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# Discursive Psychology for Applied Qualitative Research

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## Abstract

In this paper, we offer discursive psychology (DP) as a particularly useful analytic approach for engaging in applied research. We begin by overviewing the broad area of discourse analysis and then more specifically describe the contours of discursive psychology. Drawing upon a secondary, shared dataset, we provide a general discussion of the analytic process for conducting a DP informed analysis and offer some example findings. Notably, we highlight the limitations of doing DP work when working with a secondary data set and point also toward the possibilities and opportunities.

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applied research, discursive psychology, shared dataset

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# Discursive Psychology for Applied Qualitative Research

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In this paper, we offer discursive psychology (DP) as a particularly useful analytic approach for engaging in applied research. We begin by overviewing the broad area of discourse analysis and then more specifically describe the contours of discursive psychology. Drawing upon a secondary, shared dataset, we provide a general discussion of the analytic process for conducting a DP informed analysis and offer some example findings. Notably, we highlight the limitations of doing DP work when working with a secondary data set and point also toward the possibilities and opportunities.

*Keywords:* applied research, discursive psychology, shared dataset

In this paper, we introduce the broad area of discourse analysis (DA), highlighting common assumptions that undergird many (but not all) DA approaches. Specifically, our focus is on the discourse analysis approach, Discursive Psychology (DP) and it is this methodology that we describe detail. To do so, we discuss the core assumptions of DP and the three strands of DP. It is one specific strand of DP that we take up in this paper – one informed by conversation analysis (CA). To develop our discussion, we provide a general overview of the shared dataset that we analyzed and describe our analytic process in full. To illustrate the potentiality of DP, we share a set of potential findings to add pedagogical value. We conclude our argument by pointing to some of the limitations of using secondary datasets when employing DP, while also highlighting potential relevance of DP for applied research.

## An Overview of Discourse Analysis

DA is an umbrella term that includes within it a range of theories, methodologies, and methods – all of which focus in some way on the study of language use (Jørgensen & Phillips, 2002; Wood & Kroger, 2000). Discourse analytic approaches have long been used across disciplines and applied to a range of types of data, making it a particularly fruitful methodological area for applied researchers. More particularly, DA approaches generally orient to language as being performative; that is, such approaches assume that language in all its forms functions to *do* something. For instance, the utterance – "*would you like to come to the movies?"* – serves to "do" an invitation. In this way, DA approaches argue that the performative quality of language can be closely studied, allowing analysts to understand how social life unfolds (Potter, 2004). Taking up this performative perspective, analysts presume that it is through language that reality (and the social world, more specifically) is built. Such a perspective is grounded in social constructionism – a theoretical position advocating that language is ordered, produces, and sustains the social world(s) (Berger & Luckmann, 1967). Notably, DA approaches take up a critical orientation in some way, as they all – in some way – function to question take-for-granted knowledge and everyday practices (Jørgensen &

Phillips, 2002). Thus, broadly conceived, discourse analytic perspectives are (1) underpinned by a theory of language as performative, (2) steeped in a social constructionist understanding of the world, and (3) serve to question taken-for-granted knowledge and ways of being and doing.

As aforementioned, there are different discourse analytic perspectives (Lester & O'Reilly, 2016), ranging from those that take a more sociopolitical macro-orientation (such as critical DA, Foucauldian DA) to those that engage a more micro-focus, (such as CA informed DP; Wooffitt, 2005). While there are underlying similarities across these approaches, there are also notable distinctions. For example, those approaches that focus on a more *macro* socio-political orientation to the study of language (e.g., discourses of disease) are interested in the broader climate of the phenomenon, such as an interest in power and oppression. Others take up a more *micro*-orientation to the study of language (e.g., the way in which question formulations position some speakers as "knowing" versus "not knowing"), are interested in the members' orientations and ways of speaking. There are also some approaches that "sit" somewhere in the middle, attending to both *macro* and *micro* concerns. Importantly, some of these approaches to DA have sought to utilize methods for *applying* the approach and the findings to practice (e.g., Smith, 2007). Further, each discourse analytic approach brings specific perspectives and preferences related to (1) core philosophical concepts (e.g., epistemology), (2) defining discourse, (3) selecting relevant data sources, (4) interpreting data, and (5) reporting findings. As Lester and Paulsen (2018) noted:

> Given the vast differences across these approaches, it is not possible to generate a step-wise discussion of how analysis should proceed or even how to design a DA study. Rather, we assume that if you are to carry out a DA study, it is important to go deep in familiarizing yourself with the assumptions of a given approach—noting that concepts such as "language," "discourse," "data," and even "analysis" are often theorized in distinct ways. (p. 59)

Thus, what we offer next is a detailed discussion of one approach to DA, which we aim to illustrate is particularly useful for applied researchers.

