
by

Esther Wilcox

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

Department of Psychology
School of Human Sciences
University of Surrey

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INTRODUCTION TO THE PORTFOLIO – VOLUME 1

This portfolio contains a selection of work completed during the PsychD in Clinical Psychology training course. Volume 1 comprises the academic dossier, consisting of the four essays written as requirements of the PsychD, the clinical dossier, containing summaries of the six placements completed over the three years of the course and summaries of five formal case reports and the research dossier, comprising the research log book, the service related research project completed in Year 1, the qualitative research project completed in year 2 and the major research project completed in year 3.

Volume 2 of the portfolio comprises the clinical dossier containing the five case reports, the placement contracts and logbooks, examples of clinical correspondence and placement evaluation forms. This volume will be kept within the psychology department of the University of Surrey due to the confidential nature of the clinical material.

The work presented in this portfolio reflects the range of client groups, presenting problems and psychological approaches covered during the course. Within each dossier the work is presented in the order in which it was completed to illustrate the development of my clinical, academic and research skills during the period of training.
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I would like to thank all of the Surrey University PsychD course team for their help and support during the three years of my clinical training, including the clinical, research and academic tutors as well as the administration team.

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Finally I would like to thank my friends and family for their unending support and optimism over the past three years. I hope you will now help me celebrate this achievement!
OVERVIEW OF THE ACADEMIC DOSSIER

This dossier consists of the four essays written during the first two years of the PsychD training course. The essays were written over the four core clinical placements and the topics they address relate to these four placement specialities.

The essays are presented in the order in which they were written and therefore the ‘Adult Mental Health’ essay is presented first followed by the ‘Learning Disability’ essay, the ‘Child and Family’ essay and finally, the ‘Older People’ essay.
Compare and Contrast Cognitive Behavioural and Psychoanalytic Concepts of Depression in Adults and the Evidence Underlying Each of These Models

Year 1 Essay

December 2000

Word Count – 4979 words
Adult Mental Health Essay

Compare and Contrast Cognitive Behavioural and Psychoanalytic Concepts of Depression in Adults and the Evidence Underlying Each of These Models

Introduction

Depression is the most prevalent mental health need affecting adults and has been termed: “the common cold of psychiatry” (Seligman 1975, cited by Fennell 1989). Seventy-five per-cent of people who are admitted into psychiatric hospital have depression, “at any given point in time, 15-20 per cent of adults suffer significant levels of depressive symptomology”, and although depression is time-limited, relapse frequently occurs (Fennell 1989, p. 169).

The framework within which Clinical Psychology services work includes increasing initiatives to look at continuous improvement and monitoring of services. The government paper ‘The New NHS – Modern Dependable’ states that the National Institute for Clinical Excellence will lead on issues of clinical and cost effectiveness, based on scientific evidence (Cohen 1998). This issue includes the need to consider the range of available therapies and specifically to assess which therapies have been proven to be most effective for which groups of people.

A range of psychotherapies are offered for people with depression. After defining depression this essay will assess two models within the Cognitive Behavioural (CBT) and Psychodynamic (PD) schools: Beckian CBT and Interpersonal Therapy (IPT). I have chosen to focus on Beckian CBT due to its large influence on clinical practice. IPT has, to date, been less influential in Britain, but this was chosen for discussion due to its empirical base, and the high standard outcome studies assessing IPT. Furthermore, both are brief therapy models, which is clearly in line with the pressure on NHS clinical practice. I will outline some of the similarities and differences between these models and broader CBT/ PD principles and consider the evidence for CBT and PD models. Two main areas of evidence could be discussed, evidence for the models, or evidence for the effectiveness of interventions based on the models. In terms of funding and development of services and the national pressures highlighted above, the focus tends to be on
whether interventions reduce psychopathology, not on how they do so. Therefore outcome evidence will be considered in this essay\(^1\). Finally, the findings will be discussed in relation to the work of Clinical Psychologists including implications for clinical practice.

**Definition of Depression**

Champion (2000) states that the classification systems, DSM IV (Diagnostic and Statistician's Manual, 4\(^{th}\) Edition, American Psychological Association, 1994) and ICD-10 (The World Health Organisation's International Classification of Diseases, 10\(^{th}\) Edition, 1992), classify depression as unipolar or bipolar. Unipolar depression is further classified according to its severity; as a 'major depressive episode', or a less severe 'dysthymic disorder'. Bipolar disorder is characterised by the presence of two extremes of mood, excessively high or excessively low, and is often considered to have different causative factors. This essay will consider interventions with regard to unipolar depression.

**Cognitive Behavioural Models of Depression**

**Common Features**

Cognitive behavioural (CBT) models represent an amalgamation of ideas from the cognitive and behavioural schools. Over the last 30 years there has been a proliferation of cognitive and cognitive behavioural therapies for emotional disorders, including: Ellis's 'Rational Emotive Therapy' (1962, cited by Beck 1995) and Meichenbaum's 'Cognitive Behavioural Modification' (1977, cited by Beck 1995).

Moorey (1990) suggests that all the cognitive models are based on three main assumptions:

1. The person is seen as an active agent who interacts with his or her world.
2. This interaction takes place through the interpretations, inferences and evaluations the person makes about his or her environment.

\(^1\) The reader is directed to Clark and Steer (1996) and to Haaga, Dyck & Ernst (1991) for analyses of the processes hypothesised within CBT models. Champion (2000) directs readers to Arieti and Bemporad (1978) for an overview of PD case study literature relating to process outcome.
3. The results of these 'cognitive' processes are thought to be accessible to consciousness in the form of thoughts and images, and so the person has the potential to change them.

A person’s response to a situation depends upon the way they interpret the situation and: “the main distinguishing feature of a cognitive approach...lies in the emphasis given to mental processes that intervene between an environmental event and the reaction of a person” (Brewin 1988). It is hypothesised that clients with emotional disorders have distorted views of the world. The process of therapy aims to change people’s cognitive structures, using cognitive and behavioural techniques, in order that their interpretation of a situation is less damaging for them.

**Beckian CBT**

Aaron Beck was a practicing psychoanalyst when he conceptualised Beckian CBT. Initially his model was developed specifically for the treatment of depression (Hawton, Salkovskis, Kirk and Clark 1989). Beck’s model will be outlined and used as a basis for discussion. See diagram 1 for outline of this model.
As the model highlights, past experiences are stored as assumptions. People's experiences can make them vulnerable to depression, but usually the negative assumptions are not prominent in a person's mind. However, a 'critical event' can activate negative/dysfunctional assumptions and they will then influence the way the individual interprets situations. There are two main consequences of this activation. Firstly, Negative Automatic Thoughts (NAT's) enter a person's consciousness, and secondly, people experience a range of cognitive distortions, for example making
arbitrary inferences on the basis of insufficient evidence (Brewin 1988). Cognitive distortions cause clients to interpret events in a way that appears to support their NAT’s and negative assumptions (Brewin 1988). A cycle is set up whereby the behavioural, motivational, affective, cognitive and somatic symptoms of depression feed into people’s NAT’s. Beck’s cognitive triad, conceptualising a negative view of self, the world and the future (1967, cited by Brewin 1988), demonstrates the pervasiveness of these cognitive processes. The therapist helps clients to break this vicious cycle by: “teaching people to question the negative automatic thoughts, and then to challenge the assumptions upon which these are based” (Fennell 1989, p. 172). Successful therapy involves the therapist and client working together to ‘put away’ or deactivate NAT’s and negative assumptions. Beckian CBT has a problem-solving focus, is short-term and present oriented; a person’s current thinking is at the heart of therapy (Beck 1964).

In Beckian CBT therapists develop a solid therapeutic alliance with the client by demonstrating warmth, empathy, caring, genuine regard and competence (Beck 1995). Therapy includes educating clients about the nature and course of depression, the process of cognitive therapy and the CBT model. If clients understand the CBT principles, they will be able to use the techniques to address future problems and therefore the educative process aims to prevent relapse (Beck 1995).

In CBT therapy the work is collaborative, between the client and therapist. Beck (1995) states that Beckian therapy sessions are structured around an agenda, agreed with the client. This includes a mood check, brief summary of the last week, review of last week’s homework, discussing specific incidents within the cognitive model and the collaborative setting of homework. Homework is seen as a way for the client’s active role to extend beyond the therapy hour and into the rest of their life.

**Schema-Focused CBT**

Judith Beck (1995) added to Aaron Beck’s model, suggesting that assumptions consist of core beliefs (schema) and intermediate beliefs. Both of these can be modified within therapy. Young (1994) proposed an extension of Beck’s model to address the needs of people who had long-standing and severe disorders. Beck’s model had limitations in
work with these clients. Young's model is termed 'schema-focused therapy' and addresses people's dysfunctional assumptions, or schema, within therapy.

**Psychodynamic Models of Depression**

Common Features

The distinction between psychoanalysis and psychodynamic psychotherapy has been debated since Freud's time. The terms can be seen as interchangeable, or as needing a sharp distinction (Henry, Strupp, Schacht & Gaston, 1994). Psychodynamic models use psychoanalytic principles, but tend to be shorter term and more focused. For the purposes of this essay, the terms will be used interchangeably.

Farrell (1981, cited by Cooper 1990) identified the common themes of Psychoanalytic models:

1. No item in mental life or the way we behave is accidental.
2. Mental activity and behaviour is purposeful or goal-directed.
3. Unconscious determinants mould and affect the way we perceive ourselves and others. These are thoughts of a primitive nature, shaped by impulses and feelings within the individual, of which he is unaware.
4. Early childhood experience is overwhelmingly important and pre-eminent over later experience.

Malan (1995) discusses the core concepts of PD models. People use defence mechanisms to protect themselves from mental pain and conflict. These mechanisms may fail, causing difficulties, for example depression. The concept of transference is key in PD models and is defined as: "the transferring of feelings which belong to a relationship from the past into a present relationship" (Hughes 1999). This process is unconscious and the PD therapist interprets the client's transference within sessions in order to understand the client's patterns of relationships. The aim of therapy is to bring people back in touch with hidden feelings and support them to develop other ways of relating. Interpretation of client's communications is a major tool used in PD work.
The psychodynamic interest in depression dates back to Freud's 1917 paper: "Mourning and Melancholia", where he drew a link between mourning and depression and suggested that depression may also result from loss. The loss in depression is of a different kind than the loss in bereavement, for example the loss of an ideal rather than a person. For this essay, I will briefly describe a model which has its routes in the Object Relations school of psychoanalytic theorising, Interpersonal Therapy (IPT), and its concept of depression.

Attachment Theory

The Object Relations school conceptualises relationships as having central importance for people (Gomez 1997). Bowlby proposed a: "new departure in Object Relations" thinking when he developed Attachment Theory as it included a focus on people's external environments, as well as their need for relationships and the: "relational structure of the self" (Gomez 1997).

Attachment Theory proposes that human beings have an adaptive need to form strong and permanent bonds. Through their continual contact with the external world people form an "internal working model" (Gomez 1997), to represent their relationship with the world and the people in it. Internal working models develop very early in a person's life and the security or insecurity of their attachments are represented within this. Four attachment styles have been identified (see Ainsworth, Blehar, Waters and Wall, 1978, Main & Hesse, 1990). An individual's pattern of attachment extends across their life-cycle.

If people do not have secure attachments they may represent themselves, within their internal working model, as for example unlovable. This sense of being unlovable can be triggered by external events which may appear to confirm a person's assumptions about themselves, leading, for example, to depression (Bemporad & Vasile 1999). Bowlby's (1988) approach to therapy supposes that the client can be given a new experience through the provision of a secure attachment with the therapist. This base can enable the client to explore their world and its alternatives. In turn this can lead to a change in their internal working model, and therefore the quality of the relationships they are able to
The therapeutic relationship is not a pre-cursor for effective therapy, but is the main focus of therapy.

**Inter-personal Therapy (IPT)**

Koss and Shiang (1994) describe IPT as a psychodynamic approach. IPT's psychodynamic roots are in Attachment Theory and ideas from the psychodynamic interpersonal school (Sullivan 1953, cited by Swartz 1999). IPT draws on ideas from the social relations school (Meyer 1957, cited by Swartz 1999) and social psychological findings which suggest that certain interpersonal relationships protect people from developing depression (Brown & Harris 1978). The model also notes the cyclical relationship in that depression can have a detrimental effect on interpersonal relationships.

Psychodynamic principles are clear within the IPT framework. Depression is related to loss, in line with Freud's early theorising, The threat of loss, or actual loss of an attachment figure is experienced by children who do not have a secure attachment pattern. This loss is not successfully negotiated in the way in which children who have secure attachments are able to negotiate separations and loss. IPT suggests, therefore, that if a child does not experience a secure bond, they will be disposed to the development of depression (Klerman, Weissman, Roundasville & Chevron 1984). The model makes no further suggestions about the causes of depression, but rather: "uses the connection between onset of depressive symptoms and current interpersonal problems as a pragmatic treatment focus" (Weissman & Markowitz 1998).

IPT is a manualised, three-phase treatment model. Phase one concerns the diagnosis of depression, explanation of this to the client and giving the 'sick role' to the client (Parsons 1951, cited by Weissman & Markowitz 1998). This relieves the client from social obligations, but at the same time, requires the client to use their energy, within treatment, to become well again. Information collected includes the "interpersonal inventory" (Weissman & Markowitz 1998), a summary of clients' relationships, particularly any changes in these which preceded the development of depression. In phase two the current issues are discussed with relation to the person's 'interpersonal
contact' and past experiences. The manual highlights specific tasks to be undertaken in the second stage, according to the interpersonal issue identified as a problem. Four such issues are used in a formulation shared with the client, and to direct therapeutic work: grief; interpersonal role disputes; role transitions and interpersonal deficits. In the final stage termination and its implications are discussed (Klerman, Weissman, Roundasville & Chevron 1984). Homework tasks are not explicitly given.

Despite the PD base, IPT focuses largely on the 'here and now' within therapy, although links are drawn with previous relationships. The focus is on problem solving and exploring options, of which the client may not have been fully aware. Successful therapy supports clients to examine their social functioning and master social roles and thereby experience different ways of relating.

**Comparison of Cognitive Behavioural and Psychodynamic Models of Depression**

**Overview**

There are a number of similarities and differences between the CBT and IPT concepts of depression. Indeed, given that Beck was trained as a psychodynamic therapist, a psychodynamic influence on CBT is expected. CBT and IPT were both developed for work with people who are depressed, and now have been demonstrated to be efficacious with clients with other difficulties (Weissman & Markowitz 1998, Hawton, Salkovskis, Kirk & Clark 1989). Both models are standardised in the form of a manual. It is suggested that this enables them to be reliably implemented (Roth and Fonagy 1996).

In CBT, clients are encouraged to compare their difficulties which arise as a result of depression, to difficulties which may arise as the result of a physical illness, and to realistically attribute 'other' problems to their depression (Fennell 1989). It is envisaged that this will enable clients, who may be participating in far fewer activities than before they were depressed, to judge themselves by more realistic standards. This is analogous with the giving of a 'sick role' in IPT. Beckian CBT and IPT both clearly acknowledge current life events in order to understand fully the triggers of depression. In CBT this is
called the 'critical incident', the IPT concept is of the range of interpersonal relations which are associated with the onset of depression (Klerman et al., 1984).

However, clearly there are also differences between IPT/ PD models and CBT. Unlike Beckian CBT, for example, PD work does not explicitly use homework assignments with clients. Further specific aspects of the similarities and differences between the models will now be discussed.

**Education**

CBT and IPT both educate the client about depression, to increase the client's commitment to therapy and assure clients that therapy will be useful in managing and reducing depression (Klerman et al., 1984). However, whereas CBT aims to educate the client about CBT, PD models, including IPT do not educate clients about PD principles (Hardy, Barkham, Shapiro, Reynolds & Rees, 1995) and PD models other than IPT do not even include explicit education about depression.

**Brief Psychotherapies**

CBT and IPT share the similarity of being brief interventions. Koss & Shiang (1994) summarise the common features of brief therapeutic approaches. Therapeutic goals within such approaches stem from the belief that clients are able to make changes throughout their life and assessment methods require the: “careful selection and exclusion of patients”. Fennell (1989) notes that Beck believed that certain types of depression were not suitable for CBT. Any demonstrated efficacy of CBT and IPT may therefore only apply to a particular group of people with depression. Koss & Shiang (1994) note that therapists using brief models have a high level of activity, for example in terms of directing the conversation. With longer term, including traditional psychoanalytic models, the therapist's role is less active. Furthermore, they suggest that with any brief psychotherapy, termination is an issue within therapy from the beginning, whether or not this is explicitly a part of the model. Clearly, this is explicitly a part of IPT. In CBT models, however, the focus is not on the meaning of termination for a client.
Systemic and Feminist Comments on CBT and IPT

CBT and IPT concepts focus on the symptoms of the depressed person, and as such are both subject to the same critique from the systemic schools of thought. The belief in the centrality of the systems people are a part of, leads to the belief that 'problems' develop as a function of systems. Therefore: "neither symptoms nor insight can be an appropriate focus for treatment interventions. Rather the system that generates the problem behaviour is an appropriate target for intervention" (Roth & Fonagy 1996). In PD and CBT models as a whole, despite the awareness of the role of the client's early experiences and life events in depression, there is also a belief that the individual's inner world is a suitable focus for therapy.

Feminist critiques are similar. Women are twice as likely as men to be diagnosed as suffering from depression (Brown and Harris 1978). Feminist arguments suggest that models such as IPT and CBT focus on women adjusting to their circumstances, including their oppressive social norms. Such therapies can, therefore, be seen as oppressive (Ussher 1991). This criticism is not aimed solely at CBT and IPT but to a range of individual therapies offered for people who are depressed.

Early Experiences and Social Context

CBT and PD models acknowledge the importance of a client's early experiences, despite the different terminologies used to describe these experiences and the way they are encoded. However, in Beckian CBT early experiences are used in formulation, but therapeutic work is often directed at other levels. IPT's use of attachment issues also includes a focus on early experiences, but uses the term 'internal working models' rather than schemas or assumptions (Gomez 1997). IPT is unique within PD models, as the work is on current relationship patterns, despite the acknowledgement of a person's previous experiences in the formation of these patterns. Broader PD models focus therapy much more on early life events, early conflicts and early relationships. This CBT/PD distinction may be less clear with 'schema-focused' CBT, however.
Unconscious Processes

Beckian CBT includes the concept of NAT’s, which has no parallel in psychodynamic models. PD models including IPT focus on unconscious, hidden feelings and desires. CBT models consider solely the feelings, desires and thoughts of which a person is aware. Schema can be latent, but it appears that the concept of latency parallels with the concept of the sub-conscious rather than unconscious. Blagys & Hilsenroth (2000) note some effects of this distinction. When clients attempt to avoid topics or activities within therapy, PD models consider the unconscious meaning of this; CBT models simply seek to overcome avoidance. Furthermore, PD models focus on affect, as used to expose unconscious aspects of the psyche. CBT uses thoughts as a therapeutic emphasis, therefore the CBT focus on affect is on controlling, managing and reducing emotion. Finally, PD models concentrate on wishes, dreams and fantasies, which may be unconscious and which do not feature in CBT therapy. These distinctions are clear within CBT/ PD models in general, as well as IPT and Beckian CBT for depression.

Therapeutic Alliance and the Transference Contribution

The therapeutic alliance has been identified as one of the key characteristic of therapy (Roth and Fonagy 1996). Bordin (1979, cited by McCleod 1998) suggested that therapeutic alliance is the agreement over goals in therapy, mutual understanding about therapy tasks, and a bond between therapist and client. These elements are emphasised within Beckian CBT and IPT concepts. It has been calculated that 22 per cent of the difference in the rates of therapeutic success can be credited to the characteristics of the alliance (Martin, Garske & Davis 2000).

An interesting dichotomy arises when comparing CBT beliefs regarding therapeutic alliance with PD beliefs. CBT therapists view the alliance as the basis from which to conduct therapy. In PD work, especially in Bowlby’s model, the alliance/ therapeutic relationship itself is a central element of therapy (Bowlby 1988). It is also a key element of the transference phenomena; giving information about the client’s defences, conflicts...
and relationship patterns and their unconscious (Brenner 1979 and Curtis 1979, cited by Hovarth and Luborsky 1993). This is a clear demarcation from CBT models.

I will now explore the evidence which underlies CBT and PD models, focusing on Beckian CBT and IPT.

Evidence Underlying Models

Research Issues

Roth and Fonagy (1996) draw a distinction between the efficacy of therapy; the results therapies achieved in research trials and the clinical effectiveness of therapy; the results achieved in routine clinical practice. The techniques seen in research trials are often not encountered in clinical practice. In clinical settings, for example, clients often present with dual diagnoses, in research trials clients are often highly selected to remove this effect. Research trials often involve random allocation to different therapeutic situations and extensive monitoring of client’s progress. Roth and Fonagy (1996) suggest difficulties with extrapolating the findings of research trials to clinical settings. The quality of therapies within research studies is often monitored to be of a high and pure standard, which is not paralleled in day to day clinical work. On the other hand, there may be factors within clinical settings that could increase the effectiveness of a therapy, for example matching a client’s preferences and style to a therapy. The MAS report (Manpower Advisory Services 1989) states that a major strength of Clinical Psychology is knowledge of a wide range of therapeutic techniques and the ability to match the needs of a client with the offerings of a therapy. This is not reflected in randomised research trials. Furthermore, research trials are rarely structured within the same boundaries and pressures within which clinical work takes place, for example constraints on the number of sessions that can be offered.

Structured research projects, however, tend to be the largest and most respected source of evidence for the effectiveness of psychotherapies. Therefore I will discuss the comments on effectiveness of IPT and CBT therapies for depression as represented in the research literature. Evidence for the effectiveness and efficacy of PD models is often
presented in the form of case studies. However, over the last two decades there have been an increasing number of research studies comparing PD approaches, including IPT, with CBT approaches for depression. Due to the necessarily limited scope of this essay, a few outcome studies will be discussed as examples of trends in broader findings and case study findings will not be discussed.

**Research Findings**

CBT has been consistently shown to be effective in the treatment of depression. Hollon et al. (1992), for example, report on a project comparing CBT with drug therapy (Imipramine) for depression. Raters were blind to the treatment groups and similar results were obtained after a 12-week intervention period, for clients who had received either CBT, Imipramine and clinical management, or Imipramine and CBT, regardless of initial severity of depression. However, at a 2-year follow up, clients who had received CBT showed a significantly lower relapse rate. The study did not use a control, which would be needed to fully consider the effectiveness of treatment modalities.

Weissman, Prusoff, DiMascio, Neu, Goklaney & Klerman (1979) reported on the first study of IPT to treat acute depression. Using a 16-week randomised trial, an IPT group was compared with an AMI (Amitriptyline Hypochloride, an anti-depressant) group, an IPT with AMI group and a control group. There were no significant differences between IPT and AMI treatments at the end of the study, although AMI had reduced symptoms faster. Both therapies exceeded the control. However, at a one-year follow up it was found that clients who had received IPT developed better psychosocial functioning than clients in other groups, suggesting that IPT led to additional lasting effects (Weissman, Klerman, Prusoff, Sholomskas & Padian 1981). Kupfer et al. (1992) report on a project considering effectiveness in terms of long-term maintenance. Depressed clients were initially offered IPT and Imipramine (IM) and those who reached the recovery criteria were assigned to one of five groups: IM and clinical management, placebo and clinical management, IPT and IM, IPT and placebo, IPT alone. Results showed that IPT was superior to placebo in the prevention of relapse at a 2-year follow up. However, the study used no control and only 20 participants.
The NIMH (National Institute for Mental Health) major research programme, specifically compared Beckian CBT and IPT treatments for depression. Initial results suggested that IPT and CBT outcomes are equivalent for people who have depression (Elkin et al. 1989). Clients were randomly assigned to CBT, IPT, IM with clinical management or medication placebo plus clinical management groups. The effectiveness of IM was assumed and the medication condition was used as a control. Clients who had been in the placebo group were most symptomatic at the end of the study, all other groups were comparable. Subsequent analyses (Elkin et al. 1995) noted a trend towards greater effectiveness of IPT than CBT for more depressed clients, suggesting the need to consider client variables in the interpretation of findings.

**Maintenance of Gains**

Given the knowledge about relapse rates for depression, it is clearly important to consider the maintenance of therapy gains in a consideration of the efficacy of models. Shea et al. (1992) studied the NIMH research study literature and found no significant difference in the maintenance of gains over an 18 month period for clients who had been offered either IPT or CBT, but there did appear to be a non-significant trend towards CBT. There was a trend for the psychotherapy to have lower relapse rates than the IM plus clinical management group.

**'Equivalence Paradox'**

The 'equivalence paradox' describes the possibility that different interventions have similar outcomes because what they actually do is very similar (Stiles 1986). Hardy, Shapiro, Stiles and Barkham (1998), however, concluded that CBT and PI (a PD model similar to IPT, but based on Hobson's (1985) conversational model), were experienced differently by clients. Clients reported that CBT seemed more problem-focused and PI seemed more focused on obstacles, including difficulties with the client-therapist relationship. Blagys & Hilsenroth's (2000) review noted features which clearly differentiated CBT from PD models and which have empirical support. In addition to the points noted in the previous section, PD models place greater emphasis on the inter-personal, whereas CBT models focus on the intra-personal, including patterns of
thoughts and beliefs. This central difference is reflected within therapies. Therefore it appears that despite the similarities in some aspects of the models, the similarities in terms of outcome may not be due to CBT and PD models saying different things, but doing the same.

To conclude this brief over-view of the outcome literature, I quote Roth and Fonagy (1996): “the best studies in the field demonstrate that interpersonal therapy and CBT are effective in the treatment of depression...the two modes of treatment were equivalent in their efficacy”. And I add to this that the models may be reaching similar outcomes via different routes.

**Conclusions and Implications for Clinical Practice**

Depression is a common form of mental health need and causes distress for sufferers, families, carers and friends. Depression can be considered life threatening; 15% of people suffering from clinical depression will commit suicide and up to 40% will make attempts (Paykel 1989). Clinical Psychologists are increasingly working within an environment concentrating on clinical effectiveness, cost-effectiveness and the reduction of waiting lists. The Mental Health National Service Framework has set the goal to reduce the suicide rate by at least one fifth by 2010 (Department of Health 1998). The concept of ‘Clinical Governance’ requires local NHS organisations to consider the quality and effectiveness of the services they offer. Clearly this fosters a need to consider the choice of therapies used with clients.

This essay has focused on two models within the CBT and Psychodynamic schools; many more have not been covered, but the discussions apply to other models within the CBT and PD fields. The evidence suggests that the models share a number of similarities, for example a focus on early experience in the development of depression, and the concept of an external event which triggers a structure, and an active therapist role. Differences include the use of the therapeutic alliance concept, different use of educative aspects and a PD focus on unconscious issues, versus a CBT focus on conscious thoughts. A number of findings have been discussed, as well as cautionary points in extrapolating findings from research studies into clinical practice. In terms of
both the short-term and longer-term effectiveness, Beckian CBT and IPT have demonstrated efficacy in randomised research studies. However, at this point evidence cannot lead either Beckian CBT or IPT to be strongly advocated above the other in the treatment of depression. It does appear that the models may be achieving similar results in different ways. Evidence relating to outcome studies from other CBT or PD models has not been able to be discussed.

A further implication for practice is the need to contribute to the development of further knowledge about the effects of therapies, including extending trials beyond the random, and considering how client characteristics influence the choice of therapy and outcome. Due to the range of methodological and philosophical issues with conducting this type of research, it appears likely that this debate will continue for many years.
REFERENCES


Garfield (Eds.). Handbook of Psychotherapy and Behaviour Change (4th Ed). (pp. 664- 
700). Chichester: John Wiley & Sons Inc.

Kupfer, D.J., Frank, E., Perel, J.M., Cornes,C., Mallinger, A.G. Thase, M.E., McEachran, 
A.B. & Grochocinski, C.J. (1992). Five Year Outcome for Maintenance Therapies in 
Recurrent Depression. Archives of General Psychiatry, 49, 769-773.

Main, M. & Hesse, E. (1990). Parents Unresolved Traumatic Experiences are Related to 
Infant Disorganised Attachment Status: Is frightened and/ or frightening parental 
behaviour the linking mechanism? In M.T.Greenberg, D.Cicchetti & E.M.Cummings 
(Eds.). Attachment in the Pre-School Years (pp. 161-184). Chicago: University of 
Chicago Press.


Martin, D.J., Garske, J.P. & Davis, K. (2000). Relation of the Therapeutic Alliance with 
Outcome and Other Variables: A Meta-Analytic Review. Journal of Consulting and 
Clinical Psychology, 68, (3), 438-450.

Ltd.

handbook (pp. 226-251). Milton Keynes: Open University Press.


Sexually Abused and/or Sexually Abusing: what is the role of
the clinical psychologist in working with people with learning
disabilities who have been abused or who abuse others?

Year 1
Learning Disability Essay

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Sexually Abused and/or Sexually Abusing: what is the role of the clinical psychologist in working with people with learning disabilities who have been abused or who abuse others?

Introduction

The most widely used definition of learning disability is the American Association on Mental Retardation definition: ‘substantial limitations in present functioning’ and ‘significant subaverage intellectual functioning’ together with limitations in at least two ‘adaptive skills’, e.g. communication, social skills or self-care. A ‘subaverage IQ’ score is 2 standard deviations below the norm, approximately 70 – 75, or less (Hatton, 1998)

The definition of sexual abuse is complex (Moss, 1998). Brown, Turk and Stein (1994, cited by Moss, 1998) define sexual abuse of people with learning disabilities as: “one-off assaults or sexual acts within an ongoing relationship in which the power differences are so great that they preclude the possibility of the person with learning difficulties freely giving their consent” (p.177). Non-contact and contact abuse are differentiated. Non-contact abuse encompasses: “looking, photography, indecent exposure, harassment, serious teasing, or innuendo” (Brown & Turk, 1994, p.32). Contact abuse includes touching, masturbation and penetration (Brown & Turk, 1994). Evidence suggests people with learning disabilities are more vulnerable to sexual abuse than people without learning disabilities (Stromsness, 1993). Men and women with learning disabilities are both vulnerable to sexual abuse, although Brown & Turk’s study (1994) highlighted that women are victims 73% of the time and perpetrators 3% of the time. Fellow service users with learning disabilities are frequently the perpetrators, staff members and family are also perpetrators, but strangers rarely are. People with all levels of ability are vulnerable.

This essay outlines the various roles of clinical psychologists working with people who have all levels of learning disability and have experienced sexual abuse, concentrating on work with adults. The role will be explored within the context of the history and present stories which impact the lives of people with learning disabilities. Moss (1998) suggests clinical psychologists offer intervention on two levels for people who have
learning disabilities and have been sexually abused. This includes interventions on the context in which people with learning disabilities live, as well as interventions for individuals who have experienced abuse. Context is interpreted as both the context of services and the broader societal context. After discussing the prevalence of sexual abuse for people with learning disabilities and reasons for this increased vulnerability, I will explore issues that arise in working with people who have been abused and outline the range of therapeutic and preventative roles which clinical psychologists can offer on both these levels. It is recognised that the role also encompasses unique issues in working with people who have a learning disability and sexually abuse. Authors have noted that people who have been abused are more likely to be abusers and clearly the issues are inter-linked (Blackburn, 1993). However, it is felt that the scope of this essay does not allow full consideration of both these issues.

Prevalence of sexual abuse

Since the end of the 1980's awareness of the particular vulnerability of people with learning disabilities to sexual abuse has increased (Fenwick, 1994) and services have been increasingly able to ‘think the unthinkable’ (Brown & Craft, 1989). The role of the clinical psychologist includes promoting understanding of the vulnerability of people with learning disabilities to being sexually abused, and explanations for this, in terms of individual factors and broader factors (Moss, 1998).

Moss (1998) highlights the difficulty with ascertaining the true extent of the sexual abuse experienced by people with learning disabilities. If abuse is not reported by the client, or not recognised and reported by the person's carers, then prevalence rates remain an estimate. Brown & Turk (1994) noted inconsistent reporting of sexual abuse of adults across regions, suggesting much abuse is not reported. Depending on definition and methodology, however, prevalence rates have ranged from 4% to more than 50% (Moss, 1998).

Kempton & Stanfield (1988, cited by Stromsness, 1993) estimated people with learning disabilities are four times more likely to be sexually abused than people without. Given that 'verbal telling' is often the main way sexual abuse is disclosed (Turk & Brown, 1992),
Fenwick (1994) wonders about the implications for discovering abuse of adults who do not communicate verbally. A range of indicators have been suggested to indicate the presence of sexual abuse with children, including changes in behaviour, physical, medical or emotional signs (Fenwick, 1994). These factors may also indicate the sexual abuse of adults with learning disabilities. Cole (1986, cited by Fenwick, 1994), however, suggests that too often these are simplistically considered to be part of the person's handicap, or institutionalized behaviour.

The identification of sexual abuse is further compounded as abuse may be taking place even when the person has apparently consented (McCarthy & Thompson, 1996). McCarthy (1993) suggests that although the stereotype of people with learning disabilities is that they are immune from usual social pressures, in fact stereotypical gender roles are shaping the sexual experiences of women with learning disabilities: "... sex was primarily for the men's pleasure...men took their pleasure at the expense of the women's" (p. 278), and: "the abuse by men with learning disabilities, with whom the women are often in close daily contact, is usually not perceived by the women themselves as abusive, but rather as normal sex" (p. 283). Thompson (1994) highlighted the extent to which men with learning disabilities are having unequal sex with men without learning disabilities, experiences that were out of the control and choice of the men with learning disabilities. Whilst it is important to recognise the extent of exploitative relationships people without learning disabilities experience (Thompson, 1994), this consideration remains as one which muddies the issues concerning the 'real' rate of abuse.

Theories concerning increased vulnerability

Sobsey's (1994, cited by Moss, 1998) ecological model suggests this increased vulnerability can be explained by considering a range of levels of interaction, from individuals to communities and institutions and wider cultural factors.

Vizard (1989, cited by Moss, 1998) suggests that factors which make people vulnerable to abuse are more likely to be present for the person with a learning disability, including communication problems, having to rely on others for intimate and personal care, having
low self-esteem and having trouble understanding the appropriateness of another's behaviour.

Lovett (1996) suggests: "The less powerful (and therefore less believable) a person is, the more abuse is liable to occur. With this awareness, it comes as no surprise that people with disabilities are at risk for physical and sexual assault" (p.205). The lack of power of and value given to people with learning disabilities contributes to an increased vulnerability to abuse. Walmsley (1989) suggests that people with learning disabilities are often denied access to basic choices, such as when to have a drink, and therefore have limited opportunities to learn how to make difficult personal decisions, for example, when to reject a sexual advance. Sobsey & Mansell (1990) highlight that the aim of many education services for people with learning disabilities has focused on unquestioning compliance and suggest that message increases vulnerability to exploitation and abuse.

The low value placed on people with learning disabilities was influential in establishing institutional care (Burns, 1993). Institutions are a dehumanizing environment and provide the dynamics within which abuse can become widespread (Crossmaker, 1991). McCarthy & Thompson (1996) suggest that some elements of institutional life have transferred into community settings. Furthermore, the lack of an appropriate range of service both for people with learning disabilities who sexually abuse and those who have been sexually abused sometimes means these clients are provided for within the same service (McCarthy & Thompson, 1996).

Despite the difficulties with estimating prevalence evidence suggests men and women with learning disabilities are particularly vulnerable to sexual abuse. Offering training for staff working with people with learning disabilities is therefore one of the roles of clinical psychologists. Hames (1996) found that training could influence the knowledge and attitudes of day centre workers regarding the vulnerability of people with learning disabilities to sexual abuse, although misunderstandings about vulnerability to abuse from staff were more pervasive.
Effects of sexual abuse

The role of a clinical psychologist includes understanding and contributing to the knowledge about the psychological and practical outcomes of sexual abuse and disseminating this to others working with this client group.

Fenwick (1994) notes a paucity of literature discussing the impact of sexual abuse for adults with learning disabilities. She notes that Senn (1988) discussed Finkelhor & Browne’s (1985) four ‘traumogenic dynamics’, or affects of sexual abuse (traumatic sexualisation, betrayal, powerlessness and stigmatisation) as relevant to the sequelae of sexual abuse experienced by children with learning disabilities. These dynamics suggest a range of behavioural and emotional outcomes including identity issues, aggressive sexuality and difficulty trusting others. Increasingly, the concept of Post Traumatic Stress Disorder has been applied to aid understanding of the consequences of sexual abuse (Fenwick, 1994, Christo, 1997), although this cannot fully explain the range of effects. Christo’s (1997) review of the psychological consequences of child sexual abuse can be extrapolated to suggest what effects people with learning disabilities who experience abuse, as an adult or as a child, may experience. Smith and Bentovim (1994 cited by Christo 1997) used six categories to describe the range of sequelae: sexualising effects, emotional effects, for example guilt and feelings of responsibility, depressed mood, including feelings of anger, anxiety effects, behavioural effects and specific effects resulting from ritual abuse.

Ussher & Dewberry (1995, cited by Christo, 1997) highlighted variables which may predict the long-term outcomes of childhood sexual abuse, including whether abuse occurred in the context of violence, relationship with the perpetrator and duration or frequency. Christo (1997) suggests that social support is an important mediating variable post-abuse.

A wide range of effects of sexual abuse have been posited, often focusing on the individual, but sometimes also considering the impact on the whole family (Sameroff & Fiese, cited by Christo, 1997). Beliefs that people with learning disabilities are not as negatively affected by abuse have been highlighted (Moss, 1998). Fenwick (1994),
however, suggests that symptoms experienced following sexual abuse may be exacerbated for people with learning disabilities, perhaps due to a decreased ability to understand what is happening to them, an inability to articulate their feelings, a person’s pre-existing sense of being damaged, or poor self image. Bernard (1999) highlights that marginalised people may interpret their experiences, including those of sexual abuse, differently due to the interaction of multiple marginalised identities.

Sinason (1989) introduced the concept of a ‘secondary handicap’ as a defense people with learning disabilities use to manage the pain of, for example, abuse. She suggests people with learning disabilities may be so traumatised that in order to protect themselves they ‘throw away’ parts of their brain and knowledge. This defense, therefore, exaggerates the primary disability. Stokes & Sinason (1992) suggest this allows the person to have a sense of control, albeit a self-abusive one.

Increasingly people are discussing the impact of sexual abuse for people with learning disabilities, but as yet this is not always formulated in testable models. There is a need for clinical psychologists to consider adaptation of the existing theories about reactions to sexual abuse given the unique experience of having a learning disability, including consideration of the unique defenses which may be used by people with learning disabilities.

**Gender and specific effects of sexual abuse**

Sexual abuse may have different meanings for men and women (Gartner, 1997). The effects of sexual abuse interact with powerful messages about gender identity and it is important to be aware that talking to men about sexual abuse is different than talking to women about sexual abuse (Brown & Turk, 1994). Brown & Turk (1994) highlight that: “services for people with learning disabilities, with their predominantly female workforce and male managers, replicate dynamics of power in the home” (p. 30). Power dynamics present in society are particularly demonstrated in the environments within which people with learning disabilities live.
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The message of powerlessness and victimisation which can be given by an experience of sexual abuse are at odds with a male gendered identity (Gartner, 1996a, cited by Gartner, 1997). The pressure on men to be strong can make acknowledging abuse difficult (Thompson, 1994). McDonagh (2000) suggests women with learning disabilities have been perceived as a threat because of their "undisciplined sexuality" (p. 50), but men with learning disabilities have tended to be seen as lacking some essential component of masculinity.

Clinical psychologists working with people who have learning disabilities and have been sexually abused need to consider the effects that the combination of these experiences may have had, given our understanding of gender identities. People with learning disabilities who have been sexually abused may be at a double disadvantage in terms of seeing themselves in a positive light. This understanding will underpin the interventions, both on individual, contextual and preventative levels.

**Issues in acknowledging abuse**

Fenwick (1994) suggests many people labelled as having 'challenging behaviour' may have been victims of sexual abuse. In working with people with learning disabilities, it is useful to hold in mind the knowledge that people with learning disabilities have often been victims of sexually abusive experiences which have not been 'disclosed' but which influence their emotions and behaviour. Psychological thought has contributed an understanding, however, of the many factors which may make it difficult to hold this in mind when working with people who have learning disabilities and have been sexually abused. Clinical psychologists have a unique role in using their psychological understanding to support professionals to understand the reasons it may be difficult to 'see' abuse (Brown & Craft, 1989). Until abuse is acknowledged, its effects cannot be acknowledged and support cannot be offered.

Lovett (1996) suggests behavioural techniques, which tend to discount the importance of people's emotional history, are dominant in work with people who have learning disabilities. He wonders whether these techniques protect workers from the negative emotions which may be aroused in acknowledging the experiences and emotions of
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Stokes (1987) suggested pervasive feelings of guilt can be aroused in non-disabled people when they interact with a disabled person: "...the guilt of those who are not handicapped, about the fact that they are less handicapped, which can lead to a denial of this situation" (p. 57). A handicapped person represents for non-handicapped people the unwanted handicapped and damaged aspects of themselves. In order to manage the pain of seeing one's own inability's, Stokes suggests the disabled person and non-disabled person may both deny the disability.

Sinason (1989) suggests that in 'seeing' the abuse that people with learning disabilities have suffered, we have to: "bear all the experiences that have gone into and exacerbated the experience and meaning of handicap" (p. 39). What has to be faced is not only the person's pain at having a learning disability, but the way this pain is confounded and increased by having been sexually abused. The difficulty with acknowledging a person's abusive experience will be confounded if the staff member has experienced abuse themselves (Lovett, 1996). 'Hearing' a person communicate the abuse they have suffered may cause the person to re-live their own abusive experiences. If this is something that they have not dealt with, they may avoid interactions which cause this pain (Charles et al. 1993).

Working with people who have learning disabilities and have been sexually abused

Charles, Coleman & Matheson (1993) suggest: "The dynamics of abuse are pervasive, powerful and intrusive", (p. 10), powerful feelings are provoked in staff working with people who have been abused. If these reactions are not recognised and dealt with, subsequent dysfunctional interactions may occur. The role of the clinical psychologist includes highlighting the nature of such reactions and supporting staff to understand them. Charles et al. (1993) suggest that knowledge of the damage inflicted on people who have been abused can arouse a powerful sense of inadequacy and helplessness in professionals. Working with an abused person can cause people to feel vulnerable, their view of the world as a safe place is challenged. Charles et al. (1993) suggest the reaction staff find most disturbing is sexual feelings towards the abused person, or from the abused person. It is important to be aware of the tendency of people who have been
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abused to sexualise their relationships, in order that projections of anger or sexualisation are not personalised (Crenshaw, 1988, cited by Charles et al. 1993).

Daskovsky (1998) outlined the split which people working with people who have been sexually abused can experience, between seeing the person as someone who has been sexually abused, and someone who abuses others in interactions. He outlines the psychoanalytic theories about the origin of this process as a defense against the feelings of helplessness and suggests that when people can stand these feelings, an interaction is more likely to be helpful. Clearly these counter-transference issues will be present for psychologists and other staff who work with people who have been sexually abused. However, feelings of inadequacy and helplessness may be particularly pertinent in working with people who have learning disabilities, due to communication difficulties and the feelings of helplessness and guilt that disability can arouse.

Psychological thought can promote understanding of the difficulties which can arise in the relationships formed with, and by people who have been abused. Psychologists have a role in supporting staff working with people who have learning disabilities and have been sexually abused, to have a better understanding of these issues. Re-conceptualising the behaviour of victims helps ensure clients are not rejected and that interactions do not serve to confirm clients' negative views of the self (Charles et al. 1993). Moss (1998) highlights that clinical psychologists also have a role to ensure that they receive support and supervision.

Therapy

Individual Therapy

Individual therapy is neither suitable nor necessary for all people who have a learning disability and have been sexually abused, but is for a minority (Moss, 1998) and is clearly one of the clinical psychologist's roles. Therapy depends upon an assessment which covers not only the range of factors which would be assessed when working with people who do not have learning disabilities, but also, for example, the person's
communication abilities and needs, the extent to which they understand what has happened to them, and how they communicate feelings (Moss, 1998\textsuperscript{1}).

A range of issues will need particular consideration when offering individual therapy for people with learning disabilities. Moss (1998) suggests the need to consider practicalities of sessions, for example, a person may require shorter sessions, or creativity may need to be used to make information or techniques accessible and meaningful. It may sometimes be helpful to involve other people in the ‘1:1’ therapy, for example, carers who are able to support the person to remember and practice skills explored in therapy. This needs to be carefully considered and negotiated in order that confidentiality is respected and people are not given messages about not having the right to a private life (Moss, 1998). Given the issues of differential power which run through interactions with people with learning disabilities, Moss (1998) considers it important to support the person within therapy, if appropriate, to examine the power issues and imbalances of their life. The person must also have a real opportunity to give or withhold consent to psychological treatment.

Perhaps given these complexities, pharmacological or behavioural techniques have often been the focus of interventions for people with learning disabilities, including those who have been abused (Moss, 1998). More recently however, there is increasing recognition that other approaches can be adapted for work with people with learning disabilities. Sinason, for example, (1992) uses psychoanalytical psychotherapy with people with learning disabilities, including those who have been abused and suggests positive outcomes. Moss (1998) outlines the adaptations which can be used to make cognitive behavioural therapy a useful technique to offer people with learning disabilities, including using approaches which depend less on verbal ability. Diaries are frequently used in cognitive-behavioural techniques, for example, and can be adapted. People with learning disabilities may find it helpful to keep diaries pictorially, on an audio-tape or by putting objects in a box (Moss, 1998).

\textsuperscript{1} The scope of this essay does not allow full exploration of the assessment process, but please see Moss, 1998 for more details.
Corbett, Cottis & Morris (1996) discuss the range of roles which psychologists need to offer in therapeutic sessions with people who have learning disabilities and have been sexually abused, including offering ‘belief’, exploring feelings of guilt, offering empathy and support and acting in a range of advocate roles. These roles apply regardless of the therapeutic modality and form the basic message to the client that the professional can bear the client’s experiences and offer meaningful support and also counter the experience of not being believed which many people who have been sexually abused encounter.

The therapeutic relationship builds upon an understanding of the process of recovery from sexual abuse (Moss, 1998). Corbett, Cottis & Morris (1996) consider this a process of mourning, negotiating the stages of numbness, denial, yearning and searching, anger, weeping and wailing, realisation, remembering and reminiscing, synthesis and moving on. Authors also note the importance of considering the psychological concept of attachment and the multiple losses that people experience when they are abused in order that these can be addressed in therapy, particularly given that attachment issues can be pertinent for people with learning disabilities.

Beail & Warden (1996) note that to date there is little evaluation of the psychotherapies starting to be used with people with learning disabilities. Mansell, Sobsey & Calder (1992) review the literature relating to the effectiveness of psychological treatments offered to people who have a learning disability. They noted positive preliminary results for a range of adapted interventions, including sexual abuse treatment, but suggest the need for better evaluative research. As well as continuing to offer 1:1 therapy, one of the roles of clinical psychologists working with people who have learning disabilities and have been sexually abused is contributing to the appropriate adaptation of therapeutic models for people with all levels of learning disability and research their efficacy.

**Group Therapy**

Over the last few years, there has also been an increased understanding of how groups may be of benefit for people with learning disabilities. Cruz, Price-Williams & Andron (1988, cited by Fenwick, 1994) described a treatment group for six women who had
been sexually abused. Barber, Jenkins & Jones (2000) suggest that group work may be beneficial, providing a peer group against which people can compare their life experiences which may be normalising. Hollins (1992) suggested Group Analytic Therapy was effective for people with learning disabilities. Clare & Grant (1994) believe there may be beneficial outcomes following group therapy based on ideas of Narrative Therapy (White 1988 et al, cited by Clare & Grant, 1994), with women with mild and moderate learning disabilities. However, although Barber, Jenkins & Jones (2000) found some initial positive results from a survivors group, this did not seem to be maintained at follow up. They suggested further consideration of the most appropriate adaptations for group work with people with learning disabilities.

A range of models of group work are now starting to be offered for people with learning disabilities, but research into efficacy still in its infancy. Clinical Psychologists have a role both to consider the benefits of offering adapted group work for people with learning disabilities, and also rigorous research to explore the efficacy of such work.

Prevention of Sexual Abuse

Given the vulnerability of people with learning disabilities to experiencing sexual abuse, clinical psychologists have a role in contributing to the prevention of sexual abuse. The role of the clinical psychologist can include running educational groups of a preventative nature. Clearly, however, there is a need to approach such training with an understanding of the ideologies of services for people with learning disabilities as well as the broader societal context, both of which, if left unaddressed will limit the usefulness of such work.

The knowledge of people with learning disabilities about practical aspects of sex can increase following sex education programmes (Lindsay, Bellshaw, Culross, Staines & Michie, 1992). McCarthy (1998), however, notes that women with learning disabilities: "like other women, gain all or most of their social status and self-esteem through their ability to have sexual relationships with men, this leaves them emotionally dependent and vulnerable to abuse of all kinds" (p. 549). She suggests the concept of sexual
education needs to be broadened to include emphasis on women's sexual pleasure, if it is to have a real impact.

Khemka & Hickson (2000) demonstrated that people with learning disabilities may find it particularly difficult to make decisions which would prevent abuse in simulated situations. Miltenberger et al. (1999) found that sexual abuse prevention skills could be learnt and generalised by women with learning disabilities. However, their study was with 5 women and there was no follow-up. The authors noted that behavioural programmes have generally found poor generalisation of prevention skills. People with learning disabilities are often expected to engage in 'unquestioning compliance' (Sobsey, 1994, cited by Khemka & Hickson, 2000) and this is likely to influence the generalisability of prevention training. McCarthy (1998) suggests women with learning disabilities need support to develop self-esteem and assertiveness in all areas of their lives and that interventions should not just focus on sexual issues. Khemka & Hickson (2000) highlight that any such programme is only likely to have an impact if service approaches can support the decision-making, self-empowerment and assertiveness skills, in all aspects of life, which are recognised as important elements of protecting oneself from abuse.

The prevention of abuse needs to be supported by the policies and staff of services. Policies of care services may need to be re-considered, for example, so that women can choose only to live with other women, or so recruitment fully considers the attitudes professional carers have to sexual abuse, to increase the chances that it is both prevented and responded to (McCarthy, 1998). Prevention can only be truly effective when the abuse of people with learning disabilities is considered as large an issue as abuse of people who do not have learning disabilities. McCarthy & Thompson (1996) suggests services often expect people with learning disabilities to tolerate various types and levels of abuse, which people without learning disabilities would not be expected to tolerate.

Sobsey (1994, cited by Moss, 1998) recommends that clinical psychologists have a role to contribute to the 'macrosystem' in terms of working with people who have learning disabilities and have been sexually abused. This is interpreted as the societal context within which individuals, families and services exist. This level of work includes
addressing popular beliefs about people with learning disabilities, and the impact of these. This can be worked towards by publicly supporting schemes, such as advocacy and promoting other more helpful ideas (Moss, 1998).

Clearly the prevention of sexual abuse needs to be considered as an issue broader than offering training for individuals and again the context and wider context of the lives of people with learning disabilities are highlighted as imperative. As well as running appropriate educational groups, clinical psychologists can contribute their psychological thinking and understanding to the development of theories which understand the context of abuse, and also use their research skills to develop a deeper understanding of what works in terms of prevention.

Conclusions

Over the last 20 years the role of the clinical psychologist in working with people who have learning disabilities and have been sexually abused has developed alongside a shift in service ideologies and a greater understanding of the emotional lives of people with learning disabilities. Harvey (2001) highlights the core skills of clinical psychologists to be assessment, formulation, intervention and evaluation. Clearly all of these roles are used in working with people who have learning disabilities and have been sexually abused.

Clinical psychologists work at both the level of the individual with learning disabilities and the context. The role encompasses further developing an understanding of the prevalence of sexual abuse and reasons for increased vulnerability, further developing an understanding of the effects of sexual abuse, and of the issues which can make it difficult to acknowledge abuse or work with people who have been abused. The role also includes dissemination of this knowledge to others who work with people with learning disabilities. Clinical psychologists offer a range of individual and group interventions, and need to consider the adaptation of these to meet the needs of people with learning disabilities. There has been some research into efficacy. However, it is also clear that a great deal more work is needed, both in terms of the adaptation of models and research into outcomes of group and individual work. Psychologists have a number of specific
roles which contribute to the prevention of abuse, including thorough consideration of the outcomes of preventative training programmes and the role also extends to working with advocacy services and highlighting the impact of myths about people with learning disabilities.

This essay has particularly highlighted the issues of differential power and the value accorded to people with learning disabilities which sets the scene for all the roles highlighted above. Given that sexual abuse is considered to be motivated by power differentials (Groth, 1979 & Russel, 1986, cited by Crossmaker, 1991), it appears that the devaluation of people with learning disabilities is highly influential in their increased vulnerability. Sobsey (1994, cited by Bernard, 1999) suggests that abuse may be deemed less worthy of attention, however, because of the devaluation of people with disabilities. Because of their lack of power and 'value', people with learning disabilities have historically been denied the range of interventions available for non-disabled people. Where these are offered, the position of people with learning disabilities in society may have been influential in the paucity of research into efficacy. The varied proactive and reactive roles of clinical psychologists who work with people who have learning disabilities and have been sexually abused all depend on consideration of the interlocking dimensions of power, value, gender, identity and learning disability, both at the level of the individual and the context within which they live. This essay has summarised the roles of clinical psychologists working with people who have learning disabilities and have been sexually abused within a consideration of these dimensions.


Anxiety Disorders in Childhood are Fundamentally Different from Anxiety Disorders in Adulthood. Discuss with Reference to the Theory and Treatment of Two Anxiety Disorders.
Anxiety Disorders in Childhood are Fundamentally Different from Anxiety Disorders in Adulthood. Discuss with Reference to the Theory and Treatment of Two Anxiety Disorders.

Introduction

Anxiety disorders in childhood, as in adulthood, are marked by a belief in danger or threat, causing perceptual, physiological arousal, behavioural and interpersonal symptoms (Carr, 1999). It used to be widely believed that emotional disorders in children usually spontaneously remitted (Roth & Fonagy, 1996). Longitudinal and retrospective investigations, however, have suggested otherwise (Fischer et al., 1984, Harrington et al., 1990, 1991, 1994, Flament et al., 1990, Agras et al., 1972 & Francis & Ollendick, 1986, all cited by Roth & Fonagy, 1996). The effects of childhood anxiety can be pervasive and increase as the child ages, negatively affecting peer relationship, family relationships, school difficulties, self-image, self-esteem, behavioural problems and increasing the likelihood of depression (Kashani & Orvaschel, 1990). Clearly it is important for psychologists to have an understanding of anxiety disorders as they are experienced by children.

A specific phobia is an intense fear occurring when faced with a definable event, object or situation. The fear is out of proportion to the danger posed and leads to persistent avoidance (Carr, 1999). Specific phobias are often understood and treated from a behavioural perspective, with treatments for children being essentially 'downward extensions' of those used with adults (Hagopian & Ollendick, 1993).

