

**CLINICAL PSYCHOLOGISTS' CONSTRUCTIONS  
OF THEIR WORK WITH CHILDREN**

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**Dedicated to Professor Mark Rapley  
(1962–2012)**

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## ABSTRACT

This study adopts a discursive psychological approach to an analysis of interviews with nine clinical psychologists on the subject of their work with children in NHS-based Child and Adolescent Mental Health Services. The objective of the study was to explore how child clinical psychologists talk about their work, with a particular focus on the discursive and interactional aspects of the discourse, and participants' orienting to, and providing justifications for, the morally dubious status of the various practices that they described in their talk. The analysis delineates complex rhetorical strategies of accountability management in talk about practices depicted as potentially problematic. These included: (1) the 'severe end' rhetorical device that functioned to warrant the use of medication; (2) the minimisation strategy that was used to manage diagnostic problems by constructing diagnoses in a minimal or safer manner; (3) normalisation techniques which served to downplay and re-define contested practices as less problematic or indeed as positive; (4) doing 'being democratic' that constructed troubling practice as democratic; (5) employing 'maxims of practical politics' that seemed to legitimise contested practices by invoking liberal and pragmatic arguments; and (6) the discursive move of redirecting accountability to service users or the institution. The discursive analysis of the extended accounts also demonstrated how participants oriented to notions of the moral nature of their practice and their morally adequate personal and professional identities. The results of this study indicate that clinical psychologists face a moral quandary, suggesting that perhaps clinical psychology practice, particularly with children whose distress or behaviour is conceptualised as mental illness, entails a constant grappling with moral issues. Implications for clinical practice are discussed in light of the analysis.

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## CHAPTER ONE - INTRODUCTION

This study adopts a Discursive Psychological (DP) approach to the subject of clinical psychologists' work with children. Following a DP tradition, the research did not start with a set of predetermined hypotheses. Rather, the objective of the study was to explore *how* child clinical psychologists talk about their work to see what would transpire during the research interview interaction between myself, a trainee clinical psychologist and the researcher, and the nine participants, clinical psychologists working in NHS-based Child and Adolescent Mental Health Services (CAMHS). As the analysis progressed, the analytic foci became increasingly refined. Thus, this thesis focuses on the complex rhetorical strategies deployed by clinical psychologists in their management of moral accountability in justifying their practice with children. I will argue that clinical psychologists are caught in a moral quagmire, suggesting that maybe clinical psychological practice, particularly with children whose distress or behaviour is conceptualised as mental illness, entails a constant grappling with moral issues.

In company with Rapley (2004) and Wetherell (1998) I take the view that incorporating Foucauldian ideas “offers a *deepening* of DP analysis rather than a *necessary* competing account” (Rapley, 2004, p. 12, emphasis in original). Accordingly, I will draw on Foucauldian scholarship in my introduction and the final discussion chapter in order to situate the micro-level analysis of talk-in-interaction (which itself will be explicated in my methodology and presented in the analysis chapter) within a wider context. This attempt, somewhat artificially, to separate what are sometimes considered to be the micro and macro perspectives on discourse was mainly to preserve academic and epistemological clarity.

The thesis is presented in four chapters. The first chapter critically delineates the history of child clinical psychology and what came to be called childhood mental disorders. The latter part of the chapter examines some of the problems with clinical practice with children and reviews the existing studies of professional accounts. The subsequent chapters present methodology, analysis, discussion, and a critical review of this research. First, however, it might be important to make a number of points regarding the adopted style and terminology used.

## **1.1. STYLE AND TERMINOLOGY**

I have written this thesis in the first person to acknowledge that it is a construction, rather than a disinterested and objective account, which could otherwise be implied by using the third person.

Throughout this thesis, I will frequently use the terms 'children', 'child' or 'adolescent'. I recognise that whilst these terms are rooted in a biological reality of immaturity, they are nevertheless social constructions that emerged within a particular socio-cultural, linguistic, political, economic, legal and historical context (e.g., James & Prout, 1997). For example, the notion of 'child' or 'childhood' is a relatively recent construction, since "in medieval society the idea of childhood did not exist" (Ariès, 1960, p. 125). Additionally, I often use the term 'children' because, in my opinion, the frequent repetition of 'children, young people and their families' could be distracting for the reader.

To further ease readability, I have also refrained from repeated inserting quotation marks around terms that have been recognised as problematic (e.g., Boyle, 1999; Horwitz, 2002; Rapley, Moncrieff & Dillon, 2011; Sarbin, 1968; Szasz, 1974), such as the terms currently prevalent within the mental health discourse, including 'mental disorder', 'mental illness' and related psychiatric diagnostic labels. Finally, given that in present British law 'mental illness' is considered to be a sub-category of 'mental disorder' (Rogers & Pilgrim, 2005) whereas in the introduction to the latest Diagnostic and Statistics Manual of Mental Disorders (DSM-5) 'mental disorder' is subsumed under 'mental illness', I have used these terms interchangeably in this study.

## **1.2. LITERATURE REVIEW**

To review literature for this study, I searched EBSCO, an international online database resource (all databases selected and all years available). In order to keep up to date with new material published, I searched at three discrete points in time: November 2011, August 2012 and March 2013. Variations of the following search terms were used:

- (professional) or (mental) or (psychologist) or (clinical) or (psychology) AND

- (accounts) or (talk) or (construction) AND
- (practice) or (work) AND
- (children) or (child) AND
- (discourse) or (discursive) or (analysis)

After refining the focus of the study, subsequent searches included the following terms:

- (moral) or (ethical) or (dilemma) or (issue) AND
- (justification) or (justify) or (accounting) or (accountability) or (stake)

The abstracts were reviewed and the full texts of those articles that seemed particularly relevant were obtained. I also conducted a hand search from the references of the most relevant papers. In addition, I searched Google using similar terms, which I found useful for directing me to relevant books, websites, and journal articles. Other literature included in this study was drawn to my attention through my university teaching or recommended by academics from other universities.

### **1.3. BRIEF HISTORY OF CHILD CLINICAL PSYCHOLOGY AND CHILDHOOD MENTAL DISORDER: A CRITICAL PERSPECTIVE**

Situating child clinical psychology in the historical framework is, in my opinion, crucial in understanding the current state of the profession and its praxis. Clinical psychology is a relatively young profession, having been established only about a hundred and twenty years ago. Hall (2007) noted that prior to the mid-twentieth century, British applied psychology had far more people working in child than adult welfare, and the first applied professionals were educational psychologists. The very emergence of child clinical psychology is closely linked to the rise of other disciplines prefixed with psy-, including psychiatry, psychoanalysis, educational and developmental psychology, which are referred to as the 'psy-complex' (Ingleby, 1985) by critical scholars.

### **1.3.1. The ascendancy of psy-professions**

According to Foucault (1961; 2006) the discourse of mental illness emerged during the Enlightenment through the process of social exclusion and control. In the context of the Western world, in which reasoning became highly valued, behaviour that was seen as 'unreasonable' began to be segregated into institutional confinement of the 19th century lunatic asylums. Szasz (1978, p. xviii) argued how, "with the decline of religion and the growth of science in the eighteenth century, the cure of (sinful) souls, which had been an integral part of the Christian religions, was recast as the cure of (sick) minds, and became an integral part of medicine", allowing the psychiatrists of the day to assume an 'expertise' in dealing with people now seen as mentally ill. Scull (1979) highlighted the economic and political justifications for this segregation of people who were 'unemployed and unemployable'. He argued that the monopolisation of psychiatry and its 'treatment' methods became the central mission of the newly established capitalist society and interests of the State.

Hence, by the end of the 19th century, children along with the mentally ill, the disabled, criminals, and the poor, became a target of 'individualisation programmes' by psychiatrists (Rose, 1989). Gingell (2001) has noted that children in the asylums were admitted for similar reasons to children's admissions to psychiatric wards today: they were unmanageable in the community due to perceived behavioural difficulties and dangerousness. The death rate of children was high and contact with the family post admission was minimal (Gingell, 2001).

In the context of the historical development of positivism in the late nineteenth century, contemporary psychology emerged and sought to gain 'scientific' (for which read reductionist - empiricist) credibility by aligning itself with the already well-entrenched psychiatry. It too attempted to emulate the methods of the natural sciences in theorising and predicting human conduct (James & James, 2008) and codifying suffering into disease-like categories (Rapley et al., 2011, p. 1). From its very emergence, the notion of mental illness therefore seems to be inextricably a moral endeavour framed as science, where psychologists and psychiatrists became the new arbiters of the moral code (Sarbin & Mancuso, 1970).

### **1.3.2. The stabilisation of child psychology**

'Child' psychology did not fully emerge until the foundation of Child Guidance Clinics in the early 1920s – up until then child psychology was limited to Eugenic inspired assessments of hard to educate children by psychologists, such as Cyril Burt and Lewis Terman. The early developments of child psychology in the nineteenth century also went hand in hand with the development of universal and compulsory education (Rose, 1989). Foucault (1977) argued that the introduction of mass schooling not only set criteria of what constitutes 'normal' childhood behaviour, but also authorised observing and disciplining children. According to Foucault (1977), schools resembled 'telescopes' or 'microscopes' through which the population could be scrutinised. Hendrick (1997, p. 47; see also Timimi, 2002) asserts that mass schooling turned children into attractive 'scientific' subjects for a variety of professionals, giving rise to the Child Study movement (1880s-1914). This encouraged the opening of the first child psychology clinic by Witmer in 1896 in the U.S. and Binet's development of the first intelligence scale for children in 1905.

Furthermore, the growing number of various child welfare bureaucracies and legislations with the emphasis on promoting children's health and wellbeing paved the way for 'psycho-medically' framed concepts of childhood (Hendrick, 1997, p. 50). Critics asserted that the growing public regulation of children through both mandatory education and health care occurred not because of concerns about children's welfare and rights necessarily, but because, as future workers, they required moralisation in order to ensure social efficiency and the production of "docile and capable bodies" (Foucault, 1977, p. 294; Rose 1989). Some authors (e.g., Graham, 2008; Timimi, 2002) have argued that the introduction of mass schooling may have been largely responsible for the contemporary concerns with Attention Deficit Hyperactivity Disorder (ADHD), whilst others (e.g., Baldwin & Anderson, 2000; Newnes, 2011; Timimi & Taylor, 2004) have argued that the current trend of diagnosing children with ADHD and prescribing drugs is a modern method of social control. However, Miller and Rose (1988) have cautioned against simplifying notions of 'social control' and 'medicalisation'. Whilst these are significant, these authors have highlighted the complexity of changing social, political, institutional and moral conditions,

prevailing cultural values and social expectations that have led to transformations of the meaning of childhood and normality and given rise to the regulatory expertise of subjective life in general.

In the 1920s and 1930s, the development of the influential, psychiatrically dominated and psychoanalytically oriented Child Guidance Clinics had an important impact on the ways society came to understand childhood and child-rearing (Hendrick, 1997). The significance of these clinics was not only in promoting the psychological construction of childhood but also in identifying 'abnormal', 'nervous', 'maladjusted' and delinquent children and 'treating' them within newly established multidisciplinary teams of psy-professionals (Rose, 1985). Thus, under the influence of these clinics childhood was given its own repertoire of disorders. However, the promotion of mental hygiene and the welfare movement could only be successful in so far as it managed to actively engage parents in these new ways of thinking about childhood and 'normality' so that they would commit themselves voluntarily to discipline, moralise and rear their children according to the ideal norm (Rose, 1989).

The post-war time saw the expansion of the major Welfare Acts in the UK, such as the National Health Service Act (1946) and the Children Act (1948), in an effort to intervene early and prevent future social problems. Numerous community mental health services and child psychiatric clinics were established, with a correspondingly growing number of psy-professionals being trained to deal with the 'problem families' and 'difficult children' of the deprived working class (Rose, 1989). Psy-professions could now claim to have developed a firm scientific basis and evidence-based expertise (Graham, 1976) and produce more childhood psychometric tests and child developmental theories, thus cementing the establishment of the social project of 'normalising' misfit children and moralising socially unsanctioned behaviours as we know it today.

### **1.3.3. Child-rearing and psychologisation**

Child-rearing as the domain of experts who were said to acquire specialist knowledge is, similar to the medicalisation of childhood, not a new phenomenon. In Western society between the 17th and the mid 19th centuries, local priests were the principal advice-givers to parents to ensure the moral development of

their offspring (Geboy, 1981). However, with the increased successfulness of free-market economies that led to the increase in working hours and the breakdown of traditional sources of support, such as close-knit extended families and communities (Timimi, 2006), concerned parents started to rely on the child-rearing manuals and technologies of psy-professionals.

Rose (1989, p. xi) wrote that since the 2nd World War, psychology has increasingly provided the language in which the troubles of childhood could be framed, and promised the expertise for alleviating them alongside psychiatry. These languages and norms have been disseminated via popular media, cultivating the culture of dissatisfied parents, teachers and communities who would willingly seek professional help in order to achieve the desired norm (Rose, 1989). Parents can nowadays read any number of parenting books, newspaper columns or internet websites devoted to issues of parenting, obtain leaflets created by the various government and voluntary organisations, or watch TV documentaries such as ‘Supernanny’, in which a self-proclaimed ‘expert’ comes to a family’s home to assist parents with their children’s behaviour.

Parents are expected to be able to recognise (ab)normality, but the subsequent intervention is the business of the professional. This phenomenon came to be known as ‘psychologisation’, a notion that not only professionals, but also ordinary citizens, came to view their problems as amenable to psychological treatment. Nowadays more than ever, it seems to be taken-for-granted that you need an ‘expert’ to provide you with ‘specialist advice’ on how best to manage both your healthy as well as troubled and troubling child (Timimi, 2006).

Thus as the psy-complex proliferated, inevitable claims were made about the pervasiveness of childhood psychiatric disorders. Currently, the Department of Health states that: “One in ten children aged 5-16 years has a clinically diagnosable mental health problem. At any one time, *more than a million children* will have a diagnosable mental health disorder.” (DOH, 2011, emphasis added). Similarly, the Royal College of Psychiatrists’ (RCPSYCH) website asserts that: “Mental disorders in children and young people are increasing and *represent a hidden epidemic.*” (RCPSYCH, 2011, emphasis added). And this all despite the fact that there are *no* medical tests to determine diagnosis and *no* specific

biological markers for *any* mental illness, despite years of extensive and expensive research (e.g., Rapley et al., 2011; Timimi, 2006). Moreover, it has been repeatedly demonstrated that diagnostic categories lack validity and reliability, given that no clear distinction can be made between 'normal' and 'abnormal' and the fact that there is a significant overlap between different diagnostic categories (Kendell & Jablensky, 2003; Kutchins & Kirk, 1997). Based on the above, the critics have argued that diagnosis is an exercise of subjective, moral judgment on socially unsanctioned behaviour rather than a product of scientific advancement (e.g., Boyle, 1990, 1999, 2007; Sarbin & Mancuso, 1970, 1980; Szasz, 1974).

#### **1.3.4. The neo-liberal culture**

Timimi (2010) asserts that the increase in the emotional difficulties in the UK's child population (UNICEF, 2007) is largely related to the growth of neo-liberal free market capitalism, and its endorsement of freedom, choice and individual rights at the expense of collective responsibility:

When this system shows itself to undermine children's happiness ... instead of asking ourselves painful questions about our potential role in producing this unhappiness, we view our children's difficulties as resulting from biological diseases that require medical treatment ... thus biological psychiatry gives governments new ways of regulating the population, particularly in democratic societies where states must seek to rule by consent (p. 696).

Hence, as numerous other authors (e.g., Boyle, 2011; Dillon, 2013; Smail, 2001) also argue, the biomedical model of mental distress serves to absolve powerful authorities and authority figures of responsibility for children's predicament and "provides a temporary relief to the beleaguered, intensely monitored child carers and spares all from further scrutiny" (Timimi, 2010, p. 697). As Rapley et al. (2011) note:

To describe what are actually, and essentially, morally troubling issues - in this case children behaving in ways which make manifest their adult-created misery ... or straightforwardly matters of material circumstances ... as *medical conditions* is not only to make a moral –



not a 'scientific' – choice in and of itself (cf. Bentall, 1992), but also to strain the medical metaphor past breaking (p. 4, emphasis in original).

Timimi (2010) goes on to suggest that the medicalisation of childhood enterprise fits well into the current Western consumerist fast food culture, and asserts that we have achieved the 'McDonaldisation' of children's mental health. He claims that application of medical technologies, especially psychopharmaceutical, to manage children's behaviour and emotional states resembles fast food in many ways. For example, it too does not require much consumer engagement with the product, and provides an easy solution with a potential to cause long-term damage to both individual and public health generally, creating life-long consumers. It can be argued that the recent medication-centred practice is partly a result of the Western populations' desire for instant satisfaction and a quick technical fix for complex problems, which fits into a busy lifestyle (Bracken & Thomas, 2005; Harper, 2013b).

Furthermore, in the context of neo-liberal free market economies children and their 'needs' have come to be viewed as legitimate targets for the consumer market (Timimi, 2002). Indeed, we have arrived at what Breggin (2001) named the psychopharmaceutical complex, which comprises of the multi-billion-dollar pharmaceutical industry and the American Psychiatric Association (APA), creators of the several-times-revised DSM<sup>1</sup>. It has been suggested that one of the reasons for the ever-increasing creation of new diagnostic categories, such as the newly proposed DSM-V criteria for Reactive Attachment Disorder of Infancy or Early Childhood, and related rise in drug prescriptions to both children and adults is a result of marketing strategies of pharmaceutical companies, rather than 'robust scientific' research (Baldwin & Anderson, 2000; Cohen, 2004; Healy, 1999, 2004; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997; Moncrieff, 2011). These authors have cast light on the professional, political and commercial interests, and serious ethical controversies around the increasing medicalisation of "problems of living" (Szasz, 1960, p. 115) in order to make profit. With the above historical critical perspective in mind, I now move on to delineate the current contexts of child psychology practice.

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<sup>1</sup> For a history of critiques of the DSM, see Newnes (2013b).

<sup>2</sup> This reflects longstanding philosophical disputes between realism and relativism. In their 'Death

#### **1.4. CURRENT PRACTICE AND PROVISION OF CHILD CLINICAL PSYCHOLOGY**

Harper (2010, p. 13; see also Pilgrim & Treacher, 1992) argues that “clinical psychology continues to be defined by its humble origins”. Hence, it appears that UK clinical psychology in general has struggled to escape medical hegemony, and indeed has continuously assisted psychiatry in legitimising the biomedical discourse through various practices (e.g., Boyle, 2011; Newnes, 2013a). These might include, for instance, promoting the discourse of a scientist-practitioner and evidence-based practice, undertaking psychometric assessments, or emphasising the bio-psychosocial model. Whilst the latter acknowledges the social factors in the aetiology of distress, it subsequently undermines them by implying that biology always has primacy (Boyle, 2006) and thus practically becomes a ‘bio-bio-bio’ model (Read, 2005).

Currently, all statutory services that contribute to the mental health care of children and young people between 0-18 years can be embraced by the term ‘Child and Adolescent Mental Health Services’ (CAMHS). They are organised in a four-tier system, which covers all types of provision and intervention from Tier 1 - with a focus on mental health promotion, prevention and primary level of care, Tier 2 - provided by specialist individual professionals, Tier 3 - specialist and multi-disciplinary community-based services for more severe, complex or persistent mental health difficulties, through to Tier 4 - highly specialised care services, such as in-patient units. In its recent report, the British Psychological Society (BPS, 2008a) expressed concern that:

CAMHS often employ a very medical model - locating a problem or illness within the child or young person. Frequently, the diagnosed problem is addressed by the use of medication or a course of, for example, cognitive-behaviour therapy (CBT) which is prescribed like a medication, rather than as a collaborative therapeutic approach to working with the child and their family (p. 3).

Below I will consider the current child clinical psychology practice in CAMHS in relation to some of the above-mentioned issues in greater detail, commencing with the impact of diagnosis and medication.

#### **1.4.1. The impact of diagnosis**

It has been argued that diagnosis can bring necessary services to the child, including financial benefits in the form of Disability Living Allowance or extra classroom support. However, as Newnes (2011, p. 222) points out: “In such a well balanced - and apparently mutually beneficial - system it can be difficult to remember that the child is being given toxic and experimental drugs that ‘work’ by effectively overdosing his [*sic*] metabolism.”

Furthermore, the impact of psychiatric terminology from a psy-professional can have devastating consequences, not only for the children’s lives, but also for the wider social context. For example, psychiatric diagnoses can materially affect people’s living circumstances by limiting their access to resources or through employment discrimination due to stigma attached to a mental health diagnosis. In addition, psychiatric terminology is “seriously corrosive of the sense that we can have, and make, of ourselves and our circumstances” (Rapley et al., 2011, p. 7). Chloe, a young person who was given a label of an eating disorder, offered an account of how it felt to be diagnosed: “I feel bad enough about myself anyway, why do I need to feel bad about being anorexic now?” (Leeming, Boyle & Macdonald, 2009, p. 16). Rapley et al. (2011, p. 2-5) further argue that wrapping understandable and often highly adaptive reactions to extremely challenging experiences of living, such as child abuse, into a de-contextualised language of internal individual pathology, renders complex moral, social and political issues invisible (see also Newnes & Radcliffe, 2005).

#### **1.4.2. The impact of medication**

Prescriptions for psychiatric drugs to children and adolescents have skyrocketed in the UK despite the lack of evidence for the long-term safety and effectiveness and the fatal flaws of some drug studies (Sparks & Duncan, 2004). For example, the Department of Health (DOH, 2011) and the National Institute for Health and Clinical Excellence (NICE, 2006) provide figures showing that, in the UK between

1994 and 2010, prescriptions for stimulant drugs (e.g., Ritalin<sup>®</sup>) to children under 16 rose from 6,000 in 1994 to an astonishing 660,000 in 2010, representing a 10,000% rise (see also Timimi, & Radcliffe, 2005). It has been noted that this figure is in fact an underestimate of true rates, since the DOH data do not include hospital and private clinic prescriptions (Baldwin, 2000). Leading figures in psychiatry and the critics of the use of medication in children, maintain that drugs have a similar effect on *all* individuals, irrespective of whether or not they are displaying 'symptoms' of a mental illness, therefore seriously undermining a widespread theory that medication 'repairs' a biochemical imbalance in child's brain (e.g., Breggin, 2001; Moncrieff, 2008).

Moreover, there have been serious concerns raised with regards to the toxicity of drugs on children's metabolism and their developing brains (Baldwin, 2000; Breggin, 2001; Breggin & Cohen, 1999; Timimi, 2005;). There are usually a number of adverse side-effects reported by studies and children themselves depending on the type of medication, including a flattening of emotional affect (the zombie effect), confusion, irritability, a reduction in socialisation and play, stereotyped behaviour, growth restriction, insomnia, headaches, or dizziness (Breggin, 2001; Timimi, 2005). Baldwin (2000) asserts that: "The supposedly desirable behavioural effects of, for example, ADHD medication (including passivity and reduced spontaneity) *are the primary toxic effects of psychostimulants*" (p. 457, emphasis in original).

Staying with an ADHD example, research on children's experience of medication found that many children viewed medication as "changing who they were" and reported a considerable stigma with its use (Kendall, Hatton, Beckett & Leo, 2003; Meaux, Hester, Smith & Shoptaw, 2006; Singh, Keenan & Mears, 2008). Interestingly then, when another study (McElearney, Fitzpatrick, Farrell, King & Lynch, 2005) compared children's experience of medication for ADHD and physical illness (epilepsy), the findings revealed stigma and shame associated with ADHD but not epilepsy medication use, suggesting moral verdicts associated with the use of psychiatric medication. Moreover, stimulant drugs are recognised to be highly addictive, raising concerns about their widespread abuse

(Baldwin, 2000). For example, stimulants are one of the most frequently sold street drugs (Breggin & Breggin, 1995).

### **1.4.3. Power and consent**

Newnes (2011, p. 221, emphasis in original) argues that children receiving mental health services commonly obtain “*little or no relevant and understandable information* about the reasons for their referral to a clinical psychologist”. He suggests that the widely endorsed option of choice is therefore frequently ignored. Another concern is that children are regularly referred to mental health services without consent and invaded without consent through injections of psychotropic drugs to manage their behaviour in inpatient units (Newnes, 2013a).

Dexter, Larkin and Newnes (2011) noted that children are disempowered in multi-faceted ways when they enter mental health services, given their age and social status, for example. Consequently, there is a considerable power imbalance between the child and the psychologist. The impact of such power differences are likely to be greatest where children are subject to compulsory compliance with assessments or treatments, including psychological therapies (BPS, 2008b, p. 5). Understanding and reflecting on power dynamics is an important step towards achieving ethical standards of care in contemporary psychology (Fish, 1999).