## An Abbreviated Overview of Discursive Psychology

DP is both a theory and method (Edwards & Potter, 1992). It brings with it a theory of language as performative that is grounded in social constructionism (Potter, 1996). Developed in the 1980s and 1990s by Edwards and Potter, DP was originally conceptualized as a way by which to revisit classic psychological issues (e.g., cognition, memory, learning, etc.) and reposition them as discursive entities. Standing in contrast to cognitive views, DP foregrounds the study of discourse when studying psychological matters and advocates for the examination of discourse in its own right rather than positioning discourse as a conduit or vehicle for underlying mental scheme (Edwards & Potter, 1992). As such, DP is not simply a method (e.g., set of steps); rather it involves a way of thinking and theorizing psychological concepts broadly and discourse more specifically (Potter, 2012). Wetherell (2007) pointed to the three core aims of DP as including: (1) studying psychological topics via focusing on language use; (2) promoting a new way of examining psychological constructs, and 3) advancing qualitative research methods across disciplines. More particularly, DP offers analysts an innovative approach to discourse analysis, which focuses on the micro-examination of language use. While there are a range of ways in which DP can be used (see Potter, 2012, for a discussion of three different strands of DP), in this paper, we focus on what has been described as the third strand of DP. This strand was developed in the mid-1990s and greatly influenced by

conversation analysis. Conversation analysis (CA) is a standalone qualitative methodology that focuses on studying the sequentiality, unfolding order, and micro-details (e.g., rising intonation, prosody) of talk (Sacks, 1992).

DP's close association with CA has resulted in a preference for naturally occurring data; that is, data not dependent upon a researcher's involvement or agenda (see Kiyimba et al., 2019). For instance, rather than collecting interview or focus group data, researchers using a more CA influenced approach to DP tend to collect naturally occurring data, such as recordings of everyday interactions. This preference does not mean that DP cannot be used with researcher-generated data, such as interview or focus group data. Rather, it points to the ongoing debates about researcher-generated data, which have historically been conceptualized as offering insights into people's attitudes, beliefs, minds, etc. In contrast, some DP scholars have argued that such researcher-generated data are limited and instead promote the argument that people's attitudes, memories, beliefs, etc. are made visible in and through their talk and text (Potter & Hepburn, 2005). In other words, those practicing DP do not speculate about the reasons why individuals behave as they do and they also do not speculate about their intentions or motivations, as instead they describe conduct and its constituent features (Huma, et al., 2020). Thus, what is often preferred is the collection of data that are not dependent upon researchers posing questions and/or reliant upon retrospective accounts. As Sacks (1992) noted,

> If we are to understand and analyze participants' own concepts and accounts, then we have to find and analyze them not in response to our research questions, but in the places they ordinarily and functionally occur…in the activities in which they're employed. (p. 27)

Accordingly, rather than asking people about their experiences or perceptions of phenomenon, it is preferred to collect data in the actual places where the activity or phenomenon of focus occurs. In this way, DP approaches aligning with CA can attend to the sequential organization of the interaction as well as the psychological features. The use of naturally occurring data provides depth of detail and promotes analysis of what happens in real world interactions as opposed to relying on retrospective accounts. In this way DP studies can address research questions that seek to investigate *what* happens in certain settings and *how* those things happen. For example, they can attend to the processes that occur naturally in healthcare appointments, like primary care or therapy, those that occur in educational settings like schools or universities, or in legal settings like courts or police interviews.

## Data Sources

To illustrate the potentiality, and challenges of using DP for applied research and for secondary analysis, we analyzed a shared dataset acquired via the Qualitative Data Repository (Chukwuma, Mbachu, Cohen, McConnell, et al., 2017). This dataset was collected as part of a larger mixed methods study that examined perspectives about postnatal care referral behaviors of Traditional Birth Attendants (TBAs) in Nigeria. The study was conducted in July 2006 in Ebonyi State, South Eastern Nigeria, and involved the collection of researcher-generated data through focus groups with 28 women. More specifically, three focus groups were conducted with eight health care workers, 10 TBAs, and 10 TBAs' clients – with these groups described by the research team as being "key stakeholder groups involved in referrals for postnatal care" (Chukwuma, Mbachu, Cohen, Bossert, et al., 2017, p. 3). One experienced qualitative researcher conducted the focus groups using a discussion guide, while another member of the research team took detailed notes about the interactions among the participants. All focus groups were audio-recorded and conducted in either English or Igbo language. The focus

groups ranged from 62 to 87 minutes, lasting an average of 75 minutes (Chukwuma, Mbachu, Cohen, Bossert, et al., 2017).