Social phobia is characterised by a: "marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar treatment or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing" (DSM-IV: APA, 1994, p. 416, cited by Wells, 1998). The disorder leads to either avoidance of the feared social situation(s) or to intense anxiety and distress when experiencing them. Cognitive-behavioural (CBT) treatments are increasingly being offered in the treatment of social phobia (Roth & Fonagy, 1996). Models and treatments for social

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1 See appendix for the DSM-IV definitions of specific phobia and social phobia.
Child and Family Essay

phobia in childhood are also modifications of adult models and treatments (Kashdan & Herbert, 2001).

This essay will consider the psychological understandings and treatments of specific phobias from a behavioural perspective and simple phobias from a cognitive-behavioural perspective, outlining the models and treatments used with adults and then considering their adaptation and applicability for use with children. Choosing to focus on these two anxiety disorders allows discussion of factors which apply for children of a range of ages. It will be argued that anxiety disorders in childhood are qualitatively different than those of adulthood, rather than fundamentally different. Consideration of biological factors, pharmacological treatments and issues of co-morbidity are beyond the scope of this essay.

Epidemiology

Prevalence estimates of specific phobia in children have ranged from 2.4 to 9.1%, averaging about 5% (King, Eleonara & Ollendick, 1998). The concept of social phobia was substantially revised in the fourth edition of DSM (Diagnostic and Statisticians Manual, Kashdan & Herbert, 2001). No prevalence rates based on the DSM-IV definition are yet available (Beidel & Turner, 1998). Existing prevalence rates of 1-2% of the childhood population (McGee, Feehan, Williams & Anderson, 1992, cited by Spence, Donovan & Brechman-Toussaint, 2000) may be an underestimate.

Social phobia is more prevalent in adolescence whereas specific phobias are more prevalent in pre-adolescents (Carr, 1999). Younger children tend to report higher levels of specific phobias than older children (Muris, Schmidt & Merckelbach, 1999). The usual age for the onset of a specific phobia for adult samples is during childhood (Stanley & Beidel, 1993), and depends to some extent on the feared stimulus (Field, Argyris & Knowles, 2001). Adult height phobics tend to say they have always had their fear (Menzies & Clarke, 1993, cited by Field, Argyris & Knowles, 2001) whereas animal and blood-injection phobics report their phobia started around 7 or 9 years old respectively (Öst, 1987, cited by Field, Argyris & Knowles, 2001). Studies have estimated a lowest age of onset to be under 5 years old (Marks & Gelder, 1996, Öst, 1987, cited by Stanley & Beidel, 1993). Social phobia usually starts in mid-adolescence, but several authors have reported the disorder in children as young as 8 (Beidel & Turner, 1998).
Models of Anxiety

Specific Phobia

The aetiology of specific phobias is hypothesised to involve genetic, constitutional and environmental factors (Hagopian & King, 1997, cited by King, et al., 1998). Behavioural models, which are the prevalent psychological understanding of specific phobias, will be outlined.

Rachman’s influential model (1976, 1977, 1978 cited by King et al., 1998) suggested three pathways to the acquisition of phobias: classical conditioning, (a traumatic experience with the feared stimulus), vicarious conditioning (seeing someone else afraid of the feared object) and information transfer (hearing stories or jokes about the feared stimulus). King et al.’s (1998) review found support for Rachman’s three pathways, but also suggested they may be interactive rather than independent (Ollendick & King, 1991, cited by King et al., 1998). Field, Argyris & Knowles (2001), for example, highlight that prior expectations about the outcome of a conditioning episode can assist the conditioning process. The reader is directed to King et al. (1998) for further discussion of Rachman’s three pathways and the theoretical underpinnings.

Recently the Darwinian nonassociative theory has been posing some challenges to Rachman’s three pathways, suggesting that children who have undergone normal maturational development may show fear the first time they are exposed to ‘evolutionarily relevant’ stimuli (Menzies & Clarke, 1993), for example water. This fear dissipates over time and with repeated exposures, except perhaps for people who are poor habituators or do not get the opportunity for safe exposure. Menzies & Clarke’s (1993) retrospective study found that many (56%) parents of children with water phobias believed their children were phobic the very first time they were in contact with water. King et al. (1998) suggest this finding may challenge Rachman’s three pathways model. However, a diagnosis of specific phobia requires that a child be fearful of the stimulus for a period of at least 6 months. Clearly, therefore, a child cannot be phobic the first time they are exposed to water. Perhaps the Darwinian nonassociative theory highlights a group of stimuli which we may be predisposed to being fearful of, but the development of this into a phobia may still be hypothesised to be due to behavioural processes.
Mowrer’s two-factor model suggested that phobias may be acquired through classical conditioning, but maintained by the negative reinforcement gained through avoidance (1960, cited by Stanley & Beidel, 1993). The person receives a negative reinforcement when avoiding a feared object, reinforcing their avoidance and increasing the likelihood that they will avoid the stimulus again.

Model 1 summarises the current understanding of the acquisition and maintenance of specific phobias.

**Model 1 – current understanding of the acquisition and maintenance of specific phobias.**

A hypothesised relationship between the existing influential models

Pathway 1  Classical Conditioning
Pathway 2  Vicarious Learning
Pathway 3  Information Transfer
Darwinian Non-Associative Acquisition

Possible Interaction – acquisition of phobia

Operant Conditioning and other Factors

Maintenance of Phobia
Child and Family Essay

Issues to consider in applying the model to children

Muris et al. (1999) demonstrated that specific phobias in children aged between 7 and 19 clustered into the same three subtypes as adults: animal, blood-injection and environmental-situational, suggesting congruity between the disorders in adults and children. The above models appear to have been formulated as models for the acquisition of specific phobias in both adults and children and evidence suggests they can coherently explain the acquisition of specific phobias in children (see King et al. 1998). However, closer examination of the literature suggests a number of qualitative differences that arise in considering specific phobias in children.

Diagnosis of specific phobia

Fears are a common experience during childhood and can be considered part of normal development (Hagopian & Ollendick, 1993). The content of fears change as children grow up. Specific phobias seem to develop from initially normative childhood fears, a phobia is a fear that has increased in magnitude and persisted beyond its natural course (Field & Davey, 2001). Stanley & Beidel (1993) note that the most central adaptation of the above behavioural understanding in working with children, therefore, is assessment of the age appropriateness of the fears. A diagnosis of a specific phobia is not appropriate unless the fear is inappropriate for the child’s development and age. Carr (1999) also notes that according to DSM-IV, a diagnosis of specific phobia in children does not require that they recognise their fear as unreasonable and excessive, although this is necessary in adults.

Pathways to acquisition

The literature suggests that children and adults may be differentially vulnerable to the methods of acquisition of a specific phobia. Field & Davey (2001) highlight, for example, that a conditioned stimulus is less likely to become feared if it has previously been experienced without the unconditioned stimulus, i.e. if someone has had many trauma-free interactions with a stimulus then it will be harder for that stimulus to become feared. Adults are likely to have had trauma free interactions with a greater range of stimuli. This may suggest one explanation for the reason that specific phobias most often develop in younger childhood rather than adolescence or adulthood. Öst & Hugdahl (1983, cited by Silverman & Rabian, 1994) found that
people who acquired phobias in adulthood more often than children attributed their phobia to direct conditioning than to indirect methods.

Field, Argyris & Knowles (2001) used a prospective study to investigate changes in 7-9 year old children’s fear-related beliefs given video information or verbal information about monsters. The verbal information increased fear-related beliefs when this information was given by an adult, but not by peers. They suggest young children may be particularly vulnerable to the acquisition of phobias by indirect pathways, given that they have limited other experience to draw upon. However, clearly there are large differences between fears of childhood and specific phobias and the results must therefore be interpreted with caution.

Social Phobia

Until the mid 1990’s there was no specific model of social phobia, which was understood instead from a general CBT model (Wells, 1998). The advancement of a specific model has led to increased understanding and treatment. The core of the CBT conceptualisation is the hypothesis that people with social phobia have both a strong desire to make a favourable social impression and a belief in their lack of ability to do so (Wells, 1998). There are two sub-types of social phobia in adults: discrete, where people fear and avoid a single performance situation and generalised, where people fear and avoid a number of more commonly occurring social situations, such as attending social gatherings (Kashdan & Herbert, 2001). Approximately 70% of people who seek treatment for social phobia have the generalised sub-type (Turner, Beidel & Cooley, 1994, cited by Beidel & Turner, 1998).

Wells & Clark’s (1997, cited by Wells, 1998) model of social phobia is presented in model 2 and summarised below:
Cognitive-Behavioural Model of Social Phobia

Social Situation

Activates Assumptions

Perceived Social Danger (negative automatic thoughts)

Processing of Self as a Social Object

Safety Behaviours

Somatic and Cognitive Symptoms
On encountering a social situation, previously formed unfavourable assumptions about one’s social ability are triggered, leading to negative automatic thoughts (NATs) which suggest the person will fail to present a favourable impression. In people with social phobia, this leads to a shift in attention towards the self. The person becomes self-focused and forms an image or feeling of how they believe they appear to others (processing of self as a social object). However, this image is a negatively distorted impression of the observable self (Wells, 1998).

The person believes their anxiety symptoms are more obvious or extreme than they are. The person’s beliefs and their distorted image of themselves may lead to an avoidance of social situations, meaning that they do not encounter situations which could modify their NATs and assumptions. If avoidance is not possible then the person will use safety behaviours (Salkovskis, 1991, cited by Wells, 1998), which although intended to avert social catastrophes may instead maintain the disorder. The distorted image also leads to a variety of somatic and cognitive symptoms which influence the person’s judgement of themselves in social situations and therefore contribute to the perseveration of the disorder. Blushing, for example, is interpreted as a sign of negative performance and increases the anxiety further as well as giving ‘evidence’ to the belief that the person fails at social situations. See Wells (1998) for a comprehensive account of the model.

The model hypothesises that social phobics engage in three types of processing that maintain their social phobia. In-situation processing, which has been highlighted above, and also anticipatory processing, ruminating about what will happen in future social situations with a negative bias, and post-event processing, analysing their in-situation behaviour afterwards, again with a negative bias (Wells, 1998).

**Issues to consider in applying the model to children**

Evidence suggests that cognitive models can be appropriate for an understanding of childhood anxieties. Vasey, Daleiden, Williams & Brown (1995) for example, demonstrated, using a stroop technique, that anxious 9-14 year old children, like anxious adults and unlike non-anxious children or adults have an attentional bias towards threatening stimuli. Weems, Berman, Silverman & Saavedra (2001) suggest that clinically anxious children aged 6-17 years experience cognitive distortions, an important aspect of the CBT models of adult anxieties.
Children who have social phobia fear the same situations that are feared in adults who have a social phobia (Beidel & Turner, 1998) suggesting the syndromes overlap for children and adults. The literature suggests a number of similarities as well as qualitative differences which arise when applying a CBT understanding of social phobia to children.

Deficits in social skills have been suggested to contribute to the maintenance of social phobia. Mixed results have been found in studies investigating this hypotheses with adults (Kashdan & Herbert, 2001), but there is stronger evidence for a social skills deficit in children with social phobia (Spence, et al., 2000). However, it cannot be concluded whether any problems observed are due to deficits or the presence of anxiety interfering with the performance of behaviours which are available to the child (Kashdan & Herbert, 2001).

**Diagnosis of social phobia**

DSM-IV (American Psychiatric Association, 1994, cited by Spence et al. 2000) includes a number of supplementary criteria for the diagnosis of social phobia in children. The child must demonstrate the ability for age appropriate relationships with familiar people, the anxiety must occur in peer settings, not just interactions with adults and children may not recognise their fear as excessive or unreasonable (Beidel & Turner, 1998). DSM-IV also acknowledges that children may demonstrate their distress differently from adults. Whereas adults and perhaps adolescents present self-deprecating cognitions as the reason for social problems, younger children may present with irritability, crying, freezing (Albano, 1995 cited by Kashdan & Herbert, 2001), somatic symptoms (Faust & Forehand, 1994, cited by Kashdan & Herbert, 2001), or perhaps even concerns about being looked at which can appear as ideas of reference (Abe & Suzuki, 1986, cited by Kashdan & Herbert, 2001).

To an extent, the differing presentations of the disorder are a reflection of the fact that adults have more choice in how they manage their anxieties, e.g. they may seek employment which does not necessitate their anxiety provoking situations. Children do not have this freedom and so may refuse to go to school or complain of vague physical symptoms as a way to avoid their feared situations (Beidel & Turner, 1998).
A lack of research makes it difficult to conclude whether social phobia in children is also divisible into the discrete and generalised sub-types (Kashdan & Herbert, 2001). Young people, as a consequence of the mandatory attending of school and the social aspects inherent in education, have less opportunity to avoid a range of social situations. The pervasiveness of the phobia’s impact in a generalised social phobia sub-type may not be apparent until adulthood (Kashdan & Herbert, 2001).

Acquisition of social phobia

Bögels & Zigterman (2000) suggest that cognitive theories of anxiety hinge on the finding that anxious adults overestimate the danger and underestimate their ability to cope with situations. Their research with 9-18 year old children, including children experiencing social phobia suggests that anxious children also have a cognitive bias for threat. They interpret ambiguous situations in a more negative way and underestimate their ability to cope, when compared to a clinical and non-clinical control group. Their research did not find that anxious children overestimated danger, but authors note that this may have been a consequence of the way their questions were phrased.

The model outlined above requires that people are able to take on the perspective of another person and to imagine how another person views their behaviour in order to be socially fearful (Beidel & Turner, 1998). Evidence suggests that by fourth grade children can recognise anxiety and unease in others (Darby & Schlenker, 1986, cited by Beidel & Turner, 1998) and that by 7 children may have the necessary cognitive abilities to ‘process themselves as a social object’ (Beidel & Turner, 1998). Children as young as 4 can see themselves as a social object and therefore experience embarrassment (Buss, Iscoe & Buss (1979, cited by Velting & Albano, 2001). However the abilities to take another’s perspective and anticipate and be concerned about negative evaluation from others may not emerge until about 8 (Crozier & Burnham, 1990, cited by Velting & Albano, 2001). These factors may account for the lack of appearance of the disorder before age 8. The assumptions, rules and beliefs which are triggered in an experience of social phobia are considered to be formed in childhood even if the disorder does not present until adulthood.
**Treatment**

Assessment is the foundation of a high quality treatment in work with both children and adults. Assessment of children with specific and social phobias is a ‘downward extension’ of the techniques used with adults, including the adaptation of standardised questionnaire to be completed by children, their families or teachers (Kashdan & Herbert, 2001, Stanley & Beidel, 1993). Space does not allow full discussion of the adaptation of assessment for use with children. For example, however, interviewing children often requires the use of more specific closed, rather than open, questions (Stanley & Beidel, 1993) and interviewing the child’s family is usually required to aid a good understanding of the phobic symptoms (Beidel & Turner, 1998).

**Specific Phobia**

Behavioural treatments for specific phobias in adults stem from the behavioural models of acquisition. Treatments based on a classical conditioning formulation focus on counter-conditioning, or pairing the stimulus with a response that is incompatible with anxiety, e.g. relaxation (Stanley & Beidel, 1993). Systematic desensitisation involves imaginal exposure with relaxation. In Vivo desensitisation involves actual exposure with relaxation. The fear response to a conditioned stimulus can also be diminished by devaluing the unconditioned stimulus, for example by exploring information about the conditioned stimulus, harmless exposure to it, or reinterpreting body signals as benign (Field & Davey, 2001).

Modelling treatments, the indirect pathways of treatment, suggest the extinction of avoidance and phobia occurs when a model approaches the feared stimulus and no adverse consequences ensue (Ollendick & King, 1998).

An extinction model of treatment stems from an operant conditioning formulation, proposing the withdrawal of the negative reinforcement received when the person avoids a feared object, by removing the avoidance and thereby leading to extinguishing of the phobia. This can be done with flooding where the person is asked to maintain prolonged contact with the feared stimulus, or with graded...
exposure where they are gradually exposed to increasing levels of the feared stimulus (Stanley & Beidel, 1993).

**Treatment of children with specific phobia**

As with treatment for social phobia, treatments for specific phobia tend to be downward extensions of adult treatments (Hagopian & Ollendick, 1993), but qualitative differences are present.

Stanley & Beidel (1993) note a different rate of the use of different behavioural treatments with adults than with children. Flooding is used much less with children than with adults and both ethical and practical considerations have effected this. Young children may lack the cognitive capacity to understand the procedure making it ethically questionable due to the extreme levels of anxiety it can cause. Furthermore the technique requires that clients continue a follow-up exposure and children may be less capable of completing this (Stanley & Beidel, 1993).

With adults, imaginal exposure has been found useful with systematic desensitisation, but young children may lack the necessary development and control of their imagination (Stanley & Beidel, 1993) making real life exposure more applicable. Children may also find it difficult to use relaxation as a competing response and therefore this technique is not often used when treating children (Stanley & Beidel, 1993). Modelling, however, is particularly useful in the behavioural treatment of childhood specific phobias. This strategy by-passes the need for children to learn by instruction (Stanley & Beidel, 1993) and therefore may be particularly useful with younger children. Perhaps the lack of life experience, which means modelling is particularly significant in phobia acquisition also means it can be particularly significant in treatment.

**Parental Involvement in specific phobia treatment**

Operant conditioning, or the manipulation of behaviour by altering its consequences (King & Ollendick, 1997, cited by Ollendick & King, 1998), is only used as a primary treatment strategy when the client is a child. This may reflect the greater control we are able to gain over children’s environments, and also clearly highlights the need for parental involvement in treatment (Stanley & Beidel, 1993).
Parents are often involved in the treatment of their children, differentiating the treatment of children from that of adults. Berman, Weems, Silverman & Kurtines (2000) demonstrated the predictive power of parental factors in the exposure based cognitive and behavioural treatments of 6 to 17 year old children, including children with simple and social phobia. Parents who had higher ratings of depression, hostility and paranoia were significantly less likely to have children who benefited from the treatments offered. Their results also demonstrated that parental factors become increasingly less relevant as the child becomes older.

### Social phobia

Wells (1998) suggests a sequence for the treatment of social phobia in adults, using a range of cognitive and behavioural techniques. The patient is socialised into the CBT approach by the sharing of the model and the client's specific formulation. A focus is on checking where the patient's evidence that anxiety symptoms looks conspicuous has come from, emphasising that the patient has been unable to check out other people's true reaction as they have been so focused on themselves. The model is then further explored using behavioural experiments which ask the client to both increase and decrease their safety behaviour whilst rating anxiety, self-consciousness and belief in social tragedy. This allows demonstration that social catastrophes do not occur when safety behaviours are not used and furthermore that self-consciousness and symptom intensity actually decrease (Wells, 1998). Cognitive treatment also works to de-catastrophise beliefs about what it would mean if other people observed the client's anxiety symptom and to challenge the assumptions and rules which also contribute to social phobia.

### Treatment of children with social phobia

CBT treatments for social phobia in children seem also to be downward extensions of treatments used with adults. Space does not permit full discussion of the techniques used; however examples will be chosen to demonstrate the applicability of CBT techniques in children who have social phobia.

Spence, et al. (2000) used a CBT/social skills-training intervention with children from 7-14 years. They suggest that the youngest children (7-9 years old) had difficulty
grasping the concept of ‘faulty’ or ‘negative’ thinking and believe that more practical exposure based tasks may be more helpful for these clients. Socialising the client to the model may be useful for parents, or older children themselves, but more practical interventions and language may be more suitable for young children who experience social phobia. Kendall (1994, cited by Beidel & Turner, 1998) suggests that children who appear to be having difficulty accessing their negative automatic thoughts, can be helped to do so using cartoons, which show a scene and a central character with an empty thought bubble above them. The children are asked what the person is thinking. Beidel & Turner (1998) note that this can help young children become more adept at identifying their negative thinking.

The CBT treatment of social phobia of adults often uses self-monitoring techniques, such as diaries. Beidel & Turner (1998) highlight that children often do not present themselves for therapy, rather they are presented. This may affect their motivation to complete such monitoring, as well as other aspects of therapy. There is a need to consider the format of diaries used with younger children. Beidel, Neal & Lederer (1991, cited by Beidel & Turner, 1998) found that children as young as 8 were able to use a daily diary in a useful way, but the youngest children (8-10) were more likely to complete picture rather than written diaries.

No literature could be found about using behavioural experiments with children. The literature about social phobia in children suffers from the problem of a lack of specific model which until recently affected the literature for social phobia in adults. Increased research into all aspects of the model in the treatment of children is clearly needed.

Parental Involvement in social phobia treatment

The use of families in treatment, as well as assessment, differentiates the treatment of social phobia in children from that in adults. Spence et al. (2000) found a trend towards superior results for a CBT treatment of 7-14 year old socially phobic children involving parents, than the same treatment without parental involvement. Barrett, Dadds, & Rapee (1996) showed a greater improvement using CBT interventions for 7-10 year old children with anxiety disorders, including social phobia, when the treatment involved a family treatment component. This effect was not significant with 11-14 year old children. Research suggests that parental involvement supports the generalisation of social skills learnt in a therapeutic context, to real life contexts.
Child and Family Essay

Evidence suggests parental behaviours are likely to have a significant impact on childhood anxiety (Spence et al. 2000). Dadds, Barrett, Rapee & Ryan (1996, cited by Beidel & Turner, 1998) demonstrated that parents of anxious children more often reinforce avoidant and discourage courageous behaviour. Although it is not clear whether this is a causal or just maintaining factors, it highlights the need to involve parents in the treatment of their child’s social phobia. Beidel & Turner (1998) suggest the importance of ‘parent management’ when treating children. They give an example of a father who had panic disorder, which he managed with alcohol and tranquillisers. Education of this man was necessary for the successful psychotherapy of his daughter as initially he felt she should not have the therapy but should take tranquillisers for her anxiety. In cases where a parent themselves has severe anxiety, they suggest that treatment of the child may need to be postponed until after the parent has been successfully treated. Cobham, Dadds & Spence (1998) compared individual CBT for children with anxiety disorders including social and specific phobias with the same treatment with an additional component of therapy for parents to manage their own anxiety. The results were striking: 30% of children who had anxious parents and had individual therapy no longer met diagnostic criteria after treatment, but this rose to 77% if children who had anxious parents received the same treatment while their parents also received therapy for their anxiety.

Conclusions

This essay has outlined the behavioural theory and treatment of specific phobias and the CBT theory and treatment of social phobia. In considering the issues from the point of view of working with children, it has become clear that many aspects of the theories and treatments are applicable for work with children, but many adaptations are also necessary. It appears that as children become older, the models and techniques used with adults become increasingly relevant for them and adaptations decreasingly relevant.

Central to a comprehensive understanding of these issues is consideration of the developmental level and cognitive abilities of children. Carr (1999) highlights that the stimuli which elicit fears change in parallel with developments in the child’s cognitive
and social abilities. In early childhood (5-7 years), the child's awareness of the world outside of their small world increases as their thinking develops from pre-operational thinking to concrete operational thinking, and their fears are, for example, of natural disasters, animals or injury. Later, in middle childhood and adolescence, the child starts to form a sense of who they are, outside of the family and to develop formal operational thought. Esteem can now be derived from academic or athletic performance and later, from peer relationships. The child has the ability to anticipate future dangers, including those of a social nature. This explains why children as young as 5 may develop specific phobias, but children do not develop social phobia until they are at least 8.

This essay has shown how these developmental considerations as well as consideration of the child's social relationships leads to specific diagnostic considerations, differential aetiological considerations, differential emphasises within the treatments and the adaptation of assessment and treatment techniques to suit work with children. It has also shown, however, that many aspects of the models formulated for working with adults, once adapted in line with the above considerations, can be used to understand and treat specific phobias and social phobias in children. Space has not permitted discussion of outcome data, but preliminary evidence suggests that when these needs are taken into account behavioural models can be efficacious in work with children who have specific phobias (Ollendick & King, 1998) and CBT models in work with children who have social phobias (for example, Kendall, 1990, cited by Kashan & Herbert, 2001).

Both specific phobias and social phobias can cause deleterious effects, which may increase as the disorder prolongs (Ollendick, Vasey & King 2000) Lodge & Tripp (1995) highlight that "child psychopathology is a new discipline with an accompanying short research history" (p. 29). The area has only been studied as distinct from adult psychopathology for the past 30 years. Research is still in the early stages and conclusions are necessarily tentative. The need for continuing comprehensive research into this area is highlighted, to allow psychologists to offer good quality researched therapies for children and thereby minimise the subsequent effects of specific and social phobias.

Beidel & Turner (1998) conclude that: "the clinical presentation of social phobia in childhood and adolescence is both similar and different from its presentation in
adults” (p. 55). This essay has shown that so too are the models, and treatment of social phobias and the clinical presentation, models and treatments of specific phobias. Specific phobias and social phobias appear to be qualitatively different in children than in adults and furthermore, these qualitative differences appear to diminish as children age.
REFERENCES


APPENDIX – DSM-IV CRITERIA FOR SPECIFIC PHOBIA AND SOCIAL PHOBIA
Cited by A. Carr (1999)

Specific Phobia –
♦ Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g. flying, heights, animals, an injection, blood).
♦ Exposure to the phobic stimulus produces an immediate anxiety response which may take the form of a panic attack or in children may involve crying, tantrums, freezing or clinging.
♦ The person recognises that the fear is excessive or unreasonable, although this feature may be absent in children.
♦ The phobic situation is avoided, or endured with intense anxiety or distress.
♦ The avoidance or anxiety interferes significantly with personal, social or academic functioning.
♦ If under 18 years or age, the duration is at least 6 months.
♦ The anxiety and avoidance are not better accounted for by another disorder.

Social Phobia –
♦ A marked or persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that she will act in a way that will be humiliating or embarrassing. In children the child must have capacity for age-appropriate relationships with familiar people, and the anxiety occurs in peer-group setting.
♦ Exposure to the feared social situation produces an immediate anxiety response which may take the form of a panic attack or in children may involve crying, tantrums, freezing or shrinking from social situations with unfamiliar people.
♦ The person recognises that the fear is excessive or unreasonable, although this feature may be absent in children.
♦ The feared social situations are avoided, or endured with intense anxiety and distress.
♦ The avoidance or anxiety interferes significantly with personal, social or academic functioning.
♦ If under 18 years of age, the duration is at least 6 months.
♦ The anxiety and avoidance are not better accounted for by another disorder.
♦ The fear is not related to a general medical or psychological condition such as Parkinson's disease or stuttering.

Year 2
Older People Essay

Word Count – 4987 words
Introduction

Dementia is a condition causing disturbance to memory and a range of other cortical functions, for example language and judgement and affecting daily interactions and behaviour (Jacques & Jackson, 2000). Lishman (1987) defined dementia as: "An acquired global impairment of intellect, memory and personality but without impairment of consciousness" (cited by Gustafson, 1996).

Jacques & Jackson (2000) outline some of the many causes of dementia, and state that the most common causes of dementia in older people are Alzheimer's Disease and Vascular dementia. However, as the term dementia is a clinical description rather than a term used to describe an underlying aetiology (Wade & Hachinski, 1987), there are many other conditions which can cause the collection of symptoms know as Dementia, including Lewy Body Dementia and Frontotemporal Dementia (Jackson & Jacques, 2000). Each different 'type' of dementia is associated with different rates of decline, different patterns of impairment, and hence a different disease course. Appendix 1 gives more information about some of the many conditions which can cause the collection of symptoms known as dementia.

Dementia is extremely rare in people under 60, but increases in prevalence with increasing age (Jacques & Jackson, 2000). Table 1 outlines the age-related prevalence rates of dementia.
A minority of dementias can be considered reversible, in that the illness only results in dementia whilst the cause is present, and the cause is one which can be removed, for example, dementia due to a brain tumour or syphilis. Medical treatments can remove the cause and the client can experience complete recovery as a result (Jacques & Jackson, 2000). Other dementias are also not progressive, for example, people who have experienced traumatic brain injury may often meet the diagnostic criteria for Dementia, but their cognitive functioning may improve with the passage of time (Brandt & Rich, 1995). However, as the treatments and long-term implications of these dementias are very different from non-reversible and progressive dementias, they will not be included in this essay.

Alzheimer’s Disease (AD) is the most common form of dementia (Matthews, Korbey, Wilkinson & Rowden, 2000), with up to two thirds of dementias being of the Alzheimer’s type (Small et al. 1997, cited by Keough & Huebner, 2000). This essay will focus on AD, as it effects older people, although clearly many of the principles are applicable to other types of dementia. After introducing AD, this essay will first briefly outline the current knowledge about biological causes and interventions for AD. However, through exploration of a range of psychological conceptualisations of dementia, it will be argued that dementia and its effects should be considered more than just a biological disease.

### Table 1 (from Jacques & Jackson, 2000)

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>Percentage with Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 – 59</td>
<td>0.1</td>
</tr>
<tr>
<td>60 – 64</td>
<td>1.0</td>
</tr>
<tr>
<td>65 – 69</td>
<td>1.4</td>
</tr>
<tr>
<td>70 – 74</td>
<td>4.1</td>
</tr>
<tr>
<td>75 – 79</td>
<td>5.7</td>
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<tr>
<td>80 – 84</td>
<td>13.0</td>
</tr>
<tr>
<td>85 – 89</td>
<td>21.6</td>
</tr>
<tr>
<td>90+</td>
<td>32.6</td>
</tr>
</tbody>
</table>
The essay will therefore consider a range of non-pharmacological interventions which are being offered for people with dementia and their carers. Consideration of the efficacy of such interventions suggests that whilst AD cannot be cured, in the sense that no intervention can take away the neurological damage, there is strong evidence to suggest that it does not just take its course, as the rate of decline and the associated symptoms may not be prescribed solely by the neurological changes.

**Alzheimer's Disease**

Alzheimer's Disease was first described by Alois Alzheimer in 1907 (Jacques & Jackson, 2000), although the term was originally used to describe dementia in people below 65 and not used in reference to older people with dementia until the 1970s (Downs, 2000). AD tends to have a duration of 6 to 8 years, but there are wide variations in the rate of decline, and therefore the course of the disease (Diesfeldt, 1986, cited by Midence & Cuncliffe, 1996). People with AD are prone to a wide range of associated symptoms, including agitation, delusions, anxiety, depression, irritability and apathy (Cummings, Donohue & Brooks, 2000). Estimates suggest 70-80% of people with AD demonstrate behavioural problems at some time in the disease process (Gatz et al. 1998). These aspects of AD increase the burden on the person's carer such that they often precipitate a move to institutional care (Cummings, Donohue & Brooks, 2000). As the disease progresses, people with AD may become disorientated and begin to wander, possibly trying to find their way to a familiar place (Wilcock, 1990, cited by Midence & Cuncliffe, 1996). Clients may show problems with spontaneity and initiative, show dramatic personality changes or seem anxious or depressed. Some may experience hallucinations (Midence & Cuncliffe, 1996). Speech may be impoverished and people may be increasingly unable to perform everyday acts such as shopping or dressing (Wilcock, 1990, cited by Midence & Cuncliffe, 1996). As the condition develops clients often become unable to recognise their relatives or remember recent experiences and disorientation may cause panic, aggression and an overwhelming desire to escape a seemingly unfamiliar situation (Wilcock, 1990, cited by Midence & Cuncliffe, 1996).
The ‘course of dementia’, as referenced by this essay title, is interpreted as not just the neurological progression of deterioration, but also the range of associated behavioural, cognitive and affective symptoms.

**Biological Causes and Treatments**

Allen (1999) suggests that although we have some knowledge about the neurological changes associated with AD, we actually know very little about what causes it. It is not clear whether there is one pathway to the development of AD or whether what we call AD is a collection of illnesses which have a similar end result (Jacques & Jackson, 2000). However, the current understanding about the neurophysiological changes associated with AD will be outlined, before discussion of the bio-medical treatments.

AD is associated with shrinkage of the cerebral hemispheres, the damage being particularly to the temporal lobes, especially the hippocampus which is the region involved with recent memory and the frontal lobes, the area involved with self-control (Jacques & Jackson, 2000). Excessive cell death and degeneration of neurones in these regions has been demonstrated. The degeneration of the connections and endings of the neurones are exhibited as senile plaques and neurofibrillary tangles (Jacques & Jackson, 2000). Plaques contain a protein called beta-amyloid, which may be processed abnormally in people with AD. Hardy & Allsop (1991) developed the ‘Amyloid Cascade’ hypothesis following the discovery that rare mutations in the gene encoding for the precursor of beta-amyloid always leads to AD, possibly via the increased production of beta-amyloid. Both plaques and tangles result in a reduction in the number and quality of the connections between the nerve cells in the damaged area. AD is also associated with changes in certain neurotransmitter levels, including acetycholine, noradrenaline, 5-hydroxytryptamine and gamma-aminobutyric acid. Acetycholine has received a great deal of attention over recent years due to advances in the pharmacological treatment of AD (Burns, Russell & Page, 1999). It appears that in people with AD there is a lower than normal level of the enzyme necessary for making this important neurotransmitter (Jacques & Jackson, 2000).
Table 2 summarises the current thinking about the neurological pathology associated with AD (from Jacques and Jackson, 2000).

Table 2 – The Neurological Pathology of Alzheimer’s Disease

<table>
<thead>
<tr>
<th>SITE OF DAMAGE</th>
<th>TYPE OF DAMAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral hemispheres especially temporal, parietal and frontal lobes</td>
<td>Shrinkage Enlarges ventricles</td>
</tr>
<tr>
<td>Grey matter of these areas</td>
<td>Shrinkage and cell loss or damage Senile plaques</td>
</tr>
<tr>
<td>In some subcortical nuclei</td>
<td>Similar changes</td>
</tr>
<tr>
<td>In the plaques</td>
<td>Dead cells, amyloid</td>
</tr>
<tr>
<td>Within the neurones in the affected areas</td>
<td>Neurofibrillary tangles Loss of enzymes which help make the neurotransmitters, especially acetylcholine</td>
</tr>
<tr>
<td>At the nerve endings</td>
<td>Lack of neurotransmitters, so that messages are not passed.</td>
</tr>
</tbody>
</table>

Over the past few years, a new class of drugs, the anticholinesterase inhibitors, have been increasingly influential in the care of people with mild to moderate AD (Burns et al. 1999). A recent Cochrane review concluded that they can produce improvements in cognitive function for some people with AD (Birkes, Melzer & Beppu, 2002). The National Institute for Clinical excellence (NICE) recommended they be made available in the NHS as part of the management of people with mild and moderate AD (NICE, 2001). Anticholinesterase inhibitors were first approved for use in the UK in February 1997, marking the first pharmacological treatment of AD (Matthews, Korbey, Wilkinson & Rowden, 2000). These drugs inhibit the breakdown of the neurotransmitter acetylcholine in the cholinergic synapses of the brain, important memory sites. The anticholinesterase inhibitors are more effective in the prevention of further decline rather than improving functioning (Allen, 1999). This class of drug does not have an impact on all people who have AD. Approximately half will show improvement in their dementia symptoms upon commencing the drug, and two-thirds of the remainder may show less deterioration (Allen, 1999).
This treatment only appears to benefit clients with mild to moderate dementia, making early diagnosis essential and the effects of the drug appear to be of benefit for a time-limited period (NICE, 2001). Matthews et al. (2000) found benefits for some clients with up to 18-month of drug use. When the drug regime ends, the client’s functioning may fall to below pre-treatment levels, though this may not represent a decline to below the level at which they would have been had they not taken the drugs (NICE, 2001). Evidence suggests that the anticholinesterase inhibitors are capable of effecting the course of AD for some clients, both in terms of cognitive and other functioning for a limited period of time. However, pharmacological treatments do not offer a cure for AD.

The Psychology of Dementia

Until the last decade, dementia research was dominated by the biological medical approach (Cheston and Bender, 1999). However, a number of issues suggest the need for additional understandings of dementia. It is estimated that up to twenty percent of people diagnosed with AD are found at autopsy not to have the associated neuropathology and autopsies have revealed the neuropathological changes of AD in the brains of ‘normal’ older adults (McKann et al. 1984, cited by Harding & Palfry, 1997). Correlations of measures of dementia and degree of neuropathology have been shown to be extremely weak (Kitwood, 1996). It is becoming increasingly clear that neurological damage on its own does not fully explain the causes and course of dementia and associated problems (Cheston and Bender, 1999).

Clare (1999) highlights the growing awareness within psychology that psychological needs have been too often ignored in the care of people with dementia, as outlined by the BPS Professional Affairs Board in 1994. The relocation of dementia as an experience within a personal and social as well as neurological framework has led to new understandings of the behaviour, cognition and affect of people with dementia (Cheston and Bender, 1999), and a range of interventions based on these understandings.

Although the area is marred by a lack of good quality research, initial evidence suggests that a psychological understanding of dementia can have profound impacts on the course of the disease and associated disability. This essay will outline a ‘social model’
theory and psychodynamic theories of the cause of dementia and interventions designed to effect the disease course which arise from these models. Other interventions which also appear to have an influence on the course of dementia will then be discussed.

Social Models of the Cause and Course of Dementia

The ‘social model of disability’, which has become prominent over the past decade, suggests disability is not caused by impairment but rather the circumstances and context surrounding such impairment. Dementia is now increasingly been considered within its socio-cultural context (Oliver, 1990, cited by Downs, 2000). Stokes (2000) summarises this important consideration, stating: “environments may serve to exaggerate, potentially even create, dysfunctional behaviour. Hence, when understanding dementia, environmental circumstances and the quality of social relationship are essential components of the explanatory ‘equation’” (p. 75).

Tom Kitwood’s work has been most influential in raising awareness of the social frame surrounding dementia (Cheston and Bender 1999). Kitwood (1996) summarises the ‘standard paradigm of dementia’ in the formula:

\[ X \xrightarrow{\text{Neuropathic Change}} \text{Dementia} \]

Where \( X \) represents the neurological causative factors. Kitwood critiques this paradigm suggesting it has a simplistic understanding of the relationship between mind and brain, ignores the systems of which all people are a part and assumes a correlation between measures of dementia and degree of neuropathology (Kitwood, 1996). Kitwood’s (1996) alternative and influential model of the causes of dementia is summarised as:

\[ \text{Dementia} = P + B + H + NI + SP \]

Where \( P \) represents personality, \( B \) biography, \( H \) physical health, \( NI \) neurological impairment and \( SP \) social psychology. This model allows a deeper understanding of the personal experience of dementia, and the causes and course of the disease as well as
allowing for a variety of interventions which whilst not affecting the neurological impairment can effect the course of the dementia.

Kitwood suggests that traditional ways of conceptualising dementia and caring for people with dementia, create a damaging ‘Malignant Social Psychology’. The very ‘personhood’ of the person with dementia is said to be attacked within a social environment which can disempower, infantalise and intimidate (Kitwood, 1990). Personhood is defined as the status of recognition, trust and respect that is given to a human being in a social and relational context. Kitwood (1997) has outlined seventeen factors which create this Malignant Social Psychology. These are outlined in table 3.

Table 3 – Seventeen factors contributing to the Malignant Social Psychology in the traditional care of people with dementia

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treachery</td>
<td>Using forms of deception in order to distract or manipulate a person, or force them into compliance.</td>
</tr>
<tr>
<td>Disempowerment</td>
<td>Not allowing a person to use the abilities that they do have; failing to help them to complete actions that they have initiated.</td>
</tr>
<tr>
<td>Infantalisation</td>
<td>Treating a person very patronisingly (or matronisingly), as an insensitive parent might treat a very young child.</td>
</tr>
<tr>
<td>Intimidation</td>
<td>Inducing fear in a person, through the use of threats or physical power.</td>
</tr>
<tr>
<td>Labelling</td>
<td>Using a category such as dementia, or ‘organic mental disorder’ as the main basis for interacting with a person and for explaining their behaviour.</td>
</tr>
<tr>
<td>Stigmatisation</td>
<td>Treating a person as if they were a diseased object, an alien or an outcast.</td>
</tr>
<tr>
<td>Outpacing</td>
<td>Providing information, presenting choices, etc. at a rate too fast for a person to understand; putting them under pressure to do things more rapidly than they can bear.</td>
</tr>
<tr>
<td>Invalidation</td>
<td>Failing to acknowledge the subjective reality of a person’s experience, and especially what they are feeling.</td>
</tr>
<tr>
<td>Banishment</td>
<td>Sending a person away, or excluding them – physically or psychologically.</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Objectification</td>
<td>Treating a person as if they were a lump of dead matter: to be pushed, lifted, filled, pumped or drained, without proper reference to the fact that they are sentient beings.</td>
</tr>
<tr>
<td>Ignoring</td>
<td>Carrying on (in conversation or action) in the presence of a person as if they were not there.</td>
</tr>
<tr>
<td>Imposition</td>
<td>Forcing a person to do something, overriding desire or denying the possibility of choice on their part.</td>
</tr>
<tr>
<td>Withholding</td>
<td>Refusing to give asked-for-attention, or to meet an evident need.</td>
</tr>
<tr>
<td>Accusation</td>
<td>Blaming a person for actions or failures of action that arise from their lack of ability, or their misunderstanding of the situation.</td>
</tr>
<tr>
<td>Disruption</td>
<td>Intruding suddenly or disturbingly upon a person’s action or reflection; crudely breaking their frame of reference.</td>
</tr>
<tr>
<td>Mockery</td>
<td>Making fun of a person’s ‘strange’ actions or remarks; teasing, humiliating, making a joke at their expense.</td>
</tr>
<tr>
<td>Disparagement</td>
<td>Telling a person that they are incompetent, useless, worthless, etc., giving them messages that are damaging to their self-esteem.</td>
</tr>
</tbody>
</table>

Based on this understanding, Kitwood suggests interventions for dementia which focus on adjusting the social and environmental context within which people live (Cheston and Bender, 1999). Working within this understanding, a number of interventions seem appropriate and able to affect the course of the dementia (Cheston, 1997), including helping care staff to think about their care practices and their effects, using a technique called Dementia Care Mapping, and then moving to create a culture which enhances personhood. Kitwood (1997) suggests that people with dementia need an environment that meets their psychological needs for love, attachment, comfort, identity, occupation, and inclusion, and that an environment which provides each individual with these factors can be considered to be person-centred and not malignant. Cheston (1997) suggests that in such environments, the dementia ‘sufferer’ can experience ‘rementia’, or positive changes in their functioning, clearly an example of the course of dementia being
effected. Kitwood (1997) also uses the term rementia and cites studies demonstrating this occurrence within ‘person-centred’ caring environments.

Research evidence is starting to appear which offers some support for Kitwood’s theory about the causes of dementia. For example evaluation of the ‘Domus Project’, a sheltered housing project aiming to support people with dementia in small living situations where the care is designed to maximise the client’s independence and allow them to remain in control of their lives, suggested lower rates of depression, increased rates of meaningful interaction and lower rates of decline than in traditional settings (Murphy, Lidesay & dean, 1994, cited by Kitwood, 1997), and therefore an effect on the disease course.

Psychodynamic Conceptualisations of the Cause and Course of Associated Symptoms of Dementia

A psychodynamic understanding of dementia suggests that dementia results in decreased ego functioning, together with decreasing mastery over the environment and increasing dependency. Theorists suggest that the weakened ego uses defense mechanisms to defend itself and that to some extent, those used depend on the stage of the dementia (Cheston, 1998). Insight oriented psychological treatments for people in the initial stages of dementia hinge on the assumption that ego functions can be maintained within an environment in which the client feels understood and supported (Hausman, 1992, cited by Kasl-Godley & Gatz, 2000), and therefore that the course of the disease can be effected. These treatments have been offered in both group and individual formats and in a variety of settings (Kasl-Godley & Gatz, 2000).

The sense of self is also affected by the progress of the disease, so as well as aiming to support helpful defenses, therapy often aims to support reorganisation of the sense of self to incorporate the disease and its effects (Solomon & Szwabo, 1992, cited by Kasl-Godley & Gatz, 2000). Psychodynamic psychotherapy (Sinason, 1992) and emotional support groups (Yale, 1991, cited by Cheston and Bender, 1999) have also been offered for people with dementia. Therapy is subject to some alterations in order to make it most
appropriate for people with dementia, including using more concrete and less abstract interpretations.

Psychodynamic approaches, have not been tested in controlled clinical trials, and few case studies have been published (Kasl-Godley & Gatz, 2000). However, Kasl-Godley & Gatz (2000) describes two studies which provide some tentative initial support for the efficacy of psychodynamic interventions in terms of effecting the cognitive and interpersonal functioning of people with dementia.

Attachment theory can also be drawn upon to understand the personal impact of dementia (Cheston & Bender, 1999) and design interventions to effect its course. Dementia is suggested to be experienced as an increasingly dangerous situation, activating attachment behaviours, for example, shadowing carers, crying and delusions about long dead parents (Miesen 1992, 1993, cited by Cheston and Bender, 1999). Delusions, which have been estimated to occur in 16 to 50% of people with dementia, (Cheston and Bender, 1999) may arise as attachment behaviours. Initial small-scale studies have suggested improvements with 'Stimulated Presence Therapy', where a tape of the person's caregiver is played (Woods & Ashley, 1995). Authors suggest this may be because the tape helps clients to manage their attachment anxiety, thereby reducing the behavioural manifestations of distress.

**Other Interventions which may effect the course of dementia and associated symptoms**

**Memory Interventions**

Impairment of memory is the universal symptom of AD. Episodic memory is usually impaired in the early stages of AD (Brandt & Rich, 1995), with procedural memory being relatively well preserved (Morris, 1996, cited by Clare, 1999). Interventions designed to support a person's memory aim to build on remaining strengths. However, many of the strategies used to enhance memory in often non-demented adults are not suitable for use with people with dementia, because they are based on the use of the same memory functions that are impaired (Bäckman, 1992, cited by Kasl-Godley & Gatz, 2000).
Memory techniques used with people with dementia need to be adapted, for example supporting both the encoding and retrieval skills of memory, as well as being extensively trained in, and based on skills that are not impaired (Kasl-Godley & Gatz, 2000).

The range of interventions offered to help maintain or enhance the memories of people with dementia is too extensive to discuss in detail. However, widely used memory interventions have included the use of external aids such as diaries, cognitive remediation programmes and environmental adaptations, such as the use of signs (Kasl-Godley & Katz, 2000). Caregivers also play an imperative role in supporting the memory of the person with dementia, for example they may need to draw the person's attention to the aids.

Memory strategies based on supporting the person with dementia to learn to use their remaining memory skills, particularly implicit memory skills, to manage everyday life are often used with people with dementia (Devreese, Neri, Fioravanti, Belloi & Zanetti, 2001), including the techniques of 'expanding rehearsal' and 'errorless learning'. Expanding rehearsal adjusts the retrieval time, whilst information is learned one item at a time, according to whether the item was successfully learned or not. The intervals are filled with an interfering task. The aim is to enable storage of the memory in the less effected implicit memory system (Kasl-Godley & Gatz, 2000). The memories of people with AD may also be enhanced by the use of an errorless learning technique. This is based on the knowledge that implicit memory cannot distinguish correct from incorrect responses (Wilson & Evans, 1996, cited by Devreese et al., 2001) and therefore the hypothesis that if a person is enabled to learn something with no errors, it is more likely that the implicit memory system can store the correct memory (Devreese et al., 2001). Clients are encouraged not to guess answers which they do not know and are exposed to the information as many times as needed.

The use of memory training strategies with people with dementia has been relatively well researched and demonstrated positive outcomes, particularly when intensive cognitive remediation programmes are used with people with mild dementia (Kasl-Godley & Katz, 2000). Quayhagen et al. (1995, cited by Kasl-Godley & Gatz, 2000) offered an 8-month cognitive skills remediation programme to people with dementia and their caregivers.
The person with dementia maintained their levels of cognitive and behavioural functioning and the caregiver's sense of burden and psychological distress did not increase. This compares with those receiving no treatment who reported negative changes in all the areas.

Evidence suggests that expanding rehearsal may be able to help people with AD retain for up to several months small but important pieces of information, such as orientation information (Devreese et al. 2001). However, it appears that there is no spontaneous generalisation, in that the memory for the target information is the only memory improved or supported (Van der Linden & Juillerat, 1998, cited by Devreese et al., 2001). Errorless learning is a new technique, only recently applied to aid people with dementia, although it has been used widely elsewhere e.g. head injury (Devreese et al. 2001). It has not been well researched to date. Further research is needed in order to clarify the efficacy of the technique and the method of its effects.

Memory impairment is one of the fundamental aspects of AD, and a decreasing memory ability has implications for many aspects of the client's life. Initial evidence suggests the possible benefits of a range of memory intervention techniques based both on external aids and procedures which can be used by the client to compensate for their impaired memory functions using their intact memory functions. Supporting the ability of people with AD to remember things can therefore be said to effect the course of the dementia. However, many of the outcome studies in this area are small scale or single case studies, further research using robust methodologies is needed to clarify the benefits of these techniques.

Behavioural/Cognitive Behavioural Interventions

Behavioural interventions based on the principles of operant conditioning are used with people with dementia, for example to aim for decreases in aggression or inappropriate sexual behaviour, as are problem-solving, behavioural rehearsal and relaxation training (Kasl-Godley & Gatz, 2000). Behavioural interventions are often based on the premise that the environment may be inadvertently providing reinforcers for inappropriate rather than appropriate behaviours. Gatz et al. (1998) compared the evidence for behavioural
interventions used with people with dementia against the Division of Clinical Psychology of the American Psychological Association's criteria (1996) against which they suggest treatments can be compared to demonstrate whether they are well-established, probably efficacious, or not established. Authors concluded that behavioural treatments used for the remediation of behavioural problems can be considered well-established. See appendix 3 for the criteria for 'well-established'.

Behavioural interventions have been shown to alleviate depression for people with dementia. It has proven difficult to reliably estimate the rates of depression in people with dementia, but estimates of up to 24% have been suggested (Allen & Burns, 1995). Depression appears more prevalent when people are in the early stages of AD as they may be more aware of their problems and may be grieving for the loss of their intellectual abilities and feelings of diminishing mastery and control (Kasl-Godley & Gatz, 2000). Teri, Logsdon, Uomoto, and McCurry (1997) demonstrated the effectiveness of behavioural treatments of depression in patients with AD, who were living at home with family carers, as compared to a waiting-list control group and a group receiving the standard interventions. The treatments focused on pleasant-event scheduling or utilising problem-solving strategies. Interestingly, the authors also found that the interventions reduced depression in caregivers.

People with dementia have also been offered approaches based on cognitive behavioural principles, such as identifying and modifying distorted negative thinking (e.g. Beck, Rush, Shaw & Emery, 1979, cited by Kasl-Godley & Gatz, 2000). Cognitive-behavioural strategies have been shown to be efficacious for the treatment of depression in people with mild dementia (Teri, 1994, cited by Kasl-Godley & Gatz, 2000), compared to a control group.

Interventions for Carers

The reciprocity in the relationships between the person with dementia and their carer is becoming increasingly known. Dunkin & Anderson-Hanley (1998) highlight the impact that the carer can actually have on the course of AD, including on behaviour problems and agitation. For example, they summarise research demonstrating that carers high on EE (Expressed Emotion), defined as over-involvement and critical and hostile attitude
toward the person cared for, report more distress and experience of care-giver burden, and that this may be correlated with a worse disease course. Interventions which influence the caregivers may therefore influence the course of the dementia, through their impact on the environment within which the person with dementia lives.

The task of caring for a family member who has dementia is a challenge which can create social and clinical problems (Mitrani & Czaja, 2000). Carers of people with AD experience greater physical and psychological morbidity than matched controls (Dunkin & Anderson-Hanley, 1998). Carers face changes in their occupational, social, family and financial lives, as well as coming into contact with a confusing maze of caring services. These stresses are built on a possible foundation of areas of previous tensions and conflict within the relationships. The level of such stresses are effected by a number of factors, but the level of behavioural disturbance, for example repetitive questioning, or wandering appears to be the strongest predictor of distress in the caregiver (e.g. Teri et al, 1992, cited by Mitrani & Czaja, 2000). Carers who tend to use problem-focused coping methods also seem to be less distressed than those who use emotion-focused coping (Kramer, 1997, cited by Mitrani & Czaja, 2000). As awareness of dementia has progressed, there is also increasing focus on the support needs of those caring for someone with dementia and evidence suggests carers benefit from supportive interventions. A family-therapy approach for the carers of people with dementia has demonstrated its efficacy (e.g. Czaja et al., 2000, cited by Mitrani & Czaja, 2000), through its ability to facilitate a decrease in family conflict and increase the support carers receive from their families (Mitrani & Czaja, 2000).

Carers support is increasingly being offered by bringing carers together into support groups, although the activities of the groups vary widely, and can include education, addressing emotional reactions to the diagnosis, or the sharing of coping skills (Morris & Woods, 1992). Groups using a problem-solving approach, supporting carers to explore solutions to their problems, have assisted carers to make a difference to a variety of dementia related problems (Zarit & Zarit, 1982, 1985, cited by Morris & Woods, 1992). Morris & Woods (1992) offered their 'Ways of Coping Course', which focused on coping with problems behaviours, stress management and interactions with family members and professionals involved in the person’s care, to 13 carers of people with dementia.
Outcomes were compared with a matched group of 18 carers who attending an 'information group' offering educationally focused seminars about dementia. Each group consisted of 5 sessions. Both groups appeared to benefit in that they showed an increase in problem-focused coping and a decrease in distancing coping strategies. However, no follow-up appears to have been conducted.

**Conclusions**

The past decade has seen a radical transformation of the care services offered for people with dementia, as well as their families and carers, as the recognition that people with dementia have more than just physical needs has grown. Increasingly the devaluation of people with dementia has been recognised, leading to increasingly efforts to offer interventions which focus on the person with dementia, rather than the illness. Although traditional medicine is now able to offer pharmacological treatments which can have some positive impacts for some people with dementia, the traditional paradigm (Kitwood, 1997) which simplistically views dementia as stemming from damage to the brain, has been demonstrated to be an inadequate explanation of all the facets of dementia. There is growing recognition of the range of other factors which can impact on the course of the disease (Kasl-Godley & Gatz, 2000).

Until recently, research about dementia was concerned solely with cognition, and ignored any other aspects of the human experience such as relationships and emotions (Kitwood, 1995). Within this context grew the belief that dementia did just take its course. Woods (1995) highlights the extreme devaluation of people with dementia and states that the dominant view has been: “nothing could be done to change the course of dementia; it was not worth the effort of even trying to achieve something more positive” (p. 116). Woods concludes, however, that this 'therapeutic nihilism' is not supported by the current understandings and thoughts about working with people with dementia and their families. Dementia may not be able to be cured, in the sense that the neurological damage remains, but this does not mean that the disease just takes its course.

This essay has argued that the traditional model of dementia was inadequate, by discussion of alternative models which add depth to an understanding of dementia,
together with interventions based on these models and on other psychological models and some evidence of the effectiveness of these interventions. The course of dementia, including cognitive decline, depression, behavioural problems and distress can be effected by interventions which work on an individual level, a social/ contextual level and a systemic level. The needs of people with dementia may change as the disease progresses, but the range of available interventions suggests that the disease course can be effected at all stages of dementia.

A range of other interventions offered for people with dementia have not been discussed due to the space constraints of the essay, including reminiscence and life review approaches, music therapy, Resolution Therapy, a technique based on Rogerian counselling techniques, Reality Orientation and Validation Therapy. The impact that psychological and other understandings can make when the diagnosis of dementia is shared has also not been discussed due to space constraints, although evidence suggests that the way a family is informed of a diagnosis can have dramatic effects (Davis, 1993). Instead examples have been used to demonstrate the ways that both the causes and course of dementia can be conceptualised within psychological models and therefore psychological thinking can be used to design interventions which effect the course of dementia.