### **1.4.4. Other issues related to clinical practice with children**

Clinical psychologists working with children use a broad range of interventions, which follow different theoretical models (e.g., systemic, psychodynamic, narrative, cognitive and behavioural) as well as different forms of treatment delivery (e.g., direct therapeutic work and indirect consultative work). However, even when using alternative approaches as part of an ‘eclectic’ position, clinical psychologists still work alongside psychiatrists and report progress to them. Moreover, whilst there has certainly been some recognition of the importance of working on a more systemic, community and political level (e.g., Harris, 2005), clinical psychology seems not to have moved far from internal deficit-based conceptualisations. For example, this is evident in the current Children and Young People’s Improving Access to Psychological Therapies (IAPT, 2011) Project’s emphasis on Cognitive Behavioural Therapy (CBT), an approach that

aims to modify dysfunctional thoughts residing in the individual child.

Furthermore, the NICE guidelines, journals and textbooks reviewing treatments for children, such as 'What works for whom?' by Fonagy and colleagues (2005), heavily rely on medical and positivist discourses. In this way, they often present psychological therapies as evidence-based interventions, which address *specific* childhood psychiatric disorders. Regardless of all the controversy, the BPS has welcomed a new government strategy to invest £32 million in IAPT for children and young people with mental health problems (BPS, 2011).

Additionally, despite concerns with medication, it is common to offer drugs to complement psychological therapy in practice with children. The NICE guidelines (2009) and other clinical guides, such as 'Drawing on evidence - Advice for mental health professionals working with children and adolescents' (Wolpert et al., 2006) in fact recommend medication as the *first line of intervention* for ADHD. They also advise other physical treatments for a variety of other psychiatric conditions, including psychostimulants, lithium or traditional anti-psychotic medication to reduce "antisocial behaviours in children and adolescents with co-morbid ADHD/ADD", to reduce "explosive aggressive outbursts in hospitalised groups" (Wolpert et al., 2006, p. 9).

Thus mainstream child psychology, which claims to offer alternatives to bio-medical discourses, appears to have gone along with psychiatry and together they have built a system that hardly does justice to the myriad of difficulties it claims to address, whilst producing multiple iatrogenic problems for those to whom it is applied (Rapley et al., 2011, p. 1).

#### **1.4.5. Organisational issues and individual psychologists**

The practice of all the participants in this study is based within a wider organisational context, which, as we have seen, is largely influenced by the medical model. This may present numerous issues and dilemmas for psychologists and their practice. For example, there seems to be ethical concerns with such practices as diagnosing children, which psychologists encounter every day since they are enshrined in their institutional contexts. Moreover, individual psychologists often practice within multidisciplinary teams,

discourses of which will be influenced by different and often polarised theoretical positions and the personal perspectives of individuals. This includes not only medical, but also psychological, social, humanistic, liberal or post-modern, suggesting that professionals may need to negotiate between these.

As a modern profession, child clinical psychology is firmly integrated within the pay and bureaucratic structures of the NHS (Newnes, 2013a). As such, the practice of individual psychologists is directly regulated by the DOH that sets requirements for all NHS-commissioned child services nationally. One of the recent requirements asks CAMHS to report on their performance and submit a variety of mandatory information on a yearly basis, including categories of provisional diagnosis, primary diagnosis and outcome measures (DOH, 2012). This might have significant consequences for the practice of individual psychologists. For example, as we have seen, the evidence-base for work with children tends to be organised in relation to a biomedical discourse. Authors of clinical guidelines argue that while the clustering of problems within the diagnostic framework is not ideal, it is the only way to keep it close to the evidence, which is required within the current socio-economic climate and the business model in the NHS. The argument being that the diagnosis results in a care package, which subsequently attracts much needed funding from local commissioners. The result is that the NHS has increasingly focused on those interventions that have the most well-established evidence base. From the above it appears that the profession and its members are in danger of becoming trapped in a medicalised system, as the powerful psychiatric language increasingly organises clinical practice guidelines and services.

## **1.5. PREVIOUS INVESTIGATIONS OF PROFESSIONAL ACCOUNTS**

In this section I will review studies that have undertaken a qualitative exploration of clinical psychologists' as well as other professionals' accounts of their practice.

### **1.5.1. Studies of other professionals' accounts of their practice**

Five qualitative studies are of a particular relevance to this thesis. Most of these studies adopted different methodologies and explored different elements of the

clinical practice of a range of professionals. However, two studies have some key aspects in common and reported similar findings. Namely, an Australian study by Koehne, Hamilton, Sands and Humphrey (2012) and a Canadian study by Strong, Gaete, Sametband, French & Eeson (2012) both examined how clinicians are influenced by, and respond to, the use of diagnosis in their practice. Strong and colleagues (2012) analysed the data from an online survey of 116 professionals, a website blog, and interviews with 10 professionals using a grounded theory method, and Koehne and colleagues (2012) conducted a discourse analysis of interviews with 23 clinicians working in CAMHS about their use of the Borderline Personality Disorder (BPD) diagnosis. Although using different methods of data analysis, the findings of both studies suggested that diagnosing can pose considerable practical and ethical dilemmas for clinicians applying non-psychiatric approaches in their work.

These studies outlined various strategies that clinicians used to deal with such dilemmas. Specifically, Strong et al. (2012) found that clinicians reported complying with administrative requirements by giving all clients 'unspecified' DSM diagnosis. The clinicians also reported using diagnostic language with their psychiatric colleagues, while in the therapy room they preferred the clients' language to describe their presenting concerns, and reported a more collaborative practice, which involved negotiating, exploring and choosing diagnoses with their clients. Koehne et al. (2012) found that practitioners reported managing their dilemmas around diagnosing young people with BPD either by not disclosing the diagnosis to their clients or by reframing the diagnosis with young people whilst positioning themselves carefully when disclosing a diagnosis. This was achieved by postponing the claims of diagnostic permanency, and by drawing upon qualifying language to establish their sceptical position towards the diagnosis. Thus, whilst these studies identified different strategies, they both conclude that clinicians could be seen to show resistance to, or even the subversion of, diagnostic practice.

Another study by Arribas-Ayllon, Sarangi and Clarke (2009) explored accounts of twenty UK professionals involved in childhood genetic testing. Using rhetorical discourse analysis, they too looked at the dimensions of ethical and professional



dilemmas. However, in contrast to the above studies, this research focused on the management of moral accountability in describing professional actions. The authors found that the most significant devices through which this accountability was managed included a contrast structure and the use of extreme case scenarios. For example, constructing parents as “pushy” and “demanding” tests and the child as “innocent” and “declining” (Arribas-Ayllon, et al., 2009, p. 29). These functioned to justify professional actions and facilitated the management of the moral positioning in assigning responsibility and blame.

A similar perspective on the professionals accounts to the one offered by Arribas-Ayllon and colleagues (2009) was provided in a British study by Masocha published in March 2013 that explored professional accountability of twenty-five social workers who were interviewed about their practice with asylum seekers. The findings illuminated a range of discursive strategies employed by social workers to justify their practice, including attributing responsibility and blame to asylum-seeking families who were portrayed as “not making enough effort”, and emphasising existing constraints to good practice. Moreover, the interviewees portrayed themselves as “competent” social workers, “having the best intentions” and “doing the best they can” to support their clients. This research thus complements some of the above studies by offering an insight into the moral, ethical and ideological dilemmas related to professional practice.

The final research described in this section is a study by Stevens and Harper (2007), which is distinct from the above studies in that it used discourse analysis to examine accounts of eight mental health professionals (psychiatrists, anaesthetists and psychiatric nurses) who were interviewed about their experience of administering the socially contested psychiatric intervention of electroconvulsive therapy (ECT) in adult patients. Their research identified how clinicians drew on a repertoire that constructed people receiving ECT as severely ill which had a powerful effect to warrant the urgent use of ECT and other biomedical interventions, to define who should receive ECT, to reframe distress in organic terms, and to discount the usefulness of alternative, non-physical interventions. Their findings also demonstrated that all the interviewees acknowledged concerns about ECT and managed these, for example, by

constructing ECT as a method with compared risks and benefits, downplaying potential problems with its evidence base, and undermining the legitimacy of criticism.

### **1.5.2. Studies of clinical psychologists' accounts of their practice**

There appears to be a limited number of studies that examined clinical psychologists' accounts of their work. These are mainly unpublished doctorate theses that used a Foucauldian discourse analysis (FDA) to explore a range of topics such as clinical psychologists' constructions of an old age, gender, poverty, or their work with refugees. Only two studies analysed accounts of child clinical psychologists. Whilst these used the same methodology (i.e., FDA), they focused on very different aspects of clinical practice with children, drawing different conclusions, and therefore will be outlined separately.

The first study by Skoger, Linberg and Magnusson (2011) looked at Swedish child psychologists' accounts of their practice to explore the meaning of gender. The authors identified four different repertoires at work: a repertoire of neutrality and equal treatment, grounded in a liberal political concept of equality; an individualising repertoire concentrating on individual differences and symptoms, rather than the influence of context on children's problems; a repertoire of gender-specific characteristics, emphasising fundamental internal variances between girls and boys as being central when judging what is normal; and a repertoire of gender-specific expectations. This research highlighted how the narratives often ended in accounts of individualising and symptom-focused treatments focused on gender-stereotypical adjustment to socially desired behaviors.

In the second study by Dexter, Larkin and Newnes (2011), the authors presented an exploration of eight UK child clinical psychologists' talk, with particular focus on their understanding of user involvement. The patterns of analysis outlined that children are regularly positioned as both vulnerable and powerless in comparison to parents and professionals. The authors suggested that this positioning of children has implications on how much they can be involved effectively in service evaluation and planning when parents may seem to be more straightforward candidates for user involvement within a busy CAMHS setting.

## **1.6. SUMMARY AND JUSTIFICATION FOR THE CURRENT STUDY**

In the introductory section above, we see that there is complex moral ambiguity inherent in the construct of mental illness. This is evident not only through a critical examination of its emergence and relentless widening throughout the history, which highlighted political, economic and professional interests in its creation, but also in detailing the problems with the validity and reliability of psychiatric diagnoses, thus rendering claims of their scientific plausibility far from sound. By providing an overview of some of the issues with child clinical psychology practice that relies on the use of this contested psychiatric paradigm, it is sensible to argue that such practices are morally deeply problematic. This raises a question about whether the profession and its members might be in danger of becoming trapped in a medicalised system, as the power of psychiatric diagnostic language increasingly organises clinical practice guidelines and services.

From a social constructionist perspective, which this thesis adopts (as discussed in detail in the section 2.2.), the ways in which phenomena are discursively constructed make a material difference to the very nature of those phenomena. As such, the ways in which clinical psychologists construct their practice is crucial to the delivery of mental health services to children and has a direct impact on the lives of children and their families.

This inherent power of psychological discourses as exercised by clinical psychologists (e.g., Boyle, 2011; Billington, 2006) raises a fundamental question as to how they go about their work. In my opinion this is particularly relevant to child clinical psychologists, given that children have little power in society in general and in mental health services in particular (Dexter, Larkin & Newnes, 2011). Working in a CAMHS context might therefore present various issues for clinical psychologists in how they talk about, and how they listen to, children as well as how (and whether) they listen to themselves when working with children.

Researchers rarely target clinical psychologists' accounts of their work, as they can be easily found in textbooks and journals. However, such textual accounts would be significantly different from interviews with clinicians, which have the

potential to provide conversationally richer data. In addition, Newnes (2013a) argues that there is considerable difficulty in examining clinical psychology practice because the clinical work mostly takes place away from public gaze and it is only through reporting about the work in supervision or team meetings that the practice is made visible. As such, the semi-structured interviews conducted in this study offer psychologists a chance to discuss their work in greater detail, to explore the range of concerns that they might have about their practice, to offer descriptions of, and justifications for, some of their actions, as well as establish their personal and professional identity.

By utilising the fine-grained DP analysis, this study hopes to provide an additional perspective for analysing and understanding the current practice. Such a perspective, as we saw in the review of extant research, is largely undeveloped within child clinical psychology and research examining clinical psychology practice. Therefore, this study hopes to make a contribution to both theory and practice by specifying in greater detail the ways in which practitioners conceptualise their activities. It is also hoped that this may help clinical psychologists gain a greater awareness of the performative nature of their language, and thus potentially enhance both practitioners' critical reflectivity and reflexivity.

## **1.7. RESEARCH QUESTIONS**

It is common in traditional psychological research to formulate a clear research question before starting the research. However, within discursive psychology approaches, rather than posing a specific research question, the focus is often on explicating the workings of specific type of social practice operating in the setting, perhaps with the ultimate aim of making broader sense of the setting as a whole. This means that questions are continually refined in the course of the analytic process (Potter, 2012).

Accordingly, this research started with a broad question asking how clinical psychologists talk about their work with children. As I became increasingly engaged with the data, focusing on the rhetorical and interactional aspects of the

discourse, the analytic foci developed. This thesis therefore looks at clinical psychologists' orientations towards, and justifications for, the challengeable status of the various practices that they described in their talk. A more detailed discussion of the methodology will follow in the next chapter.

## **CHAPTER TWO - METHODOLOGY**

This chapter provides an outline of the epistemological position and methodological approach adopted in the study. This is followed by a detailed description of the method used, including sampling, participant recruitment and profile, data collection, transcription and the approach to analysis. The chapter concludes with an account of my positioning in the context of this study. I have provided a critical review of the study and further reflection on my position in the final chapter.

### **2.1. METHODOLOGICAL RATIONALE**

This research aims to investigate how clinical psychologists construct their work with children and account for their practices. Accordingly, there are two related implications for choosing the methodology for this study. First, the interest of the study is clearly not in measuring, comparing or predicting quantifiable variables nor asking people to rate themselves on a scale, but rather in exploring the details of their talk. This is best facilitated by using qualitative methods (Harper, 2012). Second, since the concern is with *how* participants use language to describe and account for their practices within the occasioned talk-in-interaction, a discourse analytical, and more specifically discursive psychological methodological approach, was considered to be the most appropriate.

### **2.2. EPISTEMOLOGICAL POSITION**

Methods and analytic perspectives are typically underpinned by broader philosophical principles and assumptions (Potter, 2003). This study adopts a social constructionist approach to exploring how clinical psychologists draw upon

language to construct their work with children. Gergen (1985) outlined some basic assumptions of social constructionism, including:

- Scepticism of the taken-for-granted knowledge claims about the world;
- Versions of knowledge and reality are historically and culturally specific,
- reified through particular socially occasioned processes, and
- bound up with and carrying social actions.

More specifically and in line with my methodological commitments, I will have aligned myself with a relativist brand of social constructionism, which is sometimes called ‘radical’/‘strong’ social constructionism (Harper, 2012), ‘discursive constructionism’ (Potter & Hepburn, 2008) or ‘discursive psychological social constructionism’ (Rapley, 2004). This relativist position insists that “realities are always realities becoming” (Mehan & Wood, 1975, p. 32), which brings to the fore notions of haecceity and indexicality (Rapley, 2012). According to Rapley (2012, p. 182), the recognisable structures of social reality are not fixed but rather constantly and collectively brought into being in their uniqueness as what they are (haecceity) within the local occasion of their use in (inter)action (indexicality).

Relativism/discursive constructionism is a practical position that is productive in research terms in that it views language as actively *constructing* the notions of the world rather than merely *reflecting* or *mirroring* them (e.g., Potter, 1996). Proponents of this perspective are pervasively sceptical of any guarantee about the nature of ‘reality’ or ‘mind’ that is independent of local descriptions of them. For researchers this means that they are interested in the viewable, verifiable and accountable, that is, they treat people’s accounts as analytic start-points themselves, rather than focusing on invisible, hypothetical and abstract concepts, with which we cannot be in direct contact. Also, multiple interpretations or readings of data are to be expected.

This approach is commonly confronted by the advocates of what is sometimes referred to as the ‘weak’ or a more ‘critical realist’ end of the realism-relativism constructionist continuum, who point to the undeniable reality of rock, furniture, death or macro-social contexts of institutions and power relations within which any discourse takes place (Edwards, 1997, p. 52). Thus they accuse discursive psychological social constructionists of ontological and moral relativism (Harper,

2012).

However, the relativist perspective does not necessarily propose a denial of the objective reality of phenomena, which would be “as realist a move as endorsing that reality”<sup>2</sup> (Potter, 2003, p. 787). Harper (2012) further clarifies this standpoint and notes that researchers who are epistemologically or methodologically relativist, are not necessarily ontologically relativist. In other words, “they are relativist about what we can know about the world but they are not relativist about whether there is a world at all...An epistemological relativist goes about their life in the same way as everyone else, treating the world as if it exists” (Harper, 2012, p. 91).

Similarly, arguing that there are different interpretations of the world does not necessarily imply moral relativism or accepting that ‘anything goes’ (Hepburn, 2003, p. 9). In fact, researchers using the variant of discursive constructionism have produced numerous works that highlighted ethically troubling social and political issues (e.g., Coulter & Rapley, 2011; Hepburn, 2000, 2001; Wetherell & Potter, 1992; Rapley, 2004). This project similarly hopes to do so by conducting a detailed analysis of professional talk.

### **2.3. DISCOURSE ANALYSIS**

The approach adopted in this study can be conceptualised under the umbrella term discourse analysis (DA), which encompasses a broad collection of related but varied approaches (Edwards, 2004), such as Foucauldian Discourse Analysis (FDA), Critical Discourse Analysis (CDA) or Discursive Psychology (DP). In general, DA approaches are aligned with social constructionism (Gergen, 2009), focus on the use of language (Willig, 2001), and provide a powerful resource for researchers who wish to question the status quo (Hepburn, 2003). The difference

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<sup>2</sup> This reflects longstanding philosophical disputes between realism and relativism. In their ‘Death and Furniture’ paper Edwards, Ashmore & Potter (1995) skillfully argued that the very act of invoking material reality, such as tables and rocks (the reality that *cannot* be denied) and of various kinds of death, poverty and suffering (the reality that *should not* be denied), inevitably makes them representations in talks and texts analysable as constructions and rhetorical devices, thus exposing the way they were constructed to have their effect. Indeed, consistent with its epistemic assumptions, it can be argued that the discursive constructionist perspective is *itself* a literary construction (Potter & Hepburn, 2008).

between the various types of DA is in their assumptions, emphasis and methods of analysis<sup>3</sup>.

The DP approach adopted in this study developed out of a particular strand of discourse analytic work outlined by Potter and Wetherell (1987). Its unique features were subsequently laid out by Edwards and Potter (1992) and later Potter (1996) and Edwards (1997). The project of DP is distinctive in applying DA principles specifically to psychological topics (concepts such as emotion or identity). These are, however, reconceptualised as discursive practices rather than treated as fixed psychological facts, cognitive processes or inner mental states. In other words, DP views discourse to be actively constitutive of the subjects of psychology, and treats psychology as a topic rather than a resource (Edwards, 2004; Edwards & Potter, 1992, 2001; Rapley, 2004). Moreover, DP focuses on the way psychology is a public and social endeavour, and how it is co-constructed and used in social practices. Thus, DP has presented some of the most rigorous critiques of the dominant, traditional ways of doing psychology, including the notions of individualism and cognitivism (e.g., Hepburn & Wiggins, 2007).

Another important distinction noted by Potter & Hepburn (2008) is that DP assumes a more restricted notion of discourse<sup>4</sup>, in comparison to the extended notion of discourse commonly used in FDA. These authors assert that this, however, does not mean that the type of analytic work done in DP might not draw on some of Foucault's observations about institutions and practice. Similarly, DP satisfies many of the essential characteristics of CDA, for example, by its involvement in critical and political analysis (Hepburn & Wiggins, 2007, p. 13).

The DP approach was used in this study because of its potential to map out the complex rhetorical work employed by the participants (e.g., management of stake and accountability) and to get a better understanding of the micro-mechanisms of the production and re-production of practices that tend to be glossed over by other DA approaches with a more 'macro' focus on the discourse (Whittle &

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<sup>3</sup> For an overview of differing discourse analytic commitments, see e.g., Edwards (2004), Harper (2006), Hepburn & Wiggins (2007), or Wooffitt (2005).

<sup>4</sup> Discourse is defined in DP as texts and talk as parts of social practices (Potter, 1996).



Mueller, 2011). Indeed, Potter and Hepburn (2009) assert that such a detailed level of analysis is essential for understanding the production of institutional order.

## 2.4. DISCURSIVE PSYCHOLOGY

DP has also been increasingly informed by conversation analysis (CA) developed by Harvey Sacks (1989, 1992) who was himself influenced by ethnomethodology (EM) founded by Harold Garfinkel (1967). This EM/CA inspired DP approach allows detailed analysis of interactional practices to expose “the seen but unnoticed” aspects (Garfinkel, 1967, p. 180) of *how* the things are accomplished (e.g., how practices are justified) by ordinary members of society (including the psychologists<sup>5</sup>) to create the commonsensical notions of everyday (in this case professional) life and cultural knowledge (Heritage, 1984; Sacks, 1984).

The analytic perspective of DP typically draws on three key features of discourse, which overlap considerably with basic assumptions of both CA and EM<sup>6</sup> (see Edwards & Potter, 2001; Hepburn & Wiggins, 2007). The first aspect is the action-orientation of discourse, which emphasises that talk around a given topic, such as psychologists’ practice, accomplishes certain social actions. That is, in speaking we construct versions of events in order to achieve certain interpersonal objectives (for example, to attribute blame or refute responsibility) and to manage our own stake and interest<sup>7</sup> (Edwards, 1997; Potter, 1996). Thus, as psychologists provide reports of their practices that describe issues of accountability in those practices so, concurrently, they are inevitably demonstrating and managing their own accountability in the provision of the

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<sup>5</sup> This approach does not assume that psychological knowledge is of an inherently different order to that of the ordinary person (Baker, 2003, p. 396).

<sup>6</sup> The relationship between DP, EM and CA is complex. For more elaborate coverage of methodological developments and their interrelation see e.g., Hepburn & Wiggins (2007) or Wooffitt (2005).

<sup>7</sup> Potter (1996) clarifies that “the argument is not that social researchers should interpret people’s discourse in terms of their individual or group interests ... [which would be a cognitivist move. Rather] ... The argument here is that people *treat each other in this way*. They treat reports and descriptions *as if* they come from groups and individuals with interests, desires, ambitions and stake in some versions of what the world is like. Interests are participants’ concern, and that is how they can enter analysis.” (Potter, 1996, p. 110; emphasis in original).

report.

Second, DP understands discourse as situated. It is sequential, such as any utterance within conversation follows on and orients to the previous conversational turn, whilst the new utterance provides the context for what is said next. Discourse is also situated institutionally, in the sense that institutional activities (e.g., doing the research interview) and identities (clinical psychologist or researcher) will be relevant to what happens. However, the context should not automatically be assumed by the analyst; rather it needs to be made pertinent by the participants themselves by the way they invoke and reconstruct contextual structures in the course of their talk (Schegloff, 1997). Finally, discourse is situated rhetorically (Billig, 1991). That is, constructions in talk are frequently formed in a way that counter or undermine potentially significant alternatives.

Third, consistent with its epistemological assumptions, DP treats discourse as both socially constructed (how are accounts assembled in social interaction?) and constructive (how do accounts build versions of the worlds/events/actors in order to accomplish social action?). DP is therefore interested in both *how* people employ specific constructions and with what effects.

In this study, I will draw on the above notions to demonstrate the ways in which psychologists describe and account for their practices with children. I will pay particular attention to the complex set of conversational moves in psychologists' talk and the management of accountability and identity work within the local context of the talk-in-interaction. Although psychologists inevitably orient to their stake in describing any of their practices (Antaki, Ardévol, Núñez & Vayreda, 2005), it would be expected that the accounting and identity work is the most pervasive was when they talk about the potentially controversial and morally contested practices, given that speakers tend to orient to implicit problems when accounting for events (Widdicombe, 1993). This raises the broader issue of how psychologists construct their work with children as part of making moral sense of their practice. Antaki et al. (2005) put this concisely:

“The idea is that in any interaction, participants do things for which an account might, in principle, be called for and given; things that 'make sense' interactionally and in the moral order. This is not an analyst's

fiction; it is visible in the behaviour of participants themselves, as they design their talk and actions so as to avoid, or disarm, query or challenge. Participants sometimes orient very visibly to the challengeable status of what they are doing (e.g., in such formulae as '*this may be a funny question, but...*' or '*I'm not a racist, but...*'), but can (and routinely do) exploit more subtle aspects of talk in interaction to address, disarm, or flaunt their accountability” (p. 2, emphasis in original).

