



**AN ANALYSIS OF MENTAL HEALTH PROFESSIONALS' DISCOURSE:
THE ROLE OF THE CLINICAL PSYCHOLOGIST**

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Abstract:

This thesis introduces the use of discourse analysis to the field of mental health professionals' discourse. It involves the qualitative analysis of discourse in functional terms, and incorporates the use of verbatim transcripts of interviews with two clinical psychologists and four multi-disciplinary case-conferences held within a psychiatric unit.

An exposition of the work in discourse analysis is given and, as a great deal of this work has concentrated on scientists' discourse, the current project is seen as an extension in which the language of the scientist-practitioner is examined. The importance of considering discursive variation as an analytical resource is raised. Arguments are also given for using this approach to examine therapeutic language as an aspect of practitioners' discourse, in a review of the current analytic practices in this field.

The case-conference transcripts are analyzed in terms of the professional roles defined by the priorities of the clinical topics. Particular emphasis is given to the role of the clinical psychologist in this setting. Aspects of turn-taking, the avoidance of verbal conflict, and the function of the case-summary are also examined.

The two interviews are used to try to make explicit the relationship between psychological theory and practice as this is directly relevant to the way accounts are given to justify the activities of clinical psychology.

Finally, the role of the clinical psychologist is examined using material from the two interviews and the conclusions of the analysis of the case-conferences. The general conclusion attempts to assess the benefits of this form of analysis in the examination of psychology as a field of enquiry.

Statement:

This thesis contains no material offered for any other degree or material already published, to the best of my knowledge or belief, except where due reference is made in the text. If the thesis is accepted, I give my permission for it to be photocopied.

Signed,

A.J. Soyland.

September, 1988.

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Chapter One

General Introduction

This is a report on some research into the way a particular group of mental health professionals use language. In the broader perspective it is about how people use words to perform numbers of discursive actions. It is hardly an original claim to suggest that words are very important to the way we live our lives. We perform actions in the way we speak all the time as we argue with each other, sell each other things, strike agreements, question each other, and so on. The way words are put next to each other has a large number of consequences in the fields of politics, law, business, and science. And most of us only gain insight into a lot of these events through the various forms of journalism which interview social actors and construct descriptions as part of their profession. It is then perhaps a little surprising that psychology has not placed a greater emphasis on examining verbal behaviour in functional terms. This is hardly the place to start a discussion of the historical background to psychology's concentration on assuming human behaviour is fundamentally passive or reactive (but see Bazerman, 1987; and Fransella, 1972). Nevertheless, it is important to note from the outset that the basic approach in this thesis is still somewhat unusual in main-stream psychology. As a result, some of the early material I cover is a defence of the methods I have employed.

The theoretical perspective adopted in this report has been taken from a new field of literature in psychology known as discourse analysis. In very general terms, researchers from this area have argued that human verbal behaviour should be regarded as another form of action. That is, people do things with words (Potter and Wetherell, 1987, following Austin, 1962). Of course, people communicate different kinds of information when they speak (or write), but the form the information is given, or the way information is put into words, has a number of consequences and, thus, can be used to perform a range of actions. Discourse, then, is used in this context to cover any form of spoken or written language (Potter and Wetherell, 1987), and discourse analysis is

the investigation of the way in which language is used. A more detailed discussion of discourse analysis is contained in chapters 2 and 3.

While the perspective of discourse analysis is being used as a theoretical framework throughout this study, an investigation of the way in which language is used by mental health professionals involves working in an area in which little material exists. There are, nevertheless, a number of different academic disciplines which contribute to this area and at times the boundaries between various fields become blurred. In the course of this research, I have examined material from social psychology, meta-psychology, sociology, the philosophy of science, medical anthropology, psychiatry, and various forms of linguistics. But, overall, I think the current analysis belongs within the discipline of psychology for two reasons. First, this material concentrates on a very important aspect of human behaviour; the use of language in different social settings (see discussion in chapter 3). Second, the content of the discourse being examined is primarily concerned with aspects of psychology as a field of enquiry, and as such constitutes an addition to psychology's critical examination of its own activities (see chapters 6 to 8).

Although clinical psychology does not have a very long history in the mental health field (Reinehr, 1975; John, 1985), this report has been written at a time when the status of clinical psychology as a profession is well recognized in America (Napoli, 1981), the United Kingdom (Liddell, 1983), and Australia (John, 1985, 1986; Barrett, 1987). The role of the clinical psychologist is currently expanding, and research is being conducted on various ways of continuing this expansion (e.g. Sharpley, 1986; Mohl, 1987) and monitoring its effects (Kahill, 1986). Professional organizations have been established, and positive legislation has been passed or proposed to ensure its progress (Groth-Marnat, 1988). The present study, then, is an attempt to examine the way in which the role of the clinical psychologist is discussed by clinical psychologists in particular, and other mental health professionals in general.

The role played by clinical psychology is important to the way patients in the mental health system are treated, and psychology has undoubtedly played a part in the

way such services are provided and the way those services have changed. The changing role of the clinical psychologist has also had an effect on the other mental health professions. There is, for example, some indication that members of the psychiatric profession may regard clinical psychologists as a threat to their professional autonomy (Shepherd, 1982; and see Kingsbury, 1987). Such professional and therapeutic differences form part of the background in which this study has emerged.

The mental health system has also undergone some fairly recent administrative changes. There has been a large scale adoption of a policy of de-institutionalization (Barrett, 1987), and a call for shorter periods of hospitalization (e.g. Lieberman and Strauss, 1986). It should also be noted that the use of multi-disciplinary teams and case conferences is a fairly recent development. Thus, the area of mental health services has undergone a large number of changes, and it is likely that this trend will continue.

Some of these changes are a result of criticisms of the way mental health patients have been treated (see Cade, 1979, for a short history). There are now many studies which have been critical of the mental health system and the professions associated with it (for example, Szasz, 1962, 1987; Laing, 1959; Zilbergeld, 1983; Goffman, 1961; Perry, 1966; Reinehr, 1975; Foucault, 1967; Anthony et al., 1986). While some of this material has been useful in the development of the present study, there has been no attempt to synthesize these studies or use them as a theoretical framework. Any influence stemming from such studies has been indicated in the text.

Overall, this study is not intended to be critical of the way mental health professionals work. I do not intend to cast doubt on the professional integrity of any of them by analysing their discourse in functional terms. This study is a descriptive one which does not claim, and cannot provide, a review of the techniques and practices which are discussed by the respondents. This study was motivated by questions concerning the role language plays in an applied setting in which psychology was involved. It is hoped that it will constitute an addition to the small but growing body of research into this field.

I have used this chapter to introduce some of the background to this study. I have indicated the sort of questions which initiated it, and briefly described the theoretical orientation adopted. Finally, I want to give a summary of the material covered in this report.

Chapter two develops the description of discourse analysis and considers a few theoretical and methodological issues including the question of generalizability. It is argued that language is essentially functional, and some consideration is given to the implications of this approach.

Chapter three continues the discussion of discourse analysis by examining variations in verbal discursive practices. It also introduces some preliminary discussions of the causes of this variation by considering ecological effects on cognition.

Chapter four contains a discussion of previous studies concerned with analyzing therapeutic discourse. It has been included to show what methodological approaches have been used to examine the discourse of mental health professionals, and argues for methods which are concerned with examining discourse in functional terms.

Chapter five is a discussion of the way in which the present study was initiated, the methods employed in transcribing audio recordings of psychiatric case-conferences, and a discussion of how the analysis was undertaken.

Chapter six is the first of three analytical chapters, and develops an analysis of case-conference discourse. It deals with questions regarding the activity of each speaker, the way in which different professionals enter into the discussion, the avoidance of verbal conflict, and offers some suggestions concerning the function of the 'case-summary'. Overall, the emphasis is on the role of the clinical psychologist in this setting and the way in which it is defined by the conference process.

Chapter seven examines the relationship between theory and practice as it is described in two interviews given by the clinical psychologists who attended the case-conferences analysed in the previous chapter. This discussion further examines the role of the clinical psychologist by considering the effects of training and current research,

the use of common sense and reasoning on the basis of clinical experience, and the importance of research methodologies.

Chapter eight continues the analysis of the two interviews in a more specific discussion of the role of the clinical psychologist. Two broad discursive repertoires or accounting practices are identified which stress the importance of either personal determination or ecological constraints in the definition of professional activity. This material is then compared with the conclusions of the discussion of case-conference discourse. Finally, I briefly discuss the way discourse analysis has been used in this study, and offer an assessment of this approach for future research.

Chapter 2

Discourse Analysis

Theory and Method:

Discourse Analysis (DA) is still fairly novel within most fields of psychology. So, one of the burdens of this thesis will be to explain the motivations and implications of this approach. While some works exist which document its theoretical background (e.g. Potter, 1983; Potter and Wetherell, 1987), much work remains to be done with regard to its scope and fruitfulness. It is not my intention to repeat the material which already exists on this subject, although some exposition will be necessary in order to show how the arguments developed.

The first studies involving some form of DA appeared in the late 1970's. These studies focused on the analysis of scientists' discourse (Mulkay, Potter, and Yearley, 1983) and were motivated by recent developments in the philosophy of science (Potter and Mulkay, 1985). The work of such writers as Popper (e.g. 1979), Kuhn (e.g. 1970), Feyerabend (e.g. 1975), and Lakatos (e.g. 1970) had an enormous effect on the way science was perceived, and since then a large literature has developed which has the activities of science as its object of study. The theoretical approach which has been labelled DA is part of that examination of scientific practice.

But that is not the only topic with which DA is now associated. The range of possible topics has been greatly expanded as researchers within DA move into the areas of everyday discourse. DA is being used to look at the language of racism (Wetherell and Potter, forthcoming), constructions of the term 'riot' (Potter and Litton, 1985; Litton and Potter, 1985), the language of the nuclear defence (Cohn, 1987), academic discussions of assessment (Grimshaw, 1987), coherence in psychotic discourse (Swartz and Swartz, 1987), health promotion talk (Freeman, 1987b), doctor-patient communication (Cicourel, 1983; 1985; 1987), the language of gender issues (Wetherell, Stiven, and Potter, 1987; Wetherell, 1986) and the lay understanding of the term 'schizophrenia' (Barrett, 1987). In this chapter I will attempt to give an account of the

common theoretical thread which these studies have, and to draw out some of its consequences.

What is Discourse Analysis?

DA is a very different approach in psychology and that approach is still evolving. It can be aligned with several major trends in contemporary thought, although it can be shown to conflict with some of the detail of these movements. It is somewhat misleading to suggest that DA has a single unified theoretical perspective: the writers in this field are often eclectics. Nevertheless, I think DA will continue to increase in popularity and it could have a fairly large impact on general psychology.

DA is an approach for studying language which, like any other scientific method (Bazerman, 1987; Pepper, 1942), has a particular set of philosophical assumptions. DA's main assumption is that language, in both the written and spoken forms, can be viewed as having several different kinds of function. A normal declarative type of sentence may be a description of some kind, as in:

'I am not feeling well'

This is a simple statement of someone's internal state. If we have more information about the speaker and the circumstances in which the speaker made this remark, we may understand the sentence in a particular way. Thus if the sentence was uttered by a high-school student at the beginning of a physical education lesson, we may take it as a justification for being excused from the lesson. The student may well be trying to persuade the teacher that participation should not be expected under such circumstances. The student may also be trying to persuade the teacher without actually being ill. A knowledge of things external, but relevant to, a given sentence is necessary in order to reach a workable understanding of it.

The important distinction I want to deal with is the difference between what is said/written, and what the words are intended to do for the social actor. This involves looking at the context of a piece of discourse, and making some sort of inference about the intention of the speaker. I am not suggesting that this involves any specialized

knowledge; I think people make use of such information all the time in normal speech. We quickly understand, for example, that if a guest says that the room is cold, the intended meaning is a request for more heating, or the window to be closed.

Language has not always been seen in such a way. Wetherell and Potter (forthcoming) suggest that some branches of psychology assume that:

"...language acts as a neutral, transparent medium between the social actor and the world so that, normally, discourse can be taken at face value, as a simple description of a mental state or an event." (Wetherell and Potter, forthcoming)

Wetherell and Potter go on to argue that language is functional and that people's discourse is used to perform actions. Rommetveit (1987) has also argued that:

"Assessment of linguistically mediated meaning with no concern for discourse situations and contexts of use seems to rest upon the assumption that the world can be exhaustively analyzed in terms of context-free data or atomic facts and captured in a semantically closed language." (Rommetveit, 1987: 78)

As we saw in the example above, it is necessary to have an understanding of the circumstances in which a sentence was uttered and, given that understanding, the sentence can be seen as performing particular functions (also see van Dijk, 1985, vol. 2: 2).

There is, of course, a sense in which statements and words are neutral. When we look up a word in a dictionary, for example, the word is often defined without reference to particular circumstances. So we need to distinguish between language as it appears beyond given instances, and language which is embedded in a broader discursive system. Paul Ricoeur labels the first of these 'language', and the latter 'discourse'.

Ricoeur (1971) identifies a number of traits which, he suggests, show the difference between language and discourse. Discourse occurs within a particular amount of time and always involves some sort of reference to the speaker. Thus instances of discourse are self-referential (Ricoeur, 1971:531). Language is seen as something beyond these components: language is abstract and its signs only refer to

other language signs, as in a dictionary. Discourse is always about something; it claims to represent the objective world (I won't deal with examples from the nonsense genre, although I suspect the argument still holds). Finally, whereas language is only the code used in discourse, communication is always an instance of discourse.

I think Ricoeur's distinction is useful in avoiding confusions and so I shall employ it in the following discussion, although other writers I will refer to do not draw such a distinction.

In talking about the function or purpose of a piece of discourse it is easy to assume that a social actor has some conscious, yet covert intention. There is, however, no reason to believe that something sinister is always going on. Wetherell and Potter (forthcoming) also stress this point:

"...much of the time people in their lay explanations will not be strategically planning, or self-consciously adjusting their discourse in a Machiavellian fashion...." (Wetherell and Potter, forthcoming)

The actor may indeed believe that a straightforward description is being given. A person describing a population statistic, for example, may not realize their words have a function. Foucault (1978) has argued that such an innocuous piece of discourse may participate in some larger discursive action and thus the speaker may not be aware of the function being fulfilled. I will look at some of the conclusions Foucault has drawn later; for the moment I want to look at a piece of discourse which appears to merely describe a situation but which can be seen as being employed for rhetorical effect (see Billig, 1987, for a discussion of rhetoric).

There are two general ways of looking at discourse. The first one I'll call the 'straightforward' view (also labelled the realist account); that is, what someone does when they say something is transfer information from one to another. Perhaps this seems a little naive when put in those terms, but this is often the assumption behind a lot of psychological research and well worth looking at. I'll come back to this when looking at implications.

The view I'll be contrasting with the straightforward view is the one which informs DA. This approach suggests that *whenever* language is used it should be seen in functional terms; that is, we should not just be aware of the content of the words, but also what the words *do* for the speaker.

The best way of tackling most theoretical issues is by looking at examples, so I'll start by looking at a recent exchange of views in a debate on the philosophy of science. I'll sketch a little of the background to put the discourse in context. The journal *New Ideas in Psychology* has a format which allows writers to submit comments on recent articles within the journal and then allows the original author to reply to criticisms arising from the debate. The debate I want to look at in particular involves an article by Paul Feyerabend called "On the limits of research" (Feyerabend, 1984a). Feyerabend summarizes the article in the following way:

"...science contains and always has contained a form of research that does not accept any lasting boundary conditions and that may change any one of its ingredients." (Feyerabend, 1984a: 5)

Two articles of commentary follow Feyerabend's article in the same volume; one by McMullin and one by Stove. Stove's (1984) article focuses on Feyerabend's 'Anything goes' statement (Feyerabend, 1975, 1984a).

*"What he means would, perhaps, be best summed up by saying:
(5) Cognitively, everything is permissible.
This thesis, though comparatively unfamiliar, is of course far from being new. We had the same thing from Pyrrho over two thousand years ago....(and if (5) was silly, old, and boring around A.D. 200, what is it now?)." (Stove, 1984: 23)*

Feyerabend's reply follows in the next volume and addresses three mistakes which, he argues, commonly arise in criticisms of his work. He also makes some specific comments on some of his critics:

"Stove's article is announced as a 'commentary' on my paper but has nothing to do with it. Stove obviously never looked at it, he just misremembered one or two lines from my earlier work and then went off on his rampage. I don't know how he earns his living but his employer certainly would be well-advised to give him a combined eyellQ test. Bunge and Stove write like political hacks, without regard for detail,

nuance of expression, context, historical background but with all the self-righteousness (and, in the case of Stove, the humour) of small-time hoods." (Feyerabend, 1984b: 132)

What are we to understand Feyerabend as saying? We could take him literally; in which case he would be saying that he does not know what Stove does for a living, and that if Stove had better eye-sight Feyerabend would be more confident that his article would at least have been read.

Stove's main method of attack is a common one in philosophy. He spelt out a particular assertion of Feyerabend's and then drew consequences from it that were clearly unacceptable. The main part of Feyerabend's reply is to deny that he holds the assertion in question. Feyerabend denies that he holds any philosophy at all, and certainly not 'anything goes'. This exchange of discourse is certainly a philosophically legitimate one, but what do the excerpts quoted above add to the argument?

Feyerabend made use of an *ad hominem* argument; rather than restrict his discourse to the arguments in question, he employed this particular fallacy in order to personally discredit his critic. Such a fallacious argument lends nothing to the merit of his case but it does help him re-assert his own position of power in this situation. We can make this suggestion about the function of this part of discourse from an understanding of the circumstances in which they arise. Feyerabend was being criticized, laughed at, and his position had been reduced to a single line. Clearly, anyone persuaded by Stove's critique would see Feyerabend as the under-dog. The opportunity then arose for Feyerabend to reply, making use of whatever arguments were allowed within the framework of a formal journal. I suggest, then, that this piece of Feyerabend's discourse functions as a way of re-establishing the power of his position in this debate. Such an interpretation could not be allowed by a theory of discourse which held that instances of language were a straightforward description of the world. As Wetherell and Potter (forthcoming) suggest:

"The realist model...assumes that discourse is organized in a way which reflects the nature of the entities it describes. For discourse analysis, however, language is put together, constructed, for purposes and to achieve particular consequences." (Wetherell and Potter, forthcoming)

My interest in this example is to show that the suggestion that language is a transparent medium through which the truth can be revealed is inadequate. And I doubt that anyone would take it seriously if they were reading Feyerabend. However, DA wants to go further than just pointing to a few cases where the bias or rhetoric is very obvious. The suggestion is that discourse is *always* functional. This is not to suggest that people consciously consider what function their words will perform at any moment, actions can have consequences without involving degrees of intention. But I do want to say that people achieve more than merely the transfer of information whenever they open their mouths or put pen to paper. The Feyerabend example is appropriate because it's obvious what he's doing. The game gets more complicated as the functions become more subtle. Nevertheless, there are ways of empirically showing how a piece of discourse works, and the results can give us interesting insights into how complicated human verbal behaviour can be.

DA is a macroscopic, qualitative analysis of language. It needs to be contrasted with more microscopic forms of analysis (discussed in chapter 4), and the larger qualitative forms which involve the classification and coding of utterances (e.g. Winefield et. al., 1987; see also chapter 4 on therapeutic discourse). To give some idea of what could be classified as a micro-analysis, Labov and Fanshel (1977) published a book which reported the findings of 10 years of research into 15 minutes of therapeutic discourse (also discussed in chapter 4).

Essentially, DA involves treating words as data: while frequency counts are possible, they are not necessary. The content of the discourse is what is most important. The main point to emphasize is that the DA approach evolved out of a lot of methodological doubts about psychology's ability to say what is really going on in peoples' minds, and, especially in relation to social psychology, researchers using DA have had doubts about measuring such things as attitudes (see discussion in chapter 3). It is important to realize that DA is non-cognitive; it makes no claims about anything beyond the words of a particular text, no claims about what people really think.

Doing this reduces the importance of questions concerning bias, whether the speakers mean what they say, and the level of insight a respondent has on a given topic. In principle almost any form of discourse is open to analysis. On this point Potter and Wetherell state:

"We argue that the researcher should bracket off the whole issue of the quality of accounts as accurate or inaccurate descriptions of mental states. The problem is being construed at entirely the wrong level. Our focus is exclusively on discourse itself: how it is constructed, its functions, and the consequences which arise from different discursive organizations. In this sense, DA is a radically non-cognitive form of social psychology." (Potter and Wetherell, 1987: 178)

To summarize: once we take the step of denying the straightforward view of language, we deny that language can be used as a transparent medium through which the facts of the real world can be revealed. Therefore, the purpose and end-point of this form of analysis is to shed some light on the function of peoples' discourse. Because the analysis is limited to the specific text, nothing is said about the world beyond the text. Moreover, the possibility is excluded by denying the straightforward view. The major empirical claim implied by these ideas is that people's discourse will vary as the functions change. That is, on any one topic, what people say will be different under different circumstances, but the variation will be fairly systematic. Before giving evidence for this claim I shall briefly describe how the discourse is analyzed.

Methodology:

A more detailed account of the method used to analyze the present data will be presented later (in chapter 5); what follows is a brief overview.

DA is a qualitative measure and as such it does not need, and probably could not cope with large sample sizes. For the majority of studies performed so far the standard method is to perform open-ended, or semi-structured, interviews. Some studies (including the present one) involve recording naturalistic conversation. The discourse is audio-taped and the recordings are then transcribed. The level of detail which is transcribed varies from study to study depending on the object of the analysis. A few

studies (e.g. Mulkay, 1985) have side stepped this stage by looking at personal correspondence and newspaper articles and so on.

Once the analyst has a large number of words on paper, various episodes of discourse need to be categorized under various topics or themes. This categorization needs to include all borderline cases as well (Potter and Wetherell, 1987). From here there is no standardized template to follow. The texts need to be read many times and various hypotheses and ideas about their organization need to be tested against the words. The analyst needs generate with a valid, coherent account which will shed light on the majority of episodes under a particular topic.

In writing the research report, typical examples are quoted in full to illustrate a particular account, and the researcher gives the constructed interpretation in full so that the reader can see what has been done and how a given conclusion was generated. In this way, the reader is involved in a sort of replication of the findings. This is not the case, for example, in language studies which involve the coding and translating of words into numbers, where the coding process is often less specific (see Winefield et al., 1987, as an example).

The main thing the analyst is looking for is inconsistency and variation and this is done by directly comparing various episodes of discourse. The research question then becomes: how can we account for this variation? The answer will be in terms of the function a particular episode has.

I shall now address several important issues concerning the status of the conclusions which DA generates. I shall start by looking at the possibility of making generalizations on the basis of particular pieces of discourse, and then I will look more specifically at how those generalizations can be assessed as valid or invalid.

Generalizability as an issue for DA:

A major concern for researchers using the discourse analysis approach is the extent to which the conclusions of such analyses can be generalized. In the more frequently used forms of analysis, within the social sciences at least, measures are taken to ensure that the replication of results is possible, and that conclusions reached may be

extended beyond the sample in question. The question of replication in DA is fairly easily dealt with: portions of the original text are quoted and the important points drawn out by the analyst. Thus the process of interpretation is made in front of the reader who is at liberty to agree or disagree with particular instances. In this way, a particular reading may be replicated by each reader.

Generalizations are more difficult. Michael Mulkey points out, with reference to a series of letters he has analyzed:

"... the rules provided above are designed to generate texts which lead to confrontation and scientific stalemate. I don't not know how widespread this form of textual practice is and I cannot suppose that I would necessarily have obtained the same set of rules if I had examined a different set of letters." (Mulkey, 1985: 67)

I think this highlights a problem, and what I want to do in this section is look at the issue of generalization as it relates to DA.

There is as yet no consistent story on generalizability in the DA literature. While outlining a couple of disadvantages of DA, Wetherell and Potter state that:

"... work of this kind is not suited to the production of the kind of broad empirical laws which are commonly the goal of social psychological research.... our findings are specific to a particular class of New Zealanders at a particular point in New Zealand history. Nevertheless, we do not see this as an inadequacy of the approach so much as a consequence of the fact that explanations are always fitted to specific occasions and constructed out of the available interpretative resources." (Wetherell and Potter, forthcoming)

They go on to talk about DA being a new and untried method in which there is bound to be further theoretical elaboration. However, if the quoted statement becomes the way DA is regarded, I think it leaves itself open to much criticism - putting it in a defensive position.

Remarks of generalization are more encouraging in other places. In their study of scientist's interview talk, Potter and Mulkey point out that:

"... it has been shown elsewhere, not only that all three of the criteria of theory choice identified by Fasham [a pseudonym for a particular biochemist] above are subsequently undermined in his interview but that this is typical of participants' responses in this and other topics as

different as biochemistry and social psychology." (Potter and Mulkay, 1985: 258)

So, there has been some level of success in finding language used in similar ways across different contexts, and Potter (personal communication) suspects that the results from the New Zealand racism study will also generalize. Very few DA studies have been published thus far, so it is encouraging that, even at this early stage, some results are consistent across populations. Bearing this in mind, it is interesting to ask whether DA's problem of generalizability is different, in principle, from that faced by any other method in the social sciences.

Generalizations are always risky things to make at the best of times. A typically conservative summary from a psychological study will restrict itself to indicating statistically significant results, will suggest that further study is needed to bear out the reliability of the results, and may venture a generalization derived from the hypotheses in question. Typically, it is only when an area has been studied in a number of investigations do more sweeping generalizations emerge - and with some justification given the amount of work behind each report. But in the early stages of a field of enquiry, psychological reports are more frequently confined to the straightforward presentation of numerical trends.

Discourse analysis involves the use of qualitative techniques:

"There is no mechanical procedure for producing findings from an archive of transcript. There is no obvious parallel to the well-controlled experimental design and test of statistical significance. In fact the results of studies of discourse are warranted, and critically examined, in a way that is novel to psychology." (Potter and Wetherell, 1987: 168)

As a result, the conclusions of a piece of DA cannot be communicated in the traditional manner. Standard psychological reports state the findings which result from some statistical manipulation of the data. The data has been interpreted and converted to another form. Discourse analysis does not do this. Representative sections of the data - as text - are quoted at length and the process of interpretation carried out in front of the reader:

"The overall goal is to openly present the entire reasoning process from data to conclusions." (Wetherell and Potter, forthcoming)

The conclusions are generalizations about the text and do not involve manipulations or conversions of data.

To return to the question posed, I think the problem of generalizing results may be simplified by looking at the differences in the way traditional and DA methods treat their data. Traditional forms of analysis channel various responses and frequently code them so that they are in a more manageable form. The questionnaire technique, for example, involves the construction of a series of questions which the researcher hopes will split the sample populations in interesting and comprehensible ways. Once a respondent has completed the questionnaire, each answer is converted into a number. Statistical tests are then employed to look for trends in the resultant series of numbers. The investigator is finally faced with the task of constructing a reasonable account of the outcome of the calculation. This actively involves the researcher in interpretation and speculation. The conclusions are then said to hold some level of generalizability depending upon the sample size, the power of the statistical tests, and the levels of statistical significance attained. Also very important is how representative the sample size is of the population about which the generalizations are being made (but see Mook, 1983, for an interesting argument for external invalidity).

We can take it for granted that any investigation is going to try to get a representative sample (but see Wetherell, Steven and Potter, 1987: 61, for a disclaimer). So far, the samples looked at by DA have been fairly specific; biochemists (Gilbert and Mulkay, 1984), social psychologists (Potter, 1983), medical doctors (Cicourel, 1987; Tannen and Wallat, 1987), psychotic patients (Swartz and Swartz, 1987), etc. But there is a growing body of material which looks at broader issues and have more general samples (Potter and Wetherell, 1987; Wetherell and Potter, forthcoming; Wetherell, Steven, and Potter, 1987).

Obviously, it is not possible to compare the use of tests of statistical significance, but there is nothing inherent in the process of statistical calculation which

ensures a level of generalizability. Conclusions based on statistics are only descriptions of whatever specific circumstances the study has looked at. The only advantage which statistics can claim here is the ability to summarize large amounts of data from a large sample. The bigger the sample size, the more likely it is that generalizations are reliable. Does this rule out the use of small samples? For most statistical procedures, it does. The reliability of inferences is related to sample size.

Here is where DA and quantitative methods part company. Analyzing the discourse of a huge number of people is virtually impossible given the amount of effort involved in transcribing the original material. But large sample sizes are really irrelevant to this form of qualitative analysis because large numbers are not what makes a particular interpretation of the text valid or reliable. Some studies have appeared in the literature which give an analysis of a single interview (Potter, 1982; Måseide, 1983; Swartz and Swartz, 1987). Måseide argues that:

"First the study of one of a few cases instead of a large population generates insights into important problems and phenomena that would remain unknown in a more general and abstract study.... Second, the study of single cases reveals aspects of critical importance to any general theory about the phenomena that are studied. The study of one particular case may, for instance, lead to insights into the general value of certain theoretical models, and such insights may have a degree of generality." (Måseide, 1983: note 1)

The point here is not that qualitative methods should replace quantitative ones, rather that there are advantages to methodological pluralism. While there are some arguments, which I will come to later, which show grounds for methodological concern about quantitative methods, writers in DA are always quick to point out that the question is not one of replacement (Potter and Wetherell, 1987).

Discourse analysis involves a reading of the text which is fruitful, coherent, and which accounts for the material the analyst has. This makes explicit the role of the analyst in the active construction of meaning. The presentation of the data shows how that investigator arrives at and justifies the conclusions. It makes the reader aware that the analyst has built up a particular reading of the text while not excluding the possibility that other equally valid readings are possible.

Two parallels need to be drawn to the traditional quantitative method. First; I have already argued that quantitative methodology involves the researcher in the interpretation of the statistical outcomes. The numerical results need to be translated in order to be understood in the way the researcher intends. Both methods, then, involve a level of active construction. Secondly; people who pursue quantitative methods are usually less explicit about this process of interpretation (Bazerman, 1987). There are some very good reasons for this difference (Gilbert and Mulkey, 1984) and it is perhaps to be expected that upholders of other methods would criticize DA on this point.

This difference arises because the conception of knowledge held within DA is not the same as that held by most users of quantitative methods. I don't want to compare and contrast ideas about realism, pragmatism, and relativism here. I will, however, make a review of the epistemological claims of DA in the next section. For the present purposes it will be useful to discuss the status of the data/text used in DA.

Discourse analysis can be used in the investigation of any form of linguistic communication and has as its end point an account of the function of that communication. It does not endeavour to say what is really meant by a piece of text. Such claims would place the analyst in a privileged position (the necessary position would be the same as the one needed to show the validity of the correspondence theory of truth, like Tarski's metalanguage). DA does not make any claims about the epistemic status of a text either. It looks at the way accounts are constructed without making evaluations concerning the extent to which the text is true. I shall come back to this point in a later discussion, but it should be noted here that DA distances itself from claims of absolute knowledge. Mulkey (1985) makes an important point about truth and our conception of knowledge:

"... there is no such thing as a final text... All texts are used as the starting point for some new textual production... I suggest that we replace the notion of knowledge as a set of constant propositions with a conception of knowledge as that which contributes of a continuing process to textual production." (Mulkey, 1985: 76)

Mulkay's comment (which is similar to one developed by Rorty, 1979, 1987; and see Davenport, 1987) is relevant to the discussion of generalizability in that it argues that all propositions and conclusions exist in a dynamic, evolving context. Thus any generalization is not, in principle, immune to criticisms and exceptions (Popper, 1979; Mortensen, 1987). Traditional forms of analysis do not hold a privileged position with regard to generalizability.

Theoretical influences of DA:

It will be useful, in a discussion of theoretical influences of DA, to look at how the term evolved. This is important because:

"The use of the term 'discourse analysis' to describe our analytic perspective signals affinities with research in both the 'empirical' (van Dijk, 1985) and 'continental' (Barthes, 1979; Dreyfus and Rabinow, 1982) traditions." (Wetherell, Steven, Potter, 1987: 60)

While this mix of perspectives has been fruitful, it can also be problematic (see Woolgar, 1986; and later discussion). It is possible to distinguish between two major research programs in what has been labelled here as the 'empirical' tradition of DA. I will discuss the second of these shortly, but begin the discussion in terms of the current perspective in contrast with the 'continental' perspective.

Of the two traditions, the 'continental' is the more subtle and complicated, but the similarities with the present study will be apparent if I reconstruct one of Foucault's arguments. In his preface to *The Birth of the Clinic* (1973), Foucault begins by defining critique or commentary as an examination of what is said, or intended by a piece of discourse. That is, commentary tries to make explicit the truth contained within discourse (it should be noted that by using the term 'commentary' Foucault is referring to the hermeneutic tradition, a summary of which can be found in Ricoeur, 1978; and Frank, 1987). Foucault then argues (in structuralist terms) that the assumption of commentary is both that the truth is not well defined, and that it remains implicit within the language. So the task of commentary is to say more in order to better get at the truth. But the task is never ending because language is assumed to never be a complete

translation of the real world, thus the process of commentary continues. Foucault then asks:

Is it not possible to make a structural analysis of discourse that would evade the fate of commentary by supposing no remainder, nothing in excess of what has been said, but only the fact of its historical appearance?" (Foucault, 1973: xvii)

Here we have the major theoretical move which is made in discourse analysis of this form: the whole issue of truth existing beyond a given set of words is side-stepped.

It is reasonable to ask whether there is a correspondence between words and reality but the answer is different for different writers. Whereas the empirical tradition is implicitly pragmatic, and merely avoids the complications which are involved in discussing ontological truth, the continental tradition adheres to some form of coherence theory or relativism. The differences between these two traditions are clearly described by Woolgar (1986).

Woolgar points out that the term 'discourse' has different epistemological consequences for writers from different traditions:

"At first sight, there is an obvious similarity between this aspect of French structuralism and the kind of scepticism which the social study of science brings to bear upon the claims and achievement of natural science." (Woolgar, 1986: 311)

That is; both see the relationship between discourse and reality as being problematic, but the consequences are much more wide-ranging in the continental tradition. For Foucault there is no reality independent of the way in which it is signified. The Anglo-Saxon version of DA, on the other hand, only makes "the assumption that participants' discourse is too variable and too dependant on the context of its production" (Gilbert and Mulkay, 1984: 13) to be analyzed in any straightforward way (realism). Woolgar suggests that Gilbert and Mulkay (1984) come closest to what he labels as the Anglo-Saxon version of the term discourse (Woolgar, 1986: 313) because they restrict their discussion of the way scientists talk to what accounts of action and belief are given. Thus the grounds for restricting the discussion to people's accounts is that:

"The degree of variability in scientists' accounts of ostensibly the same actions and beliefs is, in fact, quite remarkable. Not only do different scientists accounts differ... but scientists furnish quite different versions of events within a single recorded interview transcript..." (Gilbert and Mulkay, 1984: 11)

I will look at some of the evidence for this claim in the next chapter. It is only important here to note that to claim one particular piece of discourse is a more correct representation of what a respondent believes is to assume that the analyst is in a privileged epistemological position. Such a methodological assumption, although taken by a lot of sociological research, can not easily be substantiated.

While both forms of discourse analysis place an emphasis on the way things are communicated, and both focus on the way discourse is constructed, the continental tradition has a much more ambitious program which could also have ontological rather than simply epistemological consequences. In this thesis I intend to follow a development of the Anglo-Saxon version of DA (e.g. Mulkay, 1985; Potter and Wetherell, 1987) and avoid the interesting, but far more complicated, continental tradition (e.g. Barthes, 1977; Foucault, 1967, 1973, 1978; and see Smart, 1985 and Skinner, 1985, for overviews).

I now want to briefly discuss connections with behaviourism and idealism before examining the other research program within what has been labelled empirical DA.

Idealism and Behaviourism:

Given the discussion of the term DA and its philosophical assumptions, something needs to be said about the relationship which can be drawn between DA, idealism, and behaviourism. I shall take these in turn.

Ricoeur's (1978) discussion of structuralism shows how placing the entire emphasis of discourse results in a Nietzschean denial of the existence of an objective world because:

"The death of God is the death of 'truthful' discourse and the rules of 'correct expression.' Then, reference, farewell!" (Ricoeur, 1978: 264)

It is possible for the analysis of discourse to make the same leap - the denial of ontological realism - retreating to a form of idealism in which the signifiers are never thought to refer to anything extra-linguistic. However, this step is not a necessary one. It remains possible to bracket off questions concerning the truth-content of a piece of discourse in order to look at its function. This methodological step can be taken without making the philosophical assumptions associated with similar forms of analysis, and this is the one made by Anglo-Saxon DA (but see Bowers, 1988).

Some parallels may also be drawn with behaviourism in the same way: because DA focuses on verbal behaviour without making inferences about what the social actors 'really think' it can be seen as non-cognitive in the same way that behaviourism is non-cognitive. The same reply can be given: to the extent that behaviourism does not make inferences about mental processes on methodological grounds, it is similar to DA. However, some forms of behaviourism involve a further philosophical assumption; conscious mental processes are relegated to being epiphenomena. Discourse analysis, as it is used in the present study, does not entail this assumption; it is non-cognitive on methodological grounds alone.

In this chapter, I introduced some of the arguments which have led to the development of the discourse analysis approach. A distinction was made between language and discourse, and it was argued that discourse could only be understood within a particular context. To illustrate this point, an example was taken from a recent debate in the philosophy of science. After a brief summary of the DA methodology, I discussed the issue of generalizability by comparing qualitative and quantitative methods. I then gave a short review of some of the theoretical influences of the present study, and rejected similarities with idealism and behaviourism.

Chapter 3

Verbal Accounting Practices

Much of the material analyzed by discourse analysts thus far has been concerned with the discourse of scientists (for example; Yearley, 1981; Potter, 1982, 1983, 1984, 1988; Gilbert and Mulkay, 1984; Mulkay and Gilbert, 1984, 1986; Mulkay, 1981, 1985; Knorr-Cetina, 1981; Latour and Woolgar, 1979; Collins and Pinch, 1982; McKinlay and Potter, 1987). While there is no theoretical or methodological consensus concerning every aspect of these studies, they have all helped to develop a form of research which attempts to examine the processes involved in the production of scientific knowledge. For the most part, these studies form the background of the present chapter.

Other studies interested in examining science as a social process have been criticised by discourse analysts for assuming that their conclusions are more justified than those given by the social actors being studied (Gilbert and Mulkay, 1984; Potter, 1983). That is, some studies have been based on the assumption that they hold a privileged epistemic position from which to evaluate various knowledge claims. This position has been denied by discourse analysis which does not attempt to assess the truth values of statements maintained by respondents (Potter and Wetherell, 1987). Instead of attempting to show what is 'really going on', discourse analysis has focused on describing different forms of discourse, showing the level of variation involved, and drawing conclusions about the functions of discourse. Discourse analysis, then, is very much concerned with what people 'do with words' (following Austin's, 1962, analysis).

In this chapter, I will show how various accounts can be generated about people's actions and beliefs, review some examples of variation in discourse, and offer some theoretical directions for the analysis of the psychological causes of such variation. This final section will be an attempt to synthesize some work from different branches of psychology, and the resultant theoretical perspective will then be adopted in the analytical chapters which follow.

Accounts of Actions:

Accounts of actions generated in the sciences may appear in many different guises ranging from the formal, stylized journal to informal discussions with colleagues. The amount of variation in such accounts of the same action can be very great (Mulkay, Potter, and Yearley, 1983) but they are all accounts with no *a priori* grounds for deciding between them. A problem exists, therefore, in how to treat accounts which arise out of different situations. If the aim is to look closely at the actions of scientists:

"...how can the analyst characterize actions and thereby allocate them to a specific form, without recourse to participants' accounts of those actions?" (Mulkay, Potter, and Yearley, 1983: 190)

In a great number of situations (experimental reports, news media coverage, law courts) we are limited to a particular account of a situation and it must be remembered that it is an *account* of the situation. It is virtually impossible to get away from the problem of accounts of action (Gilbert and Mulkay, 1984); the only way to do this would be to be present during the course of the action (as Latour and Woolgar, 1979, were). However, if the researcher is present during a particular action, an account of that action must still be produced for others and so the problem returns (Potter, 1987; forthcoming). Indeed, we could argue that we produce an internal account of the action for ourselves. Accounts of actions are underdetermined by the corresponding events. As a result, it becomes important to look at the process of account production - the common methods and limitations.

Depending on the account generated, the same set of actions may:

"...constitute an experiment, an attempt indirectly to raise more research funds, an effort to secure professional credibility, a bid for more students;...depending on the context in which the actor is talking or writing about these acts..." (Mulkay, Potter, and Yearley, 1983: 190)

It is useful to point out that there exists a large number of contexts in which a particular action may fit. The meaning of acts is variable and context-dependent.

By way of illustration, while writing this report I attended a concert for 'cello and piano; the following list of composers was represented:

BEETHOVEN

SCHUBERT

SCHUMANN

SHOSTAKOVICH

It is normal, in such circumstances, to assume that the way the program was assembled was not by random allocation. What should we, as observers of this list, conclude about the underlying principle? The following list, which is by no means exhaustive, occurred to me before the concert started:

- 1) Chronological ordering;
- 2) Alphabetical ordering;
- 3) First the Europeans, then the Russian;
- 4) First the western composers, then the communist;
- 5) Two duets, then a piano solo to give the 'cellist a rest before the demanding final piece.

Each of these principles is true for the above list, but which one, or combination, was used by the performers in making their decision? Obviously, what I should have done was to go and ask one of them, but there are many circumstances where the researcher is unable to ask such questions, and other situations where the respondent may be unaware that such principles of organization even exist. To continue with my example, if I had asked, the performers could easily have answered with option 1, although, when discussing it amongst themselves, the main motivation could have been option 5. This is not to suggest some deviousness on the part of the performers: they could have been aware of both options 1 and 5, but only considered it appropriate to discuss option 1 with a member of the audience. That is, the accounts they could give regarding their behaviour could vary as a function of the situation.

Human discourse involves a degree of flexibility which allows for the generation of accounts which render plausible an enormous range of circumstances and

actions (Gergen et al., 1986; Potter and Wetherell, 1987: 74; John and Soyland, 1988), and it is the variation which results from such flexibility which is the object of discourse analysis. As the example illustrates, the many varieties of discourse around us (whether verbal or text) are open to different interpretations by both actor and observer.

It is quite easy to understand why accounts of actions vary. Behaviour of any sort is bound by conventions to remain within what is regarded as appropriate for a given situation. What may be regarded as a reasonable verbal account in one situation is not necessarily going to be acceptable in a different situation. Thus, an account of an experiment acceptable for publication may differ from an account which aims at achieving more graduate students. The field of political diplomacy provides an even greater range of examples. Thus, as the situations vary so too do the criteria for judging what is appropriate and therefore, what accounts will emerge under those circumstances. I make this as an unsubstantiated claim; it remains to be seen whether evidence may be gleaned for this explanation. I shall now examine a couple of examples which have documented the extent of variation in the discourse of two groups.

Studies of Variation:

Wetherell and Potter (forthcoming) conducted a study which examined the interpretative repertoires of a group of (81) New Zealanders as part of an extended study on racism. A review of this study is beyond the scope of the current study, but I think it is well worth quoting some of their data as it is relevant to the present issue. I have selected two extracts, one of which comes from list A (1), the other from list B (3). I think it will be obvious what these two categories could be labelled:

1. I do this bible class at the moment, not highly religious, I just think children ought to know about religion...and last night we were just discussing one of the commandments, love your neighbour, and I had this child who said "what would happen if you got a whole lot of Maoris living next door to you?", and I said to him "that's a very racist remark and I don't like it", and he shut up in about five seconds and went quite red in the face, and I realised afterwards that obviously it wasn't his fault he was, turned out to be like that, it came directly from his parents (42).

3. And this is the part that I think is wrong with (.) a bit wrong with the Maoris as well there, the problems they have, they're not willing, I mean it's a European society here and they've got to learn to mix and get in and work, otherwise it's, I mean you can't tell them to go back to where they came from (55). (Wetherell and Potter, forthcoming)

Having presented three examples from each list, Wetherell and Potter point out that all of the extracts come from a single interview with the same speaker, and that this pattern of responses was typical of the variation to be found throughout their transcripts.

Wetherell and Potter (forthcoming) go on to argue that the extracts quoted above show the speaker to be drawing on different discursive resources as they seem appropriate at different points in the interview. As a result, it would be difficult to give a definitive label to the attitudes expressed, and hard to imagine a standard psychological measure of the underlying attitudes often assumed by such methodologies. Such variation is usually excluded by the construction of the techniques such as the standard questionnaire used to isolate respondents' attitudes and characteristics. So, by examining a greater range of accounts generated in the course of people's discourse, Wetherell and Potter hope to show some of the complexity of human social behaviour and to view debates on such issues in a new way (see also Potter and Wetherell, 1987; Wetherell, Stiven, Potter, 1987; Potter, 1988). I now turn to a second example.

A larger study of variation in respondents' accounts was carried out by Gilbert and Mulkey (1984), and it is important to briefly review their findings because some aspects of the repertoires they identified will be relevant to material covered in later chapters.