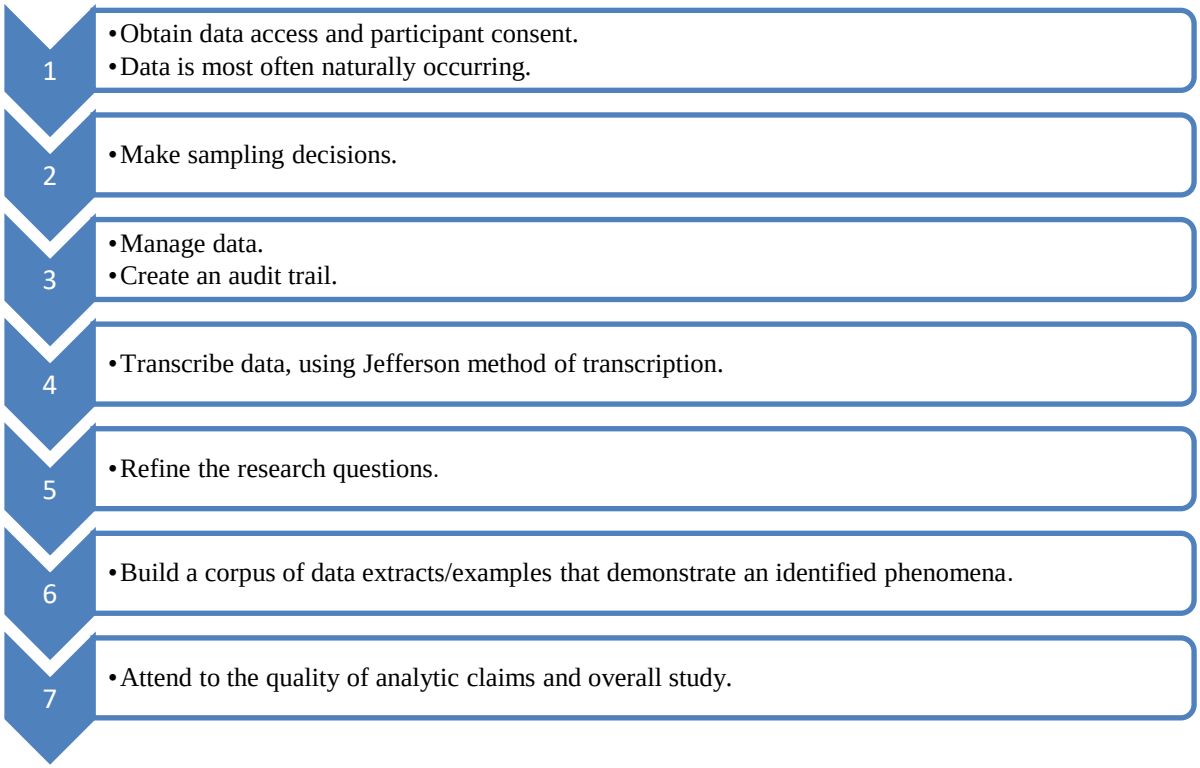
We accessed the data via the Qualitative Data Repository (https://doi.org/10.5064/F67H1GGS), which is a repository that archives, stores, and allows for data and research documentation to be digitally shared. While the original research team audio-recorded the focus groups, we were only able to gain access to the transcribed focus groups. We also had access to the focus group discussion guides and consent forms. For the purposes of our analysis, we analyzed the three transcript files.

## Analytic Process

The pedagogical process for undertaking a DP analysis has typically been for experienced analysts to work closely with those learning the process by "doing" analysis together in the form of data sessions. There is not a linear stepwise procedure whereby the analyst navigates through a series of steps, rather there is an iterative engagement with the data whereby discursive resources, rhetorical practices and performative endeavors are identified and given meaning through alignment with the DP process. While such an iterative and exploratory engagement with data is the best way to learn and understand DP, the contemporary methods environment of parsimonious pedagogy for novices has led to some tentative written procedures to facilitate those new to the approach. Potter (2012) offered seven phases for completing the analytic process, as summarized in Figure 1. While Figure 1 presents them in a linear fashion, it is important to recognize that the analysis is iterative and *not linear*.

**Figure 1**

*The seven phases of carrying out a DP study (Potter, 2012)*




Especially notable in Potter's (2012) process is that all methodological decisions, including the nature of the data, the ethical process and the transcription are built into the

analytic phases. Furthermore, quality assurance is endemic to the approach. The approach then has a series of phases rather than discrete steps to account for the circularity and iterative nature of doing analysis. The ethical decisions and process of obtaining the data (preferably naturally occurring) is part of the process itself and through the data collection and application of ethics the analyst becomes familiar with the setting and the data. Sampling becomes an important phase in doing DP, and while there are broader debates in the qualitative paradigm regarding sampling adequacy, for DP studies it is about depth and richness of the interactional data (Peräkylä, 2004). As the analyst engages with the data, transparency and audit trail are important so that there are clear analytic notes attached to analytic decisions and these are tied to the digital files and transcripts. Notably, in DP the transcription process of producing a Jefferson transcript (see Appendix A) and is itself part of the analytic approach. In this way, the transcription process and transcription decisions contribute to the engagement with the data and the level of detail shapes the interpretative process. Notably, the transcript process is one that attends to both *what is said* and *how it is said* – something that is dependent upon having access to the actual recordings of the data. Thus, micro-interactional features, such as intonation, emphasis, pitch, etc., are all assumed to matter when analyzing the data. Notably, as the analysis unfolds, it becomes possible for the researcher to reshape, refine and define research questions that are pertinent to the project so that a specific direction can follow. This allows the analyst to focus and identify a corpus of practices or phenomena of interest to pay more detailed attention to. In so doing, careful attention to detail, micro-examination of those phenomena and language in use are explored and an analytic pattern identified. This then provides a foundation for the final phase which is quality assurance.

## Example Findings

In following the DP approach to analysis, analysts pay attention to the social actions that are performed through talk, and typically attend to the sequential positioning to appreciate how the members of the social interaction make sense of each other's turns. However, in researcher-generated data like focus groups, the interlocutors within it are typically responding to a question posed by the focus group moderator, even if the specific turn is building on the response to that question by another speaker, and thus the research agenda guides the kinds of turns and social actions that are produced by speakers. This is one key reason why DP researchers prefer to work with naturally occurring data. However, as we noted earlier, it is acceptable to work with researcher-generated data provided the analyst accounts for the nature of the interaction. Given that this paper focuses on secondary analysis, the nature of the data was dictated by the goal of the special issue, and we therefore work within those parameters. In this analysis, we illuminate the social actions and their performative nature within the data to demonstrate the discursive process of analyzing data. Of course, in a data corpus like this there are many different social actions identified and limited scope to discuss them, and thus we have selected a frequently reoccurring social action identified in all three groups; that of epistemic positioning.