The analysis therefore focuses on sequences of talk where psychologists orient to particularly sensitive areas of interactional concern, with the aim to demonstrate *how* discourse can be used to do the work of moral accounting and how it can be used to work up moral credibility. It is hoped that through a fine-grained analysis of psychologists’ accounts, it will be possible to make inferences about the cultural properties of the moral and social world (Schegloff, 1998), in this case clinical psychological practice with children.

## **2.5. ETHICS**

Ethical approval was sought and obtained from the University of East London Research Ethics Committee<sup>8</sup>. NHS ethical approval was not required to interview NHS staff because they are not considered vulnerable within the current ethical policies. Standard ethics protocols were followed, including gaining informed consent from participants, adhering to confidentiality arrangements, and protecting the anonymity of participants. All names and identifiers have therefore been changed. Participants were informed that they may withdraw their decision to take part in the study at any time without consequence and obligation to give a reason.

## **2.6. SAMPLE SIZE AND GENERALISABILITY**

As with other DP projects and in contrast with quantitative psychological research

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<sup>8</sup> See appendix one.

rooted in statistical and aggregationist models (McHoul, 2001; Rapley, 2012), the approach to sampling in this study follows the position of the quantum physicist, Richard Feynman, who suggests that: “Nature uses only the longest threads to weave her patterns, so each small piece of her fabric reveals the organisation of the entire tapestry” (Feynman, 1965, p. 34). Accordingly, the question of sufficient sample size becomes moot, because the order we are seeking here is not statistical in character; rather it is inherently present even in the tiniest fragments of materials we have available. This notion was coined the ‘order at all points’ by Sacks (1992). Schegloff succinctly outlines Sacks’ position:

“This view ... understands order not to be present only at aggregate levels and therefore subject to an overall differential distribution, but to be present in detail on a case by case, environment by environment basis. A culture is not then to be found only by aggregating all of its venues; it is substantially present in each of its venues.” (Schegloff in Sacks, 1992, xlvi)

Consequently, there are at least two associated implications for this study regarding to the representativeness of data and the generalisability of its claims. First, important insights can be gained from what might, from a positivistic viewpoint, be deemed to be a relatively statistically insignificant sample size. Second, if certain discursive practices are revealed in a detailed study of a small sample of talk-in-interaction, it can sensibly be assumed that this also reveals something of the wider cultural practices. Thus, exploration of the kind of moral accounting located within the talk-in-interaction, may also say something about the wider moral order.

## **2.7. PARTICIPANT SELECTION CRITERIA AND RECRUITMENT**

The exploratory nature of this study highlighted the value of approaching a range of child clinical psychologists. Therefore, a broad cross-sectional approach to selecting participants was used in order to elicit the widest possible variety of potentially interesting avenues of inquiry. Participants had to be qualified clinical psychologists working with children in NHS-provided mental health services. There were no other specific inclusion and exclusion criteria.

Given the time constraints for completion of this study, a multi-level strategy of recruitment was adopted. Firstly, the heads of Child and Adolescent Mental Health Services (CAMHS) in London were approached to discuss the outline of the study and to obtain approval for the study to be carried out within their service. They were sent an invitation letter,<sup>9</sup> supplied with a participant information sheet,<sup>10</sup> and were asked for this to be distributed throughout their teams. Psychologists were asked to contact the researcher if they were interested in participating. Five participants were recruited in this way. Secondly, an advert<sup>11</sup> was placed on the research board within the British Psychological Society's Division of Clinical Psychology. No participants were recruited via this route. Finally, the snowballing technique was used by approaching clinical psychologists working in CAMHS who were already known to me. They were invited to participate, sent a participant information sheet, and asked in turn to invite other clinical psychologists they knew to participate to whom they also distributed the information sheet, and so on. Four participants were recruited in this way.

Potential participants were usually approached via email, although occasional follow-up telephone calls were also made. During the initial contact, basic information was gathered to assess if the participant met the inclusion criteria discussed above. Participants had an opportunity to ask questions if they had any. Arrangements for a mutually convenient time and location of the interviews were made at this stage.

## **2.8. PROFILE OF PARTICIPANTS**

Participants constituted nine qualified clinical psychologists working with children in NHS-provided mental health services. Seven females and two males were recruited. Two participants were aged between 26-35 years, six participants between 36-45 years, and one participant between 46-55 years. Seven participants were White-British, and the remaining two described themselves as

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<sup>9</sup> See appendix two.

<sup>10</sup> See appendix three.

<sup>11</sup> See appendix four.

White-Asian and White-Other. The psychologists worked in a variety of CAMHS settings, including Tiers 2, 3 and 4, and one learning disability service. Their work locations spread across the North, South, East and West areas of London. The number of years since qualification ranged from 1 to 18 years. Participants formed a mix with regard to theoretical orientation and speciality, often describing themselves as applying more than one therapeutic approach, including cognitive-behavioural therapy (CBT); systemic; psychodynamic; group analytic; cognitive-analytic therapy (CAT); mentalisation-based therapy (MBT); and eye movement desensitization and reprocessing (EMDR) therapy. Some specialised in working with adolescents, trauma, parenting, attachment theory or Autistic Spectrum Disorders (ASD) assessment, whilst others described themselves as having an integrative or generic CAMHS orientation. Table 1 in Appendix five provides a summary of participants' demographic details.

## **2.9. INTERVIEWS**

Child clinical psychologists were chosen to be interviewed because the objective of this study was to look at how they describe their work, to explore the range of concerns that they might have about their practice, and to see how they argued and accounted for these. This decision was made with an awareness that several authors (e.g., Potter & Hepburn, 2005; Potter & Mulkay, 1985) have highlighted limitations of using interviews as a data collection method in DP studies. One of the main criticisms is that it creates an 'unnatural' type of interaction, and therefore should not be used as a substitution for more 'naturally occurring' talk.

On this basis it can be argued that for the purposes of this research, I could have recorded more naturally occurring interactions by attending case conferences, for example. However, as Potter and Mulkay pointed out: "The very artificiality of interviews may be their main advantage and provide their best justification." (Potter & Mulkay, 1985, p. 269). Accordingly, the research interview was considered an appropriate method, because it allowed me to take a more interventionist approach (Potter & Wetherell, 1987) and explore instances of talk about the areas of clinical practice that would otherwise have been difficult to collect in naturally occurring talk, given the logistical and time constraints for this

study.

Despite the critiques, research interviews remain thoroughly analysable (Edwards, 2004, p. 270), and can address important issues (Hepburn, 2000; Wetherell & Edley, 1999). Baker (2003, p. 396) asserts that if the interviews are treated not so much as methods of getting at information or retrieving participants' views (although participants often orient to them in this way), but more as in-their-own-right-analysable instances of talk-in-interaction, they can yield insight about a range of matters, such as the production of situated identities and the moral work of accounting.

As such, it is important to stress that the interviews in this study did not depict the ways psychologists may interact in real life by extrapolating the participants' views that would somehow mirror their actual practice. Rather, the interviews were treated as co-constructed locally occasioned research interactions, and designed to be open-ended and conversational. This meant that there was no assumption of my neutralist stance as a researcher; instead I adopted an active interviewing style (Holstein & Gubrium, 1997), in which the topics were fluidly followed and participants' contributions were at times challenged in order to generate a wider range of discursive practices. Such an approach to interviewing is common in DP studies (e.g., Hepburn, 2000, 2001; Potter & Wetherell, 1987; Wetherell & Potter, 1992). Conceptualised in this way, this study looks at what happens when a trainee clinical psychologist starts asking some qualified clinical psychologists about their work within the research context. From a DP perspective, this study therefore is interested in the management of accountability that such questioning might produce.

A total of nine conversational interviews were conducted. The interviews were guided by an interview schedule,<sup>12</sup> and started with a broad opening question: "Can you tell me how do you work with children?" The interviews ranged in length from 47 minutes to 123 minutes, with an average of 65 minutes. Natural endings in interviews were agreed between participants and myself. Each interview was recorded using two digital recorders. All interviews took place in the respective participants' work places at times convenient to them. Prior to the interview,

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<sup>12</sup> See appendix six.

participants were asked to sign a consent form,<sup>13</sup> to complete a demographic profile form,<sup>14</sup> and confidentiality arrangements were explained. There was an opportunity for participants to ask questions about the research at the beginning and the end of the interview, and reflect on their experience of the interview process.

## **2.10. TRANSCRIPTION**

Interviews were transcribed verbatim using a variety of notation symbols commonly used in CA, based on a variation of the Jefferson system<sup>15</sup> (see e.g., Atkinson & Heritage, 1984). This simplified convention<sup>16</sup> was designed to capture features considered most essential for the current analytic task (Hollway, 2005; Potter & Wetherell, 1987). This convention facilitated readability whilst also allowing me to capture more fine-grained features of the talk-in-interaction, such as overlap, emphasis, pauses, and contextual information. All identifying details were altered or omitted to ensure anonymity and confidentiality. Interviewees are identified by a pseudonym.

## **2.11. ANALYTICAL PROCEDURE**

The variant of DP used here is broadly associated with the Loughborough University's School of Social Sciences.<sup>17</sup> However, I have also drawn on, and followed, the procedures for analysing discourse suggested in the more classic texts of Potter and Wetherell (1987) and Wetherell and Potter (1992). In addition, I attended the Loughborough's Discourse and Rhetoric Group (DARG) where I took some of my data (that are not presented in this thesis) prior to conducting my analysis to practice how to conduct a DP analysis, and to get a better understanding of the data from an interactional point of view (i.e., focusing on the process and the action orientation of talk rather than the content).

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<sup>13</sup> See appendix seven.

<sup>14</sup> See appendix eight.

<sup>15</sup> See appendix nine for the transcription notation.

<sup>16</sup> This type of transcription convention is sometimes referred to as 'Jefferson-Lite'. See Potter & Hepburn (2005, p. 8) for a debate regarding challenges and benefits of its use.

<sup>17</sup> This type of DP is associated with micro-level analysis and a relativist position.



Whilst it is recognised that there is no distinct method to discourse analysis and that the analytic process is iterative, it is nevertheless possible to describe different phases of analysis.

### **2.11.1. Reading**

The first phase included the reading and re-reading of printed transcripts. During this preliminary reading stage, I noted my initial observations in the margins of the transcripts, marking points that were interesting either in terms of *what* was said, or *how* it was said. Whilst doing this, I asked myself a number of questions such as, 'What might be the effect of particular accounts on the interaction or what are the participants doing in their talk?' Being familiar with other discursive psychology studies was particularly beneficial in helping me to recognise discursive features already depicted in other work.

### **2.11.2. Coding and Initial Analysis**

The second stage involved coding and initial analysis to make examination of transcripts more manageable. This involved going through my comments in the margins and identifying interesting themes and actions produced in talk that could be grouped together. In this way, 14 themes/actions were identified and marked on the transcripts with coloured stickers.<sup>18</sup> Those sections of the transcript that could be linked to one or more themes/actions were coded under several themes.

The themes/actions were as follows:

- Construction of children
- Construction of difficulties/distress
- Construction of psychologist role
- Parental responsibility or blame
- Child responsibility or blame
- Expert versus lay knowledge
- Power imbalance in child work
- Rhetorical strategy of 'doing being ordinary' or 'cover identity'
- Rhetorical strategy of 'doing being collaborative or democratic'
- 'Selling' psychology

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<sup>18</sup> See appendix ten for an illustration of coded transcripts.

- Good, morally adequate psychologist
- Positive self and negative other
- Justifying practices
- Interview process

After the initial coding process, I re-read those sections of discourse that related to each of the above categories separately, transferring them into separate word documents with correspondingly named files. Once printed, these became the subject of a detailed analysis of the discursive features that were present. In this step, I also colour highlighted those sections of discourse that provided examples, which related directly to the theme or where there was apparent rhetorical work being done. These then became the most suitable examples for potential inclusion in the study.

### **2.11.3. Selection of Extracts**

At this stage of the process it was essential to identify an analytical focus for the study. Although there were many areas of potential interest, such as participants' constructions of children and their distress, I selected those sections of discourse where participants could be seen to be justifying and accounting for their practice, especially when they appeared to be orienting to issues of morals or areas of contestation. This decision was based on my view that these instances appeared to be particularly interesting, seemed to permeate a substantial amount of the research interaction, and were examples of a combination of related themes/actions, including 'Justifying practices', 'Power imbalance in child work', 'Rhetorical strategy of 'doing being ordinary' or 'cover identity', Rhetorical strategy of 'doing being collaborative or democratic', 'Good, morally adequate psychologist', and 'Positive self-negative other'.

The final extracts selected were based on how well they demonstrated participants' orientation to moral accountability and subsequent justificatory rhetorical work. By doing so, I hoped to demonstrate some of the tensions and moral dilemmas around clinical psychologists' practices with children. It is recognised that my choice in selecting or discarding extracts, will shape the conclusions drawn from this research and that this research is itself socially

constructed.

#### **2.11.4. Analysis**

After selecting the most relevant sections of discourse, I examined each individual extract in greater detail, concentrating particularly on the use of discursive devices that I considered pertinent to understanding the talk-in-interaction.<sup>19</sup> A full account of the analysis is provided in the following chapter.

### **2.12. POSITIONING OF THE RESEARCHER**

Qualitative research should involve a degree of reflexivity about the researcher's personal perspective, and how it may have impacted on the selection of topic and the research process generally (e.g., Burr, 2003). In terms of the development of this study, I was influenced by ideas from critical psychology, philosophy of relativism, and my passion for working with children. These interests grew out of my personal experience prior to starting a professional doctorate in clinical psychology, and were further developed over the course of my training at UEL. During my classes and in discussion with academics at UEL, I also became interested in discourse analysis, particularly discursive psychology, as well as ethnomethodology and conversation analysis, because of their questioning stance to social order and their potential to facilitate deconstructive readings of language.

My experience of working in CAMHS prior to clinical psychology training and also recently on my child placements have fuelled my scepticism about the idea that children's difficulties are best understood as mental illness. I have observed the role of social environments impacting on children's lives, such as poor housing or being victims of neglect and abuse. Yet, it is often individual children in whom the problem is located and who remain the focus of the intervention along with their families. Through these observations, I have become increasingly critical of the medical model, which I think is particularly problematic when applied to children who have the least power in society.

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<sup>19</sup> See appendix eleven for an example of a section of analysed transcript.

My position as a trainee clinical psychologist from the University of East London, and my reason for doing this research as a requirement for my qualification was made explicit in recruitment. While every effort was made not to lead participants' thinking, I recognise that my own stance on the topic may have been conveyed at some level during the interviews, and could have had an impact on the data collected.

In addition, I am aware that my identification with social constructionist and critical approaches to psychology have coloured my approach to data analysis, and that other researchers may offer a different reading of the data. For example, when engaging with the data I became increasingly interested in the ways that ethical issues were oriented to, and managed in, the interaction, which I have sought to demonstrate by the selection of the extracts for the final analysis. However, I hope that by including a variety of quotations, of which some included longer sequences of talk, readers will develop their own conclusions about the data, and give them the opportunity to inspect the conclusions that I have drawn.

## **CHAPTER THREE - ANALYSIS**

In this chapter I present an analysis of the research interviews carried out with nine child clinical psychologists. The chapter starts with contextualising the talk by looking at the participants' orienting to the interview requirements, as well as the professional and personal moral identities<sup>20</sup> within the research interaction. Attention then shifts to the main part of the analysis that examines the strategies of accountability management in talking about practices depicted as potentially problematic.

### **3.1. CONTEXTUALISING THE TALK-IN-INTERACTION**

Several authors have highlighted the importance of delineating the relevant context and identity work in understanding the interview-talk (e.g., Leudar & Antaki, 1996a, 1996b, 1997; Potter & Hepburn, 2012; T. Rapley, 2001). The key

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<sup>20</sup> Identity is not conceptualised here in a traditional psychological sense as a fixed, internal 'entity'; rather, it is understood as a social and fluid construct.

question is, however, how much context is *relevant* and *consequential* for understanding what is going on in the interaction? Such a quandary is profound and difficult to resolve as exemplified by high profile debates on this issue (see Billig, 1999a, 1999b; McHoul, Rapley & Antaki, 2008; Schegloff, 1997, 1998, 1999a, 1999b; Wetherell, 1998).

In the analysis that follows, I will therefore pay attention to what I considered to be arguably the highly relevant and consequential notions of context and identity in understanding the business of talk in this study. To facilitate this task, I will pay attention to varying 'footing'<sup>21</sup> (e.g., Clayman, 1992; see also Goffman, 1981; Levinson, 1988), for example, shifts from 'I' to 'we'. Marking footing can indicate who should be held accountable for the description and any potential inferences. I will also draw on Sacks' (1992) conceptualisation of 'identity' in his work on 'category membership'. Sacks argues that identities are made relevant to a specific setting because of there being certain activities that are understood to get done in that setting. These membership categories are not held to be the immutable properties of people, but rather can be invoked, implied or mentioned within the context of particular interaction, and thus are much more permeable and occasioned. In the situation of this interview, the participants and I could be seen to shift between a range of identities according to the occasioned context of the talk, including the Interviewer + Interviewee, Trainee + Qualified Psychologist, and other possibly relevant identities. It is also of critical relevance that participants and I share the same professional background.

It is also important to be aware of *how* the interview-talk is locally and collaboratively produced by both the interviewer and the interviewee (Leudar & Antaki, 1996a, 1996b; T. Rapley, 2001). I will therefore endeavour to provide relevant context from which the talk was produced, including my turns in so far as the word limit allows. Baker (1997) has noted that interviewers' questions and the membership categories they implicitly invoke in their questions are vital to

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<sup>21</sup> Potter and Hepburn (2005) caution that to define the footing can be a rather complex and complicated task in the interview interaction, as it is sometimes difficult to tease out exactly from what position the speakers are speaking, and consequently there may be different readings and different nuances of, for example, the pronoun 'we'.

producing interviewees' accounts. In the analysis that follows, I will attempt to show how the types of questions I ask invoke different versions of my identity. For example, I will illustrate how my position shifted between doing being a 'facilitative and neutral interviewer' with the aim to encourage talk in a non-leading way (T. Rapley, 2001), and how, at times, as a part of the conversation and as previously used in discursive psychology studies adopting interviews (e.g., Hepburn, 2000, 2001; Potter & Wetherell, 1987; Wetherell & Potter, 1992), I challenged participants' contributions in order to generate a wider range of discursive practices.

### 3.1.1. Orienting to the research requirements

Mazeland and ten Have (1996) argue that interview interaction tends to be organised around three requirements. First, interviewees orient to the fact that their task is to talk about their viewpoints and experiences. Second, interviewees have an awareness that within the interview setting they should provide answers to questions. Third, they understand that their accounts will contribute to a research project, will be used for analysis, and possibly also published. The authors assert that, based on these requirements, interviewees have the complex task of determining the right level of description: reporting their views whilst meeting the interviewer's research needs.

During the recruitment process participants were made aware that the study was being undertaken as a requirement for the researcher's Doctoral Degree in Clinical Psychology at the University of East London, and that their task was going to be to talk about their work with children. The following two brief extracts taken from interview four and five are examples of participants' orientation to the requirements that were placed upon them as part of participating in this research.

#### **Extract 1:** KK/P4:<sup>22</sup> Lines 2518-2519, p. 62

2518 Liz: Is that what you have been looking for?  
2519 Kat: Yeah..((recording stopped))

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<sup>22</sup> KK refers to me, P4 refers to the participant number four.

**Extract 2:** KK/P5: Lines 2129-2133, p. 53

2129 Val: =But, eh (.) I hope there's something there that  
2130 you can work with.  
2131 Kat: Yeah, okay ((both laugh)) I'm sure! Thank you so  
2132 much!  
2133 Val: A pleasure!

Liz's question "Is that what you have been looking for?" (line 2518) and Val's statement "I hope there's something there that you can work with" (line 2129) directly relate to both my identity as the 'researcher' and the academic objective of the research interview. Their turns therefore function to underline the expectations placed upon them as interviewees who were to provide me with the required information. The very fact that Liz asks me to evaluate her performance in this respect reveals of her orientation that I could be somebody who might be in position to evaluate her performance in this interview.

**3.1.2. Orienting to personal and professional moral identity**

Many authors highlighted that interview talk places moral demands on speakers who endeavour to present themselves in a morally adequate light (e.g., Baruch, 1981; Buttny, 1993; Mazeland & ten Have, 1996; Silverman, 1985; T. Rapley, 2001).

In her book the 'Categorization and the Moral Order', Jayyusi (1984) suggested that categories of persons are routinely bound up with moral assessment of performance of the duties that are related to a particular category. She noted that for specific categories, the fulfilment of these duties is a necessary prerequisite for category membership:

"...For some categories X, not only does the displayed lack of competencies provide grounds for saying that a person is either not an X or not a good X...*but further that some categorizations are usable in explicitly moral ways, so that the fulfilment of moral duties and commitments is basic for the assessment of the performance of category tasks* and thus for a person's being constituted as a good X,

which is itself central to the notion of being a *genuine* X, e.g., a good doctor..." (Jayyusi, 1984, p. 44, emphasis in original).

The fundamentally moral nature of psychologists' talk becomes evident in the following two extracts taken from interview number nine, with Cathy, and interview three, with Don. Both participants can be seen to orient to their professional status through invoking the duties of mental health professionals.

### 3.1.2.1. Orienting to professional moral identity

**Extract 3:** KK/P9: Lines 663-665, p. 17

663 Cathy: ... I think at- all mental  
664 health professionals have a role and a duty to  
665 think about what they're doing.

**Extract 4:** KK/P3: Lines 934-935, p. 24

934 Don: =Ehm (.) But also our job, (.) is to keep people  
935 alive (.), [and to] keep them well. (.)

In the above examples, the participants can be seen to orient to their professional incumbency as mental health professionals who *ought to* keep people alive and well (Don's excerpt) and should reflect on their practice (Cathy's excerpt). Participants therefore display their awareness of a set of obligations bound with their professional identity as a 'psychologist' and consequently the moral judgements that may be invoked through the (lack of) fulfilment of those obligations. Within this research interview set up, participants might respond in a certain way to display their commitments towards their clients and their ability to reflect on their practice in order to work up their identity as (morally) adequate practitioners, particularly so if potentially morally disputable issues are evoked.

### 3.1.2.2. Orienting to personal moral identity

In the following extract taken from interview number one, Robert is managing to orient directly to the issue that advocating unethical practices might have implications for personal identity. However, he is doing this in a way that places himself in contrast to his colleague whose practices allegedly are of dubious



moral standing.<sup>23</sup> Such a move allows Robert to show that he knows what the issue is, without any of it being personally relevant to him; indeed he casts himself as a moral crusader on the issue.

**Extract 5:** KK/P1: Lines 2659-2669, p. 66

2659       Kat:        Is it what they say?=  
2660       Robert:    =Yeah  
2661       Kat:        ...or-- [Mmm     ]  
2662       Robert:        [Because], because, I'm a good person!  
2663       Kat:        Mmm.  
2664       Robert:    (.) Yeah? (.) If what you're saying is true,  
2665       Kat:        Mmm.  
2666       Robert:    ...if this is unethical, and I advocate something  
2667                    that's unethical=  
2668       Kat:        =Mmm.  
2669       Robert:    ...then I must be a bad person. (.)

The significance of the above formulation could well be transferred to this interview setting. Accordingly, it could be argued that if the psychologists participating in this interview advocate something that is being interactionally constructed as unethical, then consequently they would risk being seen as bad people. Note that the implications for participants' moral identity are thus far more extensive: not only could they be perceived as *morally inadequate psychologists*, but they could also be seen as *bad people*.

I argue that, in their attempts to rhetorically defend against the potential criticism of being morally inadequate psychologists and bad people, participants are caught up in a dilemma. On the one hand they want to acknowledge and demonstrate their awareness of potential ethical issues in their practice and thus portray themselves as reflective and concerned practitioners. On the other hand, however, this inherently creates trouble for them because their audience knows that they are part of such practices, and therefore they will have to start inoculating and providing justifications for these practices. In other words,

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<sup>23</sup> See appendix twelve for the talk preceding this extract (lines 2634 to 2669).

participants will have to manage their stake and accountability (e.g., Potter, 1996) and the dilemma of how to appear morally adequate whilst talking about contested practices of which they are part. The framing of both professional and personal accountability in terms of a moral imperative sets the scene for the coming analysis.