Gilbert and Mulkey undertook a study of the formal and informal discourse of a group of biochemists working in the area of bioenergetics (1984: 18). They begin their extended analysis by showing the extent to which accounts vary even when given by a single individual. The formal account, they argue, is dominated by the empiricist repertoire in which scientists' personal attributes are removed from the discourse to the extent that they only appear in terms of:

"...being forced to undertake experiments, to reach conclusions, and so on, by the unequivocal demands of the natural phenomena which he is studying or as being rigidly constrained by invariant rules of experimental procedure which are, in turn, required by the nature of the physical world." (Gilbert and Mulkay, 1984: 56)

The empiricist repertoire is to be seen in contrast with the contingent repertoire in which speakers "depict professional actions and beliefs as being significantly influenced by variable factors outside the realm of the empirical" phenomena (1984: 57). Thus, in giving accounts of errors for example, scientists speaking informally often:

"... rely heavily on notions such as prejudice, pig-headedness, strong personality, subjective bias, emotional involvement, naivety, sheer stupidity, thinking in a wooly fashion, fear of losing grants, threats to status and so on." (Gilbert and Mulkay, 1984: 79)

These discursive elements do not appear in the empiricist repertoire (which is one way of validating the claim that such a repertoire exists; see chapter 5), and the biochemists were shown to draw on these two different ways of accounting depending on the function a section of discourse was to perform.

Gilbert and Mulkay go on to pose the question: "If scientists regularly draw upon and move between two quite different repertoires, how is it that potential contradictions between these repertoires do not require constant attention?" (1984: 90). They suggest that the scientists use a discursive device which allows the speaker to resolve any potential conflicts by asserting that, despite contingent factors interfering, the 'truth will out' (hence the TWOD label, 1984: 91).

The TWOD allowed some of Gilbert and Mulkay's respondents to distinguish between the effects of empirical and contingent factors in their reasoning. They could, therefore, discuss the contingent influences, but discount them by suggesting that their importance would diminish over time. Thus, the "main effect of the TWOD is to restore the primacy of the empiricist repertoire" (Gilbert and Mulkay, 1984: 110; see Gieryn and Figert, 1986: 80, for an example of this from psychology).

To summarize: Gilbert and Mulkay (1984) suggested that scientists draw on two repertoires, the empirical and the contingent, under different circumstances and to perform different discursive actions. That is, the two repertoires are inconsistent with each other, but can be shown to have different functions. They went on to argue that, when such inconsistency is recognized by the social actor, it is reconciled through the use of a device which allows the speaker to diminish the significance of the contingent repertoire by claiming that the 'truth will out'. Gilbert and Mulkay (1984; and see Mulkay, 1985) went on to show that treating variation in discourse as an analytical resource was a very fruitful way of examining scientific consensus, the use of diagrams and other representations, and for analyzing the scientists' use of humour.

I suggested earlier that it was easy to understand why variation does occur in people's discourse given that certain behaviours are only appropriate under particular circumstances. I now turn to an attempt to synthesize some theoretical studies which may account for the psychological processes behind such variation.

Ecological Realism and Existentialism:

Variation in verbal (and written) accounting practices is difficult for standard social and cognitive psychology to deal with but, as I have shown, it is easy to demonstrate. It is therefore necessary for psychology to offer some explanation for this behaviour. I will briefly discuss some possible reasons for this variation before offering a suggestion concerning its motivation.

The problem is this; if we all have a particular set of attitudes, beliefs, and personal characteristics, why do we give differently constructed accounts of our actions in different circumstances? I draw on two very different writers to give some theoretical grounding for this discussion. These writers, J.J. Gibson and J-P. Sartre, both emphasize the importance of the impact which the environment has on cognitive functioning.

In very general terms, Gibson's (1979) theory suggests that information is contained in the environment which affords a certain range of actions. The term 'ecological realism' has been used to describe this view because Gibson has argued that

the world (objectively) contains certain things which serve as restrictions upon actions within particular circumstances. Thus it is the world, rather than internal, individual characteristics, which dictates what is perceived and what will or will not happen as a result.

Gibson has restricted most of his discussion to visual perception, but this perspective has recently been applied to social perception (McArthur and Baron, 1983), and it has been argued that:

"... the direct detection of meaning in objective stimulus information, as opposed to the subjective construction of meaning, is evidenced by (a) adaptive responses to stimulus information by cognitively limited organisms, (b) adaptive, online responses to stimulus information that is rapidly changing, and (c) responses that vary directly with specifiable changes in the objective stimulus information." (McArthur and Baron, 1983: 235-36)

The most important point for the current discussion is the last one because it highlights the need for looking at how environmental changes affect responses. What I want to suggest is that external things like questions from colleagues, contracts for employment, institutional hierarchies, publication formats and so on, go to make up the objective world in which we act and speak, and that alterations to that world entail changes in behaviour.

The idea that the world imposes limits upon the range of our behavioural freedom was also one which Sartre entertained in an early essay (1957, originally published 1937) which marked the change from phenomenological arguments to existential ones. Again, to give a brief summary, the emphasis is on the role played by the environment. Sartre takes consciousness as being the origin of person-hood (something which Gibson does not discuss to a large extent; see Fodor and Pylyshyn, 1981, for a discussion), and that it is our apprehension of the world which constitutes our internal states, which in turn constitute the 'self'. Once we are aware of external events, those events shape our self-concept (1957: 83) thus there can be no understanding of an individual in isolation from the world (1957: 104).

For Sartre, then, it is our relationship with the world which affects who we are and how we behave. This is not to suggest that humans are not in control of their behaviour, but it does stress the importance of negotiations between internal and external influences (something not often regarded as important in a lot of psychological theories).

There are, of course, issues on which Gibson and Sartre disagree completely (as do Radical Behaviourism and Existentialism, although some common points can be shown), but the detail of each theory is not as important to the present purposes as the way in which they both approach human behaviour. The suggestion that humans react to and, in some respects, are constituted by the environments in which they live offers some insight into the mechanisms which create variation in discourse. People, I am suggesting, respond in good faith to their present circumstances and as the environment changes so do the accounts they give of their actions and of themselves.

A very similar argument has been recently developed by Shotter and Newson (1982; which is also similar to a recent analysis by Rommetveit, 1987: 80). They draw on the work of Gibson (1979) to show that an ecological perspective is a fruitful way of examining cognitive development:

"The strength of a thoroughgoing ecological approach is, we feel, that it emphasizes the interfittedness of things and directs attention away from the child as a wholly isolated entity (and away from the hidden 'internal processes' presumed to be going on inside her somewhere). It directs us instead towards what is out there in her world... towards the totality in which she is embedded." (Shotter and Newson, 1982:32-3)

They go on to argue that people exist in a "mutually constitutive and mutually defining" relationship with the world. The world is full of demands, requirements, and limitations which are experienced as external and which afford a certain range of actions. Thus actions are negotiated, criticised, corrected and have numbers of implications for future actions (Smedslund, 1984).

Shotter and Newson also discuss joint actions by pointing out that the actions of others "determine our conduct just as much as anything within ourselves" (1982: 44). That is, actions (including discursive actions, presumably) are greatly affected by the

way relationships develop given that individuals bring different assumptions and expectations to each situation. The way actions evolve, Shotter and Newson argue, cannot be simply attributed to individual characteristics.

It must then be asked what motivates these responses to the environment. One of the characteristics that research in social psychology suggests people have is the need to be consistent. But if research in discourse analysis shows that this is not the case, then some explanation must be suggested about why people are inconsistent.

There is an indication in some of the material I have cited in this chapter that people's behaviour and discourse is influenced by the perception of power relationships (Potter and Wetherell, 1987: 108-10; Shotter and Newson, 1982: 48; van Dijk, 1985; John, 1988; and some of Sartre's later writings e.g. 1966). There is also a strong element of the analysis of power relationships in the works labelled earlier (chapter 2) as coming from the 'continental' tradition (in the works of Foucault and Barthes, for example; see Skinner, 1985, for a detailed discussion) which has a long history of discussions on this topic (see Kaufmann, 1985). While I do not intend to review this material, I think it is useful to point out that examinations of the possible effects of power, and psychology's role in the maintenance of some power relationships, has largely been ignored by mainstream psychology.

There is some suggestion, then, of the importance of power relationships in analyzing human behaviour. What I want to suggest is that it is the perception of such relationships which motivates the way people account for their behaviour (their use of 'power-knowledge' in Foucault's terms) and, as those relationships are negotiated and maintained, different accounts will be regarded as appropriate and the discourse will vary. Further research would be needed to decide whether this argument is a reasonable explanation.

Finally, I want to note that an analysis of this form was developed by Freidson (1970: 87-9) as part of a large study of the way medical practice became an organized and formal profession. Freidson argued that the environment is an important variant of the behaviour of various professionals and, whilst not discussing variation of

professionals' discourse, Freidson made an important suggestion in this regard by pointing out a number of studies which had shown that:

"...[a] significant amount of behaviour is situational in character- that people are constantly responding to the organized pressures of the situations they are in at any particular time, that what they are is not completely but more their present than their past, and what they do is more an outcome of the pressures of the situation they are in than what they have earlier 'internalized' " (Freidson, 1970: 90)

This argument is similar to the one developed in this chapter, and it only needs to be pointed out that the generation of discourse is an important part of the behaviour of the professional in order to see the importance of Freidson's assertion to the current research (see also John, 1988).

In this chapter, then, I have shown how discourse may vary whilst still containing sincere accounts of a person's perception of a situation. I reviewed some empirical examples of such variation and introduced Gilbert and Mulkay's (1984) empirical and contingent repertoires. I then went on to indicate the importance of the environment in such variation and mentioned some theoretical studies which have argued for more consideration to be given to external influences on behaviour. Finally, I suggested that a primary motivation for being responsive to external influences was the perception of power relationships, and I briefly reviewed Freidson's (1970) discussion of power in the organized medical setting. It is, then, with this theoretical framework that I approach the analytic portions of this research (chapters 6, 7, and 8).

Chapter 4

Therapeutic Discourse.

In this chapter I will review some of the studies which have attempted to examine therapeutic discourse. This is relevant to the current study in two ways. The professionals who participated in this project are all involved to some extent in dealing with patients in therapeutic terms. Therefore some examination of their verbal behaviour in dealing with other professionals may have some bearing on an examination of other aspects of their professional discourse. Secondly, by looking at some of the analytic strategies already employed in examining therapeutic discourse, a case may be made for the fruitfulness of regarding professional-patient communication in functional terms. Thus I will be pointing out some of the advantages of applying the perspective of discourse analysis to this material. It is hoped that by drawing some of this diverse literature together, some directions for future research may be indicated. Finally, this chapter does not constitute an exhaustive review of the research conducted in each of the following areas. I have merely chosen some studies from a range of areas in order to show the diversity of methodological approaches.

There is now a growing body of, unfortunately disconnected, studies all of which aim to bring some understanding to the function of language in the clinical setting (Russell and Stiles, 1979). While many of these studies are descriptive, they are seen as important to the future refinement of therapeutic and professional techniques and for the communication of those techniques in tertiary education institutions. Given the importance of this area, it is, then, perhaps a little surprising that it is not given a higher priority in the education of Australian professional psychologists.

A number of different disciplines contribute to this field, each one bringing with it a different set of theoretical and methodological perspectives (Freeman, 1987a). Thus, although the common interest is the function of language in clinical settings, researchers in social and clinical psychology, medical sociology, sociolinguistics, and anthropology all analyze this material in their own way with little or no reference to

each other. References such as the *Handbook of Discourse Analysis* (van Dijk, 1985, in four volumes) have attempted to draw some of this work together, but while there has been some attempt to review, there has been little attempt at synthesis. The number of theoretical differences between disciplines may even frustrate the possibility of such a synthesis.

Throughout the chapter, I have grouped various studies under different headings. This should not imply that the categories are mutually exclusive, or that studies classified together are without theoretical or methodological differences. The headings are used merely to impose some sort of order on the following discussion.

Freeman (1987a) raises the issue of comparability of studies in the area of medical discourse in general. She points out that there is a scarcity of even basic descriptive data and that, although there is a common element to the existing research, the area is divided by "major differences in theoretical orientations and in methodological approach" (1987a: 4). She goes on to contrast Discourse Analysis (DA) and Conversation Analysis (CA). However, the contrasts she makes are based on a misreading of discourse analysis as it is presented here (that is, the Mulkey and Potter form). Further, she is vague about what studies she classifies under the DA label. Criticism of Labov and Fanshel (1977; discussed later), for example, as less formal than studies in CA seems unfounded, and the emphasis on representing "talk as heard" in transcripts through the inclusion of various nuances is given as an advantage without showing how such additional information affects the final analysis.

Freeman (1987a) briefly indicates two other themes: the importance of the context in which discourse emerges, and differences in the sampling of 'routine' versus 'problematic' cases. Some studies consider short segments of discourse in isolation from a particular context, while other studies are only initiated to consider situations where communication is perceived as inadequate. Nevertheless, she goes on to argue that comparisons of material from this field are possible given an understanding of these issues.

Overall, Freeman's review concentrates more on the impressive samples used by some studies (e.g. "500 hours of videotape representing 1000 interactions", 1987a: 8) rather than the results generated by these studies. This seems to be an attempt to justify particular methodologies, and it is worth pointing out Potter and Wetherell's (1987) remark about large sample sizes not necessarily contributing to a study's validity or the usefulness of its interpretations. Finally, Freeman's attempt at comparing some of the studies in this area is undermined by a confusion of terms: Labov and Fanshel's (1977) study is classified as DA at one point (p.5) and CA at another (p.12).

Participant Observation:

In this section I shall briefly review a number of studies which have emerged from the sociology and anthropology of medicine disciplines and which give qualitative analyses of therapeutic discourse and environments.

One of the main motivations for this form of study is that a participant observer becomes more aware of the meanings of discourse as a result of being involved in the social situation in which such discourse emerges (Wootton, 1975: 13).

Wootton (1977) undertook a study of the use of the term 'sharing' in a psychiatric unit where he acted as a researcher/therapist for a period of eight months. He dictated extensive field notes, and conducted and tape-recorded interviews with patients shortly after admission and also when they left the ward. The analysis consists mainly of the expansion of his field notes.

Wootton was interested in the way the 'share your experiences with other patients' rule was used by staff members as part of the therapeutic process. He suggested that sharing was interpreted in two main ways; patients were encouraged to share details of their past, and, in a more restricted sense, patients were expected to provide accounts of similar experiences to those initiated by other patients. The professionals involved decided whether a patient's discourse was a relevant or appropriate form of sharing and, because psychiatry was the dominant perspective, each account was expected to refer to the speaker's affect states.

Wootton's (1977) study generated some broad conclusions on the basis of a great deal of participant observation. It did not focus on particular instances of the discourse which occurred, but chose to describe a number of generalized situations which served to complicate the account of the concept of sharing. Wootton described therapeutic discourse in functional terms but did not provide enough data to allow the detailed analysis attempted in the present study.

Bloor (1981) cites Wootton's study in her analysis of a 'paradox' observed in the discourse of professionals working within a psychiatric setting. This study involved the researcher acting as a participant observer in a psychiatric day hospital, in contact with both patients and staff, and collecting field notes for a period of four months. The field notes were then divided into categories concerning aspects of the patient culture which were either beneficial or detrimental to the formal treatment program. The results of this initial analysis were then discussed with the day hospital's staff, and then a coding procedure was developed and used to modify the original analysis. A draft of the analysis was then circulated amongst staff members and interested patients, and reactions to the analysis were incorporated into the final report.

The analysis involved reporting things said by patients and staff, but no attempt was made at reproducing the exact words. Bloor (1981) argues that hospital staff regarded informal relationships at times as being beneficial, and at other times to be detrimental. Both of these points were communicated to the patients as prescriptions for behaviour. This sometimes resulted in the patients being aware of this apparent contradiction. When such an occasion arose:

"Staff would self-consciously make their own inconsistency an occasion and a topic for therapeutic work by drawing to patients' attention the paradoxical constancy of recurrent inconsistency in everyday social life." (Bloor, 1981: 368)

Bloor goes on to describe the way the staff reacted to criticism on the grounds of inconsistency by saying that patients need to "recognize and accept the contradictions and qualifications of every day life".

Bloor's (1981) analysis did look at therapeutic discourse in functional terms, but her method of data collection precluded any detailed analysis of interactions in which the topic of a contradiction was negotiated with a patient. Further, it would be possible to argue that, because the analysis was undertaken in consultation with staff, the analysis was merely an extension of staff discourse. That is, the account generated by staff members to justify various inconsistencies in their discourse was included, and used as the conclusion of Bloor's discussion. Only a detailed examination of patient-professional interactions could show whether these accounts were indeed compatible with accounts which suggest that such contradictions are of therapeutic value. It may be the case that accounts generated by staff members to resolve the use of contradictions are similar to the accounts used by scientists to resolve different and inconsistent discursive repertoires (see discussion, in chapter 3, of the TWOD suggested by Gilbert and Mulkey, 1984).

Bloor (1986) conducted another study using similar methods to examine the therapeutic community of two halfway houses for disturbed adolescents. She developed contrasts between the therapeutic approaches adopted by the two institutions and gave some evaluation of each approach, again in consultation with the staff involved. This study is less concerned with therapeutic language than the previous one, however similar criticisms may be used. That is, the study is based on the assumption that the researcher is able to describe what is 'really going on' in the institution in a way that, perhaps, the staff could not. Secondly, while summarized versions of conversations are given as data, the possibility that the analysis may be a reproduction of accounting practices inherent in the discourse is not raised. This second point is complicated by the analysis being generated and modified in consultation with staff members.

Måseide's (1987) study also involved participant observation; the researcher attended a psychiatric unit as an informal therapist for the period of a year. Unable to make use of a tape-recorder, notes on conversations in both therapeutic and staff-

meeting settings were taken either during the event or from memory after each session.

On this point Måseide notes:

"Ethnographically supported field notes are, as is often the case with scientific data, less than perfect. However, when the field notes are based on observations of and participation in therapeutic interaction over considerable time, they develop through a reflexive process of movement between data and theory, a process that is essential to field research." (Måseide, 1987: 69)

The use of field notes is a standard practice of sociology and anthropology (and were used extensively in Latour and Woolgar's study (1979: 15-17) which was mentioned (in chapter 3) as being an analysis of scientists' discourse). The field notes were used as a way of generating transcripts of therapeutic conversations. Excerpts of these transcripts were then analyzed in a way similar to that suggested by Gilbert and Mulkay (1984).

Måseide (1987) goes on to argue that the majority of therapeutic procedures involved talk, and every activity undertaken on the ward was seen as potentially therapeutic. Formal, asymmetric patient-professional situations were actively developed, but informal relationships were seen, by the professionals, as important sources of potentially important information about the patients. Thus, in practice, there was little distinction between formal and informal discourse.

Måseide identifies three forms or strategies which could be used to classify patient discourse: (a) passivity or the lack of attempts to initiate discussion, (b) aggression in the form of violent verbal outbursts, and (c) conformism or behaving in accordance with staff expectations. He uses these labels to develop an analysis of therapeutic interaction as ceremonial or rule-governed (Barrett, 1987, developed a similar argument in an analysis of interviewing procedures used when admitting people with schizophrenia to a psychiatric unit). Måseide goes on to discuss this therapeutic discourse in functional terms by suggesting that therapists use it as a way of enforcing social control without being explicit about their actions (Måseide, 1987: 77; see also Kaswan, 1981).

Måseide describes and is critical of the tacit model of communication employed in what he calls ritualized therapy. This tacit model is similar to what was described (in

chapter 2) as the straightforward model in which information is 'sent' from therapist to patient (see also Måseide, 1983, discussed later). He notes that the situational context was taken into account only to the extent that it could be controlled by the therapists. He goes on to suggest more appropriate models of therapeutic discourse.

Barrett (1987) conducted a large ethnography of a major Australian psychiatric teaching hospital while conducting a study on the definition of the term 'schizophrenia'. In the course of this study Barrett analyzed verbatim transcripts of interactions between a psychiatric registrar (a trainee psychiatrist) and an in-coming patient, and between the registrar and the patient's mother. He dealt with both interviews in detail, examining both the way the concept of schizophrenia was used, and the way in which issues concerning the admission of the patient were negotiated (see also Scheff, 1968, discussed later). The researcher was a qualified psychiatrist and attended both interviews. Thus, while the researcher was present as an observer, he was also recognized as having a higher status than the registrar.

Barrett's main concern in this section of his (1987) study was to show the way in which the registrar selected and reinforced different parts of the discourse, and how these elements were later transformed into the written case-notes and documents necessary in admitting the patient to the hospital. Overall, the methodology emphasized the functional aspects of the discourse and examined alternative ways in which the written account could be constructed using the same verbal material. His extended argument went on to examine the ways in which discourse was made objective by removing it from its context and placing it in the format expected by the psychiatric system. Whilst not strictly following the discourse analysis approach suggested by Gilbert and Mulkay (1984) or Potter and Wetherell (1987), Barrett's study had similar aims and methods.

The studies covered in this section all involved the researcher spending time in the environment in which the professional discourse emerged. Whilst some studies made use of audio-recordings of discourse, most relied on the use of field notes. I pointed out that studies which involve the researcher as a participant must be aware of

the possibility that their analyses may reproduce the accounts generated by other participants.

Sociology of Medical Discourse:

Cicourel (1983, 1986, 1987) has contributed a great deal to the analysis of medical discourse and doctor-patient communication. His methodology involves the recording and transcription of medical discourse which is then subjected to a detailed form of analysis. This methodology has developed along similar lines to the approach adopted in the present study. In this section, I shall review one of the studies cited in order to discuss this particular approach.

Cicourel (1986) gave an analysis of the relationship between power and knowledge in medical decision-making which, he points out, is similar to some of the discourse analysis studies (he cites Knorr-Cetina, 1981, and Latour and Woolgar, 1979). He also argues that the distinction between the empirical-analytic and historical-hermeneutic sciences is difficult to sustain when examining the use of common sense reasoning in clinical settings (this will be discussed in chapter 7).

Cicourel (1986) examines the complete transcripts of two interactions: the first between a patient and a medical intern (training fellow). In the second interaction, the intern related the interview with the patient to a supervising doctor. The researcher, who had been observing people in this setting for some weeks, was present at both meetings, and the interactions were selected from a number of recordings and was not regarded as unusual (or problematic, in Freeman's, 1987a, terms).

Cicourel describes the knowledge needed to understand episodes of discourse in an analysis which, with the aid of the supervising doctor, highlights the intern's lack of clinical expertise (a topic to be discussed in chapter 7). Citing the work of Tversky and Kahneman (1981), he argues that the discourse is framed or schematized by the local knowledge maintained by both doctor and patient (see also Tannen and Wallat, 1987, discussed later). He points out that the intern's discourse could not readily be assessed without the help of a medical expert because, while the patient's utterances indicated that the intern was in a position of authority, only the supervising doctor had a more

secure knowledge base from which to undermine the authority of the intern's discourse. Thus, Cicourel argues, research on technical discourse is problematic (see also Gilbert and Mulkay, 1984).

So, Cicourel (1986) used two fairly short transcripts which he analyzed in detail to illustrate the level of local and technical knowledge needed to understand and analyze medical discourse. Whilst he suggested that his approach was similar to some discourse analysis studies, Cicourel was addressing methodological questions concerning such research rather than analyzing the content of his respondents' discourse. He did not stress the functional or constructive elements in his transcripts, nor did he attempt to identify various discursive repertoires (such as those discussed in the previous chapter). Thus while the method is similar, the scope of the analysis is more restricted than those labelled (in chapter 2) as 'Anglo-saxon' discourse analysis.

Måseide (1983) also conducted a study of doctor-patient communication which uses an approach similar to that used by Cicourel (1986). In this study Måseide gave a detailed analysis of a verbatim transcript of an interview between a medical doctor and the mother of a young patient. Måseide's analysis was very critical of the standard model of clinical communication (one similar to the one described, in chapter 2, as the straightforward view; simple transfer of relevant information).

The situation Måseide (1983) describes is one in which the patient's mother wants her child to see a psychologist for a 'behavioural problem'. The mother, then, sees the interview with the doctor as a simple matter of ruling out any biological causes of the child's behaviour. That is, the mother has already decided what cause of action will be the outcome of the interview, and sets about controlling the flow of information to favour a referral to a psychologist. Thus, Måseide suggests that any model which tries to account for aspects of clinical reasoning must take into consideration elements of 'strategic communication'. Following this analysis of discourse in functional terms, he argues that:

"... sometimes the clinical interview will function as a self-fulfilling prophecy, where the institutionalized context transforms insignificant information into clinically relevant and acceptable information. That is,

the patient's information is put into a system that produces specific information that fits, conforms, and supports certain medical schemata."
(Måseide, 1983: 254)

From this point (which is consistent with the independent study carried out by Barrett, 1987), Måseide goes on to suggest that the perception of the clinical interview as equivalent to a scientific analysis (also see discussion in chapters 7 and 8) is one which underestimates the importance of aspects of power, status, and social and communicative negotiation (see also Giles and Wiemann's, 1987, discussion). I shall continue the discussion of power relationships in the next section.

Finally in this section, I want to briefly review an analysis given by Tannen and Wallat (1987) which involved the use of video-taped interactions of a medical examination. The particular interaction they examined involved a pediatrician, a young patient and her mother.

Tannen and Wallat (1987) discuss the various linguistic registers (pitch) and knowledge frames and schemas used by the doctor in conducting the examination (reporting them to the video audience), playing with the child, and answering the mother's questions. A schema, they suggest, refers to "patterns of expectations and assumptions about the world" whereas a frame refers to "the alignment participants take up to themselves and others in the situation" (Tannen and Wallat, 1987: 215). These two theoretical concepts are used by Tannen and Wallat to show how the doctor's discourse operates on a number of levels and, they suggest, such an analysis could be usefully applied to other forms of discourse.

The studies reviewed in this section all used verbatim transcriptions of discourse involving professional communication. Each one was concerned with describing such discourse in functional terms and thus are similar to the studies labelled in previous chapters as discourse analysis although some differences were mentioned.

Analyses of Power Relationships:

A number of studies, using a variety of methodological approaches, have now been published which have the issue of power relationships as their main focus of attention. This topic was raised in the last chapter as a possible explanation for

variation in discourse, but I will not attempt any extended analyses of power relationships in later chapters of this report. I give the following review, then, to show the variety of examinations which have been made in this area.

Rubenstein and Lasswell (1966) conducted a large study of a psychiatric hospital which included the examination of transcripts of patient-professional discussions. Their book *The Sharing of Power in a Psychiatric Hospital* contains discussions of a variety of ways in which transcriptions can be analyzed, such as the amount of time taken by staff members and patients in discussion, the frequency with which each professional participated in such discussions, and the classification of the tone of such discussions.

Overall, Rubenstein and Lasswell were concerned with the possibility that psychiatric institutions could be run on a day to day basis by both patients and staff with power being "genuinely shared" (1966: 265). That is, their study was both descriptive and a prescription for future institutions. It is beyond the scope of the present study to review their recommendations.

Other studies have been less ambitious in their analysis of the effects of power relationships. Scheff (1968), for example, argues, in reference to interviews conducted by psychiatrists and lawyers, that power is a very important element in the negotiations between professional and client. Following the work of Berger and Luckmann (1966), he suggests that the professional, and to a lesser extent the client, actively constructs an account which best suits the purpose of the interview. Thus, in the analysis of the transcription of an initial interview between psychiatrist and patient, Scheff argues that the psychiatrist selectively reinforces or ignores aspects of the client's discourse. The result of this negotiation process is a definition in which the patient is responsible for her situation, and the importance of external influences were minimized.

Scheff (1968), then, used transcriptions of interviews to demonstrate the extent to which discourse has functional consequences. He also argued that the professional is usually in a more powerful position than the client, and that such a position may be used to influence negotiations. He goes on to discuss the extent to which such

negotiations involve conscious bargaining, and concludes by drawing a similarity with experimenter-effects in the social sciences.

Mathews (1983) conducted a review of literature concerned with patient-professional interactions. She suggested that changes in society such as better education and the rise of consumer groups, and changes in the roles of professionals working in clinical settings such as the development of a more independent nursing profession, have affected clinical communication. That is, the power of the medical practitioner is being modified by social change. Nevertheless, she argues, 'appropriate' information continues to be defined and controlled by the practitioner.

Shapiro et al. (1983) conducted a study in this area and reported the findings of a questionnaire which sought to examine the effects of gender and social class in obstetrical encounters. They suggested that obstetricians "greatly underestimate the desire for information reported by their clients" (1983: 144). Further, they presented data which suggested that women who attended public hospitals, and who were of lower social status, were less satisfied with the information they received in interviews with their obstetrician. Thus, Shapiro et al. (1983) attempted to make explicit some of the effects of power in doctor-patient encounters by collecting data concerning patients' perceptions of such relationships.

The final study I want to discuss in this section was concerned with the use of 'influence tactics' in various psychotherapies. Cooke and Kipnis (1986) conducted a study which used a quantitative coding procedure (discussed in the next section) to gain information about the social power of psychotherapists. The data consisted of segments from 22 hour-long audio-tapes provided by 6 male and 5 female therapists (psychiatrists and psychologists). Each utterance made by the therapist, then, was coded in terms of the goal of the influence (9 point scale) and the strength of the suggestion (7 point scale).

On the basis of their results, Cooke and Kipnis (1986) suggest that:

"... male therapists made more attempts to influence their clients and interrupted their clients more often than did female therapists, that there were systematic changes in the tactics used over the course of the

therapy hour, and that more active forms of influence were directed towards female clients than towards male clients." (Cooke and Kipnis, 1986: 26)

Cooke and Kipnis' (1986) study shows one methodological approach for the investigation of therapeutic discourse. I now turn to a more general review of quantitative techniques to supplement this summary.

Quantitative Analysis:

The quantitative analysis of therapeutic discourse can be undertaken by researchers who have not necessarily come in contact with the environment in which the discourse emerged, as indeed can many of the qualitative techniques. It involves the categorization of segments of discourse which may then be numerically coded and subject to various forms of statistical analysis. There are a large number of studies which have used an almost equally large number of categories for the coding of such discourse, and this remains one of the drawbacks of work in this area (Russell and Stiles, 1979).

Russell and Stiles (1979) conducted a review of the studies which have attempted to classify therapeutic discourse and produced a number of recommendations for the future construction of categories. It is beyond the scope of the current project to discuss their suggestions. I merely want to indicate that the quantitative analysis of discourse is not easily described by a number of key studies. In this section, then, I will review a recent study from this area in order to discuss the general form such analyses may take.

Winefield et al. (1987) suggested that the *number* of utterances made by a patient during a psychotherapy session was related to the effect of the therapy. A patient could, for example, become less egocentric as the therapy sessions progressed, and say less as a result. To investigate this possibility, the researchers set out "to describe the amount and interactional pattern of the speech of a patient and therapist over the course of a successful therapy" (1987: 119). To this end, 52.3% of transcripts of "a 172-hour course of psychodynamically orientated psychotherapy" (1987: 119) were coded using Stiles' (1978) Verbal Response Mode (VRM) system.

Winefield et al. suggest that a major advantage of the VRM system is "the objectivity of its decision rules for determining intent" (1987: 118) and they cite very high correlations between the two people who coded the transcripts. Each session was coded using three main dichotomous decision rules: (a) focus, where the speaker is or is not presuming an understanding of the other; (b) frame of reference, in which the speaker may or may not impose their own frame; and (c) the source of experiences under discussion, either the speaker or the other.

The resulting statistical analysis of the data suggested that, over the course of the complete, and successful therapy, the relationship between patient and therapist was one of decreasing asymmetry. That is, the therapist began to speak more and presume to understand the patient's discourse less. At the same time, the patient began to become more attentive and the number of utterances made by the patient decreased. Winefield et al. (1987) suggested that this indicated the patient was becoming less self-preoccupied and more socially adaptive. They argue that:

"Rather than the patient learning specific cognitive skills or attributes from the therapist, the process of psychotherapy appears to be more akin to that implied by those who describe the goal of therapy as patient self-knowledge, and the patient's contribution to the process as one of providing... facilitative interpersonal conditions for this growth."
(Winefield et al., 1987: 123)

Within the quantitative paradigm, statistically descriptive studies, such as Winefield et al. (1987), are necessary in order for later *prescriptive* studies to emerge. That is, if the object of this form of research is the identification of the functional elements of discourse which make such conversation therapeutic, then quantitative evidence concerning changes in the asymmetric interaction between patient and therapist can only be preliminary. A more detailed qualitative analysis of the content of therapeutic interactions would be entailed by, and would benefit from, such quantitative studies.

Comprehensive Discourse Analysis:

This term was adopted by Labov and Fanshel (1977) to describe their form of analysis which involves the micro-analysis of usually fairly short episodes of discourse

and takes into consideration the speed, inflection, intonation, and linguistic structure of their material.

Labov and Fanshel (1977) analyzed an audio-recording of a 15 minute segment of a psychotherapy session which was part of an ongoing treatment of a young woman who was suffering from anorexia nervosa and problems related to her family circumstances.

Labov and Fanshel analyzed their transcript by methodically making explicit any pronouns or pro-forms and provided this information as an expansion of each portion of the discourse (1977: 356). They also developed a running commentary of all of the propositions necessary for an understanding of the discourse but left implicit by the respondents. They then used their analysis to suggest a large number of conversational rules and forms which could be applied to any form of discourse (1977: chapter 3).

Whilst the therapeutic sessions were reported to be successful (Labov and Fanshel, 1977: 347), a micro-analysis of this kind would not be an appropriate way of examining the function of therapeutic discourse. Labov and Fanshel's study was fruitful in providing a large number of abstract rules of discourse, and further study has continued along such lines, but the methods employed would prohibit analysis of questions posed by discourse analysts because of the great deal of time such an analysis would require.

Medical Conversation Analysis:

Freeman (1987b), who labels her own work as Conversation Analysis (see Schegloff, 1987), conducted a study of the way issues concerning preventive care were raised in routine doctor-patient relationships. Freeman observed and audio-taped approximately 200 such encounters which were then selectively transcribed. These encounters were observed "over a two-year period in a total of 11 practices" (1987b: 961).

Freeman identified three patterns which were common in discourse in which aspects of 'health promotion' were included. The first pattern concerned the initiation

of such a discussion by the doctor with reference to a specific illness condition (usually a fairly well know condition). The second pattern involved general lifestyle variables, usually brought up toward the end of an interview, and were not tied to the problem the patient initially presented. The final pattern was illustrated by the doctor initiating a discussion of preventive issues only to have the topic rejected by the patient. Freeman then suggested that conversations which fitted the third pattern revealed that "neither participant is comfortable with the topic in the first place" and thus "the topic can be abandoned at little cost to the conventional domain of medical problem-solving" (1987b: 965). She concludes by suggesting that:

"If health promotion talk is to become an effective part of the medical interview, it cannot simply be added to an existing list of information-gathering and information-transmitting tasks, but must be evaluated as a separate and substantively distinct communicative task." (Freeman, 1987b: 965)

The distinction between conversation analysis, as it is used by Freeman (1987a, 1987b), and discourse analysis is perhaps not a very substantial one (Potter and Wetherell, 1987; but see Levinson, 1983). Freeman gave a detailed examination of verbatim transcripts, and analyzed the discourse in functional terms. Her conclusions have important ramifications for professional discourse, and could be adopted in order to modify the ways in which health promotion talk is introduced into the medical encounter. Freeman's (1987b) study constitutes a good argument for the use of detailed, qualitative examinations of health professionals' discourse and may indicate a converging trend in some of the studies in this area.

Conclusion:

In this chapter I have briefly reviewed a number of studies from a wide variety of methodological and theoretical perspectives all of which were concerned with professional therapeutic discourse. Future analyses of therapeutic discourse would benefit from a consideration of studies beyond the range of a single discipline or methodological approach by attempting to synthesize some of the conclusions generated by this body of research. Whilst such a synthesis was not attempted here, I

hope I have shown some of the similarities in such studies while arguing for the consideration of therapeutic language in functional terms. I now turn to a discussion of the methodological background to the present study.

Chapter 5

Initiation and Methodology

This chapter is in four sections. I describe how the case-conference study was initiated, and how the two interview case studies were approached. Third, I discuss the method of transcription and analysis. Finally, I list the conventions I used in the format of the transcriptions.

Case-conferences:

Contact was initially established with a Senior Clinical Psychologist who worked at two psychiatric hospitals. A request to attend case-conferences at one of the psychiatric units was made and permission granted. It was originally proposed that the researcher would attend the conferences to see whether the proposed research was feasible and to allow the researcher to become familiar with the language and procedures used within the case-conference setting. A period of 10 weeks was used to this end.

Once general approval from the University's Committee on Ethics of Human Experimentation was gained, an additional research outline was drafted in consultation with the Senior Clinical Psychologist. This outline included a detailed set of constraints which would ensure anonymity and was distributed as an internal memo to all the staff within the psychiatric unit (see Appendix 1). The proposal said, in part, that the "study will be an investigation of communication between different professionals participating in the standard case-conference situation. It is part of a larger study which applies the techniques of discourse analysis to the verbal behaviour of clinical psychologists." The research proposal was then scheduled as part of the agenda for the next 'policy-meeting'. The researcher attended this meeting and staff were given the opportunity to ask questions and raise objections. Permission was granted for the research to proceed with the proviso that the staff be given access to both the completed transcripts and the final thesis.

The recordings were made using a standard stereo cassette tape-recorder, and a pair of professional-quality microphones. Recordings of the formal proceedings of 10 case-conferences were made over the period of a month. The researcher was present at each session but said nothing.

The amount of time needed to transcribe all ten conferences was prohibitive given a study of this size, therefore the decision was made to only make full transcriptions of the first two and last two sessions. The original numbers were retained for convenience, thus transcriptions were made of conferences 1, 2, 9, and 10.

The transcriptions were made by the researcher, typed directly into a word-processor. As each transcription was completed, it was compared with an additional play-back of the tape to check for errors and omissions. Members of staff were consulted about the various abbreviations used throughout the conferences, and the names of various drugs used were compared with a publication called *Drugs in Psychiatry: A Hillcrest Hospital Manual* (James, 1985).

All references to the names of patients, members of staff, and any other personal details which could allow identification were removed to ensure anonymity. All other material; hesitations, pauses, false-starts, interruptions, laughter, etc., was included. The length of time taken by each pause, and the various sorts of verbal intonation, was not transcribed. In all, the case-conference transcripts amounted to over 34,000 words.

The only identifying material used in the transcripts was the professional role or status of each speaker. These were as follows:

Psychiatrist (P, in charge of the psychiatric unit)

Psychiatric Registrar (PR, a trainee psychiatrist)

Medical Officer (MO, a medical student attending as part of training or internship)

Clinical Nursing Consultant (CNC, in charge of nursing staff)

Senior Clinical Psychologist (SCP, employed on a half-time basis)

Clinical Psychologist (CP, employed part-time)

Social Workers (SW, two of which attended the session recorded)

Psychiatric Nurses (PN, at least one assigned to each team)

Enrolled Nurse (EN, junior nurse, attended conference no. 2)

Interviews:

Permission was sought from the two clinical psychologists who attended the case-conferences to tape-record separate interviews with them. The interviews were conducted within the institutions in which they worked. A small portable cassette recorder was used in both interviews.

An interview schedule was constructed for the first interview (with the clinical psychologist) which was based on the list of 32 questions used by Potter (1982; 1983). The first schedule consisted of 23 questions which were supplemented by points of clarification during the interview (see Appendix 7). The first interview took approximately an hour and a quarter. It was transcribed in the way described above and came to a total of 9,363 words.

The second interview (with the senior clinical psychologist) was conducted in the same way using a slightly different interview schedule (see Appendix 7), and took approximately an hour and a quarter. It was transcribed and came to a total of 6,214 words.

Analysis:

In all, almost 50,000 words were transcribed and constituted the data base for the analyses contained in chapters 6 to 8. Much of the method or approach of DA is contained in the analytical texts that have been published thus far. That is, it is described by example rather than by using an abstract schema or recipe (Yearley, 1981; Gilbert and Mulkay, 1984; and Mulkay, 1985, are good examples to this end). Nevertheless, the following analysis followed the steps set out in Potter and Wetherell's (1987) book, *Discourse and Social Psychology*. I will now give a summary of their chapter on the methods of analysis while also giving an account of the present study.

Potter and Wetherell (1987: 158-176) begin their discussion of the stages involved in the analysis of discourse by noting a few of the recent developments in the history, philosophy, and sociology of science. The works they cite have argued that the distinction between theory and data has been thrown into doubt (see also Mitroff,

1974), the rejection of hypotheses on the basis of crucial experiments has been discounted, and the importance of replication has been called into question (see also Mulkey and Gilbert, 1984; 1986). They then go on to describe ten stages of discourse analysis, as follows.

- 1) Research Questions: all the questions asked must be concerned with discourse "in its own right" (1987: 160) and relate to its function and construction. The present study aimed to examine the discourse of a multi-disciplinary team of mental health professionals with particular emphasis on the construction of the role of the clinical psychologist.
- 2) Sample Selection: sample sizes are usually small as a result of the demands of the process of analysis. The present study was limited to the examination of four case-conferences and interviews with each of the two clinical psychologists who attended the case-conferences.
- 3) Collection of Records and Documents: a large range of materials may be of interest, but should only be used with full permission. Permission to make the recordings used was outlined earlier.
- 4) Interviews: the same specific questions may be asked of the sample (see also Kvale, 1983; Potter and Mulkey, 1985). To this end, a schedule of specific questions should be constructed and the interview questions must be included in the transcript.
- 5) Transcription: the amount of time and effort involved in transcribing varies as a function of the detail included. The ratio of tape-time to transcription-time can vary from 1: 10 to 1:20. In the present study, the interviews took approximately 12 hours each to transcribe. A case-conference took a minimum of 18 hours.
- 6) Coding: transcriptions are then sub-divided into categories which relate to the research questions chosen and should include all 'borderline' cases. In the present study, the two interviews were divided into sections which concerned either the relationship between theory and practice or the role of the clinical psychologist. The coding of the case-conferences will be covered in the next chapter (6).

7) Analysis: "There is no mechanical procedure for producing findings from an archive of transcript" (1987: 168). The process involves reading and re-reading various passages in an attempt to find a systematic pattern. There is an emphasis on the detail of each passage rather than simple content. The main elements of interest are the points at which accounts vary and where there are similarities. Hypotheses are then formulated concerning the possible functions of the discourse examined.

"It should be clear, then, that there is no analytic method, at least as this term is understood elsewhere in social psychology. Rather, there is a broad theoretical framework, which focuses attention on the constructive and functional dimensions of discourse, coupled with the reader's skill in identifying significant patterns of consistency and variation. (Potter and Wetherell, 1987: 169)

8) Validation: four techniques are identified; (a) analytical claims should give coherent accounts of the effects and functions of a body of discourse; (b) the participants' orientation should be considered in the analysis; (c) the analysis should lead to new ways of considering the data; and (d) the analysis should be fruitful in explaining other forms of discourse. In the present study, these points were considered as part of the process of analysis.

9) The Report: representative examples of the data should be reproduced, and a detailed interpretation given in a way which allows the evaluation and replication of the analysis by the reader. Thus an interpretation of each section of material quoted from the full transcripts was included in the analytical chapters of this study.

10) Application: Potter and Wetherell conclude by suggesting that the issue of application should not be ignored in discourse analysis, but only offer preliminary suggestions about how this stage is to be undertaken. Application was considered to be beyond the scope of the current project.

Transcription Conventions:

Transcripts do not read like plays. Speakers interrupt themselves, lose track of their sentence structure, pause for thought, search for more appropriate words, repeat themselves, and answer their own questions. Speakers also leave sentences unfinished, interrupt other speakers, and speak simultaneously with others. All of this can make a

transcription difficult to follow, but a few simple visual devices can help to show what has happened in the, often very rapid, verbal interaction.

There is no standard way of notating transcripts and it varies considerably on the basis of the level of information necessary for the analysis. As the current research did not involve a micro-investigation of language *per se*, aspects of the data such as intonation, the length of pauses, speed of delivery and so on were not encoded (but see Edmondson, 1981; Labov and Fanshel, 1977; and Potter and Wetherell, 1987 for examples).

In the transcriptions which follow, I have included all of the non-verbal vocalizations (e.g. er, um, hmmm, etc.). These vocalizations can be an indication that a speaker is hesitating and may, for example, show why a speaker makes a grammatical error. Some speakers also make use of very long sentences which may include other comments (metacomments, Swartz and Swartz, 1987) on the subject of the particular sentence. To make these sentences more comprehensible, I have broken them up into smaller sentences.

Each utterance (or turn) was numbered and the role of the professional speaking was signaled using abbreviations. I classify as an utterance anything a speaker says in a single turn without interruption. These range from non-verbal vocalizations to around 25 lines of transcript text. A dash was used to signify a false start or self-interruption (e.g. what I-). If an utterance could not be deciphered or was inaudible this was listed as [inaud.]. Pauses were indicated with dots for short pauses and as [pause] for longer pauses. Square brackets were also used to indicate extra-linguistic cues such as [sighs], [laughter] and so on. The transcriptions frequently contain some level of laughter. For the most part, such laughter is short and subdued.

The transcripts contain a great number of interruptions and simultaneous utterances. If someone was interrupted, three dots were used to finish a line and the new speaker's turn was preceded by three dots. In the following example, three people take turns in a quick interaction:

344 PN: *Yes, it had- she hasn't been weighed this morning...*
 345 P: ... *No...*
 346 PN: ... *but she'll be weighed tomorrow, but she was at 42 yesterday which is the lowest that she's been since admission...*
 347 CNC: ... *Hmm...*
 348 PN: ... *and it's been a gradual down...*
 349 P: ... *Yes...*
 350 PN: ... *downfall...*
 351 CNC: ... *She was about 43 something... (Quoted from transcript no. 9, see Appendix)*

This technique is used in some play-scripts (see also Rubenstein and Lasswell, 1966) and I elected to use this technique rather than the conventional bracket between lines (see Potter and Wetherell, 1987) because of the number of speakers involved, and because it was more often the case that a person was being interrupted rather than two people speaking at once.