Finally, this essay has also highlighted the current lack of good quality research investigating the efficacy and effectiveness of the range of interventions offered for people with dementia, and their carers. This developing field would benefit from being able to learn from such research and to further develop the range of interventions which effect the course of a dementia.
REFERENCES


APPENDIX CONTENTS

APPENDIX 1  -  CAUSES OF DEMENTIA

APPENDIX 2 - DSM – IV Definition of Alzheimer’s Disease

APPENDIX 3 - Criteria for a ‘Well-Established’ Treatment
# APPENDIX 1

## OUTLINE OF SOME OF THE CAUSES OF DEMENTIA

**FROM JACKSON AND JACQUES, 2000**

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>TYPE OF DAMAGE</th>
<th>TREATMENT AVAILABLE?</th>
<th>POTENTIAL MEDICAL TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer's Disease</td>
<td>Plaques, tangles, transmitter defects, abnormal amyloid deposition</td>
<td>Yes</td>
<td>Anticholinesterases, nerve growth factor</td>
</tr>
<tr>
<td>Vascular Dementia</td>
<td>Multiple infarcts, stroke, small vessel disease</td>
<td>Yes</td>
<td>Aspirin, lower blood pressure, lower cholesterol</td>
</tr>
<tr>
<td>Lewy Body Dementia</td>
<td>Lewy bodies, transmitter defects</td>
<td>Yes</td>
<td>Anticholinesterases</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>Lewy bodies especially in basal ganglia</td>
<td>No</td>
<td>Antiparkinsonian drugs do not help dementia</td>
</tr>
<tr>
<td>Frontal Lobe Dementia</td>
<td>Various, including Pick's</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Normal Pressure Hydrocephalus</td>
<td>Obstructed cerebrospinal fluid flow due to previous damage, e.g. subarachnoid haemorrhage, meningitis</td>
<td>Yes</td>
<td>Surgery (shunt)</td>
</tr>
<tr>
<td>Punch-drunk Syndrome</td>
<td>Repeated head injury</td>
<td>Yes</td>
<td>Stop the damage</td>
</tr>
<tr>
<td>Slow-growing brain tumour</td>
<td>Pressure causes destruction of brain</td>
<td>Yes</td>
<td>Surgery</td>
</tr>
<tr>
<td>Condition</td>
<td>Type of Effect</td>
<td>Is Yes?</td>
<td>Treatment/Prevention</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Aluminium and Other Metals</td>
<td>Direct toxic effect</td>
<td>Yes</td>
<td>Remove the poison</td>
</tr>
<tr>
<td>Wilson's Disease</td>
<td>Toxicity of copper</td>
<td>Yes</td>
<td>Penicillamine</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>Toxic effect and thiamine</td>
<td>Yes</td>
<td>Abstinence, thiamine treatment</td>
</tr>
<tr>
<td></td>
<td>deficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Huntingdon's Chorea</td>
<td>Genetic abnormality</td>
<td>No</td>
<td>Screening available</td>
</tr>
<tr>
<td>Syphilis (GPI)</td>
<td>Infective</td>
<td>Yes</td>
<td>Antibiotics</td>
</tr>
<tr>
<td>AIDS</td>
<td>Infective, secondary infection</td>
<td>Yes</td>
<td>Anti-AIDS drugs</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CJD</td>
<td>Infective</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Vitamin (e.g. B12 deficiencies)</td>
<td>Toxic</td>
<td>Yes</td>
<td>Replacement</td>
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<td></td>
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<td></td>
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<tr>
<td>Hypothyroidism</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Parathyroid Disorders</td>
<td>Calcium metabolism altered</td>
<td>Yes</td>
<td>Medical or surgical</td>
</tr>
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</table>
APPENDIX 2

DSM-IV DEFINITION OF DEMENTIA OF THE ALZHEIMER'S TYPE
American Psychiatric Association, 1994

A. The development of multiple cognitive deficits manifested by both
   (1) memory impairment (impaired ability to learn new information or to recall
       previously learned information)
   
   (2) one (or more) of the following cognitive disturbances:
      
      (a) aphasia (language disturbance)
      (b) apraxia (impaired ability to carry out motor activities despite intact motor
          function)
      (c) agnosia (failure to recognise or identify objects despite intact sensory
          functioning)
      (d) disturbance in executive functioning (i.e. planning, organising, sequencing,
          abstracting)

B. The cognitive deficits in Criteria A1 and A2 each cause significant impairment in
   social or occupational functioning and represent a significant decline from a previous
   level of functioning.

C. The course is characterized by gradual onset and continuing cognitive decline.

D. The cognitive deficits in criteria A1 and A2 are not due to any of the following:

   (1) other central nervous system conditions that cause progressive deficits in
       memory and cognition (e.g. cerebrovascular disease, Parkinson’s disease,
       Huntingdon’s disease, subdural hematoma, normal pressure hydrocephalus,
       brain tumor)

   (2) systemic conditions that are known to cause dementia (e.g. hypothyroidism,
       vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia,
       neurosyphilis, HIV infection)

   (3) substance-induced conditions
E. The deficits do not occur exclusively during the course of a delirium.

F. The disturbance is not better accounted for by another Axis 1 disorder (e.g. Major Depressive Disorder, Schizophrenia)

**Code** based on type of onset and predominant features:

**With Early Onset:** if age of onset is at 65 years or below.

- **290.11 With Delirium:** if delirium is superimposed on the dementia
- **290.12 With Delusions:** if delusions are the predominant feature
- **290.13 With Depressed Mood:** if depressed mood (including presentations that meet full symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.
- **290.10 Uncomplicated:** if none of the above predominates in the current clinical presentation.

**With Late Onset**

- **290.3 With Delirium:** if delirium is superimposed on the dementia
- **290.20 With Delusions:** if delusions are the predominant feature
- **290.21 With Depressed Mood:** if depressed mood (including presentations that meet full symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.
- **290.0 Uncomplicated:** if none of the above predominates in the current clinical presentation.

*Specify* if (can be applied to any of the above subtypes):

**With Behavioural Disturbances:** if there is clinically significant behavioural disturbance (e.g. wandering).
APPENDIX 3

Criteria for ‘Well-Established Treatment’
Outlined by the Division of Clinical Psychology of the American Psychological Association


1. At least two good group design experiments demonstrating efficacy in one or more of the following ways:
   
   A. Superior to pill or psychological placebo or to another treatment
   B. Equivalent to an already established treatment in studies with adequate statistical power
   
   OR

2. A large series of single case design experiments (greater than 9) demonstrating efficacy. These studies must have:
   
   A. Used good experimental designs and
   C. Compared the intervention to another treatment as in 1A

FURTHER CLARIFICATION FOR BOTH 1 and 2

3. Experiments must be conducted with treatment manuals
4. Characteristics of the client samples must be clearly specified
5. Effects must have been demonstrated by at least two different investigators or investigatory teams
OVERVIEW OF THE CLINICAL DOSSIER

This dossier consists of the summaries of each of the six placements completed during the three years of my clinical psychology training and a summary of the four case reports, which are contained in the confidential volume 2 of my portfolio. A case report was written during each of the core placements (adult mental health, people with learning disabilities, children and families and older people) and represents one of the psychological interventions undertaken during these placements.

These documents are presented in the order of the placements undertaken.
CORE ADULT MENTAL HEALTH PLACEMENT

Placement Details

Dates: October 2000 – March 2001

Supervisor: Robert Marsh (Clinical Psychologist)

Region: Brighton, East Sussex

Summary of Placement Experience

The placement provided valuable experience of working within cognitive behavioural, psychodynamic, cognitive-analytic and solution focused perspectives with a variety of adult mental health problems in the context of an outpatient psychology department. Clinical work comprised of assessment for treatment interviews, offering short term interventions, psychometric assessments with both outpatients and inpatients and co-facilitation of an 'assertiveness skills' group based on cognitive-behavioural principles. In addition the placement experience included teaching second year postgraduate counselling diploma students regarding the cognitive behavioural therapy understanding of panic disorder.

Clinical Skills and Experience

Experience was gained of a range of presenting problems including depression, panic disorder, obsessive compulsive disorder, eating disorders, post traumatic stress disorder, specific phobia, bereavement issues and chronic fatigue syndrome. A variety of assessment procedures were used including WAIS-III, WASI, NART, RMT, Hayling-Brixton, BAI, BDI, HADS, Panic Rating Scales, SEDS (Stirling Eating Disorders Scale) and TABS (Trauma Attitudes and Beliefs Scale).
Meetings, Seminars, Visits and Research

Meetings were arranged with a variety of local professionals and organisations as an aspect of the placement induction. In addition fortnightly CMHT meetings and monthly psychology meetings were attended.

An evening seminar on ‘Sexual Relationships after Traumatic Brain Injury’ and a lunchtime seminar on ‘Borderline Personality Disorder: Psychopharmacological and Psychological Therapies’ were also attended during this placement.

My service related research project: ‘Exploration of clients’ experiences of their initial assessment session and subsequent wait for therapy within a psychology department’ was conducted whilst on this placement.
Case Report Summary

Year 1 – Adult Mental Health Case Report

The Assessment and Treatment of Anxiety using Cognitive Behavioural Therapy with a 45-Year Old Female Client

All personal details have been altered to preserve the anonymity of the client

Referral

Ms Picard was referred by her GP because she had been experiencing panic attacks. It was not until the fourth session that Ms Picard disclosed she had also been experiencing symptoms consistent with a diagnosis of OCD (Obsessive Compulsive Disorder). She had experienced these symptoms for approximately 20 years but had never previously discussed them with anyone.

Assessment

Ms Picard attended two assessment sessions. These focused on exploring the presenting issues, her history and current life. Ms Picard had been diagnosed with Rheumatoid Arthritis 20 years previously.

Assessment Tools

Following these sessions, Ms Picard completed the Beck Depression Inventory – Second Edition (BDI-II), (Beck, Steer & Brown, 1996) obtaining a score of 29, indicating severe depression and the Beck Anxiety Inventory (BAI) (Beck & Steer, 1987), obtaining a score of 31, indicating severe anxiety. However, due to Ms Picard’s physical health needs, these scales may have over-estimated her depression or anxiety due to their inclusion of biological symptoms. She also therefore completed the Hospital Anxiety and Depression Scale (HADS) (Snaith & Zigmond, 1994). Her depression and anxiety scores...
of 10 and 20 respectively indicated mild depression and severe anxiety. Ms Picard also completed the 'Panic Rating Scale' (Wells, 1997)

Formulation

Given studies demonstrating the efficacy of cognitive behavioural approaches for people experiencing panic disorder (Roth & Fonagy, 1995) or OCD (Abramowitz, 1998), Ms Picard's anxieties were understood from a cognitive-behavioural perspective.

Ms Picard's panic symptoms were formulated within Clark & Ehlers (1993) panic cycle. The formulation hypothesised that Ms Picard's previous experiences predisposed her to interpret some thoughts or changes in physiology in a catastrophic manner, triggering a panic cycle. Ms Picard's OCD symptoms were formulated within Salkovskis et al.'s (2000) model of OCD. This suggests that the appraisal that one is responsible for causing or preventing harm marks out people who have OCD. Ms Picard appeared to feel such a level of responsibility and her experiences as a young child were hypothesised as important in this development.

Intervention

Ms Picard attended 13 treatment sessions, all conducted independently by the trainee. A focus for sessions was agreed with Ms Picard, focusing mainly on her panic attacks but also exploring her obsessions and compulsions.

Initial sessions centred on further developing the therapeutic relationship with Ms Picard, socialising her to the model (Wells, 1997), psychoeducation regarding how our bodies react to anxiety (Clark, 1989) and using behavioural experimentation to illustrate the problems with trying to suppress thoughts (Tallis, 1992). A further focus was on normalising Ms Picard's experiences. She was encouraged to talk to other people both about their experiences of anxiety and also about whether they had thoughts about hurting their children, allowing her to discover how normal her experiences were. Verbal reattribution techniques were used to challenge some of Ms Picard's dysfunctional beliefs (Wells, 1997) and a panic diary was instigated.
During the intermediate sessions, the consequences of Ms Picard's decreasing involvement in activities which she had found relaxing were explored. Verbal reattribution techniques were continued, as was exploration of rational responses to Ms Picard's thoughts during panic attacks. 'Coping Cards' were introduced to help Ms Picard access rational interpretations when panicking, as recommended by Beck (1995). The technique of 'exposure and response prevention' (Salkovskis & Kirk, 1989) was introduced as a technique to manage Ms Picard's OCD symptoms. In the following session Ms Picard reported a dramatic change in her compulsion to act upon, and a greater sense of control over her urges.

Relapse prevention and issues around termination were the focus of the final four sessions. A 'Therapy Blueprint' was designed with Ms Picard to reinforce her contribution to progress and highlight the techniques she found useful (as recommended by Wells, 1997).

**Outcome**

Ms Picard again completed the BDI-II, BAI, HADS and Panic Rating Scale in the final sessions. Her score of two on the BDI-II indicated minimal depression, and her score of two on the BAI indicated minimal anxiety. Her depression score on the HADS placed her within the 'normal' range as did her anxiety score of one. The Panic Rating Scale indicated that Ms Picard's interpretations of sensations and resultant behaviours had changed. She no longer felt she would have a heart attack, loose control, go crazy or scream when anxious and no longer believed that her panic attacks would never end.

In the 11\textsuperscript{th} session Ms Picard reported that she was panic free and remained so for the remainder of the sessions. She also reported that her obsessive thoughts had decreased in frequency and that she usually felt able to ignore them, noting that her obsessions and compulsions decreased in strength as she managed to ignore them. She said that she also now realised the importance of having time for herself to participate in activities she found relaxing and that she had particularly gained from her increasing confidence which enabled her to face situations she had been avoiding.
Salkovskis, Forrester, Candida-Richards and Morrison (1998) suggest it is relatively rare for panic symptoms and OCD to be co-morbid, but that where this occurs: "it is usually beneficial to begin by cognitive formulation of the panic, then incorporating appropriate normalisation material where needed" (pp. 69). Outcomes suggested this approach was useful for Ms Picard.

**Prognosis**

Ms Picard became increasingly aware of factors that contributed to or maintained her anxiety symptoms during therapy and had learnt to be her own therapist. She had become increasingly able to discuss her problems with other people and was committed to decreasing avoidance and facing what she feared. These factors suggested a good prognosis. However relapse rates for panic disorder can be high (Wiborg & Dahl, 1996) and Ms Picard's worry about the ending of sessions and commitment to anxiety medication suggested she remained vulnerable to experiencing anxiety symptoms in the future.

**Reformulation**

Ms Picard's needs were reformulated from within a psychodynamic perspective, suggesting that she could have been offered potentially useful therapy using a different model to understand her presenting symptoms and presented history.

**REFERENCES**


CORE LEARNING DISABILITY PLACEMENT

Placement Details

Dates: April 2001 – September 2001

Supervisor: Celia Heneage (Clinical Psychologist)

Region: Worthing, West Sussex

Summary of Placement Experience

This placement provided invaluable experience of working with people with mild, moderate and severe learning disabilities, their families, carers and professional support systems. This included involvement with the team’s ‘Consultation Model’, offering intervention based on systemic principles. In addition the placement provided experience of adapting and facilitating an ‘emotional literacy’ group for 6 people with learning disabilities as well as allowing further experience of psychometric assessments. The placement provided experience of work with both adults and children with learning disabilities.

Clinical Skills and Experience

The placement provided experience of using systemic theory, narrative therapy, emotional literacy ideas, cognitive behavioural therapy, psychodynamic ideas, behavioural theory and attachment theory ideas in work with clients referred because of a range of presenting needs, including bereavement, anger problems and challenging behaviours. Assessment tools used included behavioural and coping skills questionnaires. Evaluation of the work was conducted through the use of the questionnaires the team have developed for service users and others, as well as through the use of questionnaires designed by the trainee for specific pieces of work. A variety of psychometric assessment procedures were used including the WAIS-III, WMS III, DMR.
Meetings, Seminars, Visits and Research

In addition to meetings with professionals and services arranged as an aspect of the placement induction, throughout the placement monthly psychology meetings and multi-disciplinary meetings were attended. The placement also offered the opportunity for participation in the learning disability psychology team 'away day', including discussion of the implications of the 'Valuing People' white paper.

Experiences of teaching and presentation during the placement included feeding back results of psychometric assessment to staff teams, a presentation to the psychology team regarding 'consent' and arranging a training day for care workers regarding 'understanding client's needs'.

During the placement I attended a conference titled: 'Valuing People: a new strategy for learning disabilities for the 21st century'.
Case Report Summary

A Systemic Approach to Working with a 30-year old Woman with Learning Disabilities, Referred Because of ‘Bereavement Issues’, and Her Staff Team, Using Ideas from Narrative Theory and Emotional Literacy

All personal details have been altered to preserve the anonymity of the client

Referral

Ms Kirk, a woman with a mild/moderate learning disability, was referred because the staff team of her residential home were concerned that she had not come to terms with the deaths of her mother and grandmother, who had died respectively 15 and 5 years prior to the referral.

Assessment

Ms Kirk and a support worker from her home attended an assessment session conducted by the trainee. The trainee also talked with the manager of Ms Kirk’s home and read Ms Kirk’s case notes.

The assessment addressed the current concerns of Ms Kirk and her support staff, the residential team’s understanding of Ms Kirk’s learning disability and her communication skills, Ms Kirk’s history, her daily life and important relationships. The assessment also focused on exploring the considerable previous contact that the staff team had with the community learning disability team.

Formulation

The difficulties presented were understood within a systemic framework, using narrative ideas (White, 1997; Freedman & Combs, 1996) and ‘emotional literacy’ ideas (Cooper &
Sawaf, 1997; Goleman, 1996), emotional literacy being understood as the ability to know, understand and communicate with others about feelings.

Ms Kirk’s team presented with a ‘problem saturated story’ (McLeod, 1996). The problem narrative, as understood in this formulation, suggested that Ms Kirk’s current upset stemmed from past bereavements and that only ‘experts’ could help. The staff team were not seen as ‘experts’. Alternative stories were being silenced, including those that suggested other reasons for Ms Kirk’s upset and allowed the staff’s ability to support Ms Kirk to understand and cope with her emotions.

Ms Kirk’s communication difficulties arising within the context of her learning disabilities were understood as making it hard for her to fully express what she was feeling. This was understood as strengthening the problem story and also Ms Kirk’s distress.

A model of the hypothesised maintenance of the difficulties within the system was offered, based on systemic notion of ‘circular causality’ (MacKinnon & James, 1987, cited by Donati, Glynn, Lynggard & Pearce, 2000).

**Intervention**

Based on this formulation a systemic intervention was initiated, using both narrative therapy ideas and emotional literacy ideas. Three sessions with Ms Kirk and her keyworker and a ‘feedback’ session with the broader staff team were offered. All these sessions were conducted independently by the trainee. In addition the trainee had several conversations with the manager of the residential home. The model of work that the psychologists of the community learning disability team used precluded offering further sessions.

The emotional literacy ideas aimed to increase Ms Kirk’s ability to understand and cope with her emotions as well as to increase the emotional literacy present in her environment. The trainee introduced feelings symbols for happy, sad, afraid and angry (Mayer-Johnson, 1996). These were the basis for discussions about what the feelings were like and what events might cause them. They also became the basis for work
conducted by Ms Kirk and her support workers outside of the sessions, including completing feelings sheets (outlining for example what made Ms Kirk happy or sad) and a feelings diary.

The narrative intervention aimed to strengthen the alternative stories about the problems that were present within the staff team. The trainee asked deconstruction questions, questions which opened space for other stories, preference questions, questions to develop preferred stories and meaning questions, as well as ensuring that the conversations created an audience for the preferred story (see Freedman & Combs, 1996). During the conversations the problem story was named 'losing Ms Kirk', but a counter story told of the many times that 'losing Ms Kirk' did not happen. Stories about the competence of the staff team and their success in supporting Ms Kirk were also given space.

**Evaluation of Work**

As standardised questionnaires were not felt to be an appropriate way of measuring the outcome of this work, the trainee designed an questionnaire to be completed by the staff team before and after the intervention. The questionnaire asked staff how confident they felt in their ability to support Ms Kirk when she was upset, how much they felt they understood the reasons why she got upset, how much her feelings could be helped by changing things around her and how well staff felt they understood the needs which Ms Kirk had as a result of her learning disability. This questionnaire was completed by the staff team following the assessment and was also distributed for their completion at the end of the intervention. However, despite requests for the team to complete and return the questionnaires these were not returned by the end of the placement.

The narrative work was judged to have allowed space for different stories about the problem to be told and heard, suggesting significant development in the staff team’s perceptions of their role in supporting Ms Kirk with emotions and confidence to do so. The emotional literacy ideas had also been well received by the staff team.
Prognosis

Following this intervention, however, the manager of the home said she had applied for funding, hoping to arrange private counselling for Ms Kirk. Given the power of the managers views it was felt that the team would continue to believe that Ms Kirk needed 'expert' help.

Reformulation

The presenting issues were reformulated from within a psychoanalytic perspective, specifically using ideas about the socially structured defense mechanisms which can become used in institutions to protect people from the anxieties such settings can evoke (Menzies-Lyth, 1988). Within this perspective the excessive demands for 'experts' to work with the clients who lived in the home was understood as a defensive manoeuvre which kept staff distant from the pain of their clients.

REFERENCES


CORE CHILD AND FAMILY DISABILITY PLACEMENT

**Placement Details**

*Dates:* October 2001 – March 2002

*Supervisors:* Jane Wallace (Clinical Psychologist) and Hugh Milburn (Clinical Psychologist)

*Region:* Uckfield and Hastings, East Sussex

**Summary of Placement Experience**

This placement provided invaluable experience of working with children, their families and professional supports using cognitive behavioural therapy, narrative therapy, attachment theory and systemic approaches with a variety of presenting problems in both a CAMHS and an EBD (Emotional and Behavioural Difficulties) school setting. Clinical work comprised of assessment interviews, short-term interventions, psychometric assessment, family therapy work and organisational work within the school setting. In addition the work included arranging and co-facilitating a ‘temper taming’ group for nine 13 and 14 year old boys in one year group of the EBD school, based on narrative and cognitive-behavioural principles. The ages of children worked with throughout the placement ranged from 7 to 17 years.

**Clinical Skills and Experience**

Experience was gained of a range of presenting problems including anger problems, anxiety, obsessive compulsive disorder, depression, low self-esteem, aggression, conduct disorder, behavioural difficulties, pervasive refusal syndrome and school refusal. In addition a psychometric assessment was carried out with a boy with suspected frontal lobe damage. A variety of assessment procedures were used including SCAS (Spence Children’s Anxiety Scale), Birleson Depression Scale, Bene-Anthony Family Relations Test, WISC, WORD, WOLD, WOND and Wisconsin Card Sorting Test.
Meetings, Seminars, Visits and Research

In addition to meetings with professionals and services arranged as an aspect of the placement induction, weekly referral and allocation meetings and a psychology meeting were attended. The placement also included a visit to the local adolescent in-patient unit.

A presentation on 'attachment theory' was offered for a group of health visitors and evaluated using specifically designed questionnaires. Feedback was positive.

'Emotional literacy' training offered for all staff at the EBD school was also attended.
Case Report Summary

Year 2 – Child and Family Case Report

Case Report of the Psychometric Assessment of an 8-year-old Boy with Behavioural Problems and Suspected Frontal Lobe Damage

All personal details have been altered to preserve the anonymity of the client

Referral

Benjamin Sisko and his family were attending Family Therapy Sessions because of relationship difficulties within the family and Benjamin’s behavioural difficulties. The team noted that Benjamin’s speech was sometimes difficult to understand. Benjamin’s mother thought his behaviour might be caused by frontal lobe damage. Psychometric testing was requested to ascertain whether there was evidence of frontal lobe damage or specific language difficulties or whether a better understanding of Benjamin’s patterns of abilities could inform interventions.

Presenting Problems

Benjamin’s mother reported that Benjamin had a number of behavioural problems, including aggression towards his sister, stealing and frequent running away. Benjamin was currently in danger of being excluded from school due to his behavioural difficulties.

History

The assessment explored the history of the presenting problems, Benjamin’s medical and developmental history as well as his personal and family history.

Benjamin, his older sister and his mother were involved in a car accident when Benjamin was a baby. His sister suffered a head injury causing cognitive and physical symptoms and continued to receive on-going support from a specialist head injury organisation,
including regular visits from a health psychologist. Although there was no evidence of any serious injury at the time, Benjamin’s health psychologist had suggested that his behavioural difficulties could be the result of frontal lobe damage.

The CAMHS team had serious concerns about the parenting Benjamin received and had frequently shared their concerns with the Social Service team. It was alleged that Benjamin’s mother used to tape his dummy into his mouth, and that his father had stabbed him in the hand with a fork because he did not like Benjamin reaching across the dinner table. The file noted that Benjamin’s father frequently hit him and did not allow Benjamin to cry, threatening to hit him more if he did.

Hypothesis and Aims

Testing was devised to test the following hypotheses:

1. Benjamin had damage to his frontal lobes
2. Benjamin had a specific language or reading difficulty

It was also felt that clarification of Benjamin’s profile of cognitive and social strength and needs could usefully inform the interventions offered.

Rationale

Based on a review of the relevant literature the trainee administered the following tests over six one and half hour-long sessions conducted independently by the trainee:

1. WISC (Wechsler Intelligence Test for Children, 3rd Edition, Wechsler, 1992)
2. WOLD (Wechsler Objective Language Dimensions, Rust, 1996a)
3. WORD (Wechsler Objective Reading Dimensions, Rust, Golombok & Trickey, 1993)
4. WOND (Wechsler Objective Numerical Dimension, Rust, 1996b)
5. WCST (Wisconsin Card Sorting Test, Benjamin & Berg, 1993)
Presentation During Assessment

Benjamin’s presentation and behaviour during the assessment sessions were noted to inform the interpretation of the test results.

Findings

With the exception of his score on the FDI (freedom from distractibility index), Benjamin’s IQ and index scores on the WISC were within the average or high average range. His FDI score was at the bottom of the low average range. It was noted that the observed level of difference between this index score and the other scores was significant and would be expected in approximately 15% of children (Wechsler, 1992).

Benjamin’s scores on the WOND were within the average range, his scores on the WORD tests were within the average or low average range and his scores on the WOLD were within the average range. Ability-achievement discrepancy analyses were conducted. Benjamin’s obtained scores on the WOND were compared with those expected, given his WISC scores. No significant differences were noted. His obtained scores on the WORD were compared with those which would have been expected given his VIQ (verbal intelligence quotient) score. No significant differences were noted. His WOLD scores were also compared with the expected scores given his VIQ estimate, again there were no apparent discrepancies.

Benjamin’s scores on the WCST were all within one standard deviation of the mean for non-clinical samples. His scores all fell within the below average to average classifications of a normal range and above the impaired range (Heaton, Chelune, Talley, & Curtiss, 1993).

Discussion

The results failed to support the hypothesis that Benjamin had damage to his frontal lobes or specific learning difficulties. It was suggested that Benjamin’s behaviour difficulties were unlikely to have been caused by frontal lobe damage or his profile of
cognitive abilities. However, it was felt that the knowledge about his strengths and weaknesses that was gained could usefully inform the structuring of interventions. The report discussed Benjamin’s cognitive strengths and needs as suggested by the tests.

**Formulation**

Benjamin’s difficulties were formulated from an attachment theory perspective, whereby Benjamin was hypothesised to display a disorganised attachment style, arising within the context of his experiences of being parented (Lyons-Ruth, 1996). This itself was seen within the context of his mother’s experience of sexual abuse as a child, and her frequent ‘absences’ because of her unstable diabetes mellitus.

**Recommendations**

The profile of cognitive strengths and abilities, together with the formulation, led to a series of recommendations. These included exploring the appropriateness of a diagnosis of ADHD for Benjamin, given that his profile on the WISC is similar to that sometimes seen in children with ADHD. Recommendations also focused on how tasks could be structured to draw on Benjamin’s strengths and the behavioural management strategies which may be likely to most benefit Benjamin, given his profile of abilities.

**Critique**

The critique included consideration of the ethical issues involved in the lengthy testing which at times Benjamin appeared to find aversive, together with the ethical issues which may have arisen had the testing been discontinued given its potential positive impact.

**REFERENCES**


CORE OLDER ADULTS PLACEMENT

Placement Details

Dates: April 2002 – September 2002

Supervisor: Corrie Meesters (Clinical Psychologist)

Region: Worthing, West Sussex

Summary of Placement Experience

The placement provided valuable experience of working using cognitive behavioural, client centred, systemic and behavioural theories as well as of neuropsychological assessment in both an outpatient psychology department and inpatient unit. The work consisted of assessment interviews and short-term interventions both with individuals and with a staff team, as well as neuropsychological assessment with a range of presenting issues. The placement experience included work with clients whose ages ranged from 65 to 87.

Clinical Skills and Experience

Further therapeutic experience was gained of a range of presenting problems including depression with suicidal behaviour, panic disorder, generalised anxiety disorder, social phobia, obsessive compulsive disorder, specific phobia, bipolar affective disorder, and drug and alcohol abuse problems. The placement experience allowed consideration of the specific issues which arise when working therapeutically with older people and appropriate adaptations of such work.

Neuropsychological experience was also gained of a range of presenting issues, including suspected Alzheimers or other Dementias and memory problems. A variety of neuropsychological assessment procedures were used including WAIS-III, MEAMS, RBMT, RCPM, RMT, Doors and People, WTAR, AMIPB and free drawing tests.
Meetings, Seminars, Visits and Research

Meetings were arranged with a variety of local professionals and organisations as a facet of the placement induction. In addition monthly psychology meetings were attended.

As an aspect of the placement an 'Integrative Therapies' training day was attended. This included exploration of the use of cognitive analytic therapy and attachment theory specifically in relation to work with older people. One day of the annual PSIGE conference was also attended.

During the placement the trainee also arranged and delivered a presentation on 'Mindfulness' to 15 professionals including Speech and Language Therapists and Nurses.
Case Report Summary

Year 2 – Older Adults Case Report

The Assessment and Treatment of a 65-year-old Woman Experiencing Symptoms of Depression and Anxiety Using a Client-Centred Approach

All personal details have been altered to preserve the anonymity of the client

Referral

Ms Archer was referred by her GP who said she had been experiencing anxiety.

Presenting Issues

Ms Archer reported feeling low and depressed, not enjoying things as she used to and often being extremely fatigued, regardless of how much she slept. Ms Archer said she sometimes felt panicky but felt that her depression was the main issue and the anxiety symptoms a consequence of this. Rogers (1951) described diagnosis as contra-indicated when using a client-centred approach as it places the locus of evaluation external to the client and within the therapist. It was therefore felt important not to clarify whether Ms Archer’s difficulties would be considered depression, anxiety or both according to normative classification systems, but to accept Ms Archer’s knowledge about herself, demonstrating the philosophy of a client-centred approach.

Initial Assessment

Assessment included exploration of Ms Archer’s previous experience of depression. Ms Archer said she had been depressed from 1994 to 1998 and had received support from the CMHT. Her recovery coincided with her husband’s increasing sickness as a result of his cancer. Her husband subsequently fully recovered.

Assessment also included exploration of Ms Archer’s medical history. She suffered from heart disease, which had necessitated two balloon angioplastys, the last one occurring
one year prior to referral. Ms Archer was diagnosed with an underactive thyroid in 1984 and had been taking medication for this ever since. Ms Archer agreed for the trainee to write to her GP to seek clarification about whether her blood thyroxin levels were within the normal range, given that the symptoms of depression, including fatigue, can present with hypothyroidism (Stanley, 1997). The GP confirmed that her thyroid levels were within the normal range.

Assessment also included exploration of Ms Archer's family history, relationship history and occupational history.

**Assessment Tools**

Ms Archer completed the HADS (Hospital Anxiety and Depression Scale, Snaith & Zigmond, 1994). This was chosen as the HADs assesses anxiety and depression without asking about symptoms which could be due to physical illness (Snaith & Zigmond, 1994). Ms Archer's depression score of 11 indicated moderate depression and her anxiety score of 14 indicated moderate anxiety.

**Formulation**

Ms Archer's presenting issues were formulated from within a client-centred understanding, stemming from the work of Carl Rogers (Mearns & Thorne, 1999). It was hypothesised that Ms Archer grew up in an environment which encouraged the development of many 'conditions of worth' and that she learnt how to conform to others' expectations of her. She may have found it necessary to silence her 'organismic valuing process' in order to gain approval. As a result Ms Archer may have lived for most of her life dependent upon the evaluation of others for her sense of self-worth, although for much of her life was able to act in ways which solicited enough approval.

This formulation allowed for understanding of her previous depression within the context of work problems which preceded it, and her recovery within the context of her husband's sickness. The conditions of worth she internalised as a child included the need to put others and their needs before herself, as a method of gaining approval. Her
husband’s illness may have triggered her into a caring role, this being a role within which she could therefore achieve external approval.

Ms Archer’s depression at the time of this work was understood within the context of Ms Archer’s worsening heart condition. At the same time Ms Archer’s mother-in-law, with whom she had a difficult relationship, began to experience increasing health problems. Ms Archer said her husband spent a lot of time with his mother and criticised her when she asked him if he could spend more time with her. This was understood as an incident of conflict between Ms Archer’s need for external approval and the lack of such approval being offered.

**Intervention**

Ms Archer attended 5 sessions of client-centred therapy, all conducted independently by the trainee.

The aim of therapy was to create the conditions within the therapeutic relationship which encouraged the natural growth process of Ms Archer. Therapy was therefore based on a relationship aiming to offer the three ‘Core Conditions’ of a client-centred approach (congruence, unconditional positive regard and empathy, Rogers, 1951) which are posited to allow people to become able to listen to and trust their inner voice.

The trainee was unable to offer further sessions as the placement had come to an end. However, Ms Archer was clear that she would like to continue meeting with a psychologist to ‘get to the bottom’ of her problems. Ms Archer was taken on by the trainee’s supervisor for further non-time limited client-centred therapy.

**Outcome**

Ms Archer again completed the HADS at the end of session 5. Her depression score of 12 indicated moderate anxiety and her anxiety score of 14 indicated moderate anxiety. These scores confirmed the qualitative assessment of the need for further therapy.
Ms Archer indicated that she had found the sessions useful. She said she had decided that she needed to be more assertive, indicating a move to a more internal locus of evaluation. She also indicated that she had valued the relationship with the trainee.

Prognosis

Ms Archer continued to show the characteristic of a client who is suggested to be able to benefit from client-centred therapy (Thorne, 1996), suggesting she would have been likely to benefit from continued therapy.

Reformulation

Ms Archer’s needs were reformulated from within a cognitive-behavioural perspective, whereby the second balloon angioplasty was the critical incident (Fennell, 1989) which activated Ms Archer’s dysfunctional assumption that in order to be considered worthwhile she must do what other people expect of her. The depression would then have been triggered by a decreasing ability to do what others expect arising primarily from her physical ill health, but compounded by the effects of depression itself. However, the reformulation also explored the possible mis-match between this client and a cognitive-behavioural approach.

REFERENCES


SPECIALIST LEARNING DISABILITY PLACEMENT

Placement Details

Dates: October 2002 – March 2003

Supervisor: Jane Edmonds (Clinical Psychologist)

Region: Eastbourne, East Sussex

Summary of Placement Experience

This placement provided invaluable further experience of working with people with mild, moderate and severe learning disabilities, their families, carers and professional support systems within a multi-disciplinary community learning disability team. In order to most usefully supplement the core learning disabilities placement, the focus on work was on working with staff teams. Often this work was in conjunction with other professionals of the multi-disciplinary team. In addition, however, the placement allowed opportunity for parenting assessment work, individual therapeutic work and assessment of a person’s capacity to consent to an operation in conjunction with a Speech and Language Therapist. This placement also provided the opportunity for a small amount of work with the working age adult ‘Options’ team. This used a social constructionist approach, including reflecting teams.

Clinical Skills and Experience

The placement primarily allowed development of ideas and experience in using social constructionist ideas, however, further experience of using psychodynamic ideas and ideas from attachment theory was also provided. A range of presenting issues were worked with including anxiety, bereavement, depression, inappropriate sexual behaviour and challenging behaviours. The work of the placement included consideration of the role of psychologist within a multi-disciplinary community team and appropriate work for and supervision of assistant psychologists.
Further work included leading on the creation of feedback questionnaires for service users and professionals to be used in the assessment of consultation sessions offered by the team members and leading on a project to co-ordinate the range of consultations which were being offered by various team members.

**Meetings, Seminars, Visits and Research**

In addition to meetings with professionals and services arranged as an aspect of the placement induction, team meetings and a multi-agency working party meetings considering multi-agency working with parents who have learning disabilities were attended.

Training sessions were offered regarding ‘autism’, ‘managing fear’ and ‘attachment theory and learning disabilities’.
Case Report Summary

Year 3 – Specialist Learning Disability Case Report

Stories of Power and Empowerment: Using a social constructionist approach, including a reflecting team, with a 55-year-old woman with learning disabilities referred because of 'bereavement'

All personal details have been altered to preserve the anonymity of the client

Referral

Ms Janeway was referred for bereavement counselling at the request of her family who were concerned that Ms Janeway had not grieved 'properly' following the death of her father in 1998. The referral also reported that Ms Janeway did not think anything was wrong.

Assessment

Working within a social constructionist framework led to a very different understanding of an 'assessment', as it was important to reflect about the constructing implications of conversations and questions.

Ms Janeway was diagnosed with a mild learning disability as a child. She had worked in a local hotel for 27 years. Ms Janeway became known to the local social services assessment team for people with learning disabilities two years before we met. As an adult she had received no previous learning disabilities services. The family said they were told that this team could not offer services for Ms Janeway, as she was 'too able'.

Ms Janeway's family shared their concerns about her 'lack' of grieving for her father. They said she must be holding her emotions in, which was not healthy. However, they talked most about their concerns about what would happen to Ms Janeway when her mother, who was now in late seventies, died. Ms Janeway lived with her mother, and her
social life centred around her mother’s friends. Her family said Ms Janeway found it
difficult to make friends because she lacked confidence. Ms Janeway’s family wanted
her to make her own friends. They hoped that when her mother died a friend could move
in with Ms Janeway, allowing her to remain at home whilst receiving social contact and
support. Ms Janeway did not say what she thought about her family’s ideas.

**Initial Formulation**

The trainee’s initial hypotheses, which informed the initial sessions, were presented.
Consideration of whether Ms Janeway was a ‘customer’ for therapeutic interventions
(Fidell, 2000) together with the possible implications of society’s dominant story about
how grief should be handled led to a hypothesis that Ms Janeway’s version of reality had
become in competition with her family’s version of reality.

**Action Plan**

Ms Janeway and her family were offered sessions with the team’s family service. This
was based on explicitly social constructionist ideas and used a reflecting team approach
(Andersen, 1987, 1992). The trainee was the lead clinician for this work. The sessions
were aimed at facilitating the construction of new realities.

**Intervention**

Ms Janeway, her mother, brother and sister attended two family service sessions. The
trainee worked in the sessions to remain curious, (Anderson & Goolishian, 1992) whilst
asking circular questions Checchin (1987), reflexive questions Tomm (1987) and using
externalising conversations (White, 1988).

Despite their seeming to engage in the reflecting team conversations, the family said
they wanted Ms Janeway to have individual grief counselling. Ms Janeway said she
wasn’t sure she wanted counselling. Her siblings made sense of this choice within their
story about new experiences being difficult for her and also feeling that she didn’t really
know enough about counselling to make a ‘real’ choice.
At the end of the second session Ms Janeway said she wanted to meet with the trainee individually to talk about counselling.

**Adaptation of Action Plan**

Ms Janeway and the trainee arranged four sessions to focus on exploring her understanding of counselling, helping her to think about whether this was something she wanted and also thinking more about other services the team could offer. As this work was also conducted from within a social constructionist framework the sessions were seen as an opportunity for exploration of Ms Janeway’s stories and stories about her family’s stories. The aim was, as before, to help create space for the development of new realities.

**Intervention**

Individual sessions focused on exploring with Ms Janeway her understanding of counselling and offering information where appropriate, as well as talking about her father’s death and her current life and exploring her understanding of emotions.

The trainee asked Ms Janeway the ‘miracle question’ (O’Connell, 1998). Ms Janeway said she did not want anything to be different, she liked her life how it was now.

In the third session Ms Janeway said she had decided she not want to have counselling and did not want to meet with the trainee again. Ms Janeway asked the trainee to tell her mother about the sessions and her decision. In this conversation, Ms Janeway’s mother talked about the family’s frustration with services and their lack of trust in the caring services resulting from previous interactions.

**Final Formulation**

The current ‘stuckness’ was understood as being created through the interaction of various competing stories, together with the service context, in that the family’s previous
interactions with social services had left them feeling that other options for change were not available to them.

**Outcome and Prognosis**

Further conversations with the family and Ms Janeway led to conversations about alternative ways that a difference could be made, to which all the family could be customers. It was agreed that Ms Janeway would be offered psychometric testing to clarify her cognitive strengths and needs. It was felt that this would allow the professional system to work with the family in thinking about how to meet Ms Janeway's future support needs in ways which could be empowering for all. Ms Janeway's sister expressed her relief at the new understanding which had been reached, saying that initially their situation had seemed "all over the place" and extremely anxiety provoking. She said the work we had done together meant that the family could now see a "way forward". Ms Janeway was happy that her wish not to have individual therapy was being respected.

The team's client questionnaire was sent to Ms Janeway but not returned by the end of the trainee's placement.

**Reformulation**

The presenting issues were formulated within a perspective of 'abnormal' grief (Worden, 1991). However, the report demonstrated that Ms Janeway would not have been considered suitable for individual therapy.

**Critique**

The power issues that may have been contributing to the presenting needs were explored.
REFERENCES


SPECIALIST LEARNING DISABILITY PLACEMENT

Placement Details

Dates: April 2003 – September 2003

Supervisor: Margaret Henning (Clinical Psychologist)

Region: Horsham and Crawley West Sussex

Summary of Placement Experience

This placement provided invaluable focused experience of using narrative therapy with clients with a range of presenting needs and in a variety of settings, including primary care work, CMHT work and in-patient work. Clinical work consisted of using narrative therapy with individuals, couples and families and liaising with other team members as appropriate. The placement experience included attending a fortnightly narrative therapy supervision group.

Clinical Skills and Experience

Experience was gained of using narrative therapy with a range of presenting problems including post traumatic stress disorder, depression, obsessive compulsive disorder, psychosis, eating disorders, social phobia, relationship difficulties and alcohol abuse. Other focuses of the placement included the use of techniques from other models, including cognitive behavioural therapy, within a narrative therapy approach.

Meetings, Seminars, Visits and Research

In addition to meetings with professionals and services arranged as an aspect of the placement induction, CMHT sector meetings, monthly psychology meetings, monthly business meetings and a psychology team away day were attended. A CPA review
meeting was attended and discussions with psychologists focused on the CPA system and its implications for psychologists.

The trainee also met with a psychologist working in a local refugee detention centre to discuss her trauma work within this setting and spent a day with the AOT (assertive outreach team) discussing their role and links with other services as well as observing practitioners at work.
OVERVIEW OF THE RESEARCH DOSSIER

This dossier consists of the research log book which summarises the research skills and experience gained during the three years of the clinical training course, together with the service related research project completed during the first year of clinical training, the qualitative research project completed during the second year of clinical training and the major research project completed during the third year of clinical training.

The letter confirming that the findings of the service related research project were presented to the service in which it was conducted can be found in appendix 1 of the service related research project, on page 171.
<table>
<thead>
<tr>
<th>Year</th>
<th>Description of how Research &amp; Experience acquired</th>
<th>SKILLS/EXPERIENCE</th>
<th>RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-2003</td>
<td>Conducted comprehensive literature searches for all the essays, case reports, and research papers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is intended that the final log will be inserted into your Research Dossier on your final portfolio and should demonstrate the experiences, skills, and attributes required for the research dossier. If you have already done the list then add new categories and appropriate description of your experiences. Alternatively, you may print out a blank IS-then add a new card and appropriate description of your experience.

Below is a list of examples of research skills which you are encouraged to gain experience in during your training. You should obtain a copy of the online version of your portfolio to print this list.

---

**Log of Research Experience**

Research Log Book
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2000 - July 2001</td>
<td>This research was conducted using a discourse analytic method. Therefore, throughout the discussion process, the researcher was involved in the development of the research methodology. A detailed research design was implemented to ensure that the research questions were addressed. The data was collected through interviews, document analysis, and participant observation. The research team met regularly to discuss the data and to develop the research questions. The results were presented at a conference. The research was conducted over a period of two years.</td>
</tr>
</tbody>
</table>
| February 2001 - July 2001 | A detailed research protocol was developed for the project. The protocol included the following steps:  
1. **Written Proposal**  
2. **MRF (Major Research Project)**  
3. **ORR (Optional Research Project)**  
4. **SRR (Specific Research Project)**  
5. **Research Question**  
6. **Research Goal**  
7. **Research Method**  
8. **Research Findings**  
9. **Research Conclusion**  |

Research Log Book
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2001</td>
<td>Researcher raised concerns about the design of the study. The committee decided to conduct a qualitative analysis of the interviews to understand the components of the intervention.</td>
<td>This was an iterative process.</td>
</tr>
<tr>
<td>February 2002</td>
<td>A questionnaire for the pilot study was designed and distributed to a small sample of participants.</td>
<td>The questionnaire was pilot tested and refined.</td>
</tr>
<tr>
<td>March and April 2002</td>
<td>The study protocol was approved by the institutional review board.</td>
<td>The protocol included provisions for participant confidentiality and data security.</td>
</tr>
<tr>
<td>March and April 2002</td>
<td>The study protocol was approved by the institutional review board.</td>
<td>The protocol included provisions for participant confidentiality and data security.</td>
</tr>
<tr>
<td>May 2003</td>
<td>Data collection was initiated. A standardized data collection form was used.</td>
<td>The data collection forms were pilot tested and refined.</td>
</tr>
<tr>
<td>July 2002 - January 2003</td>
<td>Data collection continued. The interview schedule was revised and refined.</td>
<td>The interview schedule was revised based on feedback from the initial interviews.</td>
</tr>
<tr>
<td>April 2002</td>
<td>Data collection was completed. The data was analyzed using SPSS.</td>
<td>The analysis was conducted using descriptive and inferential statistics.</td>
</tr>
</tbody>
</table>

**Set up a data file**

Research participants

Collect data from a

Obtain approval from a

Committee

Research ethics

Objection and amended research form

Write a participant information sheet and consent form

Judge ethical issues and receive feedback from committee

Analytic methodology

Research ethics was also considered throughout the design and implementation of all the research projects.
<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
<th>Description</th>
<th>Research Logbook</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2003</td>
<td>July 2003 and July 2003</td>
<td>Discussion of the MRP will form the focus of the final year oral examination in September 2003. In addition, reports were written specifically for the participants of the SRNP and MRP projects.</td>
<td>Produce a written report on a Research Project</td>
</tr>
<tr>
<td>October 2002</td>
<td>July 2001</td>
<td>The MRP plans were presented to the second year clinical rotation. The findings of the SRNP were presented to the faculty by members of the Psychology Department. The findings were formally presented to the members of the Psychology Department.</td>
<td>Present Research findings/Plans to an audience</td>
</tr>
<tr>
<td>March – July 2003</td>
<td>March 2003</td>
<td>Recommendations for future research were developed for various possible clinical scenarios. The analyses of the MRP data were considered in relation to previous research findings and implications of the data.</td>
<td>Present results from a study analysis/plan in summary results in qualitative data</td>
</tr>
<tr>
<td>May 2002</td>
<td>July 2001</td>
<td>The analysis of the MRP data was considered in relation to previous research findings and implications of the data.</td>
<td>Present results from a study analysis/plan in summary results in qualitative data</td>
</tr>
<tr>
<td>June 2001</td>
<td>June 2001</td>
<td>The graphs and bar graphs were used to present the findings of the SRNP project.</td>
<td>Present results from a study analysis/plan in summary results in qualitative data</td>
</tr>
<tr>
<td>February – April 2003</td>
<td>February – April 2003</td>
<td>Discussed analyses and compared accordingly. After examining the received information, the MRP data was analyzed using a Foundation course.</td>
<td>Present results from a study analysis/plan in summary results in qualitative data</td>
</tr>
<tr>
<td>April 2002</td>
<td>After examining the received information, the MRP data was analyzed using a Foundation course.</td>
<td></td>
<td>Present results from a study analysis/plan in summary results in qualitative data</td>
</tr>
<tr>
<td></td>
<td>Descriptive statistics were used to describe the data. A correlation matrix was also used to analyze relationships among variables.</td>
<td></td>
<td>Present results from a study analysis/plan in summary results in qualitative data</td>
</tr>
</tbody>
</table>

Research Logbook
Apply research findings to clinical practice (give examples of 3 papers published during your training which influenced your practice).


Submit report for publication in a
journal/book

I am planning to publish the findings of the MRP following its finalisation and have started discussing appropriate sources of publication.

After September 2003
Exploration of clients' experiences of their initial assessment session and subsequent wait for therapy within a psychology department

Year 1

Service Related Research Project

Word Count - 2998 Words
Acknowledgements

The trainee would like to thank the research supervisors of the university and clinical placement who offered invaluable advice and guidance and the trust's clinical audit department for their practical support for the project. The trainee would also like to thank all the clients who took the time to respond to the questionnaire. Without the high quality responses received this project would not have been possible.
Exploration of clients’ experiences of their initial assessment session and subsequent wait for therapy within a psychology department

Abstract

The management of potentially long waiting lists for psychological treatments is an on-going issue, which various approaches have sought to manage. This research aimed to explore clients’ experiences of one method of managing a waiting list which is used in a psychology department.

This study was an anonymous cross-sectional postal survey design, carried out within a trust psychology department which offered clients an initial assessment session within 13 weeks of referral. If the assessment session highlighted that it was appropriate to offer the client therapy through the department, they were then placed on a subsequent waiting list. Clients were sent a questionnaire asking about their experience of their initial assessment and views about the time they have waited for therapy.

All clients who were waiting for therapy were sent a questionnaire. Two hundred and fifteen questionnaires were distributed. Two weeks after the questionnaires were sent, reminder letters were sent to all the two hundred and fifteen potential respondents. Ninety-one questionnaires were returned and analysed using descriptive statistics, non-parametric statistics and content analysis.

Findings suggested many clients found aspects of the assessment session helpful, but tended to be unhappy about the length of the subsequent wait and sometimes other implications of this model of service delivery, for example, seeing a different person for therapy than they had seen for assessment. The implications for the service offered by the psychology department are discussed.
Introduction

Management of clinical psychology waiting lists has been an area of concern for many years (Geekie, 1995), for clinical reasons as well as the constraints of the Patient's Charter (Farrell, Levenson, & Snape, 1998, Department of Health, 1996). Startup (1994) described a variety of methods psychology teams have used to manage psychology waiting lists, including restricting access, group work, referring on, consultancy, curtailing treatment length and using opt in/ out systems. Seager and Jacobson (1991) discussed the increasing use of brief therapy models as a response to increasing waiting times.

Jones, Lucy & Wadland (2000) described a 'triage' initiative in a child mental health service where families were offered an initial appointment used for a fuller assessment of the issues. Shawe-Taylor, Richards, Sage & Young (1994) describe a similar model of service delivery for adult services. All clients were offered an assessment session prior to being placed on the waiting list. McAuliffe and MacLachlan (1992, cited by Shawe-Taylor et al, 1994) suggested this allows identification of people who need more urgent treatment and is also preferred by clients and GPs. Shawe-Taylor et al. concluded that these sessions had a positive influence. Clients subsequently found their problems less upsetting or disturbing and had a stronger belief that a clinical psychologist could help them. However, clients completed data soon after their assessment session and authors note: “it may be worthwhile if future research in this area also included a follow-up study of clients still awaiting treatment after the initial assessment” (Shawe-Taylor et al. 1994, pp. 23).

White (1995) randomly allocated clients experiencing anxiety disorders to an assessment appointment where they were offered advice, an assessment session where they were also offered a cognitive self-help pack, or no assessment. White concluded that “there appears to be little value in seeing clients on one occasion prior to a three months wait”. Westbrook (1995), however, compared clients offered two assessment sessions, encompassing the giving of coping advice and self-help literature soon after referral, and clients placed straight on a waiting list. Over the follow up period of 12 months, the assessment group continued to improve significantly more than the group placed straight on the waiting list. However, the waiting time for therapy for both groups was standardised at 13 weeks. Research into an assessment session/ subsequent wait model appears to be in the early stages...
and studies focus on different aspects and therefore have found results which do not always concur.

Rupp (1995, cited by Rupp and Lapsley, 2000) focused on the economic consequences of not treating depression, suggesting that the "do-nothing mental health policy... results in economic loss" (pp. 124). Clearly there are also psychological factors which are affected by the wait for psychological interventions. Häfner and Maurer (2000) suggest that early detection and intervention can affect the course of Schizophrenia and subsequent social stigma. Birchwood, Todd and Jackson (1998) suggest that: “the early phase of psychosis presents important opportunities for secondary prevention”, although they are unclear what constitutes ‘early’. Konstatinos, Loumidis and Shropshire (1997) found that waiting more than 6 months for therapy was associated with non-attendance at a psychology department. Increased wait may lead to increased treatment need, due to the effects of a psychological disorder on life circumstances (Wells et al., 1995, cited by Konstatinos et al., 1997). Neary-Ludmer (1990) suggested that long waiting time may influence client’s engagement in psychotherapy, although it is noted that long waiting time referred to a wait of over 14 days.

The psychology department the trainee worked in offered clients an initial assessment session, usually within 13 weeks of referral. If the client was subsequently offered therapy within the department they were placed on a waiting list, often waiting for a year or more. Within the department, staff had concerns about the assessment/further wait process, but clients’ views had not been gathered. This study used a questionnaire to explore client’s experiences of the assessment session and subsequent wait. It is clear that previous research about assessment sessions and waiting times has not tended to encompass waiting times as long as those customary in this psychology department.
Research Questions

The study aimed to explore clients' views about both their assessment session and subsequent waiting times using the following research questions:

1. Assessment Session
   - What aspects of the assessment session do clients find helpful?
   - What aspects of the assessment session do clients find unhelpful?
   - Does the assessment session affect clients' perceptions that therapy can help them, or the likelihood that they will return for therapy?

2. Clients' Perceptions of Waiting Times
   - How long have clients waited?
   - What are clients' views of the waiting times?
   - How do clients manage the waiting period?

Method

Design

A questionnaire was designed for use in a cross-sectional postal survey. The design is discussed below.

Ethical Issues

Ethical considerations were discussed with supervisors. It was agreed it was not necessary to seek ethical approval through a trust ethics committee as the study fell into the category of audit. The letters sent to clients clearly stated that responses were confidential and would not affect the service people received. All clients who were sent a questionnaire have access to the results of the study. Consent was given by the completion and return of the questionnaires. Results were presented to the psychology team (please see appendix 1 for confirmation letter).