In the next section, I evidence a number of discursive moves that participants use to deal with talk concerning practices that are depicted as potentially problematic. I will argue that by offering justificatory accounts when talking about sensitive issues arising in talk, the participants simultaneously displayed their orientation to the problematic nature of such practices. These various rhetorical strategies provide a way of organising the analysis. However, it is difficult to keep them strictly separate because in practice they do not form distinct elements within the talk from which they originated, and therefore some of them might be present in other extracts that we examine. Moreover, the following discursive moves are picked out here for particular consideration, as they are recurrent across the corpus of material in this study. There are numerous other devices through which the participants' narrative descriptions, accountability and moral identity work is made relevant interactionally, and to which I will pay attention, including, for example, stake inoculation or avowals of a mental state disposition. These will act to support the main structure of the argument.

As the analysis develops, I will be referring to the relevant literature where possible. This literature has been a very useful guide in my analytic work and also inspired some of the terminology I am using here. Also, it is important to emphasise that I am not suggesting that these strategies are necessarily consciously or deliberately employed to serve a particular purpose. Rather, they are part of culturally available linguistic repertoires and everyday discursive, theoretical, and clinical practice whose origins and effects are rarely questioned (Boyle, 2011; Wetherell & Potter, 1992).

## 3.2. STRATEGIES OF ACCOUNTABILITY MANAGEMENT

### *or doing being morally adequate whilst talking about contested practices of which one is part*

The first conversational move depicted here is the ‘severe end’ rhetorical device. This strategy has been previously described in psychiatrists’ discourses in which decisions about administering electroconvulsive treatment (ECT) were justified (Stevens & Harper, 2007).

#### 3.2.1. The ‘severe end’ rhetorical device

The ‘severe end’ device focuses on the severity and seriousness of the condition to warrant the use of medication. The next extract is taken from interview number four with Liz, which illustrates an explicit orientation to the moral dilemma surrounding the use of medication.

#### **Extract 6:** KK/P4: Lines 2050-2100, p. 51-52

2050 Liz: I’m just thinking about one particular  
2051 young man I worked with who had a diagnosis of  
2052 bipolar disorder,  
2053 Kat: M-hm.  
2054 Liz: ...and I, I saw him (.) through his manic phases,  
2055 and he really was (.) you know, just very, very,  
2056 very unwell, ver- very aggressive, very out of  
2057 touch with reality, very confused,  
2058 Kat: M-hm.  
2059 Liz: ...ehm, behaving in very bizarre ways, and I, I  
2060 could see for him, that, you know, the medication  
2061 he (.) could be given helped him,  
2062 (text omitted)  
2071 Liz: But it was also deeply painful to him that he had  
2072 to be on medication indefinitely, and he didn’t  
2073 want to take it, he didn’t like the side-effects,  
2074 [you know], and (.) and, and I am perfectly  
2075 Kat: [Mmm ]  
2076 Liz: aware that the research is [often] extremely  
2077 Kat: [Mmm ]

2078 Liz: selective, you know, what [gets published],  
2079 Kat: [M-hm ]  
2080 Liz: and what gets funded,  
2081 Kat: Mmm=  
2082 Liz: =gives a very distorted [picture of] what's  
2083 Kat: [M-hm ]  
2084 Liz: (.) useful.  
2085 Kat: Mmm=  
2086 Liz: =...and, so, I, I can't unreservedly say that [I'm]  
2087 Kat: [Mmm]  
2088 Liz: (.) glad he takes his medication, I [feel]  
2089 Kat: [Mmm ]  
2090 Liz: uncomfortable, [and I] feel=  
2091 Kat: [Mmm ] =And yet, it sounds  
2092 like he still needs to take the medication=  
2093 Liz: =Well, you know, if he's not gonna be (tearing)  
2094 around naked (.) attacking people, wh(h)ich i(h)s  
2095 wh(h)at h(h)e d(h)id,  
2096 Kat: Mmm.  
2097 Liz: ...before he took it, then, yeah!  
2098 Kat: Mmm.  
2099 Liz: Yeah! Absolutely! But it's, it's, it's a deep  
2100 moral problem,

Liz's first turn occurred in the context of discussion about the practices of diagnosing and medicating young people that are common in the adolescent inpatient unit where she works. She offers a particular example from her clinical practice, in which she accounts for the use of medication as a helpful way of managing the young person's presentation. She does this by constructing this young man as having a "diagnosis of bipolar disorder", who she "saw" through his "manic phases" and who was "very very, very, very unwell, ver- very aggressive, very out of touch with reality, very confused, behaving in very bizarre ways" (lines 2051-2059). Liz uses a number of extreme case formulations (Pomerantz, 1986) to indicate the abnormality of this young man's presentation. Note that the word "very" is used nine times in one sentence. Liz can also be seen to use the strategy of reification (Potter, 1996) to construct the abstract notion of bipolar

disorder as a witnessable set of anomalous symptoms and socially undesirable behaviours, thus evoking its significance as 'real' signs of mental disorder.

Liz then moves back to the other side of the argument and displays empathy with the young man's predicament ("it was deeply painful to him that he had to be on medication indefinitely, and he didn't want to take it, he didn't like the side-effects" (lines 2071-2073). She goes on to argue that she is "perfectly aware" (line 2074) of problems with research, which is given particular emphasis through her stress on the word "perfectly", enabling Liz to display her awareness of the controversy surrounding the evidence of the benefits of medication. This, together with appeals to her personal discomfort of feeling "uncomfortable", allows Liz to portray herself as a reflective, sensitive and concerned practitioner whilst at the same time enables her to justify the use of medication against the young person's will. Note that avowals of a mental state disposition, in this case 'uncomfortable feelings', is an effective rhetorical strategy for establishing the veracity of the speaker's account, particularly in situations where there is moral credibility at stake (Edwards & Potter, 2005).

In lines 2091-2092 I can be seen to make what appears to be the contrast between Liz's personal views and the reality of the practice she describes explicit, by saying that despite her concerns it seems that "he still needs to take the medication". Such a comment is hearably challenging and latched onto by Liz's "Well" followed by appropriate justification. 'Well' signals the classic conversation analytic 'dispreference' pattern, in which a response that is interactionally dispreferred, for instance declining an invitation, is preceded by 'well' (Levinson, 1983). This is followed by "you know", which appeals to intersubjectivity (Edwards, 2003) and implies that what is to follow is something knowable to both Liz and myself; that is: "if he's not gonna be tearing around naked, attacking people, which is what he did", then it logically follows that he will need to take the medication. Note that tearing around naked invokes inappropriate sexualised conduct in public, whilst the second example of attacking people invokes risk and dangerousness to others, further highlighting the abnormality of the behaviour and makes sectioning and forced drug treatment reasonable. In addition, Liz 's emphasis that these behaviours "did" (line 2095)

happen suggests that these are not just made up examples, thus helping to bolster the factuality of Liz's account.

Of interest is a continual dilemmatic movement in the speech between the narrative of medication being morally controversial and a narrative of medication being necessary to manage extreme behaviours and states of mind. Such a flexible account presents Liz as the kind of person who can see both sides and who can question her own practice. It thereby attends to the problem of how to appear sympathetic to her clients and morally adequate within the research interview while providing justification for contested practices of which Liz is part.

The second example concerns justifying the use of medication with the same 'severe end' rhetorical strategy, but this time to manage the conduct of the child diagnosed with ADHD. Just prior to this extract, Cathy and I started to debate ADHD diagnosis and the use of medication in children.

**Extract 7:** KK/P9: Lines 2340-2346, p. 58

2340 Cathy: ...you have a child who's very difficult to  
2341 parent". And they [are]. They come in here,  
2342 Kat: [Mmm] M-hm.  
2343 Cathy: -- Ehm, I had a child who literally climbed that  
2344 bookcase and was hanging off the top,  
2345 Kat: Mmm=  
2346 Cathy: =...and tried to throw my phone out the window,

The extract starts with Cathy's account of what she would say to the parents of the child with a diagnosis of ADHD. Of interest is how Cathy constructs the child in this account: "you have a child who's very difficult to parent" (line 2340). This construction is a noteworthy formulation in that it absolves parents' blame, warrants medication and inherently locates the problem and responsibility or blame in the child. In lines 2343-2346 Cathy can be seen to mobilise the severe-end rhetorical device. Cathy provides a vivid description of a child who "literally climbed that bookcase", "was hanging off the top" in the consulting room and "tried to throw [her] phone out the window". Such descriptions support the 'literal' observable factuality of evidence of this child's undoubtedly unmanageable, risky and socially inappropriate behaviour. Hence the need for medication is warranted

to take the edge off the symptoms, as in fact claimed by Cathy herself in her talk prior to this extract in lines 2197-2199, p. 54: "...you could hypothesise, that if there is the medication that takes the edge off these symptoms, no matter where they've come from...". On the whole, Cathy could be seen to present herself as sympathetic and understanding of the parents' concerns, although the child's position seems to be neglected in this account.

To summarise the analysis of the two extracts above, the children's presentations are constructed as so extreme, risky or totally uncontrollable that the treatment by medication is strongly warranted. The above accounts are also powerful in their effects of portraying the speakers as concerned but pragmatic.

### 3.2.2. Minimisation

This section concerns the minimisation of the problem of diagnosing children. We start with the extract taken again from interview number nine with Cathy, which follows soon after Extract 1. Having previously asked Cathy what makes the problem in need of psychological input, she precedes this extract with her talk about how hard it is not to locate problems in children "and to not get fixated on diagnosis" (line 678).

#### Extract 8: KK/P9: Lines 678-728, p. 17-18

678 Cathy: ...and to not get fixated on di-- Diagnosis is not  
679 a big thing in this team.  
680 Kat: Do you have to diagnose, then, or you don't have  
681 to?  
682 Cathy: We have to do it on RIO, which is the electronic  
683 system=  
684 Kat: =Mmm.  
685 Cathy: Ehm, it's a, it's a Trust requirement,  
686 Kat: M-hm=  
687 Cathy: =...but we don't necessarily do it with the  
688 Kat: M-hm  
689 Cathy: families, and quite often we'll look for the  
690 lowest-level diagnosis to put on the system,  
691 Kat: Mmm.

692 Cathy: ...and put it as a query.  
693 (text omitted)  
719 Cathy: =And we've been promised that it's not used for  
720 anything other than commissioning and looking to  
721 see (.) where it is, it's not [something] that  
722 Kat: [Mmm ]  
723 Cathy: follows the child around,  
724 Kat: Right.  
725 Cathy: ...or that is, ehm, identifiable,  
726 Kat: Mmm=  
727 Cathy: =...on, on any other records. And it's not  
728 something that we send to outside agencies.

This extract starts by Cathy claiming that “diagnosis is not a big thing in [their] team” by which she can be seen to be orienting to the possible undesirability or unpopularity of diagnosing in her team, and thus marking her potential disagreement with diagnosing children. Such a statement also implies that her team might choose not to diagnose and consequently if they do so, then it is because they are required to. This understanding seems to be taken up by me in the next turn, in which I query whether or not they “have to diagnose” (lines 680-681). Note that whilst this question provides some sympathetic and non-accusatory features (“have to” invokes organisational requirements thus rendering Cathy not specifically accountable), at the same time it also presents potential trouble for Cathy: that she is doing something she seems to disagree with. In her response in line 685, Cathy in fact stresses that this is a “Trust requirement”, thus not only making it explicit that she is bound by these constraints but also staying on the safer side in terms of personal accountability (Hepburn, 2000). Appealing to the institutional demands has been one of the most frequently used discursive strategies to manage one's stake, which will be described under the ‘redirecting the accountability’ strategy later. Moreover, in the discussion section I will be looking at how this rhetorical device reveals the broader institutional dilemmas in which these psychologists find themselves. Mitigating one's moral culpability can also be done by means of footing, i.e., Cathy's use of institutionalised “we” throughout this extract, which makes us aware that even if she was to be accountable for practicing diagnosing, she



would not be alone. Moreover, such a footing might signify her professional membership category of concerned yet institutionally loyal employee.

To further manage her accountability, Cathy goes on to assert that they “don’t necessarily do it with the families” (line 687-689), which not only implies some kind of bureaucratic necessity of diagnosing rather than its actual clinical usefulness, but it also makes us aware that clients might be given a diagnosis without their awareness. Cathy further claims that they “often look for the lowest-level diagnosis” (line 690), which indicates a common activity of assigning what sounds like the least detrimental or pathological marker possible, and consequently possibly a less harmful form of this activity. Finally, in line 692 she claims that they “put it as a query”, implying uncertainty and reservation with regards to applying specific diagnostic categories.

In the remainder of this extract, Cathy can be seen to continuously orient to the diagnosing as a negative activity, whilst minimising her accountability in taking part in such an undesirable practice. In lines 719-728 Cathy invokes a “promise” given to her team that the diagnosis is “not used for anything other than commissioning”, “it’s not something that follows the child around or that is identifiable”, “and it’s not [sent] to outside agencies”. This list of concerns calls upon Cathy’s own special actions taken along with her colleagues to ensure that the diagnosis does not have a negative impact, which might have been otherwise inferred if Cathy did not offer her reassuring account. This suggests a careful acknowledgement of the ‘toxicity’ of diagnosis in terms of its impact on children’s lives and futures, including the fact that certain diagnoses stay with people forever. However, these potentially detrimental effects are at the same time minimised and rendered as already prevented. On the whole, such a discursive construction helps Cathy present herself as a sufficiently concerned practitioner who is actively trying to protect children from the negative impact of diagnosing thus also serving to work up an identity of a morally adequate psychologist who does not wish to pathologise children and their families.

The following extract that comes from interview number eight with Mary is another example of the minimising rhetorical strategy.

**Extract 9: KK/P8: Lines 556-567, p. 14**

556           Mary:   ...I would give them, ehm, (.) there's, there's  
557                        certain codes on ICD-10 that we can put into the  
558                        system, which count as a diagnosis, wh- but are  
559                        less, like, specific. So they might be things,  
560                        like,  
561           Kat:       Mmm.  
561           Mary:   ...ehm, (.) ((in a softer voice)) I can't remember  
562                        the exact terminology, ((resumes usual tone of  
563                        voice)) [but like, relationship] difficulties  
564           Kat:               [M-hm, mm, mm                ]  
565           Mary:   [within] the family or something  
566           Kat:       [Mmm     ]  
567                        So [I put that down],

In lines 558 to 559 Mary goes on to suggest that she would put “less specific” codes, “which count as a diagnosis”. Hence, similar to Cathy and several other participants, Mary can be seen to downplay the problems associated with diagnosing, and by doing so, she implies that there is an issue with such a practice. Although in vague terms, Mary furthermore invokes the psychosocial (“relationship difficulties within family” in lines 563-565), rather than medical concepts, perhaps orienting to desirability of displaying her awareness of the importance of relational as opposed to biomedical explanations for children’s distress. On the whole, by employing a minimising strategy she inevitably engages in a moral accounting for her actions, and provides an image of good intentions, even though the organisational constraints may lead to a more problematic practice.

In summary, the two examples above illustrate the employment of a minimising strategy that attends to the issue around diagnosing children while softening it by constructing it in a less problematic and safer manner.

### **3.2.3. Normalising techniques**

This section presents a collection of discursive moves that could be loosely encompassed under the umbrella of normalising techniques. The first strategy is

routinisation that, according to Locke and Edwards (2003, p. 245), is a robust rhetorical pattern, where the notion that one is specifically accountable for an action which requires a reason or account, is resisted by defining that action as everyday, ordinary or habitual. In this case, routinisation serves to downplay the debate about diagnosing children by suggesting that despite the apparent initial hesitation or possibly even reluctance, the need to diagnose eventually comes with more experience.

### 3.2.3.1. Routinisation

#### *or the need to diagnose comes with more experience*

The next passage of talk occurred early in the interview with participant five, Val, and follows on from our conversation about the various presentations of children coming to her service.

#### **Extract 10:** KK/P5: Lines 92-115, p. 3

92 Val: ...ehm, and they'll be referred to us, so we can  
93 explore that in more detail. Ehm (.) And for  
94 somebody who is quite new to the service, eh (.)  
95 I think I started off being quite, ehm, (.)  
96 finding it hard to accept that these children may  
97 have autism or that it may be diagnosable, at  
98 such a young (.) [age], and, perhaps, wanting to  
99 Kat: [Mmm]  
100 Val: (.) deflect or ignore some of the symptoms,  
101 Kat: Mmm=  
102 Val: =...that I was seeing, because (.) it's (.) it's-  
103 it was quite (.) tempting to, kind of, say "Well,  
104 this child is just a little bit delayed, and  
105 maybe they'll come to it later". Sometimes  
106 [it's quite] hard to see those, those things.  
107 Kat: [M-hm ]  
108 Val: But, a,as I've become more experienced in the job  
109 and working, ehm, working with more children,  
110 seeing for myself different behaviours, and  
111 a,approaches from different children,

112           Kat:     M-hm.  
113           Val:     ...it's just become easier to see some very  
114                    specific behaviours that might be (.)  
115                    [attributable] to autism.

Val works up her identity as someone who initially found it “hard to accept that children may have autism or that it may be diagnosable, at such a young age” (lines 95-98) and who “perhaps, want[ed] to deflect or ignore some of the symptoms” (lines 98-100). Note that the avowal of the person’s mental states, in this case Val’s “wanting”, can help in building up the factual plausibility of the person’s account (Edwards & Potter, 2005). Here, it perhaps helps Val work up her identity as someone who does not wish to pathologise children, thus securing her moral credentials.

What is interesting then is what appears to be a shift from ethics to competence: the above narrative is followed by “But” in line 108 and the story that seems to start justifying the very same practices that Val previously found difficult, and which are now constructed as something that “just became[s] easier to see” (line 113) with more practice. The phrase ‘I used to find it hard to diagnose, *but* as I’ve become more experienced..’ is reminiscent of Wooffitt ‘s (1992) ‘I used to be sceptical, but experience of the alien abduction has led me to think...’. This is a type of a stake inoculation (e.g., Potter, 1996) in which Val could have been avoiding criticism for pathologising children by diagnosing them at such an early age. As Edwards (1997) pointed out, the preceding scepticism is crucial, in that it:

“sets up the recommendation as unprejudiced, based on experience, and indeed counter to prior expectations. The speaker is constructed as a common-sense reasoner who was initially sceptical, just like the listener, not disposed to thinking such things, but forced to do so by experiential evidence. That is, the speaker is interactionally sensitive to grounds for doubt and attributional issues of accountability both in the reported events and their reporting” (p. 73).

Indeed, Val produces such experiential evidence by offering a first-hand account of how she was “working with more children” (line 109) and “different children” (line 111), implying a large proportion of children and thus making it sound more

reliable, and “seeing for [her]self different behaviours” (line 110) suggesting that Val had seen these behaviours with her own eyes thus building up the undeniably factual nature of her experience, which is consequently hard to deny. Although not the main focus in this analysis, here again, as largely throughout the dataset, the strategy of ‘reification’ is used (Potter, 1996) to conceptualise abstract concepts of mental disorders in children as concrete, material things, as something the children can ‘have’. Accordingly, it can be argued that the whole account acts in support of the diagnostic practices whilst allowing the speaker to present herself as a concerned, competent and morally adequate psychologist.

### 3.2.3.2. Renegotiating, re-categorising or re-defining

This normalising strategy functions to re-define potentially contested practices as something less negative and less problematic (Wetherell and Potter, 1992). The next extract taken from the interview with Robert provides an example of this strategy. Here the issue at hand is (not)problematizing children who find themselves in individual therapy.

#### **Extract 11:** KK/P1: Lines 2024-2040, p. 50-51

2024 Robert: Although I don't (.) ((clicks fingers)) ehm (.) I  
2025 don't problematise it. (.) [So I don't] (.) I  
2026 Kat: [Mmm ]  
2027 Robert: don't (.) encounter them, I think, with the sense  
2028 that “You've got a problem, and I'm here to help  
2029 you with it”,  
2030 Kat: But you're still seeing them, aren't you?  
2031 Robert: ((a bit louder than usual)) Yeah.  
2032 Kat: Mmm=  
2033 Robert: =Well, usually, they like seeing me.  
2034 Kat: M-[hm ]  
2035 Robert: [...because] (.) we have good fun,  
2036 Kat: M-hm=  
2037 Robert: =...because they get to choose stuff, [and because]  
2038 Kat: [M-hm ]  
2039 Robert: they're probably not doing something else that  
2040 they would rather not do.

In lines 2028 to 2029, Robert talks about how he does not encounter children with the sense that “You’ve got a problem, and I’m here to help you with it.” Although Robert inserts “I think” in line 2027 which, according to Latour and Woolgar (1986), is considered to be a provisional and ambivalent statement, compared to the more factual statements such as ‘X is a fact’. The effect of the whole account nevertheless can be to display Robert’s reluctance to problematise or pathologise children, and thus to facilitate a portrayal of him as being a non-prejudicial, non-judgemental and moral psychologist. However, what this claim simultaneously does is expose an inherent contradiction: If Robert does not see children as having problems and his role as helping them, then why does he see children individually in his everyday practice? This dilemma is in fact taken up by me in my next question “But you’re still seeing them, aren’t you?” (line 2030), which can be hearably challenging due to the above reasons, and so might create potential trouble for Robert because it invites him to admit that what he says, or what he would like to do, contradicts what he does. In addition, “aren’t you?” is a form of a tag question that treats the recipient as already knowledgeable about the content of the statement (Edwards, 2003).

Robert indeed displays his awareness of this by his agreement (“Yeah” in line 2031) and deals with this challenge by saying that children “like seeing [him] because [they] have good fun, and they get to choose stuff” and because it is probably more convenient than “doing something else that they would rather not do” (lines 2033-2040). Robert therefore can be seen to respond to the trouble in my question by constructing and reframing his practice as something that is a positive activity for children, implying not only harmless consequences, but also fun and the opportunity to avoid something unwanted or dreary. Such a reframe might function to de-problematise this paradox, and package the activity of children being seen regularly for individual therapy even if the psychologist allegedly does not perceive them as a problem as far less problematic but indeed enjoyable.

The next excerpt of talk, taken from interview six, was preceded by a debate about Zoe’s experience of how children understand being in therapy. Just prior to this extract, Zoe talked about how she explains the therapy set up and her role to

her young clients.

**Extract 12: KK/P6: Lines 1488-1585, p. 37-39**

1488 Zoe: you know, [not trying] to be a psychologist,  
1489 Kat: [Mmm ]  
1490 Zoe: almost. Just as if I'm somebody that's, kind of,  
1491 meeting somebody new.  
1492 Kat: Mmm.  
1493 Zoe: ...ehm, [because ]  
1494 Kat: [And what] are their responses? [How do]  
1495 Zoe: [Ehm ]  
1496 Kat: they understand that?  
1497 Zoe: (.) How they understand what they're here for?=  
1498 Kat: =Yeah, and that-- [Yeah]  
1499 Zoe: [Yeah]. I mean, th,the-- It  
1500 varies, because it [varies what]-- I mean,  
1501 Kat: [Mmm ]  
1502 Zoe: a lot of children will come here and their  
1503 parents haven't even told them where they're  
1504 coming on the day.  
1505 (text omitted in which Zoe was describing how she  
1506 always starts with asking what the children want  
1507 to do to engage them)  
1576 Zoe: Most-- It is very much an age-related thing. I  
1577 find most of the younger children I work with,  
1578 they really like coming, and they sort of think  
1579 ["Oh ]  
1580 Kat: [Younger] children?  
1581 Zoe: Yeah, [you know], "...it's just my time to play,  
1582 Kat: [Uh-huh ]  
1583 Zoe: with <interviewee's name>, [and to sort of do]  
1584 Kat: [Uh-huh, u,uh-huh ]  
1585 Zoe: stuff".

We enter at the point in which Zoe explains that she is “not trying to be a psychologist almost” (line 1488) and thus can be seen to work up a more generic, ordinary and informal membership category, namely “*somebody* that’s meeting

*somebody new*” (line 1490-1491). By casting both herself and a child as “somebody”, Zoe evokes a more symmetrical power relationship between the psychologist and the child in therapy, which works as a normalising conversational move in accounting for the potentially problematic practice (Hepburn, 2000); in this case, children possibly not consenting to therapy and not knowing why they are seeing a psychologist. It also appears that the ‘psychologist’ identity is potentially problematic in this account and that de-roling seems to be a way out.