There is no convention concerning the inclusion of full transcripts for a research report of this nature. Potter (1983) only quoted transcripts in analytical chapters, whereas Barrett (1987) elected to include entire transcripts within the body of the text. This thesis has the full transcripts of all six sessions contained in the Appendices. At times, where it does not affect the analysis but adds to the continuing of the discourse, I shall also refer to the transcript without quoting from it.

Chapter 6

Case Conference Discourse

Introduction:

The case-conferences (hereafter CCs) which provided the basis for this study are regular events within the particular psychiatric unit which was the locale for this study. While there is one large staff meeting early each Monday morning to discuss all of the activities the patients engaged in over the weekend, there are three CCs to discuss the progress of each patient in detail. Members of staff are divided into 'mini-teams'; interdisciplinary groups who pay particular attention to a subset of the current number of patients. So, while all of the staff looked after all of the patients, some staff members were more aware of the specific details of a given case. Each mini-team was responsible for about seven patients when the unit was full (which was most of the time).

Each mini-team is usually made up of a psychiatrist (P), a psychiatric understudy (either a psychiatric registrar (PR), or a medical officer), a social worker (SW), and at least one member of the nursing staff. A psychiatric registrar is a qualified medical doctor being supervised as part of the five year apprenticeship required in becoming a psychiatrist. The medical officer (MO), on the other hand, is a medical student who, as part of their intern year, is supervised in a psychiatric setting for a three month period. Medical officers could also be medical students being given a 4 week introduction to the mental health field.

Each of these professionals would only attend one mini-team meeting per week, with the exception of the supervising psychiatrist who would normally attend more than one. The clinical psychologist (CP) only attended one team meeting per week, while the senior clinical psychologist (SCP) would normally attend all of them. The CCs used in this study were taken from two of the three mini-teams in the unit. Thus transcriptions were made of two CCs of two mini-teams (conferences 1, 9, and 2, 10 respectively).

The CC could be used to discuss any matter relating to a patient under the care of the mini-team. The details of new patients were introduced, records of a patient with a previous case-history were reviewed, arrangements to modify or continue a patient's treatment were discussed, and decisions concerning discharge were made. Although other members of staff may be turned to for advice, the mini-team does not formally report its findings to any other committee for decisions. Discussions concerning a patient's long-term progress and welfare were made in the context of the business at hand which was to bring to light any changes in the patient's state, and to decide what measures would be taken in the following week. Records of these measures were written into the case-histories of each patient and these records were open to scrutiny by other professionals and official bodies, enquiries etc. (see Barrett, 1987, for a discussion). In general, each conference took between 30 minutes and an hour to run, varying with the number of patients dealt with and the number of issues covered.

Transcribing case-conferences yields a vast amount of data and a complete analysis, if such a thing were possible, would be well beyond the scope of the current study. The full transcriptions have been provided in the Appendix for the benefit of future studies in this area. Throughout the remaining chapters of this report, various professions will be referred to using abbreviations. A list of these abbreviations was provided in chapter 5, and appears at the top of each transcript contained in the Appendix.

In this chapter I will examine a number of general aspects of the function of discourse in this setting whilst also dealing with the issue of the role of the clinical psychologist. Points raised in the examination of the clinical psychologist's role will be referred to in later chapters which deal with these issues in more detail.

Analysing Case-Conference Discourse:

I shall begin with a review of the categories into which this form of discourse can most easily be divided. This will lead to a discussion of the extent to which each attending profession contributes to the conferences in general and the specific categories in particular. This will go some way toward describing the role(s) taken by

each profession within the case-conference setting. I then examine the sequences in which professions making smaller contributions participate in the discussions, and what initiates these verbal turns. In view of this analysis, I then make some suggestions concerning the function of the 'case-summary', and how verbal conflict is avoided.

Topics of Discussion:

In the first conference (transcript 1), seven patients are discussed by the six attending professionals. What follows is an indication of the major topic being covered and the professionals involved. I have grouped sections of the discourse together showing the number of turns taken on each topic. The order of the professions is constant but arbitrary.

Turns: Professionals: Topic:

001-017	P, MO: Patient A's recent operation.
018-048	P, MO, SW: Financial and family arrangements.
049	P: Summary of discussion.
050-063	P, MO: Administration.
064	MO: Case summary.
065-074	P, MO, SW, PN: Weekend leave.
075-089	P, MO, PN: Patient's behaviour.
090-097	P, MO: Medication.
098-102	P, MO: Case summary.
103-112	P, SW: Finances.
113-118	P, MO: Personal and family details.
119-125	P, SW, CP: SW initiates a joke.
126-132	P, PN: Administration.
133-134	P, SW: Finances.
135	MO: Case summary.
136-154	P, MO, PN: Medication.
155-177	P, MO, SW, PN: Patient's behaviour.
178-185	P, PN: Medication.
186-202	P, MO, SW, PN: Patient's behaviour.
203-220	P, MO, SW: Finances and family.
221-231	P, MO, SW, PN: Administration.
232	MO: Case summary.
233-283	P, MO, PN: Medication.
283-292	P, SW, PN: Industrial therapy.
293	P: Medication.
293-296	P, PN: Patient's weight.
297	MO: Case summary.
298-321	P, MO, SW, PN: Respite care (accommodation).
322-324	P, MO, PN: Administration
325-343	P, MO, PN: Medication.
343-356	P, SW, PN: Respite care.
357-370	P, MO, SW, PN: Administration (interpreter).
371-374	P, MO: Case summary.
375-379	P, MO, SCP: Patient's age and memory
380	MO: Case summary (continued).
381-387	P, MO: Medication.

388-409	P, MO: Mental state examination.
410-413	P, MO, PN: Medication.
413	P: Summary of discussion.
414-419	P, MO: Patient's behaviour (end of CC).

The topics discussed in this CC were typical of most conferences. Whilst it is possible to argue that a larger sample of discourse would be needed to show the range of topics discussed, I doubt that the overall picture would be altered using a larger sample. It is also possible to suggest that the involvement of a particular professional may be due to a professional's personal characteristics rather than the role played by the discipline. I will look at this issue in the next section.

From the analysis above it can be seen that the psychiatrist was involved in all of the topics discussed, and that the medical officer, being trained under psychiatric guidance, was also involved in many of the topics and was responsible for giving the case summaries. The other professions were involved to a lesser extent, joining into the discussion on more isolated topics. Thus, the SCP was involved in the discussion of a patient's age and memory; the SW was mainly involved in issues concerning the patient's family, finances, and accommodation; the PN was mainly active in discussions concerned with medication, behaviour on the ward, and administration issues; and the CP was not active in this particular conference.

This analysis, then, gives a preliminary indication of the role of each professional as it is defined by CC discourse. However, this analysis does not give any indication of the level of verbal activity of each professional, so the next section will examine this question by looking at all of the CCs to be examined in the present study.

Why count utterances?

A case-conference is a very dynamic situation. Participants are free to cut in, talk to the group, speak to a particular person, read aloud, and reinforce someone else's discourse. It would, then, be unfair (and more laborious) to analyze the level of participation of each profession by using a count of words or a measure of the amount of time taken by each speaker (but see Rubenstein and Lasswell, 1966). Thus, it was

decided to give a simple frequency count of the number of utterances made by each attending professional as a measure of verbal activity.

A turn can range from a short reinforcement (mmm, hmm, yes, etc.) to a long excerpt involving the use of case-notes (a case summary). A count of turns, then, will show the most active speakers - not how much, but how often. Thus, an MO can present several cases in a few turns but have little input to the overall discussion whereas a P, for example, could direct the conference proceedings with just a few well placed words. This measure also indicates to whom particular episodes are directed; all of the participants are listening to the proceedings, but the information is usually only directly relevant to one or two people. The active listener, then, is the one who acknowledges and elicits more words for the speaker.

All of this will become more important when I examine more closely the sorts of information discussed within a CC, and which professionals benefit from this information. This, in turn, will shed some light on the purpose of the CC discourse and the role of each professional who attends. I shall be arguing that the information presented at the CCs within this particular institution was often beyond the professional horizons of some professionals (notably, the social worker and psychologist) who were excluded and thus positioned fairly low within the professional hierarchy by the content of the CC discourse. All this bears on the present theme of discussing the definition of the role of the psychologist within the mental-health setting.

Transcript Analysis:

Counting the number of utterances each professional makes during a CC shows the level of verbal interaction. What follows is a breakdown of the number of utterances made by each professional in each of the four conferences which were transcribed.

Conference No. 1

<u>Professional Role:</u>	<u>Utterances:</u>	<u>Percentage of Total:</u>
Psychiatrist	180	43
Medical Officer	108	26
Psychiatric Nurse	80	19
Social Worker	47	11
Senior Clin. Psych.	2	.5
Clinical Psychologist	2	.5
Total	419	100

Conference No. 2

<u>Professional Role:</u>	<u>Utterances:</u>	<u>Percentage of Total:</u>
Psychiatrist	113	28
Psych. Registrar	146	36
Clin. Nursing Cons.	70	17
Enrolled Nurse	37	9
Social Worker	34	8
Senior Clin. Psych.	9	2
Total	409	100

Conference No. 9

<u>Professional Role:</u>	<u>Utterances:</u>	<u>Percentage of Total:</u>
Psychiatrist	267	36
Medical Officer	66	9
Clin. Nursing Cons.	157	21
Psychiatric Nurse	118	16
Senior Clin. Psych.	63	9
Clinical Psychologist	17	2
Social Worker	50	7
(general agreement)	4	-
Total	742	100

Conference No. 10

<u>Professional Role:</u>	<u>Utterances:</u>	<u>Percentage of Total:</u>
Psychiatrist	133	25
Psych. Registrar	149	28
Clin. Nursing Cons.	120	22
Psychiatric Nurse	62	12
Senior Clin. Psych.	1	-
Clinical Psychologist	12	2 (left early)
Social Worker	57	11
Occupational Therapist	2	(not attending)
(general agreement)	2	-
Total	538	100

This gives some indication of which professional is directing the discourse.

While the total number of turns taken in a particular CC is fairly arbitrary, the percentage of the total number of turns taken by a particular speaker can be seen to be fairly stable.

The supervising psychiatrist can be seen to vary in her verbal activity across conferences, but CCs 1 and 9 are fairly similar (43% and 36% respectively), as are CCs 2 and 10 (28% and 25%). The difference between these two pairs is in the status of the psychiatric registrar who was seen as the person responsible for that particular mini-team (conferences 2, 10). The other conferences were attended by two different medical officers (the CCs were taped over the period of a month) who were lower in professional status and, therefore, required more supervision. Interestingly, shortly after I began taping, rather than merely attending, the conferences, the supervising psychiatrist said that she had become more aware of her level of involvement in the conferences. She suggested that she had two different ways of responding to the conference situation, and that this difference was to be accounted for with reference to the PR's level of experience. Nevertheless, the psychiatrist's level of verbal activity, as it is measured here, is considerable in all of the conferences transcribed, and higher than any of the other non-psychiatric professionals. From this it may be suggested that the profession of psychiatry (rather than a dominant individual) is the major focus of activity, and the other professions may be regarded as responding to, and directing their attention towards, members of the psychiatric profession.

From this analysis, a question to ask becomes; what causes a less active member of the team to enter into the discussion? There is a problem here in that the clinical psychologists are not very active as speakers, so to try and answer this question, I will give an analysis of the points at which the social worker becomes active in the first conference. The question can be broken down further into (a) what cues invite the social worker to speak? and (b) who initiates the cues? I shall, then, examine in detail the social worker's verbal activity in this conference. Throughout this analysis I shall refer to utterance numbers which relate to the transcript. In this particular section, I list the turns of all the points at which the SW becomes active (11% of the total) without necessarily quoting each turn. The reader interested in more detail is referred to the Appendix.

Analysis of Conference No.1

The SW first enters the discussion [021] after the P talks about a patient leaving the unit. The P asks a question [018-020] which is briefly answered by both the MO [019] and the SW [021]. The P then asks:

022 P: Was there anything that we had to do in the line of social work?

By using the term 'we' the question is put in a mitigated form (Labov and Fanshel, 1977: 84-86) but it is interpreted, correctly, as a cue for the SW to give an account of what he had done about finding the patient a place to live [023, 025, 027, 029].

Because the discussion involved the upcoming discharge of the patient, the SW's final comment in the sequence is put in those terms:

029 SW: So it's just a matter of tidying that up before she goes. So she, that wouldn't stop her from going though.

030 P: No.

The SW's account suggests that he has little more to do for this patient and that he is not holding up the patient's discharge.

As the discussion continues, the SW adds small pieces of information [032, 039, 070, 073] but the psychiatrist is mainly interacting with the MO and PN. The SW's specialist knowledge is not needed. However, when the discussion is turned, by the P, to the financial position of patient (C) [102], the SW has a vital piece of information:

103 SW: Although they'll run into difficulties because if they are married they can't claim separate benefits.

104 P: Oh, [names SW], I didn't think of that.

The cue for the SW's entry here is not a question but the P's lack of information about the details of the social security system. The P then questions the SW about this matter

[106, 108]. Again, this sequence ends with the SW giving an account which shows that the issue is no grounds for general concern:

111 SW: So they should be aware of the fact that they are married so it's up to Social Security to sort that out.

112 P: Oh, right.

The SW's next entry [119] shows him to be making a joke (I will not be discussing CC humour here, but I will refer to it later in terms of future research). The discussion turns to the next patient (D) [129] and, before the MO can begin to read the notes, the P questions the SW:

133 P: Oh, of course, that's right, he's back. Did you catch up with him?

134 SW: Yeah, its a sickness benefit form, that's all it was.

Once again the P's enquiry is quickly discharged by the SW playing down the amount he has to do for this patient.

Later, the SW offers some information the patient gave him [142] but, as the sequence is a discussion of medication types and levels, the SW cannot (professionally) offer anything else on the subject. A similar situation arises later as the SW offers more information [173] but the MO and PN have more detailed information and so the SW does not continue. Later, the P directly questions the SW again:

203 P: Yes. [pause] Have his parents been in touch [names SW] ?

204 SW: No, not this time.

The P then voices a concern about the patient taking drugs and makes a request for information from the patient's parents [207]. The SW says he will do this [208] but offers his own account, based on the patient's financial state, of why the patient isn't

buying drugs [210, 212, 215, 217, 220]. The P, who would not normally have access to financial details, accepts the account [218] and changes the subject [221]. The SW offers more information on the new subject [222] but, again, the MO and PN have more details.

In the discussion of the next patient (E) the SW comments by laughing [288], and is answered directly by the P who joins in the SW's laughter [289]. The SW then makes a comment on the employment training program that was already being discussed [290].

While discussing patient F, the P questions the SW directly on an issue of a respite care placement (usually short-term accommodation) [300]. The SW admits that he does not know all the details of this area [301] but offers to look into it [303]. The P asks for additional information [304] and the SW expands in fairly general terms [305, 308], and repeats that he will look into it [308]. The P continues with the issue [315], and the SW gives an example of a previous situation before repeating that he will look into it [316]. The SW then leaves the conference for a moment to answer a phone call. When he returns, the P raises the problem again.

343 P: Yes, but leave the p.r.n. so that she can have that. [names SW] I really, I don't know, I'd be grateful if you'd try, but honestly, I haven't got much hope.

344 SW: So what do we do in case we don't come up with one?

The P then supplies the SW with the information he requested [345, 348, 351], and is helped in this by the PN [346, 349, 354]. The SW says nothing more and the conference ends with utterance 419.

Summary:

The contributions made by the SW in this particular CC are cued by two things. Either the P asks the SW a question directly relating to his area of expertise, or the SW contributes spontaneously on the basis of information given to him by the patient, or where he considers that his professional knowledge is needed in the discussion. Of

these two alternatives, it is the questions put by the P which cue the SW most often, and this is perhaps to be expected the level of the P's activity (see tables given earlier).

This analysis supplements the previous breakdown of the first conference into the topics which were discussed such that more detail has been given concerning the SW's contribution. The finding that much of the SW's activity in this conference is directed by questions put by the psychiatrist is important because it allows some conclusions to be made concerning the role of the SW.

The questions put by the psychiatrist, and the information offered by the SW at other times, all related to matters which were essentially non-psychiatric; that is, beyond the professional boundaries of the psychiatrist. So, it could be argued, the perception the psychiatrist has of the role of the social worker involves finance, information about the family, information about government benefit schemes, external support agencies, and so on. The SW, in turn, fulfils the role defined by the psychiatrist. But it is interesting to note that the involvement the social work profession has in family therapy, and the assessment of patients' social situations is hardly mentioned under these circumstances. This difference between wide and narrow role definitions is an important one, and I shall return to it when examining (in chapter 8) two interviews given by the clinical psychologists involved in these conferences.

What conclusions can be made about the role of the clinical psychologists in this conference?

The CP makes an aside after the SW made a joke [119-125] but, I suggest, this remark is conversational rather than professional. The SCP makes one comment confirming what day it is [066], and makes one other response [378] after having a comment directed at him by the P:

375 P: Mmm, and [names SCP] her son commented that she's bright, I mean for her age. She's seventy... one, didn't you say?

376 MO: Mmm eight, oh, no 71.

377 P: No, her husband's 78, she's 71. But, I was asking, was she forgetful, you know, apart from the, when she had the headaches?

378 SCP: Hmm.

379 P: And the son said; no, no, she's, she's you know, perfectly compliant so that's... probably something that we don't need to pursue, but we're not sure yet. Go on, I'm sorry for interrupting.

The P has made a reference to patient G's level of intelligence, but this is not taken up by the SCP. The P then says that it's 'probably something we don't need to pursue, but we're not sure yet.' Who is not sure? The P is raising the possibility of assessing G's memory ability but hasn't decided to make the request, and the offer to test the patient was not forthcoming.

This verbal contribution fits the same pattern as the one described in reference to the SW. Again, the topic being discussed is governed, largely, by the P. Thus, if the role of each professional is defined, to a large extent, by the views of the P then, in this instance, the SCP is being defined as a specialist in intelligence and memory testing. Such testing is out of the normal area of psychiatric expertise.

The taping of CC number 9 was carried out almost a month later than the first. In this conference, during the discussion of the same patient, it was noted that the SCP was indeed going to perform a short-term memory assessment (see transcript of conference no. 9, turn 733 and following).

Given the analysis of the role of the social worker made previously, one way of interpreting the small contribution made by the two clinical psychologists in the first conference is that the definition of the psychological profession maintained by the psychiatrist excludes their contribution. That is, the psychiatrist's perception of the role of the psychologist causes the majority of the material under discussion to be defined as irrelevant. The psychiatrist does not ask any questions which could be dealt with by psychiatry alone and, therefore, questions put to a psychologist must be beyond the psychiatrist's expertise. The single area raised in the first CC in which the psychologist

is seen as having specialist (that is, extra-psychiatric) knowledge is that of psychometric and related tests. This was the case for much of the discussions I observed in which either psychologist was involved.

A prediction which arises from this conclusion is that if the psychiatrist had a wider definition of the role of the psychologist, then the contribution expected by the psychiatrist would be greater. To put this another way, if it is always the case that members of the psychiatric profession direct the flow of CC discourse, then the main way of changing the level of non-psychiatric input is to alter psychiatry's perception of other professions. This analysis does not refer to psychologists' ability to alter the perception of their professional roles, but this aspect of the situation will be covered in chapter 8.

The Function of the Case-Summary:

We may now consider the kinds of information discussed in CC discourse and the degree to which this information is relevant to particular professions. In particular, I want to focus on the use of the 'case-summary' in conferences. Before doing this, it is important to note that this particular psychiatric unit had adopted a particular way of admitting patients. As the unit was part of a general hospital, it was the hospital that controlled the administrative functions of the unit. This is not the case in other psychiatric settings which are more independent entities (see discussion in chapter 8). In this particular unit, then, each incoming patient was seen by a member of the psychiatric profession. This professional would be responsible for the assessment of the patient's state of mental health, and would then administer the physical examination required, by law, for the admission of each patient. Thus, decisions concerning particular treatments, diagnoses, and case-histories were made before the patient would come up for discussion in a case conference. This initial assessment interview is very important to the role and identity of the patient (Scheff, 1968; Måseide, 1983; see discussion in chapter 4) which will then be given in terms defined by the psychiatric profession (Barrett, 1987).

The use of this administrative procedure means that the case-summaries, based on the case histories generated in the first interview, were often the method used to introduce a patient's background to the other professionals working in the unit. They could also function as a reminder, to members of the team, of who a particular patient was, but I will discuss this possible function later.

The case-summary was not a feature of every conference I observed, and it was not a part of conference number 9 which was fully transcribed (see Appendix). However, they were an important part of the conferences and were frequently used to initiate a discussion of a particular patient. In this section, then, I shall compare several case-summaries, and make some suggestions about their function and the effect they have on the role of each profession.

The first case-summary I want to discuss was taken from the first CC taped (see Appendix). I chose this case-summary as a typical example. Throughout the transcripts, patients are referred to by a single letter allocated according to the order in which the cases were covered in each conference.

232 MO: [partially reading case history] [Patient E] is a 22 year old lady who suffers from... chronic paranoid schizophrenia. She was admitted on the 11 of November following worsening of her schizophrenia. She's been having... The precipitance of this admission was that the voices that she has heard in the past have um been becoming more prominent, staying with her all day, or most of the day. And, also, she's been having tingling feelings over her body. A very... a fairly well adjusted schizophrenic young lady and she's got good insight into her condition and um... she understands a lot about um... her illness, her schizophrenia and um she can differentiate what's real and what's not. So, she's very a very good historian. What we've done for her is um increased her medication, we've commenced her on pimozide, she's on 10mgs b.d. at the moment. She's on a... a fairly large... she's on uh three different anti-psychotics, the reason being that she's had um severe [inaud.] when she's just been on a single high dose of er fluphenazine.

In this case summary the MO, a medical student, gives the patient's name, age, and sex. He goes on to say that the patient 'suffers from chronic paranoid schizophrenia' and that she was admitted because her auditory hallucinations had been 'becoming more prominent'. The patient is described as 'well adjusted' with 'good insight' and 'understands a lot about her illness'. The MO then says 'what we've done

for her' (that is, the service rendered by psychiatry) involves putting the patient on 'three different anti-psychotic' drugs.

So, this case-summary includes some information concerning various medications. But who is this information directed at? The psychiatrist in attendance prescribed the drugs; the psychiatric nurse in attendance was most likely the professional who administered any medication not directly given by the psychiatrist or medical officer. It can be assumed, then, that these professionals are the ones referred to by the use of the term 'we'. The remaining professionals, the social worker and the two clinical psychologists, have no professional expertise in the area of medication, and yet it is likely that they are the only ones who did not know what medication the patient was prescribed.

Not every case-summary, however, included information about medication, although the pharmacotherapy of each patient was almost always discussed at some point in the conferences. The following example of a case-summary does not refer to medication.

087 PR: [inaudible] is called [patient B], a 31 year old married woman who was referred by the general practitioner [names doctor], and she has an adjustment disorder with depression, and anxiety which um began about 3 weeks ago when her husband of 7 years... left her. And, um she, he'd been having an affair with the, um, 19 year old live-in nanny. They have 3 children aged 3, 2, and 1, and they were running a chicken-take-away shop together for 8 months but that's now facing bankruptcy. So she has that as a stress and also this... separation from her husband who's in the eastern states somewhere. And she'd been feeling exhausted and thinking about killing herself, and she'd had a number of vegetative features of depression, almost some dissociative symptoms, um felt very numb and confused, and um... really got to the stage when she couldn't cope with the three children any more. Now, while she's in here, um her mother's going to try and care for some of them and [a SW not present] spent some time with... the grandmother trying to make arrangements for the children. They are all being cared for... in day-care. Two of the people that do the day-care have offered to care for the youngest two children... as the grandmother's arthritis and the children's restlessness at night make it difficult for her to cope. But the grandmother has actually opted to look after the youngest and the eldest... for the time being and [the other SW] said, made a note here, that um he's going talk about accommodation, I think, or he thinks... she needs help with emergency housing as they are paying \$140 rent a week at present... where they are. They can't afford to keep that up.

This account, given by an experienced psychiatric registrar, includes much the same sort of information as the first example, but much more background information is given. Having listed a number of psychological stresses, the PR then raises the issue of accommodation, saying that a social worker is already taking care of this problem. Thus, the role of the social worker is characterised in this account as a person responsible for child-care, housing allowances, and finding accommodation.

The patient is described in this case-summary as having an 'adjustment disorder with depression' with a 'number of vegetative features' and 'almost some dissociative symptoms'. This form of language, associated with the 'medical model' (see Cade, 1979, for examples), uses technical terms concerned with illness (symptoms of illness). At the same time, a number of lay terms have been included as the patient is described as having 'got to the stage when she couldn't cope', feeling 'exhausted', 'numb and confused'. It is beyond the scope of the present report to discuss the use of lay and technical terms in psychiatric reasoning, but see Barrett (1987) for further discussion.

Before examining some other case-summaries, I want to consider the possibility that they were being used as a reminder of particular details. The main problem with this suggestion is that the case summaries were not always included in the CC proceedings. That is, on some occasions summaries were not given, and yet each professional present knew the details of each case and did not need to be reminded about them. As I noted in the introduction to this chapter, each mini-team was responsible for about 7 patients, and each professional present would have had some contact with the patients during the course of the previous week. The SCP, who often attended all three meetings, also kept notes on the details of each case and brought those notes with him to the conferences. Thus, while it is possible that the summaries were being used as a way of reminding people which patient was being discussed, I am suggesting that other functions were probably involved.

The case-summaries often contain examples of a common feature of case conference discourse. That is, the topic is constantly switching between discussions of patients in reductionist, neuro-chemical terms which describe the patients as suffering

from, or being the victim of, their biological symptoms, to descriptions of the patients as self-determined agents (see also Barrett, 1987, on this point). My field-notes, for example, contain descriptions given during case conferences of instances at which nurses would talk about patients 'playing a game' and knowing when to behave in ways which would ensure they got what they wanted. One patient was described as appearing worried and agitated whenever an MO came to talk to him in an interview situation, and relaxed and sociable whenever the MO was not directly interviewing the patient (see also Wootton, 1977). As far as I am aware, such observations were not considered appropriate things to be included in the formal case-histories (see also Barrett, 1987, for a similar discussion).

There is one instance in which a case-summary concerning the same patient was given in two different conferences (nos. 2 and 10). I shall now examine each one in detail and then draw some comparisons.

214 PR: Well, [patient E] is a 21 year old, single woman who lives [in an institution] and she had borderline intelligence and she became disturbed behaviourally and emotionally aroused and, I think, psychotic and that necessitated admission. Um, it was in response to the break-up of the relationship that she had with somebody else at [the institution] and also she- her private psychiatrist had reduced her thioridazine down to nothing. And the issues that she's stirred up about are the fact that she thinks her family has rejected her and that her sisters are going- her normal sisters are going ahead and doing normal things and she can't. And that makes her very angry. And since she's been in here she's settled down considerably but er with the re-introduction of thioridazine. But she um does tend to giggle inappropriately and she still says that her family has rejected her although it seems very easy to sort of soothe her about that. I don't know how the nursing staff have found it, but I say things like 'well, maybe it seems like that to you because you're living at [the institution] but that- you're also making a life of your own and you see them regularly and go home for visits and-' And then she sort of forgets about it for a while...

This case-summary gives the patient's name, age, sex, marital status, and notes that she lives in an institution for the mentally handicapped. The PR states that the patient (E) has a low ('borderline') level of intelligence. Patient E's admission was 'necessitated' because her behaviour and emotional state had become 'disturbed' and she was 'psychotic'. The PR then gives an account of the cause of this behaviour which incorporates two separate issues; (a) a private psychiatrist 'had reduced (E's)

thioridazine down to nothing', and (b) it was a response to 'the break-up of a relationship'. The PR goes on to say that E is 'stirred up about' her perception that her family is rejecting her. That is, the case-summary gives two accounts of the patient's behaviour in social or psychological terms (the relationship, and the family), and a third account which is concerned with the patient's neuro-chemical state (the thioridazine level).

The case-summary then includes a report of E's current state by noting that the patient has 'settled down' given the 'reintroduction of thioridazine'. The PR then gives an account of the way she 'soothes' the patient about the perception that E's family is rejecting her.

It can be seen from this case-summary that the main problem the patient is regarded as having is a neuro-chemical imbalance caused by a change in her normal medication level. Whilst it is mentioned that a breakup in one of the patient's relationships was involved in the patient's admission, the summary actually focuses on the patient feeling that her family is rejecting her. But these social factors are not given much status in the account of the patient's condition. It is the pharmacotherapy which is the cause of the changes in the patient's behaviour. Thus, the case-summary is structured such that the most active part of the patient's treatment program is the part which is outside the expertise of either the psychologist or social worker.

Although the case-summaries are given with reference to the case-notes in front of the speaker, there is some level of variation in case-summaries given by the same speaker at different times (see Barrett, 1987, chapter 4, for a discussion of the relationship between clinical writing and power). The following quotation comes from the 10th CC to be recorded, and occurred about 4 weeks after the previous summary.

281 PR: Now, [names patient D]. She's a 21 year old single woman of who's mentally retarded from an early encephalitis and lives at [names an institution]. She's the daughter of [a member of the clergy] and has 3 younger siblings. She was admitted psychotic after stopping her thioridazine, and it was all precipitated by the break-up of a rather unpleasant relationship which she had with a man [at the institution]. She's been quite slow to settle but um now seems fairly reasonable. She doesn't appear to be grossly psychotic on the ward. I don't know how the nurses have felt about it.

Again, information concerning the patient's name, age, sex, and marital status is given, but this time more detail is given concerning the cause of the patient's low intelligence. More detail is also given about the patient's family.

This time there is no mention of behavioural disturbances or emotional levels; the patient was 'admitted psychotic'. That is, the PR does not qualify her diagnosis by saying 'I think'. Another difference concerns the reason for the patient's admission; in this account, the patient was admitted after 'stopping her thioridazine'. No mention is made of the private psychiatrist's role in this process. Again, the admission was 'precipitated by the break-up' of a relationship. The case-summary is followed by the CNC introducing the topic of the patient's relationship with her family.

Overall, the second case-summary is a somewhat abbreviated version of the first, but it is couched in more psychiatric, and less social, terms. The role of the PR, in initially making this diagnosis, is also reduced. On a related point, Barrett (1987) argues that:

"The diagnosis was initially constructed as an inference, but fed through the cycle of talking and writing was transformed from diagnostic inference into a diagnostic fact. As the facticity of the diagnosis became stabilized, it was read not just as a statement about the patient but as having a real existence within the patient." (Barrett, 1987: 221)

I think the second case-summary is a good example of the issue Barrett discusses. That is, the description of the patient, and thus the identity of the patient, is being transformed, and the description given in the case-history has become a fact about the patient. It is possible, then, that neither the social worker or the clinical psychologist entered the discussion of this patient on the second occasion because the description of the patient has taken the patient out of the range of theoretical expertise of the other professionals. More generally, this may be the case for all of the patients in the unit.

What I am suggesting is that the case-summary, when it is used in a conference, helps to set up the way in which the discussion proceeds. It is given in technical, psychiatric terms, often including a discussion of current medication levels, which is often beyond the expertise of the psychologist or social worker. This means

that the non-psychiatric professions are brought into the CC discussion only on the basis of the definition of those professions maintained within psychiatry. As I have already suggested, these definitions are also largely extra-psychiatric or beyond the normal range of psychiatric expertise. Thus, the analysis of the case-summaries combines with the earlier analysis of the points at which the social worker and psychologist enter the discussion. This suggests that the role maintained by the clinical psychologist is affected to a very large extent by the language and definitions used by members of the psychiatric profession.

Avoiding Verbal Conflict:

The multi-disciplinary teams which are involved in mental health care include professions from a wide variety of theoretical perspectives. The influence of different backgrounds of training and different areas of expertise entails a number of ways of interpreting patients' behaviour (Barrett, 1987: chapter 2; see also Frank, 1987). There is, then, an *a priori* case for assuming that professional disagreements will arise in this setting.

Different professions are organized in a variety of ways and with differing degrees of autonomy. Clinical psychology, for example, does not have a very long history of involvement with psychiatric hospitals (Napoli, 1981; Liddell, 1983; and see discussion in chapter 1) and, although it is rapidly gaining acceptance in this area, it is still couched in terms of being an alternative to, or a criticism of, psychiatry. This report is not intended to add to discussions of this topic (but see Kingsbury, 1987; Shepherd, 1982). Nevertheless, it is important to take these points into consideration in the following discussion.

The psychiatrist in charge of the psychiatric unit at which I was recording conferences once told me that she hoped that the case-conferences were situations where everyone felt they could have their say without feeling constrained by formality or subject to a hierarchy (notes were taken of conversations relevant to the present study in the same way suggested by Bloor, 1981; and Måseide, 1983). This can be a very effective way for staff members in these situations to interact (Wootton, 1977), but

it may then be asked how disagreements are dealt with and how dominant staff members maintain their position.

Disagreements were infrequent in all of the case-conferences I attended and, if they did occur, they were usually minor disagreements over information about patients. Such minor disagreements were easily resolved by one professional citing evidence to call another opinion into question, as in the following example which begins with the social worker discussing patient F's sister:

414 SW: But she's [the sister] been really maintaining her. From listening to her, she's done an enormous amount.

415 PN: No it's not; it's the niece that's done it.

416 SW: Well the sister tells me...

417 PN: ... The sister tells you that she's done it. But I talked to the sister that day that [F] was really ill and I couldn't believe it. She says; I've had a stroke and I've had this and I can't do this, and my husband's got this. And apparently it's the niece that's been doing it all, and when you listen to her, you think it's the sister but it's not. The sister hardly leaves the area because she's got her own problems.

418 P: She's got angina, yeah.

419 SW: Well she certainly has, now.

420 PN: It's the niece; it's the niece that's been doing it all. And that's why she's sort of backing off.

421 SW: Hmm. Well maybe I need to contact her because nobody's-yeah, talked about that.

In this sequence, the social worker and the psychiatric nurse disagree about the level of help given to patient F by her sister. The SW can be seen to be at a

disadvantage because she has never spoken to the patient's niece. As a result, the SW accepts the information provided by the nurse and the subject is dropped from discussion. That is, the SW changed her opinion on the basis of what was said by the nurse.

Examples of Verbal Conflict Avoidance:

In conference number 9, a situation arises where there is the potential for disagreement between the two attending clinical psychologists on theoretical grounds. The sequence is too long to quote in full so I will give a summary of what was said on the issue before giving a detailed examination of how disagreement was avoided. This is important because some attempt must be made at showing how case-conferences can function smoothly despite large differences in theoretical perspective.

The mini-team begins discussing patient E at utterance 309. The patient has been described as having a depressive illness which is complicated by anorexia nervosa and low intelligence. The patient has recently been placed on a guardianship order, and is being treated with a course of E.C.T. At turn 336, the P indicates the importance of maintaining, and increasing, E's weight. The diet is described as 'improved' but the patient's weight continues to fall and the reason for this is given as the patient's interest in exercise (hot weather is mentioned but not pursued). The PN then says:

362 PN: ... But [another professional] made a suggestion this morning that we could possibly use the um fact that she wants to be with [her child] at Christmas...

This is described by the P as 'a very good line' [371]. The CNC then brings the SCP into the discussion by raising the issue of a 'behavioural program or contract' [373]. The SCP then sets about defining the problem [381, 383, 387, 389] which is described as the patient's weight loss rather than her diet. The CNC then describes how the topic of weight is continually mentioned in the patient's conversation [405, 407] and concludes by saying:

409 CNC: [pause] And [her child] is- is the prime carrot in her life. That she can have invol- you know, see her.

The P repeats that she thinks this is something on which to focus:

418 P: So- so we- I- I think that's a brilliant idea that [someone] dangles in front of her... any more weight loss and Christmas is out.

The SCP then says that the patient is difficult to motivate [422] and that the only way around this is to make a contract in which E's weight is tied to her opportunities to see her child. The CNC, P, and PN then negotiate how much weight the patient should gain over the next 10 days [429-444]. The SCP then asks about the level of exercise [459] and whether the patient's child visits the ward [468] before the PN offers to draw up a contract (in simple language) concerning the patient's weight, but this idea is dropped from negotiations when the P says:

482 P: I think it would be more verbal and reiterative, you know, if you went over the ground over and over again. You know, between now and Friday she's got to gain or she won't see [her child] Saturday or what. [excerpt from turn 482]

The PN assumes this is the end of the discussion and initiates the discussion of the next patient (F) [483] but is interrupted by the SCP who says:

484 SCP: I thought that [E]- would that be too much hassle say to take her weight on a t.d.s. basis? I mean, it's a kind of reminder that...

The SCP is suggesting a form of intervention akin to behaviour modification although the term 'reinforcement' has not been used at this stage. This is followed by a long sequence [488-564] in which the mechanics of weighing the patient at least once a day is discussed and negotiated. The problem with the SCP's suggestion is described as being that a person's weight fluctuates during the day depending on what the patient is wearing, whether they have just eaten, and whether they have just been to the toilet.

The SCP's final comment can be summarized:

556 SCP: So it doesn't really matter whether she is 42.7 [558] or 42.6 kilos [560] doesn't really matter. The whole idea is to keep reminding her that she has to watch her weight [562] and make some improvement [564] before she's allowed to go on weekend leave.

The SCP's suggestion can be interpreted as a way of dealing with the clinical situation which is in accord with what the P has discussed. The SCP's suggestion is a more formal version of the one raised by the PN and favoured by the P, whilst related to an area of psychological expertise. The CP then disagrees with this treatment program:

570 CP: The reinforcer I would have thought might be better with- with the food and the eating behaviour because I- the- the weight side is a bit abstract. I mean it's- it's...

571 CNC: ... Mmm hmm...

572 CP: ... not something you can always control, but you can control the eating behaviour.

By using the term 'reinforcer' the CP signals that he is not disagreeing with the general behaviour modification approach. The CP describes the emphasis on weight as 'a bit abstract' and 'not something you can always control'. But the use of the second person pronoun is ambiguous. The SCP's program has been suggested because it is a way of controlling the patient's weight, but the CP's utterance could suggest that the patient is the one who is in control and that there are limits to what the patient can do:

577 CP: Well that- that- I mean logically if that- I mean [laughs] it's a bit unfair if she keeps eating more and more and her weight doesn't go up...

578 PN: ... Yeah...

579 CP: ... then you have to say; look, you know, why should she be penalised for the fact that her- her metabolism for some reason isn't- isn't- is...

580 P: ... Oh...

581 CP: ... is doing whatever it's doing um...

The CP's account, which is not directed at the SCP personally, places emphasis on the patient as an agent who is at odds with her own metabolism. The point the CP is making is that the SCP's program is 'logically' 'unfair' because it 'penalizes' the patient for the 'fact' that her metabolism isn't functioning appropriately. The SCP does not respond to these comments and the discussion is mainly between the CP, P, and PN.

The difference between the SCP and CP could easily be described as a theoretical one. The SCP is suggesting a behaviourist approach in which behaviour relating to weight is 'reinforced' either positively or negatively by using a desired goal (leave to see child) as a motivator. The CP, on the other hand, is assuming a distinction between what the patient wants to do or can be motivated to do (eat properly) and what the patient's metabolism does. The function of the CP's interjection is to persuade the mini-team that, on the basis of logic, fairness, and physiology, repeatedly weighing the patient is not appropriate. However, the subsequent discussion favours the SCP's approach because the patient is described as deliberately trying to lose weight by exercising and, initially, drinking very little [582-592]. Despite this discussion the CP says:

593 CP: Well maybe I- I'd think though that aim to- to get her to eat more.

594 CNC: Yeah.

595 P: Oh yes, even more, you mean.

596 CP: Hmm.

597 P: Yes, you're quite right.

598 CP: And encourage her to do that...

599 CNC: ... yeah...

600 CP: ... you see- rewards...

601 CNC: *She loves cooking; she does a lot of cooking but um...*

602 P: ... *She doesn't eat it...*

603 CNC: ... *feeds it to everybody else. Typical story, I suppose.*

604 P: *[pause] [sighs] Yes.*

This sequence begins with the CP hedging his agreement ('maybe', 'though') with the group which has been generating an account of the patient as actively trying to lose weight. In the course of the quoted interaction, the CP's disagreement is reduced, especially by the P, to the simple suggestion that the patient be encouraged to eat more. This new version of the CP's point sits very well with the group's account and the P then agrees with the CP [587]. The CP's point has been included into the measures that will be taken in regard to patient E whereas, I have argued, the original function was to modify the measures. I should point out that the SCP's suggestion had, by this time, been written by the PN into the case-notes and was thus an accepted part of the patient's treatment program. The CNC makes a slightly different point [601] and the topic is dropped [604]. The CP did not expand on his suggestion and the group did not encourage, or perhaps even perceive, this episode as a disagreement between the two psychologists.

Thus, I suggest, the case-conference proceeds mainly by inclusion or addition, rather than contradiction or argument. This has two main consequences; the CC discussions continue with as little disagreement as possible thus not alienating any

particular individual or profession, and the dominant decision makers (in this case the SCP, but usually the P) can continue with little modification of their central ideas.

To follow this suggestion further, I shall now discuss a much shorter sequence in which disagreement was avoided, and briefly raise the issue of the function of humour in CC discourse. This example will again touch on the distinction between 'agent' and 'victim' descriptions.

A situation arose, in conference 2, in which a patient (C) had asked not to be discharged until her family had moved house over the coming weekend. The discussion then continued:

153 P: If I was moving house, I'd want to have a bed... in [this institution] over the weekend [laughs].

154 PR: Well there's no point in her going home...

155 P: ... No...

156 PR: ... because she can't go to the new house and she'll go to the old house and everything will be in boxes... and it will just...

157 SW: ... She just doesn't want to go to the old home...

158 PR: ... No, she doesn't. I think it would be silly to press it...

159 SW: ... She's very adamant about that.

160 PR: I know we're spoiling her by, by having her here and she could go to a friend.

161 CNC: She could be involved in... moving house.

162 PR: She doesn't want to do that.

163 P: Oh, dear God. Who can blame her? [laughs] It's one of life's worse experiences...

164 CNC: ... Oh, fair enough, but I, you know...

165 P: ...But most women have to get stuck in to it, yeah...

166 CNC: ... but you don't rush off to a psychiatric hospital because of it.

167 P: No. [long pause]

In this sequence, the PR states that she has decided that patient C will be allowed to stay in the unit until her family has moved house. She says that there is 'no point' in C going home and that it would be 'silly to press it'. The SW agrees, as does the P who makes a bit of a joke out of the issue. The P says that moving house is 'one of life's worse experiences'. The senior nurse (CNC) states that this is 'fair enough' but she doubts that someone should 'rush off to a psychiatric hospital because of it'.

The psychiatrist agreed with the CNC's generalized example [167] such that one should not rush off to a psychiatric hospital whenever moving house, but this agreement

was not then applied to this particular case. No changes were made to the registrar's original choice of action.

What I have suggested in this section is that having a high status professional agree with a negative comment without drawing out the implications of that comment or modifying actions on the basis of it, is a very effective way of coping with disagreement in conference situations.

Future research in this area could fruitfully investigate the use of humour in the clinical setting. A small amount of research has already been undertaken which examines humour in different settings (Douglas, 1968, 1971; Emerson, 1970; Handelman and Knapfer, 1972) and Gilbert and Mulkey undertook a study of scientists' humour from the discourse analysis perspective (Gilbert and Mulkey, 1984), but this is still a largely unexamined area within psychology. An analysis of the various functions humour has in this form of discourse would be useful to an examination of human verbal behaviour.

Conclusions:

In this chapter, I have shown what sort of topics are discussed in case conferences. I then discussed the use of counting speakers' utterances as a measure of verbal activity, and used this measure to show the activity of each speaker in all of the four conferences that were transcribed. This analysis indicated that the professions associated with psychiatry (the psychiatrist, registrar, and medical officers) dominated the conference proceedings. I then analysed the content of the discourse of the first conference in order to show the way less active speakers (the social worker and the clinical psychologists) became involved in the meeting. On the basis of this analysis, I suggested that it is the professional definitions maintained by the psychiatrist which governs the activity of the non-psychiatric professions, and that such definitions often restrict those professions from discussing patients in other terms.

The function of the case-summary was then examined, and several summaries were analysed in detail. Following from the analysis already given, I suggested that the information presented in the case-summaries was couched in psychiatric terms and

often included a discussion of a patient's medication levels. This information, in part generated in the interview held when the patient was admitted, affects the way the conference discussion developed. Thus, the accounts generated from the psychiatric perspective would be maintained by the other professions despite the variety of theoretical backgrounds involved.

I then went on to analyse a number of situations which contained some element of verbal conflict or difference between the speakers. I suggested that these sequences could be regarded as instances in which disagreement was avoided by having high status professionals agree with the alternative opinion without drawing out the consequences of such statements or altering decisions as a result of such disagreement.

While such conclusions are important for an understanding of the role of the clinical psychologist, they can only be regarded as tentative and in need of further investigation, but they go some way in trying to analyze this normally unexamined range of verbal behaviour.

Chapter 7

The Relationship Between Theory and Practice

It was pointed out (in chapter 3) that much of the material generated using discourse analysis involved the examination of the discourse of scientists. In an early study in this area, Mulkay (1979: 121) suggested that an analysis of the relationship between science and technology would be useful in testing the assumption that the application of theory (practice) is a by-product of basic research. This suggestion was taken up in the present study as a way of further examining the role of the clinical psychologist by analysing discourse concerning theoretical orientation and clinical practice. It is also intended to extend the analysis of theory and practice in psychology developed by John (1988).