Design of questionnaire

Decision about the questions to be included on the questionnaire were based on previous published research relating to clients' experiences of waiting lists.
Service Related Research Project

(Westbrook, 1995 and Shawe-Taylor et al., 1994), research carried out within the department by the trainee's clinical supervisor, and discussions with department psychologists. Length of questionnaires has been argued to affect the response rate (J. Murray, personal communication, May 14, 2001) and therefore the questionnaire was formatted as an A3 booklet.

Piloting the questionnaire

The questionnaire was piloted with two clients and also sent to all psychologists, counsellors and therapists working in the department. The questionnaire was finalised taking into account the comments of the service users, professionals and supervisors. Please see appendix 2 for finalised questionnaire.

Participants

All clients seen by the department were offered an assessment interview with a clinical psychologist and then, if appropriate, placed on a waiting list for therapy with the same psychologist, another psychologist, or a counsellor. All two hundred and fifteen clients on the therapy waiting lists at the time the questionnaire was distributed were sent a questionnaire.

Distribution of the questionnaire

A questionnaire, covering letter and stamped envelope addressed to the trust's Clinical Audit Department were mailed to clients. The covering letter was designed as recommended by Dillman (1978) and explained the study's purpose and confidentiality and highlighted that responses would not effect the service received. Two weeks after mailing questionnaires, a follow up letter was sent to all 215 service users, as recommended by Dillman (1978). See appendix 3 for covering letter and follow up letter. Ninety-one completed questionnaires were collected three weeks after the follow up letter had been mailed. Due to restrictions on time, it was not possible to include data in the analysis from questionnaires returned after this date. Pilot questionnaires were not included in the analysis as the finalised questionnaire was markedly different based on the comments received.
Analysis of returned questionnaires

Quantitative data responses were collated using descriptive statistics and non-parametric statistics. Qualitative aspects of the questionnaire were analysed using content analysis (Sarantakos, 1998)\(^1\).

**Results**

**Characteristics of respondents**

Ninety-one questionnaires were returned, representing a 42 % response rate. Table 1 presents genders and ages of respondents\(^2\).

**Table 1 – Gender and Age of Respondents**

<table>
<thead>
<tr>
<th>Gender of respondents</th>
<th>Age of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20-29</td>
</tr>
<tr>
<td>Male</td>
<td>41</td>
</tr>
<tr>
<td>Female</td>
<td>49</td>
</tr>
<tr>
<td>% of respondents</td>
<td>45%</td>
</tr>
</tbody>
</table>

**Waiting times**

Responses concerning how long people have been waiting and how long they were told they would have to wait are presented in table 2.

---

\(^1\) Due to resource restrictions a simplified version of content analysis has been used. It was not possible to ask another researcher to categorise data in order to clarify the reliability of the interpretations.

\(^2\) Please note that not all respondents replied to each question is not reported. Due to word limits, the numbers of respondents who did not respond to each question is not reported. All percentages are rounded to the nearest whole number and therefore percentages may not add up to 100%.
Table 2 – Actual wait and length of time clients were told they would have to wait

<table>
<thead>
<tr>
<th>Actual wait</th>
<th>% of respondents</th>
<th>Information given re: wait during initial assessment</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 months</td>
<td>30</td>
<td>33%</td>
<td>16</td>
</tr>
<tr>
<td>6-12 months</td>
<td>32</td>
<td>35%</td>
<td>20</td>
</tr>
<tr>
<td>12 months +</td>
<td>25 (range 12 - 20 months)</td>
<td>28%</td>
<td>19</td>
</tr>
<tr>
<td>no information given re: waiting time</td>
<td>n/a</td>
<td>n/a</td>
<td>16</td>
</tr>
</tbody>
</table>

Eighty-one respondents (89%) said it was, or would have been, helpful to know exactly how long they would have to wait after the assessment for therapy sessions. Seven (8%) said that it was not/ would not have been useful. Twenty-two respondents indicated that knowing how long they were to wait would have been ‘helpful in terms of planning’. Of these, 9 respondents stated that planning could have included informed consideration about seeking alternative therapy/ help, e.g.: “.. it is never a good idea to see more than one therapist at a time. Not knowing when my therapy with the psychologist was going to start has prevented me from seeing anyone else in the meantime”.

Seven respondents indicated that when the wait was longer than expected, they became concerned that they had been forgotten about. Fifteen respondents said that having a clearer idea about when their therapy would start would have been reassuring and instilled a greater sense of hope.

Table 3 and Graph 1 present respondent’s satisfaction with waiting times, rated on a seven-point scale.
Table 3 – Satisfaction with waiting times

<table>
<thead>
<tr>
<th>Satisfaction rating</th>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all satisfied (0-1)</td>
<td>42</td>
<td>46%</td>
</tr>
<tr>
<td>Dissatisfied (2-3)</td>
<td>27</td>
<td>30%</td>
</tr>
<tr>
<td>Reasonably satisfied (4-5)</td>
<td>16</td>
<td>18%</td>
</tr>
<tr>
<td>Very satisfied (6-7)</td>
<td>5</td>
<td>5%</td>
</tr>
</tbody>
</table>

Graph 1

![Satisfaction with waiting times](image_url)
Advice/ information regarding other organisations offered during initial assessment session

Table 4 represents the number of respondents offered specific advice during their assessment session and number of these respondents who found the advice helpful.

Table 4 – Advice offered during initial assessment

<table>
<thead>
<tr>
<th>Advice offered</th>
<th>Yes (number)</th>
<th>Yes (%)</th>
<th>No (number)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>38</td>
<td>42%</td>
<td>48</td>
<td>53%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was this advice helpful? (for respondents offered advice)</th>
<th>Yes (number)</th>
<th>Yes (%)</th>
<th>No (Number)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26</td>
<td>68%</td>
<td>6</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(26/38)</td>
<td></td>
<td>(6/38)</td>
</tr>
</tbody>
</table>

See appendix 4 for clients’ reports of the advice they were offered during assessment.

Table 5 presents the numbers of respondents who indicated they were informed about other organisations during the assessment session.

Table 5 – Number of respondents who were told about other organisations

<table>
<thead>
<tr>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Told about organisations</td>
<td>21</td>
</tr>
<tr>
<td>Given leaflets about organisations</td>
<td>3</td>
</tr>
<tr>
<td>Both told and given leaflets</td>
<td>6</td>
</tr>
<tr>
<td>Other organisations not discussed in assessment session</td>
<td>58</td>
</tr>
</tbody>
</table>

Thirty respondents indicated they had been given information about other local organisations and were asked whether they had used them. Eleven people had and were asked whether they had found them helpful. Data is presented in table 6. Appendix 4 contains information about which local services respondents used. Table
7 presents clients' responses about what was helpful or unhelpful about the organisations.

Table 6 – Were the organisations helpful?

<table>
<thead>
<tr>
<th>Did you use the organisations which were recommended</th>
<th>Yes (number)</th>
<th>Yes (%)</th>
<th>No (number)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11</td>
<td>37%</td>
<td>18</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you find the organisations helpful</th>
<th>Yes (number)</th>
<th>Yes (%)</th>
<th>No (Number)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>64%</td>
<td>2</td>
<td>18%</td>
</tr>
</tbody>
</table>

Table 7 – Responses regarding what was helpful or unhelpful about organisations recommended in the assessment session

<table>
<thead>
<tr>
<th>Helpfulness</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpful</td>
<td></td>
</tr>
<tr>
<td>Decreased sense of isolation</td>
<td>2</td>
</tr>
<tr>
<td>Style of the organisation</td>
<td>2</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td>Advice offered</td>
<td>1</td>
</tr>
<tr>
<td>Unhelpful</td>
<td></td>
</tr>
<tr>
<td>Cost of the service</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td>Style of the organisation</td>
<td>1</td>
</tr>
<tr>
<td>Incident with other client</td>
<td>1</td>
</tr>
</tbody>
</table>

Change of client needs since assessment session

Table 8 presents the clients' responses regarding any changes in their difficulties since the assessment session.
Table 8 – Change in need since assessment

<table>
<thead>
<tr>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better than when assessed</td>
<td>20</td>
</tr>
<tr>
<td>Same as when assessed</td>
<td>45</td>
</tr>
<tr>
<td>Worse than when assessed</td>
<td>18</td>
</tr>
</tbody>
</table>

Therapy through another service

Seventy-five respondents (82%) had not used other therapy services since their assessment. 5 (6%) had used therapy services which were free, 9 (10%) had used other therapy services for which they paid. Respondents who had used other therapy services were asked why they made this decision, see table 9.

Table 9 – Reasons for using other therapy services

<table>
<thead>
<tr>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not want to wait for therapy on the NHS</td>
<td>10</td>
</tr>
<tr>
<td>Felt than my counselling was more anonymous through a different service</td>
<td>1</td>
</tr>
<tr>
<td>Felt private therapy would suit me better</td>
<td>0</td>
</tr>
<tr>
<td>Felt private therapy was able to offer me more sessions than NHS therapy</td>
<td>0</td>
</tr>
</tbody>
</table>

Beliefs about counselling

Table 10 summarises client’s responses about whether their belief that therapy could help them changed because of the assessment session.
Table 10 – Change in belief that therapy can help

<table>
<thead>
<tr>
<th></th>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stronger belief that therapy can help</td>
<td>31</td>
<td>34%</td>
</tr>
<tr>
<td>No change in belief that therapy can help</td>
<td>40</td>
<td>44%</td>
</tr>
<tr>
<td>Weaker belief that therapy can help</td>
<td>9</td>
<td>10%</td>
</tr>
</tbody>
</table>

Initial assessment session

Table 11 and Graph 2 present clients’ rating of the helpfulness of the assessment session, as rated on a 7-point scale.

Table 11 – Helpfulness of initial assessment session

<table>
<thead>
<tr>
<th>Helpfulness Level</th>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not helpful (1-3)</td>
<td>28</td>
<td>31%</td>
</tr>
<tr>
<td>Moderately helpful (4-5)</td>
<td>36</td>
<td>40%</td>
</tr>
<tr>
<td>Extremely helpful (6-7)</td>
<td>22</td>
<td>24%</td>
</tr>
</tbody>
</table>
Graph 3 – Helpfulness of assessment session

Helpfulness of assessment session

Rating of helpfulness of initial assessment session
Tables 12 and 13 summarise clients' responses concerning what was helpful and unhelpful about their assessment sessions.

Table 12 – factors considered helpful in the assessment session

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt I had been understood</td>
<td>48</td>
<td>53%</td>
</tr>
<tr>
<td>It felt good to talk to a neutral party</td>
<td>47</td>
<td>52%</td>
</tr>
<tr>
<td>I was able to talk about things I was afraid or ashamed of</td>
<td>32</td>
<td>35%</td>
</tr>
<tr>
<td>I felt more confident that my problems could be overcome</td>
<td>29</td>
<td>32%</td>
</tr>
<tr>
<td>My problems seemed more manageable afterwards</td>
<td>21</td>
<td>23%</td>
</tr>
<tr>
<td>I understood my problems better</td>
<td>16</td>
<td>18%</td>
</tr>
<tr>
<td>I realised that other people have similar problems to me</td>
<td>14</td>
<td>15%</td>
</tr>
<tr>
<td><em>Message of valuing self and experiences</em></td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td><em>Helpful to gain a diagnosis</em></td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

Table 13 – factors considered unhelpful in the assessment session

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt very emotional and knew I would have to wait a long time for further sessions</td>
<td>54</td>
<td>59%</td>
</tr>
<tr>
<td>I felt less confident that my problems could be overcome</td>
<td>9</td>
<td>10%</td>
</tr>
<tr>
<td><em>Subsequent wait for services</em></td>
<td>7</td>
<td>8%</td>
</tr>
<tr>
<td>I felt I had been managing better before the session</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td><em>Interactions with assessment psychologist</em></td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>I felt I understood my problems less than before the session</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td><em>Seeing a different psychologist for therapy than for the assessment session</em></td>
<td>2</td>
<td>2%</td>
</tr>
</tbody>
</table>

* Categories not specifically asked about on questionnaire, but added to analysis as a result of content analysis of client's additional comments.
Change of psychologist

Table 14 present data about whether clients would be seeing a different psychologist for counselling and whether they would mind this.

Table 14 – change of psychologist for therapy sessions

<table>
<thead>
<tr>
<th></th>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will be seeing a different psychologist for therapy sessions</td>
<td>27</td>
<td>30%</td>
</tr>
<tr>
<td>I will be seeing the same psychologist for therapy sessions</td>
<td>12</td>
<td>13%</td>
</tr>
<tr>
<td>I do not know whether I will be seeing the same or a different psychologist</td>
<td>47</td>
<td>52%</td>
</tr>
<tr>
<td>I mind seeing a different psychologist</td>
<td>19</td>
<td>21%</td>
</tr>
<tr>
<td>I do not mind seeing a different psychologist</td>
<td>32</td>
<td>35%</td>
</tr>
</tbody>
</table>

Open comments about reasons for ‘minding’ or ‘not minding’ seeing a different psychologist were categorised and are presented in table 15.

Table 15 – Categories of response regarding seeing a different psychologist

<table>
<thead>
<tr>
<th></th>
<th>Number of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mind</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having to repeat information</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Continuity/ rapport established</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t mind</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of rapport with assessing psychologist/ felt other professional would suit my needs better</td>
<td>8</td>
<td>9%</td>
</tr>
</tbody>
</table>

Likelihood that client will come back for further therapy

Table 16 present responses concerning whether the assessment session had affected the likelihood that clients would return for therapy.
Table 16 – change in likelihood that clients will come back for therapy in the department

<table>
<thead>
<tr>
<th></th>
<th>Number of respondents</th>
<th>% of respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>More likely</td>
<td>48</td>
<td>53%</td>
</tr>
<tr>
<td>No Change</td>
<td>27</td>
<td>30%</td>
</tr>
<tr>
<td>Less likely</td>
<td>9</td>
<td>10%</td>
</tr>
</tbody>
</table>

Other comments

It was not possible to analyse all other comments due to the small-scale nature of the project. However, it was noted that five clients expressed their concerns about the cost of private counselling, which they saw as an alternative if they were unable to wait for therapy on the NHS. For example:

“I have waited a year for treatment...I have spent more than £2000 on private sessions – with the same psychologist I will eventually see on the NHS. Since Jan 2001 my psychologist has been treating me for free because I can no longer afford to pay ...but this adds to my own guilt about my illness”.

“ideally I would have liked to use the NHS but I had to find my way to an affordable counsellor. I suppose I am lucky to be working and middle class, but what will I do when I am older and poorer”.

Statistical Analysis

Satisfaction with waiting time

A Spearmans Rank Correlation demonstrated a significant relationship between time clients had been waiting and dissatisfaction with the waiting times ($r=-0.303$, $p<0.004$), see Graph 3.
Relationship between ratings of likelihood to return for therapy and whether clients minded seeing a different psychologist

There was a significant relationship between clients minding seeing a different psychologist and the likelihood that they would come back to the department for therapy (Mann-Whitney U = 151.5, p < 0.007, two-tailed test). Clients stating they minded seeing different psychologists rated themselves as significantly more likely to return to the department for therapy (mean = 0.722, SD = 0.575) than clients who stated that they did not mind seeing a different psychologist (mean = 0.241, SD = 0.636)\textsuperscript{4}.
A Kendall’s Tau_b correlation demonstrated a significant relationship between clients' ratings of the helpfulness of the initial assessment and the likelihood that clients would come back for therapy ($r=0.338$, $p<0.0005$).

**Discussion**

Data suggest the majority of clients found some aspects of the assessment session helpful. Some particularly considered they benefited from the advice offered within the session. One third of clients indicated that the assessment session had given them a greater belief that therapy could help them. Over 50% of clients indicated that they were more likely to return for therapy as a result of their assessment session.

However, clients are unhappy about the length of time they have to wait for therapy with the department and tend to state it is important that they are given honest information about how long they will wait, enabling them to make informed decisions about how to manage the wait. Herlihy, Bennett and Killick (1998) suggested there may be benefits for some clients in receiving self-help literature during an assessment, including a possible increased sense of self-efficacy. It is hypothesised that sense of self-efficacy may also be increased if clients feel more able to plan their waiting time. Only 16% of respondents had used other therapy services whilst waiting, but the main reason given for this was the length of the waiting time for therapy within the psychology department. Further comments suggested that the cost of some services may have been a significant factor in other respondents feeling unable to access other therapy services.

A minority (10%) of clients said they were less likely to return for therapy following the assessment session, and 10% had a weaker belief that therapy could help them. The main factor considered unhelpful in the assessment session, indicated by two thirds of respondents, was the subsequent wait for further contact following a session which could arouse many emotions. Further research could consider more fully other aspects of the assessment which a minority of clients found unhelpful.

Please note, the following scale was used to code clients’ responses: $-1$ = less likely to come back to the department for therapy, $0$ = no change, $1$ = more likely.
Approximately 50% of respondents did not indicate whether they minded seeing a different psychologist for therapy than the one seen for assessment. One possibility was that the layout of the questionnaire did not make it clear that all respondents were being asked this question. Of those who responded, a greater number of people indicated that they did not mind, than indicated that they did. Westbrook (1995) highlighted that therapists have concerns about clients receiving therapy from a person other than the one who had offered their assessment sessions but it appeared “patients do not share therapists concerns” (pp. 174). Partial support for this is offered, but it is also clear that a number of respondents stated that would mind seeing a different psychologist. It is interesting to consider why clients who said that they minded seeing a different psychologist were also the clients who indicated that they would be more likely to return to the department for further therapy. It is hypothesised that the formation of a positive relationship with the assessing psychologist leads clients to say that they are more likely to return, but also to have concerns about forming a relationship with a different therapist.

Data indicated that clients who found the initial assessment session more helpful were also more likely to indicate that they would return to the department for therapy. Causation cannot be concluded, but it is hypothesised that a positive experience of the assessment session suggested for clients that the department was able to offer them meaningful support.

Results suggest that despite the concerns members of the team had about the use of assessment sessions before waiting, the assessment session can be used as a useful process for clients. The usefulness of assessment session may also be improved by clear and honest communication with clients about the waiting times as well as giving appropriate advice or information about other local services. Howard, Kopta, Krause & Orlinsky (cited by Barkham & Shapiro, 1989) suggest a ‘negatively accelerating dose-effect curve’ whereby the benefits to clients of therapeutic contacts decrease after the first session. This suggests that short contacts can be beneficial for clients, in line with the findings of Shawe-Taylor et al. (1994) and White (1995). However, results also suggest that clients are very dissatisfied with the waiting times and it is clear that this is an area of concern and where further investigation could prove useful.
The system used by the department enables clients whose needs cannot be met by the department to be referred on to other services. Offering an assessment session soon after referral, rather than operating a general waiting list, enables this group of clients to be referred or given information about other services within a smaller time frame. Future research could consider the number of clients who benefit from this system in such a way, as well as their view of the assessment session.

The response rate to the questionnaire was reasonably high (J. Murray, personal communication, May 14, 2001). It is likely that following the advice of Dillman (1978) to structure the cover letter and follow up letters increased the return rate. The questionnaire was designed to be easy to complete and clear. In addition the first page of the four pages asked simple demographic and other easy questions. It is hypothesised that this also increased the response rate (J. Murray, personal communication, May 14, 2001). However, the representativeness of the returned questionnaires could not be assessed as the department did not hold data about the ages, genders and length of wait for people on the waiting list. Future research could usefully address the potentially differing response rates of groups of clients. A large range of further and more in depth analyses could have been conducted from the collected responses. However, the constraints of the project did not allow this. The trainee suggests that further research may need to consider using a smaller number of questions and areas to be covered within a questionnaire, to enable full evaluation of the data.
REFERENCES


Appendix Contents

Appendix 1 – Letter confirming research was presented to the psychology department

Appendix 2 – Finalised questionnaire

Appendix 3 – Covering letter and follow up letter

Appendix 4 – Content Analysis of qualitative responses
Appendix 1
Letter confirming research was presented to the psychology department

Department of Clinical and Counselling Psychology

19 June 2001

CONFIDENTIAL

To Whom it May Concern

This is to confirm that presented the results of the research to the Dept of Clinical and Counselling Psychology on Thursday, 21 June 2001.

Yours faithfully

Clinical Psychologist
### Client's experiences of the initial appointment session and waiting times for therapy

1. Are you:
   - Female [ ]
   - Male [ ]

2. How old are you?
   - Under 20 [ ]
   - 20 – 29 [ ]
   - 30 – 39 [ ]
   - 40 – 49 [ ]
   - 50 – 59 [ ]
   - 60 – 65 [ ]
   - Over 65 [ ]

3. Approximately how many months has it been since you had your initial appointment with the psychologist?

   [ ] months

   Please go to the next column on this page

4. How long were you told you would have to wait for further appointments?

5. Do you think that it is/would have been useful to know exactly how long you would have to wait?
   - Yes [ ]
   - No [ ]

   Please tell us why

6. How satisfied are you with the waiting times? (Please circle the number which best describes this)

   Not at all satisfied [ ]
   [ ] Very satisfied

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. During your appointment, did the psychologist offer any specific advice regarding managing your difficulties?

Yes □

No □ (please go to question 9)

Please tell us what advice you were given

8. Was this advice helpful to you?

Yes □

No □

Did not try advice □

9. Did the psychologist tell you about, or give you any leaflets about any other organisations which you could use while waiting for therapy? (e.g. drop in centres, self-help groups)

Told me about organisation □

Gave me leaflets about organisations □

Neither (go to question 14) □

10. Did you decide to use any of these organisations?

Yes □ (please go to question 11)

No □ (please go to question 14)

11. Which of the organisations that your psychologist recommended have you used?

Please go to the next column on this page

12. Did you find the organisations that you used helpful?

Yes □

No □

13. Please tell us what was helpful or unhelpful about these organisations.

14. Did the psychologist recommend any self-help books?

Yes □ (please go to question 15)

No □ (please go to question 16)

15. Were the self-help books useful?

Yes □

No □

I did not use the self-help book □

16. How have your difficulties changed since your initial assessment? (Please tick one)

Better than when I was assessed □

Worse than when I was assessed □

Same as when I was assessed □

17. Since your assessment session have you had therapy or counselling through a different source? (It is useful to know if you had to pay for this, so please tick the appropriate box)

I had other counselling which was free □

I had other counselling which I paid for □

I have not had other counselling since my assessment session (please go to question 21) □
18. Please tell us why you decided to have counselling through a different service.

Did not want to wait for therapy on the NHS
Felt private therapy would suit me better
Felt private therapy was able to offer me more sessions than NHS therapy
I felt that my counselling was more anonymous through a different service
Other, please specify

19. Which service did you obtain counselling from?

20. Were you satisfied with the counselling you received?

Yes
No

21. Has your belief that therapy/counselling can help you changed because of your assessment session? (Please tick one)

I have a stronger belief that therapy/counselling can help me
I am now less sure that therapy/counselling can help me
My belief about whether therapy/counselling can help me has not changed

22. How helpful was the initial assessment session for you? (Please circle the number which best describes this)

1  2  3  4  5  6  7
Not helpful at all  Extremely helpful

23. Please tell us what was helpful about your assessment session (tick as many as apply)

My problems seemed more manageable afterwards
I felt I had been understood
I realised that other people have similar problems to me
I understood my problems better
I felt more confident that my problems could be overcome
I was able to talk about things I was afraid or ashamed of
It felt good to talk to a neutral party
Other, please specify

24. Please tell us what was unhelpful about your assessment session (tick as many as apply)

Felt very emotional and knew I would have to wait a long time for further sessions
I felt I had been managing better before the session
I felt less confident that my problems could be overcome
I felt that I understood my problems less than before the session
Other, please specify

Please go to the next column on this page
25. Will you be seeing a different psychologist for on-going sessions than the one you saw for your assessment session?

Yes   [ ] (go to question 26)
No    [ ] (go to question 27)
Don’t know [ ] (go to question 27)

26. Please tell us what you think about seeing a different psychologist than the one you saw for your assessment session.

I mind seeing a different psychologist [ ]
I do not mind seeing a different psychologist [ ]

Please tell us why you think this
........................................................................................................
........................................................................................................

27. Has having the first assessment session made you more or less likely to come back for on-going therapy in the department?

More likely [ ]
No change [ ]
Less likely [ ]

Please tell us why
........................................................................................................
........................................................................................................

If you would like to receive a summary of the results, please call the Clinical Audit Department on [ ]. The summary will be available from July 2001.

Many thanks for your help and support. Please return the questionnaire in the envelope provided to: Clinical Audit Department.
5 March 2001

Dear

You were referred to the Clinical and Counselling Psychology Service and by now have had your first assessment sessions and are waiting for on-going therapy. Unfortunately there is a waiting list for on-going therapy and we apologise for this. We would like you to tell us about your views of the session that you have had and the length of time that you have now waited for further sessions. We feel it is important that we listen to your views and think about what clients want from the service that we provide. Enclosed is a questionnaire which will help you to tell us what you think.

The questionnaires are confidential and there is no need to put your name on them. The service you are provided with will not be affected by anything you tell us.

It will take about ten minutes to complete the questionnaire and we have also provided you with a stamped address envelope so that you can return it to us.

The things that you tell us will help us to think about the service that we offer and to make sure that clients' opinions are listened to and influence services in the future.

Many thanks for your help and support.

Yours sincerely

Trainee Clinical Psychologist
Dear

Two weeks ago a questionnaire seeking your opinion about the service offered by the Clinical and Counselling Psychology Department was posted to you.

You may have already returned the questionnaire and if so, please accept our sincere thanks. The questionnaire is anonymous and so we do not know which people have already returned theirs.

If you have not returned your questionnaire and are planning to, we would be grateful if you could do so as soon as possible. It is extremely important that your views are included in the study, the results of which will help us to consider the service we offer.

Many thanks for your support.

Yours sincerely

Trainee Clinical Psychologist
Appendix 4
Content Analysis of qualitative responses.

Question 5

Yes, it was/would have been helpful to know exactly how long you would have to wait

1. Planning

Because then I could plan out my days before my next appointment.

It may have been helpful in terms of planning around college, work experience etc.

Plan future – work etc.

Have to decide how to deal with problems within that time if necessary.

So that I have time to consider changes in my situation for counselling discussions and so that I have an idea of how long I have to cope before I can get a change to improve my mental health.

I could have better prepared myself for such a long wait.

It would have given me a time frame to prepare myself for counselling.

When one needs to talk to a psychologist it’s because they need to talk now/today and if one had a date they could be more able to put their lives in order for that time/date.

To be able to plan ahead.

Help me to plan my life.

Trying to get time off work is difficult when I don’t know for sure when my next appointment is.

Eleviate stress and worry and forward planning.

Because last minute appointments can lead to cancels.

1.2 Informed choice about other therapy/support options

You should know that anybody who want to improve and take responsibility needs this information in order to plan their further actions. It makes it impossible for people to organise other treatment when they do not know if they are waiting 1 or 3 years.

Because then I could focus on it and plan for alternatives if it was going to be too long.

I would have made other arrangements.
Because I could choose to go somewhere else or to do something else (other treatments, other doctors).

Because I could have arranged for further counselling sessions to help me over the difficult times.

As I have been advised on previous occasions that it is never a good idea to see more than one therapist at a time. Not knowing when my therapy with the psychologist was going to start has prevented me from seeing anyone else in the meantime.

Because I could have got some other type of help in the meantime.

I have been paying privately for therapy while waiting. It would have been easier to budget (and less stressful) if I had known how long the delay would be.

It has taken too long and I might have tried something else.

2. Feeling of being forgotten

In the absence of an initial appointment you hope you haven't been forgotten. However prospect of 2 years isn't much help.

Minimises the fear of being forgotten and abandoned. A need for structure. Some knowledge.

A sense of being forgotten about.

It seems that you have been forgotten.

Gives you something to aim for. And this questionnaire is the only reason I know I've not been forgotten.

After a few months I presumed I'd been forgotten.

I would have known that something was being done.

3. Sense of reassurance and hope

The problems that I have would be more bearable with the reassurance of knowing when the counselling was to commence.

I would have been reassured.

Principally because it would be easier to manage your expectations. When you are in crisis and feeling very vulnerable, you need definite. Your next appointment is very important.

It's helpful to know when you're going to get the help you need.

It helps to know that a light is at the end of the tunnel and help will be forthcoming.
To know that I will one day have an improvement – at the moment it doesn’t seem real.

To know where I stand and something to look forward to.

Having a definite date gives you hope.

You would know that there’s help sooner or later.

To have the help and support at a set date would mean something to look forward to.

Would have had something to aim for.

It would give me something tangible to hope for help.

Put mind at rest and something positive to look forward to.

I feel ready for counselling after so many years waiting for myself – have some idea might help me to cope with the need in me.

It might help to know when my problems may start to be sorted out.

4. Disappointment when appointment does not arrive at expected date

Then you don’t keep waiting for a letter that doesn’t arrive.

To find out later that it is a year until the next appointment is a but of a let down.

Causes more anxiety not knowing when. Leaves client feeling isolated.

5. Other comments

It would have been less stressful to know.

Because it would be longer than I was told.

Situations change.

Because I’ve had no help since my assessment.

Because you dredge up emotions only to be told that you have to wait a long time before any help can be given.

It’s stabilising to know what’s going on.

Because I have an ongoing problem that the therapy is going to help solve.

Because treatment is needed at the time of assessment.

In order to provide some structure to my life.

To know your claim is still ‘alive’. To be told like anything else we need to know.
Just to know what to expect.

For help with my emotional circumstances, so that I can continue with life.

Because you need help at the point of crisis, not months later.

So my problems would be sorted out sooner.

Perhaps I could have finished with life because of despondency.

To prepare myself for the long wait.

Because I had an insurance claim going on and felt if I had treatment earlier then could have been settled.

When your ill you need to know there is help.

I feel like I'm waiting in limbo, will it be this month, next month, this year I hear anything about any offer of treatment/ therapy!?

No, it was not/ would not be helpful to know exactly how long I would have to wait

Knowing I had to wait a year was like being retired before I even got the job.

I think the waiting is a useful part of the process albeit difficult. If the need is urgent, opportunities present themselves.

I was told there is a long waiting list which I understand.

Question 7
What advice did the therapist offer in the assessment session?

1. Information regarding other organisations (inc. private therapists)

I asked if there were any private organisations, given the extensive wait. I was given a name of a private analyst.

Tel numbers for counselling in case I needed it

Agreed to refer me to an organisation

To go to a self-help group, but it's not in reality enough

2. Advised that further psychological therapy needed

Counselling recommended

To wait for an appointment to see another psychologist
Counselling

To follow a psychological therapy

To see somebody else

I had to write down about how I was feeling at the time. I was told that I would get an appointment to see a counsellor.

3. Specific Techniques

Anxiety management

He gave me some leaflets on managing stress

Relaxation techniques.

A tape to listen to

Read a book

I was given a reading list and exercise sheets.

4. Validation of client's efforts and experiences

That I was coping well and that my stress strategies were good

He said that so much had happened to me and so much is still going on that we could meet again after I returned from holiday

To persevere and take encouragement that I was doing very well

5. Other advice

Think of myself rather than others

Essentially told me I was too self-contained

Visit various sites in Brighton

Spend a bit of time together

To exercise

Try to get in contact with blood relatives

Do not blame yourself

She told me to read more about it and get more knowledge and understanding over the matter

Progress slowly
Hypnotherapy was tried and helped a little

**Question 11 – which organisations used?**

Mankind at Newhaven, still waiting for a reply to my letter
Relate
79 Buckingham Road
Relaxation and get involved
Counselling
Threshold self-help group
Threshold
Greenwhich House
I phoned, can't remember name
OA
Shed meeting groups

**Question 13 – what was helpful or unhelpful about these organisations?**

**Helpful**

1. *Decreased sense of isolation*
   
   Feel less isolated, talking to others

2. *Style of the organisation/service offered*
   
   Helpful – worker would listen and guide towards understanding reasons for reactions etc.

   Approach was inviting and encouraging, waiting list again horrendously long.

3. *Waiting times*
   
   Starting counselling when I needed it, before I get to the top of the waiting list

4. *Advice offered*
   
   The advice that is available on site
Unhelpful

1. **Cost of the service**
   
The cost for a 50 minutes consultation and I had no idea how many I would need was going to 40% of my weekly wage.

2. **Waiting times**
   
   Approach was inviting and encouraging, waiting list again horrendously long.

3. **Style of the organisation/service offered**
   
   It focused on sharing the experience of being ill instead of doing something about it, like a hobby, really.

4. **Incident with other client**
   
   Unhelpful – 'stalked' by patient not stabilised and threatening to use knife. Both myself and other patients were most intimidated. I have not used communal facilities since.

**Question 18 – other reasons to obtain counselling through a different service**

I needed someone to talk to – it was at work

The insurance company have, after 22 months, agreed to pay private

The opportunity arose and I took advantage of it

**Question 19 – from which service?**

1. **Private service**

   The Rock Clinic

   Psychologist

   Relate

   Private

   Private counsellor

   EMDR – psychology associates

   Had a referral from my psychologist to a private clinic

   A private counsellor
2. Other NHS Service

Anxiety management classes, provided by NHS psychologist CPN

3. Other Service

The Women's refuge service
Brighton Housing Trust
Women's centre

Question 23 – what was helpful about your assessment session?

1. Diagnosis

It was helpful to gain some diagnosis. It just helped in as much as I needed to know what’s wrong

2. Valuing self and experiences

Felt it was not my fault
Realised killings witnessed as a child were more significant than I thought
I was asked to write about my experience to help others
I felt I was making progress

The psychologist's attitude was so open and understanding that I came away with a real sense of being understood and valued, as I had begun to understand and value myself. To have this sense of empowerment meant a great deal to me and I thank her for it, as well as myself.

3. Other comments

The psychologist can help me find more appropriate ways of coping
I realised again I needed counselling help
A relief to have someone listen to me
I felt that good questions had been asked, and there was some humour.
Question 24 – what was unhelpful about assessment session?

1. Subsequent wait

Knowing I would have to wait for more help

I could see the light at the end of the tunnel, but knew I would have to wait again to reach it. It has taken years to get this far.

To tell me that therapy would have been helpful and not to be able to do it because of the waiting time.

I clearly needed help then and there are realising that I would have to wait for so long was v. disheartening.

It is not helpful if there is no follow up. I suspected a long wait but not this long.

Still waiting to see specialist in specific area as appropriate to original referral.

I felt that therapy should be combined with medication and there have been a number of occasions I have contacted the department in the hope I would have therapy sooner.

2. Interaction with psychologist

He (the psychologist) expressed only one thing that I felt he understood. I felt that he did not give a damn.

I felt the therapist was aggressive and did not help me.

I felt discriminated against, disillusional, fearful. I cannot relate to a female. I felt as if I were being judged.

I felt we were talking about things I already knew and I wasn't being assessed as 'an individual' but as a box to fit in. The work I have already done on myself and my self-knowledge about psychology was a source of frustration because the counsellor wasn't aware of this. So the experience was very frustrating and painful after all.

3. Seeing a different psychologist for on-going therapy

I would not have opened up such pain if I had known that my assessor was not going to be my counsellor.

I was expected to talk to a complete stranger about personal issues, which this person was not going to help me with anyway. The fact that I could not have help made the situation seem hopeless.

4. Other comments

I didn't feel sure whether the psychologist would only assess me, as he's top rank, and then hand me on to one of his staff for regular appointments.

The use of a TENS machine
I felt it hard to tell truth of physical problems. Emotional and hard to admit.

I thought I was going through a door for some help only to find the door was closed.

A waste of time and money of the NHS

The psychologist agreed that there was no appropriate treat available on the NHS

Question 26
Why do you mind/don’t mind seeing another psychologist for on-going therapy?

MIND

1. Repeating information shared

Because I really liked her, felt a report and emotion understanding, didn’t want to repeat the background information with someone new I may not like so much.

It would mean completing review again.

I mind as I would have to go through it all again.

2. Rapport/continuity with therapist

I was interviewed by two psychologists and think I would prefer to be seen by someone at least familiar.

Continuity is important.

There’s no continuity.

I felt that I may not be understood or have the same rapport with another psychologist. I am fearful that it will not work out and that I will be alone, on my own with problems.

It is difficult for me to open up and trust easily, and then to divulge things about myself to different people each time.

I hope the next psychologist has a similar character to the assessment psychologist.

Because she was the first person really to understand the complexities of my problems. I’m scared that someone else won’t and I’ll have to repeat it all again.

To open up, as I did, to someone who made notes and then told me I had to wait months and have a different counsellor to me contradicts the essence of a good counselling relationship – confidentiality and a safe, trusting relationship.

3. Other comments

It is better to work with who you started with, if you get on, but she left that week so I have no choice.
Because I have seen same one for long period of time, do not want to start all over again and someone new.

As I opened up to the first one now I have to start all over again and find it difficult.

It's hard to admit to different persons my troubles.

DON'T MIND

1. Prefer to see a different psychologist

Because I prefer to see a counsellor not a psychologist.

The one I saw had no real experience (she was in training)

No chemistry – did not bond with psychologist

I am waiting on a male psychologist.

Because I did not feel I could work with the one that assessed me.

I need a male counsellor, which is stated.

I think it is essential in therapy to find the 'right' person.

I felt uncomfortable, although that could have been my state of mind at the time.

2. Other comments

My assessment was, after all with the lead psychologist. Not everyone can have on­
go ing sessions with her.

I am open to others but I would like to see the assessment psychologist as I found her very sympathetic.

Help is help

Because I have lived in a mental health project and have had different staff.

Because I just want to get better and I don't care who helps as long as I do
I just wanted some skilled help.

As long as the psychologist is female I don't mind.

One may help or listen more than the other.

I have met my new psychologist and am happy.
Question 27 – Why more or less likely to come back?

MORE

1. Positive aspects of the session

I thought the laid back, but professional attitude was very good. It made me relax a little. I felt safe in talking openly.

Because I felt probed and challenged to think for myself and answer up.

They encourage you to have confidence in myself.

My relationship with the psychologist has helped me to handle my life. I can only hope that my on-going therapy with another psychologist will prove to be helpful.

Because we discussed the different types of therapy that I might benefit from. I have decided that the most beneficial therapy for me at this particular point in my life would be behaviour therapy.

I was very encouraged by the degree to which I felt understood by her.

2. Belief that therapy can help

To finish/ complete the way and understand more on the problems discussed.

I need help, it’s that simple.

It restored my faith in counselling and the benefits it has.

Because I know that therapy will be able to help me.

I finally found a starting point to get on/ manage better my life.

I need help for my anxiety and felt this could resolve or even help me cope a little more.

Because I want to get my life sorted and move on. Counselling I feel is always helpful to me.

To sort out my problems.

Because it helped me come to terms with what was wrong.

Because I have made a giant leap forward so can see the benefit of help.

3. Other comments

Left session feeling positive, although I was upset.

Need some assistance in overcoming problems with unresolved issues.
I realise that in order to avoid becoming depressed again, I need to tackle and identify issues and problems.

Because I do not really think I got across or was understood.

Because my problem is affecting my general quality of life and that of my partner.

Because a problem shared is a problem halved but only on a one to one basis.

Because I felt able to overcome my problems.

I trust that the experience of a psychologist is the best I can obtain.

It was a help but I still need help now.

At last the acceptance that someone understands and help is very much appreciated.

I feel it will help me to understand better.

Because you feel that the first step has been taken.

I know the help I need is there, it's just the waiting and the not knowing that is so frustrating.

**No Change**

I had confidence in the dept. previously and was given no reason for that to diminish.

I am still waiting to experience counselling in the department.

I still feel the problems are present and that I need professional help to find coping strategies.

I feel if I need on-going therapy I have no choice but to wait for counselling on the NHS.

At the moment the therapy seems more interested in my writing and spelling than the real problem.

**LESS LIKELY**

1. *Waiting times*

The waiting time is very discouraging.

Because this section of the health service has no sense of urgency whilst people are losing their minds daily.

Waiting list too long – had to seek private help.

The ridiculous waiting time.
Feel unimportant and my problems must be trivial to be left like this.

Because there is such a long wait.

2. Environmental aspects

Although the conversation was a good experience, the environment, atmosphere, waiting was awful.

Any Other Comments –

1. Concerns about the cost of private counselling

I do not feel a councillor would be appropriate as I cannot afford to see a psychologist privately.

Ideally I would have liked to use the NHS but I had to find my way to an affordable counsellor. I suppose I am lucky to be working and middle class, but what will I do when I am older and poorer.

I have waited a year for treatment since my initial referral. During that time I have spent more than £2000 on private sessions – with the same psychologist I will eventually see on the NHS. Since Jan 2001 my psychologist has been treating me for free because I can no longer afford to pay and he realises how important the sessions are. But this adds to my own guilt about my illness. I will be very relieved when I finally receive NHS treatment.

The waiting time is far too long. My life is passing me by with me in limbo and I want it sorted. I have seen others on a private basis with a good deal of success, though had to end this as I could no longer afford it.

It’s frustrating and depressing to know that sessions now could help me and I have to wait till god knows when. I want to come of the anti-depressants, but I’m afraid to do so without some kind of support. I cannot afford private therapy and feel angry on my own behalf and for all those in my position.

2. Other comments

I saw a locum doctor. She was really helpful and helped me identify my problems. However, I would have preferred her to have some idea of why I was there (she hadn’t read my detailed mental health report) and so I had to repeat my entire story, which was really hard and tiring. I thought she would have reviewed my situation before seeing me. Due to my case, she felt it was best that I see a psychologist rather than a counsellor, however there was not one available. I feel that waiting months to see someone is a disgrace and I am extremely worried about my own psychological health and wonder what consequences I will have to suffer as a result of waiting so long.

It seems a while ago my first assessment. Feel let down by the year wait. By then, things may be different and it will be hard to bring them up again.
I feel that if I were not so strong it would be very possible for me to have damaged myself because I feel very dismissed.

With mental health issues, it is rarely only the patient that is affected. I don't know what is worse, thinking you are alone and there is no help, or knowing there is real help available but not yet.

I can't believe it's taken so much time for someone to try and help me come to terms with my life. No wonder so many people that need help turn to drink, drugs or suicide.

I think the long wait may have had an adverse affect – as though one day, when I start counselling, it will work as I have waited so long. I may be depending too much on counselling session without even knowing what it will be like.

I felt the counsellor was very sympathetic but I was made aware that I would have to wait up to 18 months for treatment. I am thinking of having hypnotherapy to help with my depression and own eating problems.

My initial assessments were quite disappointing as it felt like the sessions were not 'in depth' enough and remaining on a very shallow level and not addressing a person, but rather a mechanical process. The outcome was rather distressing as I felt more helpless after the session instead of helped and understood. Also I was asking very specific questions about some patterns of behaviour I had identified, but the person didn't seem to know about that.

I would have preferred to be given a rough date of starting counselling. The assessment just left me up in the air, with nothing to anchor on to.

The previous counselling sessions and assessment session opened a can of worms that despite needing to be opened was then just left for me to deal with best I could without the help I needed. Because of the unavoidable delay the can has now been closed and I'm going to have to start the painful process from scratch. I'm not sure I can go through the whole process all over again.

I want to have psy counselling because all the others were crisis counselling and I want more deep counselling to move on in my left and help me not to make same mistakes again, i.e. to change.

I think it is disgraceful that I have had to wait 9 months for the first assessment session and now have to wait a further 9 months. I is obvious that more funding is needed for the service so as to reduce this waiting time and to provide more staff to cover the obvious demands that there is for the service.

It is not professional and useless to advice patients to go for therapy and then have to wait for at least one year for it.

Do not feel that I was accurately assessed, partly my fault as I am anxious and not very forthcoming.

I found the feel of the waiting room terrifying. The space was a small mis-shapen room constructed from a larger room. The reception was located elsewhere and behind a barrier. The doctor arrived a few minutes before my appointment, but she was then joined by another doctor who took up her time for 20 minutes and I even
I felt angry later than the service was so poor and because of the social stigma attached to mental illness, nobody was going to make a fuss. The counselling I received through work helped at a time when I needed counselling and feel that if I had just waited for further session from you it may have been detrimental to my health.

I think it is really bad the amount of time that we have to wait. My initial assessment brought feelings and experiences to the surface that I had buried and I feel as if I had been thrown back out into the world, completely on my own without any help or support to cope with my painful thoughts and memories. It’s almost cruel, giving us just 55 minutes of time, as if to prove that people are doing their jobs and keeping on top of their workloads. I am very disappointed with the service provided.

Feel rather ‘stuck’ at the moment as have to wait another 6 months to commence treatment.

I was unaware that my assessment would not be the beginning of the counselling.

The service provided can only be described as useless for those individuals/ couples who have recognised their mental/ emotional pain and decided to take steps. I’m afraid that whilst those offering the service may well be extremely good – lack of resources negate anything in the service.

It is beyond description when one tells hidden thoughts and feelings to a stranger and then only to be told after 50 minutes that there is nothing to be done for at least 12/18 months. It is so hard and one feels strangely dropped into a cold shower. It’s a shock and disappointment. It was obvious that the assessor felt uncomfortable with the waiting involved also.

I think that travelling out to Hove Polyclinic for psychology appointments is extremely difficult. I have no care and 2 children under 5 to arrange child care for and no family living nearby and friends who mainly work. I would prefer a choice of venue for treatment, i.e. Brighton or Hove

What I don’t understand is to go private I would be seen by next week to stay on waiting list for NHS I wait nearly a year plus, surely that says it all.

I think the time that has elapsed since my first assessment and my next appointment is far too long. I appreciate the NHS resources are very stretched, but the service provided by clinical psychology can mean the difference between life and death.

I was confident after the first meetings, but as the time dragged on without any acknowledgement I went back into my shell and withdrew from family and friends.

I did not feel that the therapist thought I needed/ deserved therapy. I felt her attitude towards me was quite aggressive and that she was not really listening to what I was saying.

Firstly sent by my doctor, but no help. I talk, they listen, better to talk to a brick wall.

Depressed that must wait 2 years?? to see the specialist to address a mental health problem in this day and age is astounding – but appreciate that lack of funding and resources is the root problem, however to myself and 100’s like me, that doesn’t help.
The waiting time has reinforced my belief that no-one really cares.

Frankly I think this survey is a waste of resources that should be spent on providing a quicker service.

Naturally I should be keen to be given psychology therapy as soon as possible, but I understand that resources require a wait of some duration and that the length of the wait is unpredictable.

I feel angry and receiving this questionnaire instead of an appointment and think the department should put it's time, money and resources into seeing clients as quickly as possible and not asking them how they feel about the appalling delays.
What Influence do Religious or Spiritual Trainee Clinical and Counselling Psychologists Perceive their Religious or Spiritual Beliefs have on their Training, with Particular Reference to their Choice of Therapeutic Model

Year 2

Qualitative Research Project

Word Count - 2999 Words
I would like to thank the research participants, whose generosity with their time and willingness to discuss sometimes personal issues made this research possible. I would also like to thank my colleagues in the research group for their support, and Adrian Coyle, the research supervisor for his help and advice.
What Influence do Religious or Spiritual Trainee Clinical and Counselling Psychologists Perceive their Religious or Spiritual Beliefs have on their Training, with Particular Reference to their Choice of Therapeutic Model

Abstract

This study explores the impact which religious or spiritual trainee clinical or counselling psychologists perceive their religious or spiritual beliefs have on their training, particularly focusing upon how these beliefs may influence which therapeutic models they would choose to work with. Short interviews were conducted with 6 religious or spiritual trainees and the data analysed using Interpretative Phenomenological Analysis. Participant's discussion were associated to their thoughts about the nature of the relationship between psychology and their faith beliefs; the impact of their beliefs on the therapy they offered, which was usually conceptualised as positive and their understandable sense that they could be negatively judged because of their faith. The results are discussed in relation to previous literature and the affording of conditions which allow exploration of the impact of psychologist's personal values.

Introduction

Religion has suffered an often turbulent relationship with psychology (Smiley, 2001) and counselling (Zinnbauer & Pargament, 2000). Zinnbauer & Pargament (2000) highlight modern psychological antipathy towards religion, from Freud's conceptualisation of religion as 'illusory wish fulfilment' (Freud, 1927/1961a, cited by Zinnbauer & Pargament, 2000) to contemporary conceptualisations that religion is associated with irrational thinking, inflexibility, intolerance and increased emotional disturbance (Ellis, 1980, cited by Zinnbauer & Pargament, 2000). Myers (1997, cited by Myers & Baker, 1998) notes that religion and psychology are often seen as 'strange bedfellows'. This is not a new notion, as in 1974 Barbour suggested that science and religion are fundamentally incompatible because science is about facts and religion about faith, science is objective and religion is subjective (cited by Jones, 1994). This incommensurability is suggested despite the fact that religious or spiritual beliefs may be of personal relevance to the majority of psychologists (Smiley, 2001). Jones (1994), suggests that psychology's:
“noninteractive stance towards religion was based on an outmoded understanding of science” (p.184), and Genia (2000) notes that evidence in fact suggests that strong religious commitment is actually associated with positive mental health.

Smiley (2001) suggests that the current culture of clinical psychology in the UK: “assumes that most clinical practice is ‘value-neutral’: i.e. that psychologists use value-neutral clinical interventions with clients, in a way that is independent of their own beliefs and values” (p. 165). Zinnbauer & Pargament (2000) suggest that this may be the basis of the religious/psychological antagonism, perhaps as holding somewhat public strong beliefs brings into question the notion of the objective scientific psychologist. Smiley (2001) also however, cites research indicating that value-free practice is illusory, even if it is the therapists intention, and indeed attitudes and beliefs affect a range of therapeutic variables.

Increasingly psychologists are considering the relationships between religion, spirituality and psychology, in terms of the faith of therapists and clients, allowing perhaps more detailed and less attacking understandings of the impact of religion/spirituality on psychological practice. To date, the majority of research has been conducted in the US, a culture which has a different emphasis on religion than the UK (Smiley, 2001). Myers and Baker's (1998) research, however, highlighted the ways in which religiously committed British psychologists consider their faith to be helpful and protective in their clinical work, as well as their belief that clinical psychology in academia and practice ignores religious values, and their sense that their views may be dismissed by colleagues, leading to a sometimes guarded approach towards expressing their religious beliefs with other psychologists. They also highlighted the conflicts which could arise between their religious beliefs and professional work and their sense that integration of the two aspects, rather than their separation was a positive way to manage this conflict. Zinnbauer & Pargament (2000) suggest that counsellor’s values have many profound effects within therapy, including underlying their choice of therapeutic techniques (Patterson, 1989, cited by Zinnbauer & Pargament, 2000). Bilgrave & Deluty's (1998) American study found significant correlations between the particular faith of clinical and counselling psychologists and their psychological theoretical orientation with orthodox
Qualitative Research Project

Christians more likely to chose CBT, those having an Eastern religious faith to be humanistic and Jewish, aetheist or agnostic to be psychodynamic.

Clearly the relationships between religion, spirituality and psychology are complicated and sometimes tense, as well as also being seen as beneficial\textsuperscript{1}. Clinical or counselling psychologists who feel themselves to be religious or spiritual may experience this complicated relationship throughout their practice. The research to date examining the interface between religion/ spirituality and psychology appears to have been conducted with qualified psychologists. It is arguably during the post-graduate training years that clinical and counselling psychologists take their formative steps in terms of starting to decide which therapeutic models appeal to them, and given the pervasive influence of our values on our choices, it seems likely that their religious or spiritual commitment has an impact. Trainee psychologists are exposed to and work with a number of models, as a requirement of their training. This research is seeking to investigate how trainees understand the impact of their religious or spiritual beliefs on their training with a particular focus on whether, or how, their choice of models were affected by their religious or spiritual beliefs.

\textbf{Method}

\textbf{Participants}

Trainee clinical or counselling psychologists who identified themselves as religious or spiritual were recruited through the personal contacts of the researchers. Verbal consent was obtained from each participant before the interview commenced.

\textbf{Interview Schedule}

A semi-structured interview schedule was designed using open-ended questions, non-directive questions supplemented by possible prompt questions aiming to allow participants to share their experience and views about the research question. The advice of Smith (1995a, cited by Willig, 2001) was taken in considering the design and scope of

\textsuperscript{1} See appendix 1 for the different definitions of ‘religious’ and ‘spiritual’ employed in this research.
the interview schedule. Furthermore, researchers attempted to bear in mind the need to be non-directive and create conditions which allowed the participants to as fully as possible share their world-view. After asking participants to describe their religious or spiritual commitment, the schedule focused on exploring the ways that the participant's religious or spiritual beliefs affected their choice of model, where participants saw that their beliefs as compatible with the psychological paradigm, and how they managed any possible conflicts.

**Procedures**

An approximately 20-minute interview was conducted with each research participant, based on the interview schedule. The interviews were tape-recorded, transcribed and anonymised. An initial pilot interview was conducted to test the interview schedule and ensure it generated rich data. The researchers felt the transcript of the pilot interview was rich and interesting and the interview schedule was therefore not changed. See appendix 2 for the semi-structured interview schedule. The remaining five researchers conducted one interview each. See appendix 3 for the full transcript of the interview which this researcher conducted.

**Analytic Strategy**

None of the researchers held religious or spiritual beliefs, and it was felt that the researcher's beliefs in this research arena may therefore be very different from participant's. Accordingly an analytic method which recognises the impossibility of the researchers seeing a completely objective view of the participants worlds was sought, thereby acknowledging that our analysis is necessarily our interpretation of the participant's experience. The analytic methodology chosen was Interpretative Phenomenological Analysis (IPA), because whilst the aim of the analysis is to appreciate and represent the participants world view and understandings, a key principle is that the analysis will also necessarily be affected by the world view and understanding of the researchers (Willig, 2001).
Interview transcripts were therefore analysed according to the recommendations of Willig (2001) and Smith, Jarman & Osborn (1999). The transcripts were thoroughly studied to facilitate the generation of themes, which were then combined to form meaningful clusters across all the interviews. This created a summary representation of the researchers representations of the participant's talk, arising from the interview texts. The themes from each interview were discussed by all the researchers in group meetings in order to clarify which themes were common to many interviews, explore patterns and tensions and to agree the clusters. Themes did not have to be present in all interviews to be represented in the clusters; rather they had to be clear from the text, even if this was only from one interview. However, many themes which are the basis of the clusters were present in many of the interviews.

**Analytic Quality**

Willig (2001) notes that whilst traditional criteria used to judge psychological research are not applicable for qualitative research methodologies, qualitative research can be evaluated. The scope of this report does not allow in-depth discussion of this topic, but it is important to summarise the ways in which the researchers attempted to ensure analytic quality. Chenwitz & Swanson (1986, cited by Golsworthy & Coyle, 1999) suggest that qualitative work is best evaluated by considering ‘evidence’ and ‘credibility’.

Researchers ensured that the emerging themes and clusters were discussed in relation to the evidence in the texts, and clearly indicated by the text. The analysis will therefore be supported by data quotations, allowing readers to personally evaluate the analysis. The research benefited from being conducted by a team of researchers in that we were able to explore whether one person's conception of the data, themes and clusters was shared, or convincing to others. This hopefully ensured that as much as possible, the analysis presents the participants phenomenology's rather than the researchers.
Analysis

Background information

All participants were female, four were trainee counselling psychologists and two were trainee clinical psychologists, their ages ranged from 24 to 51 (mean = 35). The participants were on one of four doctoral level training programmes in the south of England, in the first, second and third years of their training. Five participants defined themselves as white: three as British, one as German and one as American, and one participant defined themselves as ‘half German, half Egyptian’. Two of the participants considered themselves spiritual and four as religious: one as Jewish, two as Christian and one as Muslim. Interview transcripts were numbered and appendix 4 outlines the characteristics of each participant.