Zoe can therefore be seen to be producing a ‘backstage’ talk of what Sacks (1992) described as a device of ‘cover identities’ or ‘doing being ordinary’. This device has been subsequently depicted in several DP studies (Antaki & Rapley, 1996; McHoul & Rapley, 2002; Rapley 2004) that have analysed the naturally occurring talk from therapeutic encounters between therapists and their patients. This research has demonstrated how the rhetorical strategy of ‘cover identity’ is employed to ‘cover’ ‘PSYCHOLOGIST + CLIENT/PATIENT identities in preference to ‘NOT-PSYCHOLOGIST + NOT-CLIENT/PATIENT’ and ‘FRIEND + FRIEND’ identities. This research suggests that one of the functions of such a device is to promote engagement by concealing the official business agenda in meeting the mental health practitioner, which is to undertake a formal assessment to ascertain evidence for mental disorder, for which a person would need ‘expert’ treatment.

This discursive strategy might have an important function not only in the actual therapeutic encounter that Zoe describes, but also within the interaction in this research interview. Here it seems to help Zoe display herself as a friendly clinician who tries to make the therapeutic encounter a less threatening and more positive experience for children, and therefore effectively avoiding the conclusion that could otherwise be inferred about the reported situation being a scary and distressing experience for children, given that they attend therapy without their awareness and thus consent, and therefore raising the issue of ethics.

Furthermore, similar to the extract above, the children’s unawareness of why they are in therapy gets reworked as a positive experience for them: “they really like coming” (line 1578), and they think: “Oh, it’s just my time to play” (line 1581). The



insertion of the word “just” could serve to further downplay the problematic nature of this situation. Note that the children’s positive experience of being in therapy is presented as an allegedly first-hand account and thus given particular emphasis through the use of a powerful device of direct reported speech (Woofitt, 2005) in lines 1581 to 1585.

What is also striking is the systematic vagueness throughout the extract, e.g., “I’m somebody that’s, kind of, meeting somebody new” (lines 1490-1491), “It varies, because it varies what-- I mean” (lines 1499-1500) or “to sort of do staff” (line 1583-1585), which might further help minimise the significance of what is being described. Edwards and Potter (1992) suggest that such vague formulations are difficult to challenge because although some account was offered, the details do not need to be necessarily delineated thus protecting Zoe from potential criticism if something inappropriate was to be said.

To summarise, in the section above we have seen how psychologists worked to reframe a potentially contested issue of children being in therapy without their consent and when they are not seen as a problem. This allows psychologists to manage the moral predicament they are caught in, and to construct their actions as well as reports of their actions as less problematic. Moreover, these respecifications can work as ‘normalising techniques’, thus, in line with Billig’s (1992) findings, they can work to ‘settle’ potential troubles. This also seems to reveal something about the institution and its traditional ways of practicing in the form of individual therapy with children, which might consequently pose dilemmas for the psychologists who might disagree with such practices.

#### **3.2.4. Doing being democratic or liberal arguments for illiberal ends (Augoustinos & Every, 2007)**

This section focuses on another discursive move, ‘doing being democratic’, which has been documented in a political and racist discourse by a number of authors, including Tileaga (2010), Augoustinos and Every (2007), and Wetherell and Potter (1992). This strategy will be demonstrated separately to the one that follows it (Maxims of practical politics), although it is recognised that they are closely related and work to achieve the same ends in interaction. That is, they both invoke liberal arguments in situations that usually involve illiberal ends, and

thus serve to build up the moral adequacy of psychologists in talk around a variety of sensitive topics.

According to Wetherell and Potter (1992), language does not need to be overtly discriminatory in order to generate oppressive effects. Based on their study of racist talk, they go on to argue that discursive practices that in fact eliminate explicit signs of discrimination in favour of liberal arguments of individual rights, choice and freedom have considerably more rhetorical power in justifying discriminatory practices and the current state of affairs. In the next two extracts, I illustrate the deployment and effects of typical liberal democratic principles of freedom and choice in psychologists' talk about contested issues in their work with children.

Here the conversation is about diagnosing children. We join the conversation at the point when Joan produces a reported speech of what she would say in her practice to a parent.

**Extract 13:** KK/P7: Lines 1892-1914, p. 47

1892 Joan: ...you know, we always (.) are very clear, "It's  
1893 your choice, whether you think that's something  
1894 you would like your child (.) to have  
1895 [as a label, if you think ]  
1896 Kat: [Oh, I see. so they don't have] to be [labelled]  
1897 Joan: [No ]  
1898 Kat: if they [don't want] to. Because different  
1899 Joan: [No ]  
1900 Kat: services (.) do need to (.) [diagnose]. [So] in  
1901 Joan: [No ] [No]  
1902 Kat: here you don't have to?  
1903 Joan: Well, we have to (.)- [i,it]-- There's a (.)  
1904 Kat: [Yeah]  
1905 Joan: a,an anomaly, in that something has to be put  
1906 down for the commissioners on the computer, (.)  
1907 [about- ]  
1908 Kat: [For everyone?]  
1909 Joan: For everybody, something that-

1910                           but [there are] various psychological categories  
1911                           that you can use, and  
1912           Kat:       Mmm.  
1913           Joan:     ...and X axis categories, where you can say  
1914                           `context-related difficulties`,

In lines 1892 to 1895, Joan begins her account with constructing the process of diagnosing as something that is the parents' "choice" whether they "would like [their] child to have as a label, if [they] think", which is something that the professionals are "always" "very clear" about, thus providing an image of democratic environment, even though, as it later becomes clear, the institutional requirements may paint a rather different picture. Note the use of the extreme case formulation "always" to establish the perennial character of what Joan and her colleagues would say in a particular situation.

Joan's democratic construction of the process of diagnosing as something that parents can decide themselves implies that not every parent might want a diagnosis for their child, and so, accordingly, one would expect that the diagnosis would then not be given. This formulation is met with my somewhat surprised reaction and questioning whether their service does not need to diagnose (lines 1896-1902) given the increased pressure on services to diagnose. With an initial series of "No" statements across lines 1897 to 1901 that appear to cement the idea of choice and deny anything other than democratic conclusions, Joan later produces a statement of "well we have to" (line 1903), which then creates a paradox and a potential difficulty for Joan, since it seems to undermine her initial formulation that diagnosing is the parents' choice rather than the necessary requirement of the psychologist's job to give a diagnosis, as it turns out, to "everybody" (line 1909).

As a way of dealing with this situation, Joan can be seen to draw on the same strategy used by the other participants previously, that is, minimisation, with the effect to downplay the problem with compulsory diagnosing by regarding it as a mere administrative task done "for the commissioners on the computer" (line 1906). This suggests that the parents' choice in the therapy room would not be affected and the notion of democracy can be resumed.

### 3.2.5. Maxims of practical politics (Wetherell & Potter, 1992)

Drawing on Wetherell and Potter's (1992) analysis of political discourse about race and Billig's (1992) concern with common sense and political legitimacy in his analysis of talk about the royal family, I will look at the 'maxims of practical politics', also referred to as 'rhetorical commonplaces' (Billig, 1996), which function as self-sufficient arguments that require little elaboration or explanation due to their taken-for-granted quality. Wetherell and Potter (1992) identified ten such commonplace arguments<sup>24</sup> that were typically deployed in political discourse, such as 'you have to be practical', which on their own seem reasonable enough, but in a particular context might provide a warrant for the adoption of discriminatory policies.

This section focuses on two maxims - 'Nobody should be compelled' and 'You have to be practical' - in accounting for two controversial areas of clinical practice: the issue of children (not)consenting to therapy and the question of (not)dealing with families' social problems.

#### 3.2.5.1. Nobody should be compelled

*or I've never tried to shut anybody in my room...*

In the following extract taken from interview number two, I can be seen to initiate a topic of what I assume to be an inherent power imbalance in the therapeutic relationship between Fran and children. This is followed by my question "How do you work with that?" (line 1017), which works to present me as an open-minded interviewer (T. Rapley, 2001) who aims to facilitate the interviewee's account about this sensitive topic.

#### **Extract 14:** KK/P2: Lines 1013-1039, p. 26

1013           Kat:       Mm, mm, mmm. Okay. Right. I mean, there clearly  
1014                            is a (.) power difference, between you and, eh,  
1015                            and children [that you're] working with. Eh,  
1016           Fran:   [M-hm            ]  
1017           Kat:        how do you work with that?  
1018           Fran:        I think there's a power difference in every

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<sup>24</sup> See appendix thirteen for Wetherell and Potter's (1992) Maxims of practical politics.

1019 relationship.

1020 Kat: M-[hm ]

1021 Fran: [Ehm], and because I think that, I guess I'm

1022 always aware that there's a power difference. I

1023 mean, with children, there's an obvious one. You

1024 [know]. It's made worse, by the fact that they

1025 Kat: [Mmm ]

1026 Fran: probably ((in a softer voice)) haven't chosen to

1027 come here. So I do spend time on - as I said at

1028 the beginning - why they've come,

1029 Kat: M-hm.

1030 Fran: ...eh, whether they want to be seen. Ehm, I always

1031 say that the door's open, I've never (.) tried to

1032 shut anybody in my room, I know that different,

1033 (.) ehm, disciplines do different things around

1034 that, but I

1035 Kat: Mmm=

1036 Fran: =...don't believe anybody should be made to stay,

1037 Kat: Mmm=

1038 Fran: =...don't believe that anybody should have to have

1039 mental health intervention.

Fran initially responds by stating that “there’s a power difference in every relationship” (line 1018-1019), which has the effect of normalising the power relations. She then, however, goes on to repair this formulation by showing her awareness of, and concern about, this potentially being an issue, and by stating in lines 1022 to 1023 that she is “always aware that there’s a power difference” which is more “obvious” with children because they “probably haven’t chosen to come”. To frame something as potentially compulsory is rhetorically undesirable from the current societal liberal discourse of freedom and human rights (Wetherell & Potter, 1992), and although such a statement works to display Fran as a good, reflective psychologist, it also requires her to subsequently justify the potential moral accountability related to seeing children who might not want to be seen. To manage this, Fran can be seen to be ‘doing being democratic’ by saying that she spends time asking children “whether they want to be seen” (line 1030),

implying that children have a say in decision-making around receiving psychological input.

Of particular interest is the subsequent justificatory account that formulates what can be recognised as a classic version of the maxim of ‘nobody should be compelled’, specifically that: “the door’s open”; “I’ve never tried to shut anybody in my room”; “I don’t believe anybody should be made to stay”, “I don’t believe that anybody should have to have mental health intervention” (lines 1031-1039).

Fran’s account is made plausible further through a mental disposition avowal “I don’t *believe*” that signals her personal moral reasoning behind her actions, and through using the extreme expressions “always” or “never” (Pomerantz, 1986). All of these devices assist in cementing Fran’s identity as a concerned, well-meaning practitioner who despite the circumstances is able to practice in morally adequate ways.

Another interesting feature of Fran’s talk is her statement in lines 1032 to 1034 “I know that different disciplines do different things around that, but I...”, which is a rhetorical device that has been described by Augustinos and Evere (2007) who termed it ‘positive self and negative other presentation’ (p. 129). These authors argued that this strategy is commonly applied in elite and particularly political speeches because of its usefulness in bringing off a criticism and re-directing accountability to others by presenting self in a positive light, whilst the other in a negative light.

#### 3.2.5.2. You have to be practical

##### *or you have to accept the limitations of what you as a psychologist can do*

Cathy’s turn occurred in the context of our discussion about the wider social issues that impact on the families.

#### **Extract 15:** KK/P9: Lines 2475-2495, p. 61

2475 Cathy: ... And there are limitations,  
2476 on what work you can do, when there’s all this  
2477 wider,  
2478 Kat: Mmm.  
2479 Cathy: ...stuff going on. [So if] somebody lives in a

2480           Kat:   [Mmm ]

2481           Cathy: council flat, and their door's being broken down,

2482   (text omitted)

2491           Cathy: ...you know. ((resumes usual tone of voice)) At--

2492   When you've got all of this going on,

2493           Kat:           Mmm.

2494           Cathy: ...(.) i, it- y, you have to accept the limitations

2495   of what you as a psychologist can do,

In this extract, Cathy directly orients to the social problems that people who come to consult her face in their lives, and thus displays herself as a reflective and concerned practitioner. However, at the same time she reiterates twice (lines 2475-2476 and lines 2494-2495) that, as psychologists, we have to accept the limitations of what we can do. Such a pragmatic realism appreciates and emphasises the practical constraint on action and invokes the commonsensical causal explanation that not only takes for granted the assumption of what psychologists working in CAMHS do (and crucially what they do *not* do), but it also seems to close down any potential enquiry that this state of affairs is open to question or change. The power of such a statement is in its very explicitness of the reasonableness of a psychologist not dealing with people's troubling environments and the wider social contexts. Employing the maxim of practical politics therefore is an incredibly effective strategy in that the reasonableness of such statements appears to justify both moral and clinical accountability for *not* taking actions. Thus again, the production of idiomatic formulations trades on their robust and hard-to-deny properties.

### 3.2.6. Redirecting the accountability

This discursive strategy serves to redirect accountability to another group of people or the institution, and to carefully distance oneself from any potential moral implications (Wetherell & Potter, 1992). In the next extract, Zoe's first turn occurs in the context of discussion about the use of diagnostic language.

#### **Extract 16:** KK/P6: Lines 990-1105, p. 25-28

990           Zoe:           we (.)-- I suppose, ((breaths out)) the reason

991   we look at normal and not normal - we don't do it





**Extract 17:** KK/P9: Lines 855-863, p. 22

855           Kat:       In this case, would it help, to give a diagnosis  
856                           of depression, you think?  
857           Cathy:   It depends. Some-- I mean, some (.) some  
858                           teenages- teenagers come  
859           Kat:       Mmm.  
860           Cathy:   ...and they tell me "I'm (.) totally depr(h)essed".  
861                           [They al]ready use (.)  
862           Kat:       [M-hm    ]  
863           Cathy:   [they already use the language] ((laughs))

Following my question in lines 855 to 856, through which I endeavour to present myself as a 'neutral' questioner (T. Rapley, 2001) and I can be seen to invoke my identity of an active interviewer who elaborates on Cathy's previous account and invites her to express her opinion on the helpfulness of giving a diagnosis in a particular case that she discussed just prior to this extract. Cathy first replies "it depends" (line 857), which is a flexible resource in that it can be used as a response to any challenging question leaving both possibilities open: it acknowledges that sometimes it might or it might not be helpful to give a diagnosis of depression, thus offering protection from potential criticism if a more specific claim was offered.

In her subsequent account, Cathy further appears to avoid a more detailed response. Rather, in lines 857 to 860, she goes on to invoke "some teenagers", her clients, who "already use the language" and tell [her] that "[they are](.) totally depr(h)essed". Note that this account is given particular emphasis through the use of direct reported speech and emphasised words. Holt (1996) has proposed that direct reported speech frequently serves to dramatise accounts and to construct them as more vivid and plausible, and is regularly employed when it is important to produce evidence of what someone else said. On this occasion it could be argued that the device functions to accentuate Cathy's construction of some of her 'clients' being those who initiate the use of medical terminology, rather than her. This enables her to situate the potential problem largely with them, and consequently further minimise her accountability and cement the membership category of a good psychologist. Hence, the ability to construct

something as coming from 'clients' is useful when issues of accountability arise.

### 3.2.6.1. Invoking of institutional demands

#### *or we diagnose because we have to*

One particular type of redirecting the accountability is the invocation of the institutional context. A similar rhetorical device has been detailed by Hepburn (2000) in her study examining the way teachers deal with an implied accusation that they were bullying pupils. She demonstrated how an appeal to the institutional demands of the job and invoking the 'general setup of the school' offered a justification for teacher bullying and enabled teachers to distance themselves from being held accountable for reported intimidation. Such a strategy has been less explicitly employed and already described in some of the extracts above, in which the participants used the institutionalised 'we' as footing that provided them with a less self-threatening position on occasions that might have been problematic to personal or professional identity. In the following final extract, I will offer one more illustration of a direct invoking of the institutional requirement.

#### **Extract 18:** KK/P6: Lines 102-167, p. 3-5

102 Kat: M-hm. What do you mean - if I can [interrupt] you  
103 Zoe: [Yeah ]  
104 Yeah=  
105 Kat: =...by these, by these things, like, eh, obsessive-  
106 compulsive disorder, or the one you mentioned  
107 before- it was attachment  
108 Zoe: Yeah.  
109 Kat: ... child disorder.  
110 Zoe: Yeah. What [do I mean?]  
111 Kat: [Yeah ]. What do you mean by  
112 ((Zoe laughing)) those things?  
113 Zoe: Yeah. Well, we (.) have to (.) [diagnose] people  
114 Kat: [Mmm ]  
115 now, [here], which is a new thing.  
116 Kat: [Mmm ] Okay.  
117 Zoe: Well, it's not new, obviously, kind of, in the

118 health service, [but it's] new (.) in terms of it  
119 Kat: [M-hm ]  
120 Zoe: being a mandatory requirement. [So we all] have  
121 Kat: [M-hm ]  
122 to work within a, sort of, new constraint,  
123 (text omitted)  
161 Zoe: ... Not everybody in  
162 this t(h)eam, [ag(h)rees wit(h)h] th(h)at.  
163 Kat: [Yeah ]  
164 Zoe: Not everybody [in this] team thinks that's always  
165 Kat: [Yeah ]  
166 Zoe: helpful, but that's what our Trust says that we  
167 have to do.

In this extract, I could be seen to work up my identity of someone who, perhaps rather uncharacteristically for a third year clinical psychology trainee and thus perhaps somewhat confusingly for Zoe, appears to be enquiring about what the diagnostic terms mean (lines 102-112). Accordingly, I could be seen to build my category membership of 'NOT PSYCHOLOGIST' who claims not knowing, if only for the local research purposes. Of particular interest, however, is Zoe's response to such an ethnomethodologically<sup>25</sup> (Garfinkel, 1967) informed, deliberately agnostic and consequently non-neutral and interventionist questioning. That is, rather than explicating what the diagnostic categories mean, Zoe can be seen to offer justification of why she has to diagnose children and thus manages to directly orient to potential yet unspoken criticism of diagnostic practice. She makes me aware that they "have to diagnose people now" (lines 113-115) and that this is a "mandatory requirement" (line 120), implying that if diagnosing is being interactionally constructed as a bad practice then Zoe would not be responsible for doing it, since she is required to follow the rules set for her. Such a conversational move appears to play an important role in distancing her from individual accountability and functions to justify Zoe's practice by emphasising the existing constraint to her practice and the lack of choice in her decisions, and

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<sup>25</sup> Garfinkel was famous for his 'breaching experiments', which are forms of empirical inquiry in which ordinary social interactions and unstated social roles are violated in order to reveal the processes that are at work in constructing the reality as 'normal'. Garfinkel (1967) argued that one must breach expectancies in radical ways to see how the system works.

thus ultimately serving to work up her identity as a competent and morally adequate psychologist.

In lines 161 to 167, Zoe then goes on to claim that “not everybody in [her] team agrees with that” and “thinks that’s always helpful”, and as such, she can be seen to express her potential disagreement with diagnostic practice, continuously orienting to it as something negative and sometimes unhelpful. This acknowledgement of undesirability of such a practice, however, is done carefully and in a less direct manner through the footing of an ‘animator’ (Goffman, 1981) who reports the views of her team rather than Zoe’s own.

In summary, appealing to an external situation can be seen as being about handling the stake: the actions follow from wider contextual constraints ‘out there’ that are not in the speaker’s control. This presents diagnosing as simply a sensible response to the ‘ways things are’, rather than something that can be questioned or changed.

It is important to re-iterate here that I am not arguing that the participants are intentionally or consciously doing the things described above. What I am suggesting is that from the discursive psychological perspective it is possible to analytically read the text in a way that reveals what effects the talk might have.

## **CHAPTER FOUR - DISCUSSION**

This chapter has several objectives. First, I would like to revisit the aim of the study and provide a summary of the main analytic patterns and related conclusions. The results will then be situated in the wider macro context and compared to other studies. The next section will identify the research and clinical implications of the study, followed by a critical review of this research. The chapter concludes with a reflexive review.

### **4.1. SUMMARY AND DISCUSSION OF FINDINGS**

This study aimed to explore how clinical psychologists construct their work with

children, with a particular analytical focus on participants' orientations towards, and justifications for, the challengeable status of the various practices that they described in their talk. The analysis began with contextualising the talk by looking at participants' orienting to the interview requirements. Attention was then paid to the exploration of participants' orientation to their professional and personal moral identity within the research interaction. The main part of the analysis examined the strategies of accountability management, focusing on sequences of talk where participants oriented to particularly sensitive areas within the talk-in-interaction.

The analysis evidenced a number of discursive manoeuvres employed by participants to manage their accountability in talking about practices depicted as potentially problematic. These included: (1) the 'severe end' rhetorical device that functioned to warrant the use of medication; (2) the minimisation strategy that was used to construct diagnosis in a minimal or safer manner; (3) normalisation techniques that comprised routinisation, which served to downplay problems with diagnosis by claims to competence; and renegotiating, re-categorising or re-defining contested practices as less problematic or indeed as positive; (4) doing being democratic that constructed troubling practice as democratic; (5) employing 'maxims of practical politics' that seemed to legitimise contested practices by invoking liberal arguments ('Nobody should be compelled') or by emphasising the practical limitations on the work of psychologists ('You have to be practical'); and finally (6) the discursive move of redirecting accountability or potential blame to service users and the institution, enabling participants to distance themselves from being held accountable for problematic practices.

The discursive analysis of the extended accounts demonstrated that a pervasive feature of all the interviews was participants' attentiveness to building up the moral nature of their practice and consequently their personal and professional identity. As a result, what may sensibly be inferred from this observation is that the research interview was a setting in which participants' moral credibility was under scrutiny. Whilst DP is suitable for analysing the social actions performed in talk, it is not concerned with attempting to explain why. However, it is possible to make some suggestions to account for this finding and to begin to situate the

results of the analysis in a wider body of literature.

First, it was suggested that the research context in which participants were interviewed in their category membership of a 'psychologist' is bound up with a moral assessment of the performance of their duties, which requires them to present themselves in a morally adequate light (e.g., Baruch, 1981; Jayyusi, 1984). In addition, it could be suggested that because the controversies in clinical practice, such as children not consenting to therapy, were made relevant in the research interviews, the moral credentials of the psychologists interviewed were called into question by virtue of these subjects being discussed.

Second, it is possible that *the mere fact of asking* psychologists to describe their practices is reason enough to invite questions about legitimacy and to place doubt on their moral credentials, as sometimes the most radical thing can be to ask a really mundane question, such as "How do you work with children and why?" Indeed, it is possible that any interview with professionals about their work is likely to invite questions about legitimacy.

Third, participants were aware that I was a trainee on the UEL clinical psychology programme. As clinical psychologists in London teach and supervise trainees from this programme and many have also been trainees on the programme, they are often aware that it includes some teaching that is critical of psychiatric diagnosis and other practices of the psy-complex. Also, the title of my thesis on the information sheet stated "constructions of psychologists' work" implying my social constructionist background, which is known to be associated with a stance that questions knowledge and dominant practices. Therefore, this might have posed a threat to participants in that it might require them to account for their practices.

However, it could equally be proposed that there is something very particular about mental health practices with children and conceptualising children's difficulties as mental disorders that require psychologists to morally exculpate themselves. Support for this suggestion was outlined in the introduction chapter where the literature demonstrated serious scientific and moral issues associated with the notion of mental illness, and consequently with practices that endorse

the biomedical paradigm. It was suggested that mental illness does not have a basis as a scientific construct leading to the conclusion that the process of diagnosing children with a mental disorder is a moral judgment on socially unsanctioned behaviour (Boyle, 1990; Sarbin & Mancuso, 1970, 1980; Szasz, 1974) and a more palatable way to deal with complex moral, social and political issues impacting on children's difficulties, which results in pathologising practices (Rapley et al., 2011). Accordingly, if these practices are questionable from a moral standpoint, then the psychologists interviewed for this research were faced with the rather urgent task of having to legitimise their practice and manage their moral credibility in the context of being interviewed by a trainee clinical psychologist who is aware that they are part of such practices.

Considering the findings in the light of the critical literature and Sacks's (1992) notion of 'order at all points' (see methodology chapter, section 2.6.), I argue that clinical psychology, whilst framing itself as a science, is fundamentally a moral enterprise, particularly when you are dealing with children whose distress and socially unsanctioned behaviour is being conceptualised and treated as mental illness. From this perspective, individual clinical psychologists are caught in a real predicament, a moral quagmire, suggesting that perhaps clinical psychology practice with children entails a constant grappling with moral issues.