At the time of writing there had only been one study within DA which looked at the relationship between theory and practice. Potter (1982; and a slightly longer version, 1983) conducted an interview with one practitioner from the field of Social Skills Training with the object of looking at four main questions:

"(1) In what sense might a social psychological theory be applied? (2) To what extent is social psychology ever applied? (3) In what way are the fields of application and theorizing separated and what sort of interchange takes place between them? (4) In what ways are theories transformed in the process of application?" (Potter, 1982: 23)

In this chapter I will examine in some detail Potter's analysis and conclusions, and expand on and verify them by looking at interviews with two clinical psychologists who are also able to engage in some areas of research whilst employed by a large psychiatric hospital.

Potter labels the view that science and technology (or research and practice) are intimately related as the "ideology of application" (Potter, 1982: 23) or the "standard utility account" (Potter, 1983: 82; Potter and Mulkay, 1985: 258). This view suggests that what happens in academic and research institutions has a direct connection with what happens outside of those institutions; research findings are frequently discussed in

terms of the value of their utility (also see Freidson, 1970: 74, on this point). This relationship is often not questioned because it is so pervasive, but there are some recent studies in psychology which are concerned with an evaluation of these claims (e.g. Cohen et al., 1986; Morrow-Bradley and Elliot, 1986; Stiles et al., 1986).

All of these discussions assume that there is a distinction between theory and practice, but this distinction can hardly be questioned given that, as John (1988) points out:

"The organization and functioning of higher education reflects and perpetuates the distinction between basic and applied science as do recent changes in the organization of associations of psychologists in Australia, G.B. and the U.S." (John, 1988)

Thus, in very general terms, psychology has developed an account of its activities which is predicated upon the delineation of research and practice as separate areas. This allows accounts to be generated which portray the two as antagonistic (as I will show later).

Potter (1982) begins his examination of an interview with a single practitioner with the claim that the respondent gave accounts which described theory and practice as separated. I want to quote Potter's data because of the similarity it has with the interviews I will examine later.

"1.(a) Interviewer. What would you say were the important theories that you use in social skills training? (b) (pause) (c) Respondent. Important theories? (d) Interviewer. Yes. (e) Respondent. I suppose it's a learning theory really, or what I consider learning theory to be. I see social skills training very much, really, as based on an educational model. It is skills training. And one can relate it much more to an education type viewpoint, which is based on learning theory. (f) Interviewer. And how about the particular theories of Argyle and Dean on gaze and Ekman and Birdwhistell on kinesics and so on? (g) Respondent. I don't take much notice of those I must admit. I mean, obviously their stuff is very useful in providing information, and in terms of instructing clients one usually gives a talk on, say eye gaze, and that may draw on the work of Argyle to just indicate the way in which eye gaze is used." (Potter, 1982: 33)

Potter's analysis uses other sections of transcript to further illustrate his points but I think this excerpt will be adequate enough to show what he is focusing on. He

interprets this interaction in terms of Gilbert and Mulkey's (1984) distinction between formal (empiricist) and informal (contingent) repertoires (a discussion of which can be found in chapter 3).

Potter argues that this interaction can best be interpreted in terms of a pair of inconsistent verbal repertoires. Part of the account fits well with the standard utility account, but this is undermined by other sections of the account which better fit the informal repertoire suggested by Gilbert and Mulkey (Potter, 1983: 107). The beginning of the account shows the respondent to be surprised by the assumption within the interviewer's question (notice the pause). Potter then suggests the respondent produces two contradictory statements ("I don't take much notice of those" and "obviously their stuff is very useful") which can be resolved by looking at the account as a production of two different accounting systems (Potter, 1982: 34).

Potter then goes on to argue that, although the traditional model would suggest that there is a continual interchange between theory and practice, there is no indication that this is the case. Practitioners modify their own activities on the basis of personal experience rather than theoretical developments (see also Morrow-Bradley and Elliott, 1986). Potter's respondent also gave accounts which suggested that people who attempted to do practical things only on the basis of an understanding of the literature were very bad at it (1982: 37). This last point is perhaps not surprising in the light of John's (1988) examination of the standard view of the relationship between theory and practice which suggests that a third level of knowledge is taken for granted. This third level, the knowledge gained from performing practical activities, is built into the education of the practitioner on the standard model (For the psychiatrist this involves 5 years as a registrar; for the clinical psychologist 2 years of supervision before registration). Nevertheless, Potter's point that practical knowledge is not fully available in literary sources (1982: 37) is an important one because practitioners may read theoretical reports in a different way as a result of this tacit knowledge. This may result in the modification of theories as they are applied, but I will come back to this point in the analysis of the interviews.

In conclusion, Potter suggests that the level of interchange between theory and practice is less than the traditional model (the standard utility account) would suggest, and that the amount of utilization is dependent more on previous practice than theoretical evaluation. Thus, any changes within practice tend to result from practical circumstance rather than theoretical development and, when theories are adopted, they undergo a level of transformation. Finally, the claim that theoretical work is justified because of its relevance to clinical practice needs to be examined more closely (1982: 46-7).

So far I have just looked at the relationship between theory and practice from the perspective of a scientist-practitioner. However, there has also been some work done on this issue from the academic perspective. Jones (1986), for example, claims that a paradox inherent in academic life can account for some psychological research having little impact on clinical practice. While I think he uses a form of the standard utility account Potter identified, he uses it as an ideal to be attained once a number of mainly sociological obstacles are overcome (and again, there are similarities here with the Gilbert and Mulkey repertoires). It is worth examining Jones' argument to see this different perspective. For example, he claims that:

"Generations of earnest young graduate students have been turned into remote, aloof middle-aged professors, doing research only of interest to a handful of like-minded others." (Jones, 1986: 536)

Jones then goes on to give five influences which help to bring this situation about. First, he suggests that academic institutions promote the idea that "good research requires abstraction and detachment from the real world" (p.537). Research can be cited to show that common sense is incorrect thus placing a distance between ordinary and scientific knowledge. A second related point is that academic departments isolate themselves from different disciplines, each one having "a different tradition of research and theory" (p.537) and claiming to have the most valid perspective. Third, Jones argues that academics are individually isolated from the social world they purport to study. Fourth, he points out that there are constraints placed on research by

academic environments. Finally, Jones suggests that senior academics become most influential, through teaching and non-expert seminars, at the time that they are least involved in the examination of data. Jones concludes his discussion by claiming that more research of an applied nature will ensure that academic psychology has more to offer clinical practice. It may be that this does little to the current situation given that, as Potter (1982: 29) points out, a great deal of psychological research remains applicable rather than applied, however, I do not intend to assess the validity of Jones' claims. I merely cite them as an example of the sorts of grounds people give for criticism of current research practices, and I will come back to them when I look at the interview to be examined later.

Introduction to the Case Studies

Interview 1:

The clinical psychologist (CP) who agreed to be interviewed for this study was chosen because he was involved with the case-conferences analyzed earlier. He was assigned to work for one morning of each week [014] at the psychiatric (hereafter, S) unit to which I was given access. The CP was employed as a full-time clinical psychologist by a large psychiatric teaching hospital (hereafter, L) and had worked there for about 18 months when the interview was conducted [002]. He was engaged in clinical work at that institution where he also worked on a number of research projects. He had obtained both an Honours degree (B.Sc. maths science) and a Ph.D. in psychology, before working for 2 years towards registration which is a compulsory part of becoming a psychologist in most states of Australia. At the time of the interview, he was also an office-holder in a professional organization of psychologists.

Interview 2:

The senior clinical psychologist (SCP) who gave the second interview was also chosen because he attended the case-conferences examined in the previous chapter. He had been working in clinical psychology for 12 years [002]. He had also been employed by a large psychiatric teaching hospital (L) for about 3 years [008] during which time he was involved to some extent with the psychiatric unit to which I had

been given access, and began working there on a half-time basis 12 months prior to the interview [012]. He had obtained both an Honours degree (B.A.) in psychology and a professional clinical masters degree (M.Phil.) from overseas institutions.

While it may be possible to argue that these particular respondents answered questions in idiosyncratic ways which were unrepresentative of the majority of clinical psychologists, it should be noted that these psychologists both worked with a group of other psychologists (13) in a fairly large department, and practiced in two different psychiatric settings with many other mental health workers. There was no indication that they practised in any unusual ways or that they were not highly regarded by their colleagues. The accounts they produced were acceptable and unchallenged as the considered views of qualified and experienced practitioners working within publicly funded institutions.

The first interview was conducted by the researcher who had become familiar with the CP during the 3 month period in which case-conference were monitored. It is important to remember that the CP was responding to questions put by a postgraduate student in psychology, trained in the same educational institution.

The second interview was conducted by the researcher with the SCP who helped in gaining permission to attend the case-conferences prior to the commencement of the field work. The SCP acted as a kind of supervisor or mentor in that setting and answered the many questions put to him over the three month period. Thus it could be said that the researcher had acquired discursive frames and schemas in common with the respondents (see Tannen and Wallerstein, 1987, for a discussion of this point).

In the analysis that follows, I shall examine each interview in turn before drawing conclusions on the basis of the accounting practices described. I do this in order to preserve the sense of continuity maintained in each interview.

Analysis of Interview 1:

I think a fairly clear distinction can be drawn between the research done on a particular topic and the tacit knowledge gained by the clinician (John, 1988). Rather than being guided by a theory, a practitioner may come to rely on the accumulation of

experience and common sense. Common sense is not the sort of thing which can be taught and can sometimes be described in opposition to knowledge derived through theories (Jones, 1986). With this distinction in mind, I put the following question:

061 INT: In seeing a patient, how often do you come to rely on the training you've had, and how much do you think is based on common sense?

062 CP: [pause] Um [pause] Well I hope the- that er common sense over-rides training although I have been aware, in the past, of sort of down-grading some components of my training, and realizing with more maturity that er some learning theory and so forth has a lot of relevance in the clinical context. So I've changed my view to a large extent as far as knocking some areas that I've thought were a waste of time before.

In this sequence common sense is portrayed as more important than training. The respondent says that he has previously ignored parts of his training but has now come to be aware of its importance. However it is not made explicit exactly which theories are relevant to the clinical context although there is some reference to 'learning theories'. A further implication of this segment is that, for at least some part of this psychologist's practice, some aspects of theory and training were not used at all. Thus, this account suggests, the CP could practise successfully without some components of his training and, even now, common sense will 'over-ride' training in some circumstances. I then asked for more detail:

063 INT: But you did see it in those terms?

064 CP: Well I think my- my feeling was really, when I was teaching some of those areas and relating it in applied settings, and thought; well that's a lot of rubbish. When I've come here I've often sort of found myself religiously adopting it because I knew it was the process that, especially working in terms of helping people with phobias and so forth. And I've- to my sort of shock and horror, I've found that's it's very effective, works very well. Plus I've also found that er having people keeping diaries is an invaluable way of ensuring one can er assess what's happening and er and so, I'm getting off the point a bit here but I, you know, this sort of gear which I thought was sort of rather the weak side of psychology, and I realize now is a very important side, a very important component of clinical work. And it has a very er- I wouldn't say that ah to- to try and answer your question, the inference, almost, is that's not common sense; I guess it's just my- my er theoretical bias

away from learning theory but I've found that er it has a very strong practical relevance to working with patients. Um but yeah, common sense, I think, over-rides generally er most- most of what you do. And I guess there a- there is a sort of a theory which, to a large extent, makes up common sense. So it's very much an interactive type of thing.

In this segment some theories are described as 'a lot of rubbish' and it was with 'shock and horror' that they were found to be applicable to clinical practice when 'religiously' adopted. Again the theories in question are just labelled 'learning theories' but this time the reason for doubting them initially is given as 'theoretical bias'. This suggests some reasoned denial of a particular theory whereas in the previous segment it was implied that they were just not relevant. At the end of the segment it is suggested that common sense is 'sort of a theory' which is also 'interactive'. Thus, the account given depicts common sense as a theory which evolves in the light of practical experience. Slightly earlier, we have the distinction between theory and common sense being questioned and the importance of some theories being asserted. It was then asked:

065 INT: So then what standard psychology- er psychological theories would be relevant to what you are doing in the clinical setting?

066 CP: [pause] Um [pause] That's a bit of- of a broad question. Um, well, as I've mentioned, a lot of learning theory in treatment of er um particular phobias and anxieties sort of... Um er not quite sure what other theories you- I would say that a lot of personality theory doesn't have much relevance for me as a clinician. Certainly psycho-analytic theory, I find not terribly relevant at all. [pause]

When asked what specific theories are relevant to practice, the CP begins to answer with a disclaimer after a pause which is uncharacteristic of the rest of the interview responses. This is followed by the examples of 'learning theory' but it is still not made clear which learning theory is being indicated. There are, after all, a great many learning theories which have been proposed by psychology but I am unaware of any which propose the use of 'diaries' [064]. It may be the case that the CP is referring to a change the theory has undergone in being translated to a practical setting (Mulkay,

1979) and this is a possibility which Potter discusses (1982: 39-42), but the transcript does not contain enough detail to verify this point.

I do not wish to suggest that an account could not be generated which did give examples of theories relevant to clinical practice. However, in this instance the CP is obviously not very comfortable with a discussion of the relationship between theory and practice (and here a similarity can be drawn with Potter's, 1982, analysis). The question is deflected by giving an example of a group of theories which are not relevant, perhaps in an attempt to find relevant theories by a process of elimination. In particular, psycho-analytic theory is portrayed as 'not terribly relevant at all'. However psycho-analytic theory is a very broad group of theories which are frequently dismissed, in a Popperian fashion (Popper, 1979), because they are untestable or unverifiable. Within mainstream psychology, then, at least as it is described in textbooks, psycho-analytic theory would not be regarded as a theoretical rival. The reason for bringing it into the discussion can be seen in the next segment:

067 INT: Whereas, some psychologists here would?

068 CP: Oh I don't think so, I mean, I'd be very surprised. I mean I think people dabble in it from an historically interesting point of view, and one does also come across some- quite a few psychiatrists who are that way inclined but I would say very few psychologists.

Psycho-analytic theory is described as relevant to 'quite a few psychiatrists'. So, to the extent that psychiatry makes use of these theories, they are important in clinical practice. However, the CP would 'be very surprised' if psychologists made use of this approach. This excerpt gives some insight into the way psychologists may account for theoretical differences between psychology and psychiatry, but it is still unclear what theoretical approaches are used by this particular psychologist. Later in the interview the CP says:

074 CP: ... and um from a research point of view, I feel more comfortable in the area where I'm working now which is very much involved with the assessment of dementia and um generally problems associated with memory.

075 INT: Right.

076 CP: *And er obviously, because of my background in the area, I'm very familiar- relatively familiar with research and feel quite comfortable in terms of er keeping up with the relevant research...*

077 INT: ... Hmm...

078 CP: ... and er I don't- I think probably in other areas of clinical work my level of commitment to keeping up with the relevant research is superficial.

I have included utterance 74 of this sequence because it relates to a point to be brought up shortly. I think this sequence can be summarized in the following way. The CP is currently undertaking both research and practice in the area of memory and dementia and describes himself as familiar with current research. The CP then refers to the other areas of his clinical work and says he doesn't attend to a lot of theoretical developments [078]. While theory was described in previous excerpts as having some importance to clinical work [063, 064], developments are not given a very high priority.

This particular CP is also undertaking his own research on a topic [076] which can be seen as related to his doctoral research [010]. In the sequence quoted above the CP, in response to a question concerning the relation between theory and practice [069], suggests that there is a fairly close relationship between the two. But slightly later a conflicting (if not contradictory) account is given:

080 CP: *Well and- well yes, and also with other teams in the hospital. There's the schizophrenic unit, for example, which I've got very er little clinical involvement with, I've got quite significant research involvement with. So that's er- the two don't necessarily go together... In some ways, I think that's not such a bad thing.*

081 INT: *Do they go together more with the geriatric unit?*

082 CP: *Well [pause]. To be honest, I- I think my involvement with the er research with the geriatric unit really um [pause]. I'm really sort of*

helping or facilitating others, also really focusing on material which particularly interests me. Um that's largely what my role in the hospital generally has been; co-ordinating most of the quality-assurance work that now goes on in the hospital, and being associated with the research committee, and generally um helping people who want to do research. And um, I'm probably getting off the topic. I personally don't find a great deal of overlap between my particular research that I've been doing and it's relevance to my clinical work.

083 INT: *Hmm.*

084 CP: *Directly, anyway. [pause] (extract from turn 84)*

The sequence begins with the point that research and practice do not 'necessarily' go together and that this is 'not such a bad thing'. When more detail is sought [081] about this relationship in the area mentioned earlier [074], the CP says that, 'to be honest' he does not find a 'great deal of overlap' between research and practice [082] in any 'direct' way [084].

We can see from this second account that even when the CP is an expert in the research currently being done on a topic, that expertise is not seen to have much effect on the work he performs as a clinician. Thus in considering Potter's second question concerning the level of interchange between theory and practice, I am suggesting that some accounts may be formulated which show little interchange even when both activities are carried out by the same person.

It is interesting to look at situations where a single person performs both theoretical and practical functions because, in the standard utility account where research is said to have a direct effect upon what is done in practice, this should be the ideal case. The researcher should be able to refine aspects of the current theory and put them into practice. I am not trying to argue that such situations could not occur or even that they are unlikely. However, in this case, even when the opportunity is there to combine the two activities, keeping them separate is seen as a good thing. Therefore the question is not whether there is a close connection between theory and practice, but

under what circumstances accounts are given which depict them as being interconnected.

There is a further complication in this account. One of the ways psychologists can account for their involvement in a clinical area is to say that they bring to a situation expertise in approaching a problem scientifically. Thus, it can be argued, research skills enable them to deal with clinical situations in ways which could not be undertaken by other professionals (I return to this point in the next chapter). This is a kind of clinician-experimenter account which argues the benefits of a research orientation in examining clinical problems.

...my perception of the way I do er a clinical- or my work with a patient, is very [like] a model of how I'd approach a research problem. And I try and basically follow the same write-up [excerpt from turn 084]

The other area of expertise that I think a psychologist particularly contributes is er the- the area of being able to adopt a scientific, research-based orientation to problem solving. [excerpt from turn 094]

These two segments are examples of accounts which stress the importance of research practices in clinical work. Working with patients is described as a 'model' of a research problem, and psychology's 'expertise' is in 'solving' problems in a 'scientific, research-based' way. These accounts make use of the language of a scientist in a way which most of the accounts I have examined in this chapter do not. There is, for example, no use of the term 'common sense' in these examples, although it could be possible that a psychologist's common sense mirrors research practices.

Until now, I have developed the analysis in terms of a divorce between theory and practice. But the accounts I have examined are more complicated than this because, under some circumstances, the research orientation is described as one of clinical psychology's important assets. Practice can be described as modelled on research even though the current research on a particular topic may not be seen as relevant.

Here we see an interesting antagonism between research and practice. Research findings are often dismissed as irrelevant to current practice, while practice is often described as being methodologically similar to research. Thus the research method is described as important and, *at the same time*, findings derived from such methods are ignored by clinicians. The research method is an important part of the repertoire used to justify the involvement of psychologists in certain fields while not being described as an important way to produce knowledge relevant to what clinical psychologists do.

There has been some empirical work which has found that some of the important sources of information which practitioners rely on are discussions with colleagues (Cohen, 1979; Cohen et al., 1986) and experience with patients (Morrow-Bradley and Elliott, 1986). Potter's case study also pointed out the importance of knowledge which was "not fully available from literary sources" (1982: 37). This was raised with the CP in the following way:

123 INT: So when you came into clinical practice, were there then areas which you then had to go and study up on your own because the academic side didn't provide it?

124 CP: Oh very much so. Very much so. Um, I knew very little about er [pause] anything associated with psychiatric disorders; very little about schizophrenia, very little about er [pause] depressive disorders. So that- that [laughs] I more or less had to catch up that whole area. It wasn't really, from my recollection, covered at all in my course.

In this segment the CP offers a criticism of his academic training by saying that psychiatric disorders weren't 'really covered at all' by his course. Initially, he knew 'very little' about the 'psychiatric disorders' which he now dealt with in clinical practice. Given the empirical work which indicates the importance of discussions with colleagues (Cohen et al., 1986), the next question was:

125 INT: So in doing that, how much would you come to rely on um colleagues you'd have, say, in this situation? Is there a lot of knowledge passed around in your own environment about what sort of things would be expected of you, or did you select these areas and go out and get better at them?

126 CP: Well I probably relied a bit more on my reading to er become more familiar. And when I found I didn't um understand or agree with relevant issues er I would then discuss it with colleagues and others in the clinical field. They didn't have to be psychologists necessarily.

In this reply the CP contradicts the empirical study just mentioned by saying that he relied more on reading. However, the CP describes his use of reading as a way of becoming 'more familiar' with particular areas. This is perhaps not surprising given the way the CP described his understanding of 'anything associated psychiatric disorders' in the previous excerpt. If we interpret this as the CP relying on his reading to initiate his understanding certain topics, we can then see that the CP is emphasizing the (predicted) importance of discussions with colleagues. The CP also points out that discussions could be held with professionals from other disciplines. The CP then gave an example:

127 INT: Who else would they be in that case?

128 CP: Oh, in some cases social workers, er in some cases psychiatrists. I mean areas like grieving and so forth; variation in terms of theories associated with it. Things like that came up and I talked to a social worker who'd probably often be a er person... [the (90min) tape finishes and is turned over]

129 INT: So er the social worker would then what? Introduce you to the theories concerning grieving, or would they discuss those er in question more in terms of practical application?

130 CP: Well, I guess, largely it would be a balance of theory of the person's er reflection of her understanding of the theory, and er in- in practice; how she's found- she may have come across 50 or 60 patients that she's dealt with who have been er um severely affected- er say, for example cases of still-birth or things- issue- things like that and what sort of experiences she's found. So er I think that er- a lot of that information you don't find in books, and er it's very much a thing- I er respected those sorts of opinions and directions.

The area of grieving is raised with reference to a particular social worker (this topic will come up again in the next chapter on the role of the psychologist). This sequence is an example of the CP's use of the term 'balance' which acts like a recurring

theme; it is used in reference to tertiary education [120], assessment and research tasks [174], development of practical application packages [190], and here in regard to theory and practice. It is also a term used by the respondent in the next interview to criticise practitioners who have a single therapeutic approach with which to treat every patient.

In this sequence the CP assumes a distinction between an observable phenomena (grieving) and 'variations in terms of theories associated with it'. In the next response the CP begins by referring to a 'balance of theory' but chooses to use the mediated form of 'reflection of her understanding of the theory' [130]. This may relate to the theory being modified by the social worker's understanding and practical application of a theory (see earlier discussion and Mulkey, 1979), but again the transcript does not give more detail on this point.

The most important part of this segment is the stress laid on the authority gleaned from practical experience. No reference is given to the social worker's training in this area, just as no reference is made to her critical evaluation of the relevant theories. That is not to suggest accounts could not be generated which include these points, but in this example the CP indicates the amount of practical experience the social worker has; 'she may have come across 50 or 60 patients that she's dealt with'. This information is vital, it is suggested, because it cannot be found in books.

Another similarity can be drawn here with Potter's (1982, 1983) study. Potter's respondent suggested that people without practical experience:

"... may look at so and so's feeling about so and so. And that's the way they operate...they may well do some good, somewhere, but you don't really know what the hell they are doing. And they may do some harm."
(transcript quoted in Potter, 1983: 97)

Potter's respondent was talking about people who launched themselves into clinical work with only an understanding of the relevant literature and can be seen to be critical of such people on that basis. It is then perhaps to be expected that in generating an account concerning the benefits of holding discussions with one's colleagues, the CP lays stress on the amount of practical experience the social worker has.

That concludes the analysis of the relevant excerpts of the first interview. I shall now examine the second interview in the same way, before generating the conclusions.

Analysis of Interview 2:

Both interviews were conducted using similar interview schedules which allows a comparison of the accounts given by the two professionals at several points. Thus the first question relevant to the current discussion was put to the SCP in the same way:

035 INT: Right. [pause] In seeing a patient, how often do you come to rely on the training you've had, and how much do you think that common sense is involved?

036 SCP: Oh I think training is very important. Um [pause] If we get a patient- Um, personally, I really do not believe that common sense alone can enable someone to um provide an adequate professional service to a client. And I think the er clinical training is tremendously important because training provides the- the clinician with the basic er theoretical expertise. Um and it is only with this theoretical and practical expertise that we get from the training courses that we feel confident in approaching any particular problem that the patient presents. And I think again the other important factor which [pause] guarantees an adequate and professional service is that of the experience of the clinician. Now without the training and experience I don't think [pause] the clinician would be in a position to er- to give a er an adequate service. I'm not playing down the importance of common sense um because I still think what makes a good psychologist is the psychologist's ability [pause] of exercising a lot of common sense in quite a number of quite diversified situations [pause] but I still would like to put training and experience above that of common sense.

In this account the SCP says that training is 'very important' because 'common sense alone' is not adequate enough to give a professional service. It should be noted that there was no suggestion in the question that this might be the case (although this point is discussed by Smedslund, 1972: 77-8). The SCP goes on to say that training provides the 'basic theoretical expertise' which enables the psychologist to 'feel confident in approaching any particular problem'. This is followed by the introduction of two new discursive elements: the importance of experience is stressed for its role in providing a professional service, and common sense is 'not played down' because it allows the psychologist to work in 'quite diversified situations'.

There is an interesting comparison to be made with the first interview in which the CP gave an account structured in the opposite way. Whereas the SCP suggests that theory (in the form of training) and experience should be put above common sense, the CP hopes that common sense would 'over-ride' training. So, while both accounts deal with the same elements, they place a different emphasis on the importance of those elements.

Common sense is mentioned in other parts of the second interview:

So there are areas in day to day clinical management that each and every profession tend to chip in. [pause] And I don't think it is a um- a problem of sort of one profession acting to the detriment of another profession. I'm quite receptive to the idea that er any person who is er professionally qualified or confident in er [pause] running these groups and providing this sort of service, and who has a fair degree of common sense. They should do very well. But with the more specialized approaches in intervention, right, like the behavioural approach or um [pause] seeing a certain patient for a cognitive-behavioural intervention; techniques like cognitive restructuring, I think that should be left with somebody who is well trained, well skilled, and well experienced in the field. [excerpt from turn 076]

This account suggests a slightly more complicated version of the importance of the use of common sense. This extract comes from an answer to a question concerning the relationship between clinical psychology and social work (to be dealt with in the next chapter). Here the use of common sense is important in the areas of family therapy, stress management, communication and so on [076]. However, it is argued, in 'more specialized' aspects of clinical practice, common sense must give way to training, skill and experience. This implies a stronger emphasis on the role of theory in areas of specialization. The next question in the schedule relates to this point in a general way, with more specific questions to follow:

037 INT: So um what standard psychological theories would be relevant to what you do in clinical practice?

038 SCP: [pause] A lot of people have- may answer this question by sort of straight- ploughing straight into the er different orientations in psychology like psycho-analysis or behaviourism or the more humanistic approach and so on. But personally I like to take one step back um and consider a sound knowledge of basic psychology as important because I

think it is from a sound knowledge and understanding of the basic psychological principles that all these different orientations er branch out. And so um I think a- a good psychologist should have a sound knowledge of general psychology. He or she should be knowledgeable about abnormal psychology er [pause] and the next step would be for the psychologist to decide on an orientation or an approach which suits his own, not so much personality, but his own philosophy of life. Because I think um in a lot of cases the reason why a particular psychologist is drawn towards any particular theoretical orientation has a lot to do with his own philosophy in life. For example, a lot of people just cannot accept the um, what do you call it- the mechanistic um approach or behaviourism. Personally, I think it is a misunderstanding of behaviourism. But um I know a lot of people who simply cannot um get themselves to accept behaviourism because of a philosophical belief that they have.

The SCP begins this account, not by describing particular *theories* but the way some psychologists may answer the question by focusing on three main *orientations*; psycho-analysis, behaviourism, and humanistic psychology. He then expresses a preference for an understanding of ‘basic psychology’ and ‘basic psychological principles’ and suggests that the different orientations in psychology ‘branch out’ from these areas. It would involve a different form of investigation to reveal the extent to which the different orientations mentioned share a common set of principles, however there are some descriptions which suggest that the level of unification in psychology is very low (Staats, 1983), and it would be possible to argue that orientations like psycho-analysis and behaviourism were incommensurable (in some sense of the term).

The SCP’s account goes on to imply that, once an understanding of basic psychology is attained, a psychologist should then ‘decide on an orientation’ which suits ‘his own philosophy of life’. Thus, this account implies a rational progression from basic principles to theoretical superstructure (and such an account would be denied by writers such as Pepper, 1942, and Mitroff, 1974). I then asked the SCP to describe his own orientation:

039 INT: So how would you describe your theoretical orientation in that case?

040 SCP: I consider myself a behaviourist, there’s no doubt about it. [pause] Although may- I may qualify this statement by saying that I’m- [pause] in a way I’m [pause] a softer behaviourist than say I was 10 or

12 years ago [pause] because I think my clinical approach, although still it's still deeply rooted in behaviourism; like I believe we need to deal with the here-and-now problem without- without um getting back into speculation of childhood experiences um, and I don't believe in making any sort of unsubstantiated conjectures about what goes on inside the organism, and I still believe that the most pragmatic way of approaching any problem is to consider the observable. [pause] And I also believe um that the only way we can evaluate whether our approach is effective is through some reliable measure of the variables concerned. So my approach I would call um scientific and behavioural but I- when I say soft- a softer approach is because um I can say that I'm more aware of the prevailing emotions and attitudes [pause] presented by my clients than I was about 10 or 12 years ago.

The SCP describes himself as a behaviourist before qualifying the description by saying that his approach is 'softer' than it was 10 or 12 years ago. He then lists a number of theoretical characteristics which he maintains and describes his approach as 'scientific and behavioural'. Perhaps this could be re-described as pragmatically behaviourist in that it is different from the empty-organism model suggested by radical behaviourists because it is sensitive to 'prevailing attitudes and emotions'.

This constitutes a modification of a theoretical position and as such, relates to the previous discussion on theoretical changes brought about by practical application. Both in Potter's (1982) study and the previous interview, this issue could not be examined in detail. Therefore, in this context it becomes important to isolate the possible causes of this modification:

041 INT: So um, what theory would have influenced your softening of the behaviourist approach or is that softening to do with practical experience?

042 SCP: Um I would say it is [pause] more clinical experience than any prevailing psychological theory that has softened up my um what used to be a very radical behavioural approach. [pause] The- say back in the early 1970s when I did my training, everything was very well laid down; like when you're presented with this problem all you need to do is use this approach. And every treatment which the clinician follows was a very er stringent er procedure; like flooding, or cessation, or assertive-training. Each and every individual treatment regime is so well laid out that all the clinician needed to do is to follow these procedures in steps and the patients- the clients would get better. But as you really um moved into the reality of the clientele, then apart from the presenting problem they also have these other concerns like the family, like er mood-state, like their attitude of how they perceive er of the therapist and how they perceive of themselves. And all these other what once-

they called extraneous variables, becomes so important, I feel I cannot sort of negate it as the extraneous variables. And so um- and I feel that it became important to try to address some of these issues, and from experience I- I sort of discovered by trial and error that if I acknowledged some of these prevailing emotions and attitudes, and how they perceive of the situation and so on, um there was a dramatic improvement in the kind of rapport that I had with the clients. And that was very rewarding because it contributes toward a very positive therapeutic effect which I think adds something on to the traditional behavioural approach. So say if I approach someone from a very traditional behavioural um oriented procedure, I might not get as much a positive therapeutic result as when I acknowledge some of these prevailing emotions and attitudes, and try to um clarify some of the perceptions or perceived ideas of the therapist, themselves and their family and so on. So I get um- be drawn sort of more and more into the ones they called the unspecific factors in treatment, and um begin to look at some of these very important areas. I think this is where um I think common sense comes in.

In the last part of this sequence there is another account of the role of common sense. In this case common sense is used in order to modify a practical technique which had been based on a 'very radical' version of behaviourist theory. This account also stresses the importance of having learned 'from experience', 'by trial and error', the value of changing his technique in order to suit the 'reality of the clientele'. There was 'a dramatic improvement' which 'adds something' and achieves a more 'positive therapeutic result'.

Another parallel can be drawn with Potter's (1982: 38) study on this point. In both cases, accounts generated by the respondents depict modifications or alterations various theories have undergone in dealing with the 'reality' or the context of practical application. However, whereas Potter's transcript would not allow conclusions to be made about the causes of such changes, the SCP's account is quite explicit on this point; changes were brought about by trial and error, and the use of common sense.

It may then be asked whether the SCP modified his therapeutic approach purely on the basis of common sense and trial and error. That is; it may be asked whether this account is consistently adopted in the interview.

Quite a large amount of interview time was spent discussing aspects of family therapy and at one point the SCP mentioned that he had 'borrowed' [054] some

interviewing techniques. This issue was then raised in terms of how new information is acquired:

065 INT: ... How did you come to be aware of those techniques from family therapy? [pause] Was it through um discussions with other clinical psychologists or...

066 SCP: ... Oh I see yes...

067 INT: ... was it on the basis of some publication on family therapy that had come out?

068 SCP: Right, right. The standard sort of training procedure for family therapy um is to participate in many, many therapy sessions with a supervisor. And er almost all the [inaud.] the trainee will observe the sessions through a one-way screen. You know, a one-way mirror. And so it is more a process of role-modelling on the er supervisor and, of course as the sessions proceed, there will be a lot of discussions generated behind the screen amongst the trainees and possibly the supervisor. And through these observations and role-modelling procedures that say, for myself, I began to discover that there are alternative ways of questioning, for example. Um in a more sort of traditional, orthodox behavioural or behaviour therapy approach, I don't think it's any different from a standard sort of medical examination approach. That you ask quite specific questions to the um- to the clients er and we want fairly effectual answers from them. Ah but in family therapy, there are more um round about ways of getting at the same answer without er the unnecessary feeling of being interrogated.

This account describes the process in which new techniques are learned as 'role-modelling' and observation although the emphasis on active 'discovery' is also important. The 'traditional, orthodox' behavioural therapy interview is described in medical terms and it is implied that a client may feel 'interrogated' under such circumstances.

The first thing to note about this sequence is how closely it conforms to the conclusions of Morrow-Bradley and Elliott who argue, on the basis of the results of a survey, that therapists "learn about therapy overwhelmingly from practical experience... and only rarely consult therapy research..." (1986: 194). The SCP then elaborates on the interviewing technique:

070 SCP: And I think it's a very important aspect in the technique of the interviewer. And of course there are a number of very standard behaviour therapy- er no; family therapy type of questions. Like questioning the client of their own perception of um what they expect from a change and how they perceive er say um certain parameters; how they compare their own perception with that of another person. And I don't think this sort of information was emphasised in a behavioural approach. So I've- I found that this technique of say questioning a comparison between different perceptions um, and the questioning the person's own idea of what the change is, and so on, is very useful in getting um relevant clinical information.

This account resembles the one given in turn 042 in that they both consider the importance of recognizing the perceptions and emotions of clients. However, this particular account suggests that the techniques developed for dealing with such contingencies are attributed here to a position developed within family therapy. There is, therefore, an inconsistency between accounts which imply the adoption of a technique on the basis of role-modelling and supervision, and the previous one which emphasized trial and error and common sense. It would, undoubtedly, be possible for the SCP to resolve this discrepancy if the two accounts were put to him, but the point is that there is no straightforward way of deciding which one of these elements would constitute a sufficient cause in modifying the SCP's original theoretical stance. Potter's solution (1983) for analyzing this variation of accounts is to treat it as a resource rather than a methodological difficulty (see also Gilbert and Mulkay, 1984: 13). Thus, the first sequence may be seen as an account of the personal development of the SCP, whereas the second account functions as a description of the benefits of the family therapy approach. The variation may be construed as a function of the issue or question raised in the context of the interview.

Finally, I want to look at the suggestion I made in relation to the previous interview. I argued that there was an antagonistic relationship between theory and practice in that the methods used in theoretical investigations are part of the clinical psychologists' repertoire whilst not being part of the way clinicians come to acquire new information. In analysing the interview with the SCP, I have shown in more detail the sorts of discursive elements used to account for changes in theories. It remains, then, to examine the extent to which the SCP also uses the empiricist repertoire in

accounting for clinical practices. The SCP was asked to indicate how his role differed from other mental health workers:

072 SCP: Hmm. Sort of um- I perceive myself as an applied scientist. Um we work with a well defined area of theoretical expertise plus um the adequate clinical skills and experience. And we possess the knowledge of psychology which would be beneficial to the other disciplines like psychiatry and social work. Um and I think the major role of an applied scientist is to reduce the uncertainty in say the more ambiguous clinical situations. I think this is exactly what the clinical psychologist should be doing.

The SCP describes himself as an 'applied scientist' whose theoretical knowledge is 'well defined' and capable of reducing 'uncertainty'. The SCP then goes on to say that the method used by an applied scientist takes the form of an investigation. Thus what an applied scientist does:

080 SCP: ... is that first of all you have to find what is wrong or what the problem is, and from your expertise, your knowledge, your theoretical background, your experience; then you should be able to [pause] postulate some hypothesis about this problem. And once you have a hypothesis, alright, you can investigate, you can test, alright? You can investigate the hypothesis, through some of those formalised procedures.

The language used in this excerpt shows the rational progression from identifying the problem, postulating a hypothesis, and investigating through the use of formalised procedures. The account then continues:

082 SCP: And once the investigation is finished, alright, then again it is up to the person's um knowledge, skill, experience to make some sense out of the data [pause] what shall we call- interpretation. [pause] Try to draw up a er conclusion on the basis of the investigation. Alright? And I don't think it should stop there. Once you get the data; once you get some either confirmation or rejection of your hypothesis, it gives you, the clinician, er the basis um to modify your original hypothesis. And to go on to investigating other areas that may be relevant to the um situation. It's more like a series of detective work; that you proceed from one hypothesis to the other until you are satisfied that, yes, this is a er all the data or the information that I need for me to draw a conclusion. [excerpt from turn 082]

The account describes how an investigation proceeds by the rejection or confirmation of a hypothesis on the basis of the data, thus maintaining the empiricist repertoire. However, some points of the account are inconsistent with that

classification. By including such things as 'interpretation' and proceeding 'from one hypothesis to another' through modifications, this account could also be seen to describe the hermeneutic process or "hermeneutical circle" in which one "moves back and forth in a dialectic between one's world and the object, constituting meanings, altering one's horizons, until the object and the world are unified into a coherent whole" (Agar, 1980: 258). This is just to suggest that the SCP's account could be understood to contain both linear and circular elements which may be difficult to resolve with a standard empiricist repertoire.

Conclusions:

In this section I want to draw together the two interviews and Potter's (1982, 1983) study, all of which I think indicate what a rich source of information the research interview can be in examining the organization of discursive accounting practices (Potter and Mulkay, 1985).

The interviews revealed a number of different uses of the term 'common sense' which had different levels of significance for the two clinical psychologists. Firstly, common sense was described as a way of modifying different theories in their application to clinical contexts such that common sense could act as a form of theory itself. Second, common sense was regarded as a necessary characteristic of a good practitioner. This version of common sense can easily be regarded as an extension of the first. The third form was only identified in the second interview. This version suggested that common sense was most useful in working with less specialized forms of therapy. This last account implies a high reliance on theory-driven techniques which was exactly the position rejected by the CP in the first interview. Nevertheless, common sense was regarded as fairly important overall, although it is not an element usually stressed in more theoretical or abstract accounts of psychology.

The second interview, unlike the first and Potter's study, allowed some examination of the causes of modification brought about in applying theories to clinical settings. Two slightly conflicting accounts were given; one stressed the experience of trial and error, while the other described the effect of role-modelling and observation.

The first version is consistent with research from other areas which suggested the importance of practical experience (Morrow-Bradley and Elliott, 1986), while the second is consistent with the observation that discussions with colleagues are an important source of information (Cohen, 1979; Cohen et al., 1986). Neither interview respondent suggested that monitoring the research journals was important to the development of their techniques, and this accords with Potter's study.

It was also pointed out that, even when a practitioner was actively researching in an area associated with clinical practice, theory was not described as directly relevant to practice, and this was seen as 'not such a bad thing'. The respondent in Potter's study and the two respondents in this study also gave unspecific accounts of *particular* theories which were relevant to them. There was also some indication that the term 'theory' was being used broadly by all three respondents, and in one case it was used interchangeably with the term 'orientation'.

Whilst specific theories were not employed in the accounts examined, accounts of the general research methodology used in psychology were utilized frequently. I suggested that there existed an antagonistic relationship between research and practice in this regard. That is, while the respondents talked about the benefits of experience, common sense, training courses, and discussions with colleagues, they did not significantly give accounts of theoretical or experimental developments. Therefore, information produced using the empirical model, in which hypotheses are evaluated using experimental data, is not directly relevant to these accounts. However, the respondents did account for their own clinical practices by stressing the importance of employing the empirical model. Thus the relationship is an antagonistic one because employment of the empirical method is treated as important while results generated in this way are not.

Finally, I suggested that there were aspects of an account given in the second interview which did not fit the standard empirical model but which were similar to the hermeneutic one.

This chapter has gone some way toward verifying and expanding the conclusions drawn by Potter (1982) although the analysis I have made must be regarded as tentative and in need of further verification. I shall now turn to the final chapter of this report where I will deal with the role of the clinical psychologist.

Chapter 8

The Role of the Clinical Psychologist

Psychology in general, perhaps more than most fields of enquiry, has always sought to question and define its role (Sarason, 1981; Kaswan, 1981; Staats, 1983; and John, 1986, are good examples of critical reviews). Clinical psychology in particular, has been subject to evaluation by clinicians and educators as part of an ongoing question, but does not seem close to finding a definitive answer concerning its role and function (John, 1985), and Reinehr has pointed out that discussions on this topic are a frequent cause of confusion (1975: 126). Rather than develop this point by giving an extensive review of the literature on this question, I have chosen to illustrate some of the problems of the debate by looking closely at a very recent Australian article written by Groth-Marnat (1988). Having shown some of the assumptions made in this article, I will go on to show how similar discursive practices were used by the clinical psychologists I interviewed (see chapter 7) and who were members of the mini-team discussions I analyzed (see chapter 6).

Groth-Marnat (1988, hereafter GM) starts by listing a number of studies which have "assessed and helped to define the roles of Australian professional psychologists". He then points to other studies which have shown the cost-effectiveness of psychologists employed within hospital settings. He then states that:

"It is through ongoing assessment of the nature and extent of psychologists' activities that training programs can be revised to prepare for future professional demands and adequate human resource policies can be developed. This is particularly important in the acute medical area where psychologists have often been dominated by the biomedical model and restrained by narrow role definitions (Birnbauer and Leech, 1982; Sharpley, 1986; Thomas et al., 1985)." (Groth-Marnat, 1988: 128)

Subsequently, he states that:

"In particular, Thomas et al. (1985) found that psychologists in rehabilitation settings were perceived as most appropriately performing IQ and personality assessment and, to a lesser extent, providing in-

service training and consulting with other members of the rehabilitation team." (Groth-Marnat, 1988: 128)

The article then goes on to show the results of a survey which was sent to administrators of large Australian hospitals in a bid to find out where psychologists' services were being utilized, and what future plans were held for psychologists. The administrators were given a list of 15 areas in which, it was suggested, psychologists *could* be utilized, and were asked to indicate how many were *actually* employed in such a capacity and whether the number would change in the future. The results were presented statistically, thus assuming that the hospitals employed psychologists in a homogeneous way, and a list was generated which summarized which areas were important and which areas were going to become important. The results also included unsolicited comments from some of the administrators who pointed out that some of the areas which were suggested as related to psychology were fulfilled by other professions; psychiatrists, social workers, and chaplains were mentioned.

GM then discusses the results suggesting that, while a psychologist can adopt a diverse number of roles, administrators do not always perceive the range of possibilities. A number of reasons for this conclusion are discussed and can be summarized as follows:

1. Narrow perception of role because psychology has not educated the various policy makers,
2. Lack of legislative support for psychologists' autonomy,
3. Lack of academic and professional training,
4. Competition from other disciplines.

The article concludes by saying that:

"... efforts from the profession to ensure adequate training, positive legislation, and education of relevant policy makers can increase the likelihood that this expansion [of professional psychology] will continue to occur." (Groth-Marnat, 1988: 133)

Although they were raised in discussion, this particular survey did not address the issues of positive legislation and in-service training . So, the main points of the GM argument may be schematized in the following way:

1. The role of the professional psychologist needs to be defined,
2. The role they have is restricted by the perceptions of others, therefore,
3. Psychologists should find out what roles are required by administrators and policy makers, and,
4. Alterations to the way professional psychologists are trained should be made on the basis of point 3.

Presumably, this sequence can be used any number of times.

I now want to argue that these claims are based on interesting but conflicting implicit assumptions, before going on to show how similar assumptions underlie the discursive practices of some clinical psychologists.