We provide an analysis that is organized around the social action of claiming rights to knowledge, either through: (1) category entitlements (that is, rights to knowledge by virtue of a role, see Potter, 1996); (2) an appeal to competence (that is, professional competence or incompetence) often aligned with an orientation to epistemic hierarchies (which can be utilized to elevate the superiority of one version of knowledge over the other); and/or (3) through experiential knowledge (that is, persons have unique and individual rights to knowledge about their own experiences, feelings and views, see Sacks, 1992). The social action we identified then is an allocation of rights to speak with authority, which was often accomplished with moral overtones and modal verbs that dictate the way events *should* be. Participants in the groups

point to the competencies required to fulfil certain expectations and provide a critical narrative when there are negative consequences. In utilizing the concept of epistemic positioning, therefore, we refer to how interlocutors' epistemic stance is taken and displayed through talk and what such a position performs discursively.

As Heritage (2009) noted, speakers talk in ways that display what they know relative to others, orient to what they might be entitled to know, and what they have rights to describe. Aligned with this, the notion of positioning refers to the discursive construction of a personal story and this positioning can be one constructed by the self or positioned by an institution or others (Harrè & Langenhove, 1999). While positioning was notably aligned with the ethogenic views of discourse (e.g., Harré & van Langenhove's work) or post-structural projects where positioning was seen to uncover how people's minds work, an epistemic discursive psychological view of positioning examines the local discursive processes where speakers utilize the features of ordinary talk to make relevant their own identity or that of others as part of some social business with interactional logic and in situ relational consequences (Korobov, 2013). We therefore examine the extent to which three different groups of members can participate in the activity of the focus group in discussion of pre-, peri- and post-natal care and how they take up, accomplish, and orient to certain epistemic positions in doing so.

In leading through the analytic messages, we seek to highlight how such a focus on social action, the performative action in discourse and the epistemic claims made by speakers, provides an important insight into postnatal health care for translation into applied contexts, while simultaneously illustrating a pedagogy for understanding the process of an approach. In other words, our analysis is both methodological in line with the analytic techniques utilized, and also pedagogical in the sense that our process is illuminated more explicitly as an explanatory tool. For ease of reading, we refer to the health care workers throughout analysis as HCW; the traditional birthing attendants as TBA; and women who delivered their babies at home as WDH.

## Epistemic Positioning One: Category Entitlements

When presenting accounts of events or circumstances, speakers may facilitate that version by orienting to their entitlement to knowledge by virtue of belonging to a certain category. In making claims a speaker may display the factuality of their account through an appeal to a category, whereby the category is imbued with certain knowledge statuses, and being a member provides an expectation of certain kinds of knowledge (Potter, 1996). Potter argued that membership to a category is something accomplished in talk and the relational entitlements are built, developed and made relevant to the interaction. It is thus important to explore category membership in talk, to examine what features of the category are achieved in interaction (Sacks, 1992). Categories are not natural entities but are discursively produced and maintained through collaboration (Potter, 1996).

An epistemic positioning that was fluidly negotiated in the focus groups was an appeal to specificity of role, either through the explicit stating of a category or by a description of tasks typically associated with a certain role. The members of different groups oriented to their rights to certain kinds of knowledge by referring to the role they occupy in terms of birthing and postnatal activity, and recognized limitations to knowledge based on their roles.

> Because we, the TBAs do not give injections. I tell them to go back to the health facility after six weeks of their delivery. I also visit them to know whether they have gone for the baby's injection. (TBA-P9)

A clear identification with a role category is utilized in the account provided by this TBA. Here the TBA accounts for not providing *injections* to the mother or the baby, and firmly positions this as outside of the category entitlement of a TBA. In this narrative we can see some management of stake and interest in the account presented, in the sense that navigation of the parameters and boundaries of the role potentially ward off any questions from the focus group moderator that might be inconsistent with the role identity constructed. Indeed, the TBA presents the alternative of the *health facility* as meeting this health requirement, which is juxtaposed with the TBA responsibility of checking that the mother followed through with the requirement. Thus, the accountability of the TBA is positioned as encouraging the mother's attendance at the center, and not to provide the service of *injections*. In presenting the role identity of the TBA in this clear way of what is *not* part of the role, there is an indication of what *is* part of the role.

Conversely, some professionals focused on the specifics of their role by describing what they do. "Our role is to assist women in the community during the deliveries" (TBA-P10). In clear terms, the TBA outlined what the role of the TBA is in the context of discussion. In this sense, the expertise of these workers is constructed as one of *assisting* and working in the *community*. The collective pronoun *our* aligns this speaker as belonging to the category of TBA, and in so doing points to the relational aspect of the role. It collectively embraces the other speakers in the group and functions to align with the other members of the category, but also of the focus group in which she is speaking. For some speakers, they provided more explicit orientations to the role expectations by listing activities typically associated with the category.