#### **4.2. SITUATING FINDINGS WITHIN THE WIDER DISCOURSES**

There is an argument that attention to what seems to be merely micro-instances of talk will detract from important broader ideological and political matters (Potter & Hepburn, 2012). However, an alternative argument proposed argues that it is possible to dissolve the dichotomy between the 'macro' oriented discourse analysis and this more detailed discursive analysis (see Hepburn, 2003; Rapley, 2004, 2005; Wetherell, 1998; Widdicombe & Woffitt, 1995; Wooffitt, 2005). So how do the micro-interactions described in the analysis relate to the broader socio-political and institutional context? There are two ways in which this could be considered: the effects of macro on micro and vice versa.

#### **4.2.1. The effects of macro on micro**

Given that a number of participants drew on the 'invoking of institutional demands' device suggests something about the wider organisational structures in which individual psychologists work. For example, whilst participants oriented to the problems with some of their practices, they were clear that these stemmed from the institutional structures, legislative frameworks and policy provisions that regulate their practice. In their accounting work, participants often presented their personal beliefs, values and preferences in contrast with institutional agendas which were frequently presented as rigid. Although rhetorically this enabled them to manage their accountability and portray themselves as being competent and morally adequate psychologists, it also made us aware that individuals might not have much power to change the institutional realities determining their practice.

This also allows for some tentative remarks to be made about policing what psychologists do. From the Foucauldian perspective (e.g., Dreyfus & Rabinow, 1982), it can be argued that psychologists and their clients are interconnected in a disciplinary space where both parties are operating under the powerful gaze: psychologists are actively looking over the children and families whilst they themselves are being overlooked by their employers, and ultimately the government bodies, such as the DOH. These macro conditions in which these psychologists practise thus provide a particular reality that poses a variety of dilemmas for them. For example, while it requires them to submit necessary information (e.g., give a diagnosis) to the commissioners to secure service funding and, as employees, ultimately their salaries, it also requires them to practise in ways that they might not choose. Therefore, an alternative formulation of the findings could be that the discursive moves that these psychologists have drawn on are attempted solutions to an institutional problem.

The analysis presented here also demonstrates how participants drew on the mainstay principles of Western liberal democracies and neo-liberal philosophies, such as 'choice' and 'freedom' that are incorporated in governmental policies. The analytic patterns also showed how people's desires are shaped by contemporary notions of mental health, and how both children and parents may feel they have problems and seek help. Furthermore, the findings suggest that



psychologists' ways of accounting reflect the common cultural understanding noted by Harper (2013a):

Many people in distress and their relatives seem to feel that without diagnosis, they will, in some way, be 'blamed' or seen as morally responsible for their distress. That a moral discourse is so culturally available as an alternative to a discourse of psychiatric diagnosis hints at its powerful social functions (p. 80; see also Coulter & Rapley, 2011).

Harper (2013a) goes on to suggest that, if we are to move away from a diagnostic discourse, we need to consider how we address these social functions. Later in this chapter I will consider this further.

#### **4.2.2. The effects of micro on macro**

Drawing on works of Wetherell and Potter (1988, 1992) and Hepburn (2000, 2001) (see also Rapley, 2004, 2005), it could be argued that a micro level analysis of talk, which focuses on people's discursive patterning, can reveal how language is used to preserve existing dominant institutional structures. The above analysis suggests that psychologists' accounts could work to 'settle' the current state of affairs (Billig, 1992). The participants presented themselves as concerned, reflective, friendly and democratic psychologists. Yet, on the macro level, these positive attributes can potentially be usable for more politically problematic tasks (Wetherell & Potter, 1988; 1992). These authors argued (see also Hepburn, 2003, p. 185-190) that the debates can be stopped by reasonably sounding liberal arguments and undermined by pragmatic realism. They go on to assert that part of the power of such arguments comes from the fact that they do not have to be kept discreet, but rather are publicly sayable and heard as positive. However, whilst each discursive move that functions to justify contested practice is relatively innocuous on its own, the implications of applying it in the larger context of mental health services for children, where professionals have more power to determine the course of treatment, might not be so positive. It is only when looking at the organisation of the accounts as a whole that their potential effects become apparent.

The interest is neither to blame the individuals, nor to identify whether they are 'really' morally adequate, since we all, as professionals, come to work everyday trying to make a difference to children's lives. Rather, the aim is to gain a deeper understanding of how these accounts *on the whole* might function to valorise and reproduce particular forms of practice and make them seem reasonable, and so consequently they can never be problematised, thus inevitably serving to maintain the status quo. The value of such a micro-level analysis then is in showing how these broader claims are built upon a more detailed discursive work, rather than arising through more abstract ideological claims.

In her writing (2011), Boyle similarly delineated various strategies that both psychiatry and clinical psychology deploy in order to construct distress as a mental illness, including avoiding confronting the potential importance of the environment in causing distress. She argues that whilst these are not used in a planned and conscious way, on the wider level clinical psychology seems to have an investment in preserving the status quo in return for academic and professional privileges. For example, disregarding the context allows psychology to maintain its scientific credibility, hence ensuring both academic and professional acceptance (Boyle, 2011).

### **4.3. COMPARISON WITH OTHER STUDIES**

In addition to the studies that guided my analysis (e.g., Augoustinos & Evere, 2011; Stevens & Harper, 2007; Tileaga, 2010) and which have already been considered in the analysis chapter because they evidenced similar discursive devices, the findings of this research also resonate with a number of the studies outlined in chapter one.

The results of my research also echo the studies of Koehne et al. (2012) and Strong et al. (2012) in that they both reported that diagnosing posed considerable technical as well as ethical dilemmas for some clinicians from a non-psychiatric background. Although the Strong et al. (2012) study has not adopted discourse analysis and so has not focused on the action orientation of participants' talk (as did the current study and Koehne et al., 2012), there are similarities in what

participants said on a content level. For instance, Strong and colleagues (2012) comparably noted that clinicians dealt with their dilemma around needing to give a diagnosis by assigning a less specific DSM code to their clients (e.g., 'unspecified' DSM diagnosis), while Koehne and colleagues (2012) reported that clinicians, similar to some participants in this study, often chose not to disclose the diagnosis to their clients. From a discursive perspective then, these accounts have been described as a minimising strategy that functioned to 'soften' or 'cushion' the impact of diagnosing. Moreover, the professionals in the Strong et al. (2012) study likewise reported to commonly viewing diagnosis as having limited clinical currency, rendering diagnosing a necessary administrative task.

The findings of the current study as well as the studies by Strong et al. (2012) and Koehne et al. (2012) thus seem to support the suggestion outlined by Kelly and Rhodes (2013, p. 29) that whilst clinicians reject psychiatric diagnoses with one hand, they assign disorders with the other, raising ethical and professional concerns with the current practice within mental health services. However, on a more positive note, these studies also seem to demonstrate the gap between the producers of diagnostic manuals and the practitioners who are required to use diagnoses in their daily practice which, according to some (e.g., Kelly & Rhodes, 2013), is widening, suggesting that alternative ways of dealing with people's difficulties would be timely.

In addition, analogous patterns of accounting identified in the current study, namely, assigning responsibility and blame to others to justify professionals' actions have been reported by both Arribas-Ayllon et al. (2009) and Masocha (2013). Masocha's (2013) study, which explored how social workers justify their practice with asylum seekers, offers some further striking similarities with the current study. Specifically, he reported that the social workers used a range of discursive strategies to "absolve professionals of potential charges of being individually involved in discriminatory and oppressive practice as well as complicity in unethical practices" (Masocha, 2013, p. 13) through portraying themselves as "competent", emphasising their "best intentions" and "doing the best they can" to support asylum seeking families. Comparably, any potential problems with their practice were attributed to either service users or institutional

constraints. Thus, the results of these studies support Sacks' (1992) notion of 'order at all points', and provide further evidence for the possibility that mental health practitioners engage in a similar type of moral accounting when talking about their work within the research interview.

#### **4.4. RESEARCH AND CLINICAL IMPLICATIONS**

In this section I outline how the results of this study might be useful for generating further research and for informing clinical practice.

##### **4.4.1. Possibilities for future research**

One possible area for future research would be to undertake a participatory and emancipatory investigation in order to explore what discursive patterning would be devised if it were children, young people or their parents asking psychologists about their practice.

The current study suggested that children might be ambiguous about seeing a psychologist. Therefore, another possible avenue of inquiry would be an investigation of children's constructions of their therapy and the meaning they make of seeing a psychologist.

The new research project could use naturally occurring talk in real therapeutic encounters rather than interviews. This would provide talk-in-interaction that occurs in a less controlled setting, and could potentially identify different ways of accounting. This could include examining how psychological practices are produced as they happen, for example, how does the 'parents' choice' in diagnostic assessment and therapy get negotiated, and where does this leave the child's voice? How are the issues of responsibility and blame dealt with in clinical interaction? Or how do children and their parents negotiate the diagnosis and medication in their meeting with the professional? (cf. McHoul & Rapley, 2005). Additionally, it would be interesting to look at the operation of power in therapeutic encounters between clinicians and their young 'clients'.

A study could be also conducted using the recordings of naturally occurring talk in team meetings, case conferences, supervision meetings and other clinical

settings when potentially contested issues are raised to see whether similar discursive accounting occurs in different settings. Such a study might also allow observation of the operation of power in professional interactions, for example between different professionals or between trainees and qualified psychologists.

It would be interesting to investigate if a similar moral accounting would transpire during interviews with physicists, asking about their work; the hypothesis being that when we deal with human beings, rather than physical constructs, people might not be required to engage in moral accounting for their activities.

#### **4.4.2. Implications for clinical practice and possibilities for future action**

##### 4.4.2.1. Developing reflective and reflexive practice

Reflection and reflexivity are crucial for responsible and ethical practice (Bolton, 2010). Through paying particular attention to details of talk, this study has attempted to make visible “the seen but unnoticed” (Garfinkel, 1967, p. 180) aspects of everyday child clinical psychologists’ practice by exposing the profound moral dilemmas that child clinical psychologists have to deal with in a clinical setting. By doing so, this study has contributed to a greater appreciation of the fundamentally moral nature of child psychology practice, and therefore also to a deeper reflection of contemporary child work.

Clinical psychology claims its commitments to being reflective (BPS, 2006). However, this study suggests that psychologists are largely unaware of the strategies they deploy in justifying and legitimising contested practices. Consequently, identifying and acknowledging the discursive patterning in professional accounts may enable psychologists to develop their awareness of the taken-for-granted ways of practicing and the performative nature of their language. As a result, this might lead to a more critical and reflective appraisal of clinical practice, one’s own values, identities, and the potential effects of psychological discourses. One possible way to aid such reflexive practice might be to implement models of discourse analysis in training, supervision and service research contexts. An illustration of this offers, for example, Heena’s (1998) use of ‘reflexive discourse analysis’ that enables expanding the focus of clinical supervision by considering professional and therapeutic discourse in a wider

context.

#### 4.4.2.2. The role of the psychologists and clinical practice

The findings also point to the fact that perhaps practitioners lack ways of talking about the dilemmas and thus resolve them through unconscious rhetorical strategies. The implication being that maybe, as clinical psychologists, we need to become more transparent and find ways of acknowledging and articulating the ethical, professional and practical problems of working with children. This could be done by discussing these issues more openly with families, other professionals and wider regulatory bodies. For example, it could include providing families with more independent, varied and balanced information about the medical model, acknowledging controversy around diagnoses and risks associated with medication, offering support with critical evaluation of official information available to children and parents as well as media representations of distress, and encouraging debates about the variability of childhood (e.g., Burman, 2008) and the environmental causes of distress. Parents seeking help could be supported with their decisions in the face of pressure to adopt biomedical solutions for their children's difficulties and could be signposted to alternative resources, such as the works of UK psychiatrist Sami Timimi (e.g., *Pathological Child Psychiatry and the Medicalization of Childhood*, 2002) or the website of the US psychiatrist Peter Breggin offering information about medication practices

([http://www.breggin.com/index.php?option=com\\_content&task=view&id=38](http://www.breggin.com/index.php?option=com_content&task=view&id=38)).

Parents could also be encouraged to discuss issues of potential feelings of blame openly with practitioners, rather than rushing to medical solutions. It is, however, recognised that whilst this is an important task to consider, it is also a complicated one. Perhaps this could be done by acknowledging and normalising unavoidable confusion and ambivalence about causes of children's difficulties (Read, Seymour & Mosher, 2004). Moreover, Coulter and Rapley (2011, p. 172) suggest that it may be helpful to recognise that "‘being in some way responsible for’ an outcome does not, inevitably and necessarily, imply the *intent* to cause it (and hence attract the moral opprobrium that is ‘blame’)".

The findings presented here also indicate that psychologists are trapped in a web of societal demands (e.g., the wishes of parents, schools, NHS managers, etc.). Consequently, one of the dangers of working within such systems is that one can become inured and accustomed to ways of working that might be seen as collusive by critics. Perhaps there needs to be more discussion about innovative ways of practicing and dealing with these complex issues. The possible alternatives, which are consistent with the findings of this study, have been outlined (e.g., Boyle, 2011; Dillon, 2013; Harper, 2013b; Rapley, et al., 2011; Smail, 2011), and are summarised below:

- Making the context of paramount importance in theory, research, teaching, case discussions, media presentations and everyday conversations between service users and professionals.
- Abandoning medical language in preference for multiple interpretations of concerns and people's own descriptions of problems.
- Reframing problems – for example, “Instead of saying that fidgeting, inattention and disobedience are symptoms of ADHD, say that bored children are likely to misbehave in school” (Rapley, 2010); “Instead of asking what is *wrong* with someone, we should ask *what has happened* to them” (Jackie Dillon, Chair of the Hearing Voices Network, England); “Instead of asking what's *inside* people's heads, ask what their *heads are inside*” (Harold Garfinkel, Sociologist).
- Sharing power with people using our services and engaging in advocacy.
- Critically evaluating our own actions and self-interests.
- Offering therapeutic interventions based on non-pathologising approaches, such as systemic and narrative therapy. However, as Smail (2004) has pointed out, these practices often sit too comfortably in mainstream medically oriented mental health services, and thus might unintentionally obfuscate and sustain the oppressive practices.
- Adopting critical and community psychology approaches (e.g., Prilleltensky, 1999) and setting up or contributing to community services and voluntary organisations, such as the Kid's Company that offers practical support to vulnerable children who have been neglected or

abused (<http://www.kidsco.org.uk>) or the Music and Change (MAC-UK) project that makes help accessible to deprived young people.

#### 4.4.2.3. Policy and service delivery

Whilst the BPS raised its concerns with the increasing medicalisation of people's difficulties in its response to the revised DSM-5 (BPS, 2012) and while the NICE and other practice guidelines acknowledge the problems with the application of biomedical models to children's difficulties, the standards for 'good practice' are nevertheless continuously based on them (as discussed in the introduction chapter). The results of this study indicate that policy makers and producers of clinical guidelines should give further consideration to how bureaucratic requirements might impact on the daily practice of individual clinicians, and most importantly how this might affect the people who use the services.

Further action might involve clinical psychologists entering into debates with the BPS and regulatory bodies, such as the DOH, and expressing their concerns about increasingly medicalised practices. Psychologists are arguably in a privileged position to use their articulation skills, power and position in a social hierarchy to advocate for the probity of child practices and express their views in campaigning activities. Furthermore, the issues could be publicised more across the wider professional literature and other media with the ultimate effect of improving service delivery to children and their families.

#### 4.4.2.4. Dissemination of findings

This form of intervention would involve making my study widely available on the web, which would make the findings freely accessible to a wider audience. This would also involve publishing my findings in academic journals. By disseminating my findings in these ways, I would hope to make a small contribution to a growing body of critical and discursive literature calling for a radical change in conceptualising and dealing with children's difficulties and for moral integrity in child clinical practice. I would also disseminate my findings to the child clinical psychologists who participated in the interviews and, should they require, make a copy of my thesis available to them.



## **4.5. CRITICAL REVIEW**

This section provides an evaluation of the research based on Antaki, Billig, Edwards and Potter (2003) who propose six analytic shortcomings against which the quality of discourse analytic research can be evaluated. Below I will demonstrate how I ensured these shortfalls were avoided in my study.

### **4.5.1. Under-analysis through summary**

Under-analysis occurs when the data are presented as prose summary, which can result in a loss of valuable discursive detail (Antaki et al., 2003). In this study, perhaps one of the benefits of undertaking the 'micro' level analysis was that it helped me stay close to the actual language used and facilitated explicating the action orientation of talk by giving specific examples of the utterances produced by both participants and myself.

### **4.5.2. Under-analysis through taking sides**

This shortcoming can occur when the evidence of the analyst's own moral, political or personal position towards the data results in taking sides, censorship or simplification of what the speakers actually say. However, rather than suggesting that analysts should remain neutral, the idea is to avoid substituting sympathy or scolding of speaker's talk based on one's presumptions (Antaki et al., 2003). As such, although I hold my own position towards the subject matter as outlined in my methodology section, I have not let this interfere with my data analysis. I have endeavoured to be mindful of, and transparent about, my position, and to stay close to the data. Providing a range of extracts, situating them within the occasioned context of original conversation, including sequences with my turns, and substantiating my claims within the details of actions done in talk, has hopefully evidenced this.

### **4.5.3. Under-analysis through over-quotation or through isolated quotation**

In this particular shortcoming, the analysis usually presents a fair amount of quotations but fails to provide the analyst's comments on data extracts (Antaki et al., 2003). In this study, I aimed to balance each extract with the in-depth analysis. Also, as much as the word constraint allowed, I attempted to include

extended extracts, providing some discursive context in order to avoid presenting single 'stand alone' quotations.

#### **4.5.4. The circular identification of discourses and mental constructs**

This shortfall can happen when patterns of talk are claimed to be evidencing the existence of the wider ideologies, repertoires or discourses, which are then used to explicate the particular utterance, resulting in circular identification. In the analysis of the data, I sought to support my arguments with the details of the actual talk and specific conversational moves. When claiming to use a particular discursive device, I drew on other discursive works and tried to explicate the function of the specific device in the occasioned context of my data. Also, when I made references to the wider ideologies (e.g., impact of language on preserving institutional structures), these were discussed separately from the actual data analysis (i.e., in the discussion chapter) and presented tentatively only.

#### **4.5.5. False survey**

Antaki et al. (2003) argue that this error occurs when researchers extrapolate the conclusions drawn from their study to the world at large. Given the qualitative nature of my study and specifically the discursive psychology method, I make no claims to the generalisability of my finding to a wider population. However, with reference to Sacks' (1992) notion of 'order at all points' and Feynman's (1965) idea of the tapestry, I argue that the findings are suggestive of the fundamentally moral nature of the clinical psychology enterprise. Thus by shining a light on one bit of the fabric, one *may* sensibly envisage that shining a light on another parts of the fabric might reveal similar moral accounting elsewhere in professional accounts, including supervision, training courses, or practical reports. Furthermore, one might argue that the prevalence of certain constructions and devices imply that these are very culturally available. As much as these suggestions are qualified, the absolute generalisability nevertheless cannot be claimed.

#### **4.5.6. Under-analysis through spotting**

This final criterion refers to limiting one's analysis to the mere recognition of discursive features. Antaki et al. (2003) argue that whilst this is an important part

of the analytical process, it does not constitute the analysis itself. Therefore, in this analysis I have endeavoured to demonstrate the employment of specific rhetorical devices illuminating the *function* that they were accomplishing in the talk, rather than just spotting interesting features of the discourse.

## **4.6. REFLEXIVE REVIEW**

In providing a reflexive review, I intend to offer a reflection on the approach taken in this study, on the process of reporting this study, and finally a further consideration of my position towards the subject matter to that already provided in the methodology chapter.

### **4.6.1. Reflection of the methodological approach**

I found the discursive psychological approach liberating as it presented me with a stimulating alternative to realist and positivist research with which I have previously been involved. Whilst it took some practice to 'see' the action in the talk and perceive data from a process rather than a content level, I found this extremely rewarding in that it has influenced my 'world view' and how I have come to understand communication that goes beyond this study. For instance, I have noticed that I have become more mindful of the discursive strategies and their potential social function in media reporting, as well as clinical settings, enabling me to notice and point to things that have potential to spark curiosity from friends and colleagues, and initiate intellectually stimulating and potentially important debates, such as deconstructing taken-for-granted ways of practicing.

### **4.6.2. Reflection on research write-up**

Potter and Wetherell (1994, p. 51) argued that discourse analysts should be self-conscious about their own use of language and methods of argument structure. Accordingly, this study can be reflected upon in how it utilised a number of rhetorical devices to produce a convincing argument, such as methods of constructing a factual account by adding statistical figures when reporting concerns about rising ADHD drug prescriptions, to name one. Such reflection, however, need not undermine the work. Rather, it can arguably generate a more

honest account of one's work that admits that one's writing falls under the same social psychological processes too.

In addition, I recognise that any research reporting is necessarily a post hoc reconstruction of the original research dialogue (Leudar & Antaki, 1996b), and therefore inevitably a subjective construction (Harper, 1999) presenting only one small part of the world and the data itself. As such, in this study I have not endeavoured to say: 'it is like this' but rather "look at it this way" (Stainton Rogers, 1991, p. 10).

#### **4.6.3. Further reflections on my position**

Whilst conducting the interviews for this study, it was important that the participants and I shared a professional background. This was not only because I knew that some of the practices, of which they were part, were potentially problematic, but also that I too could be held accountable for any potential moral implications resulting from talking about contested practices, given my membership category of a 'trainee psychologist'.

Additionally, at times I used a pronoun 'we' as my footing<sup>26</sup> through which my professional identity was evoked. It could be suggested that adopting such a footing was my attempt to maintain interview rapport. Moreover, during the interviews at times I felt uncomfortable asking challenging questions or questioning assumptions. Therefore my use of 'we' could also serve to downplay my stake in reference to my challenging turns, and allowed me to show my empathy towards the participants. In that case, my use of the institutional 'we' could function to push the accountability back to the institution or the institutional practices and our shared identity as clinical psychologists, rather than leaving participants needing to be accountable for their individual practice. Consequently, my footing of 'we' could be seen to perpetuate the notion of 'there is an institution we are all in'.

Finally, although I attempted to take an interventionist approach and explicitly set up the interviews as conversations (following a DP method), I nevertheless frequently lapsed into the position of a traditional interviewer, in which I asked

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<sup>26</sup> See appendix fourteen for examples of my use of 'we' as footing.

questions and responded with monosyllabic answers to encourage the interviewees to continue talking. Therefore I could have missed interesting avenues of inquiry, which I consider to be my learning point.

#### **4.6.4. Final reflections**

While previously I have been aware of the ethical issues in child practice, over the course of completing this study I have become more appreciative of the moral and professional dilemmas that individual psychologists wrestle with in their everyday practice. Thus, what I truly relished about this project was the way the analysis of the talk-in-interaction brought the area of morality into very clear focus for me, and provided me with a different perspective on the subject of child mental health and clinical practice with children. I feel that conducting this study has led me to think carefully about how I intend to work as a clinical psychologist.

## REFERENCES

- Antaki, C., Ardévol, E., Núñez, F. & Vayreda, A. (2005). "For she who knows who she is": Managing accountability in online forum messages. *Journal of Computer-Mediated Communication*, 11, 1-18. Retrieved from <http://jcmc.indiana.edu/vol11/issue1/antaki.html>
- Antaki, C., Billig, M., Edwards, D. & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*, 1(1). Retrieved from <http://www.shu.ac.uk/daol/previous/v1/n1/index.htm>
- Ariès, P. (1960). *Centuries of childhood*. Harmondsworth: Penguin Books.
- Arribas-Ayllon M., Sarangi, S. & Clarke, A. (2009). Professional ambivalence: Accounts of ethical practice in childhood genetic testing. *Journal of Genetic Counseling*, 18(2): 173-184.
- Atkinson, J. M. & Heritage, J. (Eds.). (1984). *Structures of social action: Studies in conversation analysis*. Cambridge: Cambridge University Press.
- Augoustinos, M. & Every, D. (2007). The language of 'race' and prejudice: A discourse of denial, reason, and liberal-practical politics. *Journal of Language and Social Psychology*, 26, 123-141.
- Baker, C. D. (1997). Membership categorization and interview accounts. In D. Silverman (Eds.), *Qualitative research: Theory, method and practice*. London: Sage.
- Baker, C. D. (2003). Ethnomethodological analyses of interviews. In J. A. Holstein & J. F. Gubrium (Eds.), *Inside interviewing: New lenses, new concerns* (pp. 395–412). London: Sage.
- Baldwin, S. (2000). Living in Britalin: Why are so many amphetamines prescribed to infants, children and teenagers in the UK? *Critical Public Health*, 10(4), 453-462.