The first major assumption that GM makes is that the role the clinical psychologist adopts is not inherent in the way they are trained. It would be less likely that such a survey would be made of, say, the role of the psychiatrist or nurse in a hospital. Although this is not to suggest that the roles of professions other than psychology are not also flexible. Perhaps the point here is that unlike people trained in more specific ways, the psychologist is much *more* flexible and can adapt to different circumstances. While such flexibility could be portrayed as an advantage (which does happen in some of the accounts I will look at later), GM assumes this is a disadvantage. The reason is that apart from psychometric assessment, the tasks a hospital allocates could be fulfilled by a number of different professions. Thus flexibility is a double-edged sword because the areas in which psychologists could be employed are not peculiar to psychology.

The consequences of this flexibility create a problem for GM's analysis. If psychologists do work at a large spectrum of tasks, it is only because their training encourages such flexibility. However, GM's call for specific training in a subset of those areas would surely result in the reduction of the role's flexibility. Psychologists

can only respond to the demands a hospital makes of them because their current flexible training enables them to rapidly gain the skills required in specific settings.

Concentrating on training specific skills at an institutional level would encourage a hospital to define a psychologist in terms of those skills, and psychometric testing is a good example of this. So, while following the GM prescription would help define what a psychologist does, it may also exclude psychology's involvement in those areas where specific training was not undertaken. If a number of different professions are competing for work in a variety of areas, it can only be because each profession can give a sufficiently broad account of itself to justify its involvement. Therefore, I suggest, the consequences of GM's reasoning would lead to the negation of his conclusions.

I will illustrate this further by showing how two clinical psychologists employ a number of different discursive repertoires in giving an account of their roles while pointing out some striking similarities with the brief analysis offered by GM.

Before doing that, it will be useful to develop some of the work of Freidson (1970) as part of the background to the analysis of the role taken by a particular profession. Freidson gives an analysis of the formal characteristics of any profession by looking at medicine in particular, and this analysis bears some similarities to the work of Goffman (1961: 279-336) who examined the roles of the professions involved in the mental health field.

Freidson's first point is that in making a distinction between a profession and an occupation, it is important for a profession to show that it is a "legitimate, organized autonomy" which has been deliberately granted "the right to control its own work" (1970: 71-2). Clinical psychology's attempts to do this are described by Napoli (1981) who gives an historical account; by Barrett (1987: 81) who notes the importance of clinical psychology's success in securing third party reimbursement of fees for private practice; and can be seen in more prescriptive studies such as that of Thomas et al. (1985) and Groth-Marnat (1988). As Freidson notes:

"A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it..." (Freidson, 1970: 72)

In the case of clinical psychology, some of this patronage came in the form of third party reimbursement of fees, but earlier influences included the interest of the Veterans' Affairs Department and the National Institute of Mental Health in America (Napoli, 1981; John, 1985). Thus, clinical psychology can be seen as having the characteristics of a developed profession which, whilst much more recent than psychiatry (Barrett, 1987: 81), is continuing to penetrate the expanding area of mental health services. Some of the antagonism between psychology and psychiatry (Shepherd, 1982: 21, 55) may also be understood in this context.

Freidson goes on to outline the steps an occupation needs to go through in order to attain the status of a profession:

- 1) development of formal (university) training
- 2) development of theoretical background
- 3) development of code of ethics and form of registration.

Once this has been achieved, Freidson argues, a profession can develop more formal characteristics, and these include:

- 1) prolonged specialized training
- 2) a service orientation (also see Goffman, 1961: 286-7)
- 3) determination of own standards
- 4) legal recognition of licensure
- 5) admission board controlled by profession
- 6) profession to be involved with legislation
- 7) freedom from lay evaluation (Freidson, 1970: 77).

Of these, Freidson emphasises the social and political importance of maintaining autonomy rather than aspects of training and technique. Therefore, clinical psychology's ability to consolidate and increase its level of autonomy can be regarded as crucial and worthy of internal debate. It is, then, perhaps to be expected that studies

in this area which hope to contribute to the definition of the role of the clinical psychologist frequently offer support rather than criticism.

It is also useful to consider the way various professions enter into in-service training programs. This is usually done on the basis of individual presentations (see later analysis), and can be regarded as small-scale versions of what an individual's profession is attempting. I will go on to show that the education of other professionals is frequently characterized as a way for the individual to find an autonomous niche from which other competitors can be excluded. Thus, Freidson's analysis of professions can be usefully applied to particular individuals as well as to occupational groups.

Introduction to the Case Studies:

I am aware of only one previously published study which presents an analysis of the discourse of a practicing applied psychologist (Potter, 1982). This analysis follows the initiative set by that study, and extends the one undertaken (in chapter 7) on the relationship between theory and practice. Thus, I shall not repeat any of the introductory material concerning the background or the validity of the discourse of each respondent. Again, each interview is treated separately before the conclusions are drawn.

I intend to analyse this material in terms of the theoretical background given in chapter 3 where it was argued that the variation which can be identified in people's discourse can be explained in terms of different responses made in accordance with changes in the environment, and that a major motivation for giving different responses is the respondents' perception of power relationships. In the following interviews, power is spoken of as having an internal locus (derived from the individual) or an external one in the case of psychiatry or the hospital context in general.

Analysis of Interview 1:

The manner of accounting for the role of the clinical psychologist can often come to rely on how it was perceived by a predecessor (this point is made generally by Freidson, 1970: 95). The perception which other professionals then have of the new

psychologist can be influenced by the predecessor, and accounted for in terms of something which needs to be altered:

020 CP: Well, again, both of them were relatively unstructured. I mean it was up to the individual to some extent although the guide-lines were er... I guess, established from one's predecessors to some extent. Um you fulfilled the role that er they had done before you. But I think there was an element of, once you became familiar with the job, of having a degree of flexibility. I was not really associated with [S] long enough really to do anything different. I think that er what I did with the emergency team, because of my research background and my orientation towards that sort of area, and the fact that clinical load was small, I developed a very strong interest in quality-assurance work. And er I would say that realistically half my time was spent um on evaluating um the work that was being done in the er in the emergency team. And er...

In this account, the CP says that, at [S], his role was 'relatively unstructured' but restricted by the role of the previous psychologist. It was also suggested that, over time, the role could be altered. I will come back to accounts of this influence in a moment when I look at a longer episode. The CP also accounts for his development of a 'quality-assurance' program as something he initiated because his clinical load was 'small'. Thus, both personal interest and environmental restrictions played a part in what the CP did.

In this account, the role taken by the CP was divided in two, with 'half' of the time being devoted to the evaluation of the 'work that was being done' by the other professionals on the team [021]. The CP then expanded on this part of his job:

022 CP: Yep, and generally how the unit was operating and um and proposing different ways in which- also that related to the hospital as a whole, in terms of information collection, storage, and usage; that sort of thing.

The CP was engaged in an assessment of how the unit operated and 'related to' the rest of the hospital. He was then asked whether he would describe this task as 'program evaluation' (a term used to refer to a section of social psychology):

024 CP: Well it was a number of- I mean, what had- what hadn't been done up until then was that the way in which information was collected, or data, was collected about the unit; it was just nonexistent, or if it was there the data that had been collected was very erroneous. So what I

tried to do was systematically er begin a process of evaluating the data; so, working out what sort of people actually came in, what were the problems, demographic background of the patient, and what happened to them when they were assessed; ah whether they were um sort of statistical ah- what numbers of people were admitted, if they weren't admitted, what happened to them. And er just that sort of information so that er really that the unit could define its role more clearly.

In this account, the CP states that he began a systematic 'statistical' 'process of evaluation' in order to 'define' the role of the unit he was in because, previously, 'data' was 'nonexistent' or 'very erroneous'. Here the repertoire identified in the previous chapter as emphasizing the utility of the psychologists' research methods can be seen to operate. The language used focuses on the rational, detached assessment of the available data, and is similar to that used to describe an experiment.

It is interesting to speculate on the effect such quality-assurance work would have had on the role of the CP because, as Freidson points out (1970: 76), other professions, such as nursing for example, would not be able to take on tasks involving evaluation. The right to evaluate assumes a level of role equality with all of the people being assessed, and Barrett (1987: 216-19) has argued that authority within psychiatric institutions is usually associated with the act of writing. Thus, for a clinical psychologist to be able to initiate and write up a study of such information gives some indication of the status attained by psychology in this setting.

At utterance 028 (not quoted), we see the influence played by the larger psychiatric hospital (L) in assigning the CP to the position of duty officer. This will be seen to constitute a second external influence, and allows an interesting comparison with the SCP's work to be described later. Earlier, the CP described his clinical load as 'small' thus implying that a great deal of the role was unstructured or 'flexible'. I will show that there is some degree of variability in developing this account by looking at an episode in which this point is made again, but making reference to a wider range of considerations:

176 CP: No, no, I think there are definitely a lot of different faces [of psychology]. And I think it's flexible too; you can change faces [pause] depending on the moods. Realistically, at the moment, um- the thing is when- the thing I found actually with er working in the emergency team,

because of the intense vying for patients and so forth, many of the people who are pure clinicians got very bored and very angry with the fact that their work-load, if you like, was small. They didn't have anything to do. Um they didn't know how to occupy their time constructively. The thing is- what happens- I- I dread that sort of exercise.

In this sequence we again find the emphasis on flexibility (or ability to change) but the implication here is that, if a psychologist did not take advantage of the situation, they could become 'very bored and very angry'. Here we see a tension between two different ways of accounting for the situation. The account of the role being determined by the clinician, through taking advantage of its flexibility, is undermined by the account of the clinician being determined by the hospital environment. This discursive tension continues a moment later:

And er so we've got er- at the moment on staff we, [pause] unless you just twiddle your thumbs, I think most people who- who have gone through the formal training have got more ability than that; they want to do something constructive when they're not er actively involved in the duties they're employed for. [excerpt from turn 180]

When not actively employed in the tasks defined by the hospital, it is possible that a psychologist may do very little. The narrow definition imposed by the hospital, it is implied, does not take advantage of 'most' psychologists' abilities (note the similarity with the GM analysis). This account suggests that restrictions on what a psychologist does can come from both the hospital's definition (external) and the psychologists' acceptance of that definition (internal).

So, accounts can be given which either emphasize personal flexibility or ecological constraints. A good example of the latter occurs in a description of the CP's current position:

138 CP: My role is a lot different now. My role is very much more defined in terms of working in the geriatric area.

This account suggests that the level of structural constraints placed on psychologists varies within the hospital. The constraint is then indicated as 'formal assessment' requirements:

140 CP: I guess the person who does the formal assessment, and er largely it's er very much more structured.

141 INT: And was it structured because you took over the roles that er a previous psychology- er psychologist had had? Or did you come in with those sort of intentions?

142 CP: No; in the geriatric area it was simply because I have taken over- I took over from a neuro-psychologist.

In this sequence the CP says that his role was structured 'simply' because of the role taken by the previous psychologist. It also echoes the excerpt quoted earlier [020] which pointed out the importance of this factor. He then gave more detail:

144 CP: And he had probably exclusively um involved himself in assessment. What they want me to do now also is extend, I guess, the level of service from more than just simple assessment to also looking at treatment, and that's something I'm trying to er develop at the moment. But er just at this stage I'm finding that er most of my time is taken up purely with assessment and um...

145 INT: ... When you say 'they' what do you mean? Who's 'they'?

146 CP: Oh well, I guess, you can always work with nursing staff and medical staff and, when somebody new comes on the scene, people want to get to know you and er so it's both the medical staff and the nursing staff er and social workers. One tends to er get on with these people, it makes life easier and er they're- I- I'm very impressed with the level of competence in that particular unit and certainly I think it's very rewarding work with people I find have a lot of credibility.

147 INT: So you're being guided, then, by the members of an interdisciplinary team?

148 CP: [pause] Ah, well [pause] very, very gently, yes. I mean, they're encouraging me to do my own thing to- to a large extent. Obviously, in that unit, er more than any other unit in the hospital, er the neur- neuro-psychological is er is fundamental. But er one thing that they haven't really had before was er the opportunity of having a psychologist working in a treating component, whereas they've always had just simply a person working in a- an assessing component- in an assessing

position, should I say. And er the scope is- is er- is very er- very large for having a psychologist working in a treating capacity.

149 INT: And you're initiating the treating side of it?

150 CP: Well yes. Yes, but, as I say, um at the moment it's er- it's- it'll take, I think, a couple of years before it's established. [extract from turn 150]

This is a rather long sequence to quote, but I think it is important to show how these two antagonistic ways of accounting for the role are adopted. Again we have an example of the role of the previous psychologist having an influence [144] because he had 'exclusively involved himself in assessment'. This is followed by an interesting assertion from both the self-determination repertoire and the ecological one [144]. The CP is 'finding' himself occupied 'purely with assessment' while also being influenced by other people's desire to have the psychological service extended; accounts of external influences which are conflicting by themselves. At the same time the CP portrays himself as responsible for the development of the treatment. This example from the self-determination repertoire is reinforced in turns 148 and 150 where the CP suggests that he is initiating the development of the treatment program. The ecological repertoire, on the other hand, is brought forward particularly in turn 146. The reason cited for being responsive to external influences is; 'one tends to get on with these people, it makes life easier'. I also quoted a segment from utterance 150 which describes the amount of time, at least on this account, needed to alter the current task practices.

It should also be noted that the previous psychologist's role is accounted for in self-determining terms: the previous psychologist 'exclusively involved himself' in neurological assessment. There is no mention of the previous psychologist being affected by a third psychologist, or even the requirements implicit in the tasks to be performed.

It can be seen from the sequence quoted above that the influence of conflict in the determination of professional roles is also an important feature of accounts in this interview. This was made more explicitly in other accounts:

I guess as er- it was a very competitive area in terms of, ironically, in terms of getting um patients. And er um many of my own cases actually came from the ones I had assessed at casualty. It was a way of getting your own cases so to speak. You see, so it was a bit of a er... it was a bit unfortunate that that has- that was how it worked. [extract from turn 034]

The level of competition between different clinicians is seen here as the cause of particular patients being assigned to different disciplines. The situation is described as 'unfortunate' and 'ironic' but the way 'it worked'. This shows the influence of competition which implies some form of conflict, but in other accounts the influence of conflict is made more explicitly:

When one tends to provide er similar services to others there does become a potential for conflict um and if you can actually find an area er and say this is where I'm- this is where I am um then people feel comfortable. It just makes working in a team a lot easier: your- your situation's clearly defined. [excerpt from turn 094]

A number of professionals from different areas may all be able to provide similar services under some circumstances (as the GM study pointed out). To that extent, there is a level of flexibility in many, if not all, of the professions operating in the mental health area. This situation is described as one in which there is 'a potential for conflict' which can only be avoided by making a clinical area 'clearly defined' thus making others feel 'comfortable'. A hypothetical conflict was then put to the CP:

107 INT: So the relationship, then, between psychology and psychiatry would be one where er, if you had decided you could treat this particular person, then psychiatrists would not over-ride it and um prescribe certain medications?

108 CP: As a general rule, that would be the way. I mean there was a bit of common sense that also some people- I mean most of the psychiatrists that I dealt with had- were fairly common-sensical about things, and respected one's professional opinion. But I am aware that there would probably be other psychiatrists that would be quite

obstinate and er ignore what I would have to say. But that hasn't personally happened to me. [extract from turn 108]

Unless a psychiatrist was 'obstinate' the CP's opinion would be respected, and whilst some psychologists had encountered such psychiatrists, the CP said he had not. Here it is possible to see an example of the "permanent conflict between psychiatry and psychology" which was noted by Barrett (1987: 81) and an indication of psychology's position in the hierarchy of the particular institution.

These accounts all imply some form of active role negotiations in which the outcome of such negotiations then form part of the ecological background. The environment is seen as containing competition from others, the possibility of conflict in specialized areas, and the power relationships between disciplines. Also important are external factors such as the role taken by a previous psychologist, and the influence of other professionals in particular teams. Accounts which emphasize the importance of these factors have been labelled examples of the *ecological* repertoire. These accounts indicate the negotiations involved in role definition, but the extent to which these negotiations are portrayed as important also varies considerably. The following examples offer a contrast to the previous ones:

131 INT: So would grieving then be part of er the areas you talked about where duplication happens between, say, what a social worker does and what a clinical psychologist does?

132 CP: Well it could be, it could be. I mean I chose not to er work in that area because at the time the particular social worker, who's er very competent, and wasn't over worked, if I can put it like that, um was quite happy to have referrals of that type. So we worked in balance, you know, in harmony sort of thing. But if- if the situation were that er I didn't have that option, then I'd be happy to probably um [pause].

Here a social worker is described as 'happy' to take referrals in a relationship which has 'balance' and 'harmony'. If this was not the case, the CP would be happy to take over in this area. As it stands, the CP 'chose not to work' in the area taken by the social worker.

Shortly after giving the account concerning potential conflict [094], the CP was asked to contrast his role with that of a psychiatrist and a social worker:

099 INT: Er how do you see those- your role as being different from those two did? Purely in terms of assessment procedures or would there be a fair amount of overlap?

100 CP: Well to me they all complement each other.

Rather than use terms involving competition and conflict, the CP chooses to say that each discipline complements the other. The CP then expands on the roles taken by each discipline:

102 CP: That- so that one doesn't er duplicate unnecessarily um- I er [pause] It's probably not a bad thing; some degree of duplication, I mean, obviously, in terms of history taking and that sort of stuff, but one often gets similar sorts of backgrounds. But er as I saw it, the social worker, as a general rule, tended to work as well with the family and was involved in terms of er a lot of the legalistic side of things in terms of organizing the person's er- the patient's basic resources; their finances. And that was completely foreign to me. I had very little- [names SCP] on the other hand, I might say, was much more involved in terms of family therapy programs; that wasn't an area I was um...[portion of turn deleted] Obviously, the psychiatrist, in any context, was there again from a legalistic point of view in case the person was detained, and had to make certain judgements about the person's mental state from the legal side of things. If medication was obviously appropriate then it was the psychiatrist's jurisdiction. [pause] But, apart from medication, [pause] most of the time I think with some- with many psychiatrists, one tended to work on a similar level er. Perhaps they would have different perceptions of the psychologist, I'm not sure.

The CP begins by saying that professions complement each other in order to avoid unnecessary duplication, but goes on to say that duplication is 'not a bad thing' in some areas and gives 'history taking' as an example. Accounts are then given of the roles of the social worker and the psychiatrist. The social worker's role is described as one in which they 'work well with the family'. The CP says that this area was 'completely foreign' to him but also notes that the SCP was involved in 'family therapy programs'. Thus, the social worker's role as family therapist, for example, is not indicated. The social worker is also described as involved in the 'legalistic side of

things' and the patient's 'finances'. I will later compare this account with the one synthesized from the way case-conference discourse functioned.

The role of the psychiatrist is also accounted for as being 'legalistic' because they were involved in the process of legally detaining someone. The CP also notes that the area of medication, if 'obviously appropriate', was the 'psychiatrist's jurisdiction'. The account is concluded with the remark that 'most of the time' with 'many psychiatrists, one tended to work on a similar level'. This account is then put in a mediated form by noting that perhaps the psychiatrists would 'have different perceptions of the psychologist'. Thus, while the CP thinks that his role is similar to that taken by a psychiatrist, he is 'not sure' that the same account would be given by a psychiatrist (compare with the analysis in chapter 6).

Overall, this account is an extension of the remark the CP made in stating that the roles of the psychiatrist, social worker, and psychologist were complementary. The roles assigned to each are described as fairly clearly delineated and, although the psychiatrist and psychologist work 'on a similar level', conflict and negotiation processes are not emphasised. In other parts of the interview, the self-determination repertoire was more prominent:

So er I'm happy with where I am. And I certainly think that er ultimately what seems to happens with psychologists, and it's very fortunate, is that they do-they are generally in positions to let the er- their positions be moulded by their- by their degree of personal preference. [excerpt form turn 170]

The CP says that psychologists are 'fortunate' that they are able to mould their positions according to 'personal preference' and went on to give a motivation for this:

172 CP: And I think that's very good from the point of view of your job giving you satisfaction.

Thus it can be seen that self-determination is accounted for as an important component of job satisfaction.

If we ignore the ecological repertoire for a moment, it then becomes important to examine accounts which discuss how professionals from disciplines such as psychiatry become aware of the interests and preferences of psychologists:

134 CP: I think there's a strong component of being a sales-person after a fashion. And in terms of the emergency team, at that time, the social worker was a very articulate woman and er she was involved with er a number of in-service training programs. Certainly one of them wasn't er- was in relation to grieving and er she presented in that area um. In the same way, psychologists also spoke about sort of the areas that they sort of have expertise and I think that was a very effective sort of channel for telling people what- what you can do and what you can't do; what areas you want to do and those you don't. [excerpt from turn 134]

In this account, being an 'articulate' 'sales-person' and running in-service training programs is held to be the way a clinician can make others aware of their preferred areas. The adoption of the sales metaphor plays down the importance of the constraints noted in the ecological repertoire. Personal choice and initiative are the components stressed in these accounts.

Finally, an excerpt from the end of the interview in which the self-determination repertoire is most prominent. The CP was asked whether there was a formal assessment procedure which governed what tasks he performed:

208 CP: There's no- there's no formal way, really. [pause] Well [pause] there maybe technically a for- a formal way, but in practice there is no formal way really of [pause] controlling what a person does to some extent. I mean, there is- I mean there are basic guide-lines you have; one is employed with a duty-statement which covers everything. Um and what happens is that the person sort of usually er develops their own er niche in the institution that- that, one would hope, would make most people happy. [pause] And also, obviously, makes the clinician happy.

Although he was employed with a 'duty-statement' which gives a number of 'basic guide-lines', there is no formal professional assessment. Each clinician, then, 'develops their own niche' in which they can be happy, and this niche is created through choice, preference, being a sales-person, and complementing the roles taken by other professionals. This example of the self-determination repertoire completes the analysis of the first interview.

Analysis of Interview 2:

There are a lot of similarities in the ways the two clinical psychologists answered questions, and they were basically asked the same questions. However, there was a considerable difference in the form these responses took. The SCP had much more clinical experience on which to draw and often gave responses in terms of clinical psychology in general. The CP's responses were most often concerned with his particular duties and activities. Bearing this difference in mind, I shall begin by examining accounts generated in response to questions concerning the role of the clinical psychologist in comparison to the other professions involved in the area:

071 INT: How would you see your role as different from other mental health professions working in, say, this unit?

072 SCP: Hmm. Sort of um- I perceive myself as an applied scientist. Um we work with a well defined area of theoretical expertise plus um the adequate clinical skills and experience. And we possess the knowledge of psychology which would be beneficial to the other disciplines like psychiatry and social work. Um and I think the major role of an applied scientist is to reduce the uncertainty in say the more ambiguous clinical situations. I think this is exactly what the clinical psychologist should be doing.

The SCP adopts the label of 'applied scientist', a variation of the scientist-practitioner or scientist-professional term usually applied to clinical psychologists (John, 1985). He goes on to suggest that a psychologist's knowledge, skill, and experience 'would be beneficial' to the functioning of the other disciplines. Whereas previously the role of the clinical psychologist had been accounted in terms of flexibility, this account suggests that the role of the clinical psychologist is inherent in the skills and knowledge of the psychologist's role as 'applied scientist'. The role of every applied scientist, it is suggested, 'is to reduce the uncertainty' of 'the more ambiguous clinical situations'. Again, the emphasis is on the importance of experimental methodologies identified in the last chapter:

074 SCP: Um, in psychiatry for example, very often they rely on subjective judgements and um in a lot of situations, they have to make a decision on the basis of inadequate data. Which I think in many

circumstances is not justified on the part of the client. And a psychologist can help the team or the other professions to try to reduce the amount of uncertainty by providing more objective data. Whether it could be a self-rating questionnaire or behavioural rating um or some other tools or instruments, or even a second opinion from the psychologist can help to reduce this ambiguity in clinical decisions. [excerpt from turn 074]

Psychiatry is criticized for relying on 'subjective judgements' made 'on the basis of inadequate data'. Psychology is able to supply 'more objective data' which will enable team members to reduce 'the amount of uncertainty' in the decisions they have to make. The account then starts to list a number of ways in which psychology is able to do this by using 'tools or instruments' developed by psychology. It could also be argued that this account is undermined by the SCP referring to the use of a 'second opinion'. Of course, it is a perfectly legitimate strategy to call for second opinions in making decisions. However, such opinions could also be sought from other psychiatrists who have already been criticized in this account for relying on subjective data. The SCP has not given an account which suggests that, when he has not made use of 'tools or instruments', his 'second opinion' is less 'subjective' than that of a psychiatrist. Thus, it could be said that the SCP has reduced the rhetorical force of his argument (see Billig, 1987; and McCloskey et al., 1987 for discussions of rhetoric in the social sciences).

Barrett makes some interesting comparisons between psychiatry and psychology:

"Both professions invoke the legitimating symbols of science. For one, this was the positivist medical science, for the other it was positivist experimental psychology, psychometrics, statistics and quantitative research. Both claimed special knowledge of biology, especially in the area of brain function. For one, this accrued from medical expertise, for the other it accrued from expertise in neuro-psychological testing. Finally, both claimed expert knowledge of the patient as a mind. For psychiatry this was expressed in the control of psychodynamic theories of mind. For psychology, this was expressed in a control over behaviourist theories of mind." (Barrett, 1987: 82)

Thus, the SCP can be seen to be criticizing psychiatry along fairly standard lines.

However, there is also a tension in this account between expertise gained on the basis of

the employment of particular tests, and expertise gained through clinical experience.

As I will argue, it is from a repertoire which stresses the importance of clinical experience that the last portion of the account is derived. The SCP completes the turn in the following way:

Of course on top of that the psychologist also has the kind of skill and expertise and experience um to deal with a number of well defined or specific problems that the client may have. And to offer some alternative treatments er to some form of disorder. A good example is, say, obsessive-compulsive disorder; the psychiatrist will tend to, say, prescribe a drug - clomipramine - which they feel that could be- er would help the obsessive-compulsive disorder but er from a psychological point of view, the same disorder can be tackled by [pause] some behavioural approach which is just as effective. [excerpt from turn 074]

Again, the role of the psychologist is defined as an alternative to the psychiatrist by citing 'the obsessive-compulsive disorder' as an example of something which may be treated in two completely different ways. This account emphasizes an area in which psychological activity is well defined and could be regarded in opposition to accounts which stress flexibility. On the GM account, this area would be a candidate for specialist training courses. The SCP was also asked to contrast clinical psychology and social work:

076 SCP: Mmm, well, I um- I think with all the different professions, there are over-laps in their roles. That holds true between psychology and psychiatry, and between psychology and social work. Um but again I have to sort of amplify the the fact that er, apart from these over-laps, there are distinct um contributions and differences um in the approach among different disciplines. Say between psychology and social work, [the (90 min) tape finishes and is turned over] The most common overlap would be in the areas of, say, family therapy. A lot of treatment-of social workers see themselves not as social workers but as family therapists. And some psychologists tend to do the same thing, and that also holds true of some psychiatrists, they see themselves as family therapists. Um and a lot of social workers run groups, like stress management groups, er assertive training groups, communication groups. A lot of psychologists do the same, also a lot of nurses do the same thing. And um occupational therapists.[portion of turn deleted] I'm quite receptive to the idea that er any person who is er professionally qualified or confident in er [pause] running these groups and providing this sort of service, and who has a fair degree of common sense. They should do very well. But with the more specialized approaches in intervention, right, like the behavioural approach or um [pause] seeing a certain patient for a cognitive-behavioural intervention; techniques like cognitive restructuring, I think that should

be left with somebody who is well trained, well skilled, and well experienced in the field. And should remain within the realm of clinical psychology.[excerpt from turn 076]

This account begins by noting that there are 'over-laps' between all of the professionals working in the mental health field (this was also noted in the GM study). But where this point gave rise to accounts referring to conflict between professionals in the interview with the CP, this account prefers to 'amplify the fact' that 'there are distinct contributions and differences' among disciplines. The SCP then gives a number of areas in which the activities of social workers and psychologists do over-lap but says that he is 'quite receptive' to other professions maintaining similar services. This account is then qualified by stating that 'more specialized approaches' should 'remain in the realm of clinical psychology'. That is, the role of the clinical psychologist as specialist in the performance of a particular range of functions should not be disputed.

Some studies in this field have suggested that one of the areas, if not the main area, in which clinical psychology should be regarded as a specialist discipline is that of psychometric testing (Liddell, 1983: 17; and Barrett, 1987, quoted above). Reinehr has argued that testing "is the activity which put clinical psychology in the mental health business" (1975: 128). But other studies have argued that defining clinical psychology in terms of a testing discipline is narrow and restricting (e.g. Thomas et al., 1982; and Groth-Marnat, 1988, discussed above). So, it can be seen that there is a potential for some variation in discourse as a result of trying to be specific about areas of specialization in psychology, while not being restricted by the resultant professional definition. This is not necessarily just the case with psychometric testing, as such tension may be caused by any narrow field of expertise, but the issue of testing was raised by the SCP:

077 INT: So um how important, then, do you think is psychology's role as a testing discipline? [pause] Things like the EPQ [Eysenck Personality Questionnaire] and IQ scores.

078 SCP: [pause] I- right- I'm not a hundred percent happy with the term 'testing'. Er I seldom use the word 'testing' er even if I do

'testing', or even if give a WAIS [Wechsler Adult Intelligence Scale] or the personality questionnaire, whatever, I would tend to use 'investigation'. Because 'testing' implies a very mechanical execution or administration of a particular procedure. And it also sort of implies that it is a- that it will yield a score um which can pigeon-hole someone according to a particular category. But if you can get away from this concept of 'testing', and you perceive your- your um procedures as 'investigations', alright? They- it gives you a totally- a new dimension of meaning, because what you are doing is an investigation, and not a testing, alright?...

This account shows that the SCP is particularly sensitive to the use and function of the term 'testing' (I'll come back to this at the conclusion of the thesis). The term 'testing' is said to imply a 'very mechanical execution or administration of a particular procedure'. The SCP says that he prefers to use the term 'investigation' to describe this part of his activities because it does not have these negative over-tones.

This account shows the SCP knowingly engaged in the active construction of the definition of clinical psychology. The use of the term 'testing' would undermine the importance of the psychologist's expertise and clinical experience, whereas the term 'investigation' implies that there is something more to the assessment of a client than something akin to meter-reading. That is, the account comes from the repertoire which stresses the importance of clinical experience rather than the data-orientated research repertoire. Thus, the account also functions as a description which allows a more equal comparison between psychology and psychiatry. But the SCP's account also maintains that psychologists have access to more objective data through the employment of experimental methods [as seen in turns 080 and 082 analyzed in the previous chapter]. I argued earlier that there was an inconsistency between such accounts when the SCP offered a criticism of psychiatry [074].

The assumption which underlies research methodologies is that any competent researcher could apply the described method and reliably achieve the appropriate results (accounts of this sort can be found in the various editions of the APA Publication Manual). The method should not require the level of tacit knowledge implied by the idea of clinical experience. But, as Potter (1982) noted, practitioners can be critical of others who do not have significant levels of experience and, in the

accounts I have described, such practical experience is depicted as a necessary component of clinical psychology. The SCP's emphasis on objective methods continues in the following sequence:

And that is I think the basis of [pause] a scientific investigation, and I think it is different from what people construe as a 'test' [excerpt from turn 082]

083 INT: ... Yes... 084 SCP: ... a one-off type of activity. 085 INT: So it's- it's more like an experiment. 086 SCP: Yes. 087 INT: That sort of approach. 088 SCP: Sure, yes.

The SCP points to the distinction between 'scientific investigations' and a 'one-off' test and agrees when the interviewer suggests a similarity with the experimental approach but, as I argued in the last chapter, the SCP's account also resembles the hermeneutic process. There is a close similarity between this sequence and the descriptions the CP gave in the first interview when a case study was accounted for in experimental terms.

Despite the accounts given in both interviews, I argued (in chapter 6) that the discourse which occurred in the case-conferences, and which was primarily directed by the psychiatrist or psychiatric registrar, classified the psychologists' activities as those of a mental tester. I also suggested that the role definitions held by psychiatry acted as (ecological) constraints on the definitions maintained by psychologists. This issue was then raised with the SCP:

089 INT: But um I wonder how psychology is perceived, and whether the role of the psychologist is perceived by, say, psychiatry as the testing discipline.

090 SCP: [pause] Oh, it is up- I suppose it is up to the psychologist to- to sell his image to the other professions. Er some psychologists do it very well, some don't. Um it's pretty hard to make any sort of generalized statement about how er the psychiatrists perceive the role of a psychologist or- because it- really it differs from institution to institution, from psychologist to psychologist, from psychiatrists to psychiatrists. And I think it all depends on how broad-minded the psychiatrists are, and I think the, so called, the new generation of psychiatrists; they are, on the whole, quite good in the sense that they

are less dogmatic about the medical model, and they are appreciative of the contribution of the other professions. And er- if but you er come across psychiatrists, say, of the 1930 or 1940 vintage, then you may get quite a different picture; that they would expect you to kiss their feet before you do anything.

In this segment we see examples of what I have labelled the ecological and the self-determining repertoires. The SCP says that a psychologist must 'sell his image to the other professions' and that the ability to do this varies between psychologists. This use of the sales metaphor was also noted in the previous interview. He then goes on to suggest that different psychiatrists accept the image the psychologist wants to project depending on the psychiatrists' adherence to the 'medical model' and the period in which they were trained. Thus, the account begins by suggesting that the role a psychologist holds is determined by the ability of the psychologist to promote his preferred role-definition (self-determination), and ends by suggesting it is largely governed by various psychiatric orientations (ecological constraints). I shall now concentrate on this second influence.

Before examining the next excerpt, I need to point out an important difference in the ways that the two psychiatric institutions referred to operate. In the analysis of the previous interview, it was pointed out that the larger of the two institutions (L), a large psychiatric teaching hospital, had a policy of having different professions act as the first point of contact for patients. Thus, senior nurses, social workers, medical officers, psychiatrists, or clinical psychologists all took turns being rostered for this task. This was not the case at the smaller institution (S) which, because it was part of a general hospital, had opted for an admission procedure which required a psychiatrist to be the first point of contact. Therefore, if a person was to be admitted at S, a psychiatrist would conduct both the initial psychiatric interview and the psychological examination required by law for admission to a psychiatric institution. This administrative difference means that the psychologists working at S would normally only come into contact with a new patient by referral from a psychiatrist or by showing an interest in a patient during a case-conference discussion. Statistical studies of the roles taken by clinical psychologists, such as the GM study, can be criticized on the

grounds that there are important differences in the way particular hospitals are run thus precluding any straightforward comparison.

It can be seen, then, that a psychiatrist's conception of the role of a clinical psychologist is all the more important when the system of referral is a major source of clinical practice. The SCP was asked what sort of referrals were sent to him:

098 SCP: Um, if it is a referral for intervention um [pause] the referral usually specifies the problem area. Sometimes the referral may give an indication of the type of [pause] a service that the referring person would like to happen for example; relaxation training um, increase the person's assertiveness, or some social skills training. Um but as a rule I think what the psychologist should do is not to [pause] get his approach sort of coloured by the request, but the psychologist should go about looking at the situation from his point of view and decide for himself what would be the most appropriate mode of intervention. [pause] So the majority of the referrals that, say, we get from this unit is for the psychologist to provide an alternative form of therapy [inaud.], or um to see the client on a supportive basis which serves as an adjunct to the, say, the chemotherapy the patient is already getting. Or the other sort of social-network therapy that the patient is getting. So the- to um provide the patient with the necessary psychological support, so that a much more comprehensive um service could be provided. Um with the more psychometric orientated referrals; they usually um ask a fairly specific clinical question; like is so and so suffering from dementia, is so and so's drinking problem affecting his memory functioning; if so which area, how bad it is. And of course all this ties in with the very important and relevant decision, and that is [pause] what is the best way of managing this patient given the cognitive status of the person whatever it is. One very important clinical question that had been sort of overlooked by- by a lot of clinicians, and we- we can find it in many cases, that a psychiatrist may make a- neuro-psychological referral to the psychologist, and the psychologist will see the patient um before investigations, or 'testings'; come up with the conclusion, yes, so and so's short-term memory is poor but his long-term memory is intact and so on. And, in many cases, it- the whole thing seemed to stop there which I don't think is right. I think um the- the importance of the investigation, really, is to try to shed some light on to how this particular person will manage in his life given the- the results; the psychologist's findings, and what will be the best alternative for this person; whether he should stay at home, whether he should, for his benefit, go to an institution or a nursing-home or what.

This account begins by noting that the referring psychiatrist (labelled 'referring person') usually both defines the 'problem area' and indicates what 'type of service' they 'would like to' have happen. That is, the referral could be construed as an ecological demand. But the SCP goes on to assert that the psychologist should not let

his assessment of the situation be 'coloured by the request'. The psychologist should 'decide for himself' what course of action to take.

The SCP is also critical of some psychologists who, he suggests, limit their investigations to drawing conclusions on the basis of empirical findings which go no further than a factual statement requested by the referral. This can be regarded as an extension of the account reviewed earlier in which the SCP suggested that 'investigations' involved more than the application of certain tests and, again, would involve a high level of clinical expertise.

In accord with the questions asked in the first interview, the SCP was asked how psychiatrists (as the only professionals giving referrals directly to the psychologist) knew what activities were undertaken by psychologists:

102 SCP: Uh huh. Oh, [pause] in this unit, I would put it down as the result of a continual process of mutual feedback between the psychiatrist and the psychologist. Um and say when a psychiatrist has been working with a psychologist for [pause] a reasonable length of time, the psychiatrist will get a pretty good idea of the areas of it- expertise of the psychologist; what areas this particular psychologist is good at, um and what sort of referrals will be handled adequately and professionally by the psychologist. And of course on the part of the psychologist, again it is a process of communication with the psychiatrist, say; oh, I don't think this referral is appropriate. And then the psychiatrist will know that- [pause] the psychiatrist will refrain from making the same mistake next time.

The account offers a more complex version of the ones involving the sales metaphor in that it suggests a 'continual process of mutual feedback' occurs between psychologist and psychiatrist. This was the only account I was able to identify which implied an interaction between personal (self) and environmental (other) influences. However, the rest of the account concentrates on the effect the psychologist has in this interchange. The psychiatrist is described as achieving, over time, a 'pretty good idea' of the psychologist's expertise, and the psychologist is described as telling the psychiatrist what referrals are appropriate and whether the psychiatrist has made a 'mistake'. That is, while the account begins with the suggestion that this communication is 'mutual', it goes on to focus exclusively on the ways in which the

psychologist determines which roles are adopted. The SCP then goes on to discuss other psychologists:

104 SCP: Some psychologists like to lay down [pause] a list of the areas that they would [pause] like to get into, alright? But I think it is more important, that if there is an on-going er flow of communication between the psychiatrist and the psychologist [pause] rather than laying it down in black and white.

In this sequence the SCP implies that he did not 'lay down a list' of areas in which he was willing to work. Again, the issue of role negotiation is raised with reference to a 'flow of communication' but no more detail is given.

The SCP was also asked whether his role had been affected by the one taken by the previous psychologist.

114 SCP: ... No, I- I won't say that because it was a um [pause] very peculiar situation, because when I started to work here on a half-time basis it was, again, the time that coincided with a change-over of the medical staff. Um so in a way, I was new here when I started on a half-time basis, and so were the psychiatrists...

116 SCP: ... so it was possible for me to sort of um start from scratch without sort of- [pause] to worry about the old tradition. [pause] So it's different.

The SCP states that this was not a factor in this particular setting because the medical staff was changed at the same time he began working at S on a half-time basis. However, the SCP did not seem surprised that the question was asked, and the possibility remains that, in other circumstances, the role set by the predecessor would be seen as important, as the first interview suggested.

Conclusions:

In this analysis, I have identified a number of discursive repertoires which are employed by both respondents. These may be regarded as two pairs of inconsistent repertoires.

Research expertise vs. Clinical expertise accounts.

The SCP criticized psychiatry for relying on subjective judgements, and went on to say that the clinical psychologist could remove elements of ambiguity in clinical decisions. The CP, too, generated accounts which stressed the positive contribution provided by psychology through the use of research methods. The importance of the use of research methods was also identified in the discourse analyzed in the last chapter where it was shown to be a vital part of the repertoire which connected clinical practice to academic research.

However, one aspect of the research method is the application of tools or instruments to test particular hypotheses. I have also shown the importance of psychiatrists in setting or, at least, suggesting what these hypotheses will be. The combination of these elements may lead to the clinical psychologist being characterized by the somewhat restricted role of 'mental tester'. Thus, a second repertoire was shown to emphasize the level of clinical expertise involved in the psychologist's activities.

The clinical-expertise repertoire is inconsistent with the research repertoire because it stresses the tacit knowledge attained through a similar socialization process to that of the psychiatrist. This clinical repertoire was discussed in the last chapter in terms of the role of common sense which was, at times, characterized in opposition to theoretical or research based knowledge. I am not trying to cast doubt on the validity of the clinical opinions offered by psychologists, but I am trying to point out that these two different forms of accounting practices are not easily resolved, have different functions, and may be employed in response to different situations.

Ecological vs. Self-Determination accounts: 'Relatively unstructured but...'

The role of the psychologist as a mental tester is also rejected on the grounds that this is a restricted or narrow definition (both in the interviews and in the literature on this subject). But this definition is not the only constraint which the hospital environment is depicted as imposing upon a psychologist's activities. A number of different elements were identified in both interviews.

Accounts of the role of the clinical psychologist can vary widely with restrictions on individuals either emphasised or played down. I have suggested that such accounts can be broadly described as either *ecological* or *self-determination* accounts.

Ecological accounts show the importance of negotiation, conflict, competition, expectations from other staff members, and specialization through the lack of flexibility. The possibility was also raised that a predecessor could affect the perception of the psychologist's role, and the effects of administrative procedures, hospital placements, and organizational hierarchies were also noted.

The self-determination repertoire was defined in opposition to the ecological one. It focuses upon the psychologist's own flexibility in the creation of a professional role; the ability to promote certain professional capabilities was a personal characteristic. Within this repertoire, the various mental health professions were labelled as complementary, and the psychologist was able to create a professional niche on the basis of his own interests and orientation. One way this process was accounted for was through mutual feedback between psychologists and psychiatrists; the psychologists were able to correct or alter the way their roles were perceived as professional relationships developed.

I think the GM study discussed earlier can also be described in terms of the two repertoires I have suggested. The study prescribed a number of ways in which the role of the professional psychologist could be actively re-defined by members of the profession (self-determination). However, the way this re-definition was attempted was to consult hospital administrators about the way they perceived the role of the professional psychologist. Thus, while recognizing the influence of ecological determinants of what psychologists do, it discounted the active contribution made by psychologists in whatever setting they are placed. I suggest, then, that Groth-Marnat's analysis inconsistently drew on these two discursive repertoires and failed to successfully synthesize their various elements.

Finally, I want to integrate the conclusions of this analysis with those of the analysis of case-conference discourse (chapter 6). In that chapter, it was argued that case-conference discourse was largely determined by the language and definitions maintained by the profession of psychiatry. That is, the way the psychiatrists spoke in the conferences could be regarded as an ecological determinant of the role of the clinical psychologist. Such a conclusion is compatible with the current analysis in that the clinical psychologists' discourse frequently refers to the activities of various psychiatrists. This is, perhaps, not surprising given the high status of psychiatry in the mental health setting.

It should also be noted that there is a considerable contrast between the accounts generated in the case-conference setting, and those generated in the interview situation. It was suggested in chapter 6 that the definition maintained by members of the psychiatric profession of clinical psychology was essentially a non-psychiatric role. That is, clinical psychology was not regarded as having the professional scope or variety of expertise which psychiatry enjoyed (see also Kingsbury, 1987). Such an account, I suggest, was not reflected in the interview discourse. Further research could draw out the implications of these two forms of discourse, and the effect they have on the way the role of the clinical psychologist is defined.

General Conclusions:

Part of the theoretical perspective of this thesis has been to show how language is used to construct aspects of our social world by looking at discourse in functional terms. It is interesting, then, finally to examine a couple of examples of discourse which show that the mental health professionals I was recording were very sensitive in perceiving discourse in just those terms.

In conference number 9, the psychiatrist reads out a letter from a Guardianship Board.

310 P: I- I- I'll just mention that I- the legal side of it; they wrote to me from the Guardianship Board a letter which fortunately they didn't pass on to her because the letter is...

311 CNC: ... [laughs]...

312 P: ... couched in the most negative terms. Have you got the letter there, love, I'll read it out?

The psychiatrist is focusing on the consequences of constructing a letter in what she regards as negative terms. A moment later she gives an example:

"...you are not able to make an informed decision about whether or not you should have" - and then they don't blench at it - "shock treatment. Most difficult decision to make. We believe that shock treatment" - this bits alright - "is likely to be beneficial" [laughs] - I wish they wouldn't call it that. (extract from turn 323)

In this segment, the psychiatrist has decided to read out the letter as an illustration of something she does not regard as appropriate. The psychiatrist suggests that the label used to describe a particular treatment (Electro-Convulsion Therapy) should not have been used in a letter which functions as an official communication.

The letter is discussed again some time later:

605 PN: [pause] Actually, when you were talking about- you were glad she didn't get that letter; she was told all that there anyway...

606 P: ... I know, I know she was...

607 PN: ... and when she came back she was quite angry being told...

608 P: ... I know...

609 PN: ... Low intelligence!

610 CNC: [laughs]

611 P: Yes, I know. Um but just the phrasing of it seems to be very unfortunate; it seems to be very legal rather than psychiatric.