Findings

The interviews appeared to allow the participants to share their thoughts and world-views, generating wide-ranging data. The three master themes arising from the analysis are outlined in table 1, together with data examples. Due to the word limits of this project, the first master theme will be focused upon in this analysis, as this aspect of the participant's phenomenology is viewed as influencing all aspects of the relationship between their faith and their psychological work. However, the second and third master themes will first be briefly outlined, based upon the quotes in table 1.
<table>
<thead>
<tr>
<th>Master Theme</th>
<th>Constituent Theme</th>
<th>Examples from Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nature of relationship between beliefs and psychology</td>
<td>• Compatibility</td>
<td>‘R5: I have come across similarities and I have found that it helps. Eh, and if we were talking about, I don’t know, person-centred, Islam does teach, Eh, to find the goodness in other people, and to be good to other people and to empathise with other people, so you’ve got all the core conditions within Islam as well’</td>
</tr>
<tr>
<td></td>
<td>• Conflict – scientific evidence vs. belief</td>
<td>‘R4: I feel that my identification with the Jewish religion and cultural definitely helps me in my clinical work. I feel that it puts me in a privileged position of being able to understand how ethnic minorities may feel’.</td>
</tr>
<tr>
<td></td>
<td>• Integration of beliefs into self</td>
<td>‘R5: I think I probably go against religion, in particular with Islam. Eh, on the one hand Islam tells you to be extremely open to people and to, eh, let them chose their path, let them do what they want, on the other hand Islam teaches that, eh, if you feel that somebody is not on the right path to guide them’</td>
</tr>
<tr>
<td>2. Impact of beliefs on therapy</td>
<td>• Search for meaning</td>
<td>‘R3: I suppose both of them are about looking at meaning and religion, spirituality or whatever can be one kind of context for looking at meaning, and I think for many people religion is about a search for meaning’.</td>
</tr>
<tr>
<td></td>
<td>• Power</td>
<td>‘R2: I suppose one of the things that feels very crucial to me is the issue of power um and that probably, perhaps more than anything else comes out of sort of the way in which I’ve come to understand my spirituality’.</td>
</tr>
<tr>
<td></td>
<td>• Shared journey/mutuality</td>
<td>‘R2: So how would you describe your, your role as a therapist and the way you work within this mentality that you just gave us? R2...it’s a shared journey....but I actually believe that its served by a, something that’s recognised to be a mutual process’.</td>
</tr>
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<td></td>
<td>• Empathy/understanding/acceptance</td>
<td>‘R1: I think empathy is a consequence for me it is an automatic consequence of understanding or having a spiritual viewpoint’</td>
</tr>
<tr>
<td></td>
<td>• Conceptualisation of client/models</td>
<td>‘R2: There are aspects of the person-centred model that are very appealing to me because I do believe in the sort of human capacity for relationship and sort of a bent toward growth, actualisation, human development and a lot of it does come out of this sort of religious orientation’</td>
</tr>
<tr>
<td>3. Perceived Image</td>
<td>• Exposure</td>
<td>‘R2: talking about my experience of spirituality is probably one of the most personal things I could talk about. Might find it easier to talk about sex sometimes’</td>
</tr>
<tr>
<td></td>
<td>• Defensiveness</td>
<td>‘R2: I’m not sure why I’m getting so dry, I think it’s hard to talk about this stuff because you don’t know really how people view it and I’m very aware of the fact that people can have quite strong views about religion.’</td>
</tr>
<tr>
<td></td>
<td>• Fear of Criticism</td>
<td>‘R3: Freud and a lot of psychodynamic theories would see religion as a crutch that you depend on because you can’t face up to issues in your life’.</td>
</tr>
</tbody>
</table>
Impact of Beliefs on Therapy

This master theme refers to the ways participants spoke about their religious or spiritual beliefs (faith) interacting with the therapy they offered. Participants felt that their faith may influence the way they conceptualised clients, 'good therapy' and the therapeutic process. Participants felt drawn towards a number of psychological models, although mostly identified the need to use aspects of models in an integrative and flexible way.

Perceived Image

Participants made many references to their keen sense of how others may perceive their faith; often feeling this may be in negative terms. Participants were therefore somewhat wary about sharing their faith beliefs within their professional life².

R1: Separating yes and no I am separating in my logic at work because you have to accept that you are not on a religious course, that they don't want (laughs) you know to hear about karma and stuff.

Nature of relationship between beliefs and psychology

Participants explored ways they considered their faith to be both compatible and at conflict with a psychological paradigm and held both these positions in mind during interviews. The compatibility theme was evident in participant's talk about their faith as one influence on choosing a counselling or clinical psychology career.

R3: ..I would see it as part of being a Christian and seeing other people's value and kind of, um, feeling that you should do your best by other people and treat them how you'd like to be treated..Yeah, something about it's not right that people have a shit time, and something also probably about, well what, feeling some sense of responsibility for doing that and seeing psychology as a, the thing that best suits my personality and skills as well as values and attitudes and religion on top of that.

² Please note that R refers to the participants talk and I to the interviewers talk.
Interestingly many participants embraced, to some extent a positivistic scientific paradigm of psychology, valuing ‘proof’ and ‘evidence’ whilst holding in mind the notion that their faith could not be proven or evidenced. This was an area where participants therefore identified conflict between their faith and psychological work.

R6: I mean the whole of psychology is a science really.

R4: I feel that there are many aspects of my religion that I identify with that are at odds with many aspects of psychological theory, such as life after death and belief in god. I mean obviously psychology is a very scientific, working from an evidence-based stance and these are certainly not things that can be proven.

Participants were left with the need to manage this incompatibility and some did so by describing their faith and psychology as so different they are incomparable.

R3: In a way it would be like me saying, well you don’t believe in god because you haven’t had that proven to me. In a way you can have different beliefs about different things because they’re different realms.

Despite seeing their religious values as a possible strength within the therapeutic process, e.g. in predisposing them to look for the good in people, participants discussed their ambiguity about bringing their religious/spiritual values into therapy. This was seen as another way of managing the allegation of incompatibility or value-laden practice. Some participants shared a view that these ‘different realms’ could be split and therefore that the belief and value system of their faith would not impact their clinical work.

R4: I don’t feel that my religion or culture influences my conception of any clients at all, I am fully able to detach myself from my own beliefs, values, et cetera for the sake of my clinical work.

Although participants could explore the impact of their religious/spiritual beliefs on their psychological work and thinking, it was also clear that some participants also considered
this a very difficult, if not impossible question to answer, and this is captured in the 'integration of beliefs into self' constituent theme.

R3: I wouldn't be able to pull out my religion from my personality and I'm sure that personality is really closely linked to what models appeal to you and what ones work for you and make sense in your head.

Participants were seen as having belief structures which were integrated, at the same time as their faith impacting on their decision, they were aware of an myriad of other impacts, all of which interact in a complicated way.

Discussion

This research has demonstrated a complex relationship between trainee clinical and counselling psychologist's faith, their psychological conceptualisation, practice and choice of models. It appears that these religious or spiritual trainees considered their faith may influence their clinical training and their choice of models, but in complicated ways, and perhaps we cannot expect to fully separate this impact from the multitude of other influences. The perhaps simplistic research question may have highlighted a great deal about the phenomenology's of the researchers who were therefore pleased that participants were able to elucidate their more complicated view of the impact of various beliefs! Previous literature has tended to focus upon the alleged conflict between religion/ spirituality and psychology. Our participants phenomenology's also felt this conflict, but they also clearly discussed a range of ways in which they considered their faith is advantageous to their psychological thinking and work in ways akin to, but also broader than those reported by Myers & Baker (1998).

Like Myers & Baker's sample (1998) these trainees were acutely aware of how their beliefs may be judged, perhaps especially by other professionals, and I believe this reflects the judgmental stance that psychology as a 'science' has taken to religion, as outlined in the introduction. Trainees are therefore left with the task of managing a created tension and defending themselves against potential criticisms, and this could be argued to be magnified because of the focus on constant appraisal and evaluation within
the training schemes, whereby trainees are sometimes judged against the value system of supervisors. Participants demonstrated two ways in which any incompatibility is managed: seeing psychology and faith as different realms, or stating that religious values are ‘left at the door’ of therapy. Recent thinking, however, suggests that the ‘postmodern’ strategy of segregating science, art and morality is actually undermining to the profession (Parrott, 1999) and that: “a value-free or neutral approach to psychotherapy has become untenable, and is being supplanted by a more open and more complete value-informed perspective” (Bergin, Payne & Richards, 1996, p. 297). Parrott (1999) suggests this is imperative for ethical practice. Myers and Baker’s sample of qualified psychologists (1998) valued integration as a way to manage conflict in a way not explored by our participants. It is possible that this is also a reflection of the trainee status of our participants, both in terms of their constant evaluation and the fact that the managing of this ‘conflict’ is relatively new to our participants.

Every psychologist, whether religious, spiritual or neither, has sometimes strongly held personal values and beliefs, stemming from a variety of experiences, which will influence their psychological work (Parrott, 1999). This research may suggest the benefit of a greater understanding of the impact of every psychologist’s values and belief systems within a position which does not single out those with faith, as I am not aware of any evidence which suggests those without faith are any more able to be value-free in their psychological work. Training is an ideal opportunity to start to explore the impact of our own beliefs, a position which has been suggested as imperative for ethical work (Parrott, 1999). However, putting trainees with faith under a scrutinising spot-light may not aid this process, and may to some extent force trainees to adopt somewhat simplistic mechanisms to manage the alleged conflict, and this may not be conducive with more extensive exploration of values.

This report has necessarily been an overview of very rich conversations and transcripts. The research question was part of an extremely large topic, and it is felt that interviews could easily have continued for well beyond the allocated 20 minutes, and therefore that in many places further exploration would have been interesting and useful but was not possible. The research may have benefited from interviewing just religious or spiritual trainees it is possible that the phenomenology represented is an amalgamation of
disparate phenomenologies. Nevertheless the interviews appear to have allowed participants to share aspects of their phenomenology, allowing some understanding of the experience of being a religious or spiritual trainee counselling or clinical psychologist.
REFERENCES


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APPENDIX 2 – Semi-Structured interview schedule

APPENDIX 3 – Full transcript of researcher’s interview

APPENDIX 4 – Outline of each participant
APPENDIX 1

DEFINITIONS OF RELIGION AND SPIRITUALITY
TAKEN FROM SMILEY (2001)

- Religion is defined as a: 'particular established system of faith and worship, especially of a God or gods' (Concise Oxford English Dictionary, 1982). A 'person's religion' or 'religiosity' is taken to refer to the overall nature of their adherence to the beliefs and practices of established religious institutions.

- Spirituality is defined as 'personal beliefs which may or may not include the concept of God and may or may not emanate from a particular religious institution, but which are concerned with meanings that transcend the self and material reality.'
APPENDIX 2

SEMI-STRUCTURED INTERVIEW SCHEDULE

What influence do trainee clinical and counselling psychologists perceive their religious and/or spiritual beliefs have on their training, with particular reference to their choice of therapeutic model.

1. Demographics
   - Age
   - Gender
   - Ethnicity
   - Education
   - Marital Status
   - Children

2. Do you consider yourself to be religious and/or spiritual?

3. What does being religious/spiritual mean to you?

4. What influence, if at all, do your religious/spiritual beliefs have on your clinical/counselling training, with particular reference to choice of model?

   (Prompts:
   - What therapeutic models appeal to you?)
• Do your beliefs influence the model(s) that you work with? If so, how? If not, why do you think this? Can you give an example(s)?

• In what ways, if at all, are your religious/spiritual beliefs and your choice of model(s) compatible?

• Is this compatibility important?

• In what ways, if at all, are your religious/spiritual beliefs and your choice of model(s) at odds with each other?

• How do you deal with any apparent incompatibility? Can you give an example(s)?
APPENDIX 3
Full Transcript of Researcher's Interview
11th April 2002

Age: 30
Gender: Female
Ethnicity: White British
Educational Attainment: Previously completed MSc, now in third year of Clinical Psychology Training Course
Marital Status: Single
Children: None

I: OK, so thanks for agreeing to do this interview with me. It should only take us about 20 minutes to do. As you know we're going to talk about religion and psychology. Do you consider yourself to be religious?

R: Yes, I would.

I: What is your religion?

R: Christian

I: Apparently there are particular branches of that, which one do you consider yourself?

R: I wouldn't define myself by any particular branch, I don't think. I was confirmed as Episcopalian, which is the Church of England and Scotland, I think, but I was baptised in some branch of the Church of Scotland. Anyway, I would consider myself to be Christian.

I: What is the church you go to most?

R: My parent's church is the only one I consider myself to belong to and that's Episcopalian.
I: What does being religious mean to you?

R: Umm, I suppose it’s a set of beliefs which I hold and might also be attitudes or values. Quite difficult because at times I’ve felt more spiritual than religious in that it hasn’t been buying into any particular religion, but it’s been a set of attitudes or beliefs that are to do with spiritual things, but I would say that at the moment I’m more religious than spiritual.

I: What does that mean to you? What do you see as the difference?

R: What do I mean by religious?

I: Yeah.

R: I suppose a set of things that are actually particular to Christianity rather than just believing about something to do with a god or gods or a one-ness or other-ness that’s to do with kind of some other being.

I: Something bigger than us kind of thing?

R: Yeah. Generally I’ve always had those views but at times they haven’t been specifically religious about god or Christ...

I: Right.

R: Or certain historical things I suppose.

I: How does being religious, does that affect your view of life?

R: Yeah, definitely. I think, I’m not quite sure in a way. There’s something about having been brought up, obviously I have similar beliefs to my parents, that some of the moral codes that I feel I’ve got from them has been to do with religion...
I: Right.

R: but maybe not necessarily all of it and I would be hard pushed to say certain beliefs that I have about say, all people's rights to kind of equal things, I don't think that specifically comes from my religion, but I would see it as being part of being a Christian and seeing people's value and kind of, um, feeling that you should do your best by other people and treat them how you'd like to be treated.

I: It sounds like it's kind of hard to separate it out, like what is because of religion and what's because of upbringing...

R: and values, definitely.

I: Because you don't have to have a religion to have a moral code.

R: Yeah, exactly.

I: OK, so that's a bit of a, of course you can't say what came from where. OK, so does religion affect your view of other people? You might have just answered that.

R: Yeah.

I: Does it affect how you think of yourself? If it does.

R: I suppose just applying the same moral codes to the things that I do rather than... and I suppose in a way, because of the differences between Christianity and other religions, it has more of a should or must or shouldn't or mustn't to it than other religions do.

I: Uh-hum, like Buddhism?

R: I suppose, I mean I think Christianity can be more kind of about you should do this and you should do, and I think maybe other religions are more about, maybe not having
such tight codes, but then other religions have even tighter codes, y'know about what you eat or certain things, so I don't know.

I: Yeah.
R: and I think also because Christianity, because it's quite a prevalent religion as well, in Britain I think Christianity's had to change...

I: Uh-hum

R: So it's not as strong as you must you mustn't, as it was say 40 years ago. Because it's had to keep up with things like, being gay being more acceptable, living together before being married being acceptable.

I: The changes in society, values and...

R: Yeah, changes in society, yeah.

I: Anything else you want to say about religion?

R: No, I don't think so.

I: OK, well this is a really big question, what influence, if any, do your religious beliefs have on your clinical training?

R: Umm, I don't know that it's that direct link, but I think my religious beliefs have influenced my kind of values and attitudes and I think that's influenced and been influenced by my training, so something about getting really strongly pissed off about people in...yeah, I think, but I could see that people could come to the same point without having religious views, but I think for me being religious is caught up in that.

I: Uh-hum.

R: That kind of deep sense of injustice about how people's lives are shit and...
I: Right, so something about responsibility...

R: Yeah.

I: for others, and getting quite cross when that's not...

R: Yeah, something about it's not right that people have a shit time, and something also probably about, well what, feeling some sense of responsibility for doing that and seeing psychology as a the thing that best suits my personality and skills as well as values and attitudes and religion on top of that. So it's kind of one of the things, but it's not the major thing, that influences, kind of, yeah.

I: That's important to you, to see that in the world, and psychology's a way for you to put that into practice, because maybe there's other ways to put that into practice but maybe they don't suit you too well?

R: Yeah.

I: The moral codes important to you?

R: Well, no, the moral code is one of the things and the moral code maybe partly comes from religion and partly doesn't, but yeah, it's all part of this 101 reasons why going into psychology, or doing something like that really, and religion's probably one of them.

I: Uh-hum.

R: But it would be hard to pick out, I wouldn't be able to pick out how much religion was part of my personality, or part of my upbringing, or part of my...

I: Yeah, yeah. Are you saying that in some sense, you don't know how much, but maybe religion was part of the reason you wanted to do psychology, deciding to?
R: Um, I don't know really, because I don't know what I would be like if I didn't have those views.

I: It's an impossible question.

R: Yeah.

I: Does it have an influence, perhaps you're talking about a clinical way here, but does it have an influence on academic work or training experience?

R: Umm.

I: Some people think that we don't cover enough about religions and the meaning they have for people, so if you're not religious yourself, then...

R: Yeah, I think it's difficult for courses to do that because then you're going to alienate people who aren't religious, and if you talk about spiritual, then you might alienate the people who might not be spiritual at all. We had teaching about spirituality that wasn't so much teaching as workshops and so on and that was really interesting, talking about how religion, or spiritual beliefs, as part of any other beliefs might influence your practice.

I: It was about you reflecting on yourself?

R: Yeah, and kind of work and stuff, being in groups.

I: Do you ever kind of get, when you're working with someone, as sense that religion could help, but they're not religious, or may they are but you don't know if you can go down that route?

R: Umm, I don't know. I was talking about this with my supervisor the other day. We were just talking about approaches that he uses, he's Buddhist, and umm, and he was saying that he feels, if someone brings religion into the conversation, or spirituality, then
it's fine to use it. But if someone’s talking about, he would never, I don't think he would raise it and certainly how I feel about it, is I wouldn’t raise it if someone else didn’t...

I: Uh-hum

R: but if someone was saying say, the church has always been important to me and now I feel lost, then as one of the things of talking about where might you find support, y’know, I might say, oh, well do you think you might want to look at...

I: Mmm.

R: But I don’t think I'd say you should go to church or do you want to go to church, but is church one of the things, y’know, do you think that one of the things you might want to think about is going to church, going to an exercise class or thinking about adult education...

I: Right.

R: Some other places of meeting people and I think I’d put it like that rather than.

I: And that’s only if they've introduced it.

R: Yeah, if they've introduced it, or if they've kind of hinted that they'd be interested if they talked about something and I thought, oh that sounds like they're quite into spirituality, then I’d maybe say, y’know, are you interested in ways of looking at the world or spiritual things.

I: Right.

R: But I think unless they've given some hint it’s not something I would go into, because I think people are usually quite... I think being a psychologist is quite a powerful position and you have to be careful.
I: What therapeutic models appeal to you most?

R: Er, psychodynamic and systemic are the two that I think fit best with how I work and how I think.

I: Any particular in systemic, is it just across the board or is there anything within that?

R: Just general sort of...

I: A bit from here and a bit from there?

R: Yeah, just ways of thinking systemically, I suppose, in a very generic way, a general way.

I: So not getting too bogged down in structural stuff, for example.

R: No, I wouldn't sort of think this is structured, this is Milan, this is post-Milan, whatever. Umm, I guess not very structured stuff because I don't work in a very structured way.

I: Do you think your religious belief influence the models that you work with and the fact that those two appeal to you?

R: Umm, I don't think so, I haven't actually thought about it. I suppose both of them are about looking at meaning and religion, spirituality, or whatever can be one kind of context for looking at meaning, and I think for many people religion is about a search for meaning.

I: Uh-hum.

R: And making sense of who you are in the world, and how you are in the world.

I: Mmm.
R: But, I mean as opposed to CBT or something which doesn't generally look at meaning and that kind of search for things.

I: So, CBT's more looking at solutions?

R: Well, not so much, just that CBT's very much more structured and isn't a kind of wondering, it's more of a knowledge based, boom, boom, boom, do this, do that, whereas I think in psychodynamic work and in systemic work there is room for a kind of reflecting on things and grappling with some of the bigger issues, all kind of, I mean existential therapy kind of fits in with the psychodynamic therapy in that kind of, what is this about? And systemic therapy as well, the both kind of look at the fact that mental health isn't a discrete entity, and this is mental health and this is mental illness and there's nothing in between...

I: Yeah.

R: and I think CBT doesn't say there's nothing in between, but it's much more black and white.

I: Yeah, it's really into DSM and you do this for this, so you have to know that the this is.

R: Yeah, exactly, there's much more certainty, and I think both psychodynamic and systemic (inaudible).

I: So is it hard to say whether your beliefs have directly impacted, but it's something about what's important to you in life comes out...

R: Yeah, again it comes back to that thing of I couldn't say what my personality would be without religion, but I'm sure it's something to do with the match between my personality and the models.

I: Something about them being inter-linked rather than that causes that causes that.
R: Yeah, exactly, that I wouldn’t be really able to say that.

I: Can you give me an example of where that search for meanings been important?

R: Someone I worked with in my older adult placement very much wanted to look at kind of life review work, it was about the fact that she’d been a heavy drinker for a number of years and she’d stopped drinking now, but drinking had actually helped her cope with a lot of things and she now wanted someone to talk to about how she could might cope with things.

I: OK.

R: We agreed to meet for 6 sessions and just talk about how her life had been about and how she made sense of her life. And I suppose that sense of kind of making sense of your life and knowing that you’re coming to the end of your life and wondering what it’s all been about...

I: Mmm.

R: To me fitted in quite a lot with thoughts about spirituality. Although we didn’t talk about it a great deal in the therapy, she referred to it a couple of times and it was on my thoughts for a lot of that work. She talked about the work we did together as a search for joy, trying to get some joy back into her life, and kind of work out how she got the joy back into her life, which was really interesting.

I: It felt very much like that search for meaning thing?

R: Yeah, and that’s where spirituality came into a bit, yeah.

I: In what way are your religious beliefs and choice of therapeutic models compatible.

R: They’re quite compatible. But I know, well psychodynamic approaches to, well, Freud.
R: Yeah, well it's funny. The kind of Jung ideas of spirituality and looking for meaning were quite compatible with spirituality, whereas Freud and a lot of psychodynamic theories would kind of see religion as a crutch that you depend on because you can't face up to issues in your life...

I: Yeah.

R: and therefore you have to defer to this great being. But I don't know how, I mean I've heard those ideas, but I don't know if that is pure psychodynamic, in the way that is a strongly held across psychodynamic views...

I: Mmm.

R: but in a way that doesn't influence how I work, use psychodynamic work.

I: You use psychodynamic in a way that makes sense to you and if there are people saying that, whatever.

R: Yeah, because psychodynamic is huge, it's lots of bits of things that people have said about different things. Psychodynamic work and how you use it, you don't need to, y'know.

I: Everything that anybody's ever said, you have to...

R: Exactly, you don't need have to adhere to it, like it's some kind of.

I: What about evidence? Psychodynamic, well, this is one way of looking at it, is quite into evidence. Freud came at it very psychodynamically.

R: Blimey, I didn't know that.
I: And in that way I see it as similar to CBT, although CBT has really run with that! And you can’t scientifically prove god.

R: You can’t scientifically prove the sky.

I: Scientists might argue you could.

R: I think in a way, evidence can be taking a case to supervision and thinking about it and what you did, to kind of check out whether you’re doing things that make sense.

I: Do you have quite a broad definition of evidence, does it fit better and make more sense.

R: No, I think if I was into CBT I don’t think that would be incompatible.

I: We started thinking about this because of a person we know who is really into CBT and really religious and we were thinking that CBT is very much based on evidence that you can scientifically prove things and then do it. But you can’t prove god. I don’t really believe in that rhetoric of science, but she really is, whole-heartedly.

R: But that wasn’t always behind CBT. The evidence-based practice stuff has come in more recently and CBT’s the kind of stuff that stands up to it, but actually psychodynamic stuff stands up to it, systemic work stands up to evidence-based practice. It’s just that CBT is the one that’s held up by that, but if you think about it, what they’ve said in all the studies is it doesn’t matter what you do, it’s the therapeutic alliance.

I: Mmm.

I: How would you feel about using a therapy that didn’t stand up to the evidence-based stuff?

R: What?
I: Well, in a way, you can't prove god, it's faith.

R: Faith, yeah.

I: So are there things you have faith in, in psychology that aren't proven, can't be proven, haven't been proven.

R: I don't know, because in a way, you wouldn't get taught things that weren't, do you know what I mean?
I: So it sounds like maybe I'm thinking of it as slightly incompatible, but you're not.

R: No, because psychology sits itself in science, more or less comfortably between art and science and art would never prove anything, it wouldn't make sense at all. In a way, it sounds like you're saying you can't prove god, would you go for psychology if you couldn't prove it.

I: Yeah, kind of.

R: In a way it would be like me saying, well you don't believe in god because you haven't had that proven to me. In a way you can have different beliefs about different things because they're different realms. Does that make sense?

I: Could you tell me more about different realms.

R: You can have some things in your life that are certain and some things that aren't and that doesn't make them incompatible.

I: So are you saying that there are some things you can prove and some things that you can't and you just face it?

R: No, not necessarily, it's just different things, that's all.

I: I'm wondering how much you are into the science base of psychology.
R: Not hugely.

I: Some people I think would see psychology very much as a science.

R: I think it sits bang in the middle. But even physics has an uncertainty principle about the things that we can't know.

I: Does that mean that some of the things we do in psychology, we can know, can study in that way, but some things we can't, some things in life we can't.

R: Yeah, it depends on how you mean by study. There are some things that we can say, look I've caught a snap-shot of this and this is what I'm going to say about the snap-shot, but I can't tell you what the other 99 point whatever percent is, this is just what I'm talking about here.

I: Uh-hum.

R: And then there are things that I think you can be a bit more general about, you can say yes there are distinct differences between this and that, but psychology is such a huge thing.

I: OK, thanks very much, the broad question was what influence do your religious beliefs about on your training, with particular reference to your choice of therapeutic models, was there anything else to add to make more sense of it?

R: Yeah, I wouldn't say that my religion was something I thought about in psychology and my choice of model, but on the other hand I wouldn't be able to pull out my religion from my personality and I'm sure that personality is really closely linked to what models appeal to you and what ones work for you and make sense in your head.

I: Yeah.
R: And your values and attitudes will do that as well, and I wouldn't be able to pull out religion from those attitudes, so in that way it would be an influence.

I: And there's lots of other influences too.

R: Yeah.

I: Ok, thanks very much for talking to me about all of that. Did you find it OK?

R: Yeah, it was fine, interesting.

I: Was there anything else you wanted to add?

R: No, I don't think so.

I: Well, thanks again.
APPENDIX 4

Outline of Participants

PARTICIPANT 1 - 33 years old. Spiritual.

PARTICIPANT 2 - 51 years old. Spiritual.

PARTICIPANT 3 - 30 years old. Religious (Christian)

PARTICIPANT 4 - 27 years old. Religious (Jewish)

PARTICIPANT 5 - 24 years old. Religious (Muslim)

PARTICIPANT 6 - 44 years old. Religious (Christian)

Year 3

Major Research Project

Word Count – 19,992 words
Major Research Project

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Abstract

Using a Foucauldian discourse analysis on the texts of ten interviews with care staff this research explored the discourses used by care staff in constructing the aggressive challenging behaviours of men and women with learning disabilities and discourses differentially used to understand the aggressive challenging behaviour of only one gender.

The analysis demonstrated the use of two main discourses, an individual pathology discourse which constructed the behaviour as originating in factors stable and internal to the client and a context discourse which constructed the behaviour as a response to the client's circumstances. Participants used these accounts flexibly within their talk and also used a mixed discourse which constructed the behaviour as due to both individual pathology and context.

Despite the staff presenting their understandings as not being affected by the client's gender, the presence of two gendered individualising discourses within the interviews was also demonstrated. Women's behaviour, unlike men's, was constructed with the use of discourses about their menstrual cycle or character flaws.

The consequences of the use of these different discourses were discussed, as were the subject positions which they afford for both staff and clients. It is argued that clients are disempowered by the individual pathology discourse, that consideration of the broad contexts within which care staff actions are situated may allow them to manage blame whilst reflecting on their practice and that the impact of gender stereotypes on the understandings staff have of a client's behaviour should be a legitimate area for consideration in clinical practice.
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Introduction

This research explores the discourses used in constructions of aggressive challenging behaviours in adults with learning disabilities. Discourses used by care staff when talking about aggressive challenging behaviours will be explicating, as will discourses differentially used to understand the challenging behaviour of only one gender. Consequences of these discourses will be highlighted and implications for clinical practice explored. This introduction will, by necessity, be a short foray into a range of complex areas. Challenging behaviour will be defined, its prevalence discussed and models used to understand it overviewed. Research exploring care staff's impact on challenging behaviour and the impact of challenging behaviour on care staff will then be considered before research regarding the influence of gender stereotypes on how behaviours are understood and explained is discussed. These literatures have not been conducted from a social constructionist perspective and are therefore open to critique from such a position. However, they will be presented in order that readers can see how the current research fits within a broader picture. Finally, the methodology of discourse analysis, which this research uses to achieve its aims, will be introduced.

Challenging Behaviour

Box 1 – Reflexive Boxes

As recommended by Edwards and Potter (1992) reflexive boxes will be used throughout this text to step outside the main body of the report, allowing specific issues to be highlighted and explored.

Definition

The most commonly used definition of challenging behaviour is that of Emerson (1995): "culturally abnormal behaviour 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). Emerson et al. (2001) categorised a number of 'types' of challenging behaviour, these being: aggression (for example hitting
others with hands or objects, scratching others, pinching or biting others); destructive behaviour; self-injury and other (for example smearing faeces, inappropriate sexual behaviour or screaming). The term as used in this report will always refer to the challenging behaviour of people with learning disabilities.

Box 2 - Using ‘inverted commas’ and “speech marks”

Inverted commas are used to draw attention to the constructed nature of ‘things’ that are taken for granted (Coyle, 2000). Speech marks are used to signify that text is a direct quote either from published research or from the research interviews.

The concept of ‘challenging behaviour’ was posed as an alternative to the previous terms of ‘problem behaviour’ or ‘behavioural disorder’ and seen as moving focus from an individual’s deficit to a shared responsibility, placing emphasis on the need for services to understand and help the individual (Lowe & Felce, 1995). It became widely used after the publication of the influential document ‘Facing the Challenge’ (Blunden & Allen, 1987). In the words of Clegg (1994): “the term was intended to oppose individual descriptions of people with behaviour problems or behaviour disorder: its proponents aimed to have environments adapted to meet the needs of clients, rather than vice versa”. However, there is doubt about whether this modification in terminology has effected these changes (Lowe & Felce, 1995).

Prevalence

The degree to which a behaviour is considered challenging depends on factors such as the extent to which it is contrary to the expected norms of a given context. Given the subjective nature of the definition of challenging behaviour, prevalence estimates vary widely (Qureshi & Alborz, 1992). However, Emerson et al.’s (2001) total population study of people in contact with health, educational, or social care services in two health district areas of England, suggested that 10 to 15 percent of people with learning disabilities have challenging behaviours, the majority of these being young adults.

Many people with challenging behaviour show more than one type of challenging behaviour (Emerson et al., 2001). Estimates suggest that seven percent of people with
learning disabilities show aggressive challenging behaviours, four to five percent destructive challenging behaviours, four percent self-injury and 12 percent ‘other’ challenging behaviours (Emerson et al., 2001). Aggressive challenging behaviour is more prevalent in less severely learning disabled people and self-injury is more prevalent in more severely disabled people (Emerson et al., 2001). Challenging behaviour is more prevalent amongst people with more severe learning disabilities and also amongst people with some syndromes, for example autism (Emerson, 1998).

The available evidence suggests that challenging behaviours may be extremely persistent over time (Emerson, 1995). The behaviours are costly to manage and lead frequently to significant care and social burdens (Felce et al., 2000, cited by Moss, Emerson, Kiernan, Turner, Hatton & Alborz, 2000).

Challenging Behaviour and Gender

Researchers have shown that challenging behaviours are differentially represented in men and women (Benson, 1985). Sixty-eight percent of those identified as having challenging behaviours in Emerson et al’s (2001) study were male. The increased incidence of men amongst those identified as having challenging behaviours is further enhanced when specific challenging behaviours are considered. Borthwick-Duffy (1994), for example, suggested that 73% of people with learning disabilities showing property destruction and aggression were male (cited by Emerson, 1995). Women are more likely than men to show multiple topographies of challenging behaviour (Emerson, 1995).

Models of Challenging Behaviour

There are a large range of theories about the causes of challenging behaviour, each suggesting different interventions. Behavioural and neurobiological models have been the most influential (Emerson, 1998) and will therefore be briefly outlined.

Behavioural models view challenging behaviour as an example of operant behaviour (Emerson, 1998). The behaviour is seen as in some way functional for the person, given its consequences. Operant conditioning theories propose that behaviour is a learned response shaped and maintained by external contingencies. Behaviour is seen as both
functional and adaptive, as a means of exerting control over the environment. Neurobiological explanations have suggested the influence of three neurotransmitters on challenging behaviour: Serotonin, Dopamine and β-Endorphin, the latter two being posited as influential in self-injurious challenging behaviours. For example, β-Endorphin is released by the body in response to repeated trauma and can induce euphoria and analgesia. It is suggested that its release in response to self-injurious behaviour is an automatic reinforcer (Emerson, 1998).

However, a range of other models also hypothesise about the causes of challenging behaviour, including communication models (e.g. Carr, Levin, McConnachie, Carlson, Kemp & Smith, 1994), behavioural phenotype models (e.g. Deb, 1998; Murphy, 1999) attachment theory (e.g. Clegg & Landsdall-Welfare, 1995, cited by Clegg & Sheard, 2002; Clegg & Sheard, 2002; Janseen, Schuengel and Stolk, 2002), psychoanalytic/psychodynamic models (e.g. Berry, 2003; Sinason, 1992), ecological models (e.g. Allison, Basile & Macdonald, 1991 and Touchette, Macdonald & Langer, 1985, both cited by Whitaker, 2001), cognitive models (e.g. Jahoda, Trower, Pert & Finn, 2001; Rossiter, Hunnisett & Pulsford, 1998), and models which are explicitly multi-modal (e.g. LaVigna, Willis & Donnellan, 1989, cited by Carson, Clare & Murphy, 1998). It has also been suggested that some challenging behaviour may be atypical presentations of psychiatric disorders (Emerson, Moss & Kiernan, 1999).

There is generally a paucity of evidence regarding the impact of interventions for challenging behaviour. Medication is currently the most popular treatment for challenging behaviour, although there is little, if any, empirical evidence to support its efficacy (Brylewski & Duggan, 1999; Kennedy & Meyer, 1998). The second most popular treatment is behavioural interventions (McGill, 1993). A minority of the reported case studies using behavioural interventions were highly effective at reducing target behaviours although externally destructive behaviours, such as aggression, tended to be even less successfully treated (Didden, Duker & Korzilius, 1997; Scotti, Evans, Meyer & Walker, 1991). Evidence for the maintenance and generalisation of gains following behavioural interventions is disappointing (McGill, 1993).
Care Staff Research

Research and thinking relating to the care staff who work with people who have challenging behaviours has considered both the influence of carers on challenging behaviours and the influence of challenging behaviours on carers. These areas will be outlined.

The Impact of Care Staff Reactions on Challenging Behaviour

Studies conducted by Hastings and colleagues (Hastings, 1997a, b; Hastings, 1996; Hastings & Remington, 1995; Hastings & Remington, 1994a, b; Hastings, Remington & Hopper, 1995), who clearly espouse behavioural theories, have suggested that staff reactions are often influential in the development or maintenance of challenging behaviour.

These studies found that care staff often used short-term strategies to manage behaviour, such as providing attention or stimulation, which according to behavioural understandings would actually be expected to reinforce the behaviour. So whilst care staff tended to explain the behaviour in ways compatible with behavioural reasoning, such as describing it as a communicative act, their strategies for intervention were not compatible with a behavioural hypothesis. Hall and Oliver (1992) and Oliver (1995) suggested that staff experience challenging behaviour as aversive stimuli and thus act to reduce the experience. Any of their behaviours which in the short-term reduce the challenging behaviours are therefore themselves reinforced. These considerations have been suggested as influential in staffs' adherence to suggested interventions (Hastings & Remington, 1994a).

Such studies have, however, been criticised (Clegg, 1994) for their condemnation and blaming of care staff. Care staff do not tend to use such hypotheses themselves in understanding their clients' behaviours. Heyman, Swain and Gillman (1998) interviewed eight day-care staff about the challenging behaviour of their clients. Their participants explained incidents in terms of the clients' dispositions, circumstances and interaction strategies. It was very rare for the staff to talk about their own actions when explaining the behaviour.
Attribution theory has been increasingly used over the past few years to understand the impact of staffs’ understandings about challenging behaviours. Attribution theory attempts to explain how people try to find causal explanations for events and behaviours (Heider, 1958).

Most research regarding the impact of care staff attributions on the outcome of interventions for challenging behaviour has drawn upon Weiner’s attributional model of helping behaviour (Weiner, 1974, 1980, 1986, cited by Stanley & Standen, 2000; Weiner, 2001). Weiner’s model proposed a dimensional structure of causal attributions, whereby others’ social conduct is judged according to its locus, stability and controllability. The emotions experienced following an event are hypothesised to be dependent on attributions along these three dimensions and the experienced emotion, in turn, is suggested to determine a person’s behaviour. The model suggests that if the challenging behaviour is seen as being under the person’s control (e.g. they are seeking attention) then staff will be more likely to react with anger and less likely to help the person. From this cognitive perspective, the attributions staff make regarding challenging behaviour are seen as central in predicting their emotional and behavioural responses (Dunne, 1994, cited by Wanless & Jahoda, 2002).

Tentative support has been found for a link between attributions and subsequent staff behaviour. Maurice and Trudel (1982, cited by Stanley & Standen, 2000) asked carers about causes of clients’ self-injury and found that explanations in terms of clients’ anger were associated with the use of isolation as an intervention.

Attributions of responsibility for challenging behaviour are complicated by the perceived severity of the learning disability (Fenwick, 1995). Fincham and Roberts (1985, cited by Fenwick, 1995) found that people described as mentally disturbed were seen as less responsible for the harmful outcomes of their behaviour. The perceived severity of a learning disability may therefore influence judgements about control and intentionality, which in turn could affect staffs’ emotional reactions and behaviour. Vignette studies have also offered some support for this hypothesis. Stanley and Standen, (2000), for
example, assessed 50 care staff working in challenging behaviour day services. Their results suggested that the more able the client, the greater were attributions of client's control, the greater were the reported negative affects and the less the staffs' propensity to help.

**Box 3 – Social Constructionist Critique of Attribution Theory**

Attribution theory suggests individuals acquire assumptions and expectations which shape their behaviour (Willig, 2000) Social constructionists have critiqued this model on the basis that it overemphasises the role of cognitions whilst underemphasising the social context within which behaviours take place (e.g. Radley, 1994, cited by Willig, 2000). Instead of seeing cognitions as consistent and stable, it is suggested that talk about, for example, health cognitions is a social practice, being the “mobilisation of culturally available explanations” (Willig, 2000, p 548) rather than the expression of inner thoughts. Individual speakers are therefore likely to draw upon different and often contradictory arguments in their talk.

However, Wanless and Jahoda (2002) suggested vignettes do not evoke the same range and depth of cognitive and emotional reactions and do not take account of the existing relationship between carer and client. Their study with 38 day-centre staff found significant differences between staff responses to real and hypothetical scenarios. The real incidents appeared to evoke stronger emotions and more negative evaluations of clients and their behaviour, this being particularly so when comparing incidents of physical aggression. Staff perceptions of the real clients were significantly associated with their reported cognitive and emotional responses to the behaviour. More negatively evaluated clients were more likely to attract attributions of internality and control. In this study, aspects of Weiner's model were challenged, as high levels of staff anger and the view that the clients were in control of their aggressive behaviour were both associated with an increase in staffs' willingness to help. It was suggested that Weiner's model may not capture the stressful emotions experienced by staff or accommodate the dynamic nature of the interaction between staff and clients as described, for example, in the Hastings studies.
Care Staff Stress

Current understandings suggest those working with people with challenging behaviours experience considerable stress (Clements, 1997), although research demonstrating a causal link is limited (Hastings, 2002). Burnout is, however, often considered a risk for staff working in learning disability services, burnout being defined as a state of 'emotional exhaustion', 'depersonalisation' and 'lack of personal accomplishment' (Maslach, 1982, cited by Murray, Sinclair, Kidd, Quigley & McKenzie, 1999). Consideration of care staff stress is important not just because of staff welfare, but also because of the effects of this on their perceptions of, and reactions to, their clients (Hastings & Brown, 2002).

Increasingly researchers have become interested in possible mediating variables between the challenging behaviour of clients and the stress experienced by care staff. Murray, Sinclair, Kidd, Quigley & Mackenzie (1999) found no relationship between assault levels and staff sickness in a study of 18 staff members in residential services for adults with challenging behaviours. They suggested that the staff's emotional reactions to assault may be mediated by feelings of knowledge about the causes of challenging behaviour and strategies to reduce it, as well as positive staff relationships.

Mitchell and Hastings (2001) found that care staff stress was significantly associated with coping style used in reaction to aggressive challenging behaviour, based on research with 83 staff. They suggested a 'disengagement' form of coping was predictive of 'emotional exhaustion' and 'personal accomplishment burnout' (defined as staff members evaluating themselves and their accomplishments negatively), whereas 'adaptive coping' (for example taking action to deal with the behaviours) was predictive of feelings of personal accomplishment. Hastings and Brown (2002) included a measure of exposure to challenging behaviour in their research with 55 staff members in a school for children with developmental disabilities. The authors suggested that use of 'maladaptive coping strategies' (for example behavioural disengagement, self-blame, venting or denial) constituted a risk for staff burnout and that this risk was additional to the risk associated with exposure to challenging behaviour.
Gender

Gender has been described as a powerful lens through which we see the world (Hoffman, 1990). Orbach (1997) notes that when a child is born one of the first questions asked is if it is a boy or a girl. From that moment on the child's gender affects how people interact with it and their expectations of it (see appendix 1 for summary of social constructionist understandings of gender). Over the past three decades, and against the background of dramatically different rates of mental illnesses for men and women (Ross, Frances & Widiger, 1997), researchers have been turning their attention to the possible impact of the 'gender lens' on our understanding and labelling of the behaviour of men and women. With relation to diagnostic issues a number of studies have suggested the biasing effect of the client's gender.

The General Health Questionnaire

Redman, Webb, Hennrikus, Gordon and Sanson-Fisher (1991) investigated the effect of patient's gender on 56 primary care physicians' detection of possible psychological disturbance. One thousand nine hundred and thirteen patients (1175 women and 738 men) completed a GHQ (general health questionnaire) prior to their consultations, immediately after which the doctors completed a questionnaire rating the patient's level of emotional and psychiatric disturbance. The doctors suggested a significantly greater rate of disturbance for their female patients but the GHQ ratings did not.

Depression

Gender stereotypes also appear to impact on the treatment of men and women with depression, with women being much more likely to be prescribed drugs for depression than men (Denmark, Rabinowitz & Sechzer, 2000). Wilcox (1992) found that medical students who listened to a tape of either a man or woman describing the same typical symptoms of depression perceived the woman as less seriously ill but were more likely to recommend psychotropic treatments.
Personality Disorders

There are significantly more women than men with a diagnosis of borderline personality disorder (Simmons, 1992). One theory suggests that many behaviours, for example sexual promiscuity, excessive anger or argumentativeness, which could lead to a diagnosis of borderline personality disorder are actually more acceptable in men and therefore less likely to be considered a sign of pathology (Simmons, 1992).

Histrionic and antisocial personality disorders also have different rates of diagnosis for men and women (Kass et al., 1983 and Reich, 1987, both cited by Ford & Widiger, 1989). Ford and Widiger (1989) sent vignette studies to 354 psychologists. The gender of the client in otherwise identical vignettes affected the psychologists' ratings. Female clients were significantly more likely to receive a diagnosis of histrionic personality disorder and men of anti-social personality disorder.

Gender and Learning Disabilities

The impact of gender stereotypes has been a generally neglected topic within the field of learning disabilities (Scior, 2000) and increasingly learning disabilities services are being accused of being "gender blind" (Burns, 2000; Clements, Clare & Ezelle, 1995). Care services are said to deny a gendered identity for men and women with learning disabilities and this is suggested to have a number of powerful implications.

Despite the power of gender issues in our society, 'unusual' behaviours are usually not conceptualised with any reference to the client's gender, but often instead attributed to their learning disability (Burns, 2000). Clements et al. (1995) argue that lack of awareness about gender issues in learning disabilities services could contribute to the development of challenging behaviour. For example they suggest that challenging behaviour may arise when a service user is offered personal care by a person of the same gender as the one that abused them. Little research has considered the impact of a gender bias on reactions to challenging behaviour, although Scotti et al's (1991) meta-analysis suggested that women were significantly more likely than men to receive more
intrusive behavioural interventions, despite the lack of gender difference in the severity of behaviours.

Discourse Analysis

Discourse Analysis is a research methodology compatible with a social constructionist epistemology (outlined in appendix 2). Discourse analysis assumes that language, rather than reflecting psychological and social realities, actually constructs these realities (Coyle, 2000). As language users, we have a selection of linguistic resources available to us which are specific to the here and now and that we can use to construct a version of events (Coyle, 2000). Discourse analysts do not consider that studying people’s language gives us access to their psychological and social worlds, focusing instead on how people use language to construct versions of the world and what they achieve through these constructions.

Definitions of ‘Discourses’

Within this understanding, a ‘discourse’ is thought of as a “systematic, coherent set of images, metaphors and so on that construct an object in a particular way” (Burr, 1995, p. 184). This is perhaps best explained by example. Burr (1995) explains the concept of a discourse in relation to foxhunting, within which there could be seen the ‘fox hunting as pest control’ discourse but also a ‘foxhunting as the contravention of basic morality’ discourse or perhaps ‘foxhunting as healthy outdoor sport’ discourse. Each discourse constructs the same object in very different ways and has dramatically different implications.

Types of Discourse Analysis

There are an array of approaches under the umbrella of discourse analysis (Parker, 1999), but arguably two main types which have both become increasingly influential over the past two decades. These take, respectively, a very fine-grained analysis or a more global form of analysis (Wetherell & Edley, 1999; Willig, 2001) and can be termed ‘conversational analysis’ and ‘Foucauldian discourse analysis’. However, discourse analysts are increasingly arguing for the benefits of integrating both these methods,
whereby the discourses that people use are elucidated and, at the same time, the rhetorical strategies that people draw upon to make their accounts convincing are considered (Wetherell & Edley, 1999; Harper, 1999; Harper, 1994). This research uses a broadly Foucauldian discourse analysis, which will therefore be described. However, attention will also be paid to rhetorical strategies participants use.

Foucauldian Discourse Analysis

Foucauldian discourse analysis has grown out of the work and writings of the philosopher Michel Foucault (see appendix 3 for a brief synopsis of Foucault’s work). A Foucauldian discourse analysis focuses on elucidating the discourses available within a culture and exploring the ways of being in and ways of seeing the world these discourses make available. Analysts also pay attention go the ‘subject positions’ offered by discourses. Discourses construct subjects, as well as objects, by making positions available within networks of meaning. Speakers can take up or resist subject positions, as well as position others (see Burr, 1995 and Davies and Harré, 2001). The concept of ‘subject positions’ has been described in terms of a “discursive interpretation of the social psychological concept of identity” (Coyle, 2000, p. 259), or a “dynamic alternative to the more static concept of role” (Van Langenhove & Harré, 1999, p.14). In a social constructionist understanding therefore, such ‘identities’ can be permanent, temporary or even fleeting. Subject positions bring with them a set of rights and obligations, and once we have taken one up it is suggested that we experience the world through the lens of that position. There are therefore clear consequences to the taking up or rejecting of a subject position (Burr, 1995).

Foucauldian discourse analysis considers that the use of discourses is intimately bound up with the exercise of power (Willig, 2001). Dominant discourses are seen as those that privilege versions of reality which allow the continuation of present power relations and existing social structures. They have come to be thought of as ‘common sense’ such that it is hard to see how they could be challenged. However, analysts consider that there are always co-existing ‘counter-discourses’ which present a different version of reality and challenge the dominant discourse. Foucauldian discourse analysis also takes an historical perspective, exploring the ways that discourses change over time. Finally, this type of analysis is concerned with the way that institutions are affected by discourses,
considering that discourse are intimately bound up with institutional practices. As Willig (2001) says: “while discourses legitimate and reinforce existing social and institutional practices, these structures, in turn, also support and validate the discourses” (Willig, p. 107).

**Previous Research**

Discourse analysis has been used to explore the culturally available discourses which speakers can use in constructing a range of issues from ‘paranoia’ (Harper, 1994) to ‘sex work’ (Wetherall & Priestly, 2001). Social constructionist research regarding learning disability issues is still, however, somewhat sparse, although a few papers have been published.

Social constructionist research studies have suggested that constructions of learning disability and ‘mental retardation’ serve to demean those so labelled and construct them as objects of cultural fear (Danforth & Navarro, 1998); legitimate the social control of people with learning disabilities through the construction of “defective” identities for the learning disabled (Peter, 2000); silence the versions of events proposed by people with learning disabilities (Biklen & Lambert-Schein, 2001; Bogdan & Taylor, 1994; Gerber, 1990); and move focus from contextual factors to factors said to be inside the person (Biklen & Lambert-Schein, 2001).

**Research Aims**

To date social constructionist research has not studied challenging behaviour discourses nor considered the impact of gender stereotypes on such constructions. Exploration of dominant and counter discourses may allow for the power issues which influence services for people with challenging behaviour to be illuminated, supporting clinicians to be reflective about the full implications of interventions offered. Such deconstructing of ‘common-sense’ could therefore contribute to endeavours to empower the users of those services (Peter, 2000).
This research uses discourse analysis to investigate the following questions:

1. What discourses do care staff use to describe and explain aggressive challenging behaviour in adults with learning disabilities?

2. What are the impact of gender discourses on constructions of aggressive challenging behaviour in adults with learning disabilities?

3. What are the effects of these discourses?

4. What positions are made available for care staff, clients and others within these discourses?

5. What are the implications of the discursive constructions and subject positions in terms of practice?
Method

Research Design

Discourse analysts conceptualise all spoken and written material as texts which can be therefore subjected to a discourse analysis (Coyle, 2000). Discourse analysts are concerned to analyse anything which allows consideration of the way an 'object' is constructed. Interviews have been extensively used in discourse analytic research as they can be a particularly effective way to access the range of discourses that a participant is using, as well as the uses to which these are put (Potter, 1996a). Semi-structured interviews were therefore designed to allow participants to display the range of culturally available discourses that they were using in constructions of aggressive challenging behaviour.

This research used a broadly Foucauldian Discourse analysis, but at the same time paid attention to the textual detail, elucidating some of the rhetorical strategies participants used in the moment to moment interactions and demonstrating how these strategies worked to convince others of the factual status of constructions (following the recommendations of Harper, 1999; Harper, 1994 and Wetherell & Edley, 1999, as outlined in the introduction).

Participants

Ten interviews were conducted, five with paid carers of men with a learning disability and challenging behaviour and five with paid carers of women with a learning disability and challenging behaviour. Eight of the participants were female and two were male. Nine participants described themselves as white British and one as white Irish. Their ages ranged from 26 to 58 and they had between three and 20 years experience working with adults with learning disabilities. Six of the participants were currently working in residential services, two in community support services and two in day centres. Each of the participants worked in a different service. All participants were currently working directly with a client who had been recently referred to the same community team in the
south east of England because of the client’s aggressive challenging behaviours. Appendix 4 contains individual information about each participant.1

Ethical Approval

Ethical approval was sought and obtained from the relevant NHS trust ethics committee and subsequently from the University of Surrey ethics committee. See appendix 5 for confirmation of ethical approval.

Procedures

Recruitment of Participants

Potential participants, usually the referrer or the client’s key-worker, were approached by a clinician from the learning disability service and given a brief overview of the research project. The community learning disability team had been given copies of the participant information sheet in advance of the project commencing, and were also briefed about the project by the field research supervisor. Verbal consent was requested for the researcher to telephone the staff member and discuss the research further. Potential participants were assured that their decision to take part in the research, or not, would not affect the service they received from the learning disability team.

If the potential participants were interested in being interviewed for the research, they were sent a ‘Participants’ Information Sheet’ (appendix 6). After giving the worker time to read the information sheet, the researcher telephoned the member of staff at their place of work to further discuss the research aims and answer any questions they had.

In order to ensure that participants would have had exposure to the range of culturally available discourses about people with learning disabilities that the interviews were designed to access, carers with less than one year’s experience working with people with learning disabilities were not considered potential participants. It was also important

1 Please note that all names of people and places have been changed to protect participants’ and clients’ confidentiality.
that the worker knew the client well and therefore could discuss their life and their behaviour in detail for the interview. If the worker agreed to take part in the research and was an appropriate participant, an interview was arranged.

Fourteen potential participants were approached. One did not have the minimum experience required. One did not know the referred client well. One person said she did not want to meet with the researcher. The researcher did not ask why as it was felt that this worker should not feel under any pressure to justify her decision. One participant cancelled her interview due to pressures at work. Although she still wished to do the interview, her interview could not be rearranged within a time-scale appropriate for the research.

Piloting the Semi-Structured Interview

The first two interviews were conducted and transcribed. The transcriptions were then discussed with the research supervisors. Minor adjustments were made to the interview schedule following these pilots. Data from these pilot interviews were included in the analysis. One pilot interview was conducted with a carer of a man and one with a carer of a woman.

Interviews

Prior to the commencement of the interview the participants completed a consent form (appendix 7). Interviews took place at the participants' places of work or the community learning disability service offices and lasted between 50 minutes and 1 hour 15 minutes. All interviews were tape-recorded for later transcription.

Semi-structured interview schedule design

The interview schedule (appendix 8) was designed to allow participants to draw upon the range of discourses which they used in the construction of challenging behaviour, including allowing people to use inconsistent constructions, thereby opening these up for analysis. Potter and Wetherell (1987) suggest that one such way to allow this is to deal with the same issue on a number of occasions throughout the interview through
discussion of different general topics. The interview schedule was designed with this in mind. The interview schedule was also designed to try to ‘expose’ areas of disagreement by asking whether other people held other views.

The interview was designed such that the participant and researcher talked mainly about the behaviour of the one client recently referred to the community learning disability service. As well as collecting background data such as name, age and professional qualifications, the interview schedule asked participants about the ‘challenging behaviour’ of their client, the history of this behaviour, reasons why people thought it was a problem, thoughts about what caused and maintained it, what they would like the person to be doing instead, what responses to the behaviour have been tried and what they would like to happen in the future. Questions encouraged participants to talk freely about their ‘beliefs’, ‘thoughts’ and ‘experiences’.