- Baldwin, S. & Anderson, R. (2000). The cult of methylphenidate: A clinical update. *Critical Public Health*, 10(1), 81-86.
- Baruch, G. (1981). Moral tales: Parents' stories of encounters with the health professions. *Sociology of Health and Illness*, 3, 275-95.
- Billig, M. (1991). *Ideologies and beliefs*. London: Sage.
- Billig, M. (1992). *Talking of the royal family*. London: Routledge.
- Billig, M. (1996). *Arguing and thinking: A rhetorical approach to social psychology* (2nd ed.). Cambridge: Cambridge University Press.
- Billig, M. (1999a). Conversation analysis and the claims of naivety. *Discourse & Society*, 10, 572–576.
- Billig, M. (1999b). Whose terms? Whose ordinariness? Rhetoric and ideology in conversation analysis. *Discourse and Society*, 10, 543-558.
- Billington, T. (2006). *Working with children: Assessment, representation and intervention*. London: Sage.
- Bolton, G. (2010). *Reflective practice: Writing and professional development* (3rd ed.). California: Sage Publications.
- Boyle, M. (1990). *Schizophrenia: A scientific delusion?* London: Routledge.
- Boyle, M. (1999). Diagnosis. In C. Newnes, G. Holmes & C. Dunn (Eds.). *This is madness: A critical look at psychiatry and the future of mental health services* (2nd ed.), (pp. 75-90). Ross-on-Wye: PCCS Books.
- Boyle, M. (2006). Developing real alternatives to medical models. *Ethical Human Psychology and Psychiatry*, 8(3), 191-200.
- Boyle, M. (2007). The problem with diagnosis. *The Psychologist*, 20(5), 290–292.
- Boyle, M. (2011). Making the world go away, and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery:*

*Psychiatry, psychology and the human condition* (pp. 27-43). Basingstoke: Palgrave MacMillan.

Bracken, P. & Thomas, P. (2005). *Postpsychiatry: Mental health in a postmodern world*. Oxford: Oxford University Press.

Breggin, P. R. (2001). *Talking back to ritalin*. Cambridge, MA: Da Capo Press.

Breggin, P. R. & Breggin, G. R. (1995). The hazards of treating "Attention-Deficit/Hyperactivity Disorder" with methylphenidate (Ritalin). *The Journal of College Student Psychotherapy*, 10(2), 55-72. Retrieved from [http://www.breggin.com/index.php?option=com\\_content&task=view&id=123](http://www.breggin.com/index.php?option=com_content&task=view&id=123)

Breggin, P. R. & Cohen, D. (1999). *Your drug may be your problem: How and why to stop taking psychiatric medications*. Cambridge, MA: Perseus.

British Psychological Society (2006). *Code of ethics and conduct*. Leicester: BPS.

British Psychological Society (2008a). *CAMHS call for evidence: British Psychological Society response to the Department for Children, Schools and Families consultation*. The CAMHS review - next steps to improving the emotional well-being and mental health of children and young people. Call for evidence. Retrieved from [http://apps.bps.org.uk/\\_publicationfiles/consultation-responses/CAMHS%20Call%20for%20Evidence%20-%20BPS%20response.pdf](http://apps.bps.org.uk/_publicationfiles/consultation-responses/CAMHS%20Call%20for%20Evidence%20-%20BPS%20response.pdf)

British Psychological Society. (2008b). *Generic professional practice guidelines* (2nd ed.). Leicester: BPS. Retrieved from [http://www.bps.org.uk/sites/default/files/documents/generic\\_professional\\_practice\\_guidelines.pdf](http://www.bps.org.uk/sites/default/files/documents/generic_professional_practice_guidelines.pdf)

British Psychological Society (2011). *£32m for child psychological therapy*. Leicester: BPS. Retrieved from <http://www.bps.org.uk/news/%C2%A332m-child-psychological-therapy>

British Psychological Society (2012). *DSM-5: The future of psychiatric diagnosis* (2012 final consultation). British Psychological Society response to the



American Psychiatric Association. Leicester: BPS. Retrieved from <http://apps.bps.org.uk/publicationfiles/consultation-responses/DSM-5%202012%20-%20BPS%20response.pdf>

Burman, E. (2008). *Deconstructing developmental psychology* (2nd ed.). London: Routledge.

Burr, V. (2003). *Social Constructionism* (2nd ed.). Hove: Routledge.

Buttny, R. (1993). *Social accountability in communication*. London: Sage Publications.

Clayman, S. E. (1992). Footing in the achievement of neutrality: The case of news-interviews discourse. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* (pp. 163-198). Cambridge: Cambridge University Press.

Cohen, D. (2004). Needed: Critical thinking about psychiatric medications. *4th International Conference on Social Work in Health and Mental Health*. Quebec City, May 2004. Retrieved from <http://www.ahrp.org/about/CohenPsychMed0504.pdf>

Coulter, C. & Rapley, M. (2011). 'I'm just, you now, Joe Bloggs': The management of parental responsibility for first-episode psychosis. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-Medicalizing Misery: Psychiatry, psychology and the human condition* (pp. 158-173). Basingstoke: Palgrave Macmillan.

Department of Health. (2011). *Improved mental health therapies for children*. Retrieved from <http://www.dh.gov.uk/health/2011/10/improved-mental-health-therapies-for-children/>

Department of Health. (2012). *NHS data model and dictionary service*. Child and Adolescent Mental Health Services secondary uses data set. Retrieved from <http://www.isb.nhs.uk/documents/isb-1072/amd-12-2012/1072122012ddcr.pdf>

Dexter, G., Larkin, M. & Newnes, C. (2011). A qualitative exploration of child clinical psychologists' understanding of user involvement. *Clinical Child*

*Psychology & Psychiatry*, 7, 1359-1045.

Dillon, J. (2013). Just saying it as it is: Names matter; language matters; truth matters. *Clinical Psychology Forum*, 243, 15-19.

Dreyfus, H & Rabinow, P. (1982). *Michel Foucault: Beyond structuralism and hermeneutics with an afterword by Michel Foucault*. Brighton: The Harvester Press.

Edwards, D. (1997). *Discourse and cognition*. London and Beverly Hills, CA: Sage.

Edwards, D. (2003). Analyzing racial discourse: The discursive psychology of mind-world relationships. In H. van den Berg, M. Wetherell, & H. Houtkoop-Steenstra (Eds.), *Analyzing race talk: Multidisciplinary approaches to the interview* (pp. 31-48). Cambridge, UK: Cambridge University Press.

Edwards, D. (2004). Discursive psychology. In K. Fitch & R. Sanders (Eds.), *Handbook of language and social interaction* (pp. 257-273). Mahwah, NJ: Lawrence Erlbaum.

Edwards, D. & Potter, J. (1992). *Discursive psychology*. London: Sage.

Edwards, D. & Potter, J. (2001). Discursive psychology. In A. McHoul & M. Rapley (Eds.), *How to analyse talk in institutional settings: A casebook of methods* (pp. 12-24). London and New York: Continuum International.

Edwards, D. & Potter, J. (2005). Discursive psychology, mental states and descriptions. In H. te Molder & J. Potter (Eds.), *Conversation and cognition* (pp. 241-259). Cambridge: Cambridge University Press.

Edwards, D., Ashmore, M. & Potter, J. (1995). Death and furniture: The rhetoric, politics and theology of bottom line arguments against relativism. *History of the Human Sciences*, 8, 25-49.

Feynman, R. (1965). The law of gravitation, an example of physical law. In R. Feynman. *The character of physical law* (pp. 13-34). The M.I.T. Press. Retrieved from [www.physicsteachers.com/pdf/The\\_Character\\_of\\_Physical\\_Law.pdf](http://www.physicsteachers.com/pdf/The_Character_of_Physical_Law.pdf)

- Fish, V. (1999). Clementi's hat: Foucault and the politics of psychotherapy. In I. Parker (Eds.), *Deconstructing psychotherapy* (pp. 54-70). London: Sage.
- Fonagy, P., Target, M., Cottrell, D., Phillips, J. & Kurtz, Z. (Eds.). (2005). *What works for whom?: A critical review of treatments for children and adolescents*. New York: The Guilford Press.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison*. London: Penguin.
- Foucault, M. (2006). *History of madness*. (J. Murphy & J. Khalfa, Trans.). London and New York: Routledge. (Original work published 1961)
- Garfinkel, H. (1967). *Studies in ethnomethodology*. New Jersey: Prentice Hall.
- Geboy, M. J. (1981). Who is listening to the “experts”? The use of child care materials by parents. *Family Relations*, 30, 205–210.
- Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40(3), 266-275.
- Gergen, K. J. (2009). *An invitation to social construction*. (2nd ed.). London: Sage Publications.
- Gingell K. (2001). The forgotten children: Children admitted to a county asylum between 1854 and 1900. *Psychiatric Bulletin*, 25(11): 432-434.
- Goffman, E. (1981). *Forms of Talk*. Oxford: Blackwell.
- Graham, P. (1976). Management in child psychiatry, recent trends. *British Journal of Psychiatry*, 129, 97-108.
- Graham, L. J. (2008). From ABCs to ADHD: The role of schooling in the construction of behaviour disorder and production of disorderly objects. *International Journal of Inclusive Education*, 12(1), 7-33.
- Hall, J. (2007). The emergence of clinical psychology in Britain from 1943-1958 Part II: Practice and research traditions. *History and Philosophy of Psychology*, 9(2), 1-33.

- Harper, D. (1999). Tablet talk and depot discourse: discourse analysis and psychiatric medication. In C. Willig (Eds.), *Applied discourse analysis: Social and psychological interventions*. Buckingham: Open University Press.
- Harper, D. (2006). Discourse analysis. In M. Slade & S. Priebe (Eds.), *Choosing methods in mental health research*. London: Routledge.
- Harper, D. (2007). Clinical Psychology. In C. Willig & W. Stainton Rogers, (Eds.), *The Sage handbook of qualitative research methods in psychology*. London: Sage.
- Harper, D. (2010). Clinical psychology in context: A commentary on David Pilgrim's British clinical psychology and society. *Psychology, Learning & Teaching*, 9(2), 13-14.
- Harper, D. (2012). Choosing a qualitative research method. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 83-98). Wiley-Blackwell.
- Harper, D. (2013a). On the persistence of psychiatric diagnosis: Moving beyond a zombie classification system. *Feminism & Psychology*, 23, 78–85.
- Harper, D. (2013b). Psychiatric diagnosis and its dilemmas. In K. Partridge & S. McNab (Eds.), *Inside out/outside in: Creative positions in adult mental health*. London: Karnac.
- Harris, C. (2005). The family well-being project: Providing psychology services for children and families in a community regeneration context. In C. Newnes & N. Radcliffe (Eds.), *Making and breaking children's lives* (pp. 138-150). Ross-on-Wye: PCCS Books.
- Healy, D. (1999). *The antidepressant era*. Cambridge, MA: Harvard University Press.
- Healy, D. (2004). *Let them eat prozac: The unhealthy relationship between the pharmaceutical industry and depression*. New York: New York University Press.
- Heenan, C. (1998). Discourse analysis and clinical supervision. *Clinical*

*Psychology Forum*, 114, 19-21.

Hendrick, H. (1997). Constructions and reconstructions of British childhood: An interpretative survey, 1800 to present. In A. James & A. Prout (Eds.), *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood* (pp. 34-62). London: Falmer Press.

Hepburn, A. (2000). Power lines: Derrida, discursive psychology and the management of accusations of school bullying. *British Journal of Social Psychology*, 39, 605-628.

Hepburn, A. (2003). *An introduction to critical social psychology*. London: Sage.

Hepburn, A. & Brown, S. J. (2001). Teacher stress and the management of accountability. *Human Relations*, 54(6), 531-555.

Hepburn, A. & Wiggins, S. (Eds.). (2007). *Discursive research in practice: New approaches to psychology and interaction*. Cambridge: Cambridge University Press

Heritage, J. (1984). *Garfinkel and ethnomethodology*. Cambridge: Polity Press.

Hollway, W. (2005). Commentaries on Potter and Hepburn, 'Qualitative interviews in psychology: problems and possibilities'. *Qualitative Research in Psychology*, 2(4), 312-314.

Holstein, J. A. & Gubrium, J. F. (1997). The active interview. In D. Silverman (Eds.), *Qualitative research: Theory, method and practice* (pp. 140-161). London: Sage.

Holt, L. (1996). Reporting on talk: The use of direct reported speech in conversation. *Research on Language and Social Interaction*, 29(3), 219-245.

Horwitz, A. V. (2002). *Creating mental illness*. Chicago: University of Chicago Press.

Improving Access to Psychological Therapies for Children and Young People (2011). *Children and Young People's Improving Access to Psychological*

*Therapies Project*. Draft National Curriculum. Retrieved from <http://www.iapt.nhs.uk/silo/files/draft-national-curriculum.pdf>

Ingleby, D. (1985). Professionals and socialisers: The psy-complex. *Research in law. Deviance and Social Control*, 7, 79-109.

James, A. & James, A. (2008). *Key concepts in childhood studies*. London: Sage.

James, A. & Prout, A. (Eds.). (1997). *Constructing and reconstructing childhood: Contemporary issues in the sociology of childhood*. RoutledgeFalmer.

Jayyusi, L. (1984). *Categorization and the moral order*. Boston: Routledge.

Kendall, J., Hatton, D., Beckett, A. & Leo, M. (2003). Children's accounts of attention-deficit/hyperactivity disorder. *Advances in Nursing Science*, 26(2), 114-130.

Kendell, R. & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry*, 160, 4-12.

Kirk, S. A. & Kutchins, H. (1992). *The selling of the DSM: The rhetoric of science in psychiatry*. New York: Aldine.

Koehne, K., Hamilton, B., Sands, N. & Humphries, C. (2012). Working around a contested diagnosis: Borderline personality disorder in adolescence. *Health (London)*, 17(1), 37-56.

Kutchins, H. & Kirk, S. A. (1997). *Making us crazy. DSM: The psychiatric bible and the creation of mental disorders*. New York: Free Press.

Latour, B. & Woolgar, S. (1986). *Laboratory life: The construction of scientific facts* (2nd ed.). Princeton: Princeton University Press.

Leeming, D., Boyle, M. & Macdonald, J. (2009). Accounting for psychological problems: How user-friendly is formulation? *Clinical Psychology Forum*, 200, 12-15.

Leudar, I. & Antaki, C. (1996a). Discourse participation, reported speech and research practices in social psychology. *Theory and Psychology*, 6, 5-29.

- Leudar, I. & Antaki, C. (1996b). Backing Footing. *Theory and Psychology*, 6, 41-46.
- Leudar, I. & Antaki, C. (1997). Participant status in social psychological research. In T. Ibanez & L. Iniguez (Eds.), *Critical Social Psychology* (pp. 273-290). London: Sage.
- Levinson, S. C. (1983). *Pragmatics*. Cambridge: Cambridge University Press.
- Levinson, S. C. (1988). Putting linguistics on a proper footing: Explorations in Goffman's participation framework. In P. Drew, & A. Wootton (Eds.), *Goffman: Exploring the interaction order* (pp. 161-227). Oxford: Polity Press.
- Locke, A. & Edwards, D. (2003). Bill and Monica: Memory, emotion and normativity in Clinton's Grand Jury testimony. *British Journal of Social Psychology*, 42 (2), 239-256.
- Masocha, S. (2013). We do the best we can: Accounting practices in social work discourses of asylum seekers. *British Journal of Social Work*, 12, 1-16.
- Mazeland, H. & ten Have, P. (1996). Essential tensions in (semi-) open research interviews. In I. Maso & F. Wester (Eds.), *The deliberate dialogue: Qualitative perspectives on the interview*. Brussels: VUB Press.
- McElearney, C., Fitzpatrick, C., Farrell, N., King, M. & Lynch, B. (2005). Stimulant medication in ADHD: What do children and their parents say? *Irish journal of psychological medicine*, 22(1), 5-9.
- McHoul, A. (2001). Order at all points: Counting and accounting. In: M. Balnaves & P. Caputi (Eds.), *Introduction to quantitative research methods: An investigative approach* (pp. 2-9.). London: SAGE Publications.
- McHoul, A. (2009). What are we doing when we analyse conversation? *Australian Journal of Communication*, 36(3). 15-21.
- McHoul, A. & Rapley, M. (2002). "Should we make a start then?": A strange case of (delayed) client-initiated psychological assessment. *Research on Language and Social Interaction*, 35, 75-91.

McHoul, A. & Rapley, M. (2005). A case of attention-deficit/hyperactivity disorder diagnosis: Sir Karl and Francis B. slug it out on the consulting room floor. *Discourse and Society*, 16(3), 419-449.

McHoul, A., Rapley, M. & Antaki, C. (2008). You gotta light? On the luxury of context for understanding talk in interaction. *Journal of Pragmatics*, 40(5), 827-839.

Meaux, J., Hester, C., Smith, B. & Shoptaw, A. (2006). Stimulant Medications: A trade-off? The lived experience of adolescents with ADHD. *Journal for Specialists in Pediatric Nursing*, 11(4), 214-226.

Mehan, H. & Wood, H. (1975). *The reality of ethnomethodology*. New York: Wiley.

Miller, P. & Rose, N. (1988). The Tavistock programme: The government of subjectivity and social life. *Sociology* 22(2), 171-192.

Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. Basingstoke: Palgrave Macmillan.

Moncrieff, J. (2011). The myth of the antidepressant: An historical analysis. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 174-188). Basingstoke: Palgrave MacMillan.

National Institute for Health and Clinical Excellence (2006). *Methylphenidate, atomoxetine and dexamfetamine for Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents*. Retrieved from <http://www.nice.org.uk/nicemedia/pdf/TA098guidance.pdf>

Newnes, C. (2011). Toxic psychology. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 211-225). Basingstoke: Palgrave MacMillan.

Newnes, C. (2013a). *Clinical psychology: A critical examination*. Ross on Wye: PCCS Books.



Newnes, C. (2013b). The Diagnostic and Statistical Manual: A history of critiques of psychiatric classification systems. In J. Dillon, J. Moncrieff & E. Speed (Eds.), *De-medicalizing misery II: Psychiatry, psychology and the human condition*. Basingstoke: Palgrave Macmillan.

Newnes, C. & Radcliffe, N. (Eds.). (2005). *Making and breaking children's lives*. Ross-on-Wye: PCCS Books.

Pilgrim, D. & Treacher, A. (1992). *Clinical psychology observed*. London: Routledge.

Pomerantz, A. M. (1986). Extreme case formulations: A new way of legitimating claims. *Human Studies*, 9, 219-230.

Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: Sage.

Potter, J. (2003). Discursive psychology: Between method and paradigm. *Discourse & Society*, 14, 783-794.

Potter, J. (2012). Discourse analysis and discursive psychology. In H. Cooper, (Eds.), *APA handbook of research methods in psychology: Quantitative, qualitative, neuropsychological, and biological* (pp. 111-130). Washington: American Psychological Association Press.

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, 2, 281-307.

Potter, J. & Hepburn, A. (2008). Discursive constructionism. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 275-293). New York: Guilford.

Potter, J. & Hepburn, A. (2009). A kind of governance: Rules, time and psychology in institutional organization. In N. Llewellyn & J. Hindmarsh (Eds.), *Organization, interaction and practice: Studies of real time work and organising*. Cambridge: Cambridge University Press.

- Potter, J. & Hepburn, A. (2012). Eight challenges for interview researchers. In J. F. Gubrium & J. A. Holstein, (Eds.), *Handbook of interview research* (2nd ed.) (pp. 555-570). London: Sage.
- Potter, J. & Mulvey, M. (1985). Scientists' interview talk: Interviews as a technique for revealing participants' interpretative practices. In M. Brenner, J. Brown & D. Canter (Eds.), *The research interview: Uses and approaches*. London: Academic Press.
- Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- Potter, J. & Wetherell, M. (1994). Analyzing discourse. In A. Bryman & B. Burgess (Eds.), *Analyzing qualitative data* (pp. 47-66). London: Routledge.
- Prilleltensky, I. (1999). Critical psychology foundations for the promotion of mental health; Annual review of critical psychology. *Discourse Unit, 1*, 100-118.
- Rapley, T. J. (2001). The art(fulness) of open-ended interviewing: Some considerations on analysing interviews. *Qualitative Research, 1*, 303-324.
- Rapley, M. (2004). *The social construction of intellectual disability*. Cambridge: Cambridge University Press.
- Rapley, M. (2010). *Clinical Psychology and Epistemology 3* [Lecture to DClinPsy Year 1]. 18 November.
- Rapley, M. (2012). Ethnomethodology/Conversation analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 176-192). Wiley-Blackwell.
- Rapley, M., Moncrieff, J. & Dillon, J. (2011). Carving nature at its joints? DSM and the medicalisation of everyday life. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology & the human condition* (pp. 1-9). Basingstoke: Palgrave MacMillan.
- Read, J. (2005). The bio-bio-bio model of madness. *The Psychologist, 18*, 596-597.

- Read, J., Seymour, F. & Mosher, L. R. (2004). Unhappy families. In J. Read, L. R. Mosher & R. P. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia*. Hove: Routledge.
- Rogers, A. & Pilgrim, D. (2005). *A sociology of mental health and illness*. (3rd ed.). New York: Open University Press.
- Rose, N. (1985). *The psychological complex: Psychology, politics and society in England 1869-1939*. London: Routledge and Kegan Paul.
- Rose, N. (1989). *Governing the soul: The shaping of the private self*. London: Routledge.
- Royal College of Psychiatrists. (2011). *Intercollegiate statement on children and young people's mental health*. Retrieved from <http://www.rcpsych.ac.uk/press/pressreleases2011/childrensmentalhealth.aspx>
- Sacks, H. (1984). Notes on methodology. In J. M. Atkinson & J. Heritage (Eds.), *Structures of social action: Studies in conversation analysis* (pp. 21-27). Cambridge: Cambridge University Press.
- Sacks, H. (1992). In G. Jefferson (Eds.), *Lectures on Conversation. Vols 1 and 2*. Oxford: Basil Blackwell.
- Sarbin, T. R. (1968). Ontology recapitulates philology: The mythic nature of anxiety. *American Psychologist*, 23, 411-428.
- Sarbin, T. R. & Mancuso, J. C. (1970). Failure of a moral enterprise: Attitudes of the public toward mental illness. *Journal of Consulting and Clinical Psychology*, 35, 159-173.
- Sarbin, T. R. & Mancuso, J. C. (1980). *Schizophrenia: Medical diagnosis or moral verdict?* New York: Pergamon Press.
- Schegloff, E. A. (1992). Introduction. In H. Sacks (Eds.), *Lectures on Conversation*. Oxford: Basil Blackwell.
- Schegloff, E. A. (1997). Whose text? Whose context? *Discourse & Society*, 8,

165-187.

Schegloff, E. A. (1998). Reply to Wetherell, *Discourse & Society*, 9, 413-416.

Schegloff, E. A. (1999a). Naivete vs sophistication or discipline vs self-indulgence: A rejoinder to Billig. *Discourse & Society*, 10(4), 577–582.

Schegloff, E. A. (1999b). “Schegloff’s texts” as “Billig’s data”: A critical reply, *Discourse & Society*, 10, 558–572.

Scull, A. S. (1979). *Museums of madness: The social organisation of insanity in nineteenth century England*. London: Allen Lane.

Silverman, D. (1985). *Qualitative methodology and sociology*. Aldershot: Gower.

Singh, I., Keenan, S. & Mears, A. (2008). *Service users' experiences of stimulant drug medication*. Attention Deficit Hyperactivity Disorder: Full guideline for consultation (pp. 94-8). London: National Institute for Health and Clinical Excellence.

Skoger, U., Lindberg, L. & Magnusson, E. (2011). Neutrality, gender stereotypes, and analytical voids: The ideals and practices of Swedish child psychologists. *Feminism and Psychology*, 21(3), 372-392.

Smail, D. (2001). *The nature of unhappiness*. London: Robinson.

Smail, D. (2004). Psychotherapy and the making of subjectivity. In P. Gordon & R. Mayo (Eds.), *Between psychotherapy and philosophy*. London & Philadelphia: Whurr.

Smail, D. (2011). *Psychotherapy: Illusion with no future?* In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology & the human condition* (pp. 226-238). Basingstoke: Palgrave MacMillan.

Sparks, J. & Duncan, B. (2004). The ethics and science of medicating children. *Ethical Human Psychology and Psychiatry*, 6(1), 25-39.

Stainton-Rogers, W. (1991). *Explaining health and illness: An exploration of diversity*. London: Harvester/Wheatsheaf.