612 PN: Hmm. I wish they wouldn't call it shock treatment.

613 P: I know, I know. (extract of turn 613)

In this sequence the psychiatric nurse informs the psychiatrist that the contents of the letter previously read out was already known to the patient. The psychiatrist says that she is aware of this, but is more concerned with the 'unfortunate' 'legal' 'phrasing' of the letter. The psychiatric nurse then repeats what the psychiatrist said earlier. Thus, the psychiatrist is not disagreeing with the content of the letter, but suggests that the information contained in the letter would be better expressed in a psychiatric discourse.

Another interesting example of being sensitive to discourse in functional terms, and one which is more directly relevant to the present study, arose during the

interview with the senior clinical psychologist who performed a piece of discourse analysis on the use of the term 'testing' (discussed earlier in this chapter). The implication of the term 'testing' was regarded as having negative consequences for the way the role of the clinical psychologist was perceived.

Such examples suggest that the theoretical perspective upon which this investigation was based was also being used at some level by the mental health professionals whose discourse was being analysed. That is, they were aware of the importance of the form a piece of discourse was given.

In some ways, this entire report has been an argument for the use of the discourse analysis approach. I hope I have shown that it is a useful and fruitful way of investigating a range of questions not usually examined within psychology. It constitutes an alternative method for rendering aspects of the social environment more coherent and amenable to scrutiny. This, I assume, is the prime objective of psychological research.

There is, nevertheless, a need for further theoretical and methodological development of discourse analysis. Some writers, for example, have questioned the role of reflexivity in such forms of analysis (Mulkay, 1985; Potter and Wetherell, 1987; Fuhrman and Oehler, 1986; Potter, 1987, forthcoming), and future research will need to take this into consideration.

Discourse analysis can also entail the transcription of spoken discourse, and this process is laborious and time consuming (see also Wetherell and Potter, forthcoming) and the total amount of work required may not be reflected in the final analysis. However, many methods employed by psychology involve large amounts of time in data collection, coding, and statistical analysis. In many cases, I suspect, the amount of effort required is roughly comparable.

Above all, psychology can only benefit from incorporating the widest variety of methodological perspectives into the discipline. New methods need to be developed and their value tested against the benefits they provide. It is with these intentions that the current project was initiated.

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Appendix 1

Copy of Research Proposal:

What follows is a copy of the research proposal which was distributed to members of staff at the psychiatric unit at which the present study was undertaken.

PROFESSIONAL DISCOURSE WITHIN PSYCHIATRIC INSTITUTIONS.

AIM: This study will be an investigation of communication between different professionals participating in the standard case-conference situation. It is part of a larger study which applies the techniques of discourse analysis to the verbal behaviour of clinical psychologists.

METHOD:

Audio-recordings of four case-conferences will be taken, and transcriptions made under the following conditions:

- (1) To ensure anonymity, it will be necessary for the case-presenter to identify the patient in the first instance before the tape-recorder is started.
- (2) If any identifying details are mentioned they will be edited from the transcript.
- (3) The supervising psychologist will ensure that the transcripts do not contain any material which could identify either the patient or any specific members of the staff.
- (4) The transcripts will remain available to the staff members.
- (5) Once the transcripts are completed, the tapes will be erased.

In seeking verbal permission from the participants just prior to each conference, reference will be made to all of the conditions above and any questions will be answered.

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Appendix 2

List of abbreviations used in transcripts:

Professionals attending the case-conferences make frequent use of abbreviations. The most common are:

- a.c. (ante cibum) - before food
- b.d. or b.i.d. (bis in die) - twice daily
- I.M. - intramuscular
- I.V. - intravenous
- o.d. (omni die) - every day
- o.m. (omni mane) - every morning
- o.n. or nocte (omni nocte) - every night
- p.c. (post cibum) - after food
- p.r.n. (pro re nata) - as needed
- q.d.s. (quater in die sumendus) - 4 times a day
- rep. (repatur) - repeat
- t.d.s. (ter in die sumendus) - 3 times a day

(James, 1985)

The meaning of other abbreviations used by respondents are indicated in the transcripts in square brackets.

Appendix 3

Case-Conference No. 1:

Professionals present:

Psychiatrist (P)

Medical Officer (MO)

Social Worker (SW)

Senior Clinical Psychologist (SCP)

Clinical Psychologist (CP)

Psychiatric Nurse (PN)

001 MO: [reading details about patient A]... The operation was planned at an earlier date but was cancelled due to a severe cold that she had. So, during this admission um she was actually advised to have the operation which she consequently did earlier last week. The operation was quite successful and she has returned back to us for convalescence and further assessment for her um delusional state.

002 P: Have we got the result of the adnomer yet?

003 MO: No. I've only got a verbal result from [an] intern and that was benign...

004 P: ... oh, right, good...

005 MO: ... so I'd just like to see if its still perhaps performed....

006 P: Yes, that's not come back yet, uhuh. She's keen to go home, I gather, um but she would agree, I'm sure, to see [the psychologist] for psychological review today. And um what was the follow up from surgery? Was there anything written in the notes? I mean, did they want to see her again?

007 MO: They haven't made any remark on that.

008 P: Right.

009 MO: But she'll have to have a suture out.

010 P: Oh, yes, of course she will.

011 MO: Oh, no, no, they...

012 P: ... Did they do clips?...

013 MO: ... usually. No; in a thyroid they usually do a dissolving stitch so that she...

014 P: ... Oh.

015 MO: ... [inaud.] but the surgeons will want to check that up... so I'll have to contact er their unit to find out when they want to do that.

016 P: So she might be in 'til tomorrow easily, actually.

017 MO: Mmm.

018 P: Right. Now, when she goes home she's going home to her daughter from [another capital city], her young son...

019 MO:... That's right...

020 P: ... and that, in her own home?

021 SW: Mmm huh.

022 P: Was there anything that we had to do in the line of social work?

023 SW: I er wrote to the Housing Trust regarding Priority Housing...

024 P: ... Right...

025 SW: ... and er we may need to chase that up further. Financial she could be... a bit dicey although she's been... living in financial difficulties for...

026 MO: ... Mmm.

027 SW: ... a couple of years, or four years, 'cause she's been living in the house for that long.

028 P: Right.

029 SW: So it's just a matter of tidying that up before she goes. So she, that wouldn't stop her from going though.

030 P: No.

031 MO: Mmm. She had a few pressing bills but her daughter was going to fix them up.

032 SW: Yeah.

033 MO: She's got some extra money.

034 P: The daughter... was going to pay the bills and she could pay them back later, was that the idea?

035 MO: That's right.

036 P: That kid's only eighteen.

037 SW: Mmm.

038 MO: And she's been working over in [another capital city]. I'm not sure what she's been doing there.

039 SW: A waitress.

040 MO: A waitress.

041 P: Oh, good. And when does the daughter return to [the other capital city]?

042 MO: Well, she was staying here as long as her mother needs her.

043 P: Oh, right. So it's not immediate, there's not a date put...

044 MO: But, er actually I've heard that er, she mentioned to me that she's picked up a job in [this city].

045 P: Oh.

046 MO: And, er so I don't know how long term that is; it may be just temporary.

047 P: Mmm.

048 MO: But I think she does plan to... to go back to [the other capital city].

049 P: So the immediate plan is to evaluate her level of psychosis, if any now; um check up on the surgical follow-up; and... also psychological follow-up. I mean, not necessarily today, I mean, in general, we'll have to see what...

050 MO: Will we be following up in Out-Patients?

051 P: ... um would be appropriate. Yes. What had happened to her? She was a new patient to us last time... this time, wasn't she?

052 MO: That's right.

053 P: She'd never been an in-patient before?

054 MO: No.

055 P: No. That's right. So she hasn't had any previous... ah, you know, routine outpatient appointments?

056 MO: She has been seen by [a private psychiatrist] in the past, who is a private psychiatrist.

057 P: ... oh, yes. She had a private psychiatrist, that's right. I'd forgotten that.

058 MO: And, prior to the operation, she was happy to go back and see him.

059 P: Well, we'll have to contact him about all this, I think. Yes.

060 MO: And he was happy to... to look after her on discharge...

061 P: ... Well that actually might be the most appropriate thing. Okay. Well it might easily take a day or two to get that sorted out, so we won't let her rush us into... whizzing home this morning. Right, the next one.

062 MO: Okay, sure, which next?

063 P: Er, any one.

064 MO: Right. [Patient B] [pause, reads] [Patient B], she is a sixty year old, sixty year old Italian lady who was admitted on the 23rd of ah October. She's had a number of past admissions for um chronic paranoid schizophrenia and this admission was ah precipitated by ah paranoid um thoughts about her husband um being jealous or thinking that er he's been unfaithful to her; well, thinking that she thinks that he has, or he thinks that she is unfaithful. It's getting rather complicated [general laughter]. And during. She's been in here for a few weeks now, about er three weeks and she's.... Her main assessment is according to how her family are seeing her progress. She's having regular weekend-leave, and the last few weekends she's been showing... a few more paranoid thoughts. Whilst at home there's been arguments with the family and er they are not completely happy with the way that she is.

065 P: Like last weekend, the weekend that ended... Sunday, what did they say about her?

066 SCP: Yes.

067 P: What did they say about her?

068 PN: I haven't caught up with what the family said.

069 P: ... Oh, you didn't see...

070 SW: Apparently, they just dropped her off and left.

071 P: Oh.

072 MO: That's right.

073 SW: They didn't leave any information. So, [we'll] need to chase that up.

074 P: Mmm, oh we will.

075 PN: But she was getting paranoid on Saturday morning...

076 P: Oh yes, about being picked up late...

077 PN:while she was waiting...

078 P: Yes. Yes, I know she's not really too well.

079 PN: ... feeling that we were keeping them from her; ... had something to do with them being late.

080 P: Hmm.

081 PN: The staff that were on over the weekend... have said... that were on again last night, said that she was much more settled and more appropriate.

082 P: Oh, right.

083 PN: She seems to be... most of the time, seems to be quite reactive, appropriate....

084 P: ... in the ward?

085 PN: Her affect and behaviour is appropriate. Her conversation, I've talked to her about her, the history of her illness and stuff and she was quite appropriate.

086 P: Oh. good.

087 PN: It seems that, sometimes, when she's under a bit of pressure, that she gets paranoid and angry and and lashes out at people.

088 MO: And she gets very guarded at revealing the problems that have happened at home, the er arguments, and will tend to gloss over them, because I think she knows that, if she admits to um having any paranoid thoughts, she'll be kept in here longer and she's very desperate to go home.

089 PN: Mmm, she is.

090 P: The thing is we... it's only a day or two since we increased the anti-depressant, didn't we? Or was it friday? Which day was it we did it? Increased the anti-depressant, took her off the mogadon?

091 MO: That was yesterday.

092 P: It was only yesterday? Heavens, I've lost a day.

093 MO: So we've increased amitriptyline to 50mgs.

094 P: Right. Well, look there's no question of her going home quickly.

095 MO: No.

096 P: We'll just have to sit on her.

097 MO: Mmm.

098 P: [Patient C]: we're up to date with her.

099 MO: [reads] [Patient C] is a nineteen year old lass with um border-line personality disorder. She's of Italian extraction and she's recently married. She was brought in... well, she was transferer from [another hospital] following an overdose of amitriptyline. And it was about three days prior to the admission. Was she brought in on a detention order?

100 P: No. No, it was voluntary. It was a transfer from [another hospital], they discharged her on the same day they knew she was to be seen as an outpatient and for admission here. So, it was all done... quite smoothly... in a technical sense.

101 MO: She has a number of um on-going problems. There's a lot of conflict with her parents, in particular, her father who's black... who's banned her from returning to the family home which has caused her... some concern and resentment and anger. Also, there's conflict with her mother, and um she has been... living, only for one week, with her husband, in a flat provided by the er father of [Patient C]. And, there's been a number of conflicts with the husband. There's a big language barrier of... The marriage to this person is based on convenience because he was um... he had recently come from Greece and he wanted to stay in the country so they married with the proviso that um it was a marriage of convenience so that he could stay here but er the relationship's developed to an extent and er recently we interviewed... we interviewed [the husband], yesterday, and he wants the marriage to try and succeed and work and [Patient C] feels the same way. So, what are we planning for... we are planning for weekend leave to see how she behaves er this weekend.

102 P: The husband's a rather simple-minded man um and not very well educated. He's from Cyprus. He's aged 23, nearly 24 and his six-month visa was about to run out when he got married and it was, undoubtedly, to preserve him from being deported or having to go back. Um he says he's got fond of [Patient C] because um he recognizes that he himself had a turmoil-ridden adolescence and he asked us not to write this, and I didn't put this into the notes, but he said that he had actually been in a psychiatric hospital in Cyprus when he was aged 19, for bad behaviour. So, he sympathizes with [Patient C], but he hasn't told her this yet, that's why he asked for it not to be written down. We had [a hospital staff member] as our translator - she's excellent []. And, um the husband said that he'd become fond of [Patient C], which seems a little bit strange to those of us who take a more objective look at her, but, nevertheless, [laughter] he said he was fond of her and wanted to make the marriage work and wanted to move back with her to their flat which her father has bought. And he and [Patient C] between them, himself on his unemployment benefit and [C] on her sickness benefit (which was signed and sent off yesterday) - they'll be able to manage the \$60/week which is what the father needs, [C's] father needs to pay the bank back. And....

103 SW: Although they'll run into difficulties because if they are married they can't claim separate benefits.

104 P: Oh, [names S.W.], I didn't think of that.

105 SW: That was okay so long as they weren't living together, but as soon as they actually were living together, and they are married so they can't say they will go on a single pension or benefit (which is less than a double... by about \$20-30 a fortnight, I think). But still, they should ma... they should be able to manage, with a bit of luck.

106 P: Yes. Is there a time lag before they... so to speak, it's alright for her to put in for sickness benefit, because she's still in hospital, and will be for another, say, ten days, but is there a time lag before they catch up with her?

107 SW: Well she's revealed that she is married to the Social Security.

108 P: Did she? Did she write that in to forms?

109 SW: Yeah, the previous application that she did while she was here last time.

110 P: Oh.

111 SW: So they should be aware of the fact that they are married so it's up to Social Security to sort that out.

112 P: Oh, right.

113 MO: It's quite amazing the marriage... because he doesn't speak any, or very negligible Austral., or English and he doesn't speak any Italian. And [C] speaks Italian..... but no Greek....

114 P: ...She doesn't... Speaks no Greek

115 MO: ... And she can speak English.

116 P: But the marriage has been consummated. He revealed that, although she had told us it hadn't been consummated and I can't think why she said that. I assumed, if they lived together for a week, and even if they were fighting, that they would, undoubtedly, have consummated the marriage. But he wants (I've written that bit in), um they both want to live together. It may be heading for disaster but it's not for us to... um... it's not for us to say. I think that's fair enough. But I think the weekend leave is a fair thing to say, um for us to do, and [C's] mother was... trying to oppose us on the grounds that he'd be working in in this restaurant at night and that she'd be at home alone and up to god-knows-what. But I said [C] could go and wash dishes in the restaurant for the whole weekend it wouldn't matter at all, it'd do her a lot of good.

117 MO: But the family; they seem to want to deny her access to the flat.

118 P: Yes, I wondered about that, but they haven't sold it or anything yet. They couldn't have; the settlement was only three weeks ago.... Well I, I... she's got to! I said to her mother; there's no place she can live in but her own flat and, presumably, with her own husband. She can't stay here forever, she's not allowed home, there's nothing, there's no way of living independently, so they've got to! If if they're headed for disaster they've got to do it their own way, and maybe they're not headed for disaster. I mean; they've got youth on their side....

119 SW: It's wasted on the young though, isn't it? [laughter] As George Bernard Shaw once said.

120 P: Yes, youth.wasted on the young.

121 CP: You're showing off.

122 P: Well, anyway, we'll have to see.

123 SW: Pardon?

124 CP: You're showing off.[indicates tape-recorder]

125 SW: Sorry. [laughs] Is that what it is?

126 P: She must know that she's got to behave this weekend, [to the P.N.] you might make that clear to her.

127 PN: Sure.

128 P: Otherwise she won't get discharged.

129 MO: Who's next?

130 PN: [Patient D]

131 P: Who?

132 PN: [Patient D]

133 P: Oh, of course, that's right, he's back. You did catch up with him?

134 SW: Yeah, it's a sickness benefit form, that's all it was.

135 MO: [Patient D] is a 24 year old man who was admitted on the 12th following a... actually, presented to Casualty, following being detained by his local doctor. The local doctor was called out to the parents' home, where [D] is currently living, over a family conflict. [D] has a long history... a 4 year history of paranoid schizophrenia. Actually, it's only two years, sorry. And, um... the family couldn-... there was family um violence er with [D] ending up being punched and was attacking his parents as well, and er he's been refusing to take his medication which seems to have been one of the precipitation factors for this admission. His er current paranoid thoughts are that um high class society is out to get him and um he's very afraid of this. And, um and also high class junkies are out to get him as well, although he denies any current use of drugs or can't substantiate any reason why they should be after him. He deni-... he has a lot of problems accepting his diagnosis of er... er schizophrenia. Frankly, you know, he flatly denies it.

136 P: Hmmm.

137 MO: Which is a bit of a problem. And he doesn't want to be on his medications, and he feels that they don't help at all.

138 P: The Modecate... did help. There is no doubt that during the time he was on Modecate for those months earlier, last year and earlier this year, he was better and he came off the guardianship order. But he did gain weight; not a lot of weight but enough to, for him to feel that he didn't want to keep on with Modecate. We may um... we've put him, what have we put him on at the moment?... chlorpromazine?

139 PN: He's on chlorprom.... 100 t.d.s

140 MO: ... chlorprom, 100 t.d.s.

141 P: Yeah, right, we might later think about um changing to fluphenazine orally or something else...

142 SW: He said he doesn't like injections at all. He says he prefers oral medication.

143 P: Yes.

144 MO: But there's a big problem with compliance.

145 P: Mmmm, what...

146 PN: ... His p.r.n. dose was ceased on the 13th as well... 13th of Aug...

147 P: ... So he's just on a hundred t.d.s. now.

148 PN: He's just of a hundred t.d.s., and I... feel that probably, he could do with some p.r.n. during the day.

149 P: Could he? Or else increase the...

150 PN: ... or else increase the dose.

151 P: Um.

152 MO: One, one of the previous admissions, he came, originally, on 200mgs t.d.s. but that was tailored down...

153 P: Yes.

154 MO: ... to a hundred.

155 P: What's he like [names P.N.], around the ward?

156 PN: Um, very suspicious and guarded...

157 P: ... Yes.

158 PN: ... not coming out with anything floridly psychotic but, um if you sit down with him with any length of time... then he starts to talk about the guys that he met up in [another state]. He was talking about his eyebrows, and the fact....

159 P: ...Yes.

160 PN: ... that the guys' in [the other state] eyebrows are a lot worse...

161 P: Yes... yes.

162 PN: Um... so nothing that they were er actually out to get him or anything like that he was just...

163 P: ...Yeah.

164 PN: ... felt that... he felt antagonistic towards a group of guys up in [the other state] who he didn't identify and I've, I've had the impression that it was just...people...

165 P: ...His eyebrows meet in the middle, you know...

166 PN: ... Yes, I know, I know...

167 P: and he's got this... He did have a fixed delusion that that meant that other people thought he was homosexual...

- 168 PN: ... Yes, yes. I know.
- 169 P: and that was delusional so [] picked up the thread of that...
- 170 PN: ... And this time he's been trimming his er eyelashes.
- 171 P: Oh, dear, dear.
- 172 PN: Yes. Yeah, he's interests...
- 173 SW: ... I think he did that last time, he actually cut them last time.
- 174 PN: Yeah, he's been doing it this time. It's interesting; he said the bottom ones grow a lot quicker than the top ones. [laughter] I never really thought about it.
- 175 MO: He's got um delusions about his eyelashes that er if they grow out too far that these high class junkies are going to get him or something.
- 176 PN: Right.
- 177 MO: It's all very strange because...
- 178 P: ... Look, would you like to change the chlorprom along the lines of a hundred um b.d. and 200 nocte, would that be a... an appropriate level? I mean...
- 179 PN: ... Or I thought perhaps that...
- 180 P: ... he's not dopey during the day.
- 181 PN: ... if you reintroduced the... p.r.n. dose...
- 182 P: ... Oh just put it in p.r.n.? Alright, yes that's fair enough.
- 183 PN: ... to see how much he's going to use and then alter the dose.
- 184 P: Alright, okay, make it p.r.n. and then adjust it.
- 185 MO: He's been socializing with um two of the other schizophrenic patients... um.
- 186 P: ... Well, um was he socializing with [another patient]? I saw her making a kind of pass at him.
- 187 SW: Hmmm.
- 188 PN: Yeah, and [a third patient].
- 189 P: Oh, dear.
- 190 MO: [laughs] And [a fourth patient].
- 191 P: Well, [the 4th patient] has got her head screwed on, in spite of having schizophrenia [laughs]...
- 192 PN: ...Yes.
- 193 P: ... I don't think she'll give in to him. But [the second patient] could be up to anything. [laughs]

194 MO: I don't know if he could gain anything from her insight because she's quite... she's very aware of her condition.

195 P: [the 4th patient's] insight? Mmm, I don't know, don't know. That would be our gain.

196 PN: But he does isolate himself and withdraw a lot.

197 P: Mmm.

198 PN: The only socialization he does, really, is out of the day-room. He's normally around in here.

199 P: Oh, yes, I see; he's harmless. Is that what you meant? [laughs]

200 PN: Well, I think so.

201 P: Yes, yes, right.

202 PN: I would hope so.

203 P: Yes. [pause] Have his parents been in touch [names SW]?

204 SW: No, not this time.

205 P: ... I mean, they know you and they know us. I'm sure they will be in touch but later on, probably. He only just came to us last week. [pause] So disappointing, he'd done so well, you know, and er...

206 SW: Mmmm.

207 P: He looked as if he was heading for a job and that we wouldn't see him again and then he didn't get a job so he slipped back. He says he definitely hasn't taken any drugs. I would like confirmation of that from his parents. I, it, it...

208 SW: Well, I'll ring them today.

209 P: It would be good to know. Well, they mightn't know, but, after all, he's been living at home, and they might know.

210 SW: They... He said that he still has \$2800 in the bank, and last time he was on drugs the money just [blows air through lips].

211 P: Oh, right.

212 SW: So...

213 P: ...so, probably, he isn't on drugs...

214 PN: He's spent a...

215 SW: Yeah, so...

216 P:because he's got the money.

217 SW: ... so, well the fact that the money's still there, so, unless he's telling a lie about that but he seemed to have no reason for doing so...

218 P: No, well he didn't sound as if he was telling a lie.

219 MO: Evidently, he was... had a... paranoid thoughts about Italians out to get him and he spent a lot of money staying in [an expensive hotel] to escape them.

220 SW: That was last time. He went through about \$3000 or something last time in about 2 or 3 weeks. And that was when he went to [the other state] as well, so if he's got the money then it's unlikely that he's been spending it on, on a lot of drugs, anyway, cause he wouldn't be getting that much credit, I would have thought.

221 P: It'd be nice if we could look after him this time without having to resort to the guardianship, but we might have to, however, that'll be for the future.

222 SW: He's also very defensive about that. He asked me yesterday about the guardianship.

223 P: He hated that.

224 MO: Will we confirm his order?

225 P: Oh, he's on a three day... Oh, the three day order, I did confirm that. But, that runs out when? [inaud.]

226 P: So it does run out today. [names the PN], do you think he'd be voluntary?

227 PN: ... Doubtful.

228 P: ... I mean, I don't mind. Oh well then, I'll write a 21 day one today, I'll write it today, cause I don't want him to...

229 PN: He's not making any motions to leave now, but I think if he was voluntary...

230 P: ... It'd be safer, it'd be safer.

231 PN: [Patient E]

232 MO: [reads] [Patient E] is a 22 year old lady who suffers from... chronic paranoid schizophrenia. She was admitted on the 11 of November following worsening of her schizophrenia. She's been having... The precipitance of this admission was that the voices that she has heard in the past have um been becoming more prominent, staying with her all day, or most of the day. And, also, she's been having tingling feelings over her body. A very... a fairly well adjusted schizophrenic young lady and she's got good insight into her condition and um... she understands a lot about um... her illness, her schizophrenia and um she can differential what's real and what's not. So, she's very a very good historian. What we've done for her is um increased her medication, we've commenced her on pimozide, she's on 10mgs b.d. at the moment. She's on a... a fairly large... she's on uh three different anti-psychotics, the reason being that she's had um severe [inaud.] when she's just been on a single high dose of er fluphenazine.

233 P: Yeah, um we're splitting the anti-psychotic medication into two, still in whacking doses. It didn't cut out the [inaud.]. Um she's still on the Modecate and something we must remember is that today is the day that the next one is due. And when she's an out... She's an inpatient now, of course, she'll be off the outpatient list so we'll, we'll have to give it to her today.

234 MO: Right.

235 P: But just, uh you'll need to write that one up as a one-off.

236 MO: Um she's actually been improving. I don't know whether you've spoken to her today.

237 PN: Yes, she said that um oh, and yesterday she reported feeling a lot worse than she had done previously, but today she's saying that she seems to have noticed that her symptoms are worse in the morning.

238 MO: Yes.

239 PN: And, get better as the day goes on. And, I wonder, her medication; we've been giving it to her at breakfast time and tea time...

240 P: ... Hmm, Mmm.

241 PN: ... what if we gave it...

242 MO: ... in the afternoon...

243 PN: ... the evening dose at... 9 o'clock? Would that cover her...

244 P: ... Oh, I see what you mean.

245 PN: ... more for the morning, or...?

246 P: Yes it might. That's a, that's a good idea [names Psychiatric Nurse]. We could try that.

247 PN: Hmm.

248 P: It won't do her any harm.

249 MO: When I spoke to her...

250 PN: ... Cause she certainly picks up in the afternoon, just around lunch time, she feels much better.

251 P: Yes.

252 MO: When I spoke to her yesterday, she feels that her condition is improving since she was first admitted but...

253 P:... overall. Yeah...

254 MO: ... as you say, it is much worse in the mornings.

255 P: ... it fluctuates.

256 MO: She's sleeping well at night.

257 P: Yes, shift that tea... the 5 o'clock dose, shift to the 9 o'clock. That's what you said? That's a good idea.

258 PN: Yes.

259 MO: Just for the pimozide?

260 P: We might still increase it...

261 PN: ... well, both of them...

262 P: ... I mean...

263 PN: ... are being given at 5.

264 P: ... Mmm.

265 PN: Pimozide and... don't know what she's on...

266 P: Benztropine?

267 PN: Triflu... Trifluoperazine?

268 P: No, no, we took her off everything but the pimozide, cause I thought...

269 MO: ...No, she, she...

270 PN: ... No, she's on trifluoperazine, 5mgs.

271 MO: She's still on the triflu...

272 P: ... Oh, she's still on the trifluoperazine. So the fluphen. we stopped all together, that was it.

273 PN: Yep.

274 MO: That's it.

275 P: Pimozide substituting...

276 PN: ... She's on fluphen. as a p.r.n...

277 MO: ... p.r.n. but she hasn't had any...

278 P: ... hasn't had any.

279 MO: ... for the last fortnight.

280 PN: No.

281 P: No. I'd rather she didn't right now.

282 MO: Well, we can stop it altogether.

283 P: You can stop it. [pause] And today's modecate is due so we'll just write that in. Um [another psychiatric hospital] knows that she's not attending industrial therapy [names P.N.], did she ring them?

284 PN: Yes, she...

285 P: ... she rang them, good. As long as they know she's here. She's booked for [an employment training program], you know, next year. I don't know, we'll have to ... I just hope she's... better by January. Yes...

286 PN: Well, January is a long way...

287 P: ... long, long way away.

288 SW: [laughs]

289 P: [laughs] I know, [names S.W.] but they, they booked her before she relapsed and came in here, and she may be better after she leaves here and back on to a chronic schizophrenic level. But, um biochemically better adjusted. She might be...

290 SW: ... I think she might do well there because its um... it's a better program than I.T.

291 P: And she's keen to do it.

292 SW: Mmm.

293 P: Right. [pause] We may yet increase the pimozide a bit more, but, but we've only just put it up so we'll watch that for a few days. [pause] [names P.N.] she asked if she could um continue to lose weight but she's not on... any diet here, is she? Just on ordinary...

294 PN: ...No, not that I'm aware of.

295 P:... ward food? Good, we'll leave it how... She did lose weight just by... restricting herself.

296 PN: Mmm hmm. [long pause] [Patient F]?

297 MO: [Patient F] is a 64 year old lady who was admitted on the third of November. She's a lady that... um... was presented, or presented for... family relief. She's recently been diagnosed as having er a rapidly progressive um senile dementia. Currently, she's, she's stable but er she, her family can't manage with her at home. So, at the moment, we're looking for a nurse... or actually we've found a nursing home her, but she's er third on the list for placements so it could be several months before er she actually gets in to er [a particular nursing home]. Um so, in the interim we're planning to look for emergency nursing um...

298 P: ... temporary, temporary placement.

299 MO: ... respite.

300 P: [names S.W.] what do you think our chances of that... I know [a nurse] looked into it... was it last week or this week? I mean...

301 SW: I don't know what's been done before, but... Nor am I fully aware of what the situation is with regards to respite care, except that there are some difficulties because... of the changing legislation all the time...

302 P: ... Oh, yes. Oh, for sure.

303 SW: So we'll just have to chase up... what we can.

304 P: I wonder why [the nursing home] that she is booked in for, do they do respite?

[SW's pager sounds]

305 SW: They might, but it seems unlikely that they would offer her respite there if...

306 P: ... Yes, if they're going to take her.

307 MO: She's going to have a permanent bed.

308 SW: ... if there's a permanent bed so maybe we'd need to look at some other places. So I'll start chasing that up, if you like and... see what's available.

309 MO: I had a talk with the family. They feel that they can't look after her at home.

310 P: Yes. Yes.

311 MO: Especially with the daughter that has been looking after her, is going to hospital later this week.

312 P: Yes. Yes. And the other daughter says she can't manage, I mean, I don't think any of them can.

313 MO: She's got 5 or 6 children.

314 PN: Mmm.

315 P: Well, none of them can manager her. She's really... the ambulant demented. Um she's just the sort that... respite care is need for but coming up to christmas, [names S.W.], it's awfully unlikely that anyone...

316 SW: Well, that's just what I'm wondering. I mean, I know some months ago we tried to chase up and... they wanted us to give 3 or 4 weeks notice for respite care so that in itself presents difficulties. But, anyway, we'll chase up and find what the resources are and see how we go.

317 P: Well, she is here at the moment [names P.N.], I know we don't want to keep her indefinitely, it's just at the moment...

[SW gets up to leave]

318 PN:... I know, I know. Sure.

319 P: ... it's not immediately urgent.

320 PN: No. But, but, you know, I do feel that I'd prefer a placement in respite care.

321 P: I know, I know.

322 MO: Did her [medical benefit] form... That's going to come through to us, isn't it?

323 PN: Yeah, the meeting was yesterday so they would have approved it... well the girl I spoke to, the woman I spoke to last week, Thursday, Friday, said she could give us verbal approval if we need it, even then.

324 MO: Well that's good.

325 PN: Er, what was I going to say? Yes, you know when I was discussing with you about her medication yesterday? The fact that she was um paranoid on and off?

326 MO: Right, yep.

327 PN: Well, the staff have been saying that... that's been an increasing thing. Cause she, last night, was um paranoid about this man that following her...

328 P: ... Oh, so she needs a bit more....

329 PN: ... it's been quite recurrent. She's only on 5...

330 MO:... trifluoperazine.

331 PN: ... trifluoperazine.

332 P: Right.

333 MO: And, she's on p.r.n. doses as well.

334 PN: Yeah, she's been on quite a bit of p.r.n., about 3 doses, 2 or 3 doses a day.

335 P: Really? So she'd really be, then, on 5mgs t.d.s. long pause] I wouldn't mind her going on t.d.s., it wouldn't be too much.

336 PN: Mmm. How much was she having p.r.n.?

[SW re-enters]

337 MO: She was having... yesterday she had um a total of 5mgs, on the day before a total of um 10, the day before 10, and again. Is that two signatures... or just the one?

338 PN: Oh, just one. So she's been having one extra dose each day...

339 MO:...each day.

340 PN: Oh, yeah, just one each day.

341 P: So 5mgs b.d would be right, but an extra p.r.n... she could still have 5 t.d. er p.r.n., in addition. Yes.

342 MO: So, should we just increase it to 5 b.d.?

343 P: Yes, but leave the p.r.n. so that she can still have that. [names SW] I really, I don't know, I'd be grateful if you'd try, but honestly, I haven't got much hope.

344 SW: So what do we do in case we don't come up with one?

345 P: Well we've got no option but to keep her.

346 PN: Yeah, we've got to keep her here.

347 SW: Pardon.

348 P: We've got to keep her here until the [alternative] comes up.

349 PN: That's really... why I was fairly keen on looking into the respite area.

350 SW: Sure.

351 P: Cause they said to us it might be next week, but equally it could be after christmas.

352 PN: Aw, she's no problem here.

353 SW: I realize that, but, obviously...

354 PN: But it's an acute bed that she's taking up.

355 SW: Hmm.

356 P: Right.

357 MO: [Patient G]

358 P: Oh, dear. None of us speaks Italian do they, do, do we? No? We had [another staff member] helping...

359 SW: ... Oh, right...

360 P:... with her last time but er she has some English but not good English. And her son was the interpreter on admission.

361 MO: Yes.

362 P: He stayed, didn't he?

363 MO: Yes, he did. Yes, he was quite good.

364 P: Tell us about her.

365 PN: They used, they used [another patient] last time as an interpreter last time.

366 P: Oh, really? Of course, she speaks Italian.

367 PN: She's not very reliable, though.

368 P: No, I wouldn't think she'd be a good interpreter [laughter] but she's at least be able...

369 PN: ... But, she was, she was reasonable for stuff around the ward...

370 P: ... to chat with the old lady. Oh, yes, that's something. Go on, dear.

371 MO: She's a 70 er, a 71 year old lady who was admitted... last night. She was brought in by her... her son. And the problem has been that over the last 6 weeks she's been having severe ... back pain, neck pain, and head pains.

[a nurse comes in with a message for the SW]

372 MO: Right, so, she's been having, for the past 6 weeks, and in particular the last 2 weeks, severe back pain radi-... um radiating up to her neck and head. And um she describes the pains she's been having as er global in nature, and it's a burning sensation. She's had a... similar episode during her last, previous admission which was about 2 months ago and... er she was admitted under the er general physician's... for investigations of these headaches and they spontaneously settled with er physio to her neck. Currently, er the pain or these headaches aren't relieved with Panadol or any of the simple analgesics. The only relief that she gets from them is by Serepax and currently she's on a total of 150mgs per day and um... which is a very substantial dose.

373 P: That's routine, everyday?

374 MO: Mmm Hmm; 50 er... 30mgs in the morning, midday, and 30 just before the evening meal then 60 when she goes to bed. And she's recently been prescribed Feldeen by a private physician for her arthritis and er she claims that they haven't... provided any relief at all. Um also when she gets this head pain she claims that she loses her memory and she feels like she's got a wooden head. And er she mentions that er she er feels suicidal but when questioned about that um she explains that um that she's just speaking figuratively. That she wouldn't actually do that to herself.

375 P: Mmm, and [names S.C.P.] her son commented that she's bright, I mean for her age. She's seventy... one, didn't you say?

376 MO: Mmm eight, oh, no 71.

377 P: No, her husband's 78, she's 71. But, I was asking, was she forgetful, you know, a part from the, when she had the headaches?

378 SCP: Hmm.

379 P: And the son said; no,no, she's, she's,you know, perfectly compliant so that's... probably something that we don't need to pursue, but we're not sure yet. Go on, I'm sorry for interrupting.

380 MO: She lives at home with her 78 year old husband who suffers from chronic obstructive airways disease and, er he's having trouble coping er with seeing her up-set and suffering. Um she's... been having early morning awakening, around 5 o'clock each morning. And she actually needs 2 Serepax to get to um manage to get to sleep, and that's at about 11 o'clock. She complains of feeling depressed and er... says that she would feel a lot better in herself if the pain would go away. Her appetite... recently has been back to its normal state, but 2 weeks prior she says that she's been losing some weight. Um she's got a past history of hypertension, osti-arthritis, and peptic-ulcer disease. With the peptic-ulcer disease... [inaudible] cause it's a real contra-indication.

381 P: I know, but she's been a private patient of his, we'll have to call him in any way, on a consult basis.

382 MO: Mmm. She, she saw this... she saw [another doctor] he's a private physician and um... he prescribed her the Feldeen but um she claims that he knew that she suffered from a peptic-ulcer disease, so...

383 P: I know, and [a third doctor] was her private psychiatrist, I gather. That's where she got the anti-depressant from. And we, that's another thing we'll have to do; notify him that she's admitted.

384 MO: Mmm. During the last admission when she was... prescribed er Lorazepam but er she, somehow it's been discontinued, and I don't know why that was discontinued or who discontinued it...

385 P: ... well, she wouldn't have been given Lorazepam and Serepax so, presumably, someone decided...

386 MO: ... to just change it...

387 P: ... to stick to Serepax.

[a nurse returns with another message for the SW]

388 P: Well, with the son interpreting, did you get a mental state?

389 MO: Yeah, oh, yes. She's a [pause]

[a nurse comes in to ask advise about a drug]

390 MO: Right, her mental state is... she's dressed in a a summery-outfit, tidy appearance, and her grooming was satisfactory though she was a bit un-kept with her hair. She was reactive to the interview, gesticulating appropriately, but there was decreased facial expression. Her speech was er, as far as I could make out, was normal Italian speech; fairly rapid and er [laughter] expressive.

391 P: Ah, there's a touch of racism there. [more laughter] Yes, I'm sorry.

392 MO: I'm from a European background as well...

393 P: I rattle on. Yes, you would be wouldn't you, with your surname, yes.

394 MO: And er well, her son translated that there was no form of thought disorder.

395 P: No, no, I didn't think there was.

396 MO: Her affect was er, she seemed a bit flat and sad, and her memory was, was excellent. She could remember er recent events that had happened in the family, which her son validated, and her long-term memory was intact as well.

397 P: Was she investigated for the headache in the 2 previous admissions of this year?

398 MO: Yeah.

399 P: She was? Well, then we don't need to do it again.

400 MO: Yeah, she didn't have a C.T. scans but I can, or, they thought it was inappropriate.

401 P: ... it would be inappropriate. I think she may well do well on mono-amy-oxidaze inhibitor, you know.

402 MO: Her thought content, she's very, very preoccupied with her pains, and she was orientated [inaudible] and her attention was normal.

403 P: Mmm.

404 MO: So for, I thought, her insight was poor into her condition so I gave her, for a DSM 3 classification, an axis 1 of a-typical depression; and er the other diagnosis of Serepax dependence and tolerance - axis 2 diagnosis; axis 3, ostio-arthritis of the spine, hypertension, and peptic-ulcer disease. Her social stresses were moderate (living with a sick husband)...

405 P: ... Hmmm.

406 MO: And axis 5, I couldn't really assess from the information. So, what we plan to do is admission for assessment to... withdraw her from her Serepax. I'm not sure, I was talking to [someone else] and... whether we convert her Serepax to Valium, withdraw that over a week or 10 days...

407 P: ... Mmm, oh, we have to do that gradually.

408 MO: Also to er just check her blood-pressure cause she's hypertensive on admission, and um... a gastro-enterological review for her peptic-ulcer disease.

409 P: Hmmm.

410 MO: So, and also query the [inaud.].

411 P: Well, instead of; substituting. So we can stop the anti-depressant. We probably did that last night, did we?

412 PN: Yes.

413 P: Yes, right, and next week we can think of substitution and in the mean time, as you say, we can gradually ween her off the Serepax. Um we must ring [the two private doctors]. She's got no private... hospital insurance [names P.N.], that was why there was no... She, she was

reluctant to come in on the grounds that she's heard about [this psychiatric unit]: it was a place where very sick came and were given very strong tablets. [laughs] And I said, briskly, it must have been [a larger psychiatric hospital] she was thinking about, it wouldn't us, you see. [laughs] But she didn't have private insurance. And she did need admission; the husband or the um son's first statement was: she's driving my father nuts. And that seemed, really, a good enough reason to admit her. She was willing to be admitted, at the end of it all, wasn't she?

414 MO: Yes, yes, she was, I thought.

415 P: Yeah.

416 MO: She has a lot of focusing on the physical symptoms...

417 P: I'm glad she and [another patient] are at least going to have a chat. [laughs] [pause] Alright, that's our last one, then, is it?

418 MO: That's the last one.

419 P: Good.

Appendix 4

Case-Conference No.2:

Professionals present:

Psychiatrist (P)

Psychiatric Registrar (PR)

Social Worker (SW)

Clinical Nursing Consultant (CNC)

Enrolled Nurse (EN)

Senior Clinical Psychologist (SCP)

[the tape was started just before the formal conference started, but patients were already being discussed]

001 PR: [discussing patient A] ... and so, um I've never, yes I think I have her as an in-patient once or twice before, I don't remember...

002 P: ... Oh, right. That's great.

003 PR: ... so she's um very smartly transferred to me.

004 P: And did you do a swap? Has he taken one of yours or...?

005 PR: No, no. He's got 6.

006 P: You just acquired him.

007 PR: He's got 6, I've got 7. So um she's manic and um I, when I came in last night she wasn't on enough medication and she was refusing to have any more so I detained her. She's not very happy about that! But, um she was um threatening to leave and...

008 P: ... This was last night?

009 PR: Yes, so if you could review her detention order today or, otherwise, I think we'll have a great deal of difficulty trying to treat her. I don't know where all the rest of the case-notes are...

010 P: I wonder is [the P.N.] not coming back, himself? He went to get you but he, he was going to return.

011 PR: I don't know. [pause] I think she just stopped all her medication. [reads section of report out loud]... 'Stopped coming as a day-patient, and, on admission, was really quite hypermanic. She said she was 144 years old, a prophet to God, [reads] "I have full capacity of my mind; know everything that has happened in 144 years. [another doctor] is also a prophet"...

012 P: ... Oh, dear.

013 PR: ... She was paranoid about them and us [lists several other doctors]. 'Don't know, can't read that bit; something about evil, 'not sleeping well last week, very active, no insight, denies that has illness'. And um it looks as though she's reduced her slow-release lithium down to 300 a day. But we'll have to see whether that's enough. [pause] So, we do need [the P.N.], we need the medication charts and everything.

014 P: Yes. Yes. [pause] You remember her, do you [names SCP]?

[PR leaves to get other case-notes]

015 SCP: No.

016 P: Oh. She's an intelligent um homosexual girl who's previously been a patient of [a different psychiatrist] for years and years. I think I'm right.

017 SW: She's been, well, she's been around the wards ever since I've been here.

018 SCP: Oh, yes. That is the er...

019 SW: ... very bright...

020 SCP: ... very short...

021 P: ... Short...

022 SCP: ... natural...

023 P: ... and bright. She is bright.

024 SCP: Yes.

025 P: But, it never protects her when she gets the bi-polar swings. The thing about um [the patient's previous psychiatrist] was [names the psychiatrist] always who looked after her, you know, and er she can't go privately. I don't know her circumstances [names S.W.], do you?

026 SW: Oh, she's be on...

027 P: ... I think she's a student or...

028 SW: Yes, she is studying. She'd be on unemployment benefits or a student allowance at this stage, I would say. She never requires very much social work involvement. When she's well she's quite capable of managing. The most I've ever done is take her home to pick up clothes and something like that when she's manic.

029 P: Yeah, and the kitten; she came in with a kitten, which stayed her, I think, over night because [laughter] it was about a 6 week old kitten. It was very young, and, I think the ward staff looked after it because the friend, who was meant to look after it, didn't come. So, er...

030 SW: She has lots of friends. There's nearly always some drama with the car or something but... that sorts itself out too.

031 SCP: I'm sure I saw her somewhere.

032 P: Mmm.

[PR returns with case-notes. Very long pause]

033 PR: Um [pause] Mmm. I'm just not sure whether, if [patient A] thrives on haloperidol or quite what. You, you can't give trifluoperazine intra-muscular, can you?

034 P: No.

035 PR: It hurts.

036 P: Mm-huh.

037 PR: [pause] I'm sorry not to have this more organized.

038 P: No, dear; you've only just had her handed to you, so to speak.

039 PR: [pause] But I'd just quite like to give her... um... haloperidol... but maybe she has a horrid reaction to it. Oh no, here we are; she's had it before. [pause] I think initially we'll just give her that, a regular dose of that... and plenty of p.r.n.. How does that sound?

040 P: Mm-huh, Mm-huh. And you want it confirmed?

041 PR: Yes, I think so otherwise we're going to... not be able to... we'll go through all that hassle of....

042 P: Do you want me to put a 21 day as well?

043 PR: Well, yes. It might be a good idea, because sometimes [patient A] goes on...

044 P: ... I know.

045 PR: ... for a long time.

046 P: On one of her admissions. Do you remember? Oh, it was [another psychiatrist]. [patient A] tried to get on the same aeroplane that [the other psychiatrist] was going overseas on.

047 PR: That's right.

048 P: [the other P] was booked for a holiday...

049 PR: ... Mmm...

050 SCP: ...[laughs]...

051 P: ... and it was, I think [names other P.] only just discovered it in time to stop it.

052 PR: Mmm, mmm.

053 P: [pause] And she'd used Bankcard or something, didn't she? to try and pay for the ticket.

054 SW: Yes there was something...

055 P: ... At that stage she was quite irresponsible about cash...

056 SW: ... I think it was the people from the um travel centre that contacted us...

057 P: ... Yes, that's right.

058 SW: ... concerned that it seemed totally inappropriate...

059 P: ... That's right.

060 SW: ... and er alerted us to what was happening.

061 P: Yes, yes. I think a 21 day order would be wise.

062 PR: Alright. So, team-meeting. [pause] Um, well [names CNC] is coming in soon, we don't really know; have the progress, but the plan is; to transfer to Red-team. [pause] She was really um awfully destructive last night when I came for the um...