> We do many things for them, we do a checkup on their body system and also examine their physical appearance to know if she is healthy, you will also listen to her to know if she has any complaints concerning her body. You can also advise her on family planning. (HCW-P6)

The appeal to knowledge is embedded in the institutional activities and business carried out by the healthcare worker as presented in descriptive detail. On close interrogation of this talk, we can see that the vocabulary utilized is congruent with healthcare language, and while not overly technical, there are certain terms that point to the potential expertise of the speaker, e.g., *family planning, complaints, examine, body system* and so on. This is strengthened by the epistemic positioning as an advisor to women, that is, *can also advise her*, which orients to an ability to be able to provide advice. By virtue of offering healthcare advice, there is an implicit assumption that the speaker belongs to a category with the necessary skills to do so. By listing role activities in this way, the speaker accomplishes a display of expertise about post-natal care, but also aligns with the category of healthcare worker, thus positioning her role in the focus group context. In this way, the category entitlement performs a social positioning as some form of expert, as associated with the category of healthcare worker; as certain categories bring with them specific kinds of knowledge (Potter et al., 1993).

The expertise associated with categories was often subtly introduced by describing conditions where certain kinds of knowledge might be required in the birthing process. Thus, the alignment to that expertise was intrinsically tied by virtue of belonging to that role category.

> There are some conditions that the women will be into that will require the attention of the health workers in the health facility. (HCW-P4)

Rhetorically, the speaker describes that a certain level of knowledge and skill is necessitated in certain situations, and the role of the health worker becomes pertinent to such conditions. As a

member of this group, the speaker's own category is subtly invoked as having specialist expertise to manage these conditions and thus the epistemic position of health workers is constructed as pertinent as a higher level of knowledge.

**Epistemic Positioning Two: Role Competencies and Epistemic Hierarchies**

Professional competence in discursive terms is an interactional achievement within the local setting and not an imposed assessment of capability against a standardized set of markers. The presented competence associated with the category entitlement of the focus group members is invoked across epistemic domains of skill, knowledge, and ability to manage the healthcare of women. The professional competencies of these members are positioned by the speaker as managed at different levels as associated with expectation of the role, and in that sense therefore, speakers project epistemic hierarchies. That is, different layers of ability are mapped against the level of training and skills associated with the role of the individual and expectations about the kinds of activities they might be able to carry out effectively. Notably, the notion of competence is something that is dynamically, situationally and collaboratively achieved in the moment (O'Reilly et al., 2020). In other words, competence varies along dimensions and is socially constructed in social interaction, meaning that competence is not simply knowledge and information processing capability, but are applied conditionally (Topping et al., 2000). In the data we can see different levels of professional competence applied discursively, as speakers orient to what is within their capability and what is not.

> During delivery, I take care of them and assist them in delivery. I also take them to the health center when complications arise. (TBA-P6)

The level of ability is described by this TBA as relating to normative births, where the situation is straightforward, and her skills are necessary and helpful. The TBA reports providing a level of care as the women deliver their babies and that some healthcare intervention is provided as she assists *them in delivery*. Thus, the TBA navigates a level of competence that is congruent with the expectation of the role, in assisting women to deliver their babies, while outlining the limitations of that competence as not having the required skills to deal with *complications* as they *arise.* The implication therefore is that an additional layer of expertise is necessary for cases that do not follow the normative birth trajectory. However, it is notable that the TBA maintains a role even in these cases in facilitating the process, by actively taking the women to the healthcare center where the required health expertise can be found. A similar construction was supported by another member of that focus group.

> There are also situations whereby the woman must have delivered in my home, but when I monitor her closely and realize that she is not feeling fine as she is supposed to be, I usually rush her to the health facility. (TBA-P2)

The role of the TBA is again invoked as providing a service to women delivering babies in normative birthing situations. The environment is constructed as relevant to that epistemic positioning as being one that does that have institutional parameters or equipment as the births take place in the *home* of the TBA; a non-medical environment where the TBA takes responsibility to assist in the delivery of the baby. The competence of this speaker, as a TBA is thus accomplished by her appeal to an epistemic ability to *monitor her closely*, a skill in itself. Like in the previous narrative, this TBA acknowledged the limitation of her healthcare abilities and presents a case where the birthing experience transcends her professional competencies, and she actively pursues a more medicalized alternative in situations that

warrant additional expertise. In these cases, the TBA will *rush her to the health facility*. The urgency of such care is oriented in the very discursive construction of speed, that is, *rush*, suggesting that when a woman requires additional expertise beyond the competency of the TBA, it is necessary that this new expertise is provided quickly. Notably, here she does not invoke roles or individuals as to who might have that additional competence, and instead draws on the broader institutional environment label of *health facility*, which suggests a multidimensional range of expertise and medical competencies to deal with a situation that requires urgency.

The levels and layers of expertise were also oriented to by those with an elevated position of knowledge, as health workers also described situations where their own competency to deal with more complicated cases warranted an additional level of medical expertise.