- Stevens, P. & Harper, D. (2007). Professional accounts of electroconvulsive therapy: A discourse analysis. *Social Science and Medicine*, 64(7), 1475-1486.
- Strong, T., Gaete, J., Sametband, I. N., French, J. & Eeson, J. (2012). Counsellors respond to the DSM-IV-TR. *Canadian Journal of Counselling and Psychotherapy*, 46, 85-106.
- Szasz, T. S. (1960). The myth of mental illness. *American Psychologist*, 15, 113-118. Retrieved from <http://psychclassics.yorku.ca/Szasz/myth.htm>
- Szasz, T. S. (1974). *The myth of mental illness: Foundations of a theory of personal conduct*. Revised edition. New York: Harper & Row.
- Szasz, T. (1978). *Myth of psychotherapy: Mental healing as religion, rhetoric and repression*. Syracuse: Syracuse University Press.
- Tileaga, C. (2010). Cautious morality: Public accountability, moral order and accounting for a conflict of interest. *Discourse Studies*, 12(2), 223-239.
- Timimi, S. (2002). *Pathological child psychiatry and the medicalization of childhood*. Hove: Brunner-Routledge.
- Timimi, S. (2005). *Naughty boys: Anti-social behaviour, ADHD and the role of culture*. Basingstoke: Palgrave Macmillan.
- Timimi, S. (2006). Children's mental health: The role of culture, markets and prescribed drugs. *Journal of the Institute for Public Policy Research* 13, 35-42.
- Timimi, S. (2010). The McDonaldization of childhood: Children's mental health in neo-liberal market cultures. *Transcultural Psychiatry*, 47(5), 686-706.
- Timimi, S. & Radcliffe, N. (2005). The rise and rise of ADHD. In C. Newnes & N. Radcliffe (Eds.), *Making and Breaking Children's Lives*. Ross-on-Wye: PCCS Books.
- Timimi, S. & Taylor, E. (2004). ADHD is best understood as a cultural construct. *British Journal of Psychiatry*, 184, 8-9.
- UNICEF Innocenti Research Centre (2007). *Report card 7: Child poverty in*

*perspective: An overview of child wellbeing in rich countries.* New York: UN.

Wetherell, M. (1998). Positioning and interpretative repertoires: conversation analysis and post structuralism in dialogue. *Discourse and Society*, 9, 387-412.

Wetherell, M. & Edley, N. (1999). Negotiating hegemonic masculinity: Imaginary positions and psycho-discursive practices. *Feminism & Psychology*, 9(3), 335-356.

Wetherell, M. & Potter, J. (1988). Discourse analysis and the identification of interpretative repertoires. In C. Antaki (Eds.), *Analysing everyday explanation: A casebook of methods*. London: Sage.

Wetherell, M. & Potter, J. (1992). *Mapping the language of racism: Discourse and the legitimation of exploitation*. London: Harvester Wheatsheaf.

Widdicombe, S. (1993). Autobiography and change: Rhetoric and authenticity of 'Gothic' style. In E. Burman & I. Parker (Eds.), *Discourse analytic research: Repertoires and readings of texts in practice* (pp. 94-113). London: Routledge.

Widdicombe, S. & Wooffitt, R. (1995). *The language of youth subcultures: Social identity in action*. Hemel Hempstead: Harvester Wheatsheaf.

Whittle, A. & Mueller, F. (2011). The language of interests: The contribution of discursive psychology. *Human Relations*, 64(3), 415-435.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Philadelphia: Open University Press.

Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Phillips, J., Pilling, S., et al. (2006). *Drawing on the evidence: Advice for mental health professionals working with children and adolescents* (2nd edition). London: CAMHS Publications.

Retrieved from [http://www.ucl.ac.uk/clinical-psychology/EBPU/publications/pub-files/drawing\\_on\\_the\\_evidence\\_booklet\\_2006.pdf](http://www.ucl.ac.uk/clinical-psychology/EBPU/publications/pub-files/drawing_on_the_evidence_booklet_2006.pdf)

Wooffitt, R. (1992). *Telling tales of the unexpected: The organization of factual discourse*. London: Harvester/Wheatsheaf.

Wooffitt, R. (2005). *Conversation analysis and discourse analysis: A comparative and critical introduction*. London: Sage.



# APPENDICES

## APPENDIX 1: UEL ETHICS APPROVAL

SCHOOL OF PSYCHOLOGY  
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

**UEL**  
University of  
East London  
[www.uel.ac.uk](http://www.uel.ac.uk)

School of Psychology  
Professional Doctorate Programmes

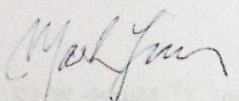
To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.






The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

  
Dr. Mark Finn  
Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ  
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937  
e-mail: [mno.davies@uel.ac.uk](mailto:mno.davies@uel.ac.uk) web: [www.uel.ac.uk/psychology](http://www.uel.ac.uk/psychology)

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## APPENDIX 2: INVITATION LETTER



### LETTER OF INVITATION TO PARTICIPANTS

< Potential Participants' Name >

< Address – Line 1 >

< Address – Line 2 >

[Date]

Dear Participant,

**Re: Invitation to participate in the research study titled:  
Clinical psychologists' constructions of their work with children.**

I am a Trainee Clinical Psychologist at the University of East London conducting a research project exploring how Clinical Psychologists talk about their work with children. I am writing to you to invite you to participate in this project, which would involve taking part in a confidential one-to-one interview at a time and place of your convenience.

I have enclosed an information sheet about the research project that gives you more details on what is involved. If you are interested in taking part in the study, please contact me on my email: [u1037628@uel.ac.uk](mailto:u1037628@uel.ac.uk).

Thank you for your time.

Yours sincerely,

Katarina Kovacova  
Trainee Clinical Psychologist

#### **Project supervised by:**

Professor Mark Rapley  
Professor of Clinical  
Psychology and Programme  
Director, Professional  
Doctorate in Clinical  
Psychology, University of  
East London

Dr Neil Rees  
Clinical Director, Doctoral  
Programme in Clinical  
Psychology, School of  
Psychology, University of East  
London.

## APPENDIX 3: PARTICIPANT INFORMATION SHEET

### PARTICIPANT INFORMATION

You are being invited to take part in a research study. In order to help you decide whether you would like to participate or not, please take time to read the following information carefully.

#### **What is the title of the study?**

Clinical psychologists' constructions of their work with children.

#### **What is the purpose of the study?**

The purpose of this study is to explore how clinical psychologists talk about their work with children. The researcher will be particularly interested in *your* narrative of these experiences. The study is being conducted as part of the researcher's Doctoral Degree in Clinical Psychology at the University of East London.

#### **Why have I been chosen?**

You have been approached to take part in the study, as you are a clinical psychologist who routinely works with children in the NHS-provided mental health services. Eight to twelve clinical psychologists will take part in the study.

#### **Do I have to take part?**

Participation in the study is entirely voluntary. It is your decision, whether or not you take part. If you do agree to take part, you will be free to withdraw any time, and you will not be asked to give any reason.

#### **What will happen if I choose to take part?**

You will be asked to sign a consent form that states that you are happy to take part in the study. Following from this, you will be invited to take part in a confidential, one-to-one, digital-recorded interview lasting about 1 hour in a comfortable setting, which could be at your work place or at the University of East London. The time and location of the interview will be arranged for your convenience. You will be given an opportunity to ask questions before and after the interview.

#### **What are the possible disadvantages and risks of taking part?**

There are no known risks in taking part in this study. However, should you

become distressed and wish to discuss this further, the researcher may refer you to a suitable organisation, for example, the relevant Occupational Health Department.

### **Will my taking part in the study be kept confidential?**

All information will be treated with the strictest confidentiality. The consent form and the demographic profile form, which bears your name and details, will be separated from the rest of the information. All transcripts of interviews will be made anonymous, only distinguishable by the code assigned to each participant. Details of the codes will be kept separately to the recordings, transcriptions and other details and stored in a locked filing cabinet. Recordings might be transcribed by another person who will be required to sign a confidentiality agreement. All digital recordings will be erased five years after the date of the last interview. Data will be stored in a password-protected computer.

### **What will happen to the results of the study?**

The results of the study will be included in a doctoral thesis. Your responses will remain completely confidential and your personal details will not be included in any documentation. The findings of this research project may be published in the future, or presented at a conference.

### **Ethical Approval**

This research project received Ethical Approval from the University of East London.

### **Disclaimer**

You are free to withdraw from the study at any time, up to the point when the data is included in the overall analysis. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

### **Contact for further information**

Thank you for taking the time to read this leaflet. If you are willing to consider participation or have any further questions, please contact the researcher on the email address below. Alternatively, you can telephone the Doctoral Degree in Clinical Psychology Office on 020 8223 4174/4567 and leave a contact number for the researcher to return your call.

### **Researcher's details:**

Name: Katarina Kovacova, Trainee Clinical Psychologist  
Contact address: Doctoral Degree in Clinical Psychology  
School of Psychology

University of East London  
Stratford Campus, University House  
Romford Road  
Stratford E15 4LZ

Telephone: 020 8223 4174/4567  
E-mail: u1037628@uel.ac.uk

**Project supervised by:**

Professor Mark Rapley  
Professor of Clinical  
Psychology and Programme  
Director, Professional  
Doctorate in Clinical  
Psychology, University of  
East London

Dr Neil Rees  
Clinical Director, Doctoral  
Programme in Clinical  
Psychology, School of  
Psychology, University of East  
London.

## **APPENDIX 4: RECRUITMENT ADVERT**

### **Recruitment advert placed on the research board within the British Psychological Society's Division of Clinical Psychology**

Are you a qualified clinical psychologist working with children in a mental health service? I am a trainee clinical psychologist at the University of East London exploring how clinical psychologists talk about their work with children. I am conducting this research as a part of my degree. If you are interested in taking part, please contact me on my email: [u1037628@uel.ac.uk](mailto:u1037628@uel.ac.uk)

## APPENDIX 5: PROFILE OF PARTICIPANTS

**Table 1.** Participant profile

| Participant | Gender | Age range | Ethnicity     | Number of years since qualification | Number of years of working with children | Theoretical orientation and speciality  | Type of service |
|-------------|--------|-----------|---------------|-------------------------------------|--|---|-----------------|
| P1 Robert   | Male   | 36-45     | White British | 10                                  | 10                                       | Integrative; critical realist           | CAMHS Tier 2    |
| P2 Fran     | Female | 26-35     | White British | 4                                   | 6  | CBT, systemic; Generic CAMHS            | CAMHS Tier 3    |
| P3 Don      | Male   | 36-45     | White Other   | 18                                  | 10                                       | Psychodynamic; Group analytic           | CAMHS Tier 4    |
| P4 Liz      | Female | 26-35     | White British | 7                                   | 7  | CAT, MBT, EMDR; Adolescents, Trauma     | CAMHS Tier 4    |
| P5 Val      | Female | 36-45     | White British | 1                                   | 3  | CBT, Systemic; Parenting                | CAMHS LD Tier 3 |
| P6 Zoe      | Female | 46-55     | White British | 18                                  | 18                                       | Attachment theory, MBT; ASD assessment  | CAMHS Tier 3    |
| P7 Joan     | Female | 36-45     | White British | 16                                  | 18                                       | CBT, Systemic, Psychodynamic approaches | CAMHS Tier 3    |
| P8 Mary     | Female | 36-45     | White Asian   | 9                                   | 6.5                                      | CBT, Systemic, EMDR                     | CAMHS Tier 3    |
| P9 Cathy    | Female | 36-45     | White British | 10                                  | 10                                       | CBT, Systemic                           | CAMHS Tier 3    |

## **APPENDIX 6: INTERVIEW SCHEDULE**

### **Opening question**

- Can you tell me how do you work with children?

### **Construction of distress**

- How do you make sense of the kind of difficulties children present with in your clinical practice?
  - Prompts: Are there any particular models or concepts that you find useful and why? Can you give me an example?
- How do you make sense of it? / How do you understand it?

### **Responsibility / Parenthood**

- How do you understand the role of parents in conceptualising children's difficulties / distress?

### **Power**

- How do you work with the power differential between you and your 'clients'?

### **Approach**

- How does the approach that you use shape your relationship with your 'clients'?

### **Therapeutic role**

- What do you see your role to be in ameliorating children's difficulties?

### **Defining terminology**

- What do you mean by the term X?
- How do you understand the term X?
- How would you define X?
- What is your understanding of the concept of X?
- You have said X, can you describe to me what exactly you mean by X?

### **Children's voices**

- What barriers do you think there might be to inclusion of the children's views into clinical intervention?

- Can you think about a piece of work where you were unable to consider children's voice / opinion / view?
  - Prompts: What were the issues? What did influence your decision? How did you explain this to the child? Any things you did particularly well or would have done differently?
- In what ways do you think child's age influences how you have these conversations / who you have them with?

### **Problem**

- How did it come to be a problem in need of psychological input?
- What did you see as a problem and why?
- How did you know it is a problem?

### **Effects**

- What do you think are the effects of your intervention?
  - Prompts: Effects on child, family, wider context.

### **Other questions/prompts**

- Could you tell me more about X?
- Can you give me an example?
- What is your clinical experience of X?
- How do you understand X?
- What do you mean by X?
- What do you think the effects of X are on the children you work with?
- What do you think the effects of X are on the parents?
- What do you think people / clinical psychologists mean when they talk about X?
- Was there anything specific you heard / experienced that led you to...?
- Is there anything else I should have asked you?
- Is there anything else you would like to add?



## APPENDIX 7: CONSENT FORM

### PARTICIPANT CONSENT FORM

Consent to participate in a research study

Project Title

#### **Clinical psychologists' constructions of their work with children.**

This form requests your name but will not be kept together with the transcription or other details of the interview.

Please tick the following boxes:

- I have read the information sheet about this research and have had the opportunity to discuss the details and ask questions about this information.
- I understand that the interview will be recorded, and that the data will be anonymised to ensure confidentiality. I understand that the recordings might be transcribed by another person who will sign a confidentiality agreement, and I agree to this. I understand that all the electronic and hard format data will be kept securely for five years, and then destroyed.
- I give my permission for anonymised quotes to be used and for the data to be submitted for publication.
- I understand that I may withdraw from the study at any time, up to the point when the data is included in the overall analysis. I understand that should I choose to withdraw from the study I may do so without disadvantage to myself and without any obligation to give a reason. I understand that should I withdraw, the researcher reserves the right to use my anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.
- I understand I am not taking part due to my status as an NHS employee or any other service in which I work.
- I fully and freely consent to take part in this study.

Participant's Name .....

Participant's Signature .....

Researcher's Name .....

Researcher's Signature .....

Date .....

**APPENDIX 8: DEMOGRAPHIC PROFILE FORM**

**DEMOGRAPHIC PROFILE FORM**

First name and surname / Code:

Contact details:

Please tick the box that best describes you, for each of the following areas:

|             |         |                          |
|-------------|---------|--------------------------|
| <u>Age:</u> | 18 – 25 | <input type="checkbox"/> |
|             | 26 – 35 | <input type="checkbox"/> |
|             | 36 – 45 | <input type="checkbox"/> |
|             | 46 – 55 | <input type="checkbox"/> |
|             | 56 – 65 | <input type="checkbox"/> |
|             | 65+     | <input type="checkbox"/> |

|                |        |                          |
|----------------|--------|--------------------------|
| <u>Gender:</u> | Female | <input type="checkbox"/> |
|                | Male   | <input type="checkbox"/> |

|                              |                                   |                          |
|------------------------------|-----------------------------------|--------------------------|
| <u>Ethnic Group:</u>         | White: British                    | <input type="checkbox"/> |
|                              | Irish                             | <input type="checkbox"/> |
|                              | Any other White background        | <input type="checkbox"/> |
|                              | Mixed: White and Black Caribbean  | <input type="checkbox"/> |
|                              | White and Black African           | <input type="checkbox"/> |
|                              | White and Asian                   | <input type="checkbox"/> |
|                              | Any other Mixed background        | <input type="checkbox"/> |
|                              | Asian or Asian British: Indian    | <input type="checkbox"/> |
|                              | Pakistani                         | <input type="checkbox"/> |
|                              | Bangladeshi                       | <input type="checkbox"/> |
|                              | Any other Asian background        | <input type="checkbox"/> |
|                              | Black or Black British: Caribbean | <input type="checkbox"/> |
|                              | African                           | <input type="checkbox"/> |
|                              | Any other Black background        | <input type="checkbox"/> |
| Other ethnic groups: Chinese | <input type="checkbox"/>          |                          |
| Any other ethnic group       | <input type="checkbox"/>          |                          |

Number of years since qualification:

Number of years of work with children:

Theoretical orientation and speciality:

## APPENDIX 9: TRANSCRIPTION CONVENTION

### NOTATION SYMBOLS

| Notation     | Example                              | Description   |
|--------------|--------------------------------------|---|
| [ ]          | over[lapping]<br>[lapping]<br>speech | Speech that overlapped  |
| < >          | <name of doctor>                     | Aspects of context not transcribed in order to protect anonymity = contextual information that has been anonymised  |
| (.)          | <u>Erm</u> , (.) okay then           | Audible short pause, less than 3 seconds  |
| (long pause) | <u>Erm</u> , (long pause) okay then  | Pause that is 3 seconds or more   |
| ( )          | (guess)                              | Speech was inaudible but a guess was made as to what was said   |
| ( )          | ( )                                  | Speech was inaudible  |
| (( ))        | ((laughs))                           | Comments on aspects of interview not otherwise identifiable from the discourse, e.g. Laughter during the interview; Descriptions of non-verbal communications |
| —            | Used to give <u>emphasis</u>         | Emphasis on vocal delivery of word, or part of word   |
| =            | Speech is=<br>=Latched by someone    | No discernable gap between speech   |
| (h)          | <u>Sto</u> (h)p <u>i</u> (h)t        | Laughter within speech is signalled by h's in round brackets  |

In addition, the following conventions were adopted for grammar and punctuation:

- Commas, semi-colons, colons, hyphens, exclamation marks, question marks and full-stops were used as per prose
- Commas were used between repeated words
- Commas were used between letters or sounds that were repeated (stutters)
- Commas were used between unlinked clauses
- Hash was used for interrupted speech (mostly self-interruptions)
- Double hash was used for false starts, i.e. when the speaker begins the sentence from scratch, or when s/he interrupts the sentence to start a new one
- Double quotation marks were used for direct reported speech, or active voicing
- Speech errors were included
- Contractions (gonna, dunno, wanna, kinda) were used, if they were included in the Oxford English Dictionary
- Slang / informal words were used if they were included in the Oxford English Dictionary
- Where a slang word was used and it was not in the Oxford English Dictionary, the spelling used was as near to the heard word as possible

## APPENDIX 10: ILLUSTRATION OF CODED TRANSCRIPTS





# APPENDIX 11: WORKED EXAMPLE OF DISCURSIVE ANALYSIS

2073 take it, he didn't like the side-effects,  
 2074 [you know], and (.) and, and I am perfectly

2075 Kat: *moral* [Mmm ]  
 2076 Liz: *acknowledged* aware that the research is [often] extremely  
 2077 Kat: *breaks* [Mmm ]

2078 Liz: selective, you know, what [gets published],  
 2079 Kat: [M-hm ]

2080 Liz: and what gets funded,  
 2081 Kat: Mmm=  
 2082 Liz: =gives a very distorted [picture of] what's  
 2083 Kat: [M-hm ]

2084 Liz: (.) useful.  
 2085 Kat: Mmm=  
 2086 Liz: =...and, so, I, I can't unreservedly say that [I'm]  
 2087 Kat: *moral state disposition* [Mmm]

2088 Liz: (.) glad he takes his medication, I [feel]  
 2089 Kat: *personal view* [Mmm ]

2090 Liz: uncomfortable, [and I] feel=  
 2091 Kat: *challenging statement* [Mmm ] =And yet, it sounds  
 2092 Liz: like he still needs to take the medication=  
 2093 Liz: =Well, you know, if he's not gonna be (tearing)  
 2094 *dispreferred* around naked (.) attacking people, wh(h)ich i(h)s  
 2095 *argument* wh(h)at h(h)e d(h)id,  
 2096 Kat: *shared* Mmm. *qualified beh.* *conscious beh.*  
 2097 Liz: *knows both know!* ...before he took it, then, yeah!  
 2098 Kat: Mmm.

2099 Liz: *Yeah! Absolutely! But* it's, it's, it's a deep  
 2100 moral problem, *explicit orienting to*  
 2101 Kat: Mmm. *moral problem-Re MEDS.*  
 2102 Liz: ...that our (.) ehm, medical solutions to these  
 2103 problems are so (.) ehm, (.) poorly understood,  
 2104 [and] (.) ehm, mmm, toxic?, [and] in, in the  
 2105 Kat: [Mmm] [Mmm]

2106 Liz: long term [potentially] neurotoxic?, [I mean,  
 2107 it],  
 2108 Kat: [Mmm ] [Mmm]  
 2109 ]  
 2110 Liz: it's extremely worrying, and, you know, (.)  
 2111 ultimately there's, you know, an argument that  
 2112 rea- it's, it's a, a method of social control,  
 2113 [that it's] (.) deeply non, non-consensu(h)al

EMPHASISE  
 can anyone be perfectly aware? Function?  
 ↓  
 Moral CP + concerned  
 ↑  
 Attends to problematic about evidence/research & consequently usefulness ⇒ displays awareness  
 A tricky profound  
 "DILEMMA"  
 management of a moral dilemma Re meds.  
 what's at stake? wants to work up a picture of a moral CP, but she is part of the system, withstanding the machinery... how is how it's managed on discourse here?  
 - attends to the possibility being smthg CP/hw shouldn't be saying?  
 - factual statement - it happened, that's what he 'DID'  
 - 'interpolated laughter' - problematic description.  
 Dilemma - management moving from one position to another ⇒ practice of Meds BAD but necessary ⇒ warrants  
 again awareness of controversy about meds & it's potential impact  
 Good, moral CP competent & reflective

justifying meds - severe end device

SEE also NEXT pages!

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## APPENDIX 12: TALK PRECEDING EXTRACT 5

The following extract provides the talk preceding extract 5 (lines 2634 to 2658).

### Extract 5: KK/P1: Lines 2634-2658, p. 65-66

2634       Kat:       =Mmm. Mmm. Mmm. Isn't it interesting that many  
2635                    things we talked about, like biases in the  
2636                    research, and everything seems to be about how  
2637                    things appear (.) on the outside level,  
2638       Robert: Yes,=  
2639       Kat:       =...eh, rather than actually doing something,  
2640                    improving something, changing something for the  
2641                    better, hopefully.  
2642       Robert: I don't know if there's any (.)-- I don't know  
2643                    how to get between those two things, because  
2644                    [when I] raised my objections,  
2645       Kat:       [Mmm        ]                                    M-hm.  
2646       Robert: ...when I raised my objections, I made a beautiful  
2647                    case, I think,  
2648       Kat:       Mmm.  
2649       Robert: ...for why it was unethical, and subsequently, why  
2650                    it was illegal,  
2651       Kat:       M-hm.  
2652       Robert: ...and then they did eventually change it, but I  
2653                    got quite in a lot of trouble over it.  
2654       Kat:       Mmm.  
2655       Robert: Eh (long pause) what I met was (long pause) "You  
2656                    know, it really is better for the children to  
2657                    have a 'managed move'. (.) It must be, because  
2658                    otherwise we wouldn't do it". (.)

## APPENDIX 13: MAXIMS OF PRACTICAL POLITICS

### Maxims of Practical Politics

1. Resources should be used productively and in a cost-effective manner.
2. Nobody should be compelled.
3. Everybody should be treated equally.
4. You cannot turn the clock backwards.
5. Present generations cannot be blamed for the mistakes of past generations.
6. Injustices should be righted.
7. Everybody can succeed if they try hard enough.
8. Minority opinion shouldn't carry more weight than majority opinion.
9. We've got to live in the 20th century.
10. You've got to be practical.

Adapted from Wetherell and Potter (1992; p. 177)



## APPENDIX 14: EXAMPLES OF MY USE OF 'WE' AS FOOTING

### Example 1: KK/P1: Lines 870-875, p. 22

870 Robert: We want to turn the coercive  
871 kids, into pro-social kids. (.) That's a  
mistake.  
872 (.)  
873 Kat: So what should we be [doing instead? ]  
874 Robert: [Well, we should] be trying  
875 to turn them into bi-strategic kids. We should ...

### Example 2: KK/P2: Lines 1920-1924, p. 48

1920 Kat: It also sounds like we've got a manual. We know  
1921 how best to parent (.) you know, [children].  
1922 Fran: [But we ]-  
1923 We sort of do but we don't, cause we don't know  
1924 their child, we don't know their family,