063 P: ... Oh, of course the Schizophrenia meeting, yes.

064 PR: ...meeting, and I just had quarter of an hour in which to interview her quickly, and make an assessment, and tell her that I was going to detain her, and alter the medication, and cope with all the flack that she gave me [laughs].

065 P: How did the meeting go?

066 PR: Very interesting.

[CNC arrives]

067 P: Many people turned up for it?

068 PR: Um about 15.

069 P: Oh, good! That was what [another psychiatrist] wanted. That's terrific. Were you here?

070 CNC: Last night? No, I wasn't here [names another P.N.] was.

071 P: I'll be coming next week. I was just too tired last night. I thought I might come in but I didn't. But it went well, did it?

072 PR: Oh, yes. They were just new and um... um... er... they'll loosen up. They was quite a lot of discussion and airing of problems and sharing of coping. Um how's [patient A] settled in after last night?

073 CNC: Um she had a broken sleep pattern most of the night. Well, she's responding to limits, that's after them being repeated a few times, and the minute you get on top of her with one issue she's off getting involved in some other type of situation.

074 PR: Well...

075 CNC: So she's um...

076 PR: ... she's hyperactive, isn't she?

077 CNC: ... very erratic. Yes, that's right.

078 PR: Irritable still?

079 CNC: No, no; she's compliant, she's taking medication, she hasn't complained about... us versus her which is... fairly common... thing with her. She gets angry and...

080 P: ... gets terribly irritable.

081 CNC: ... everyone's against her sort of thing. Her mood's not so mobile today - she was very teary yesterday inbetween all this... powerful... talk.

082 P: What happened about the kitten? I know it's a side issue but...

[enrolled nurse enters]

083 CNC: I don't know. Who picked the kitten up last night?

084 EN: Aw, we got friends um I rung up her friends and er got them... to come and pick it up.

085 P: Oh, good. It was a dear little thing but... it really needed a little looking after.

086 EN: Well it'd messed in the office. [laughs]

087 PR: [inaudible] is called [patient B], a 31 year old married woman who was referred by the general practitioner [names doctor], and she has an adjustment disorder with depression, and anxiety which um began about 3 weeks ago when her husband of 7 years... left her. And, um she, he'd been having an affair with the, um, 19 year old live-in nanny. They have 3 children aged 3, 2, and 1, and they were running a chicken-take-away shop together for 8 months but that's now facing bankruptcy. So she has that as a stress and also this... separation from her husband who's in the eastern states somewhere. And she'd been feeling exhausted and thinking about killing herself, and she'd had a number of vegetative features of depression, almost some dissociative symptoms, um felt very numb and confused, and um... really got to the stage when she couldn't cope with the three children anymore. Now, while she's in here, um her mother's going to try and care for some of them and [a SW not present] spent some time with... the grandmother trying to make arrangements for the children. They are all being cared for... in day-care. Two of the people that do the day-care have offered to care for the youngest two children... as the grandmother's arthritis and the children's restlessness at night make it difficult for her to cope. But the grandmother has actually opted to look after the youngest and the eldest... for the time being and [the other SW] said, made a note here, that um he's going talk about accommodation, I think, or he thinks... she needs help with emergency housing as they are paying \$140 rent a week at present... where they are. They can't afford to keep that up.

088 P: [names PR], you did say, but what are the ages of the kids?

089 PR: 3, 2, and 1.

090 P: Oh, they very young.

091 PR: So, she spent a fairly unhappy evening, I understand. But, eventually, was able to talk to one of the nurses.

092 EN: Yeah, well we didn't get much time to chat with her and, actually, I caught up with her a bit this morning and she seems, after, she was really tired and worn out last night...

093 PR: ...Yes, mmm.

094 EN: ... as well and she was a little teary and that but, she said after last night she, you know, it was the best sleep she's had, she couldn't remember having a good a sleep as last night, in su, in such a long time, and really felt a little better this morning and able to talk quite a bit about the relationship and that. And about the kids.

095 P: What religion is she, [names PR.]?

096 PR: I don't know; the front sheet hasn't been made up yet.

097 P: Oh, I see... it's just that 3, 2, 1 is awful quick.

098 CNC: Is it her husband, um Jehovah? Is that her?

099 EN: No, I don't think that's her, no.

100 PR: There was no mention of religion.

101 EN: No, no mention. Well she, apparently she told me this morning, she told me she had a lot of having children for a long time, like they've been together 9 years, like 7 years of marriage, and all of a sudden, you know, she'd been told early in her marriage she wouldn't probably be able to have children. An' the first one come along so they went off, you know, it

was such a surprise, the first one, then so they never took contraception again and then like the next one popped out a year later, and then the next one popped out. That's what she sort of explains it. She said it just sort of happened.

102 P: Mmmm.

103 EN: Yeah... I don't know if she's done anything...

104 PR: ... Will [the other SW.] keep her on?

105 SW: Yes, he's going to stay with her.

106 CNC: Hmm, there's a lot of social work assistance required.

107 SW: Well, having started yesterday...

108 CNC: ... Mmm.

109 SW: ... he said he's quite happy to continue.

110 CNC: Mmm.

111 EN: Yeah, she wants to shift. There's a lot of memories in the house.

112 CNC: Mmm.

113 PR: Yes, it's all been a very bad scene.

114 CNC: Yes. She's certainly isolating herself so probably need a bit of encouragement to get her along, along to groups...

115 EN: ... Mmmm.

116 CNC: ... to er start talking about things.... but she's more relaxed this morning, so...

117 EN: ...Mmmm.

118 CNC: ... she... she slept well. She had two temazepam last night and she slept well on that.

119 PR: [pause] Right, so [patient C] she's the 28 year old... woman... who um... is married and lives with her husband and 2 children aged 7 and 4, and she was admitted um with... attacks of hyperventilation and anxiety related to a number of stresses um... debts, lots of debts, and then they'd started to sell their house to pay off the debts. An' the worry of whether or not it would be sold, and then um her identity problems as she's been adopted and recently discovered her natural family. And um she's, since she's been in here, she says she's feeling a lot better and um... doesn't... that the con... the rather chronic conflict that she had with her husband seems to be... improved a little. And, since the house has been sold now, and there are plans to move into a new rented house which he's rustled round and found. And he's been very busy and really had his mind engaged in that so really didn't have any... energy and time to give to her problems; to listen to her carrying on about her natural family and how [] that was. So, he just became impatient with her, I think, and so she became, dug her toes in, and became impatient and said 'well I'm not giving any more if your not going to give me any more'. But all that's sort of unwinding and undoing and they're moving into their new house on Saturday.

120 P: This week?

121 PR: Mmmm.

122 P: Oh.

123 PR: In the weekend. Some friends are going to help them move with a truck. And um, so she's going to be discharged on Saturday. I really don't think that she's sort of a psychotherapy...

124 CNC: ... material.

125 PR: ... material. I tried and tried and um I really think she's not psychologically minded. But she... I could leave it open so that later on she wants to come back, she could.

126 P: [names PR] there is a thought which is that you've got a couple of months to run and a bit of holiday to take. If you thought she was going to be on going, you could book her with either [names two other psychiatrists] for...

127 PR: ... Mmmm.

128 P: ... for the first week of December which is when they start.

129 PR: Yes.

130 P: They're taking bookings already.

131 PR: Oh, are they really? Oh, great.

132 P: Well, [names a staff member] is taking the bookings. [laughs] They haven't started yet but they are going to. [names a psychiatrist] is starting on the 30th of this month and [names the other P] on the 2nd of December and they've both rung me and er they'll be available.

133 SW: We're getting 2 not 3.

134 P: No, we are getting the third one; [names 3rd] starts on the... 4th, I think, of December. So, we're getting 3.

135 CNC: As what, in what capacity? In what capacity?

136 P: Visiting Consultants; one of them, each of them one session a week each. Um and...

137 CNC: ... [names third P] gets this...

138 P: ... and [names first P]

139 PR: Oh, right.

140 P: But, you see, the leave period is coming up. [names first P.] is off for three weeks, [names second P.] is off for one week. I haven't discovered yet what [names third P.] wants. So, although their beginning alright, which gets them on to our books kind of thing, um it's the holiday period. There's always a sort of running adjustment to be made.

141 PR: So... um.

142 P: But I just thought of that, you see, if you thought she needed something on-going...

143 PR: ... Yes.

144 P: If you thought it was only a matter of one or two visits, obviously, you could do it yourself.

145 PR: Mmmm.

146 P: But it sounded... as if it might, perhaps, merit a bit of uncovering, you know?

147 PR: Mmmm... we'll... consider that later in the week.

148 P: Yes, yes.

149 CNC: And discharge Saturday...

150 PR: ... Mmmm.

151 CNC: ... not Friday?

152 PR: No.

153 P: If I was moving house, I'd want to have a bed... in [this institution] over the weekend [laughs].

154 PR: Well there's no point in her going home...

155 P: ... No.

156 PR: ... because she can't go to the new house and she'll go to the old house and everything will be in boxes... and it will just...

157 SW: ... She just doesn't want to go to the old home.

158 PR: ... No, she doesn't. I think it would be silly to press it.

159 SW: ... She's very adamant about that.

160 PR: I know we're spoiling her by, by having her here and she could go to a friend.

161 CNC: She could be involved in... moving house.

162 PR: She doesn't want to do that.

163 P: Oh, dear God. Who can blame her? [laughs] It's one of life's worse experiences...

164 CNC: ... Oh, fair enough, but I, you know...

165 P: ...But most women have to get stuck in to it, yeah.

166 CNC: ... but you don't rush off to a psychiatric hospital because of it.

167 P: No. [long pause]

168 PR: Um, [patient D] 32 year old man with chronic schizophrenia. He was assessed at um [a sheltered employment centre] and we haven't heard anything more from that yet.

169 P: [names a SW] has done a very long... good report to [the centre] about him.

170 PR: Has he?

171 P: Well, it was being typed yesterday, that's how I know.

172 PR: And he continues in his usual withdrawn, isolative state, with a minimum of contact and social interaction.

173 P: Uh huh.

174 PR: And it says he doesn't think much of [the centre].

175 SW: Well, [names a staff member] was quite... what's the word?... unsure of how he would be... whether he was likely to be accepted there, just in his general attitude.

176 P: But they did offer a second... visit, apparently...

177 SW: ... Yes...

178 P: ... I think, next week. Is it?

179 SW: I don't know quite when it is but, yes, they...

180 P: ... They've offered another appoint- He's got to see another group of people.

181 SW: Hmm.

182 P: I think it's next week.

183 CNC: Hmm. He's very aloof and walks about the place smiling to himself... Heading off for walks outside. He can't concentrate on activities longer than 10 minutes, even with wood-work which he... has a minor interest in; he won't stay there long. [pause] So, it's a problem, really, cause his mother's such a fussy sort of woman that she's sure to complain once he's home again.

184 P: [names the occupational therapist who is not present] is giving him special time... special attention [laughs] he wasn't giving her time, I think.

185 CNC: No. Yes, I doubt it.

186 EN: He, apparently, did enjoy that leather session yesterday, didn't he?

187 P: Did he?

188 EN: They thought he was quite good in that.

189 P: Oh, and he stuck with it?

190 EN: And he stuck with it, yeah. Yeah, they sort of encouraged him to go round there; said 'you might enjoy this' and he did actually appear to enjoy it. Which is good for [D].

191 P: Mmmm.

192 PR: [very long pause] Well, what do you think we ought to do about discharging him [names P.]? Do we keep him here for another week or 2 or 3?

193 P: Well, I think the next [training centre app.] [names SW] is the one who gave me the information. [D] did say there was another appointment booked, I'm not sure he's sure of the date.

194 PR: Yes.

195 P: [names SW] said that he had the initial appointment with one particular person who showed him around.

196 PR: Mmm.

197 P: But the next appointment's more important because he meets the sort of selection committee.

198 PR: Mmm.

199 P: And I think [the SW.] said next week, but we might ask her the date.

200 SW: Yes, they- I don't- when she came back they didn't have a date, but maybe a letter's come in the meantime...

201 P: ...Oh...

202 SW: ... [names another SW] written a report, maybe he's had a letter.

203 P: Oh, right, yes.

204 SW: From him- from- asking for more details.

205 P: Yes.

206 PR: [pause] Any um any obvious paranoid material coming out?... [names CNC.]

207 CNC: No. There's no, no behavioural changes...

208 EN: ... I haven't noticed anything...

209 CNC: ... not saying anything definite.

210 PR: ... So, we just keep him... Keep in hospital for time being. [pause] He occasionally says to me 'well, how much longer?' and I... hedge him round a bit and ...

211 EN: [laughs]

212 CNC: Can I just have a look; I'll just check if there's anything. [very long pause] No; [names another SW.] will be contacted regarding next assessment.

213 P: [inaudible]

214 PR: Well, [patient E] is a 21 year old, single woman who lives [in an institution] and she had borderline intelligence and she became disturbed behaviourally and emotionally aroused and, I think, psychotic and that necessitated admission. Um, it was in response to the break up of the relationship that she had with somebody else at [the institution] and also she- her private psychiatrist had reduced her thioridazine down to nothing. And the issues that she's stirred up about are the fact that she thinks her family has rejected her and that her sisters are going- her normal sisters are going ahead and doing normal things and she can't. And that makes her very angry. And since she's been in here she's settled down considerably but er with the reintroduction of thioridazine. But she um does tend to giggle inappropriately and she still says that her family has rejected her although it seems very easy to sort of sooth her about that. I don't know how the nursing staff have found it, but I say things like 'well, maybe it seems like that to you because you're living at [the institution] but that- your also making a life of your own

and you see them regularly and go home for visits and And then she sort of forgets about it for a while...

215 EN: Mmmm.

216 PR: What do you think?

217 EN: Yeah, I agree with that, mmm. Yeah she seems very easy- you can put the points to her. I think she forgets maybe because of her low intelligence...it's just- cause she gets a little inappropriate and um her mother's very supportive but, yeah, I've seem a few angry outbursts.

218 PR: Mmmm.

219 EN: With her mother and she really gets stuck into her... you know...

220 PR: ... Apparently...

221 EN: ...and on the phone and stuff she does.

222 PR: Yes. When she's completely well, apparently, she can tolerate going home for a night but um even that sometimes ends up in disaster so that she can really only tolerate a meal or a couple of hours at home.

223 EN: Hmmm.

224 PR: When she's well. So, she was due to see [another professional] yesterday but they made a mistake and it was suppose to be today. I've just rung [the other professional's] secretary and her mother can't take her today and the suggestion was that well she's in here and being treated by us and maybe we can cancel that appointment and make a new one for her if she's agreeable. Um and um I would think perhaps- well she can hardly send her back to [the institution] for the weekend, can you?

225 CNC: I don't know what their arrangements are down there.

226 SW: I wouldn't think there'd be any reason why not.

227 PR: Some trial leave back at [the institution] would be very useful.

228 SW: That's her residence and I don't think that anybody is compelled to leave there at weekends. You know, they can choose to go out for weekends if they want to.

229 PR: Mmmm.

230 SW: It would be worth just checking.

231 PR: Mmmm.

232 SW: From my experience, I can't see why not.

233 CNC: Is there supervision there?

234 SW: Oh, yes, yes.

235 CNC: On weekends as well?

236 SW: Oh as far as I know.

237 CNC: Mmmm. Um, because her medication- I suppose she's used to taking her Tegretol anyway it's just the thioridazine which is new. She hasn't had sleeping medication for about a week.

238 PR: She's had the thioridazine in the past while she's been at [the institution].

239 CNC: Mmmm.

240 PR: So, she's improved considerably since admission and is easily... soothed?

241 P: Comforted.[laughs]

242 PR: Comforted, about her feelings of rejection. [long pause] She still laughs inappropriately a bit.

243 EN: Mmmm.

244 CNC: Has she got a psychotic illness, or is it her intelligence...

245 PR: ... Well, I think...

246 CNC: ... and reactive situation?

247 PR: She's um, she was psychotic when she first came in.

248 CNC: Right.

249 PR: And so she's got an organic psychosis, I think. Organic delusional syndrome... I think.... And continue medication, contact [institution] re weekend leave.

250 P: [pause] She wouldn't have lost her room there through coming here would she?

251 SW: Oh, no.

252 P: No, no, I thought not. I'm sure not.

253 PR: And um- and possible discharge next week and... anything? Um...

254 CNC: ... Contact the doctor?

255 PR: No, just talk to [E] about whether she wants to keep this afternoon- I think we could persuade her that this afternoon she doesn't need to see [another professional] and that she can make another appointment because she's being looked after us so nicely.

256 CNC: For next week even. Does she see him weekly?

257 PR: I don't think so... probably see her every fortnight if he's got a space.

258 CNC: So what of those things do you want us to do?

259 PR: I'd like to contact [the institution] to see if she can get there for weekend leave, and I'll talk to her about [a doctor's] appointment.

260 CNC: Right.

261 PR: And then I'll ring up and cancel it if she can be persuaded that she doesn't need to see him. How does that sound?

262 CNC: Good.

263 PR: [patient F], a German woman of... aged 51 married to a German man. And she was admitted with a recurrence of delus- persecutory delusions involving her husband who... um who she thought was snoring purpose-fully to annoy her and sucking his teeth and various other things; money, that he was putting money away, keeping money from her, that he lies to her all the time. And she was very or had been very aroused at home about all this; it'd been coming on for some months, and the husband get to the stage where he couldn't cope and had requested help form [another psychiatric institution] and they'd sent out [a different psychiatric team]. And since she's been in here she's um been treated first with haloperidol but that made her too drowsy so she's on pimozide, and she's responded fairly well. She's had a couple of weekends at home and I think the more recent weekend was more successful than the first on. Um husband says she's um settled a bit more... and she was caring towards him during- doing the various things though he felt she's still doubtful about him. That's right. Um she's very aware of any side-effects and really doesn't want to take the tablets for any length of time so I think we'll have difficulty keeping her taking them over the months.

264 CNC: Hmmm.

265 PR: And I think... I'd like to get her to- to a stage where she'll start taking them and then we can send her home and I'll follow her up as an outpatient.

266 CNC: Mmmm.

267 PR: How have you seen her?

268 CNC: Yeah, she's certainly settled.

269 P: Mmmm.

270 CNC: She's more involved with the other women around the area; eating, conversing okay. No outward signs of paranoia.

271 PR: Mmm. Is she still talking at length about her husband?

272 CNC: Do you know [names EN.]. I don't know.

273 EN: No, she apparently came back and sort of denied there was any problems of anything on the weekend and he sort of apparently breezed in and out. And didn't know if the staff managed to catch up with him much but she just said 'oh, yeah the weekend went well' and tried to get, you know...

274 PR: He um had a or asked for an appointment with me and he er... I think this has been so insidious that he's sort of almost beginning to wonder which is real and which isn't. And um you know when she accused him of doing this or that or... um they're just little annoying things...

275 P: Mmmm.

276 PR: And he was saying 'you know, I'm sure I don't do that to annoy her'... [general laughter] And he wanted to know more about it and how it'd affect them, and what this long term business was and...

277 CNC: Is he coming to those sessions in the evenings?

278 PR: No.

279 CNC: The schizophrenia ones.

280 PR: No.

281 CNC: It might be good. Perhaps we'll invite him to the next one.

282 PR: ... to the next one, perhaps. He's really missed the beginning of the explanation of what it is.

283 P: Did you have a film last night? Was that part of it?

284 PR: Yes, we saw something called "Madness" about that actor in London.

285 P: Yes, I've seen that one. I think there's another...

286 PR: ... but it got a bit long and we have to chop it off before it finished.

287 P: I'll check with [someone] about the program next week but I think it's outpatients and follow-ups and so on.

288 SW: Would it be any help for him to read Vaughn Carr's book... "Understanding Schizophrenia"?

289 PR: Yes. I...

290 SW: I've got a copy in there that you can use.

291 PR: Alright. I'm not sure at all whether- he says his English isn't all that good although he really does speak quite good English, but I suppose he reads English. I think he's um- I don't know what he is by trade. Let's have a look; I usually write that down... He's [a trades-man] so he probably would be able to read a book by Vaughn Carr.

292 SW: It's very easy to read.

293 PR: Mmmm.

294 SW: It's just a matter of whether he's the sort of person who would read, but, anyhow, it's there if it's any use.

295 PR: Alright, thank-you.

296 SW: Just to tide him over til the group comes, because certainly being able to talk about it with other people would be a helpful to, I should think.

297 PR: Okay. Well, query discharge later this week. Follow up in outpatients.

298 CNC: Yeah, compliance is a problem because that was really the precipitant of this admission as well.

299 PR: Mmmm.

300 CNC: Perhaps we'll- although yesterday there was a discussion about medications at the er...

301 PR: ... Mmmm.

302 CNC: ... community meeting. We'll see how much of that was absorbed. [pause] Her um blood-pressure has been stabled; she's on very low dose pimozide.

303 PR: It's 4mgs b.d. isn't it?

304 CNC: Yeah.

305 PR: Well, she got better on something like that- even less, I think, as an outpatient, once before. So, stop doing blood-pressure readings and...

306 CNC: Uh-huh. Actually, another one is [another patient], she's been on a blood-pressure recording and that's fine.

307 PR: Yep, you can stop that too. And [patient G] is the last one: 17 year old youth again mentally retarded with micro-encephaly and having epilepsy since the age of three months. And he had a- an acute psychotic episode and was admitted to [another hospital] and then on here for further assessment and treatment. And he's been... Did we detain him [names P.]?

308 P: No, I don't think we had to. No.

309 PR: And he's um improved considerably with thioridazine, and he was seen by the neurologist who really didn't address what I wanted him to address; to try to draw it all together and say well this person's got brain damage and then the epilepsy and now the psychosis, and whether anything else was there that we were missing. he sort of concentrated on- he didn't explain the sort of sudden on-set of the hallucinations, and bizarre behaviour and concentrated more on the Parkinsonism which are the side-effects of the thioridazine and wanted us to reduce it. But I didn't reduce it because he was still showing evidence of quite bizarre behaviour at that stage and um, he does look slightly sedated but he's not going to sleep in the day time. He does show- he's got his mouth open and dribbles a bit and um shuffles a bit but it's not too bad. And I think later on we'd probably reduce the dose but- have you seen him about, [names P.]

310 P: No, I haven't, actually.

311 PR: Welcome your advise about him.

312 P: Did he go out with the family at all at the weekend?

313 PR: Yes.

314 P: Or did they visit him here.

315 PR: No, he's been out for 3 weekends in a row, or 2, or 2 or 3.

316 P: Really? Overnight even?

317 PR: Oh, yes, Friday and Saturday night.

318 P: Oh, I didn't know they were doing that. Oh, good.

319 PR: And Mother said that he's actually improving; he seems to remember things better now.

320 P: Mmm-Hmm.

321 PR: And he's doing his old activities that he always does; he's got a series of sort of behaviours like when Dad's reversing into the drive, he gets his old- he's got an old car wheel and he gets that and goes like this himself and various other little mannerisms that he's just picked up and he's just slipping back into his routine. But, still not that- not their usual boy at all. And um- but he seems sort of amenable in the ward.

322 CNC: Mmmm. He's, he's restless and he's distracted a lot by what's going on around him but having his Mum in has been really helpful and she always finds him activities to do and controls him very well with firm limits. And she has been saying that she would prefer him to be home now. She feels that he would be better there.

323 PR: Yes.

324 CNC: And she would be happy to have him there.

325 PR: Yeah, right. When did she say that?

326 EN: When she come back from this last weekend, and she said it again too last night.

327 PR: Right.

328 EN: She feels he really does respond much better at home in his own environment and he's much better and like- apparently, he came back from leave and in here- and he did some sort of bizarre behaviour and he sort of urinated on the floor and she said 'I had nothing like that at home'.

329 PR: Hmmm.

330 EN: And you know she was really pleased with him on the weekend and... sort of...

331 CNC: He's eating well although he has lost weight again... from... well, he's lost a kilo.

332 PR: Mmmm. Well, um the Mother didn't [names G's Mother] didn't say anything like that to me this morning but she was saying 'well who do you think's going to follow him up? Will [names a doctor] who's a pediatrician, continue with his sodium valproate... Um, so I think she thinks that [another doctor] will finish with him when he's 18 or 20... and I imagine that he'll then refer him to a physician for his epilepsy.

333 P: He's 17 now, isn't he?

334 PR: Mmmm. And I would need to keep on seeing him for his behaviour and just sort of up or down his medication depending on whether he's psychotic or not. Um, and then perhaps would I then refer him back to [names a doctor] when things seem to be steady and [the doctor] could continue. Is that how you'd handle it?

335 P: Mmm-Hmm.

336 PR: Right. Well, we could have him go home later this week I suppose.

337 CNC: Or any time, really. His Mum is saying now.

338 PR: Tomorrow, if she wants to do that.

339 CNC: I don't what preparation she needs but she's saying that she would prefer him home.

340 P: Is she in today?

341 EN: Yes, she is in today.

342 PR: Everyday and the Dad's often in later in the afternoon.

343 CNC: Plus the daughter.

344 PR: Yes, the daughter was here yesterday, wasn't she?

345 EN: [patient A] was really upsetting them quite a lot last night and I think Mum was getting upset too at [A's] behaviour towards him. And I think she found that a bit upsetting too, as well, an sort of...

346 PR: Mmmm.

347 EN: That sort of thing and 'yes, he'd be much better at home' and...

348 P: [patient A] you mean?

349 EN: Yeah, [A].

350 P: She's so obtrusive.

351 PR: Oh.

352 EN: And, like, she really was treating him just like a baby, she was really rude, really but, I mean, that's just.... No idea but... you know, and was really upsetting the apple-cart cause Mum does control him really well and [A] was sort of interfering in her care and everything so...

353 P: Mmmm.

354 PR: Yes.

355 EN: It might be better if, you know, he did go home soon.

356 PR: Well, I'll put here: discuss with mother about discharge today.

357 EN: To see what, you know, to see if she is happy.

358 CNC: He's another who's been on the blood-pressure chart for awhile. It was around 110 on 70 last week, now it's 130 to 150 on 80. Hmmm, sounds pretty good.

359 PR: Well, I won't be changing the medication so he can probably come off that if you like. And I'd really need to see him in about a week I suppose after discharge, wouldn't I? Just to make sure things are progressing.

360 P: Mmmm.

361 CNC: It will be interesting to see how much he improves now [general agreement] that Mum claims his memory for things is coming back.

362 EN: Mmmm.

363 CNC: Because he was quite blue for quite a while at [the other hospital], I understand.

364 EN: Yes.

365 PR: Mmmm. Yes, she was asking me about that this morning, cause there are really two issues: he was quite psychotic before he went into the [hospital] and then he had his fit so [general agreement] she says: was he- do you think he's more brain-damaged now after he had that fit where he became so [inaudible] and the other issue is the psychosis; whether it's an acute brain syndrome from some or other whether it's an onset of a...

366 P: ... Schizophrenic...

367 PR: ... schizophrenic sort of thing, mmm.

368 P: With him it's very hard to say. I think perhaps only time will tell; we'll do a retrospective diagnosis after he's recovered then we'll - which it looks like he's on the way to...

369 PR: Mmmm.

370 P: And then we'll be able to see more clearly because we really- Mum knows what his base-line is, but we don't.

371 PR: Yes. And um... I just don't feel um as though I've seen enough people like this to really know the picture of psychosis when- in the- in the setting of quite severe mental retardation.

372 P: And Micro-cephalics usually die in infancy and it's unusual he's survived- he's certainly brain-damaged and he's got epilepsy, but he's alive and 17.

373PR: Mmm, mmmm.

374 P: Mind you, he might not make old bones but, on the other hand...

375 PR: What do they die of?

376 P: A fit often enough, I think. But they die in infancy they don't- they don't- they die very quickly after birth, you know.

377 PR: Mmmm. I suppose they don't feed, do they? They don't maintain their... input.

378 P: And some pediatricians have said in the past... perhaps it's better if they do.

379 PR: Mmmm.

380 P: But he's not a very severe one. I've seen much worse.

381 CNC: Do we have an intelligence um rating prior...

382 PR: No.

383 SCP: No, I don't think it would make much of a difference, really.

384 P: Yes.

385 PR: We've got the...

386 SCP: ... Medium I.Q. or low I.Q. does not make it...

387 P: ... Special School had a- had a rating on him, but we didn't bother

388 PR: This is a report of [gives a date] um for his reading subject: [G] works quietly, with good concentration, and socializes well with other students. [G's] concentration has improved, he's learning to write his name, address, and phone number. [G] is improving his ability and- of understand- his ability of most survival skills.

389 CNC: What are they? [general laughter]

390 PR: [gives date] for Art: He's keen and interested in all art activities. His quiet- his pictures show a pleasing form and he uses a good range of colours. Concentration's improved. [pause] Oh, [G]- this is a subject called "Myself and Others": We've been with the good and the not so good side of growing up in the teen-age years; more specifically we've talked about human sexuality and the facts of life. [G] has indeed been an attentive and a co-operative student

[laughter] however, he seems to lack the maturity and mental ability to relate to our discussion, still our discussions will provide a foundation for future learning, perhaps.

391 CNC: [laughs] We don't know.

392 P: But I hope he is.

393 CNC: He was running around [another patient's] bedroom this morning. [laughter] He was a bit lost I think.

394 PR: There's lots of other little reports. I don't think... we'd need to go through them here. But that would give some idea of how he's been.

395 CNC: Hmm, which is better than what he is at the moment cause he's got no concentration.

396 PR: He goes shopping for a short list of items; can successfully find the goods and make a purchase. In the preparation of food he lacks manual dexterity and needs plenty of direction. But he does willing do his bit. In cleaning-up, dishes wiping-up, [G] works willingly but his work needs some direction before it's thoroughly done.

397 EN: With all the fits and that he's had, would- would he really get back to what he was before, do you think? Would it be possible?

398 P: He's had fits since about 3 months.

399 EN: Yeah, but like they've been really bad, haven't they, and quite severe and sort of...

400 PR: Well, he had 2- 2 grand-mals this year, 2 grand-mals last year, and 18 small fits the year before.

401 EN: Yeah.

402 PR: Just short ones. So I don't know which is worse; lots and lots of small fits or just two grand-mals. I've no idea.

403 P: Mmmm.

404 PR: And the most recent one, I think, was fairly damaging; well, fancy going purple.

405 CNC: Mmmm.

406 PR: Anyway, there we are.

407 CNC: Right, that's that. Good.

408 P: Thank-you [names PR]

409 PR: Thank-you Dr. [names P.]

[it was then pointed out that the final 'thank-you' was for the benefit of the tape - laughter]

Appendix 5

Conference No. 9

Professionals present:

Psychiatrist (P)
Medical Officer (MO)
Clinical Nursing Consultant (CNC)
Psychiatric Nurse (PN)
Senior Clinical Psychologist (SCP)
Clinical Psychologist (CP)
Social Worker (SW)

001 PN: [already discussing patient A when tape recorder was switched on] ... had problems with the voices for about 10 minutes a day. So, I gather that was probably in the morning which seems to be her, her worst time.

002 CNC: Hmm.

003 P: Her sister's coming this week and she'll- I know she wants home as soon as possible that's what the request...

004 CNC: ... Yeah, they...

005 P: ... to be seen was about...

006 CNC: ... yeah, 17th she's coming.

007 P: That must be...

008 CNC: It's the 15th today.

009 P: That's right. Don't they [inaud.]

010 CNC: ... Mmm, mmm.

011 PN: She came in on the 11th of last month so...

012 P: ... Yeah, right...

013 PN: ...she's been... So, what she for?

014 P: For probable discharge this week, look, maybe today or maybe tomorrow let- let's wait 'til we've seen her to um yeah for discharge today or tomorrow, you could say that for sure. The follow-up is a bit tricky because I think she won't be able to be seen anywhere until January because that um Industrial Therapy business... Oh, no...

015 CNC: ... Hmm.

016 P: ... there was something else; [names a SW] told me about. [names the SW] was going to try to get her into another um employment assessment and [names SW] was going to talk to her about it.

017 CNC: So we just miss...

018 P: ... I don't know...

019 CNC: ... and make sure...

020 P: ... what has happened about that. Yes.

021 CNC: Hmm.

022 P: [patient A] is bored with I.T. and doesn't want to do it. She wants into STEP [S.T.E.P.] directly and then we'll do it directly and [names SW] came up with this... suggestion of- it's called something 2000, would that be right?

023 CNC: Oh, Prospect.

024 PN: Prospect 2000.

025 P: Prospect 2000?

026 CNC: Well it's the Pros- it's the Prospect health cen- centre, service.

027 P: Right... look I'll ask [names SW] about it before we see [A]... because it looks as if for a lot of people now discharge this week or leaving before Christmas. There'll be a real gap before...

028 PN: ... Mmm hmm...

029 P: ... [inaud.] will pick up you know. Everything really does shut down more or less.

030 CNC: Mmm.

031 PN: [names patient B] is our next...

032 P: Is she um... I was to hear from- by way of [names another SW] from her daughter as to [B] going home this week, I think. But not- I hadn't heard the details... Do you know?

033 MO: It depends...

034 CNC: ... Have we got a Social Worker around? Yes?

[SW enters. Laughter]

035 P: Here we have [names SW].

036 CNC: We need you [names SW].

037 P: We need you [names SW].

038 SW: Oh, that's so nice.

039 CNC: Lots of Social Work questions coming your way.

040 SW: Oh, are they? Hi.

041 P: It's about er- oh yeah well um [A] is definitely [names other SW] but er about [B]; when did the daughter say she thought she would- I mean we'll discharge [B] the- when it suits the daughter but...

042 SW: ... Oh say the end of this week.

043 P: The end of this week?

044 SW: Or even earlier.

045 P: Right.

046 CNC: [B]...

047 SW: ... At this stage...

048 CNC: [B], herself, seems to think Thursday afternoon would be the best time.

049 P: Thursday?

050 CNC: For her daughter.

051 P: Alright.

052 SW: That's why I'm late; I was just speaking to [X] cause they've got another nursing home for her closer to home...

053 P: ... Really?...

054 SW: ... but er she's got... her mother- Mrs [X] has got her mother-in-law and someone else coming over at around Christmas time so er [B] will have quite a bit of- number of people her own age to...

055 P: ... Oh right...

056 CNC: ... Hmm...

057 SW: ... to mix with...

058 P: ... right...

059 SW: ... and er she herself is not looking- getting [B] involved in a new community until some time early in the new year.

060 P: Right.

061 SW: So, she could be more or less discharged...

062 P: ... Right...

063 SW: ... say Thursday, fine...

064 P: ... Right, well put discharge 17th, then.

065 PN: Okay.

066 SW: I'll- I'll ring her and let her know.

067 P: Just incidentally...

068 CNC: ... Yeah its...

069 P: ... there's a person coming from just near [a country town] um who's to see me tomorrow, who the G.P. thought was a probable admission. And I said that I thought we might have a bed by tomorrow... Is that right [names CNC]?

070 CNC: Oh, sorry, I've had 4 days off...

071 P: ... I know...

072 CNC: ... I'm not up on who's...

073 PN: ... We're full up at the moment um...

074 P: ... Even if we haven't any bed on Wednesday, the girl coming from [the country town] has relatives in [this city] and would stay with them until we did have a bed. It sounded like it might be a genuine admission...

075 CNC: ... Mmm hmm...

076 P: ... but it's irrelevant at the moment. I was just thinking that if [B] is going on Thursday that'd be convenient.

077 CNC: Mmm.

078 P: And [A] maybe.

079 CNC: Well I don't know what's happening with [another patient].

080 P: She's- she's coming up for discussion at [names PR] meeting...

081 CNC: ... Yeah...

082 P: ... save it 'til then; I'm not sure myself.

083 SW: She's going home shortly, isn't she?...

084 CNC: ... She should be...

085 SW: ... she's due to go. There was discussion yesterday that she was um liked to go home later this week or something.

086 CNC: Hmm.

087 P: Yeah, but with all the support-systems in place and I'm not sure they are yet. I don't know what was arranged. Ah, we'll leave it 'til the red team meeting.

088 PN: Mmm hmm. Er [names patient C].

089 MO: [C]... I talked with her son yesterday and they think that she- that she's not any better, and why can't we get rid of the hot feelings in her head. And he wants to see- wants her to see a neurologist.

090 P: Oh.

091 MO: And I said I didn't really think it was appropriate and he said you can't do anything, why can't we see a specialist who can do something?

092 P: [pause] You could have said, of course, that his mother is beyond human aid but [laughter] she's meant to see...

093 MO: ... [laughing] I don't think that would have gone down particularly well.

094 P: [laughing] No, no. She's meant to see [a doctor] this week. Have we...

095 MO: ... Yeah, no, he knows about that um I said that we'd probably get a review of her before she goes 'cause she's refusing to take [a medication]. She says it makes her feel worse.

096 PN: She took it this morning.

097 MO: Yeah, I- I said you know- I mean it can cause indigestion.

098 P: Yeah, well, but she- but that's his territory so to speak...

099 MO: ... Yeah...

100 P: ... I think we ought not to change medication...

101 MO: ... No, no, no. I haven't changed it...

102 P: ... without consulting him. You haven't changed it, yeah, you stuck with it...

103 MO: ... I just told her to keep taking it.

104 P: Sure. But we'll have to ask for a review if possible this week.

105 MO: Yeah, he um... listen, I said, they'll be reviewing him but he's not impressed by that; he wants her to see a neurologist [laughs]. I'm not- don't know why he...

106 P: ... Look, he can arrange what he likes privately but from our point of view there's not indication to see a neurologist; it's just ridiculous...

107 MO: ... Yes...

108 P: ... and I'm going to stick to what I said which was that she'd be home before Christmas...

109 MO: ... yes...

110 P: ... I think, I expect anyway...

111 MO: ... he's asking why...

112 P: ... if [the other doctor] agrees...

113 MO: ... why the anti-depressants weren't- I mean because people have told him before that er it's a depression that's causing this...

114 CNC: ... Hmm...

115 P: ... Hmm mmm...

116 MO: ... and it's not improving with the anti-depressants- that's why he's...

117 P: ... Well, she's beyond human aid, you see, you can always say that she's beyond [laughter] all known anti-depressant help. No, I don't really mean that. It may be true, but I don't think we should say that [laughter].

118 MO: I mean I was reading her notes and on a previous admission in July- August, then the problem was for investigation of exactly that. She had C.T. head scans, C.T. [inaud.] scans...

- 119 P: ... I know, I know, I'm not repeating any of that rubbish...
- 120 CNC: ... Hmm...
- 121 MO: ... everything for the- the same symptoms.
- 122 P: Well, then she just goes home to her normal self which is... fixed into... hypercondriasis...
- 123 PN: ... Mmm hmm...
- 124 P: ... plus depression...
- 125 CNC: ...Mmm hmm...
- 126 P: ... and that's her normal self and if in fact we haven't been able to help it- she's now on er 60 mgs isn't she- no parnate, sorry 40...
- 127 PN: ... 40...
- 128 CNC: ... 40...
- 129 P: ... she's on 4 tablets; that's the full dose. I'm not putting it up to 6 - it theoretically can be done but I- I wouldn't do that...
- 130 MO: ... Right...
- 131 P: ... um...
- 132 MO: ... she's had tricyclimates before...
- 133 P: ... Yes, oh yes. She hasn't had mono-amy-oxidaze inhibitors and I'm not- I'm not putting it up more than that...
- 134 CNC: ... Mmm, mmm hmm...
- 135 P: ... if she doesn't respond to that then that's just it then.
- 136 CNC: Hmm.
- 137 P: She can go home on that medication, but without improvement. If that's the way of it, that's the way of it. We'll have done all that- as I've said is humanly possible although I think we might- we might phrase it more tactfully. I'll- I'll see.
- 138 CNC: Well, do you...
- 139 P: ... yes I'll see one of the relatives this week...
- 140 PN: ... They seem to have unrealistic expectations...
- 141 MO: ... some...
- 142 P: ... Well some of them do and some of them don't. The other half think she's as good as can be got [laughs]...
- 143 PN: ... Yes...

- 144 MO: ... someone I've been speaking to is... one specific one which seems to kind of...
- 145 P: ... He's the one who brought her in, I think...
- 146 MO: ... Yeah...
- 147 P: ... I recognized him.
- 148 MO: Yes, yes, and he's the one... that um keeps saying that she's not getting any better all the time whereas all the others seem to think she is.
- 149 P: Well, they think she's as good as she gets.
- 150 MO: Yeah.
- 151 CNC: Yes, her...
- 152 P: ... And I think that's what we have to go on...
- 153 CNC: ... daughters especially.
- 154 P: Hmm, yeah.
- 155 CNC: Er is that worth um a family- family intervention there with their mother? Or not?
- 156 P: Ye- the some doesn't live- it's his father that he's fussing about, he doesn't live with them...
- 157 CNC: ... Yeah...
- 158 P: ... and he's fussing that [C] is going to be too much for his father...
- 159 CNC: ... yeah they've...
- 160 P: ... when she goes home...
- 161 CNC: ... all got their own families but their...
- 162 P: ... Yeah, they do...
- 163 CNC: ... all visiting and- and feeding and washing and...
- 164 P: ... she gets a lot of family support...
- 165 CNC: ... doing, yeah.
- 166 SW: Like one- we did it with [another patient] one time...
- 167 CNC: ... Hmm...
- 168 SW: ... we had that family...
- 169 SCP: ... Yes, that's right...
- 170 CNC: ... just to get the family...

171 SW: ... and that proved to be useful. I'm not- I'm not sure that this one would be but I wonder whether it's worth just one session just to explain to the whole family as a family what's going on. I don't know.

172 P: Goodness, we've done an awful lot of interviewing...

173 SW: ... Have you?...

174 P: ... of individual family members...

175 SW: ... right ...

176 P: ... you're right, we haven't done it on block, but I think [the other patient] was a- a- she was a younger- middle-aged, wasn't she?...

177 SCP: ... Hmmm...

178 P: ... and there were young- it was- it was more of a kind of um...

179 SCP: ... It was different because er [the other patient] was actively excluding the other family members...

180 P: ... Hmmm...

181 [general agreement]...

182 SCP: ... from us so the strategy at that point was to...

183 PN: ... And she was telling them a whole pile of...

184 SCP: ... get the family involved so as to [laughs]...

185 PN: ... all sorts of rubbish...

186 P: ... Terrible lies, yeah...

187 SW: ... Right...

188 SCP: ... break down these er the barrier between us and the family and that seemed to work quite well.

189 P: Hmm.

190 CNC: But- but isn't [C] splitting her family up in as far as- especially the sons protect mamma and and do what mum wants and the dau- it seems to me that the daughters are the ones who- who understand their mum is a hypochondriac and don't expect much out of her other than demands.

191 SCP: Mmm hmm.

192 CNC: I mean, isn't the family at the moment divided and- and- and er being split really by her behaviour?

193 SCP: Have you talked to the son?

194 CNC: I haven't seen the son...

195 P: ... Oh, this was- this was who um...

196 SCP: ... Yes...

197 P: ... [names MO] saw yesterday...

198 MO: ... cause um when you talk to the daughter you get a totally different view.

199 CNC: [names other SW] saw her yesterday.

200 PN: Yeah.

201 P: You see I think this really hinges on the old boy being 78 and not too hot. He's a bit fragile and really...

202 CNC: ... Hmm...

203 P: ... the only two people who live together are [C] and her husband...

204 CNC: ... Hmm...

205 P: ... the others visit but they don't live together...

206 CNC: ... Hmm...

207 P: ... And I think the son's fussed about- about the old boy and I don't quite know how much help he needs and maybe that's at the back of it. Um, she gets daily visitors, we're bound- I'll catch up with them this afternoon.

208 CNC: Definitely, yeah, they're always here...

209 P: ... With who ever comes in this afternoon. Hmm, we'll do it together- oh, no you've got the afternoon off, haven't you?

210 MO: Oh, I don't mind which afternoon I take, it doesn't have to be today...

211 P: ... Take a firm stand, otherwise you won't get one [laughter].

212 MO: Oh, I'll have one, don't worry about that.

213 P: That's a good girl.

214 MO: I might save it for a bit later in the week, though.

215 P: Right, okay...

216 MO: ... It's only Monday or Tuesday [laughter]...

217 P: ... I know, it only feels like the end of the week already.

218 SCP: Yes, because I don't know how much cultural aspect we have to build into this, I mean...

219 P: ... Hmm...

220 SCP: ... A 71 year old Italian lady...

221 P: ... She's fixed in her pattern...

222 [general agreement]

223 SCP: ... and the son is concerned about her...

224 P: ... Hmm...

225 SCP: ... She's hypochondriac...

226 P: ... Hmm...

227 SCP: ... but the son sees it is his duty to...

228 P: ... to look after his father, I think...

229 SCP: ... to look after his- yes...

230 CNC: ... Hmm...

231 P: ... he said she was driving the old-boy nuts.

232 SCP: Hmm.

233 MO: Hmm. Yeah, well I think she is- I mean she's terrible...

234 PN: ... She's driving us...

235 SCP: ... [laughs]...

236 P: ... Is- is she? [laughs] Well, I mean in the general sense [laughs]...

237 MO: ... Well, she refuses to do anything...

238 CNC: ... It's just that- [laughs] there's no change...

239 MO: ... complaining all the time, you know...

240 CNC: ... Hmm...

241 P: [pause] Right. Okay, I'll see him this afternoon, and I still think that, if [the other doctor] agrees, it'll be discharge before the end or by the end of this week. But we must get hold of his registrar, love.