> She later had some complications there and they brought her here, after examining her she was looking so pale and had to have blood. So, I had to refer her out, when they got there, they had to do blood transfusion immediately. If not for that, the woman would have lost her life like that. (HCW-P4)

The orientation to a specific case was a commonly deployed rhetorical device utilized by speakers to strengthen and authenticate a position being presented. Here we see such an example, as this health worker describes a specific woman giving birth where there were extreme medical circumstances, with a risk that without intervention she *would have lost her life*. In this case, the health worker narrates that this specific medical emergency was beyond her professional competence and role, and she was left without a choice but to *refer her out* (presumably to a doctor) where a blood transfusion and other medical care could intervene to prevent death. This referral was a third layer in the process, as the speaker illustrated that the first referral was from the TBA (*they brought her here)* and the woman was left in the care of the health facility and health workers. In attending to three layers of care, the speaker presents a case of three epistemic layers in the hierarchy of knowledge and competence as each category along the trajectory accepts the limitations and boundaries of what they can do in complicated cases:

> I take them to the health facility when the complication that is beyond my ability arises. By the grace of God, both the woman and the child usually live. (TBA-P8)

> We should not try to do something that is beyond our ability, we should refer the women early enough and not when things have gone beyond remedy. (TBA-P10)

The personal positioning of the TBAs was directly constructed by some speakers as they acknowledged the limits to their expertise. Indeed, speakers did talk about their own in*ability* to deal with complicated situations and the importance of referring to epistemic agents who were able to manage these women. Here we can see that both speakers take a similar epistemic stance on these situations, as they both show that this kind of event is *beyond our ability*. Interestingly, speaker one uses the pronoun "*my"* which personalizes the professional competence to her own unique situation, but speaker two makes a broader appeal to the role of the TBA, by speaking directly to the group, and positioning herself as part of a wider profession *"our*." In these constructions, the urgency of acquisition of appropriate expertise for the women is alluded to. Discursively, they both appeal to the challenge of time, as speaker one recognizes the risk to life *both the woman and the child usually live,* and speaker two orients to the referral needing to be *early enough.* Thus, it is noted and presented that the hierarchy of medical expertise is warranted for those cases where there is risk to women's life during the process of

giving birth, and anything beyond the normal procedure falls outside of their capability to deal with. Indeed, it is positioned as a moral imperative, as they *should* refer women, constructed as crucial or essential, rather than optional or ideal.

Interestingly, epistemic hierarchies were constructed in some cases in subtler ways through orientations to educational roles. By coopting a role of educator, the elevated knowledge position of one profession was created over the other.

> So, my opinion is to gather the TBA at least once in a while and advise them on the relevance of these things so that they will be telling the women the things they need to be doing. (HCW-P6)

Although constructed as personal opinion rather than institutional fact, the orientation here is that the TBAs require a regular education on matters that will improve their practice. In so doing, the speaker constructs the role of the health worker as an educator and advisor, positioning part of their role as necessitating time to provide support and knowledge to those lower in the epistemic hierarchy. When she speaks of gathering *the TBA at least once in a while* this is constructed in the context of a wider discussion on health workers teaching TBAs basic hygiene practices and developing a broader partnership working approach. The speaker here presents the ideology of translational knowledge, in the sense that the health worker can educate the TBA, so that in turn, the TBA can educate the pregnant women; that is, they can tell *the women the things they need to be doing*. The moral proposition then is that the women who give birth ought to be engaging in certain actions and lifestyles to promote a healthier birth, and they require an education as such. Such a moral dimension to the presented advice-giving role is further invoked by another health worker as they project a suitable institutional process for the TBAs.

> They should be having their meeting regularly and they can call a health worker around them to visiting them at least once a month. (HCW-P3)

The notion that health activities around good practice ought to be implemented in specific ways was presented as preferable by the health workers. Subtly the hierarchy is invoked as the speaker posits a certain expertise to be able to comment on the ways in which TBAs ought to be working. In so doing, this speaker argues that their meetings should be occurring regularly so that health workers can be active in their cases. Indeed, the difference in epistemic status between health workers and TBAs was also referred to by the women who had given birth in their care:

> It is good to go to the health center because they can take good care of you more than the TBA, those women do not have all the equipment to take care of any problem that arises. (WDH-P7)

A direct contrast was employed by this mother as she presented her view of the TBAs and health workers, with a hierarchical structured discursively positioning the health center as a better place to give birth. The contrast specifically elevates the health center in terms of good care and equipment. Although, the speaker points to this elevated epistemic position of workers in the health center as being pertinent in situations of a problem, the mother clearly constructs a difference in competence and capability to manage such problems between the two sets of professionals. This is something that another speaker also points to, by more explicitly presenting the skills and competences of the health workers and nurses:

> Some of the TBAs are elderly women who do not understand when you are explaining to them your condition or that of your baby, but the health workers and the nurses in the facilities understand every stage of the pregnancy to the delivery of the child, they also understand the position of the child by merely feeling your stomach. (WDH-P6)

The sub-categorization of some TBAs as *elderly women* conceptualizes their professional competences as less adequate than the health workers and nurses they are contrasted with. Indeed, it is argued that these specific TBAs *do not understand* and thus position them as lacking the professional competence to deal with their medical situation. A direct contrast is made at this point, as the speaker reports that conversely, the health workers and nurses do understand, and they understand all the relevant stages of pre-natal, peri-natal and post-natal care. By constructing this contrast between the two categories of professional, the speaker rhetorically manages the epistemic abilities of the TBAs and the health workers. The knowledge and capability are constructed as being encapsulated in a simple health activity, *merely feeling your stomach.* Such a simple action as associated with the ability of identifying the *position of the child* is rhetorically positioned as evidence that these professionals can do the job.