Analysis of Data

Transcription

The taped interviews were transcribed following Potter and Wetherell’s (1987) guidelines. Notation guidelines used are outlined in appendix 9. Potter and Wetherell (1987) note that the question of how much detail to include in a transcription is a “thorny one” (p. 166) and more or less detail can be utilised in a transcription. The researcher decided to use a basic version of discourse analytic transcription and include only those details which it was felt would actually be considered in the analysis, both because of time constraints and to present the transcripts in as accessible form as possible. A similarly ‘simple’ transcription was used by Harper (1994).

Coding

Potter and Wetherell (1987) describe the importance of the coding stage as a necessary precursor to analysis, the aim of which is to: “squeeze an unwieldy body of discourse into manageable chunks” (pp. 167). This stage aimed to identify recurring themes and to make decisions about the focus of the analysis. This coding process was done as
inclusively as possible and the researcher initially coded any references in the text, however oblique, relevant to the research questions. Often one piece of talk would appear in more than one category.

Analysis Proper

The subsequent analysis was broadly based on Willig's (2001) recommendations for conducting a Foucauldian discourse analysis, although this analysis does not speculate about the consequences of taking up subject positions for the participants' subjective experiences.

Stage 1: Discursive constructions

This stage involved identification of the ways that the 'discursive object', in this case challenging behaviour, was constructed in the interviews. Parker (1992) suggests consideration of what picture of the world a discourse presents and how it would deal with criticisms of itself.

Stage 2: Discourses

This stage focused on differences between the identified constructions of challenging behaviour. Different constructions were understood as drawing upon different 'wider' discourses. These 'wider' discourses were seen as the cultural, political and social issues which surround us.

At this stage in the analysis the researcher also examined the identified discourses in relation to whether they were used in the explanation of the behaviour of both men and women, or were used differentially to understand the behaviour of only one gender.

Stage 3: Action orientation

This stage considered the function of the identified discourses, with a focus on what was being gained by constructing the discursive object in these ways and therefore what the
implications of the constructions may be. Coyle (2000) notes that text can also be read: "mindful of what version of events it may be designed to counteract" (p. 258).

As outlined previously, this research adopted a broadly Foucauldian Discourse Analysis approach, but also used ideas from Conversation Analysis. As such, within this stage micro-level analyses were also conducted, allowing consideration of the ‘techniques’ participants used to make their versions of events convincing.

**Stage 4: Positionings**

The next stage was to take a look at the ‘subject positions’ (as outlined in the introduction) that the discourses offered.

**Stage 5: Practice**

This stage considered the relationship between discourse and practice. Consideration was given to the way that discourses and subject positions may open up or close down opportunities for action. A clear focus was on the implications of discourses in terms of what can be said or done within caring services for people with challenging behaviour. The researcher considered how certain practices become legitimate forms of behaviour within the identified discourses. Parker (1992) noted that discourses support institutions and in this stage the researcher also considered the interaction of the discursive constructions with the institutions of care for people with challenging behaviour.
Discourse analytic research clearly cannot be evaluated by the criteria used to evaluate research based on non-social constructionist epistemologies (Coyle, 2000, Willig, 2001). Here, therefore, I will outline a number of criteria which have been suggested for the evaluation of discourse analytic research.

Discourse analysts often ‘declare’ their ‘speaking position’ (Burman, 1994, cited by Coyle, 2000) as an attempt to acknowledge the factors that influence the researchers ideological framework and understanding. This aims to make research more accountable, transparent and easier for all readers to evaluate (Coyle, 2000). My speaking position is that of a female trainee clinical psychologist with an enduring interest in gender inequalities and a belief in their pervasiveness together with an enduring interest in working with people with learning disabilities and a belief in the importance of considerations of power in such work.

Foucauldian discourse analytic research can also be judged with reference to:

- its coherence – or the extent to which the analysis can present its texts as an orderly whole (Coyle, 2000; Potter & Wetherell, 1987),
- its fruitfulness – the extent to which the analysis provides ‘insights’ that prove useful and enable novel ‘explanations’ (Coyle, 2000; Potter & Wetherell, 1987),
- the extent to which the analysis is grounded with reference to examples from the texts (Elliot, Fischer & Rennie 1999),
- the extent to which the research tells a good story, i.e. one that is “clear, internally coherent and sufficiently differentiated” (Willig, 2001, p 7),
- the extent to which the research is convincing (Willig, 2001),
- and finally its application i.e. its usefulness outside the world of academia (Taylor, 2001).

A complete transcript of the fifth interview is included in appendix 10 to aid the reader’s evaluation of the quality of this research.
Analysis

The context of the research formed the backdrop of this analysis. The clients discussed were those who had been referred to the community learning disability team because of their challenging behaviour. This implies at least a potential acknowledgement that staff were unable in some ways to understand or manage the behaviour by themselves.

The accounts of knowledge used in talking about challenging behaviour which became central to the analysis were discourses of individual pathology and context. There were also clear examples of the mixing of these two discourses. Furthermore, gendered discourses appeared to be significant in the participant’s constructions. These discourses will be outlined and their effects, the subject positions they afford and their implications for practice summarised. The analysis will also demonstrate some of the ways participants’ talk worked to ensure their descriptions could be treated as factual, using a more micro-level analysis.

The Individual Pathology Discourse

This discourse constructed challenging behaviour as caused by clients’ pathologies. The pathology could be about biological difference (for example brain damage, cognitive deterioration, learning disabilities, a specific syndrome), the effects of this biology (for example communication problems) or about clients’ disordered emotions. Furthermore, the pathology was constructed either as something the client had always had or something they had acquired because of bad socialisation. However, the pathology was always constructed as stable and internal to the client and therefore the origins of the behaviour were constructed as constant and internal. This discourse was evident in all ten interviews. Extract 1, shows a participant using this discourse. The extract followed on from Jenny talking about how Wesley’s behaviour had unfairly affected his flat mates in his previous residential service.
Extract 1

I: you told me quite a lot about why, why you think (.) umm (.) Wesley has those
behaviours is there (.) how would you summarise that (basically) (.) what causes it

Jenny: well I can’t tell you the medical condition that causes (.) brain damage (.) umm
(that’s called) (inaudible)

I: so it’s to do, to (,) to do with this (,) the, the damage to his brain

Jenny: but certainly yes, absolutely, yes, he has learning disability

of the brain

As we see, in the extract Jenny’s constructed Wesley’s brain damage as the cause of his
behaviour (line 4). Her use of the terms “certainly” and “absolutely” (line 9) can be seen
as a tool to warrant her construction by removing all traces of doubt about the factual
status of the construction. In constructing the behaviour as caused by a client’s
pathology, this discourse concurrently constructs challenging behaviour as disconnected
from the context and environment in which it occurs. Carabine (2001) suggests that what
is not said (absences and silences) can be as important as what is said. Jenny did not
talk about what happened around Wesley when the behaviour occurred, focusing instead
on factors said to be within him. External factors were therefore implicitly constructed as
unimportant when offering a summary of the causes.

Because of this focus on what was going ‘wrong’ within the client, the individual
pathology discourse constructed the client as in some way different from people who did
not have such a pathology. Extract 2 demonstrates Jenny constructing this difference in
the extreme, suggesting Welsey was essentially different from other people. The extract
followed on from Jenny talking about how it had taken her 18 months of work to improve
Welsey’s behaviour such that it was good enough for him to be allowed to leave his
house.
Extract 2

Jenny: but he’s a fasc, I find him absolutely fascinating, he is really fascinating, and the (.) the autistic traits (.) y’know, obviously his, his brain is totally different than what’s (.) to us what is just a minor thing to Wesley must be devastating=

Jenny’s talk, again, worked to try and ensure her construction was treated as factual. Pomerantz (1986) suggests that people often draw on ‘extreme case formulations’ to argue for their conclusion and attempt to persuade others to reach the same conclusions. Jenny used an extreme case formulation, saying Wesley’s brain “is totally” different than other peoples (line 2), working up the persuasiveness of the constructed internal differences.

Action Orientation of the Discourse

As described in the introduction, discourse analysis assumes discourses achieve different functions. The action orientation of the individual pathology discourse in the interviews can be discussed in terms of management of blame.

Blame

Consideration of the functions of the individual pathology discourse in terms of the management of blame became a central component of the analysis. It is suggested that using this discourse protected both the clients and care staff from blame.

Although the origin of the behaviour was internal to the client, the individual pathology discourse nevertheless managed to construct responsibility in such a way that clients were not accountable for the behaviour. This is demonstrated in extract 3 which followed on from Faith’s talk about the times that Xander had bitten members of his current staff team:
I: how does it affect how people feel about Xander then, what’s that (inaudible)=

Faith: =umm (.) in terms of the biting it’s made people upset (.) because obviously he has injured (.) somebody that you work very close with, umm, it’s made people feel very angry with Xander for doing it but then (.) it doesn’t (.) that feeling in anybody that I know hasn’t lasted long at all because people are aware of Xander’s (.) umm, communication difficulties and the reason why he bites and they know that it’s not (.) y’know, a sustained attack deliberately on you because of (I: right) something umm (.) and (.) everyone’s been able to work through it (.) and (.) get over it and still continue to work with Xander

This extract seemed to seek to warrant its claim using a rhetorical device similar to what Jefferson (1984a, cited by Wooffitt, 1992) described as “at first I thought”. Using this device, speakers, such as witnesses to extraordinary events like hijackings, first proffer their original incorrect conclusion, before telling of their later correct conclusion. Speakers present themselves as making the sorts of assumptions that any reasonable person would. If they are seen as like any other reasonable person, then their claims can be treated as truthful and believable. In the above extract Faith may have oriented to an idea that it is normal to feel angry with someone who bites you, but she went on to say “but then” (line 5) and describe how this feeling did not last because of the exceptional circumstances surrounding the attack, i.e. Xander’s communication difficulties (line 7). Again within this quote we see the individual pathology discourse constructing clients as in some way different. Indeed Faith’s construction of Xander as not blame-worthy was based on constructing Xander as different because of his communication difficulties.

Constructing clients as not blame-worthy enabled staff to maintain a relationship with a client who was violent. This is clearly evidenced in this extract, where Faith said that understanding the behaviour in this way meant that people could: “continue to work with Xander” (lines 9 and 10). Assigning blame to clients might make it difficult to continue a positive working relationship with them. However, by using the individual pathology discourse blame can be directed away from the worker or the service whilst not holding
the client accountable for the behaviour. In this way positive relationships can be
maintained.

The individual pathology discourse does not only have the effect of protecting clients
from blame, it also protects care staff from being blamed. Care staff would seem to be in
a position which makes them potential targets for various types of blame, including
directly causing the behaviour or not noticing environmental triggers and modifying the
situation appropriately. It will be argued that in this way, using the individual pathology
discourse accounted for current staff failures. It will later be argued, in contrast, that use
of the context discourse accounted for current staff successes.

Extract 4 demonstrates this effect. The extract followed from Giles responding to the
researcher’s request that he ‘tell her about Tara’ by saying that Tara should have been
diagnosed as having mental health needs and her care had been neglectful because this
hadn’t been done. During the interview it appeared that Giles was using the term ‘mental
health needs’ idiosyncratically to refer to brain damage.

Extract 4

I: =what, what makes people think, or what is it that suggests she’s got mental health
needs then if she’s not, I mean she’s not had that formal diagnosis (inaudible)

Giles: she, the (.) I mean the
(.) the rages she goes into and unconnected stuff without triggers, I mean as you’re
probably aware (.) umm, most, most umm, people with learning disabilities are, are quite
predictable

(18 lines are ommitted here to clarify the focus)

Giles: so that’s his trigger, you know that he’s gonna go, Tara, you can be sit, you can be
sitting there doing the re, y’know, one of her nice things she likes, everything, she’s,
her obviously got some autism in her, because everything’s done to time (I: right=)
=so, she umm (.) she is autistic, there’s no doubt about it although she’s not diagnosed as
being autistic but everything that she does revolves around time (.) but again that could
be (. ) the mental health, because we have somebody else here who’s dual diagnosis and
all his stuff is timed (. ) so, it could be either, but it’s, it’s, it is, it’s difficult for us
because we can only go along with what people tell us (I: uh-hum) and we have to try
and facilitate everything around the information that we have (. ) and sometimes that
information isn’t correct (. ) simply, (. ) you know that there’s stuff missing because a full
( . ) umm check hasn’t been done (. ) and umm, to my mind that means that you’re having
to make assumptions (I: right) which OK, hopefully they’re right most of the times and
you can put the right things in practice

The causes of Tara’s “rages” were constructed as her mental health needs and autism.
Since she has not been diagnosed in this way there was a possibility that Giles’ account
could be questioned. Giles’ talk, however, served to protect his account from criticism. In
lines five to seven, Giles worked up his knowledge of learning disabilities, by suggesting
that the learning disabled are quite predictable - something he could only know if he had
experience of such predictability. By saying “as you’re probably aware” (lines 5 and 6)
Giles enlisted the interviewers professional knowledge to warrant his claim whilst also
corroborating his account, increasing the likelihood that it would be accepted as true
(Potter, 1996b). Having established his relevant experience, Giles then goes on to use
extreme case formulations, telling us twice that “everything” Tara does is done to time
(lines 13 and 15), further working up the persuasiveness of his account.

Giles talk constructed the behaviour as independent of external triggers and caused by
factors internal to Tara. Tara’s behaviour was implicitly constructed as unpredictable
(lines 6 and 7). Staff could not therefore be blamed on the basis of not noticing
environmental triggers because there were no patterns. Giles also constructed Tara’s
behaviour as occurring even when staff are doing “one of her nice things” (line 12),
constructing it as not a reaction to what is happening around her. Therefore staff also
could not legitimately be blamed for causing the behaviour. Having worked up this
version, Giles was then able to suggest that the staff team were having to work without
the full facts because those responsible for doing the full checks had not done so. These
people then become legitimate targets for being blamed. Giles, however, who was doing
his best despite the lack of other people’s competence, was not blameworthy.
Davies and Harré (2001) suggest that as well as considering reflexive positioning (or how one positions oneself) it is also useful to consider a text’s interactive positioning (how what one says positions another). This, together with the absences and silences (Carabine, 2001) have shaped the following ideas about the subject positions offered by the individual pathology discourse.

Given that the individual pathology discourse constructed clients as different it is not surprising that the subject positions afforded for staff and clients were markedly dissimilar. This stands in stark contrast to the subject positions offered in the context discourse, as we shall see later. In this reading of the texts, the individual pathology discourse constructed adults with learning disabilities and challenging behaviour as irrational. Talk about care staff’s reactions, however, was absent and this was therefore presented as unproblematic. An implicit distinction was drawn between care staff rationality and client’s irrationality and subject positions of a rational carer and irrational client were afforded.

These points can be explained in more detail if we look back at extract 4. Giles’ talk constructed Tara’s behaviour as abnormal given the circumstances. Giles said Tara would show the behaviour even if staff are doing her “nice things” (line 12). This constructed her behaviour as clearly unusual. It is not rational to react violently when those around you are in fact doing what you want them to be doing. At the same time the care staff’s reactions were treated as unproblematic and they were thereby implicitly constructed as rational responders to the situation. Giles also constructed the professionals’ full check as unproblematic, if carried out appropriately. If the checks had been done then carers would be in possession of the full ‘facts’ and would not have to make any assumptions, basing their actions instead on a comprehensive understanding of the client’s pathology. This implies that through clinical diagnoses it is possible to objectively ‘know’ why clients behave in challenging ways and react accordingly. Such a description resonates with the ideologies of objective science. Here, Giles’ talk presented the causes of Tara’s behaviour as theoretically knowable from a position independent of those knowing. Giles constructed facts as preferred forms of knowledge and his talk
Major Research Project

suggested that once in possession of them, the staff have a passive and unproblematic role in interpreting them.

In addition, the individual pathology discourse invited care staff into a subject position where they were legitimately in control, leaving clients with a subject position which did not afford them legitimate control. Jenny made this explicit in extract 5.

**Extract 5**

1 Jenny: I don’t condone the behaviour, I understand the behaviours stem from disability
2 (I: uh-huh) but I loathe violence (I: yeah) but it is in the sense that I mean you are hit (.)
3 erm (.) if somebody (whacked me while we were) outside I mean I would just (.) think
4 (well don’t) I, I’d want to instinctively hit back (.) it’s, we all would= (I: =hmm) but
5 because you’re in a situation where you are meant to be in control and the resident is
6 not= (I: =you can’t=) =you obviously do not

Jenny suggested that Xander’s pathology (his disability, line 1) is the reason why it would not be appropriate for him to be in control of the situation. Jenny also constructed herself as able to have control over herself - her instinct would be to hit back (line 4) but she would not actually do so (line 6) - warranting her claim that it is legitimate for her to have control of the situation. This contrasts with Xander’s inability to control himself.

The marked difference in subject positions offered for clients and carers by the individual pathology discourse resonates with the positions of a passive or dependent patient versus an expert doctor (Lupton, 1997). Davis (1993) described this as bringing with it a sick role for the patient, whereby they are expected to act in certain ways, including accepting the decisions that the doctor makes for them. Here, given the client’s irrationality and problematic reactions, it would be inappropriate to allow them to make some decisions for themselves. However, as the staffs’ reactions are unproblematised, it is entirely appropriate for them to make decisions for their client.
Implications for Practice

Given the subject positions which the discourse affords, it is not surprising that the discourse encouraged carers to 'treat' clients within a medicalised understanding of their needs. The most appropriate response became one where carers or others controlled the client by doing something to the client and appropriate interventions are those with an individual focus. This clearly included the use of medications as one of the preferred treatments. Extract 6, which followed on from talk about the damage Xander has done to himself through his self-injury, showed Jenny explicitly orienting to the need for medication as a means to treat the client's pathology.

Extract 6

1  I: is he taking any medications or
2
3    Jenny: oo::h, yes (.) yeah (I: {laughs}=) =that is, that is one thing, I don’t think we
4    would be in the same room, never mind the same (.) in the same flat
5    (unlikely) (inaudible)
6    
7    I:  I see, is that because of
8
9    Jenny: because yes (inaudible)
10    
11    I:  his behaviour would be out too much=
12
13    Jenny: =yes, his behaviour would be out umm (.) completely out of control I mean (.) the
   man needs something to help him to help himself

In the extract we can see that the proposition that Xander would not be on medication to control his behaviour was treated as so ridiculous as to be laughable (line 3). Jenny's construction of the medication having made a big difference to the behaviour is notable. The legitimacy of the medical intervention is supported by the individual pathology discourse, but, in this kind of way, at the same time it reciprocally supports the discourse (see Harper, 1999). Within this discourse a better future could be seen as one where
pathology is increasingly understood and medications are increasingly developed to control pathologies or their effects.

The interviews suggested that participants themselves orientated to the limitations of this discourse. Understanding a client's behaviour from within this discourse was constructed as limiting how optimistic we become about the future, which in turn could affect the actual future. Gwendolyn's talk in the next extract was a clear example of this. This followed on from the interviewer's question about when the behaviour was first considered a problem, given that such a decision is not "black and white".

Extract 7

1. Gwendolyn: when he (.) actually had his autism diagnosis, when he was about 4 or 5 I think (.) and umm (.) I think people just accepted, “oh he's autistic, he (.) behaves like that” (I: yeah) so I think it was quite an accepted thing rather than (.) for his mum and dad I’m sure (I: until) (.) oh, they do they still say it now, “oh, that’s just Oz”=

6. I: =oh, right, OK so for them, that’s how they see it

8. Gwendolyn so, yeah, that’s how it is, it’s like (.) it doesn’t have to be, you can stop him banging that door actually

This extract is also noteworthy for its management of blame, which was located within people in the past, notably his mum and dad because of their conflation of the disorder and Oz. In contrast Gwendolyn constructed herself as more knowledgeable and effective than they were.

The Context Discourse

The context discourse stands in marked contrast to the individual pathology discourse. Unlike the individual pathology discourse, this discourse constructed the clients' behaviours as an understandable reaction to their circumstances and environment, including how staff or other clients were behaving. However, this local context was also talked about in terms of its broader social or ideological context, for example its location
within dominant service ideologies. The causes of behaviour were not understood as internal to the client, but as due to their situations. This discourse was also evident in all of the 10 interviews.

An example of this discourse being used is given in extract 8 where Gwendolyn talked about the impact of the actions of Oz’s staff, but also situated these within the broader system that the staff were affected by. The extract followed on from talk about the way that the team have learnt a great deal about Oz’s likes and dislikes since they have been working with him.

Extract 8

Gwendolyn: we used to come into the dining room here for lunch (.) everyday (.) and on (. ) and we did it because ( . ) oh I don’t know why we did it, and then when you look back, every lunchtime the table would be tipped, he’d be banging the table on the floor and he’d be hitting the person (. ) next to him or either side of him, or (. ) umm, and hitting his head or hitting the wall and (. ) and you just thought, “oh, well that’s just what Oz does” and then when it became so busy here there wasn’t room in the dining room ( . ) we stay over in his room now, and he sits on his own at his table, we’re in his room, but we’re not like all crowded round one table= (I : =yeah=) =it’s fine

I: when did that happen, when did [other day centre] come to here

Gwendolyn: it’ll be 2 years in October ( . ) and you think (. ) y’know, you do all of this, do you do it for Oz or do you do it so that it looks good on an IP or, y’know he integrates with everyone else (I: yeah) well he doesn’t really cos he still sits on his own in a table at the end of the dining room

[ getting quite agitated=

I: getting quite agitated=

Gwendolyn: =getting quite agitated yeah (. ) and if you look back through incident forms, a lot of the incident forms are in the dining room, whilst having lunch Oz pinched me, hit me (I: mmm=) =tipped the tables, split, split tea, or (I: mmm) did he really get much out of that or was it us
Gwendolyn talked about staff actions as a potential determinant of Oz’s behaviour and therefore an important aspect of his context in that their bringing him to the dining room could be seen as causing the problem. These actions, however, were placed within the context of the IP (Individual Planning) system. Gwendolyn presented the staff actions as a reaction to their own context, they were doing what was expected by implementing an ideology which favours integration for all and defined integration in ways that may have been unhelpful for Oz.

In the extract Gwendolyn warranted her claim by referencing the evidence gathered by looking at the incident forms. Her use of the plural “you” (line 19, “if you look back through incident forms”) suggested that other people would draw the same conclusions as Gwendolyn if they too were to examine the incident forms. Potter (1996b) suggests that such plural voicing can be heard as reporting a general experience of people. In lines 20 and 21 Gwendolyn’s talk took the form of a direct quote from one of the forms: “whilst having lunch Oz pinched me, hit me...”. This is akin to Wooffitt’s (1992) account of active voicing, a rhetorical device that warrants claims by reporting the speech of others. The device works by presenting talk as something which we do not have to rely on the speaker’s judgement to believe, instead we have other speaker’s direct words to prove it. Here, instead, we have quotes from the incident forms which ‘prove’ Gwendolyn’s construction.

A further extract will be given to demonstrate the use of this discourse. In extract 9, which was a response to the interviewers question about what Xander’s challenging behaviours were at the moment, Faith spoke about a range of staff factors which could impact on Xander, demonstrating that using the context discourse can legitimate consideration of the staff needs, wishes, stresses etc. Unlike the individual pathology discourse, here the staff’s reactions were not treated as unproblematic, rather they became reasonable areas for consideration in terms of the relationship between the client and the staff.
Extract 9

1 Faith: so just to help him to understand that we understand how he’s feeling (.) umm,
2 we’ve done a lot of work (.) around Xander’s moods, so if he’s happy (.) how that makes
3 how Xander feels, how we feel (.) and how that then (.) when we interact together,
4 how that means we interact with him and also when he’s angry or sad (.) just ways to
5 help Xander work through his agitation and (.) and his behaviours rather than (.) what
6 has been previously done which is just lock the door and walk away

The Context Discourse as Normalising

At its most extreme, the context discourse explicitly constructed clients' behaviours as
‘normal’, suggesting that non-learning disabled people could be expected to react in the
same way under the same circumstances. This is in stark contrast to the construction of
clients as 'different' seen with the individual pathology discourse. Extract 10 shows Dawn
clearly stating that she may show similar behaviours if she were living in Gloria’s context.
The extract followed Dawn’s talk about how Gloria was being “held back” because she
was more able than the other clients she lived with.

Extract 10

1 Dawn: so we have said that well maybe we can get you in for the next term (.) I think she’s
2 very bored actually (.) don’t, she hasn’t got enough to stimulate her mind here
3
4 I: is that one of the things that (.) causes her behaviours is it
5
6 Dawn: I, it probably would, yeah, I think it would drive me round the bend

A further example will be given to show this discourse being used by Faith, who was also
shown to be using the individual pathology discourse in extract 3. The “they” referred to
in line 1 was Xander’s previous residential service staff.
Extract 11

1 Faith: a lot, they (.) a lot of what they told us isn’t true, umm (.) they stated that Xander
2 (.) didn’t like the word no (I: uh-hum) well, Xander (.) doesn’t like the word no (I: hmm)
3 when it’s shouted at him (I: OK=) =y’know, he will accept the word no if it’s (.) no
4 “Xander, that’s not appropriate”, if he, y’know
5
6 I: doesn’t like being shouted at
7
8 Faith: it’s like anybody really, I (.) wouldn’t like (.) and would become quite
9 angry (.) with somebody shouting at me all the time, “no, no, no, no, no”, whereas,
10 y’know if you have someone saying “no, this is the reason”, then obviously it’s going to
11 make it a lot easier

Faith constructed Xander’s reactions as normal, by talking about how she too would not
like to be shouted at all the time either and would become angry if this were to happen
(lines 8 and 9). The previous staff’s reactions were problematised and they were blamed
for the behaviour occurring. Faith and the current staff team, however, were constructed
as better than the previous staff team. Once again we can see the use of extreme case
formulations to warrant the construction offered. Faith used the term “all the time” to
describe how Xander was shouted at (line 9), as well as saying that giving a reason
makes it “a lot easier” (lines 10 and 11) to accept being told no. Faith also explicitly
constructed Xander’s reaction as normative under the circumstances in using the
extreme description that “anybody” would react the same.

Action Orientation

Once again, use of this discourse could be seen as having more that one important
function. It served both to construct staff as having influence and also managed blame,
though in a different way to the individual pathology discourse.
Influence

Using this discourse constructed dramatic change as a real possibility. Given that the behaviour occurred because of the context, changing the context could be expected to make a striking difference to the behaviour. Therefore, the context discourse constructed staff influence as potentially extremely significant.

Faith, in extract 11, for example, talked about how speaking to Xander differently could make things "a lot" easier (line 11), and this was within the context of talk about how much things had changed in terms of the behaviours since Xander was related to differently. Staff's influence was also constructed as potentially taking very quick effect. If we look back to extract 8 we see that Gwendolyn's talk constructed the behaviour change as immediately following the context change, i.e. as soon as staff stopped taking Oz to the dining room for his meals, the meal time behaviour problems no longer existed.

This discourse allowed optimism about the future and a belief in the power of the staff to effect positive change. We can see therefore that the context discourse accounted for current staff successes in terms of 'managing' behaviours, a clear contrast with the action of the individual pathology discourse which accounted for current staff 'failures' as we saw on page 263.

Blame

Clearly, use of this discourse, like the individual pathology discourse allowed a position which was not blaming of the client, given that their behaviour was both an understandable and possibly normative reaction to their circumstances.

There were many examples within the interviews of previous staff teams being blamed for the client's behaviours within this discourse. For example Faith's talk in extracts 10 and 12 clearly constructed the previous staff's reactions as problematic and causative of the behaviour. This was contrasted with the competent reactions of current staff and blame was therefore placed with the staff in previous services. Talking about context clearly opened up the possibility of blaming care staff for the behaviours. If the context
was said to be important and causative of the behaviour, then current staff could also be blamed as the providers of the individual’s context. As we saw, however, using this discourse could still serve to protect current staff from blame, as their actions could be seen within the context of the service structure, pressures and ideologies. This was most clear as identified above in Gwendolyn’s talk in extract 8.

Subject Positions

Unlike the individual pathology discourse, the context discourse constructed clients as like non-learning disabled people. Both clients and staff were offered different subject positions than within the individual pathology discourse. Using this discourse did not construct client’s actions as irrational. At the same time the staff actions were not constructed as unproblematically rational, but as affected by a range of personal and broader influences.

Clients and staff were both afforded subject positions of contemporaries who were affected by the system and in turn could affect one another. There was an implication, when this discourse was used, that people with learning disabilities are sometimes disempowered by their context. This afforded subject positions of ‘victim’ for the client and ‘advocate’ for the staff. However, there was also an implication that staff themselves could also be disempowered by their broader context. Staff were also potentially afforded subject positions of effective staff who could make a positive difference in contrast with previous services and staff groups.

Implications for Practice

Unlike the individual pathology discourse, this discourse did not limit hopes about future change. The extracts oriented to changes that had already happened as a result of modifications in context and constructed the possibility for further change given further modifications of context. The challenge to services, and their broader systems, became one of creating the contexts within which individuals with learning disabilities do not show challenging behaviours.
Because the clients were not constructed as irrational, and the subject positions afforded were more equal, it also became legitimate for clients to have power and control over their circumstances and therefore for their ideas about their circumstances, however expressed, to be taken on board. Extract 12, which followed on from Willow talking about how things had changed for the better since Joyce’s health needs had been met is presented to demonstrate this.

**Extract 12**

1 Willow: =and so, and so there are, y’know you can’t categorically say I know what’s the
2 matter with her, y’know why, why she’s doing that (you can have) it’s all guess work,
3 but if, if the guess work seems to be working and= (I: =yeah=) =making her feel OK,
4 then you kind of stick with it until you’re proved wrong or she says that’s not what it is

The extract explicitly stated that it is legitimate to listen to Joyce’s own ideas about what is going on: “or she says that’s not what it is” (line 4). At the same time, in contrast to the individual pathology discourse, Willow stated that it was not possible to know what was going on for Joyce, instead “it’s all guess work” (line 2). This stands in contrast to Giles’ assertion (extract 5) that it was possible for professional observers to unproblematically ‘know’ what was going on for someone else.

Clearly the use of this discourse made it appropriate to intervene on contextual, rather than individual levels. The appropriate focus for change was the environment, not the client’s biology. A range of contextual levels of intervention were legitimised, from changing where someone eats their dinner all the way through to political action.

**Mixing the Individual Pathology and the Context Discourses**

The extracts already discussed have demonstrated that the individual pathology and the context discourses accomplished different rhetorical functions and brought with them different invitations to action and future practice as well as different subject positions for both the speaker and those being spoken of. However the range of discourses that speakers draw upon inter-relate flexibly within their talk (Harper, 1994 and 1999),

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achieving still further different discursive functions. There were instances within all ten interviews of the flexible mixing of the individual pathology and context discourses.

Extract 13 demonstrates how one speaker mixed the discourses. Previous to this section, Cordelia had said that she thought Ethan’s anxiety disorder was inherited from his mother. The extract followed on from Cordelia talking about Ethan’s habit of urinating on the bedroom floor at night. She said this used to be thought of as challenging behaviour by some people, but this stopped being perceived as a problem when his bedroom flooring was changed, even though Ethan continue to urinate on the floor at night. “PRN” (line 27) refers to medication that is given when required as distinct from medication that is given at pre-set regular prescribed times.

Extract 13

1. I: are you saying, that, that the behaviours that Ethan used to have, y’know, when he used to escalate, when his anxiety would escalate (.) (inaudible) what and you said that that might have (.) partly been his anxiety might have come from his mother, perhaps hereditary or perhaps environmental (inaudible) are there other reasons you think that (.) about why that behaviour developed in the first place

2. Cordelia: umm (.) umm, I don’t know, umm, apart from that I can’t no, and I think, well, I mean (.) I mean the reason why it developed and it got to the extent that it did or it got that far was just (.) lack of umm (.) I think people must have always known that Ethan was gonna go through those stages of anxiety and (.) get to that point because he did it probably far more regularly (I: mmm) but the sort of (.) there was nothing put in place to actually avoid it before it happened

3. (12 lines omitted for clarity)

4. Cordelia: =I’m saying, I, I, I think it was always (.) I dunno, I think it would’ve always been there, it’s the fact that nobody (.) did the right thing about it

5. 276
I: right, so it’s managing it, d’you think

Cordelia: they didn’t manage it properly ever

I: what were they trying to manage it before then, before () kind of () what you’ve got now

Cordelia: I mean I don’t know that Ethan ever, I mean it, it, if Ethan had been given PRN it would have been probably for the, at the wrong time or () d’you know what I mean, when you’ve got an institutionalised sort of environment there’s loads of other people and () y’know, all with, with supposed challenging needs and all doing this, that and the other= (I: =hmm=) =I suppose all of those (I: hmm) behaviours are allowed to continue anyway because they’re expected of them () so he, probably Ethan spent a lot of time being quite anxious and hummy or behaving oddly when he didn’t need to if he, if he’d been given something to help him calm down beforehand or he had the right environment to help him calm down in the first place=

Here, the individual pathology discourse and the context discourses were both used. The problem was constructed as anxiety, which was worked up as internal to Ethan when Cordelia said, for example, that it “would’ve always been there” (lines 16 and 17). However, Cordelia also explicitly talked about the impact of staff’s actions on the problem. Cordelia’s talk can be seen to orient towards a dilemma which may have been posed. I asked about the behaviours that Ethan “used to have” (line 1) explicitly introducing the idea that things have changed. However, using an individual pathology discourse has already been shown to suggest that change is somewhat unlikely, because the pathology is stable. By mixing the discourses, Cordelia constructed the cause of the behaviour as internal to Ethan, whilst also accounting for change. The behaviour was explained as resulting from an interaction between pathology and context.

A range of possible reactions were legitimated, including giving PRN (at the right time) and considering the environment’s impact. Cordelia talks about the danger of seeing someone’s behaviour as just due to their pathology – “behaviours are allowed to continue because they’re expected of them” (lines 30 and 31) whilst retaining the
explanatory usefulness of the concept. This allows Cordelia to account for current staffs' referral whilst not holding them responsible for the behaviour.

Once again previous carers were blamed (this was also evident in extracts 9 and 11). Blaming of past carers for the client’s behaviours was seen on a number of occasions in the interviews. This blaming made the possibility that current staff could be blamed relevant and suggested that blame was interactionally salient in the interviews.

Another example of the mixing of these discourses is provided below:

**Extract 14**

I: what keeps that behaviour **going** because obviously it’s been going on for like many

many years

Giles: I, I think it’s, it’s umm (.) I think it’s **ingrained** in her (.) now, I think it’s y’know, (.) I think there are certain things that I think it **doesn’t** matter how much, how good you are with somebody or how much you put into place really (.) whatever you try you’re **always** gonna be behaviours that’ll never disappear (I: right) y’know, sometimes behaviours you may be able to reduce them, sometimes **substantially** but you’ll never **wipe** em out (I: mmm) it’s almost (.) it’s part of the (.) make-up of (.) of the person (.) y’know (.) I’ve seen people go from being horrendous to (.) bloody **marvellous** (.) in the space of a few years (.) but there are still some underlying **factors** (.) that you **know** come out now and again (I: hmm=) =that you’re never gonna get rid of (.) because they’re like (.) **ingrained** into the memory (I: right) whichever, however way you want to look at it but (.) I, I (.) you, you (.) anybody that says “oh yeah they were learning disabled they were like this that and the other and now they’re a normal person” I’m sorry that’s not **possible** (.) it just **isn’t** possible that **doesn’t** happen, it **can’t** (.) umm, physically, mentally, **any** other way it’s impossible to happen as you’re obviously well aware (.) but it is possible to reduce behaviours, it is possible to **improve quality of life** (I: hmm) it’s possible to (.) realise or get somebody to realise their (.) ambition a bit more, and, and to **actively** **reduce** their own stress levels y’know, there’s **ways** of doing things there’s (.) ways of **making** continuity for people which **hopefully** will enhance and improve their lives (.) but **however** much you do you’re **never** gonna change certain inherent things within these people (.) because of you can’t= (I:
Major Research Project

Shortly before this extract Giles talked about the behavioural style interventions that the team implement to control Tara’s behaviour. My question about “what keeps the behaviour going” (line 1) could be seen as a criticism of Giles and his team, implying perhaps that their interventions were inappropriate or ineffective. In response Giles flexibly used both the individual pathology and context discourses, talking about how the right context can substantially reduce behaviours, but will never stop them completely. This allowed him to construct staff as influential whilst also accounting for the continuation of her behaviours at some level without having to accept blame for this continuation.

The rhetorical device of a ‘show concession’ (Antaki & Wetherell, 1999) is evident in this extract. This has a three-part structure whereby speakers first propose something, then seem to concede something counter to it, before reasserting the original proposition. This actually has the effect of strengthening one’s original position. In lines 7 and 8 Giles first proposed “always gonna be behaviours that’ll never disappear”, before ‘conceding’ “sometimes behaviour you may be able to reduce them, sometimes substantially” before re-asserting his original construction “but you’ll never wipe em out”. Using this device allowed Giles to reinforce his original proposition, making it less vulnerable to challenge. Giles used this device twice in immediate succession. Following on from this first ‘show concession’ he then proposed “it’s part of the (.) make-up of (.) of the person” (line 9), before ‘conceding’ that “y’know (.) I’ve seen people go from being horrendous to (.) bloody marvellous (.) in the space of a few years” (lines 9 and 10). However, Giles then uses this apparent concession to restate and strengthen the original proposition that “but there are still some underlying factors (.) that you know come out now and again” (line 11).

Finally, in this extract Giles implicitly constructed Tara as not ‘normal’, when in line 15 he said "oh yeah they were learning disabled they were like this that and the other and now they’re a normal person", I’m sorry". This talk served to reject the possibility that those with challenging behaviour are normal. The use of the individual pathology
discourse, even in conjunction with the context discourse, therefore, still meant that the client could be constructed as different. When the individual pathology and context discourses are mixed there is clearly still an explicit focus on individual pathology. The context discourse therefore is not used to normalise the client’s behaviour in the sense of constructing it as something that non-learning disabled people would also do under those circumstances. Adaptation of context, instead, becomes a legitimate intervention for managing pathology and its effects.

**Action Orientation of the Discourses**

Mixing the discourses has some of the effects that we would expect from each of the discourses as used on their own. As the discussions above demonstrate, mixing these discourses can still work to protect both clients and staff from blame. The client can be constructed as not accountable for the behaviour both on account of the pathology and the context and positive relationships can be maintained. Although the pathology can be blamed for the behaviour, adding the context discourse, opens up the possibility that care staff can be blamed. However, although staff have an explicit responsibility to make a difference, they also have a strategy for deflecting blame if the behaviours continue to occur, i.e. the pathology can be blamed.

The context discourse, as we saw, invited us to think that the future could be very different, and even when mixed with the individual pathology discourses, aspects of this remain. Therefore, staff could also construct themselves as having potential significant influence.

**Subject Positions**

Clients were again constructed as different to those caring for them (as we saw with Giles’ construction of Tara as not normal in extract 14), although this may have been to a lesser extent than when the individual pathology discourse was used in isolation. However, the staff were still offered subject positions of carer and the client as the cared for. The clients were still constructed as irrational and different, and although the staff’s behaviour could now be problematised, it was also easy to defend against any criticisms.
Finally, this analysis will examine the impact of gender discourses on constructions of challenging behaviour. Although participants never explicitly talked about the gender of their clients as impacting on how they made sense of the behaviours, the analysis suggested that gender discourses were nevertheless present in the explanations. For example, four of the five participants who talked about female clients chose to talk about their domestic skills as examples of when their behaviour was not challenging. Giles talked about how Tara sometimes made tea and laid the table, Dawn about how Gloria did the laundry and could cook, Willow said that since Joyce’s behaviours had improved she now loaded the dishwasher, cooked and made drinks for others and Anya talked about Kathy offering to wash up. None of the five participants who talked about men, mentioned domestic skills in this way. Such tasks are clearly in the remit of ‘women’s work’, bringing to mind traditional conceptualisations of women’s role as homemakers (Schwartz, 1989).

The gendered discourses which became evident in the analysis were those about the menstrual cycle and women’s characters. Both of these were used in the explanation of women’s behaviours but never used in the explanation of men’s behaviours. For this reason, together with their connection with ‘wider’ discourses described below, it is argued that these discourses are gendered.

Gendered Discourse 1 – The Menstrual Cycle

Discourses about the menstrual cycle were used in the construction of the behaviour of three of the five women that the interviews focused on (Joyce, Maggie and Tara), as well as being used in the construction of the behaviour of two other women which the participants also talked about. Extract 15 followed on from Willow talking about how Joyce’s behaviour compared to that of another woman she had worked with and shows how a menstrual cycle discourse was invoked in the construction and explanation of women’s behaviours.
Willow: and there were times when we didn’t really know what was going on for her, quite a lot I think to do with, with umm, menstrual cycles and things played a big part as they do with Joyce as well=

I: =oh, do they

Willow: about how she’s feeling and umm (. ) e::rm how her moods are and whether she’s feeling emotional or angry and (. ) umm, and again, y’know, (in fact) people need to do, y’know both Joyce and this other young woman needing more support around those time, times and needing boundaries to be closer, needing things to be more predictable and more familiar, less able to cope with new because=

(58 lines omitted for clarity)

I: is it, umm, are you, are you saying that, that in your experience that’s kind of often a factor with women then

Willow: certainly to think about, certainly something to think about I think umm, especially when, depending on the understanding of what, what the menstrual cycle is and whether the person understands and can have a reasonable concept of what it is=

(I: =hmm=) so if, certainly if I understand myself and I know what, what happened to me and why it’s happening to me (I: yeah) I think umm, how it’s explained to people umm (. ) can often either help or (. ) cause more problems, I think umm=

I: =what, what would be the difficulty if people find it hard to understand then, (what’s the problem with that)

Willow: umm, I think you’re sort of like not really knowing what it’s about and cor, and it, and it being quite it distressing thing and also sort of umm (. ) finding the emotional (. ) roller coaster of it a bit (. ) y’know sort of (. ) umm, upsetting the balance of things
In the extract Willow spoke about the menstrual cycle affecting women's moods (line 7) and being an emotional roller coaster (line 30). However, when talking about women with learning disabilities, an additional layer of explanation of the reason for the menstrual cycle's effects was drawn upon. The extract showed Willow constructing a lack of understanding about the menstrual cycle and its effects (lines 19 to 23) as making an already potentially difficult experience worse for women with learning disabilities.

Brown Parlee (1994) suggests that: “PMS\(^2\) is now a repository of widely shared cultural understandings that social actors use to make sense of (some) women's words and actions” (p. 91). The dominant construction of ‘PMS’ is that it is a biological entity, somehow connected with hormonal imbalance (Vines, 1993). Discourses of ‘PMS’ have been said to construct women as biologically labile (Ussher, 1991) and have been used in construction of the causes of women's violent crimes (Parlee, 1981, cited by Rodin, 1992) or even murder (Hey, 1985, cited by Ussher, 1991; Pearson, 1997; Rodin, 1992). This discourse is widely critiqued, for example because there appears to be no simple biological substrate that marks ‘PMS’, nor any measurable relationship between hormone levels and symptom experience (Bancroft, 1993 and O'Brien, 1993, both cited by Swann, 1997). The discourse has been argued to support an argument that women must be denied certain responsibilities because of their frequent inability to make rational decisions and to mean that women's discontent can be attributed to such irrationality and therefore not taken seriously (Gottlieb, 1988, cited by Rodin, 1992).

The menstrual cycle discourse is clearly an individual pathology discourse, which therefore brings with it the effects and subject positions of the individual pathology discourses. Women with learning disabilities can be constructed as having a significant pathology (perhaps womanhood), in addition to any other pathology, which can cause them to be irrational.

As extract 16 demonstrated, the menstrual cycle discourse was also used in combination with a context discourse, such that the environment as well as biology, became a legitimate focus for treatment or intervention. For example Willow talks about giving people more support or keeping boundaries closer, or keeping things more predictable.

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2 Pre-Menstrual Syndrome
around the worst stages of the menstrual cycle (lines 9-11). However, as before, this is an intervention aimed at managing what is clearly still seen as a pathology.

As this discourse is a gendered individual pathology discourse, or one that is mixed with a context discourse, the reader is referred to the previous sections for understanding of the action orientations, subject positions and implications for practice which its use allows.

**Gendered Discourse 2 – flawed character**

The final discourse that will be discussed in this analysis is the flawed character discourse. In this, women were constructed as either manipulative or attention seeking and these explanations drawn upon to explain their behaviours. The ‘manipulative flawed character’ discourse was used in the construction of the behaviour of two of the five women that the interviews focused on (Joyce and Maggie), as well as being used in the construction of the behaviour of another woman which a participant also talked about. The ‘attention seeking’ flawed character discourse was used in the construction of the behaviour of three of the women that the interviews focused on (Maggie, Tara and Kathy) and used in the construction of the behaviour of another woman which a participant also talked about.

It is suggested that discourses about women’s flawed character are prevalent in broader society. Burns (1992) talked about the: “common portrayal of woman as the schemer, wily, manipulative and above all avaricious” (p. 114), and used a quote dating back to 1728 to demonstrate the longevity of this understanding of women: “Tis woman that seduces all mankind. By her we first were taught the weedling arts” (*The Beggars Opera*, I ii by John Gay, cited by Burns, 1992).

This discourse is similar to the individual pathology discourse in that the source of the behaviour is considered to be within the client. However, referencing the woman’s character as opposed to a pathology as the cause of behaviours, rather than protecting her from blame allows her to be blamed for the behaviour. Extract 16 shows Giles using both the attention seeking and manipulative discourses in the construction of Tara’s
behaviour. The extract followed on from Giles’ talk about the sometimes extensive restraint that it is necessary to use with Tara as a result of her behavioural problems.

Extract 16

1 Giles: I think she craves attention all the time (.) if you’re talking to somebody else when
2 you’re with her, if you’re not looking at (.) at her, or keep looking at her while you’re
3 talking to somebody else, your (.) attention is diverted all the time (.) she’ll think, “right,
4 you’re ignoring me” (.) and that’ll be it, that’ll be diff (I: OK) OK (.) so I think a lot of it is
5 attention seeking (I: right) she craves (.) people to like her, she’s always asking if people
6 still friends (.) she’ll have an episode and then:: her favourite trick is to cry her eyes out
7 after (I: right=) =cos she wants sympathy (.) she doesn’t get any (.) because obviously (.).
8 that’s a ploy that I’m not prepared to let people do=

In the extract Giles constructed Tara as an attention seeker - “she craves attention all the time” (line 1) and also as someone who tries to use ploys to get people to do what she wants, in this way attempting to manipulate the situation or people around her. In line 6, Giles talked about Tara’s “favourite trick”, implying that she used deceit to manipulate the situation and in line 8 he talked about her “ploy”, again implying manipulation. To warrant these constructions Giles claimed to know what is going on in Tara’s mind, “she’ll think, “right, you’re ignoring me” (line 4). Giles also worked to emphasise the abnormality of Tara’s actions and thoughts, using an extreme case formulation in telling us that she craves attention “all” the time (line 1).

The behaviour was constructed as something Tara wanted to do and chose to do. Using “tricks” and “ploys” implied some kind of consideration of the situation leading to a conscious decision. Her behaviour was also constructed as a choice when Giles said that “she’ll think, “right you’re ignoring me” (line 4) as again this construction implicates a conscious deliberation and decision to act in such ways. Tara is therefore accountable for her behaviour and this stands in stark contrast to the function of the individual pathology discourse which, as we saw, constructed clients as not accountable for the behaviour.

Extract 17 is taken from our talk a few minutes after extract 16:
Using this discourse in the construction of Tara's behaviour meant the most appropriate
countermove to Tara's "outbursts" became one whereby staff ensure they are in control of the
situation and use this control to deny Tara the very thing her behaviour was seen to be
seeking. In the extract Giles talked about taking Tara to the sensory room so that she
could not have the audience that she "plays to" (line 4). This was also evident in extract
17 where Giles talked about his not being "prepared" (line 8) to let people give Tara the
sympathy she wants (line 7). This contrasts sharply with the context discourse whereby,
as we saw, the appropriate reaction was to modify the environment in the way that the
client wanted.

Extract 18 provides another example of the use of the flawed character discourse. The
extract followed on from Drusilla talking about how Maggie sometimes laughed after she
had hurt someone.
Drusilla: she will position herself because we give her as much choice as possible, y’know
(and then) so she always has a choice of where she’s going to sit and she will position
herself in a busy corridor (.) and then everyone that comes by will get kicked {laughs} (I:
yeah) (so it’s like going round) (.) so it, it (.) she’s not er, she’s a very intelligent lady (I:
yeah) very intelligent, very manipulative (I: yeah) and er (.) very difficult in that way
because you’ve always got to try and keep one step ahead, y’know

I: in what, in what way is she manipulative (.) can you say a bit more about that, what’s

Drusilla: in the way it’s a, it’s (.) that is her way that she will get attention, I mean I don’t
know what’s happening in there now (inaudible)

I: so she’s very, very, very astute is she

Drusilla: yeah and she knows who (.) what sort of attention she’s likely to get from different
people as well

I: I see, I see

Drusilla: so she can judge the situation very well

In this extract, Drusilla explicitly constructed Maggie as manipulative (line 5), suggesting
that she makes a conscious choice to sit in a position in the corridor such that she can
kick people as they go by: “she always has a choice of where she’s going to sit and she
will position herself in a busy corridor (.) and then everyone that comes by will get
kicked” (lines 2 and 3). Maggie’s behaviour, like Tara’s in extract 16, was also
constructed as something that she wanted to do and chose to do. The construction of
Maggie choosing a busy, rather than not busy, corridor adds weight to the claim that she
wants to be in a position where she can kick people. Again we see the use of an
‘extreme case formulation’ to warrant the construction, when Drusilla said that
“everybody” (line 3) who comes by will be kicked.
In the extract we also see Maggie’s behaviour constructed as attention seeking. Indeed, one of the suggested aims of Maggie’s manipulation is to gain attention: “that is her way that she will get attention” (line 10). In order to add weight to both the constructions of Maggie’s behaviour as manipulative and attention seeking, Drusilla also explicitly constructs Maggie as intelligent (lines 4 and 5) and as such able to “judge the situation very well”. Given this, Maggie can therefore, like Tara, be held accountable for her behaviour.

Further examples of the ‘manipulative’ and ‘attention seeking’ flawed character discourses are given, although not analysed, in appendix 11.

**Action Orientation**

The flawed character discourse worked clearly to blame women for the behaviour. They were accountable for their behaviour because they chose to do it and the reason they made such a choice was because their character was flawed. The discourse also worked, however, to protect staff from blame. In extract 21 Giles said that Tara’s behaviours start for “no reason” (line 6) when she was attention seeking. Therefore the staff could not be expected to predict the behaviour on the basis of what is happening around Tara. More fundamentally, however, staff could not be blamed for a considered choice that she had made. Talk about the character flaws of staff was markedly absent and their actions were again treated as unproblematic. Again, therefore, the client was constructed as different from the speaker, whose actions were not considered to be manipulative or attention seeking.

**Subject Positions**

This discourse clearly afforded different subject positions for staff and clients. Clients were constructed as manipulators and staff as people who were insightful and wise to this.
Implications for Practice

Like the individual pathology discourse, because the flawed character discourse was an individualised conceptualisation, it invited carers to do something to the individual, specifically to exercise power to deny the client what they wanted. As we saw in both extracts 16 and 17, constructing women's behaviour in these ways afforded staff a legitimate role of ensuring that the client did not get what she wanted, perhaps as a way to discourage future attempts of hers to gain illegitimate control. Use of this discourse constructed women's control of situations as illegitimate and the appropriate situation as one where staff did not allow the woman to exercise the control she is seeking to exercise. This we could see in extract 20 when Giles said of Tara's looking for sympathy - "that's a ploy that I'm not prepared to let people do" (lines 8 and 9).
Discussion and Conclusions

Analysis Summary

The analysis demonstrated the use of two main discourses in the constructions of aggressive challenging behaviour seen in the research interviews: the individual pathology discourse, which constructed the behaviour as due to something internal and stable within the client and the context discourse which constructed the behaviour as a response to what was happening around the client. The individual pathology discourse accounted for current staff’s inability to adequately manage the behaviour, whilst the context discourse accounted for current staff’s successes in this regard. The mixing of the two discourses was also shown and the influence of gendered discourses on the participants’ discussions of aggressive challenging behaviour was discussed. The flexibility in participants’ accounts was demonstrated such that both pathology and context explanations were used in the construction of the same client’s behaviours by the same speakers at different points in the interviews. It is unlikely that a methodology which made assumptions about stability of participants’ explanations would have allowed this identification. The analysis demonstrated that throughout the texts, and in relation to all the discourses identified, the participants used a range of rhetorical strategies which functioned to increase the likelihood that the version of events being used in the particular moment would be treated as factual.

Summary of the Individual Pathology Discourse

The individual pathology discourse constructed the behaviour as caused by a pathology the client had and therefore as disconnected from the environment in which it occurred. It also constructed people with challenging behaviour as different from other people and the actions of care staff as unproblematic. Using the individual pathology discourse had the effect of protecting both the client and the staff from being blamed for the behaviour, thereby enabling the maintenance of positive relationships between staff and clients. Blame for the behaviour could be placed with other professionals for not doing their job properly in terms of establishing the nature of the pathology.
This discourse offered very different subject positions for staff and clients. The construction of clients as irrational and staff as rational led to subject positions akin to those of patients and doctors. It was suggested that this created a situation of discrepant power and legitimised staff control over their clients. Using the individual pathology discourse meant that the most appropriate responses to challenging behaviour were those directed at the individual client, for example the use of medications. The analysis identified how use of this discourse limited optimism about the future and limited the possibilities for positive intervention.

Summary of the Context Discourse

The context discourse was shown to significantly contrast with the individual pathology discourse. The context discourse constructed clients as like non-learning disabled people as their behaviours were understood as reactions to their context. At times it was explicitly suggested that non-learning disabled people would show the same behaviours if they were in the same circumstances. The context discourse invited consideration of both the immediate context and the broader systems of care.

Using the context discourse also protected clients from blame. Although the discourse legitimised consideration of staff's actions, opening up the possibility that they could be blamed, it also allowed care staff to deflect blame by explicit consideration of the context which they themselves were situated in. This seemed to work to diffuse responsibility to such a degree that it became meaningless to blame individual care staff. The discourse was shown to offer subject positions for staff and clients as equal partners. The context discourse invited interventions which were not focused on an individual, but rather on the context. Unlike the pathology discourse, therefore, this discourse did not limit hopes for change, instead allowing optimism about the future.

The individual pathology discourse and context discourse can be viewed as situated within, respectively, the deficit model of disability and the social model of disability. The deficit model of disability sees disability as stemming from the functional limitations of the impaired individual (Oliver, 1993). The social model, in contrast, views disabled people as collective victims of society (Oliver, 1993) and suggests a need to uncover the ways
that society disables. The two main discourses identified here can perhaps be usefully conceptualised as a deficit model and a social model of aggressive challenging behaviour.

Summary of the Mixing of Individual Pathology and Context Discourses

The mixing of the discourses was seen throughout the interviews. Here, the individual's pathology was constructed as important, but so was their immediate context. Using the discourses in this mixed way once again allowed the management of blame. Staffs' reactions were potentially problematised and they were vulnerable to being blamed. However because there was also a focus on pathology within the client, blame could be deflected. Using the mixed discourses allowed staff to present themselves as having significant influence and thereby allowing optimism about the future. However, given the retained focus on pathology, clients could again be constructed as irrational and it was therefore legitimate for others to have power and control over them.

