it the staff that said to you come and tell us if it happens?  

J Yeah.

6 lines omitted for clarification

I And what would they say when he did it when staff were there?

J They would just like, pu, pull him to the side and have a word with him.

I Do you know what they would say to him?

J No, that’s confidential. I’m not allowed to know that.

I OK and what would they say to you when you went and told them that?

J They just said thank you for telling, telling us and we’ll deal with it later or something.

Extract 16 (Barry)
And what did, what would the staff say when you used to tell them what had happened?

That they’ll sort it out.

And how would they sort it out?

Well they had a word with them and give them a warning that if they carry on doing it they’ll getting in to trouble and the police would be called in.

And did that work?

Yes

Do you think that was a good strategy?

Yeah.

Was there anything they could have done better?

Give me a bit more support and that.

Mmmm. And what how could they have done that, what would you have liked?

Them to be there as a witness to see it happen.

Mmmm. And were they not around at the time?

No they wasn’t around at the time.

And you would have liked them to seen it happen?

Yeah.

Is there anything else you would have liked them to have done to help you more?

Maybe film it, film it on film so they, so, so the police know who done it.

Mmmm.

But I don’t remember it, I, I still remember it though.

Yeah. Do you think the staff, were, erm, why did you want the staff to see it on film?

So they see it happening.
I Why did you want them to see it?
B 'Cos they might not believe me.
I What made you think that?
B 'Cos they wasn’t there at the time, it suddenly happened just like that.

Discourse 3: The perceived severity of learning disability a service-user has influences the way instances of challenging behaviour are constructed, in particular whether the ‘service-user as responsible agent’, or the ‘services as responsible agents’ discourses are drawn upon.

Extract 17 (Jason)
I OK. You were saying earlier about the guy who, in the other home who used to hit you, you were saying that 'cos he was non-verbal you got treated differently to him, do you think for people with learning difficulties people treat you differently depending on how they see you?
J Yeah of course.
I And what, what, how do they treat you differently?
J Erm, dunno like they deal with it different.
I Mmmm. So how do they deal with it differently?
J Erm, like they with that guy who hit me they wouldn’t have called the police on him.
I So do you think the general public walking around on the street would get treated differently to him?
J Yeah, they’d get the police called on them.

Extract 18 Jason is talking about a fight he had with someone who he later goes on to described as being “non-verbal”.
I And then you saw him again and he hit you again?
J Mmmm.
I Ok and then what happened after that?
J The police were called and I got arrested. [coughs]. I asked erm, if I could press charges on him for hitting me and they said No=

I Oh O::K.

J And then I was (stuck).

I So how did you feel about that?

J I thought it weren't fair. And I still don't think it's fair 'cos when I went to court for it, I had, I had to pay him like fifty pound compensation for hitting him.

I Oh OK. So, do you know, did anything happen to him in terms of him having hit you?

J Nothing.

I So that feels quite unfair to you does it?

J Yep.

I And what do you, what do you think the sta::ff thought about that?

J I don't really know.

I Did you talk to them about it at all, or did they say anything to you?

J No.

I Ok, and what about, has your mum kinda said what she’s thought about it all?

J Mum says it ain't fair.

I So she agrees with you?

J Definitely.
### Major Research Project Checklist

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<td>14</td>
<td>Devising and administering questionnaires</td>
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<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
<td>N/A</td>
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<tr>
<td>16</td>
<td>Setting up a data file</td>
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<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
<td>N/A</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
<td>N/A</td>
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<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
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<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
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</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
<td>N/A</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
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</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
<td>Y</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
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</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
<td>Y</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
<td>Y &amp; planned</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
<td>Y</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td>Y</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>Planned</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
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