**Epistemic Positioning Three: Experiential Knowledge**

Local and personal experiences of pre-, peri- and post-natal care form part of the epistemic paradigm as speakers utilize their own personal and experiential knowledge in presenting expertise around the issues at stake for the focus group. In many situations there has been a privileging of expert knowledge, but in focus groups, all knowledge is considered relevant and important to a research study. Indeed, Sacks (1989) argued that there are some knowledges that individuals would be expected to hold, and these relate to the personal experiences encountered. In other words, members can speak with authority on personal experiences, thoughts, feelings and beliefs as these are unique to the person. In expressing an opinion, reporting a thought, reflecting on a feeling, speakers can present an epistemic stance on a relevant issue or event:

> I have had different experiences and their services are not the same. A good birth attendant will ask you to go to the hospital after delivery. (WDH-P6)

Orienting to their own personal experiences of giving birth, this speaker presents a case that contrasts indirectly a *good birth attendant* with a bad one. While they do not explicitly highlight the notion of a bad attendant, it is initiated by the contrast, as something good stands against something bad. In other words, something can only be good, if one understands its opposite. In this narrative, the professional skills of a good TBA are constructed as those that actively recommend follow up care at the *hospital.* Presumably, then, a bad TBA is one that fails to make such a recommendation after the delivery of the baby. Perhaps most importantly in this construction of the good and bad TBA, is that the expertise of the mother to speak on such matters is grounded in her multiple experiences of different TBAs, and her recognition that *their services are not the same*, which suggests variation in the health competencies across the profession. Thus, the factuality of the account, is embedded in experience rather than any kind of qualification or role. Notably, in response to direct questioning as to whether the women in the focus group attended the health center following birth there was consistent confirmation, as follows:

> I went to the health center. (WDH-P2)
>
> I also went to the health center. (P3)

In aligning with such as follow-up activity, the women in the focus group oriented to the notion presented that good TBAs refer women for follow-up postnatal care, and they clarified their experiential knowledge of such referrals. In so doing, they position this as a necessary part of their healthcare experience. The narratives in this group furthered the moral dimension of postnatal care as they expressed their personal opinions on the matter, that moved from their experience to their views on the issue:

> I am also of the opinion that all women should go for postnatal care, because it is obligatory for a woman that put to bed to take the child to the health facility for immunization. (WDH-P8)

Notably, the expression of the idea that women should go to a health facility following the birth of the child was positioned as personal opinion, and one that aligned with the views of others in the focus group context. Here we see the speaker explicitly stating that what follows is that of an opinion, rather than fact, *I am also of the opinion.* Interestingly, this is an opinion shared by health workers. Here the opinion is integrated with experience, as the health worker identifies a case that she worked with where the outcome was negative because of a failure to address postnatal care effectively.

> I am also of the opinion that the women should not leave immediately after delivery, because I have also had a personal experience in my health center, the woman delivered at a TBA's home but the baby's navel was not protected …… before they could get to us, the baby died. (HCW-P2)

Inherent, then in these discourses is accountability and consequence. In these narratives the speakers orient to the accountability of different roles as aligned with expectation of the role, and the possible consequences of failure, *the baby died.* The severity of such consequences is clearly articulated that of death, and the implication is that in this case the TBA did not refer to the health center quickly enough due to the implied action of leaving *immediately* after the birth and thus not noticing that the *navel was not protected.* By invoking a sense of professional responsibility therefore the healthcare worker offers a moral judgement and account for what should happen in practice, i.e., that TBA *should not leave immediately after delivery* because such actions can result in death.

## Applications for Applied Research Practices

Through our analysis we have focused on epistemic positioning to consider how TBAs and HCWs construct their role, identity and accountability in terms of pre-, peri- and post-natal care, and how those epistemic positions are also considered by mothers. The three different perspectives were offered by focus group participants in accordance with the research agenda, and such epistemic positioning was invoked through a certain line of questioning. Although we have not included the specificity of those questions here, questions around role and responsibility were asked by the moderator. It is therefore congruent with the line of inquiry that discourses of role and identity would be constructed. Nonetheless, there are different ways in which speakers can manage the rhetorical business of epistemics and in our analysis we have highlighted three such ways that accomplished that. These three different but related discursive

responses are relevant in an applied context as the core messages can be relayed to professionals to facilitate their reflective practice.

We argue that there are several useful messages that are illuminated by our analysis. First, there is evidently a tension in the hierarchical positioning of knowledge between TBAs and HCWs and such constructions are mirrored by mothers themselves. The roles, responsibilities and limitations of what each member can achieve within the institutional boundaries of their category were negotiated and developed through discourse. This has implications for the delivery of healthcare in Nigeria and is tied to discourses of education and training, along with a willingness to share knowledge across groups, including pedagogical necessity for mothers. Second, one of the most striking issues raised through the discussions were the consequences of poor communication and a lack of congruence between TBAs and HCWs. Any epistemic tension and challenges in communication ultimately lead to poor care for mothers and risk disability or death of the infant, and potentially the mother too. Clear recommendations of creating a communication model and greater transparency in practices between the two groups could be conveyed through a combined training program encouraging both sets of workers to share stories and knowledge. Appreciating limits of competency is also bound in training and knowledge sharing, as some individuals were argued to go beyond their capabilities and role. At a higher level, a public health awareness campaign to educate expectant families of what is acceptable for each organization, and how to assert their rights and knowledge in the situation of pre- peri- and post-natal care could be helpful. However, given the resource envelope in Nigeria this is potentially challenging to create and implement in a low-cost manner.