Summary of Gendered Discourses

Two individualising discourses, the menstrual cycle discourse and the flawed character discourse, only used in the construction of women's challenging behaviours were identified, despite participants' constructions of their understandings of challenging behaviour not being affected by client's gender. The menstrual cycle discourse was seen as having the same action orientations, offering the same subject positions and having the same implications for practice as the individual pathology discourse. The flawed character discourse, however, whereby women were constructed as manipulative or attention seeking and their behaviour attributed to these personality characteristics, was seen as a different type of individual discourse, which worked to blame the client for the behaviour which they were seen as choosing to do. As such, staff were protected from blame. The discourse again constructed clients as different from staff. This discourse worked in a different way to legitimise the unequal distribution of power. Client's attempted control of a situation was illegitimate and the most appropriate staff reaction became one of denying them such control. Both these gendered discourses served to
empower staff and disempower female clients, whose views could be constructed as either irrational or vindictive.

At this stage it is interesting to consider why the analysis identified discourses used solely in the explanation of women’s behaviours but did not identify any discourses used solely in the explanation of men’s behaviours. The analysis process included looking for discourses used only to explain men’s behaviours and at the early stages time was spent exploring whether discourses about ‘losing control’ and metaphors of powerful unstoppable forces (such as a whirlwinds) were used solely in the understandings of mens’ behaviours. However, as the analysis progressed, it became clear that such explanations were also used in the explanation of the women’s behaviours.

Dominant discourses within our culture construct violence and aggression as inherently more normative for men than for women. Constructing aggression and violence as arising because of factors within men may be a simpler task given that this receives support from dominant ideologies suggesting men have inherent violent tendencies which they constantly have to keep under control (Burns, 1992). Dominant discourses, however, do not construct women as having such inherent violent tendencies and extra work may need to be done therefore to make a claim that their violence is caused by internal factors. Men and women receive markedly differential treatment within our criminal justice systems (Gelsthorpe, 1987). Authors have suggested that aggressive women are treated more harshly than aggressive men because aggression is all the more shocking in women given its breach of societal expectations of femininity and womens’ behaviour (Gelsthorpe, 1987). Heidenshohn (1996) suggests that violent women, unlike men, have flouted two sets of social rules, the second being that of breaching the confines of femininity. It is perhaps not surprising, given the wide cultural availability of discourses of the effects of PMS (e.g. Brown Parlee, 1994), or women’s character flaws (Burns, 1992), that these were the discourses drawn upon to construct women’s violence as caused by something stable, pathological and internal to them.
The Dominant Discourse

One challenge of a discourse analytic approach is the identification of which discourse is dominant given that analysts are not considered to have unproblematic access to ‘reality’. However, I suggest here that the individual pathology discourse is the dominant discourse and the context discourse is therefore a counter-discourse. This suggestion is based both on the much greater prevalence within the texts of the individual pathology discourse and the growing body of literature suggesting that individualised accounts of problems currently dominate our thinking (e.g. Gergen, 2001; Gergen, 1999; Gergen, 1990; Gergen, Hoffman & Anderson, 1996). Gergen (1990) suggests that virtually all patterns of human action: “stand vulnerable to deficit translation” (p. 353). The individual pathology account of knowledge is therefore argued to be used most often in pronouncing the ‘truth’ about the human condition (McHoul & Grace, 1993).

Gergen (1999) suggests that the dominance of individualised ways of understanding problems have arisen within the context of current conceptualisations of the self as “self-contained individuals who think, feel, weigh evidence and values and act accordingly” (p. 121). Gergen’s work demonstrates how our current conceptualisation of the self is not the only one possible, nor inevitable (see Gergen (1999) for a full discussion).

Links with Previous Research and Analytic Implications

As outlined in the introduction, attributional theories are increasingly being used to understand care staff responses to clients who have challenging behaviours. However, this model has been criticised by social constructionists, as outlined in box 3, for under-emphasising the social context within which attributions are made. Social constructionists therefore suggest individuals will make different and contradictory attributions (Willig, 2001) rather than one stable attribution. This analysis has suggested that the constructions and understandings staff use are fluid and that participants explained their clients’ behaviours in multiple and often contradictory ways. All ten participants used the individual pathology discourse, the context discourse and a mix of the two to explain a single client’s behaviour. Therefore although this research suggests that the way care staff understand and explain challenging behaviour does effect their
actions, a hypothesis compatible with attributional theories, it also suggests limitations of
the notion of attribution theory to understanding care staff practice because of the
assumptions made about stability of attributions. Instead what may be fruitful is to
consider what contexts encourage care staff to construct challenging behaviour in
particular ways.

This research has suggested that the management of blame for the behaviours becomes
a task for care staff working with adults with challenging behaviours. The care staff
literature discussed in the introduction suggests why issues of blame and control may be
pertinent. Care staff working with people with challenging behaviours may be vulnerable
to experiences of stress (e.g. Clements, 1997). At the same time, their expertise and
professionalism can be repeatedly called into question because of ideologies which
suggest their negative influence on challenging behaviours (see the Hastings studies
overviewed in the introduction). The research outlined in the introduction also suggested
negative evaluations of self by care staff could be associated with burnout (Hastings &
Brown, 2002; Mitchell & Hastings, 2001). Managing blame appears to be about
managing constructions of one's own knowledge and effectiveness. Within this context
the individual pathology discourse can be viewed as a way of dealing with the potential
threats implied by these professional ideologies and resisting the subject positions
afforded to staff by these professional discourses. However, when this discourse is used,
the care staff actions are presented as unproblematic and not a useful area for
consideration.

The research outlined in the introduction suggests that care staff's reactions to clients
can have a profound effect on the challenging behaviours, but that care staff rarely
talked about their own behaviour when explaining the client's behaviours (Heyman,
Swain and Gillman's, 1998). This analysis suggests it is the use of context discourses
that may encourage such reflective exploration as it allows staff to talk and think about
their own actions in a critical way, without having to accept blame. Talk about the
broader contexts may increase the extent to which such exploration is possible.

This analysis has also illustrated that despite care staff explicitly presenting their
understandings and reactions to behaviours as not being influenced by the client's
gender, gendered discourses were having an impact on the way that clients challenging behaviours were constructed. This resonates with the research, outlined in the introduction, which suggested that gender stereotypes have a powerful impact on supposedly ‘objective’ understandings of a person’s actions. As we also saw in the introduction, however, learning disability services have been accused of being ‘gender blind’ and there is increasing call for them to consider the effects of the ‘gender lens’ (Burns, 2000, Clements, Clare & Ezelle, 1995), for example in terms of how a client’s problem may present differently if they were a man rather than a woman, or vice versa.

This analysis adds further breadth to this argument by suggesting that whilst gender may not be overtly constructed as important by care staff, nevertheless culturally available discourses may differentially affect the construction of women’s or men’s aggressive challenging behaviours. I suggest that the current dominant situation whereby overt ‘equality talk’ presents gender as a non-issue, whilst covertly gender discourses are having an extremely significant effect on the way that we understand and explain the ‘challenging behaviour’ of people with learning disabilities, can be thought of as a ‘gender bind’ rather than ‘gender blind’ situation. As such this research also calls for putting ‘gender on the agenda’ (Burns, 2000) of learning disabilities services such that the power play involved in the constructions of a person’s behaviour become less hidden.

The hidden influence of gender on the constructions of aggressive challenging behaviour also challenges the notion, inherent within the individual pathology discourse, that care staff ‘rationally’ make ‘assessments’ of the situation and react accordingly, suggesting instead influences such as powerful gender stereotypes which make such rational objectivity an impossible attainment. Notions of objectivity and rationality may be usefully deconstructed in clinical work, again allowing exposure of existing power relations.

Goodley (2000) suggests the deficit model of disability is dominant in terms of explaining challenging behaviours. However, he also suggests that once a person is thus viewed any changes in their behaviour can be attributed to their deficit and other meanings dismissed. This includes the client’s own views about the meaning of the behaviour. This dominant way of explaining challenging behaviour, as we have seen, works to define those with it as in some way different or abnormal. Peter (2000) suggests that defining
individuals as abnormal is a key step in the exercise of power and that: “the negative value attached to this classification legitimates institutional control” (p. 356). Existing power inequalities between care staff and clients are therefore presented as fair and natural when the individual pathology discourse is used in the explanation of challenging behaviours. There is also a growing awareness and concern, however, about the lack of choice, control and autonomy of people with learning disabilities (Peter, 2000), which such power inequalities allow.

The deficit model of disability has been said to be incongruent with self-advocacy, self-help and collective action (Oliver, 1996). In contrast, however, the social model of disability has been said to provide a context within which empowerment can be situated (Goodley, 2000). It is suggested here that using a social model of aggressive challenging behaviour creates a situation in which people with learning disabilities can have legitimate choice, control and autonomy. In the words of Bogdan and Taylor (1994): “by abandoning labels, we shift attention from the deficiencies of the person to those of the society and service systems. Thus, we cease to ask what is wrong with the person and begin to ask what kinds of environments and services we can create...most important, when we abandon labels we are forced to listen to those whose perspectives we have ignored and to take what they have to say seriously” (p. 224-225).

Institutional Investment in the Dominant Discourse

However, the enormity of the task to empower people with challenging behaviour should not be ignored. Foucauldian discourse analysis encourages examination of the way that current social structures support the dominant ideology (Willig, 2001) and institutional investment in dominant discourses is seen as creating a challenge for effecting discursive change (Walton, Coyle & Lyons, in press).

The institutional investment in the dominant individual pathology discourse can be elaborated with reference to extract 14. At the end of the extract Giles said, (lines 21 to 24):
"you’re never gonna change certain inherent things within these people (.) because of you can’t= (I: =hmm=) it is a, it (.) is an impossibility (.) it’s a shame (.) but then if, if it was possible we wouldn’t be here (.) anyway=" (italics added for emphasis).

This talk suggested that the way that services are currently provided depends on a notion of individual pathology as the cause of behavioural problems. Indeed if things were different, the services, as we know them, wouldn’t even exist. One of the challenges of this report has been how to write about the challenging behaviour shown by people with learning disabilities without implying that the behaviour resides within the person. Perhaps the terminology of ‘challenging behaviour’ itself only makes sense within an individualising discourse. Within this framework, a number of service norms are also thrown into relief and we can examine a range of other ways that the individualising focus is reified. For example, referrals are made for an individual client and referral systems are often designed to encourage this, case files are kept for individual clients and the ‘Individual Planning’ (IP) system, which currently dominates in the care systems, focuses attention on the individual rather than the context. The institutions are both supported by and give support to an individualised discourse of the needs of people with learning disabilities.

Future Research

This research has focused on constructions of aggressive challenging behaviour that care staff use because of the powerful position that care staff can be in relative to those with challenging behaviour. What would, however, be an interesting avenue for future research would be to explore the constructions of challenging behaviour that people with learning disabilities and challenging behaviours themselves use in the construction of challenging behaviours as well as the impact of gendered discourses on such constructions. It would also be informative to explore the discourses used by other groups of professionals including clinical psychologists.
Critique of Discourse Analysis

Discourse analysis is not without its criticisms. Coyle (2000) critiqued discourse analysis on the basis that it can give the impression that the analysis simply excavates and reveals enduring discourses. However, clearly, given the philosophical assumptions of social constructionism on which discourse analysis is based, any such interpretation is itself a text which attempts to construct a particular version of reality. Burr (1995) highlights the need to remain open to alternative readings of the same texts. One of the challenges I found in writing this report was the difficulty with finding language that coherently presented the suggestions, whilst taking care not to present my version of reality as ‘right’. However, I would like the report to be read in terms of my saying ‘look at it this way’, rather than ‘this is how it is’ (see Stainton-Rogers, 1991, cited by Harper, 1999).

The relativist position can also confound arguments for practical and political action, because: “if all accounts are equally valid, how do we choose which one to act on?” (Harper, 1999, p. 139). Harper (1999), however, suggests that social constructionism can be compatible with having a political position. Instead of asking ‘which account is more real?’, we instead ask ‘which account is better?’, although of course, this then begs the question of ‘who decides?’.

Taylor (2001) notes that discourse analysis, unlike positivist research does not make claims about the generalisability of its findings. Instead research is thought of as situated, meaning that claims made refer only to the specific circumstances of place, time and participants where the research was carried out. We can speculate that the discourses discussed in this analysis may be available for use by other carers, at other times and for talking about other clients, and indeed perhaps the research is only useful if we do so. However, we can’t know how different contexts may create subtle or even obvious differences. As such what may be helpful at one moment may not be in another.

This last critique relates strongly to the proposal that the flawed character and menstrual cycle discourses are gendered discourses. This proposal is open to possible criticism because it makes a generalised argument from a small number of specific incidences.
However, as previously outlined, the basis for proposing that these discourses are gendered was not just the fact that the discourses were only used in the construction of women's behaviours, but also the links with previous research and 'wider discourses'. Clearly, however, further research is needed to see if similar gendered discourses are used by other people in other contexts when constructing the challenging behaviour of women and men with learning disabilities.

Many of these critiques are subject to on-going debate because there are no simple answers. However, I believe that the social constructionist position can challenge one to be continually reflective and if research stimulates this in clinical practice, then perhaps it can be considered useful despite its critiques.

Conclusions

A number of recommendations for clinical practice with men and women who have aggressive challenging behaviours and their direct care staff can be made as a result of this analysis.

Using the individual pathology discourse legitimates a situation whereby clients are disempowered and denied control. The empowerment of people with learning disabilities and challenging behaviours, including legitimation of their choices and control over their lives, is supported instead by the use of the context discourse. Using the context discourse also makes discussion of the possible influence of staff on the challenging behaviour a legitimate area for discussion. However, this creates a situation where staff are vulnerable to being blamed for the problems. It is likely that this challenge is best resolved by interactions which acknowledge the broad context factors which are impacting as much on the staff as they are on the clients.

Gendered discourses may influence how staff make sense of a client's behaviour, despite a seeming lack of 'awareness' of this. In this way the power of the gendered discourses are hidden. Furthermore, it may be that female clients are particularly vulnerable to being damned for their aggressive behaviours as the gendered flawed character discourse can be used to explain their behaviour. It is also likely, therefore, that conversations which make explicit the impact of gender stereotypes on the
understandings of the behaviour, allowing their impact to become less hidden, may also add to the empowerment of people with challenging behaviours.

My clinical experience has suggested that care staff can come to be seen by professionals as either ‘good’ or ‘bad’ in terms of the explanations they use for behaviours and their reactions to it. However, this analysis has identified the flexibility in all participants’ accounts. Once such adaptability is considered, what becomes the challenge is to consider the situations which encourage staff to use one discourse in preference to another. This analysis has also suggested that one of these areas for consideration is the impact of the dominant service ideologies.

I would like to finish this report by sharing some thoughts about how this analysis relates to the ideology of the 2001 ‘Valuing People’ white paper (Department of Health, 2001). It may be argued that this research highlights some of the problems that may be encountered in trying to achieve the white paper’s ‘new vision’ of rights, independence, choice and inclusion for all people with learning disabilities. In this report it has been suggested that individualised discourses were dominant, that these constructed those labelled with challenging behaviour as different from other people, created situations of discrepant power and legitimised staff control over clients. It is therefore suggested that the dominant discourses of aggressive challenging behaviour run counter to the vision of the ‘Valuing People’ white paper. Baum and Webb (2002) suggest that psychologists need to enter the political arena to achieve the change required to meet the ideals of the ‘Valuing People’ paper. The arguments made in this report lead to the conclusion that in order to realise fully the vision of this paper, change is needed at individual, organisational and political levels. To achieve this change, attention could be usefully paid to the full consequences of the discourses that we use in talking about challenging behaviour and the constructive implications of professional theories and actions.
REFERENCES


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Appendix 1 – Social Constructionist Approach to Gender

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Appendix 4 - Information about the Research Participants

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Appendix 6 - Participants Information Sheet

Appendix 7 - Consent Form

Appendix 8 – Semi-Structured Interview Schedule

Appendix 9 - Transcription Guidelines

Appendix 10 – Complete Transcript of Fifth Interview

Appendix 11 – Further Examples of the ‘Flawed Character’ Gendered Discourses
APPENDIX 1

A Social Constructionist Approach to Gender

The term gender is used throughout this report and it is therefore important to highlight the way the term is used by social constructionists. The distinctions between 'sex' as biological and 'gender' as social have been critiqued by social constructionists and feminists (Kitzinger, 1994) for reifying both an artificial nature/nurture dichotomy (Unger & Crawford, 1993) and suggesting that we have unproblematic knowledge of whether a difference is biologically or culturally induced (Kitzinger, 1994).

Social constructionists talk about 'doing gender' (Ussher, 1997), seeing it as an interactional accomplishment. Indeed it has been suggested that gender should be redefined as a verb, rather than noun (Unger & Crawford, 1992, cited by Burns, 2000). Gender is not seen as static, instead it is suggested that we turn up or turn down our masculinity or femininity depending on the context (Burns, 2000). From this perspective it makes no sense to assume that all women and all men share traits, behaviours etc. (Wodak, 1997, cited by Stokoe, 2000). This research, rather than making assumptions about gender as a stable fixed concept, was interested in investigating how the participants' used a concept of gender in the constructions of their clients behaviours.
Burr (1995) summarises social constructionism as a philosophy which takes a critical stance towards taken-for-granted knowledge. It provokes us to critique the idea that conventional knowledge is based upon unproblematic, unbiased and objective observations of the world. Therefore the ways in which we understand the world and the notions we accept as factual knowledges are in fact historically and culturally specific. Furthermore, knowledge is sustained by social processes. People construct knowledge between them during social interactions. Each different construction of the world invites a different kind of action. For example, seeing ‘alcoholism’ as a disease rather than something for which the individual should be blamed has brought with it radical shifts in society’s responses.
Foucault’s philosophy involved a re-thinking of the concepts of discourse, power and knowledge (McHoul & Grace, 1993). He argued that what counts as ‘knowledge’ (or what particular discourse is given the stamp of ‘truth’, Burr, 1995) is an ever changing condition (Foucault, 1970), intimately bound up with power relations. Power was not seen, therefore, as something that some people have and others do not, but rather as an effect of discourses and something that anyone can, technically, exercise through discourses (Burr, 1995). However, discourses, as well as offering a framework within which people can understand their own and others’ experiences and behaviours can also be coupled with social structures and institutions (Burr, 1995).

Foucault’s understandings of ‘knowledge’ extended to hypotheses about self-knowledge. For example, in ‘Discipline and Punish’ (1979) he outlined how what he saw as an increasing societal practice of surveillance and normalisation was internalised by the members of the society.

Foucault’s interest was in exposing the historical specificity of the status quo, highlighting that things could have been different (Foucault, 1981, cited by McHoul & Grace, 1993). For example, Foucault wrote prolifically about the scientific paradigm, highlighting that an empiricist account of knowledge, although only one possible account of events, has become accepted as the ‘truth’, perhaps even to such an extent that it is hard to see that there may be alternative, equally valid versions of the world (Foucault, 1977). His focus was not on recommending one discourse over another, but rather uncovering the conditions which allowed a discourse of knowledge to emerge or become dominant (Burr, 1995). He suggested that if we can understand the origins of ways of understanding ourselves that we can begin to question them (Burr, 1995).
### APPENDIX 4

**Information about the Research Participants**

#### Interview 1

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\(^3\) The exact age of the participants is not given in order to further protect their anonymity.
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Dear Esther

Study title: Exploring Understanding of “Challenging Behaviour” in Staff Working with People with Learning Disabilities

Thank you for your recent letter and enclosure, received on 15 April 2002.

Dr Rademaker, Chairman of the Local Research Ethics Committee, has reviewed your response to the queries raised by the Committee when they reviewed your study and I can confirm that the response is satisfactory and I am writing to inform you that Chairman’s Action has been given to approve this study.

It would be appreciated if, on its conclusion, you could supply a brief report to the Committee of your findings and conclusions.

Yours sincerely

(Mrs)
Research Ethics Committee Administrator
Dear Ms Wilcox

Exploring understanding of ‘challenging behaviour’ in staff working with people with learning disabilities (ACE/2002/32/Psych) – FAST TRACK

I am writing to inform you that the University Advisory Committee on Ethics has considered the above protocol under its ‘Fast Track’ procedure and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/32/Psych) - Fast Track The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 22 May 2002
Date of expiry of approval by the Advisory Committee on Ethics: 21 May 2007

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr M Finlay, Supervisor, Dept of Psychology
Dr J Edmonds, Supervisor
EXPLORING UNDERSTANDINGS OF ‘CHALLENGING BEHAVIOUR’
IN STAFF WORKING WITH PEOPLE WITH LEARNING DISABILITIES

You are being invited to take part in a research study. Before you decide if you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please do not hesitate to ask if there is anything that is not clear or if you would like any more information.

Background to the project
Within services for people with learning disabilities, there is often concern about the behaviour of particular clients. These clients are often said to have ‘challenging behaviour’. Working with people who are said to have ‘challenging behaviour’ is a skilled task, the largest part of which is carried out by direct care staff who work in, for example, residential or day-care settings.

Our understandings about ‘challenging behaviour’ have greatly increased over the past few decades and there are now some well accepted definitions of ‘challenging behaviour’ and ideas about how we can best offer support to people who are said to have ‘challenging behaviour’. Clearly, however, no definition of ‘challenging behaviour’ can be written in a way which is completely objective and staff therefore use their ideas and experience to consider when, and why, this label is appropriate.

Aims of the project
This project aims to add to an increasing understanding of what is a ‘challenging behaviour’. Ultimately this project will aim to increase our ability to work with and support people who have learning disabilities and ‘challenging behaviours’ by sharing some of the ways that these complicated issues are understood. This will help outside
‘consultants’ (e.g. Clinical Psychologists) to have a better understanding of the ways that ‘challenging behaviours’ are understood by those staff who work directly with clients, and to offer more helpful ideas to help these difficult situations.

**Why have you been chosen?**
I am keen to explore care staff’s understanding of ‘challenging behaviour’ by talking to experienced care staff who are working directly with adults with learning disabilities, whom they consider to have challenging behaviours. I am defining experienced as at least 1 year’s experience in working with adults with learning disabilities, in any setting. A client that you are working with was recently referred to the Community Learning Disability Service (CLDS) because of some behavioural issues and I understand that you consider their behaviour to be a challenge. This referral may have been made by you or by someone else, but I am keen to talk to someone who knows the client well, and that is why you are being asked if you would like to volunteer as a participant.

**Deciding to take part, or not**
It is up to you to decide whether or not to take part in this study. If you do not wish to take part or subsequently wish to withdraw from the study, this will not in any way affect the service your client receives from the CLDS. If you decide you would like to take part in this study I will ask you to sign a consent form once I have answered any questions you have. You will be given a copy of the consent form to keep.

**What will the project involve?**
If you decide to volunteer to participate in this study, we will arrange a time to meet and talk about the client of yours who has been referred to the learning disability service because of some behavioural difficulties. These interviews will be quite informal and we can meet either at your place of work or at the CLDS offices. I estimate that interviews will last approximately 1 hour. When we meet we would talk about the behaviour of your client and about how you and other staff make decisions about whether a behaviour should be considered ‘challenging’ or not. The interviews will be audiotaped.
Confidentiality
All names of staff and clients will be disguised in the project’s write-up and in any discussions about the research with anyone other than the research supervisors. The interview tapes will be destroyed at the end of the research process.

This research is being supervised by Dr Mick Finlay (Research Psychologist, University of Surrey) and Dr (Clinical Psychologist, CLDS).

Results of the project
The research will be written up in line with the requirements for the researcher’s Clinical Psychology training course. A summary of the research findings will also be produced and sent to all participants, as their support will have been invaluable in the carrying out of this project.

Ethics Approval
This study has received ethical approval from the Local Research Ethics Committee and Surrey University Ethics Committee.

Further contact
You have already given verbal consent for me to phone you and see if you are interested in taking part in this study to professional of the CLDS. I will phone your place of work to speak with you in the next couple of weeks. When we speak you may ask me any questions you have before making a decision about taking part or not. If you do take part, I can be contacted via the CLDS with any further questions you have either before or after the interview.

Many thanks for giving the time to consider taking part in this study.

Esther Wilcox
Trainee Clinical Psychologist
In training at the University of Surrey
RESEARCH PROJECT CONSENT FORM

Exploring Understandings of ‘Challenging Behaviour’ in Staff Working with People with Learning Disabilities

Investigator: Esther Wilcox, Trainee Clinical Psychologist

I have read the participant information sheet for this research and understand the aims and nature of the research. I have been able to ask any questions that I have about the research and have been satisfied with the answers I have been given. I understand that I retain the right to withdraw from the study at any time and that this will not affect the service my client receives from [NHS Trust Name Removed] Community Learning Disability Service.

I understand that my responses in the interview will be anonymised in the research reports. Completed consent forms will not be included in the research write-ups.

I consent to participating in this research project as outlined on the participant information sheet.

Name (capital letters)  

Signature  

Date  

Work Address  

Signature of Researcher  

Date
Appendix 8

Semi-Structured Interview Schedule

Please note – prompts, which may be asked to follow up the answers participants give to the questions, are indicated in brackets and italics after the questions.

Introduction

Thank you for participating in this study. As you know, this research is concerned with finding out more about how staff who work directly with people who have learning disabilities understand ‘challenging behaviour’ in people with learning disabilities. We will be spending the next hour or so talking about your client, x, their life and their behaviour. We will talk quite informally, so please let me know if there is anything I say that doesn’t make sense or you don’t agree with and please ask any questions that you may have as we go along. If you’d rather not answer any questions, please feel free to say so and you also have the right to say that you want the interview to end at any point and you don’t have to tell me why. We’ll talk for about an hour, and if we go over that time, I’ll check with you that it’s alright to carry on. Also, please let me know if you want a break at any point. Do you have any questions before we start?

1. Background Details

♦ Name
♦ Age
♦ Job Title
♦ How would you describe your ethnic background?
♦ What professional qualifications do you have or are you working towards? (e.g. NVQ’s, degree, DipSw)
♦ If you have already obtained these qualifications when were you awarded them?

2. Experience with adults with learning disabilities

♦ How much experience do you have in working with adults with learning disabilities?
♦ How much experience do you have in working with adults who have learning disabilities and ‘challenging behaviours’?
♦ In what setting was your experience gained? (Day centres? Residential care?)
♦ How long have you worked in your current place of work?

3. Role in relation to referred client

♦ What is your role in relation to X?
♦ How long have you known/ worked with X?
4. Description of behaviour

♦ What are X’s ‘challenging behaviours’ at the moment? (Can you describe them in detail? How often do they happen? Where do they happen?)
♦ Can you tell me about a time when this behaviour happened?
♦ Why should X not be doing this behaviour?
♦ Who does the behaviour effect? (How does it effect the client? Other clients? Staff? Family? In what way does it effect these people? Do other people think that the effects are different? Why?)
♦ Have there been other behaviours that have been a problem in the past?
♦ You may work with or have worked with in the past, or be working at the moment with other clients who have ‘challenging behaviours’. How does X’s behaviour compare with theirs?

5. History of behaviour

♦ When was the behaviour first thought of as a problem? (There isn’t a line which divides what is a problem from what isn’t, so what factors do you think meant that this was thought of as a problem?)
♦ Who first identified it as a problem? (Do you think other people would have thought that it was a problem too? If not, why?)

6. Why is the behaviour a problem now?

♦ What consequences is the behaviour causing that means it is a problem. (Was this the same when it was first seen as a problem? Do other people think these consequences are a problem? Why do these differences exist?)
♦ How does the behaviour make people feel and why is that? (Frustrated? Angry? Do different people feel different things? Why? What is it about the behaviour that makes people feel that?)
♦ Would the same behaviour be a problem if someone else were doing it, or is there some other factor that I need to understand which helps explain this? (For example, different circumstances or different expectations as appropriate to the client?)
♦ So that I understand the contrast, can you tell me what things, if any, X does which are not considered challenging, or times when their behaviour is not challenging. (Why is this behaviour considered to be not challenging? Does anyone think that this behaviour is challenging?)
♦ Are there things x does that other people consider to be ‘challenging behaviours’ but which you do not?

7. Thoughts about causes of the behaviour

♦ Why do you think x has this behaviour? (What was it about X that led to this? What was it about what was happening around X? Was it something that other people were doing?)
♦ Would another person have developed the same behaviours in the same circumstances? (If yes, why, if no, why not?)
♦ Do other people have other ideas about why this behaviour developed? (E.g. their family or staff from other places, or other staff from the same place as you?)
8. What factors maintain the behaviour?

- Why do people think differently? (Who’s ideas do you agree/disagree with?)
- What experiences or ideas help you to understand or think about X’s behaviour?

9. Preferred behaviour

- What, if anything, would people like X to be doing instead of this behaviour? (Are there any disagreements about this? What is the basis of these disagreements?)
- Do other clients who don’t have this ‘challenging behaviour’ do this instead? (What do they do if not this? What is it that people without learning disabilities might do instead?)

10. Previous responses to the behaviour

- What has been tried to manage/respond to the behaviour?
- Who’s suggestion was this/these responses? (Why do you think the person/people thought this would be useful?)
- What responses have you felt to be useful? (Why is this? What difference did they make?)
- What responses have you felt were not useful? (Why is this? Did it make any difference? What part of the behaviour was not changed?)
- Do other people respond in other ways? (What effects do these responses have? Are the responses useful/not useful?)

11. Suggested responses for the future

- What ideas do you have about what else might be tried/ tried again to manage/respond to the behaviour? (Why might this work/what effects might this have? What parts of the behaviour would you want to be changed by this?)
- What do you think X would think of this? (If they might not like it, what factors mean that it is important to do anyway?)

12. Any other diagnoses that x has

- Does X have any other diagnoses that might be important for me to know about, e.g. autism, or mental health needs (please specify).
- Are these diagnoses quite well accepted or are they somewhat contentious?
- Who agrees with them and who doesn’t?
13. Closure of the interview

♦ Is there anything else that you think I need to know about X's behaviour, their life, relationship etc.?
♦ Is there anything else you would like to tell me about your experiences that I have not asked in this interview?
♦ Is there anything else you would like to tell me about the understandings you have about challenging behaviour gained through your experience in working with people who have learning disabilities and challenging behaviour?
♦ How did you find this interview? (What did you think of the questions I asked? Would it be good to ask other questions/ ask questions in a different way?)

14. Thanks for taking part

Thank you again for taking part in this study. I will be sending all the participants a summary of the findings when I have written this up, but please be aware that it will take me many months to get to that stage! I would like to reassure you again that all you have said today will remain anonymous and confidential. Your name, X's name and any other names will be changed in the research reports.

Prompts to be used throughout the interview to encourage detailed responses -

Could you tell me more about that?
What makes you say/think that?
I would like to know more about that.
Why is that, do you think?
Appendix 9

Transcription Guidelines

Taken from Potter and Wetherell (1987)

1. Square bracket in the blank line between speakers’ talk marks the start of overlap between utterances.

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

3. A full stop in brackets indicates a pause. Pauses have not been timed.

4. Two colons indicates an extension of the preceding vowel or sound.

5. Underlining indicates that words are spoken with added emphasis.

6. Round brackets indicates that there is doubt about the accuracy of the material in the bracket.

7. Round brackets around the word inaudible indicates that the speaker’s utterance was inaudible.

8. Square brackets denotes information which has been added for clarification or that information has been deliberately omitted for the sake of anonymity.
Appendix 10

Complete transcript of the fifth interview

Interview 5
19\(^{th}\) November 2002
Giles and Tara

Age – 40's
Job Title - Deputy Home Manager
Ethnic Background – White British
Professional Qualifications – Working towards Level 4 NVQ, registered manager’s award

I: How much experience do you have in working with adults with learning disabilities
Giles: umm, about, about 5 years, 6 years (.) I think this is gonna be my sixth year, directly working with (people with learning disabilities)
I: how much of that was with people, or adults who have learning disabilities and challenging behaviours (as well)
Giles: all of it
I: all of it
Giles: yeah, I've, I've only worked with challenging behaviour (.) and they've stepped up as I've gone but, y'know=
I: =yep=
Giles: =was pretty challenging to the average person, so yeah=
I: =yeah
Giles: if someone new went into that they, they would have found it difficult, so, yeah, most of it
I: well, what it, umm, you're saying homes is that what you, you got that experience in residential homes
Giles: community homes yeah=

I: =mmm=

Giles: =and, and actually the institution as well

I: and in the institution

Giles: yeah

[interview interrupted]

I: how long have you been working here

Giles: I’ve been here (.) yeah, I think it’s in my seventh month (.) and I have actually worked with Tara on quite a lot (inaudible)

I: yeah, and Tara’s been here all that, all that time=

Giles: =I’ve had to go down there and deal with Tara lots of times

I: she’s been, she’s been here

Giles: she’s been here all that time, yeah

I: right, so you’ve known her 7 months

Giles: since I started, she was here when I started

I: it sounds like your role is, you, as well as the management side you do stuff=

Giles: =I get stuck in, yeah

I: yeah

Giles: I’m probably the only one in the management who does (.) but then it’s what I’m used to and (.) it’s how I deal with things and it’s good for me because I get (.) (respecting from all the staff) so it works for me as well

I: (that’s right)

Giles: yeah

I: will you tell me about Tara then, can you=

Giles: =yeah, yeah, she, Tara’s, umm (.) I think, I can’t find her thing in here, she’s, I think she’s 22

I: uh-hum
Giles: umm (.) she's umm (.) she's very umm, knowledgeable of things, she's deaf, partially sighted

I: right

Giles: umm (.) we do think that she can hear (.) the odd high pitched noise

I: oh, she's really quite, quite profoundly deaf is she

Giles: umm we have seen reaction from her occasionally when a big bang or something, there's been something there, but y'know maybe I'm reading something into it that isn't umm, her vision out of one eye is, is pretty good y'know and the other eye is not good at all (.) umm, she's pretty concern, conversant with sign language, umm, be it (.) y'know BS or she develops it into her own=

I: =hmm=

Giles: =so she actually is very lazy (.) umm

I: and clever I guess if she can (inaudible)

Giles: she'll like, y'know, in, in, instead of going like "good morning"

I: uh-hum

Giles: y'know, "good morning", she'll go [makes gesture] but we know that's good morning

I: so it's kind of like we say hi instead of hello, is that, yeah=

Giles: =yeah, that's it, exactly, and she just (.) sort of converts that into sign language [is that her sign language

Giles: she does have her own signs for words that (.) we wouldn't use, but she does, but the staff who work with her know what those signs are, so sort of (.) umm (.) she's a very challenging young lady, she's umm, very able

I: uh-hum

Giles: umm (.) she cooks (.) with support

I: uh-hum=

Giles: =umm, she can make tea, she can do all sorts of things with, with a bit of support, umm, she does need a lot of coaxing because I think she is inherently lazy, she likes people doing things for her (.) umm, when she does take an active role in, in something, sometimes it goes down very well and other times it doesn't (.) there's no (.) it's very difficult to read Tara (.) there are obvious signs with her as to whether she's going to (.)
umm (.) behave inappropriately, you can see things brewing, sometimes you won’t, you’ll be sitting there and she’ll be happy and all of a sudden she will go for something and it will be so fast and so sporadic that you won’t see a trigger a sign, anything=

I: =uh-hum

Giles: so (.) she can be unreadable which makes her, y’know, even more of a problem

I: uhm

Giles: umm, she’s on umm, regular medication, umm

I: for her behaviour or for

Giles: yeah, she, she has umm, we, we’ve not long had her assessed, she’s had umm, we thought that maybe she may have some underlying epilepsy

I: OK

Giles: umm, because (.) umm, some of her (.) outbursts, for want of a better word, were (.) alongside when some sort of like rigour:::rs and some (inaudible)

I: =right, I know I’ve not, I’ve not heard of it, however you say it I’ve not heard of it {laughs}=

Giles: =but umm, yeah, it’s quite an old term actually, but=

I: =OK=

Giles: =we’ve used it (inaudible) but occasionally she would shake, umm (.) sometimes if she goes on the floor, she’ll pull people on the floor and she’ll go down on the floor herself

I: uhm

Giles: umm, there’d be like a shaking and a, and a rapid head (.) y’know (.) my personal opinion is that it’s 99.9% behavioural

I: uh-hum

Giles: as a paramedic and from a professional point of view and dealing with epileptics a lot

I: yeah

Giles: I would say that it is more behavioural but
I: has she got epilepsy then, or is she

Giles: no she hasn't been diagnosed with it, they wouldn't give her (.) a brain scan because they felt there was absolutely no point (.) umm

I: (inaudible)

Giles: I mean my opinion on that's irrelevant but that is (.) their decision

I: what is your opinion

Giles: I think she should be entitled to the same things that everybody else gets, y'know I think that if it showed nothing, or they felt it was a waste of time, at least (.) y'know, to go through the motions and to try is better than to do nothing

I: (inaudible)

I: well, why, why are they unwilling to give her (.) that scan

Giles: because umm, I think (.) the umm (.) the psychiatrist that is dealing with Tara (.) for the brain scan side of it said that he felt that it would show nothing (.) that it would put her through a lot of a, I think (.) the main reason why it was was that she would have to go through a GA

I: right (inaudible)

Giles: and I think that they felt that that was going to be a lot of hard work for them (.) and they couldn't justify it, or they felt they couldn't justify it (.) that (.) for the result that would come out, umm=

I: =so that's not the learning disability's psychiatrist (or is it)

Giles: no, umm, that's the umm, the mental (.) side (.) she, she has got umm, although she's diagnosed as learning disabled, she has obviously got some mental health problems there=

I: =i=C=g=Ges: (inaudible)

Giles: but she is diagnosed as learning disabled

I: is it mild learning disabilities=

Giles: =umm

I: (do you have any idea)=

Giles: =yeah, if, if you want to take, yes it, I would say it's, it's umm moderate (.) mild to moderate even because I think that most of her problems is er, mental health issues
I: uh-hum

Giles: and I think her behaviour and stuff like that is more mental health than, than learning disability, that’s my opinion, y’know, umm, but I would say that (.) I mean I have spoken to her umm psychiatrist (inaudible) we’re actually losing her, she was really good

I: is she a CMHT psychiatrist

Giles: yeah (.) she, she’s umm (.) excellent and unfortunately she’s going (.) umm, we’ve already had a new one that’s already made 2 major mistakes which I’m gonna be complaining about, but (.) umm, but when I said to her, “well realistically she is dual diagnosis isn’t she”, she said “well, she’s down as learning disabled but yes, I would agree with you she is dual diagnosis pretty certainly”

I: what, what are her mental health needs then what’s

Giles: umm (.) well none really because she’s not actually down as mental health, so we don’t have a specific thing there to say that (.) y’know umm (.) she’s treated as severe learning dis, disabled=

I: =right=

Giles: =which to all intents and purposes is what she is, but I, I do think that, y’know, the reason why we, we this is why we wanted to do the, the brain scan, it wasn’t simply just to test for the epilepsy to see if there was anything there, but it was also to get a, a better diagnosis, like maybe (.) what damage was there or whatever else that would, could (promote them to say) well, y’know,” there’s, there, there’s got to be mental health problems here because of this”, y’know, “this is so badly damaged” or “this part is just not working” or whatever else (.) for them to give us a definition (.) umm, but they won’t do it, so=

I: =what, what makes people think, or what is it that suggests she’s got mental health needs then if she’s not, I mean she’s not had that formal diagnosis (inaudible)

Giles: =the (.) the rages she goes into and unconnected stuff without triggers, I mean as you’re probably aware (.) umm, most, most umm, people with learning disabilities are, are quite predictable

I: =right=

Giles: =you have autistic, we have autistic people, we have people with mild learning disabilities, we have people with moderate learning disabilities and they all emanate in different ways (.) certain behaviours, but you can, y’know, I know that when a specific client goes (inaudible) I just (.) stay out of his way
I: right=

Giles: =cos he's gonna go off= [inaudible] so that's (.) so something about, right for Tara it's (.) there is no (inaudible)

Giles: so that's his trigger, you know that he's gonna go, Tara, you can be sit, you can be sitting there doing the re, y'know, one of her nice things she likes, everything, she's, she's obviously got some autism in her, because everything's done to time

I: right=

Giles: =so, she umm (.) she is autistic, there's no doubt about it although she's not diagnosed as being autistic but everything that she does revolves around time (.) but again that could be (.) the mental health, because we have somebody else here who's dual diagnosis and all his stuff it timed (.) so, it could be either, but it's, it's, it's difficult for us because we can only go along with what people tell us

I: uh-hum

Giles: and we have to try and facilitate everything around the information that we have (.) and sometimes that information isn't correct (.) simply, (.) you know that there's stuff missing because a full (.) umm check hasn't been done (.) and umm, to my mind that means that you're having to make assumptions

I: right

Giles: which OK, hopefully they're right most of the times and you can put the right things in practice

I: umm

Giles: for that particular client, y'know, in Tara's case (.) y'know, there's a lot of things that we do which (.) maybe isn't written about or whatever else but it works for Tara

I: right

Giles: er, umm (.) you, you have to accommodate the client's needs in order to make the best of whatever it is you're doing (.) really, y'know, Tara is such a com, complex person that (.) it is that you can be doing something absolutely spot on, every day of the week she's enjoying it and on the 5th day of the week she will go nuts, you know=

I: =so you're doing the same thing

Giles: yeah, exactly the same, and she'll ask (do), you ask her (.) would you like to (.) whatever and she'll like (.) "yes please", y'know (.) off you go to do it (and that's when
you'll get) (.) whatever, y'know (inaudible)

[ ]

and that's, that's one of the things that's an indicator of

(.) mental health needs

Giles: I think so, yeah=

I: =right, is there other stuff

Giles: sorry

I: is there other stuff

Giles: umm, yeah, I mean we, we did have umm, an incidence (.) er, it was just before I came, umm, Tara, y'know, Tara's (.) 2 to 1

I: uh-hum

Giles: she's got 2 people with her all the time because she does need restraining regularly (.) umm, all the staff are trained in one, one specific type of restraint (.) restraint obviously (.) the company policy and the house policy is that restraint is a last resort

I: hmm

Giles: and with Tara (.) restraint is actually almost a first resort

I: right=

Giles: =simply because (.) of circumstance (.) it needs to be or somebody will get hurt, y'know, it will be another client, or another member of staff (.) umm, so we try and reduce that as much as possible, now sometimes Tara can be restrained (.) on and off for 4 - hours (.) y'know, not continually hold on to her, you ease the pressure, there's not a tight restraint, it's a specific hold (.) and=

I: =(inaudible)

Giles: it's (.) it, it would be, I mean you have, you have a person either side, I can show you some securicor (.) photos afterwards, but you basically have a person either side

I: yeah

Giles: with an arm round each arm

I: uh-hum

Giles: and a hold on there which is like a stage 1, it's only a general hold

I: yeah

Giles: and it's just a case of you've got her, you're not causing her any damage=

340
Giles: =there’s no pressure, no blood flow restriction, anything, it’s just that there’s 2 of you controlling (.). y’know, we’re talking about a woman that is so extremely strong you wouldn’t believe

I: =yeah=

Giles: absolutely, she’s tiny, I don’t know if you saw her on the way...

I: [no, I’ve not, I’ve not seen her]

Giles: she’s, she’s very small (%) umm (%) but she’s, I mean she’s actually physically lifted me off a chair with one of her arms and I weigh 12 stone.

I: right

Giles: alright, now this is (%) the power we’re talking about, she can pull 3 people on to the ground with her (%) alright, so that’ll give you an idea of how strong this person is (%) umm

I: is that another, so are you saying that’s another one of the things that makes you think mental health needs is it, that (%) restraint is likely to go on for so long

Giles: yeah, it is so (%) yeah, it’s not, it’s so (%) er, a lot, a lot, in, in my opinion, a lot a learning disabled people (%) umm (%) tend to do things on the spur of the moment, in terms of behaviours

I: OK

Giles: umm (%) yeah sometimes you can see them coming, sometimes you can’t but, they’re normally short lived (%) for a start, they don’t last long, you can normally talk somebody down (%) in minutes if not in seconds sometimes depending on what it is (%) umm, but you can see her hatching plans in their head (%) you can see it in her eyes=

I: =what Tara

Giles: it she’s, she’s (%) working out exactly what she’s gonna do (%) when you get to know Tara a bit you, you get a rough idea of what she is going to do (%) now and (%) in my umm (%) experience and opinion (%) ordinary learning (%) disabled people don’t do that (%) there’s a trigger, there’s something that sets them off, there’s something (%) or it might be, y’know

I: [it’s very sort of spontaneous]

Giles: yeah and it’s like, bang, over (%) but with Tara it’s (inaudible) and you can watch it (%) you can actually watch it y’know=
I: =so she's sort of planning what she's gonna do in (.) half an hour or more

Giles: =oh yeah, yeah, yeah and she plans it like
a military thing, yeah, yeah=

I: =that far ahead=

Giles: =oh literally, yeah (.) umm (.) that's=

I: =what, what does she plan for

Giles: umm

I: =I mean what's her aim when she's planning

Giles: her aim is to umm (.) normally go for somebody

I: =right

Giles: somebody specific (.) umm, she's=

I: =someone who's annoyed her or

Giles: no, no, no, oh, no, she doesn't (.) she's, she's not, umm (.) biased against
anybody, she's just, whoever she feels, I mean you will get a new person come in the
house and she'll be all lovey dove, la, la, la and all of a sudden she'll go cwough, and
that'll be it, she'll go, y'know (.) so staff have to be on the alert all the time, I mean you
can't leave her alone, you don't leave her with one person, she's actually taken the
clothes off of people, she's ripped the shirt off of my back before, completely

I: uhmm

Giles: umm, so (.) y'know, on more, one, one occasion, she's left (.) women staff (.) half
naked, simply because she's just ripped their tops apart, y'know, which is obviously very
distressing and embarrassing for the member of staff (.) y'know, it's difficult for me
because I'm trying to intervene and help out and I've got this poor woman here who's
embarrassed and half naked, holding on to her

I: (just got her bra on)

Giles: yeah, and, y'know, it's (.) so yeah, there's a lot of planning there (.) umm (.) I think
she's very clever

I: uh-hum

Giles: I do think she's very clever

I: uh-hum=
Giles: =she knows exactly what she’s doing (.) there’s absolutely no way that she doesn’t know what she’s doing because she does because she’s very directional, if she’s going for a man she’ll go for his genitals every time

I: right

Giles: because she knows that that is the weak spot (.) umm, if she goes for women=

I: =in what, what, what, sorry, in what way would she go for them (inaudible)

Giles: [she’ll (.) get hold of them (.) I tell you what, you try and break her grip it’s very difficult to do, she’s very, like I said she’s (.) once she’s got hold of something you, you can’t break that grip (.) no (.) you try, y’know, “let go please” and (.) try all the things and give it, if it’s not hurting you, if it’s like, normally it’s clothing she’s got hold of, you just (.) I mean staff (are talking)

I: so you mean she goes, she goes for male genitals but might end up just holding their trousers or something=

Giles: =umm (.) if she knows she can reach ‘em she’ll got for ‘em and if she manages to get hold of ‘em you’re in trouble

I: (inaudible)

Giles: right, so it’s a case of=

I: =protecting yourself=

Giles: =yeah, the males here are aware of that (.) umm, so yes they do go in sort of at a bit of an angle and (.) y’know (.) the hands being held, but she’s very clever because she’ll, (we’ll) say “you need to calm down” (whatever else, are you calm) she’ll go (.) and you just let the slightest bit of pressure off and she bouff (.) and (.) that, I don’t know where she gets her speed from but it’s incredible (.) and you need to be aware all the time that (.) you release the pressure (.) to be ready for her to go=

I: =uh-hum=

Giles: =she doesn’t always go (.) it might be 9 times out of 10 one day, she might not go at all the next day, umm (.) it’s just Tara, what she decides she wants to do (.) she will go for women’s boobs

I: right

Giles: umm, she’ll, any jewellery you’ve got on she’ll rip it off you (.) earrings, necklace, none of the staff are allowed to wear watches now, cos I lost my three hundred pound Italian necklace the first week I was here, she ripped it off me

I: did you, did you get it back
Giles: no, it needs repairing, but it's OK, but it's gonna cost me probably forty quid to get repaired (.) but I will put in a claim for it (as of now) because (inaudible) [ yeah, I was imagining that you've got quite a (. ) budget for (inaudible) ]

Giles: well our head office just pays direct so it's y'know (.) and she has put people in hospital before (.) erm, she tried to drown a member of staff (.) about 18 months ago

I: uhm, in the bath [ Giles: quite literally, no in the swimming pool (.) umm, unfortunately for this people only person got in the water with her (.) which was a huge mistake ]

I: yeah, I was imagining that [ Giles: well our head office just pays direct so it's y'know (.) and she has put people in hospital before (.) erm, she tried to drown a member of staff (.) about 18 months ago ]

I: right

Giles: umm (.) I wasn't here then and the company that I work for (.) weren't here then (.) but from my:: understanding is, is that the person who (.) nearly got drowned also suffered severe disciplinary from their company as well=

I: =oh, god (.) because they shouldn't have been in the water alone with Tara, oh my god [ Giles: because of the situation that they put themself in, yeah (.) which is, y'know ]

I: tough

Giles: it is tough, but then (.) y'know she could be dead this person

I: maybe, yeah (.) if you put it that way she's actually quite lucky, isn't she [ Giles: I mean (.) Tara being as strong as she is, on a 1 to 1 ]

I: uhm

Giles: y'know, I mean (.) even as, in that I struggle with her (.) on a 1 to 1, on the occasional times that I'm not weak (.) and I really did, it takes everything that I've got to keep hold of her [ I: how often, how often are these kind of things happening ]

Giles: every day

I: uhm

Giles: er:: sometimes it'll happen (.) I, I, that's a bit of a lie, because she does have her purple days
I: purple days (.) days when

[ ...]

Giles: =yeah, she'll go through a purple patch

[ ...]

I: =is that a good, a good day=

Giles: =yeah, umm (.) I think we went, one time I think we went (.) three days (.) with virtually nothing from her, y'know, just=

I: =what's, what's she like then, what's she like when she's having her purple days

Giles: =umm (.) just, just relaxed, calm (.) umm (.) you can converse with her

I: yeah, she's quite chatty=

Giles: =umm, yeah, umm, she might do a few things with you (.) y'know, maybe lay the table

I: has she, has she got any things to do, hmm

Giles: =she likes to walk down the shop (.) she likes a walk (.) she likes going for drives but only in the car, she doesn't like people carriers and things like that=

I: =she doesn't like what sorry=

Giles: =people carriers (.) she goes out in the people carrier

I: =too many people around

Giles: =no, it could just be

I: oh, even if it was just her (she wouldn't like that)=

Giles: =she has to go out with 3 people (.) umm, she had one driver and 2 in the back with her (.) cos it's unsafe for her to go out (with one) (.) umm (.) she's (.) I suppose on an average day, on an average (.) I'd say an average Tara day (.) she'll (.) need to be restrained (.) anything from 3 to 10 times, and those restraints can be anything from (.) 30 seconds

I: =to 4 hours=

Giles: =that's not learning disabilities=

I: =yeah=
Giles: =that's mental health and that's=

I: =what, what do you think her mental health needs might be, what's your experience (.) even though she hasn't got (.) a diagnosis, what's

Giles: it is (.) umm (.) she, I think (.) I think she **craves** attention all the time (.) if you're talking to somebody else when you're with her, if you're not looking at (.) at her, or keep looking at her while you're talking to somebody else, your (.) attention is diverted all the time (.) she'll think, “right, you're ignoring me” (.) and that'll be it, that'll be **diff**

I: OK

Giles: OK (.) so I think a **lot** of it is attention seeking

I: right

Giles: she craves (.) people to like her, she's always asking if people still friends (.) she'll have an episode and then:: her favourite trick is to cry her eyes out after

I: right=

Giles: =cos she wants sympathy (.) she doesn't get any (.) because obviously (.) that's a ploy that I'm not prepared to let people **do**=

I: =right, it feels like that's, that's (.) a **game**

Giles: she, we, yeah (.) it is a ploy, it is a ploy, umm (.) because you can say to her you “stop crying (.) and calm down and we'll talk” and whatever else, **sometimes** she'll stop within a few minutes, sometimes it'll take her (.) 20 minutes, half an hour, umm (.) but for the **most** part it is a ploy (.) most certainly

I: hmm

Giles: umm (.) you can=

I: =a ploy for what (sort of thing)

Giles: for, for (.) for people to, cos she'll **ask** for a cuddle and things

I: right=

Giles: =umm, after, y'know, she might have just tried to rip your head off

I: uh-hum

Giles: but then she's like (.) oh, y'know (.) she **knows** when she's been bad and she'll say she's been bad
I: right

Giles: and she'll say sorry

I: uh-hum

Giles: and she'll say things like "I won't do it again" (.) umm (.) but obviously her, her, her routine (.) just (.) seems to (.) it seems to be part of her routine is, is to display challenging behaviour (.) it's very rare that you get a day that she doesn't do anything, you do get better days (.) sometimes than others (.) we've had her for periods where she's gone 4 or 5 days (.) absolutely ragging the staff to bits for 4 or 5 days (something) so she'll go to bed, whatever 8 o'clock at night, she'll get up at 5 o'clock and she's start

I: right=

Giles: =until she goes to bed at 8 o'clock and then 5 o'clock=

I: =right=

Giles: =and that'll go on for 3 or 4 days sometimes (.) and you can imagine the pressure that it puts on the staff that work with her (.) it's, it's (. . ) phenomenal (. . ) I mean I've spent complete shifts with her simply to give staff a rest (. . ) (inaudible)

I: yeah

Giles: cos I know who the people that can really handle her well (.) the person [key worker] that you were going to talk to can, so occasionally I'll (.) like say to one of (those) "right you can work with somebody else (.) I'll work with Tara and [keyworker] all day"=

I: =right=

Giles: =and I'll spend time with her=

I: =is that one of the ways that you manage it (.) is to, to

Giles: to try and give people breaks, yeah=

I: =right

Giles: =yeah and [keyworker] never wants a break (. . ) she's quite happy working with her all the time which is (. . ) I don't quite, I can't quite read the psychology in that, but

I: {laughs}

Giles: umm, she's happy doing it and she's very good with her

[but it works does it]

Giles: it does and she's very good with her and, and Tara does have a lot of respect for her, y'know=
I: =right=

Giles: =no doubt about it (.) er (.) but having said that she still goes for her

how does that show (.) that she's got particular respect for someone

Giles: because you, you (.) you'll find that umm (.) you'll get (.) sometimes it'll emanate in less behaviours with that person

I: right

Giles: umm (.) sometimes it'll be (.) simply the amount of affection that she might show that person

I: asking for more cuddles and things like that=

Giles: =yeah, I mean, it's always when [keyworker's] not here it's umm (.) it, it, it's "where's lady F" (.) all the time, "when, when, when's she coming" (.) as soon as she comes in "what time are you going home" (.) yeah, she wants to know how long she's there with her (.) umm, she did it with me for a little while actually, I don't quite know why, probably because I did quite a few sessions with her, worked with=

I: =right=

Giles: =her quite a lot and she was always wanting to see me and y'know, I mean I do cuddle her, I come in and sometimes she'll ask me for a cuddle=

I: =yep

Giles: she'll come, she'll give me a cuddle and she'll sit down (.) and other times she won't want to know

I: right=

Giles: not cos I've done anything wrong (.) simply she won't want to know (.) it's she'll dictate when y'know and she does want to dictate, dictate everything that happens (.) but [keyworker's] very good, she's very strong with her, (.) umm she'll say er" I want a cup of tea" and [keyworker] say "you, you've just had one, wait for a little while"

I: uh-hum

Giles: now some people could say that and it'd be cwoo

I: right=

Giles: =but [keyworker] can get away with it (.) because she, she knows that she means it (.) and that if she attacks [keyworker] (.) [keyworker's] just gonna (.) not (.) bow down to
her demands, y'know and that she, she also knows that [keyworker'll] make her wait even longer

I: right=

Giles: =simply because you know=

I: =do, do some people do that (.) would they (simple) get her a cup of tea if she wants it

Giles: yeah (.) yeah (.) because some people would feel (.) that (.) it's a means to an end, it'll stop (.) them getting ragged

I: right

Giles: if they give her a cup of tea but my philisophy is and what I tell people is no (.) if she's gonna behave in, inappropriately until she can behave (.) y'know (.) in a manner which she should do (.) that's she's capable of then you don't give in to her demands

I: right=

Giles: =because demand by force obviously is not let in this house it's not a policy that I've (.) prescribe to

I: is that a particular issue like asking for tea=

Giles: =umm=

I: =or is that just an example or is that=

Giles: =it's an example, I mean tea is (.) she does like a cup of tea

I: yeah

Giles: umm (.) she goes into the sensory room (.) although she rarely asks to go in the sensory room but when she's actually in there (.) {sniffs} excuse me (.) she's very relaxed for the most part

I: uhm

Giles: umm, if she's having a (.) one of her (.) outbursts

I: right

Giles: umm, we tend to now take her to the sensory room (.) because it's quiet nobody else is in there and it's calm

I: oh right, yeah
Giles: umm, because it's got a relaxing atmosphere and sometimes it works to calm her down quicker. The fact that she doesn't have an audience as well, she does play to an audience.