In doing applied research using DP then, it is necessary to articulate the unique value that the analytic approach/perspective of focus might bring when engaging in *applied research practices*. Particularly, the relevance of the work for individuals such as practitioners, organizations, and/or policy makers can be made explicit, as we have illustrated by our example above.

## Limitations of Secondary Data

Scholars who use DP have tended to collect their own data, rather than relying on secondary data sources, although there can be value in data sharing. Notably, there is a precedent for working with secondary data, particularly when this data is in the form of recordings. For instance, the CAVA project is a repository of audio-visual data of human communication with spoken and signed language (https://www.ucl.ac.uk/ls/cava/about.shtml) and the Centre for Academic Primary Care at the University of Bristol launched a data repository with 300 general practitioners/patient consultations. These kinds of repositories generally require a researcher or research team to request access, and in some cases, there may be a fee payable. Notably, these repositories generally include the actual audio or video recordings, instead of transcripts alone. This speaks to one of the limitations of this dataset; that is, we did not have access to the recordings of the focus groups. Why does this matter for a researcher conducting a DP study? As noted above, DP examines closely both *what* and *how* a given interaction unfolds; thus, having access to quality recordings is paramount for producing a quality analysis. A recording allows for an analyst to closely listen to or view not just *what* is hearable in an interaction (e.g., the words uttered) but also *how* utterances are conveyed, and, when relevant, the role of embodied interactions (e.g., hand gestures).

Relatedly, another limitation of not having access to the actual recordings is that we were not able to be involved in the transcription process. As we described above, DP orients to transcription as interpretative and a central part of the analytic process (Jefferson, 2004**;** Ochs, 1979). Quite often, the researcher is involved in crafting the transcripts, rarely solely relying

upon a transcription produced by someone else. Even if a researcher using an outside transcription service, when using DP, it is assumed that producing a Jefferson transcript requires the researcher to further refine and develop the transcript, using the specialized transcription process. Thus, in the case of the shared dataset of focus in this paper, only having access to an already produced transcript was somewhat limiting to our interpretive process. In addition, given the transcripts in this dataset included translation, notation, or deletion of utterances produced in Igbo, we were limited in our ability to further make sense of the language used – a fundamental aspect of producing a DP analysis. Meaning is always lost with translation, which is particularly relevant for researchers focused on studying language use. Further, even utterances produced in English (the language we both speak fluently) brought with them particular cultural meanings, which was likely lost (at least in part) during the analysis process given our western positionalities. Indeed, we brought no cultural expertise to our analysis, which limited the degree to which we could offer a culturally nuanced and informed interpretation and limited the applied recommendations we could offer. More traditionally in applied work, researchers would consult and engage communities and stakeholders to facilitate the applicability and relevance of the research, but this was not open to us in this instance.

## Conclusions

Through our pedagogical guide expressing the theoretical, pragmatic, and processual aspects of DP, we have utilized a secondary data analysis to illustrate the potentiality of this approach. While there were challenges in pushing the boundaries of the approach and compromising on some of the quality indicators to be able to undertake this secondary analysis, we have nonetheless illustrated the value of using DP for applied research. To do this we engaged with a specific data corpus and identified a core social action of epistemic positioning utilized in the language of members of the focus groups. This enabled us to immerse in the data and through our own data consultations as authors we have provided a full DP analysis in a pedagogical style to show readers the value of using this approach to inform practice.

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Appendix A: Jeffersonian symbols (Jefferson, 2004)

| Symbol | Meaning |
|---|---|
| **(.)** | A period inside brackets denotes a micro-pause; that is, a pause that is hearable but not measurable or significant enough to measure. |
| **(0.2)** | A number inside brackets denotes the length of a pause. |
| **[ ]** | Square brackets denote overlapping speech. |
| > < | Text encased with "greater than" and "less than" symbols denote a pace of speech that is hearable as faster than the surrounding speech. |
| < > | Text encased with "less than" and "greater than" symbols denote a pace of speech that is hearable as slower than the surrounding speech. |
| **( )** | A space between parenthesis denotes that the words spoken are unclear and therefore impossible to transcribe. |
| **(( ))** | Double parenthesis with an inserted description provides contextual information where no symbol of representation is available. |
| **Under** | Underlining a word or a part of a word denotes a rise in the volume or emphasis. |
| ↑ | An upward arrow denotes a rise in intonation. |
| ↓ | A downward arrow denotes a drop in intonation. |
| → | An arrow denotes a particular sentence of interest to the analyst. |
| **CAPITALS** | Capital letters denote that something was said loudly or even shouted. |
| **Hum(h)our** | A bracketed "h" denotes laughter in the talk. |
| = | An equal sign denotes latched speech; that is, a continuation of talk. |
| **:::** | Colons denote elongated speech; that is, a stretched sound. |

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