I: OK=

Giles: = (inaudible) the more people that are in the room, the more chance there is that she's gonna go for no reason simply because there's a lot of people to see her.

I: why, why would she want a lot of people to see her.

Giles: umm (.) the attention again I think.

I: right=

Giles: = y'know the fact that there's a lot of people seeing her so a lot of people are (.) she's gaining everybody's attention all at once.

I: uh-hum

Giles: as opposed to just having the two people that work with me.

I: right.

Giles: I've got like 6 people.

I: (it's gonna be)

Giles: and it's like (.) you can see it (.) you can read it in her eyes, you can this is, you can read her like a book when you know her (.) to a degree.

I: hmm

Giles: certainly I think [keyworker's] probably the one that can read her more than anybody else (.) umm, but=

I: = and that's one of the things that helps is to take her off to somewhere like the sensory room where you just

Giles: certainly, yeah=

I: = (inaudible)

Giles: = I mean it, it, it's not just for her benefit, but obviously that's for the benefit of everyone else that lives in the house because they shouldn't be subjected to that (.) it's not fair to them to, to, to have to y'know (.) carry her burdens {laughs} it's, y'know, they have enough problems in their lives without somebody else adding to them=

I: = are you talking about the clients.
Giles: yeah=

I: =yeah

Giles: well and staff as well, if staff aren’t working with Tara and they’re trying to work with other people to have that sort of going on behind you or in the same room it can make it y’know it can also trigger other clients into inappropriate behaviour=

I: =hmm, is that, is that just her sort of grabbing or attacking people, hitting people is that always at the staff or is that, I mean I don’t know quite (inaudible) [no, no,]

Giles: she goes for the clients as well, she’ll go for visitors, she’ll go for

I: people she doesn’t know

Giles: it’s not even people she don’t know, it’s she doesn’t differentiate=

I: =right=

Giles: =as such, she will attack whoever she feels like going for really umm

I: if she, if I passed her in the street and she was

Giles: for the most part it is staff

I: wanting that would she, would she attack me, might she attack me

Giles: she has done it, she has done it in the past=

I: =right=

Giles: =yeah, but it’s I mean for the most part when she’s out she’s normally reasonably good I had an incident where I took her shopping with her last keyworker who’s not with us anymore she was actually agency but she was very good with Tara Tara had been “can I go shopping, can I go shopping” she’d been told “if you’re good then you can go shopping” y’know

I: uhm=

Giles: =for the next couple of days, if you’re good up until Thursday you can go shopping

I: uh-hum

Giles: and she was actually reasonable good, for Tara she was good umm so this particular member of staff said “can we take her”, I said “well we haven’t got a driver other than me but I’ll do it, we’ll do it”
I: hmm

Giles: we promised her to go out so we'll take her out (.) she was great, she was all smiles, and duh, duh, duh (.) there was only 2 of us then because this was before we, we, we'd (.) re-assessed her=

I: =right=

Giles: =and because with since she's been here, y'know, it literally only happened a couple of months ago (.) that we've had her re-assessed and it turns out that (.) her umm (.) costings and everything else seeing that because of the amount of care that she needs, so because the care condition they were paying us for

I: wasn't right=

Giles: =wasn't even, wasn't not even scraping what we were doing y'know and we just (.) didn't have the provision to do as much=

I: =hmm=

Giles: =as we wanted to (.) so anyway we've had the OK (.) to cut a long story short

I: yeah

Giles: =umm

I: so it's really since, it's the last (.) few months that it's been 2 to 1

Giles: yeah=

I: =has it and 3 to 1 when she's out=

Giles: =yeah, officially yeah, well 3 to 1 when she was out before you could go out with 2 of you

I: uh-hum

Giles: because normally she was OK in a car to a point (.) now I took her out in the people carrier because we didn't have a car at that point

I: yeah

Giles: we've only got a car recently as well (.) and er she wanted to buy (.) no we wanted to buy some bits for the house (.) now if she goes shopping and she knows (.) that there's stuff for her (.) that's what she wants to do (.) she wants to go shopping (.) buy the things that she wants and then come home=

I: =what things (.) does she
Giles: anything she might buy (.) she likes her bum bags which we don't allow her to buy anymore because she just rips them in half

I: uh-hum

Giles: she has one at home at her parents and every time she goes to her parents which is about every 3\textsuperscript{rd} weekend

I: hmm

Giles: we've only just re-established that again after a long break

I: uh-hum

Giles: she goes to her parents about every 3\textsuperscript{rd} weekend and she has a bum bag there (.) and she's told "you have one at home"

I: uh-hum

Giles: "you can have it when you're at home, you're not to have one at [residential service], no bum bag at [residential service] because you break them" (.) and she knows that she understands that (.) so she doesn't (persevere) but she likes (.) designer clothes (.) i.e. (.) for 6 months she'll be Nike mad and she'll want Nike trainers=

I: =OK

Giles: Nike top, Nike, y'know (.) then they'll go out the window and, and next month it'll be (.) Diodora or whatever, y'know, so she's very=

I: =I haven't actually heard of them=

Giles: =yeah (.) well she's very conscious of y'know

I: right

Giles: what she's wearing and er=

I: =she knows the labels does she=

Giles: =yeah, yeah (.) yeah and if you come in and you're wearing trainers, she doesn't know you (.) she'll want you to take one off and give it to her so she can have a look and see what it is (.) umm (.) she's (.) I, I think that she's capable of so much more than she does

I: uhm

Giles: but I think she chooses not to (.) do what she's capable of, umm (.) she's very (notable) (.) and you don't (.) some of the things that she says, I mean without putting my (.) finger on it (or anything) you, you just know that there's a lot more going in there
I: uh-hum

Giles: than meets the eye (. ) there’s, there’s no doubt about it at all

I: [what like she’s understanding
more

Giles: yeah, yeah, I mean she, she’s (. ) she’s aware of things that are happening around her (. ) I mean one of the other clients went for her this morning (. ) grabbed her here

I: mmm

Giles: pulled her like that (. ) umm (. ) nothing horrid y’know and just and then walked away (. ) and she laughed her head off at that (. ) she thought that was hilarious

I: oh

Giles; absolutely hilarious

I: that didn’t wind her up that didn’t (inaudible)

Giles: not really (. ) not really (. ) umm (. ) unless it was because (. ) it made her nervous and it was a reaction to that

I: what her laughing might have been nervous or something=

Giles: =yeah, I mean (. ) [keyworker] said she thinks it was because (. ) she felt a bit nervous or a bit threatened by it that she’s laughing to sort of (. ) y’know to smooth it over (. ) I still think she thought it funny

I: uhm

Giles: personally (. ) but I’m not going to (go near) [keyworker]=

I: =yeah=

Giles: =cos she knows her better than me but just (. ) y’know, my psychological (. ) look on things if you like=

I: =is that, yeah=

Giles: =was that I think she quite enjoyed that

I: is that the, is that a, have I got picture of her behaviours do you think of grabbing people (. ) umm

Giles: yeah, she doesn’t umm

I: obviously quite painfully
Giles: umm (.) her biggest, her biggest thing which I haven't mentioned yet umm (.) is er, self harm

I: OK

Giles: umm, she has (.) a big (.) crack (.) down the front of her head, it looks like a, a peach basically

I: right

Giles: very deep because she will (.) smash her head on things (.) and she'll tell you that she's going to do it

I: uh-hum

Giles: she'll ask you if she can do it (.) she'll go (.) quite, quite regularly (.) now a little while ago we had an incidence where she actually managed to get to the window (.) before the (.) like staff could stop her

I: uh-hum

Giles: and just put her head straight through the window

I: uh-hum

Giles: another piece of glass coming down and was sticking out the top of her head (.) she just stood there like nothing had happened (.) she was covered in blood (.) got her rushed to hospital (.) she went berserk in the hospital (.) cos she doesn't like hospitals

I: right=

Giles: =or doctors or (.) anyway I mean we got the (.) bit of glass out (.) (inaudible) and I think she's impervious to pain

I: right so it's like she wasn't feeling it

[ Giles: she must be impervious to pain because if you'd seen the state of her head (.) umm (.) you, you'd just think how could anybody hit their head that hard and not=

I: =hmm

Giles: =and she whacks her head so hard (.) and sometimes she'll do it without warning (.) and she could be sitting there eating lunch quite happily

I: hmm
Giles: and all of a sudden she’ll just go bang like that I mean it’s it’s (.) y’know you could
hear it (.) up here=

I: =why does she do that do you think, why do you think it’s (.) all of a sudden

Giles: how long’s a piece of string, I really don’t know (.) it’s gone on for a lot a lot a
years

I: yeah

Giles: umm (.) I don’t know perhaps in the past whether she got admonished for
something when she was young she’d (.) y’know she did live with her parents for quite a
long time (.) y’know, maybe she was told off by something and her reaction was just to
head butt something

I: uhm

Giles: and it became (.) a habit

I: right

Giles: y’know, every time she got told off she’d do it but it became such a thing that it just
(.) y’know “I can’t get me own way I’ll bang my head, I want some attention I bang my
head” (.) everything results (.) y’know “if I bang my head things happen”

I: (does she do a lot of the time does she)

Giles: yeah, yeah, I’m at, I’m, I’m (.) actually be convinced it most probably caused her (.)
a lot more brain damage anyway than she already had

I: right

Giles: you can’t (.) bang your head that hard cos

I: she’s banging it at the front does she=

Giles: =yeah that’s right, it’s here (.) it’s very specific she does it with exactly the right
spot every time (.) and you can’t tell me that ain’t pre-meditated cos if it’s just gonna
bang your head you’d hit your head in different places wouldn’t you=

I: =right=

Giles: =because you’d do it so fast (.) (this one’s) right on that spot and there ain’t a mark
on her head anywhere else

I: uhm

Giles: it’s there=
I: always the same place

Giles: exactly the same place, yeah

I: hmm, what about like into the environment does she every kind of (.) y’know

Giles: yeah she goes out, umm

I: oh sorry no, I didn’t mean that I mean

Giles: sorry

I: the environment around her inside the house does she ever (.) sort of go for that

Giles: er, she’s, she’s=

I: =or is it more for people that she goes=

Giles: =yeah she is destructive with things, but I think that’s (.) just the start (.) like she may be eating in the lounge umm (.) quite normally and then all of a sudden she’ll just (pick something up) and throw it across the dining room or (.) umm she’s not directional with that

I: right

Giles: umm if it’s objects she doesn’t tend to be directional, she’ll just throw it

I: right

Giles: if it’s an attack she’s very very directional very very understanding of where she’s going for (.) umm::, like I said before her speed is incredible you have to (.) you’ve got to be lightening fast yourself because once you get grabbed that’s it, the chances of you can fix and hold her

I: hmm=

Giles: =basically but that’s all you can do because she (.) you try and pry her fingers off it’s almost impossible (.) and then you’ve got=

I: =so what say like you pull her hand (into you to)

Giles: yeah, that’s it

I: right

Giles: umm, saying she, she doesn’t tend to get hair very often but occasionally she does

I: (same thing)
Giles: yeah I can remember a night staff when we come in in the morning there was hair everywhere she’d (.) had her and she’s actually got her and dragged her across the room (.) by hair (.) both those members of staff got an absoloute (.) ripping off from me the next morning because they’d split up (.) and Tara was up and they weren’t working together and they’d (.) literally at about a week before it’d been drummed into them the importance of

I: staying together=

Giles: =the 2 on 1 (.) so (.) as much as I was compassionate to the girl for her injuries (.) I was also really annoyed at the fact that (.) she wasn’t supported by the other member of staff

I: why d’you think, why does Tara let go then at times like that what (.) what in the end means that she lets go

Giles: {sighs} (.) either she’s fulfilled her important purpose and she’s happy with what she’s done (.) or it’s because you’re continually asking her to let go and then she gets fed up with it so she will let go

I: right

Giles: or:: (.) it may be that you force her to let go

I: so you can pry her fingers off

Giles: sometimes, yeah (.) and I mean it depends on the situation I mean we don’t use umm (.) pain tactics here at all (.) umm (.) I (.) I do and I don’t agree with that I mean it’s not our policy I think in some, some (.) some situations certainly call for (.) some kind of tactic that’s gonna get somebody released and if it’s a dangerous situation (.) y’know if somebody’s got their hands around somebody’s throat and there’s no way of getting them off

I: yeah=

Giles: =other than maybe bending their finger or (.) y’know, pinching their ear lobe or something (.) that their not expecting then I’m (.) y’know if I was gonna get into trouble for it I’m afraid I’m gonna protect the vulnerable person because

I: you’d do it anyway

Giles: y’know as far as I’m concerned that’s my job, y’know umm (.) never had to use that with Tara because we’ve either been able to fix and hold her

I: uh-hum

Giles: erm, the odd occasions that I have removed her, I’ve been able to remove her (.) umm (.) I mean the one time I had to remove was because I had a member of staff that was just about naked and I had to get her off so this member of staff could get (.) away and cover up her embarrassment
I: hmm=

Giles: =and so I did prise her fingers apart (.) I'd asked her quite a few times (.) in the end I just

I: right

Giles: didn't hurt her at all

I: right

Giles: hurt **me** more than her because [text omitted for anonymity]

I: right

Giles: er (.) but I, I, I think that (.) y'know (.) as, as far as is humanly possible (.) it's fix and hold (.) and that it is

I: hmm and keep talking, keep asking her

Giles: yeah

I: to let go of (inaudible)

Giles: yeah, reinforce all the time, y'know (.) I mean we use please, y'know, let go is that so it's let go please (.) y'know (.) it's just keep doing it with the please

I: how d'you do that if you've got, if you haven't got any hands free, is it the **other** person (communicates)

Giles: you get a third person into

I: OK to

Giles: y'know

I: communicate

Giles: there's only 2 people ever on the restraint (.) I've actually occasionally caught 3 people down there, simply because they've been so over-powered (.) and I "no, move away" (.) "but we can't" (.) I say "yeah you can you've been trained how to hold her (.) and if you're holding her the right way you can restrain her, you can keep her there" (.) and then they've adjusted their (home) hold, the tro, the trouble is it's all, it's all well and good having a policy (.) umm and training in place to do a specific thing (.) but everybody is different and sometimes it isn't physically possible to hold a person a certain way

I: isn't it=
Giles: =y’know, and, and because somebody moves so fast, it’s, it’s not like I can say, right you sit there while I get my=

I: ={laughs} while I get my, yeah=

Giles: =y’know it doesn’t, this is the real world (. ) y’know=

I: =yeah

Giles: and it doesn’t always happen like that, with Tara, her, her, her (. ) the premeditation and everything else (. ) the speed with which she attacks

I: uh-hum

Giles: is, y’know, sometimes you, you’ve just got to grab the arm with the first (. ) pair of hands you’ve got , it’s not a case of (inaudible) you can’t do it, you don’t get the time (. ) you don’t get the, the opportunity (. ) y’know, hopefully once you’ve got over her you can then start to manoeuvre into the position

I: right

Giles: which is the ideal situation and once you’ve got somebody in that position (. ) it’s, I mean, we, when we did the course, we did it with loads of people in this room, about 11 people

I: yeah

Giles: they did it, the people that did the course very very good they are (. ) they’re called securicare and they train airline staff

I: hmm=

Giles: =pub staff, everybody you know (. ) in techniques and self preservation and all sorts of things (. ) now this particular hold you do (. ) I thought “I’m gonna test out a couple of these staff” cos one of them was quite (inaudible) the other was agency, we even got some of the agency though I don’t use them now trained (. ) umm (. ) so I fell to the floor and then I(.) got up, picked them both up, walked round in a circle but they had hold of me the whole time

I: ={laughs}

Giles: so the hold works

I: right

Giles: you can’t break out of the hold (. ) you can throw em all over the place but you can’t, you’re in the hold (. ) so everybody else around you is safe (. ) and like you might get banged against the wall or thrown on the floor (. ) but all the time you’ve got that hold on that person is not going to get to anything else
I: yeah=

Giles: =they’re not going to get to anything (. ) fragile on you (. ) they’re not going to rip
your clothes off they’re not gonna (. ) pull your privates out=

I: =(cos it’s their arms in the lock, yeah)

Giles: exactly, so

[tape turned over]

I: yeah, what, what, what con, what are the consequences (. ) of Tara’s behaviour, what
do you think (. ) (inaudible)

Giles: it’s umm (. ) we try not to umm, use (. ) umm (. ) well if you do that you’re
not going there or you’re not, y’know (. ) too much, because that can actually provoke her

I: right=

Giles: =to (. ) behave badly sometimes, cos it maybe that (. ) she don’t want to walk to the
shops today

I: mmm

Giles: so “alright I can get out of this by mis-behaving”

I: right

Giles: umm (. ) I think reinforcement of, of telling her (. ) y’know (. ) how bad it is to behave
like that obviously (. ) if she, if, if she behaves well (. ) y’know, it’s much nicer for her and
the people around her, it’s just reinforcement that y’know what’s right and wrong (. )
although she knows what’s right and wrong

I: right=

Giles: =and she knows exactly what’s she’s doing anyway (. ) umm (. ) we do sort of
y’know (. ) sometimes umm, she’ll, after, immediately after something she might say umm
(. ) umm “can we go for a beer tonight at the pub”

I: hmm

Giles: she likes (inaudible) like a Kaliber Shandy (. ) umm and it might be well (. ) “OK well
if you’re behaviour’s OK (. ) for the rest of the day then we’ll think about it”

I: uh-hum

Giles: but it’s only think about it, it’s never (. ) “yes if you’re good we’ll go” (. ) it’s “well if
you’re good we will think about it”

I: right
Giles: “see how it goes”, y’know (.) sometimes she will remain good because she wants to go for a beer (.) other times she won’t so therefore (.) it will be staff that say no (.) y’know

I: right

Giles: the, the, the appropriate behaviour’s not there so therefore we’re not gonna go to the pub (.) umm and she does understand that and she knows why, but we try not to use it as a tool an that

I: yeah

Giles: as if you do this y’know we won’t do that because I think that’s (.) but with some people that might work but with Tara I don’t think it does cos I think she’s too clever, she can see through that

I: uh-hum

Giles: (I’m the one) “I don’t want to go out, not you” and

I: hmm

Giles: “I don’t care” (inaudible) y’know, so it’s

I: well how would her life be different then if she didn’t (inaudible)

Giles: {sighs} (.) (we could do a lot with her so)

I: yeah

Giles: there, there is so much opportunity there for her

I: what things could she be doing

Giles: ev, everything, sports, horse-riding, swimming (.) bowling (.) she could go out every day of the week, college

I: uh-hum

Giles: y’know she’d be quite happy doing an awful lot of things at college, I mean she can write a bit

I: uh-hum
Giles: she can read (.) she, she actually reads when they sat down and went through the whole alphabet (.) phonetically the other day she did all the signs for the whole alphabet (y’know)=

I: =she knows them

Giles: yeah (.) y’know I mean her, her (.) her actual capabilities are very good (.) mentally

I: uh-hum

Giles: physically (.) she’s not really had the (.) y’know in many ways at all I mean she’s a little bit cumbersome but that’s because she’s inherently lazy and she doesn’t do enough

I: (inaudible)

Giles: she’s, she’s (.) I think simply because she lumbers a lot because she’s= [inaudible]

I: =right

Giles: she doesn’t tend to y’know she’s capable of (.) y’know getting up and going she does have some breathing difficulties she is asthmatic

I: is she

Giles: umm (.) so therefore she (.) when she walks to the shop she wants to walk really fast (.) and you have to physically pull her back and slow her down because obviously she’s starting to wheeze

I: oh really that sets her asthma off

Giles: it’s too much {coughs} and obviously anything (.) if Tara’s not feeling well

I: uh-hum

Giles: that’s a big trigger

I: oh OK so it makes it worse if she’s not feeling well

Giles: yeah I mean if she’s, if something’s uncomfortable on her or (inaudible) what sort of thing

I: is uncomfortable

Giles: =well I mean if she’s got a headache or something like that she’ll just behave aggressively because of it you know (.) umm (.) it does, it does bring the bad behaviour (inaudible) umm she’s over-weight

I: why, why, why (inaudible)
Giles: sorry
I: why would that be
Giles: I think frustration a lot of the time=
I: =oh right=
Giles: =she will ask, she will say she's in pain, she will ask for painkillers=
I: =uh-hum=
Giles: =and we will give them to her=
I: =mmm=
Giles: =y'know if she's in pain (.) umm but I think she gets frustrated umm (.) she, she used to be very (.) sex, sexually active and I think (.) a lot of her frustration is due to her sexual (.) she doesn't now (.) when she sees one of the men naked occasionally cos they'll come out of the room inappropriately or something=
I: =yeah=
Giles: =oh that makes her day
I: really
Giles: y'know or she sees something on the telly might make her (.) y'know=
I: =does she have a boyfriend at the moment
Giles: no (.) she never has (.) in her history (.) but she's (.) she has masturbated most of the time and she uses tools
I: right=
Giles: =(it's like when she goes to bed with em) she, she used to use a hair-brush and things like (.) at one point used umm, a hair-dryer (inaudible)
I: how do you, how do people know that
Giles: well obviously there's been times you, you (.) you need to check on people you may go into the room and, and y'know (.) she's (.) deaf so knocking on the door is no good=
I: =of course, yeah=
Giles: =so you need to just enter because obviously (.) all the clients here, well apart from a couple of clients get checked out because (.) for various reasons they need to be
and, and we do (.) I, I found always with, with sort of learning disability people a lot of them do (.) masturbate, it's (.) one of the only pleasures they have in life=

I: =hmm=

Giles: =and that (.) I'd actively encourage that as long as it's in the appropriate place, y'know (.) umm=

I: =and with Tara it is

Giles: yeah, she's, she, she, y'know, but she occasionally I think that is why she targets mens (.) genital, genitals because I think not only does she know that it's a very sensitive area (.) but I also think it actually gives her a bit of a thrill as well

I: =why, why, why=

Giles: =because, well she was having a lot of problems with her periods

I: was she

Giles: umm, she knows what periods are and everything

I: uh-hum

Giles: umm, she used to say umm, when am I going to bleed, she'd ask when she was gonna bleed and then she'd say I'm pregnant

I: =she worried, is she=

Giles: =yeah, yeah

I: or would she be happy

Giles: no I mean I (.) hard to say, I don't think she'd be happy (.) I think she's more worried that she was pregnant than (.) pleased about it certainly but she wanted to know why she wasn't bleeding if she wasn't bleeding (.) why am I (.) y'know=

I: =why am I not bleeding=

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Giles: =why am I not bleeding, and it's, it's quite difficult to get across that y'know (.) it's a hormonal thing there's no sign language for hormones there's no

I: =hmm=

Giles: =because it's just not something that you learn as a day to day thing (.) umm (.) so yeah, I mean, y'know (,) sexually she's aware and she's aware of her own body, she says she's fat and over-weight and she knows she's over-weight (.) and she laughs when she
(inaudible)

I: she knows that she is over-weight=

Giles: =when she last went to the doctor the doctor said (,) y'know (,)" she needs to lose a bit of weight she, y'know needs a bit more exercise" and that was (.) relayed to her (.) so she knows that

I: =hmm=

Giles: =when she last went to the doctor the doctor said (,) y'know (,)" she needs to lose a bit of weight she, y'know needs a bit more exercise" and that was (.) relayed to her (.) so she knows that

I: =hmm=

Giles: =when she last went to the doctor the doctor said (,) y'know (,)" she needs to lose a bit of weight she, y'know needs a bit more exercise" and that was (.) relayed to her (.) so she knows that

I: =hmm=

Giles: =when she last went to the doctor the doctor said (,) y'know (,)" she needs to lose a bit of weight she, y'know needs a bit more exercise" and that was (.) relayed to her (.) so she knows that

I: =uh-hum=

Giles: is very accurate as well, y'know she knows what she's saying (.) umm

I: what, can I, how, how, how longs she's had the (,) behaviours that she's got (.) that, well the sort of grabbing people, what

Giles: I, I think as long ago as she was physically able to do it

I: right=

Giles: =basically (,) I mean she's actually put her own (,) father in hospital (inaudible) she's given her mother sort of quite severe (,) problems (to start with) umm

I: what, what, what would have started it do you think, (what do you think was going on)
Giles: umm (.) I think she's always been quite abusive erm (.) even, even as (.) y'know looking at past history I mean she's obviously (.) this is her (inaudible)

I: hmm

Giles: umm and I think as she's developed her strength and knowledge (.) she's learnt to target her aggression which she obviously has got this pent up, always has and always will have this pent up (.) aggression inside her

I: hmm

Giles: and umm (.) she found a way to channel it one day which was maybe by accident she went for somebody or whatever else and it made her feel good (.) and it sort became a regular thing

I: (she's still got the aggression)

Giles: yeah, I mean if there's nothing there that (.) that stipulates exactly when it started or why it started but I mean to my mind I would think that

I: (you wonder)

Giles: if somebody has that pent up emotion inside of them and they find a release for it even by accident (.) then they're gonna use that release

I: what, why would she have that, why would she have had that pent up emotion

Giles: frustration I would have imagined mostly (.) y'know not being able to communicate effectively, y'know=

I: =uh-hum=

Giles: =having difficulty understanding other people (.) cos you've got to remember as well when she was young she was (dieing) and she had her learning disability, she obviously (.) whether they wanted to admit it at that point had some mental health issues as well

I: =uh-hum=

Giles: =from whatever damage she had (.) she had physical disabilities i.e. she was deaf (.) umm, she was partially sighted even (.) as a youngster=

I: =(inaudible)=

Giles: =y'know, even without the learning or mental (.) disabilities
I: uhm

Giles: for somebody to be able to (.) learn sign language, lip read and things like, y'know
(,) the necessary requirements to lead as normal a life as possible is hard enough (.) but
then when you've got somebody with learning disabilities (.) trying to learn all this and
trying to understand all this and take it in

I: right

Giles: it's gotta be (.) pretty damn frustrating I would think=

I: =so it's that, that would have been what (.) caused it=

Giles: =and I, I would imagine that that was the start of the triggers was to simply the
frustration=

I: =frustration

Giles: of her every day life, trying to get on with it and not being able to

I: what, what was it, I'm, I'm wondering if umm (.) umm (,) it's, it's fairly, it's well it's more
common that people with learning disabilities would have (.) hearing problems or visual
problems

Giles: umm, yeah, it does seem to be (.) you know=

I: =do you think umm (,) if some, another person had had the same (inaudible) as Tara
they'd have (,) gone, gone the same way or (,) is there something

Giles: what somebody who wasn't learning disabled

I: well someone who was but just a different person who

Giles: umm

I: who had the same

Giles: not necessarily, no, I think there's certainly some mental health issues there which
is why I think

I: right=

Giles: =y'know, obviously er, there is some mental health involved becau, for her to have
taken that path (,) umm=

I: =mental health you do you mean damage to her brain=

Giles: =yeah, yeah=

I: =from (,) since birth=
Giles: =certainly (.) not just inherent learning disabilities I mean there is obviously some (. ) damage (.) there at some point in her life which is (.) which (.) promoted these umm (.) y’know, it’s, it’s amazing really because a, because of the way she is to the way she could be as well, the intelligence that she actually has is, is

I: hmm

Giles: quite phenomenal really, y’know, there’s, there’s, there’s no doubting there’s a lot of intelligence there but the trouble is she (.) directs her intelligence (.) the wrong way if you like (.) she doesn’t chose to use it as much as she could (.) and she chooses to vent her frustration, her frustration and anger on (.) the people around her, the people that are trying to help her basically (.) and=

I: =why, why d’you, what keep her (.) behaviour going (inaudible)

Giles: sorry

I: what keeps that behaviour going because obviously it’s been going on for like many many years

Giles: I, I think it’s. it’s umm (.) I think it’s ingrained in her (.) now, I think it’s y’know, (.) I think there are certain things that I think it doesn’t matter how much, how good you are with somebody or how much you put into place really (.) whatever you try you’re always gonna be behaviours that’ll never disappear

I: right

Giles: y’know, sometimes behaviours you may be able to reduce them, sometimes substantially but you’ll never wipe em out

I: mmm

Giles: it’s almost (.) it’s part of the (.) make-up of (.) of the person (.) y’know (.) I’ve seen people go from being horrendous to (.) bloody marvellous (.) in the space of a few years (.) but there are still some underlying factors (.) that you know come out now and again

I: hmm=

Giles: =that you’re never gonna get rid of (.) because they’re like (.) ingrained into the memory

I: right

Giles: whichever, however way you want to look at it but (.) I, I (.) you, you (.) anybody that says “oh yeah they were learning disabled they were like this that and the other and now they’re a normal person” I’m sorry that’s not possible (.) it just isn’t possible that doesn’t happen, it can’t (.) umm, physically, mentally, any other way it’s impossible to happen as you’re obviously well aware (.) but it is possible to reduce behaviours, it is possible to improve quality of life
I: hmm

Giles: it's possible to (. ) realise or get somebody to realise their (. ) ambition a bit more, and, and to actively (. ) reduce their own stress levels y'know, there's ways of doing things there's (. ) ways of making continuity for people which hopefully will enhance and improve their lives (. ) but however much you do you're never gonna change certain inherent things within these people (. ) because of you can't=

I: =hmm=

Giles: it is a, it (. ) is an impossibility (. ) it's a shame (. ) but then if, if it was possible we wouldn't be here (. ) anyway=

I: =what, what would you like to see for the future then (inaudible)

Giles: I'd, I'd like to see (. ) I'd like to see the umm, the behaviour reduce, certainly (. ) most certainly (. ) I'd like to see (. ) well actually we have already seen her self (. ) abuse has lessened quite a lot (. ) umm (. ) I don't know whether that would ever disappear, I'd like to think that one day it would

I: what, why, why shouldn't she be doing that, that kind of hitting other people

Giles: why shouldn't she

I: yeah

Giles: well she shouldn't be doing that because it's {laughs} (. ) wrong, it's inappropriate, it's not (. ) fair on other people (. ) I mean you, they say you hurt the one you love, I don't know, I don't (. ) y'know (. ) it corresponds to this but she

I:kind of rings true a bit does it

Giles: tends to most, the people that suffer the most are the people that are trying to do the most things for her (. ) the people that are trying to improve her quality of life, y'know (. ) umm and unfortunately they're the ones that are suffering so it's, it's very frustrating for them, well it must be y'know as I say I've worked with Tara quite a few times=

I: =mmm=

Giles: =but I don't work with her day in day out (. ) if I were to work with her day in day out it's a pretty thankless

I: right

Giles: for the most part I think (. ) umm (. ) especially when sometimes you feel like you're banging your head against the wall because you're simply not getting (any more)=

I: =getting anywhere=

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Giles: =but it feels like nothing’s changing (.) but I’ve got to be honest there has been some change now there’s no doubt there has been some changes so I first started here till now

I: right

Giles: the behaviours have lessened (.) she certainly does behave at certain times with certain people differently

I: right, why’s that, what’s (.) what what’s working=

Giles: =I think, I think (.) I think some of it is umm (.) a feeling of trust

I: uh-hum

Giles: she trust certain people it’s definitely an element of trust there (.) understanding

I: (you mean that) people understand her

Giles: yeah and that she understands them as well umm (.) I think continuity (.) of all, all, all, all types y’know, any type of continuity at all in her life whether it be around (.) I mean she does like to eat at certain times (.) she likes to (.) have a bath at a certain time, she like to have her meds on time, y’know (.) if you provide that continuity that’s (.) another thing that she’s not going to get stressed about because it’s happened at that time she wants her morning meds at 8 o’clock

I: uh-hum

Giles: we try and make sure that she has her morning meds at 8 o’clock (.) then she likes to take her bath

I: right, and that helps you think (.) does it=

Giles: =y’know, yeah, so (.) when she does things on time (.) things do seem to improve (.) around those periods

I: uh-hum

Giles: then you have the periods between the times that you have to, umm (.) she knows that (.) she lives here (.) she was given 28 days notice to quit this house a while back, when I first started she was on 28 days notice to leave (.) and we said,” no hold on (.) y’know, why are we chucking her out of here” (.) that’s because we:: did not have the resources to go on blah blah blah blah blah I said “so:: how do we think another house is gonna cope with it”

I: hmm

Giles: I said “what we need to be doing (.) (imagine myself living here) is that what we need to do is refund this re-cost this person”=

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I: right, so you were able to keep her because you got that

Giles: we (.) put a new programme into place before starting as much as anything else (.) umm, which we’ve done we are awaiting (.) if once a client leaves here (.) umm (.) we have another client with us in a separate (like) flat we’re gonna put that client in to the person who leave’s room

I: right

Giles: which has been discussed with them and their parents and they’re all OK with it (.) and we’re gonna Tara (this man’s) flat

I: right

Giles: and she’s gonna have her own staff team in there (.) now she’s gonna stay in that flat, it’s in the house (.) but it’s, y’know

I: it’s own kitchen=

Giles: =away from, yeah

I: yeah

Giles: totally self-contained, her own entrance and exits=

I: =hmm=

Giles: =she’ll have her own car=

I: =uh-hum

Giles: she’s gonna have a dedicated staff team to just work with Tara (.) that will not only improve the quality of (.) them but also (.) the rest of the people who live here the rest of the staff that work here (.) in all we’re hoping that because she gets that (.) umm (.) flat, it, it’s gonna be, it’s individual to her, it makes her be (.) feel like she’s a real individual she’s got her own little place which we’re hoping will (.) be positive for her

I: =uh-hum

Giles: she’s got her own staff team (.) there’s nobody else around getting attention because she’s the only one in there now we’re hoping that all these things will point to (.) her being (.) more relaxed about her life and where she lives and things around her=

I: =yeah

Giles: umm (.) y’know, we’re trying everything we can we’re trying to put into place things that we think will help her (.) umm (.) that’s not to say that any of it’s gonna work (.) we don’t know if it’s gonna work but we need to try
I: hmm

Giles: umm (.) so we are and it's been quite difficult to get her refunded, it is (.) an awful lot of money (.) umm (.) and I think the reason that they've accepted it is that simply because they know how difficult it is (gonna) (.) (get her housed) somewhere else

I: right

Giles: =because if we were to tell the truth about her to people (.) there's not many people that's gonna want to take her on apart from a specialist unit

I: so that's another way that the future, what you'd like for the future is=

Giles: =yeah=

I: =her own like flat, flat and see (.) how that helps things

Giles: yeah, yeah, we'd like to yeah, we'd like her to live here and for this to be her home for as long as (.) y'know

I: she wants=

Giles: =is required, yeah (.) umm (.) having said that, y'know (.) if it doesn't worse (.) if things (.) progressively get bad because it's not working whatever, then we'll have to re-think it (.) because I don't think it's fair to staff to be (.) continually (.) have that pressure on them, physical abuse (.) which is also mental abuse as well, really

I: yeah

Giles: y'know, even though it's not verbal it is still mental abuse=

I: =mmm=

Giles: =cos you've got (.) you can't tell me that somebody's gonna get ragged for 6 or 7 hours (.) go home and, and be relaxed=

I: =yeah, yeah

Giles: y'know, it has an effect on them and (if I'm looking after that I wouldn't) so mentally and physically it's (.) very, very demanding and I don't think it's fair to subject people to that for long-term periods (.) and if this doesn't make a difference (.) a noticeable difference=

I: =uh-hum=
Giles: =then we're really gonna need to (.) y'know, it may be that one day she will have to go to a specialist unit where they can cope with her (.) y'know, not everybody's like (.) [keyworker]

I: hmm

Giles: [keyworker] can cope with it, she's had a couple of days where it's (.) got to her (.) but for the most part she copes very well (.) but not everybody is capable of that

I: hmm=

Giles: =y'know, she's exceptional in them terms I think simply because (.) I think (so it's) wondering what would happen if she leaves

Giles: I couldn't do what she did day in day out

I: hmm

Giles: because it, it just gets me in here (.) and I'm (.) y'know quite good with clients (.) I'm less patient with the staff than I am with the clients, so y'know, I, I have got, y'know, I'm very impatient with general people outside (.) but when (.) I'm dealing with clients, residents, whatever you want to call them, I've got the patience of a saint (.) but even I know that after a certain amount of time (you need more than the patience of a saint to be with Tara all day)

I: =wondering

Giles: =because you can't help it working with Tara (.) and you can't just go out of somewhere after a day like that and turn it off (.) it's not possible (.) you're a human being and you can't do that and so y'know it does have a knock on effect (.) and I think long-term (.) the worst thing that could happen to me is that (.) y'know, you have 2 people work with her for, y'know, most of their shifts through the week and they both turn round at the end of the week and say I can't handle this anymore, I'm leaving (.) y'know=

I: =hmm=

Giles: =I don't want to lose staff
I:  you worry about that  

Giles:  which for the most part are good staff (.) that's gonna effect (.) everything because it's gonna effect Tara  

I:  hmm  

Giles:  because it's gonna be harder for me to staff Tara it means that she 's gotta have people she doesn't know very well (.) so that's gonna be a problem straight away  

I:  uh-hum=  

Giles: = (inaudible) so it, it has all sorts of knock on effects, it has sorts of y'know (.) it's like a big vicious circle really (.) and so you I think the continuity is the biggest (.) the biggest thing that we can give her (.) at the moment  

I:  uhm  

Giles:  is that everybody does the same thing (.) everybody works to a plan (.) and (.) she needs, she needs a programme in her life she does need (.) stipulated things (.) there's no doubt about it  

I:  what like (.) are you saying that she, that you kind of feel that she's (.) got (.) autism (.) (inaudible)  

Giles:  yeah, but I think, yeah, but I just think (.) yeah, and  

I:  that sort of (.) sort of programme that you might put in (.) in those services  

Giles:  yeah, but I think she needs umm (.) she needs umm (.) stimulus as well in her life (.) umm (.) hopefully you know once she goes into the flat and we begin to put a programme together whereas maybe she's going out (.) regularly=  

I:  =right=  

Giles:  =certain places, y'know, things that she'd like to do (.) she'll be involved in it and asked what she wants to do, because she knows what she likes and what she doesn't (.) absolutely no point in taking her horse-riding if she hates horses (.) y'know it's just asking for trouble so obviously you know (.) the home-work we'll do (.) along with the history, what she, talking to her personally (.) people that have worked with her and we try and build a picture up and get a programme together that will (.) hopefully suit her (.) that will give her a lot more in life=  

I:  =uh-hum=  

Giles:  =and maybe that (.) combined with her own space (.) her own staff (.) will promote (.) some better behaviour and feeling (.) umm, y'know=  

I:  =I was just looking at umm (.) sort of to see what questions I've missed and umm
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Giles: uh-hum

I: and one of them I forgot to ask was how Tara feels when she does that (.) (like going for, y’know when she)=

Giles: =she feels angry (.) she says she feels angry

I: right

Giles: and umm (.) you ask her why y’know what why are you (.) umm (.) bad (.) and she’ll go (.) which is angry

I: which is angry

Giles: yeah and it’s like I’m angry, why are you angry, I don’t know

I: how does she feel afterwards

Giles: umm (.) sometimes she’s remorseful although she doesn’t use that word she says she’s sorry

I: uh-hum

Giles: umm (.) what else, she’s er (.) I think that’s the main one she says she feels sorry, y’know and she she’ll (.) reiterate she doesn’t know why she was angry (.) and (.) she knows she was bad it was bad to do it (.) and she’ll say, “I, I’ll be good now that I know I’ve been bad” and you know (.) I mean she’s well aware of (.) what she’s doing (.) she’s well aware of (.) how it makes her feel what the consequences might be (.) y’know, umm=

I: =she’d be aware of, she could see ahead could she

Giles: mmm

I: she knows

Giles: yeah I mean it, it, it’s (.) like I said going back to the beer thing (.) y’know (.) if she knows what she’s doing then it’s her choice for her behaviour sometimes (.) and it might be that she feels (.) “I don’t feel like going (inaudible) but I don’t want to tell em no so I’ll just mis-behave and they won’t take me anyway”, y’know you don’t know how she feels=

I: =you wonder if that=

Giles: =but it’s a good supposition (.) sometimes

I: but you know (.) what what do you think her parents think so she’s obviously she lived at home for a long time

Giles: hmm
I: what why do they think (.) (inaudible)=

Giles: we er (.) it’s, it’s, it’s quite a (.) (tetchy) ground with them umm (.) (remember that) we’re, we’re just building bridges with them at the moment simply because (.) because (.)

Tara was given notice

I: uh-hum

Giles: umm I mean they went totally anti us

I: right

Giles: and this was last summer, I mean I literally started just after she was given notice (.) so they went anti (the whole company) umm (.) anti care manager anti psychologist=

I: =right=

Giles: =anti ever, they were gonna sue everyone and their dog basically=

I: =really

Giles: umm (.) they can be quite difficult (.) to deal with (.) sometimes (.) I mean when they’re nice they’re very nice (.) but when they’re not

I: (inaudible) but have, have they (.) given any indications of what they think

Giles: umm (.) they (.) we lit, (would say then) the last couple of months we’ve got the home visits started again (.) which is a huge step

I: uh-hum

Giles: the first home visit she had (.) ended in a nightmare (.) she actually had her when I got round there we got a frantic phone call we got round there and she had her mother in a hold on the bed (.) and as soon as I walked in the room she let go (.) went to get her stuff and came back here

I: uh-hum

Giles: now that could have been one of two things (.) it could have been the fact that she hadn’t been home for a long time

I: uh-hum

Giles: and (.) she didn’t think she was coming back here (.) she actually likes being here believe it or not (.) umm (.) or it could simply have been (.) y’know (.) anger (.) it’s almost like (.) I’m, it’s really nice because (.) because a (.) not long (.) she’d been good all weekend

I: uh-hum
Giles: and it might have been the fact that “I’ve had a lovely weekend and I’m really angry why haven’t you had me for so long” sort of thing

I: uhm=

Giles: =that could have been over there (.) umm (.) they’ve (.) never really (.) said anything positive or any reasons why (.) certain things are just that (.) that’s always been like that (.) basically=

I: =right=

Giles: =umm (.) y’know I’d like to think that at one point if things get better that I can (.) have a bit more out of them maybe I mean they won’t visit her in the house=

I: =so at the moment it’s really hard to know (that is)

Giles: yeah, they, they value=

I: =(inaudible)

Giles: yeah, there’s, there’s, I mean there’s a lot of things going on and the last thing they said was they’re going to sue this (.) (psychiatrist) because he didn’t (.) refused to do the brain scan

I: OK so that they’re still

Giles: yeah, so they’re still, although they’re find they’re getting on better with us now (.) especially now they know she’s staying here we refunded her and we’re

I: they’re happy=

Giles: =doing this that and the other and the flat so (.) (yeah it moves us) but it, it they’re quite strange (.) they umm (.) I mean we, we, we’re gonna get her a special restraint seat-belt for Tara so that we don’t have to (.) depend on 3 people to go out basically (.) I mean she’s got full movement it just means she can’t get to anyone else because it’s a harness seatbelt (.) umm so it’s not restricting her in any way other than it’s stopping her (.) to get in to someone (.) umm and when we’ve, we’ve spoken to them about the harness (.) umm (.) they’re answer at the time was (.) “I’m not putting that in my 45 thousand pound Mercedes on my white seat” (.) woar (.) OK fine (.) shows you a lot of caring and (.) wanting to help us=

I: =hmm=

Giles: =help your daughter (inaudible) y’know but in the next breath they’ll be really (.) wonderful about something else so it’s, it’s quite a=

I: =does she, if when she goes on home visits does (.) do any staff go with her

Giles: only to take her
I: oh right so how do they manage then

Giles: how do they manage her (.) she as I say apart from the first (.) (3 visits) she's been pretty good (inaudible)

I: [is she different at home]

Giles: umm (.) her mother has a really strict regime with her they do specific things always

I: uh-hum

Giles: when she goes there the first thing she'll do is (.) take off all her clothes and throw em on the floor

I: uh-hum=

Giles: =they stay there till she comes back to (.) [residential service]

I: right

Giles: (inaudible) they eat breakfast in bed (.) together

I: uh-hum

Giles: she gets in with mummy and daddy and they (get back in) bed she (inaudible) specific things for breakfast y'know the whole weekend is like that

I: [and they have (they think it)]

Giles: yeah, yeah and the whole weekend normally goes OK

I: sort of thing

Giles: yeah, yeah (so routine does) (.) as I say it does make a difference there's no 2 ways about it (.) but it's finding the right routine for her here

I: yeah (.) what would what people like her (like her) to do instead (inaudible)

Giles: I think they'd like her to be as (.) for want of a better word (inaudible) y'know a, a bit more er sociable (.) and, and less, less umm (.) (threatening) (.) less physical certainly

I: yeah=
Giles: y'know, especially knowing that, that, her capabilities are there and the knowledge is there

I: yeah

Giles: y'know there absolutely no doubting the intelligence is there y'know

I: mmm

Giles: probably as intelligent as or more than some of the people walking up the road at the particular moment outside, y'know, so y'know =

I: =not, not, not (inaudible)=

Giles: =but there's obviously some y'know some very repressed stuff inside her that makes her behave the way she does cos she doesn't know what it is either all she knows is that she suddenly feels angry and that's the answer=

I: =so you said some very repressed stuff

Giles: it's well it seems

I: yeah

Giles: y'know to me y'know if somebody explodes like that

I: right, so (inaudible) mmm

Giles: so it is, it is sort of repressed if you like, well perhaps, perhaps I'm using the wrong word but that's my

I: and what do you think Tara's repressing that (inaudible)

Giles: god knows absolutely god, I think y'know it could be lots of things

I: (we, we don't know what it is)

Giles: it could be the quality of her life the way she feels she might feel angry that she can't hear things she knows other people can, she can't see properly, there's there's lots of obstacles and things that are in her life and have been in her life y'know are all inside her obviously somewhere
I: mmm

Giles: and maybe it’s a build up of these things maybe it’s where she was at another home she may have been abused (.) she may have been abused by her parents for all I know

I: right

Giles: I don’t think that’s the case but you don’t know

I: right so it’s a possibility that was (inaudible) trauma (inaudible)

Giles: if you’re not there (.) there’s, there’s all sort of things, yeah (.) yeah obviously her whole life has been a trauma

I: mmm

Giles: to a degree (.) certainly I mean she’s had some huge (.) boundaries (.) to get over (.) and hurdles=

I: =(you mean like the) (.) not being able to hear=

Giles: =yeah, with the, with the deafness and y’know, you put all that on top of a learning disability, possible mental health problems (.) y’know (.) and her asthma

I: what, do, yeah that just brings me on to umm (.) just (.) just so I understand what diagnoses she’s got (.) she’s got a learning disability

Giles: yeah, she’s mild asthmatic

I: she’s got mild (.) asthma, she’s there’s a query over epilepsy

Giles: yeah and they’re (.) seem to think there’s a (.) possibility that there’s a very mild form of epilepsy she’s been put on some (.) epileptic drugs (.) umm (.) phenatoin they’re quite mild (.) epileptic drugs but they also have umm (.) a very calming effect (.) they’re not an anti-psychotic they are an epileptic drug but they’re a very old one (.) one of the first ones that came out=

I: =it’s quite recent she’s gone on it is, is it working

Giles: yes and they do have a calming effect (.) she’s sleeps

better at night

I: right

Giles: umm (.) her sleep pattern’s very predictable (.) she goes to bed at 8 o’clock and (she’ll be up at) 5 (.) so you (inaudible) when she gets up and she goes to bed the only thing that they do seem to do is (.) they seem to make her a bit more tired (.) and occasionally sort of 5, after, after dinner, sort of half past 5, she has to eat at 5 o’clock (.)
she eats quite quickly and when she's finished she has to leave the table because if she
don't that table will go basically

I: right

Giles: so y'know (. ) so sometimes there's even a set pattern in her behaviour with her,
y'know

I: mmm

Giles: her acceptable behaviour there's a pattern there

I: do you think she should carry on with those (. ) medication for epilepsy

Giles: umm (. ) I'd like to see how it goes umm

I: right

Giles: they say it (. ) can take up to 3 months (. ) to see and she's been on them

I: a bit early days to see really

Giles: this is, yeah but this is, I think this is the start of her 3^rd month actually (. ) umm,
y'know, their one of these drugs that takes a long time to get into the system it's like it's a
gradual build up=

I: =yeah=

Giles: =she's not on huge doses of it in fact they just upped it on the last one by (. ) a sort of a ¼

I: right

Giles: of what the dose she was on=

I: =still seeing whether

Giles: yeah (. ) I mean it does seem to have umm (. ) a slight calming effect on her (. ) if
you give her (. ) PRN (. ) y'know as required medication (. ) for her behaviour (. ) and for the
most part we don't

I: right

Giles: because umm (. ) she's on Diazepam

I: what regularly

Giles: no (. ) as a, as a

I: as required=
Giles: as required and umm we very rarely give it to her because simply the behaviour for that period is usually over umm, but having said that it's amazing how quickly she calms down when you decide to give her so it's almost like a placebo because she knows what they are.

I: (inaudible)

Giles: oh yeah

I: what, you say she's got, you think she's got autistic tendencies, traits or

Giles: mmm

I: is there anything, any other diagnosis

Giles: umm

I: or stuff going on that I need to know about is there any particular disorder that's caused her learning disability or anything

Giles: umm no the only thing I mean there's stuff here (about strategies) loads of things that have been tried and tried and tried

I: what, what's been tried that has not worked then

Giles: lots of things I think I mean in the time I've been here I mean we're still persevering with certain things anyway umm because I think in order for anything to work it has to be given a reasonable amount of time simply because of Tara being Tara y'know umm her moods and whatever change from day to day anyway or week to week or even month to month so it may be that you start on something and she seems to cope but blow me down 2 weeks later she's (inaudible) so it is d'you know what I mean it's, it's an on-going thing it's a case of finding, you, you know there are some almost some generic things that she's always gonna like

I: uh-hum

Giles: i.e. her bath, she loves her bath

I: she loves her bath does she

Giles: she loves it gets a lot of pleasure from it you know that's not going to change

I: yeah (inaudible)

Giles: (inaudible)

I: what, is there anything else, I just thought, I think we've just about come to the end there, I just wondered if there's anything else that you feel that you'd like to tell me that I haven't asked in understand Tara and her behaviours
Giles: umm
I: or about your experiences

Giles: I just think it is extremely complex, extremely complex
I: hmm

Giles: umm, I don’t think we’ll ever understand her fully
I: uh-hum

Giles: because I think there’s always gonna be something in the background of whatever (inaudible) for whatever reason (.) there’s obviously a lot going on in there (.) I’m not gonna say whether personally I like her or dislike her because I don’t think that would be pertinent and I don’t think that would be professional (.) let me just say that I agree with the decision to keep her here

I: right

Giles: I think the easy way out would be to get rid of her
I: right

Giles: so umm

I: you’re glad that (.) you’re persevering with her

Giles: obviously (.) tells you I am committed to her

I: yeah

Giles: and I’m quite prepared to back that up (.) by putting in the work and trying to (.) y’know hopefully change things for her (.) (inaudible) (.) yeah, I’d like to think that we can make a difference, I think that she is better than she used to be certainly

I: hmm

Giles: y’know whether it be that or that (.) there is

I: progress (inaudible)

Giles: y’know there is some noticeable progress (.) whether that continues or not (.) I couldn’t put me hand on my heart and say (.) I’d like to think that we could get it better than it is (.) umm but if it didn’t I wouldn’t be surprised either
I: you still want to (. . .) you still want to persevere

Giles: and I'm not being defeatist I'm being realistic, yes I do, yeah (I kept saying
that) (. . .) umm but I think in to be (. . .) y'know realistic (. . .) a realistic statement for me would
be (. . .) I'd like to think that we could improve it but if, if, if we didn't (. . .) it's not through our
failure (. . .) cos we're going to try what we can do
Appendix 11

Further Examples of the ‘Flawed Character’ Gendered Discourses

Extract 19 – ‘attention seeking’ flawed character discourse
1 Gwendolyn: so she didn’t do it, cos she knew that that wasn’t (.) our thing, it wasn’t (.)
2 didn’t get the right response from us (.) and it wasn’t like she really wanted to hit herself, 
3 but she knew that it would get her mum’s attention (I: right) (a bit of a devil one that)

Extract 20 – ‘manipulative’ flawed character discourse
1 I: what is, how does Oz’s behaviour compare with, with hers
2
3 Gwendolyn; ah (.) oh it’s completely different she was very calculated (.) umm (.) I don’t 
4 think she had (a diagnosis) she had a diagnosis, I can’t remember what, only like one other 
5 person in the country had it 
6
7 I: oh right, so very, very rare= 
8
9 Gwendolyn: =very, very rare (.) she was very, very clever, she (inaudible) oh, she would 
10 just lost it completely, but (.) be aware that she was doing it 
11
12 I: uh-hum
13 
14 Gwendolyn: and be aware that (.) she used to have like um (.) hand, foot restraints and 
15 hand restraints, because she used to hit her face and hit you she’d often say oh can I have 
16 my hands tied because she knew 
17
18 I: right, OK, so she (.) she could (.) tell in advance that=
19
20 Gwendolyn: =yeah (.) she, you’d be getting her up and you, you’d feel her all like, trying 
21 not to hurt you and (.) sometimes she just couldn’t stop herself 
22
23 I: she, so she’s quite (.) quite manipulative 
24
25 Gwendolyn: very=