242 MO: Oh yeah, I'll- I'll ring [names someone].

243 P: Good.

244 MO: They're hard to get ever since I had to give them [C], understandably...

245 P: ... I know, I know, I realize she's not anybody's favourite patient [laughs]...

246 MO: ... but I'll persist on this occasion [laughs] cause he hasn't really seen her properly.

247 PN: Right; [names patient D] is next... so...

248 P: ... Oh, yes...

249 PN: ... he was having problems with side-effects over the week-end.

250 P: Yes.

251 MO: Yes, he's got that head- head-tremor and um...

252 PN: ... Hmm...

253 P: We halved his fluphenazine...

254 PN: ...his fluphenazine...

255 P: ... we increased his bztropine and I spoke to him yesterday [names MO] and said that he was not to nip off early which he'd thought, like yesterday...

256 MO: ... Hmm, oh I did tell him...

257 P: ... you said the same, until we'd had time to assess what the changes were going to do for him...

258 MO: ... Hmm...

259 P: ... but somebody said that perhaps what had brought [D] back to the point of wanting early discharge was [another patient's] return. She was making a play for him and he was kind of um... like a big sook going a long with it [laughs]. I don't know, is that right?

260 PN: He doesn't seem to be rejecting any...

261 P: ... That- that's what I was afraid of...

262 PN: ... and he plays this role...

263 P: ... and I'd rather he rejected her...

264 PN: ... Hmm...

265 P: ... Yes... I wonder- I wondered if that was connected with why he so obligingly said to me oh if you want me to stay in a few days...

266 PN: ... Yes, yes...

267 P: ... more, that will be alright he said...

268 CNC: ... Hmmm...

269 P: ... and then I saw him and [the other patient], heads together and looking very um...

270 PN: ... Then we might have...

271 P: ... cozy...

272 PN: ... to- have to treat him for infestations as well.

273 P: Oh, look for heavens sake is she not clear- she must be clear by this time, she's been scrubbed so often.

274 CNC: Hmmm.

275 P: This is an outbreak of scabbies in the ward which we wanted confined to just the one person who had it who's not on this team meeting um and er we didn't want her infecting anyone else.

276 MO: I think I've caught the itches [laughs].

277 P: I know [laughs].

278 CNC: It is infecting isn't it?

279 P: It is, I know.

280 PN: So, if he has no more problems...

281 P: ... Well, yes by the end of this week I might give him another weekend with a very early discharge, like discharge Monday...

282 CNC: ... Hmm...

283 P: ... that sort of thing...

284 PN: ... Right...

285 P: ... I just wanted time for that- for the head-tremor to subside, the finger-tremor to subside, the medication to get into balance, and maybe stop the fluphenazine perhaps even... not against that but what...

286 MO: ... but in that case...

287 P: ... what we did in that case was to cut it down by half...

288 MO: ... Hmm...

289 P: ... and we might cut it again by the week-end perhaps and then work out his next dose um of flupenthixol which is just before Christmas, isn't it?

290 MO: Hmm, yeah.

291 P: Yeah. And then out-patient follow-up after that. We can work all that out in a day or two.

292 MO: Yep.

293 P: Oh, I guess, if [that other patient] is the one who keeps him happy, well who am I to object?

294 CNC: Oh.

295 P: [laughs]

296 SW: She keeps anybody- everybody happy that goes through the place...

297 CNC: ...Yes...

298 SW: ... [names another patient]...

299 PN: [laughs]

300 SCP: Are there any others in the ward that have been infected?

301 CNC: No [laughs].

302 P: Well, there was somebody who went to an old ladies home that slept in the same bed as [the patient with scabbies] and [laughter] we were uncertain as to whether it was a direct causal effect there or not... um, it's been dealt with...

303 SW: ... [inaud. laughs]...

304 CNC: ... Yeah...

305 P: ... people scratching is just- staff scratching is just er peeling sunburn, that's what it is...

306 MO: ... Yeah, it's very difficult to catch scabbies unless you sleep with them of something like that...

307 SCP: ... Yes...

308 P: ... in my case any way [laughs]. Don't do that [laughter]. Right.

309 PN: [names patient E] is next.

310 P: I- I- I'll just mention that I- the legal side of it; they wrote to me form the guardianship board a letter which fortunately they didn't pass on to her because the letter is...

311 CNC: ... [laughs]...

312 P: ... couched in the most negative terms. Have you got the letter there, love, I'll read it out?

313 CNC: Yeah.

314 PN: It's in the back.

315 P: It's in the back of...

316 CNC: ... Their impression is negative?

317 P: Theirs. The first bit of the letter- the front bit of the letter is what [E] got which is the ordinary thing saying that she's got to be reviewed after the 8th of January and... so on.

318 CNC: By the board?

319 P: Oh by the board yes...

320 CNC: ... Oh yeah...

321 P: ... but not necessarily there, a report may be enough...

322 CNC: ... Oh yeah...

323 P: If she's doing well and they cancel it that's fine, if she's not doing well and they want a month's extension that's fine. It's not a personal turn up. But on the back of it, Mr- I'll read it cause really as I said you wouldn't want a patient to read this. This was addressed to me: [someone] addressed the meeting, he said: I think it is important that the doctors should know the reason for our decision and should be sent a copy of this summary with the order. We have not found it an easy matter to reach a decision. We have decided that we do have jurisdiction

to make a guardianship order because we believe that you - it's addressed sort of to her but not directly - that [E] has a mental illness which has serious implications. We have, after giving the matter careful thought, reached the decision that, because of your illness, and also because of the complications caused by anorexia and your low intelligence, [laughter] you are not able to make an informed decision about whether or not you should have - and then they don't blench at it - shock treatment. Most difficult decision to make. We believe that shock treatment - this bits alright - is likely to be beneficial [laughs] - I wish they wouldn't call it that. The difficult aspect...

324 PN: ... Yeah...

325 CNC: ... Hmm...

326 P: ... [continuing to read] is er in making a finding that a person is not able to make an informed decision about it so we therefore make the guardianship order and give our consent to further E.C.T. extended over a period of a month as of - er the original date. We will not restrict the treating doctor to 7 or 8 treatments but will limit for a period which will commence from the date of the order and will expire on the 8th of January and review the situation in January. We are influenced in the decision you had E.C.T. in the past and, according to your family, you did benefit; you had better health for a while and went back to living in the community. [stops reading] I've worked it out that the 12th E.C.T. will be about Christmas eve; about the Wednesday and if there's a natural break then, which there will be in any case...

327 CNC: ... Hmm...

328 P: ... and I'm away for a fortnight's holiday but [another psychiatrist] will review her. And I don't think they'll ask for the er report of the 8th which is um a Friday, I think, I'll put it in when I come back on the 11th or 12th - am I right?

329 PN: I think it said something about within 28 days of the- on the bottom of the...

330 P: ... sorry the paper [inaud.]...

331 PN: ... when they want the report.

332 P: 28 Days of the 8th, is it? 28 days of the... [reads] [names herself] must report to the board within 28 days of the completion [stops reading]...

333 CNC: ... Oh, right...

334 P: ... So that gives me 28 days from Christmas...

335 CNC: ... Mmm hmm...

336 P: ... So I've got time to do it. Now I spoke to [E] about that yesterday- er not about the bit I read out to you, of course, about the- just the formal arrangements and I said that we hoped that she'd be finished- we expect she'd be finished E.C.T. by Christmas. She said I want to spent Christmas with the family; with [names E's child], and I said fine but you know your weight has to be good by then. And it's not discharged on Christmas, I didn't want her to think she was going home...

337 CNC: ... Hmm...

338 P: ... well for good but she can probably have a few days leave. Um and then I explained about me being away and [the other psychiatrist] would check her in January and she just said um... I just want to lose more weight and exercise more and I'll be right.

339 PN: Hmm.

340 CNC: [laughs].

341 P: So I said don't pursue that line [laughs] it won't do you any good. Um.

342 CNC: Yeah well.

343 P: Her weight is in fact still going down, isn't it or...?

344 PN: Yes, it had- she hasn't been weighed this morning...

345 P: ... No...

346 PN: ... but she'll be weighed tomorrow, but she was at 42 yesterday which is the lowest that she's been since admission...

347 CNC: ... Hmm...

348 PN: ... and it's been a gradual down...

349 P: ... Yes...

350 PN: ... downfall...

351 CNC: ... She was about 43 something...

352 PN: ... no matter how- how many times...

353 P: ... And she's been seen to eat. The point is she's seen to eat and the exercising is done...

354 PN: ... yeah, and her diet has improved...

355 P: ... yeah, better mixed diet...

356 PN: ... but she's still obviously doing something or- also the hot whether- she's...

357 CNC: ... a bit dehydrated...

358 PN: ... bound to lose something...

359 P: ... I can [inaud.]...

360 PN: ... So she's- to chart her fluid- I've got her to chart her fluids as well...

361 P: ... Yes, I saw her [inaud.]...

362 PN: ... But [another professional] made a suggestion this morning that we could possibly use the um fact that she wants to be with [her child] at Christmas...

363 P: ... as a...

364 PN: ... as a proverbial carrot...

365 P: ... Right...

366 PN: ... that she needs to maintain a...

367 P: ... something...

368 PN: ... a- a set weight...

369 P: ... yeah...

370 PN: ... according to us, for her to be able to do that.

371 P: That's a very good line.

372 PN: So...

373 CNC: ... [names SCP], [E] was the one that we mentioned at last week's meeting about some type of um behavioural program or contract. She's intellectually disabled...

374 P: ... Yeah, [names SCP] knows her.

375 CNC: Right.

376 SCP: Yes.

377 P: Is a kind of- what were the use- a kind of token-economy almost, was it?

378 CNC: Well, it can be a token thing.

379 P: Yes.

380 CNC: Well basically exchange...

381 SCP: ... The main problem is her not eating...

382 CNC: ... for behaviour and benefits...

383 SCP: ... vegetables or...

384 PN: ... Yeah.

385 P: Except that now it's visibly eating- she is eating but...

386 CNC: ... Um...

387 SCP: ... But she's doing...

388 P: ... but still losing...

389 SCP: ... other things to...

390 MO: ... Lose weight...

391 P: ... Well, we think it's the exercising.

392 PN: Yeah, what she does is she says now because- in the past it was we wanted her to eat a reasonable diet. She's saying now well I'm eating, but she's...

393 SCP: ... Hmm...

394 PN: ... she's still not gaining weight...

395 MO: ... Exercises to lose it...

396 PN: ... Well, it worked a little bit on the weekend because of the fact that- that on Saturday when she hadn't lost- when she'd lost some weight she wasn't to go on leave, she gained that weight and a little bit more on Sunday so that she could go on leave. But then she's lost it again... since then so.

397 CNC: Um in- in conversation she often- often picks a topic for a day. So on one day you'll get- any conversation she's involved with is all- will all end up the same way, like- like, well, last week one of them was that aw are you accusing me of being a bad mother, are you?

398 SCP: Hmm.

399 CNC: And the next she's said that to everybody- she steered conversations...

400 SCP: ... Hmm...

401 CNC: ... so that was her issue for the day.

402 PN: Yeah she changes the subject when you talk to her...

403 CNC: ... As well as; she wants to donate blood and um...

404 P: ... God...

405 CNC: ... be careful of her diet because of all the starving people in the world. So it's quite inappropriate and even though you say, you know, alright that's it, we've had our conversation, let's look at how you can do things other ways...

406 SCP: ... Hmm mmm...

407 CNC: ... it goes straight it goes straight back to the same things. So, she does- she does go back to certain issues of losing weight to save people in the rest of the world, and um, people misunderstanding her and just trying to tell her that she's an awful mother.

408 SCP: Hmm.

409 CNC: [pause] And [her child] is- is the prime carrot in her life. That she can have invol- you know, see her.

410 P: I think if- by the way the- the family's Christmas is to be held at the house of the sister that [E's child] is staying with...

411 CNC: ... Yeah...

412 P: ... so that she very much wants to have Christmas there with [her child] but also with her sister and her parents; they'll all be there, the other sisters as well.

413 SCP: Oh, that's down at er [names a suburb], isn't it?

414 SW: Mmm hmm.

415 P: Yes.

416 CNC: Yes.

417 SCP: Yes.

418 P: So- so we- I- I think that's a brilliant idea that [someone] dangles in front of her... any more weight loss and Christmas is out.

419 PN: Did we decide upon a- a...

420 SCP: ... Yes, I mean knowing...

421 PN: ... target...

422 SCP: ... [E]- I mean it's really hard to motivate her on the ward level...

423 P: ... at ward level...

424 SCP: ... and the only incentive that we can use is [her child]...

425 P: ... Yes, yes...

426 SCP: ... and er so we can make out a sort of contract that um she- her weight has to stabilize and...

427 P: ... I- I like to...

428 SCP: ... before we can send her...

429 P: ... like to say to her; look you get up to 44 by Christmas or... you don't go out. Or do you think that's too harsh?

430 PN: That's 2 kilos, from where she is at the moment.

431 P: Yeah, 2 kilos in what? We've only got a week or so, perhaps.

432 PN: So, 43 and a half?

433 P: Yeah, that'd be fa- fair, you're right, you're right.

434 CNC: Stay at admission weight.

435 P: Yeah, oh no, it's well below admission weight.

436 PN: Admission weight's way up.

437 CNC: Oh, God.

438 PN: Yeah, see like- see she's steady- steady decrease.

439 CNC: Hmm.

440 P: But- but still, two- a kilo... it's a wee bit- it's a week and a half. Yes, it is a week and a half.

441 PN: It's 10 days.

442 MO: It's only...

443 P: ... 10 days, yes I think that's not unfair.

444 PN: Okay, 44 then. Okay.

445 CNC: And- and is that including things like shopping... privileges and um leave privileges...

446 PN: ... Yeah...

447 CNC: ... as well?

448 PN: Well, I've said- said to her...

449 P: ... Well- well we've already started the leave thing. She can't go on weekend leave unless she's up.

450 CNC: Mmm hmm.

451 P: That's most significant that she got up- between Saturday and Sunday she got up.

452 PN: Hmm.

453 P: That's very important that is. She doesn't seem to be a vomiter; no-one has observed her vomiting.

454 CNC: No.

455 P: [pause] She's so gormless I- probably so- I honestly feel if she- if she were vomiting, somebody would have noticed, you know?

456 CNC: Hmm.

457 P: She wouldn't be able to conceal it. I don't she is doing that; I don't think she's ever done that.

458 CNC: No she's only been observed to be- to do a lot of exercising prior to coming down stairs and having breaky and...

459 SCP: She's just what? Walking around or?

460 CNC: Aw um, on the floor; leg exercises and um this sort of thing.

461 SW: Hmm. Even then she shouldn't lose that much weight should she with just some exercising? You'd have to do a lot of exercising a kilo of weight.

462 PN: Oh yeah, but when you're down- down to that...

463 P: ... level, yeah...

464 PN: ... level already.

465 MO: I mean the point of that- a lot of that would have been fluid. If she went home...

466 PN: ... Yeah...

467 MO: ... and she wasn't drinking particularly well on the Sunday.

468 SCP: Does [E's child] come and visit her?

469 P: NO, she has to taken to er to the sister's house.

470 SCP: Hmm.

471 P: Now, for instance, she can go and see [her child] Saturday and Sunday, if she managed to gain something between now and then. She could have 2 days out to see [her child] provided she gains- not- not lost, but positively gained.

472 PN: [pause] Well, shall I draw up, maybe a written contract?

473 P: [pause] You see, she's so dumb, love, I don't think...

474 PN: ... In fairly simple terms...

475 P: ... yeah, [laughs].

476 MO: You will do this or we'll do this...

477 CNC: ... Well she's got to understand that we're concerned about her weight...

478 P: ... Mmm hmm...

479 CNC: ... and- and...

480 P: ... It's just that would- would- well it's just that the written bit- doesn't mean much to her.

481 PN: No.

482 P: I think it would be more verbal and reiterative, you know, if you went over the ground over and over again. You know, between now and Friday she's got to gain or she won't see [her child] Saturday or what. You know, all that. [pause] Oh dear.

483 PN: [pause] [names patient F].

484 SCP: I thought that [E]- would that be too much hassle say to take her weight on a t.d.s. basis? I mean, it's a kind of a reminder that...

485 PN: ... Mmm hmm...

486 P: ... It's...

487 SCP: ... er you take her weight oh twice a day or daily or...

488 P: ... I- t.d.s.; it depends on things like whether you've had a piddle before and or not [laughs]. I don't think it, do you know what I mean, it's...

489 SCP: ... yes I...

490 P: ... it's subject to very minor variations but it's done at the moment...

491 SCP: ... because- because of her low intelligence, I mean we really have to...

492 PN: ... yeah, well we're doing it...

493 P: ... Oh I see, I see what you mean...

494 MO: ... if we keep weighing her...

- 495 P: ... to get it across to her...
- 496 SCP: ... to reinforce the idea that er...
- 497 CNC: ... Yeah...
- 498 SCP: ... that she has to maintain her present body weight or er...
- 499 PN: We were doing it randomly...
- 500 SCP: ...yeah, right...
- 501 PN: ... but we could do it on a regular basis.
- 502 SCP: Ah huh.
- 503 CNC: Problem would be to um- her getting changed all the time.
- 504 PN: Well what about daily basis then?
- 505 CNC: So that we're weighing her in the same articles of clothing otherwise...
- 506 P: ... Oh yeah...
- 507 MO: ... you could weigh her in a gown actually...
- 508 PN: ... if we did it on a daily basis...
- 509 MO: ... in the same...
- 510 CNC: ... well at the moment that's what she does in the morning. We just have to organize that.
- 511 P: When she's weighed tomorrow... that's after E.C.T. and after breakfast, is it? Or before?
- 512 PN: Before.
- 513 CNC: Before.
- 514 P: Oh.
- 515 SCP: But- but the whole idea is to reminder her...
- 516 PN: ... Mmm hmm...
- 517 SCP: ... constantly...
- 518 P: ... yes...
- 519 SCP: ... ah that she has to maintain her body weight...
- 520 PN: ... Well she could- she could be weighed in the morning...
- 521 SCP: ... Yes...
- 522 PN: ... once she gets up in her night clothes and then as she goes to bed when she's in her night clothes.

523 SW: Even if you did it say 3 times a day and then just averaged the weight.

524 SCP: That's right.

525 SW: You just divide it by 3- you just have one weight.

526 CNC: But she wouldn't be able to work that average out.

527 SW: No we wouldn't- she- she wouldn't have to but we would in terms of being- you'd still have to reinforce her by being weighed 3 times a day...

528 CP: ... Mmm hmm...

529 SW: ... by taking an average you reduce some of the highs and lows...

530 P: ... Yes, I see what you mean...

531 CNC: ... Hmm...

532 SW: ... and then er bring it back a little bit so that we can have something to work on while still providing the reinforcement.

533 P: I think that's a good idea, but can the nursing staff fit it in?

534 CNC: I think that all she would see would be the other weight and if she's is weighed in clothes at lunch time that gives her a couple extra points. That's what she'd remember.

535 SW: Yeah, that's a point.

536 CNC: Even though we are talking about averages, she...

537 P: ... Well er, is b.d. best? Once in the morning and once at the night when she's in her night clothes..?

538 PN: ... yeah, once in the morning- and when she's in her night clothes.

539 CNC: Well... we want it around eating time.

540 SCP: Well the actual reading is- is not that important really as the whole idea of reinforcing...

541 CNC: ... Hmm...

542 SCP: ... this weight business to her; that she has to gain some weight before she is allowed to see [her child]. That's more important than the actual weight.

543 PN: I suppose...

544 CNC: ... Well we...

545 PN: ... maybe prior to each meal...

546 CNC: ... she could just use a white gown, I guess.

547 P: Yeah.

548 CNC: And she'd just have to strip off and get dressed.

549 CP: Is- is her er food being monitored as well?

550 PN: Yes.

551 P: Oh yes.

552 CP: So that's being...

553 PN: ... and that has improved...

554 CP: ... and her exercises?

555 P: Yes, yes.

556 SCP: So it doesn't really matter whether she is 42.7...

557 CNC: ... The exercises to a point...

558 SCP: ... or 42.6 kilos...

559 P: ... yeah, yeah...

560 SCP: ... doesn't really matter. The whole idea is to keep reminding her that she has to watch her weight...

561 P: ... Yes...

562 SCP: ... and make some improvement um...

563 P: ... She was on fruit juice and tomato only...

564 SCP: ... before she allowed to go on weekend leave...

565 P: ... when she came and she's now on a much more mixed diet.

566 CP: Yes, yes.

567 P: So that bits- um we're not unhappy about the diet bit...

568 CP: ... well so...

569 P: ... but you're quite right it's- we don't seem to be getting it home to her.

570 CP: The reinforcer I would have thought might be better with- with the food and the eating behaviour because I- the- the weight side is a bit abstract. I mean it's- it's...

571 CNC: ... Mmm hmm...

572 CP: ... not something you can always control, but you can control the eating behaviour.

573 PN: Mmm hmm.

574 CNC: Hmm.

575 CP: Um you know, if you...

576 PN: ... yeah her- her eating behaviour has improved.

577 CP: Well that- that- I mean logically if that- I mean [laughs] it's a bit unfair if she keeps eating more and more and her weight doesn't go up...

578 PN: ... Yeah...

579 CP: ... then you have to say; look, you know, why should she be penalised for the fact that her- her metabolism for some reason isn't- isn't- is...

580 P: ... Oh...

581 CP: ... is doing whatever it's doing um...

582 PN: ... well what she's doing is she's eating and then she's- because that was issue originally, we were saying; look [E] you're got to eat a reasonable meal, so now she's saying; well am I eating a reasonable meal? But then she goes off and she does these exercises and things in the morning...

583 P: ... Yes, she does...

584 PN: ... to lose the weight...

585 P: ... oh she sneaks off to do those, that's not done under our eyes...

586 PN: ... and she wasn't drinking either so she was losing weight because she had- she wasn't taking in her fluids. But now that's- she has to chart her fluids as well so that's increased it.

587 CP: Hmm.

588 CNC: She's not eating enough to put on weight.

589 [general agreement]

590 CNC: She's eating better than... tomato and orange juice...

591 ... [general agreement]...

592 CNC: ... but, yeah.

593 CP: Well maybe I- I'd think though that aim to- to get her to eat more.

594 CNC: Yeah.

595 P: Oh yes, even more, you mean.

596 CP: Hmm.

597 P: Yes, you're quite right.

598 CP: And encourage her to do that...

599 CNC: ... yeah...

600 CP: ... you see- rewards...

601 CNC: She loves cooking; she does a lot of cooking but um...

602 P: ... She doesn't eat it...

603 CNC: ... feeds it to everybody else. Typical story, I suppose.

604 P: [pause] [sighs] Yes.

605 PN: [pause] Actually, when you were talking about- you were glad she didn't get that letter; she was told all that there anyway...

606 P: ... I know, I know she was...

607 PN: ... and when she came back she was quite angry being told...

608 P: ... I know...

609 PN: ... Low intelligence!

610 CNC: [laughs]

611 P: Yes, I know. Um but just the phrasing of it seems to be very unfortunate; it seems to be very legal rather than psychiatric.

612 PN: Hmm. I wish they wouldn't call it shock treatment.

613 P: I know, I know. [pause] Well, [names patient F].

614 PN: [F].

615 P: She's our last, is she?

616 PN: Er no, I actually left out [names patient G]; we've got to go back to...

617 P: ... He's actually today...

618 PN: ... Yeah, today...

619 P: ... Yes. I saw him last night when he came back and he said er everything was well and he wanted to keep this up...

620 CNC: ... Yeah...

621 P: ... for a few days. And I said alright, I hope...

622 PN: ... Yeah, well evidently [another patient] has been evicted from the...

623 P: ... Evicted?!...

624 PN: ... flat, too. Something to do with...

625 CNC: ... Yep...

626 PN: ... having boozey party- parties and the police being called around...

627 CNC: ... that cheque- that cheque that disappeared...

628 SW: ... Ah...

629 PN: ... and whatever...

630 P: ... Good Lord...

631 CNC: ... He had- he had cashed those cheques that [G] had asked him about when you went home with him.

632 P: Oh heavens!

633 SW: So [G] finally found that out did he?

634 CNC: Yes; 300 and something dollars worth.

635 P: And the...

636 SW: ... No wonder he didn't last- the money...

637 CNC: Yeah.

638 P: And the eviction is er right now, you mean? Or is [F] putting him out?

639 SW I wouldn't know, myself.

640 CNC: I haven't heard.

641 P: Or the landlord putting?

642 PN: See this is- we're just sort of hearing...

643 P: ... Well one just discovers it, yeah...

644 PN: ... it from [G] so we don't know.

645 P: Could- could we find out from the landlord, maybe, what the facts are? It was a rent-free care-taking arrangement and that boy certainly could be thrown out, I'm sure, if the landlord wanted it.

646 SW: He'd probably go back to Offenders-Aid which is where he was before.

647 CNC: Mmm hmm.

648 P: Yeah. [G] must be livid over the two cheques...

649 CNC: ... very angry...

650 P: ... 300 dollars gone!

651 CNC: Well, yeah, he's been angry all the time at other people and now I guess with [the other patient] having dug his own hole really...

652 P: ... Mmm hmm...

653 CNC: ... that that's going to solve a lot of problems for [G] in that [the other patient] won't be home...

654 SW: ... It was the straw that broke the camel's back.

655 CNC: Hmm.

656 P: Do you mean [G]- well it sounds as if [G] is better off without [names G's son].

657 CNC: Hmm.

658 SW: I think they're probably better off without each other.

659 PN: They're probably both better off.

660 CNC: Both of them, yeah.

661 P: But will [names G's son] see it in that light? Is that what you're saying?

662 SW: [pause] I think [G] has got a lot of guilt feelings about the son, but I think that the behaviour problem is reinforced that hey it's just not going to work. Although [G] was reluctant to accept for a long time that his son had spent the money, cause I asked him; what do you think? And he kept sort of saying; no I don't think he has, no he hasn't, well perhaps he has, but no I don't think so. And he sort of played games so this is finally brought out all the anger by the sound of it. Cause also the will was an issue you see, where he lost- he didn't...

663 CNC: ... Mmm hmm...

664 SW: ... wasn't a beneficiary of the will and the son got a couple of thousand and spent it all on stereos and stuff like that.

665 P: Actually [the son] is only 16, he shouldn't have had his hands on it!

666 SW: So, it will be interesting to see what [F] does now. [pause] I wouldn't be surprised if, in 2 weeks time, their back again but...

667 CNC: You reckon?

668 SW: Hmm.

669 P: [pause] Anyway, I don't know if [G] knew that at 4 o'clock yesterday, which is when I saw [G], he was just back from work and said he just wanted to continue for the rest of this week. And I couldn't see any reason why not.

670 CNC: Mmm hmm.

671 P: And it's only recently that we've heard about this cheque thing, is it? Last night or something?

672 PN: Hmm, and later.

673 P: Yes, yes. Okay er...

674 PN: ... Are there any plans for...

675 P: ... for [F]...

676 PN: ... [G]...

677 P: ... well maybe [names SW] would enquire about the landlord bit of it- side of it and, in the meantime, I'm happy to let [G] stay. And I'll- one or other of us much catch up with him some time...

678 MO: ... Hmm...

- 679 P: ... He comes back about 4, at least that was when I saw him yesterday.
- 680 PN: Yeah he's going to be back a bit early today so...
- 681 SW: ... But did [G] say that the son's eviction equalled his eviction?
- 682 P: No...
- 683 PN: ... No, no, no, [G] can stay...
- 684 P: ... only the son's eviction...
- 685 SW: ... I wouldn't have thought so. Right so- I mean if his status quo is still the same then...
- 686 P: ... then that's alright...
- 687 SW: ... he can be discharged any time, couldn't he?
- 688 P: Yes. Well the end of the week is what he asked for...
- 689 SW: ... Right...
- 690 P: ... and that bit's alright. Uh huh.
- 691 SW: Well I'll chase that other bit up.
- 692 P: Right. I think I'd just like to know the facts, if you know what I mean.
- 693 SW: Just curiosity, yeah.
- 694 PN: So he's a probable discharge for the end of this week?
- 695 P: Well Saturday when he finishes work or something, yeah. [pause] Sorry, [F] we don't seem to have tackled yet [laughter] We er...
- 696 MO: ... With good reason...
- 697 P: ... We haven't been able to get hold of her husband or her son. But she says she's going to look it up in the phone book and give us the work number of the son today.
- 698 SW: Oh the son works at [names a place], I can get you the number if you like.
- 699 P: Oh could you [names SW]. She said [names the same place], it's just....
- 700 MO: ... Hmm...
- 701 P: ... that her eyesight wasn't good enough to look it up in the phone book, she said.
- 702 SW: Yeah.
- 703 P: If you give us the number that'd be great cause what we're really keen to work out is er- we haven't seen anyone since the weekend.

704 SW: Hmm.

705 MO: Haven't seen anyone for a while.

706 P: If you've got the number that's terrific; we'll ring him then. That's great.

707 CNC: Yeah and she's getting more agitated here and- and continually asking for leave for home and again she wanted that this morning. So we asked her to phone up her husband or some- this evening and ask them if they need her at home for anything. So that put her off another day.

708 P: Yeah. And I want her to have the next Modecate before Christmas. I can't remember the date it's due.

709 CNC: Last one on the 7th.

710 P: Well it's due on the 21st. [pause] Ah.

711 CNC: Well I'd say she'd come back as a day patient.

712 P: I think she probably would, I think you're quite right, if she- if she were promised, I think...

713 CNC: ... Yeah, well if not [a member of the nursing staff] could go out with um...

714 P: ... yeah that's right we could fix that up before Christmas...

715 CNC: ... somebody and...

716 P: ... And you know, I wanted her to have it before Christmas then the gap doesn't matter. Um [names nurse just mentioned] away I know for 3 weeks.

717 CNC: Yes, [names a replacement] will be in there, in out-patients.

718 P: Good.

719 CNC: But, yeah, I think [F] is just much status quo, really...

720 P: ... Yeah...

721 CNC: ... and just getting agitated by the few people around here who don't respect her.

722 PN: Yeah, [E] stirs her up a bit.

723 P: Mmm. She and [another patient] have no sort of common ground at all...

724 CNC: ... No...

725 P: ... in spite of speaking Italian. And I mean why should they; it's not enough common ground [laughter].

726 CNC: I think that's [the other patient]; she's a very selfish, single minded woman who wants to just stay all by herself.

727 P: Yeah.

728 CNC: And she gives everyone that message around here...

729 P: ... I know...

730 CNC: ... I'll make my own tea and sit by myself, and if someone sits down there she gets up with her pillow and bags and off she goes.

731 PN: So have we got sort of any plans about her discharge?

732 P: Probable discharge this weekend provided we can get er communication with her son.

733 MO: The only thing with her was short-term memory testing.

734 PN: Yeah um...

735 MO: ... Wasn't that mentioned?

736 SCP: I've...

737 P: ... Oh what did we decide about that [names SCP]? I've forgotten.

738 SCP: I've got her down in my diary for today.

739 P: Oh! you're- oh that's grand...

740 SCP: ... Yeah just for the er- for base-line memory functioning...

741 MO: ... Yeah...

742 P: ... Yes, that's fine [names SCP], I'd completely forgotten that. That's great, that's great.

[conference ends. Some members stay on for the next CC; see Appendix 6]

Appendix 6

Case-Conference No. 10:

Professionals present:

Psychiatrist (P)
 Social Worker (SW)
 Psychiatric Nurse (PN)
 Psychiatric Registrar (PR)
 Clinical Nursing Consultant (CNC)
 Clinical Psychologist (CP)
 Senior Clinical Psychologist (SCP)

001 P: [discussing patient A] ... that came out yesterday that I got- that you don't know about. A little bit of it's written up there.

002 PR: [reading quietly] Very concerned about [inaud.] For example he rang his wife this morning to ask if the house had been burgled. [inaud.] has the idea that he is being undermined by several co-workers...

003 P: ... People in the office...

004 PR: ... everyone against him...

005 P: ... Yeah...

006 CNC: ... It's probably true [laughter] He's the assistant-manager.

007 PR: He thought wife would electrocute him [inaud.] Refused medication because nothing suited him.

008 P: That was when he took the um battery acid. [names PR], I think there is something we ought to do, because the wife's reported it, but whether it's true or not, I don't know. What I think we ought to do is to ring [names another general hospital]; he was in a medical ward and a surgical ward, and seen by a psychiatrist. But he apparently, this is the bit I have trouble believing, he apparently said to the psychiatrist that he'd seen the error of his ways, frightened himself, wouldn't do it again, was alright now. And that was the end of it. I can hardly believe that any psychiatrist faced with a battery acid ingester would take that blithe view of it! It's much more likely that the psychiatrist said; I'd like you to see somebody privately, and he said; yes indeed I will. And then [laughs] never followed it up. Um that's much more likely. Because that's been the pattern, [names PR], he's dodged; he refused to attend [names a psychiatrist], and he told his wife [names psychiatrist] had said he was cured. But the wife found the accounts labelled 'failure to attend'. That's what happened; that's why he didn't follow that one up.

009 PR: Hmm. Well, shouldn't we confront him with some of that?

010 P: Oh, yes, I'm going- I'm going to [laughs]. I have to see him today...

011 PR: ... Can I see him...

012 P: ... with you, yes. That's exactly what I was hoping we could do because the 3 day order expires at midnight. The wife says he's too smart to walk out at midnight, but she thinks we're going to have great trouble in getting him to reveal anything significant. And that he'll use his cleverness, his earning capacity, and his deviousness, I suppose one could say, to get himself down to [names a tourist resort area] for the weekend. Which is, what he's saying to her, is the only thing that'll fix him. And she said to me, pathetically; we haven't had a

holiday in I don't know how many years. She said; I'd love to go [to the area] for a couple of days.

013 PR: she needs to go by herself, doesn't she? And the kids.

014 P: I said; would you feel safe going with him? I was wondering how she felt about it. She said- she said; he might be alright, it was just that... I didn't feel a bit happy about it.

015 CNC: Hmm. [pause] Especially all that driving; him having thoughts about driving into traffic.

016 P: Oh [sighs]. [names CP], I've spoken, [names PR], in your absence this morning...

017 PR: ... Hmm, I'm sorry I was late...

018 P: ... Oh, no, no. I didn't mean that...

019 PR: ... Oh...

020 P: ... I meant that, of course, I always- I see [names CP] first anyway because we do the Blue team meeting first. [names CP] says he's got time to see him this morning, and I thought that would be great...

021 PR: ... Yes, that would be good.

022 CP: Mmm hmm.

023 PR: Um, for what? Um what would you do with him? Are you looking at personality or...

024 CP: ... Well that might be an idea...

025 PR: ... what will you plan to do with him?

026 CP: Um it seems all a bit of a question mark at the moment. Um I'd just- I assume first just have a chat and see er- perhaps an MMPI [Minnesota Multiphasic Personality Inventory] might give some indication but that's more long term um for the...

027 PR: ... You know the MMPI is still at [names someone's house] [laughs].

028 P: [names a different patient, X]; it's very similar to that sort of case.

029 CP: Hmm.

030 P: [X] was putting on a facade of normality was very paranoid underneath, and this may be the same except that [X] wasn't- hadn't [A's] sort of social skills in a sense, you know?

031 CP: Hmm

032 P: So...

033 CP: ... He doesn't- he doesn't actually want to stay in hospital?

034 P: Oh, no.

035 CP: Right.

036 PR: No, he thinks he's going to be out by the end of the week.

037 PN: He's very difficult to keep in hospital [pause] and his other 2 presentations have been exactly the same as he is now.

038 CP: Hmm.

039 PN: He um- very angry when he comes in, and settles very quickly, and sits there; never ever reveals any thing about what's happening.

040 CP: Hmm.

041 PN: And, usually within a few days, last time I think it was 9 days, but usually with a few days, is just discharged.

042 CP: Hmm.

043 P: With the label of 'brief reactive psychosis', that's what it's been every time, and, I bet, that's what [the other hospital mentioned] said too.

044 PN: Hmm.

045 P: Except battery acid, really!

046 CP: Hmm.

047 P: That's pretty bad, you know.

048 PR: Well, [pause] I haven't gone right through his history, I just wondered whether he's got some anti-social traits? But, I suppose, that might show up with the MMPI, mightn't it?

049 P: Hmm. The drinking seems to be episodic and comfort drinking; secondary alcoholism, rather than primary. As reported by him to you, and by his wife to me. She said; it's not primarily the drink, he only drinks when he gets so wound up. She said, he doesn't know how to relax so he drinks.

050 PR: Hmm.

051 PN: One of the problems last time, [names P]; they tried to get him to go to different things to relax because he was so involved with his work. And as soon as it came time for a break, whether it was a holiday or a break away from work, he'd collapse; he just could cope with the fact that he wasn't working, and now had to spent time with the family. He was doing things like- I mean he was working full-time, doing his matric, where he got distinctions, um plus doing some other studies, plus a 9 month old baby and everything else. And he coped with that very well. But as soon as there's a lull in that, this happens to him.

052 P: You gave him a relaxation tape, [names PN], it's in the old notes, and he took it home with him. I'm sure he played it industriously [laughs] but he didn't get any benefit at all.

053 CNC: [laughs]

054 PN: He tries to bargain; he's a very intelligent gentleman, he's quite- but he loves to bargain with you

055 [general agreement]

056 PN: I'll do such and such if you let me do such and such.

057 P: I now feel, [names PR], that the reason he wasn't insured privately was deliberate. [names the private psychiatrist] wanted him to go to a private hospital and he said, with quite

pride, [laughs] I think, that he hadn't any private hospital insurance. Which I now see as deliberate, you see.

058 PR: Well yesterday he didn't complain loudly, but he said; why aren't I seeing [names P]? As if, you know, wanted the boss-lady...

059 P: ... [laughs]...

060 PR: ... and- I said you were the boss-lady and just- the overseer sort of thing and that I did the- I was one of the registrars...

061 P: ... [laughs]...

062 PR: ... and I did the hack-work and he was- he was stuck with me.

063 P: Oh, [names PR]! You could have re-phrased all of that ni- much more nicely! [general laughter].

064 PR: [laughs] I didn't put it quite like that...

065 P: ... Only joking, yeah that's awfully funny, yes...

066 PR: ... But um, he er- I said if you come to a public hospital that's really the way it always is and if- if you want um, you know, people of your choice, you really need to take out private insurance. So we didn't really get anywhere there.

067 P: Right, well we...

068 PR: ... So [speaking and writing] chase up [names other hospital] notes. Um, [names CP] to see...

069 P: ... or even, on the phone, get them to read out a summary or something...

070 PR: ... Yes. [names CP] to see...

071 P: ... And we'll see him this afternoon. Are you here this afternoon?

072 PR: Yes, I'll be here this afternoon. Or, you not free this morning to see him? Strike while the iron's hot?

073 P: Well let [names CP] see him first...

074 CP: ... Hmm, I might see him now if that's alright?

075 P: Yes, if you don't mind, that's fine...

076 PR: ... Oh, alright, sure. Gee that's...

077 P: ... cause [names CP] is only here for the morning...

078 PR: ... Right. That's quick off the mark. And no medications because he's not accepting any.

079 P: Well, just- not just yet, accept I think I may do a bit of bargaining [laughs].

080 CNC: Mmm, yes, he's been a moderately heavy alcohol drinker ever since he first turned up here. So, he's obviously trying to help himself through that somehow.

081 P: Yes. Yes, I see what you mean; as a substitute for medication.

082 CNC: Hmm. Which he's missed out on since [inaud.]

083 P: That's lovely.

084 CP: Okay? [CP leaves conference]

085 PR: Thanks, [names CP]. [pause] The next one is [names patient B].

086 CNC: Mmm Hmm.

087 PR: [B] is a 35 year old married woman, with a 10 year old son. Lives with her husband and son; she's home duties. And she has er schizophrenia. [pause] And um she was admitted [pause] from [another professional's] referral, I think that's how it goes, because of um really what was seen as a crisis. Er she was thought to be about one week overdue with her period. She's pregnant and she doesn't really want to be pregnant and it- the um ambivalence about the pregnancy really um brought her almost to a pre-psychotic level, I think. She was starting to feel controlled by music, and she was over-involved with listening to music. And she says that she's not thinking properly and she became irritable with [names B's child] her 10 year old son. And she says that's always a sign that she's not well. [the (90 min) tape is turned over]... helped 10 years ago with the first pregnancy because she was mentally unwell at the time... um now ten years old and can't support her, and her husband... grandfather who is not well, her father isn't well and the mother's just said she can't cope either. She's got chronic conflict with her husband - he's an ex-crim who's a rather disengaged man, hard sort of fellow. Um she doesn't really get support from him. He's got two jobs and um doesn't support her emotionally. And um she's got this nice relationship with [her child] which she fears will be disrupted when she has the new baby and a strong likelihood that her illness will get worse too... in the late stages of pregnancy or in the early period- post-natal period. So, there are lots of reasons for her to have a termination. But the husband, who's recently seen the light and become a Christian... [laughter]

088 CNC: ... Mmm...

089 PR: ... says that he doesn't agree with it and won't let her have one. And she thinks now that it's wrong...

090 P: [sighs]

091 PR: ... this morning she said it was wrong...

092 CNC: ... Mmm.

093 PR: ... husband thinks she ought to go through with the pregnancy and have the baby adopted, but I don't think she wants to have the baby adopted.

094 CNC: Mmmm.

095 PR: She'll want to keep it. And she's still not thinking right, she says, she lacks motivation and she's um not interested in anything and she just feels there's a block in her head... in her thinking.

096 P: [names PR] could we get round it by - what ever church the husband's joined - by getting the minister of that church, you know what I mean. Could we by-pass the husband by getting the minister to come and talk to her and maybe give her the O.K. for a termination if that was... What church is it?

097 PN:... Could be one of those that don't agree with it...

098 SW: Yes.

099 PN: ... you know, one of these born-again Christians.

100 CNC: Was she registered on the front page as any particular religion?

101 PR: Other.

102 CNC: Right.

103 P: Your right, of course I don't know that but sometimes.

104 PR: What's the legal state? She can't unilaterally have an abortion, can she?

105 PN: No, I think, I think you've got to have...

106 SW: ... I think you've got to have joint consent.

107 PN: ... the two have got to agree. But she was saying things yesterday like um quite rightly, at my age, the child could be Mongoloid as well. You know, she was talking quite

108 P: ...Yes...

109 PN: ... reasonably about some of her problems.

110 PR: Yes, well that's one of the other worries.

112 P: She's about 5 weeks just at the moment, have I got that right?

113 PN: Six.

114 PR: When do they start counting a pregnancy? Is it...

115 P: ... you're the expert...

116 PR: ... from when it was conceived or from the last menstrual period? I'm never sure.

117 PN: I did the blood-test last week when she came in...

118 CNC: ... Usually it's last menstrual, isn't it? And they go backwards, they just back date it?

119 PN: [pause] And she was- I think she was showing 4 weeks or something, so it's supposed to be about 4 weeks.

120 P: Well, that would make her 5 weeks this time. She's still okay from that point of view.

121 PN: Mmm.

122 CNC: Yeah.

123 P: But the minister might, you know, if it was somebody that you could have a discussion with, might be an influential person on both of them, possibly, possibly.

124 PR: Well...we could um...

125 CNC: ... Yeah, what's- have you seen the husband ?

126 PR: Oh, yes.

127 CNC: What's he like?

128 PR: He's 50...

129 CNC: ... Yeah, so he's older than her...

130 PR: ... rather... yes, unshaven blonde man with wrinkly skin who um is quite disengage from [patient B]. And um has said things to her like well, of course if you don't take your medication it will serve you right you'll get sick again. And um he's sort of saying now well you know, you let yourself get pregnant, should have done something about it and now your going to have to have your baby cause I'm not going to let you have a termination. So, he's particularly unfeeling and lacks... the kind of support that I think she'd need to go through with it.

131 CNC: Mmmm.

132 PR: And he- she's saying all the time that she doesn't- she feels angry towards him and that she doesn't feel close to him. She regrets being pregnant... He just, I know he won't support her. He'll go to [another country] again.

133 CNC: When has he done that before?

134 PR: Oh, he's just come back from [another country] recently, I think. He has these holidays by himself.

135 CNC: Right. For a long time or...?

136 PR: ... Cause he likes to get away. Four weeks at a time, mmm.

137 P: How does he afford it?

138 PR: Well, he has two jobs you see. And that's another reason; he works shift work and he's never home.

139 CNC: ... He's never around.

140 SW: Sounds as if they've separated at some time. I was looking at [another professional's] notes. She'd been involved with her on a previous admission. [inaud] I haven't read her notes, but the impression I got was that they hadn't been living together... in theory, but he kept coming- you know, it was a funny sort of a separation but... that would have been, perhaps, 3 or 4 years ago. So it's been very on-off by the sounds of it.

141 PR: Well, they hadn't had sex for quite some time and she said that, looking back, she was mentally unwell... at the time and she somehow seduced him and got this sudden urge to have it and so they did and now she's paying the price. So she feels- she keeps harping back to that and she feels guilty about it. [pause]

142 CNC: So she hasn't been mentally really crash-hot for a long time, even before pregnancy.

143 PR: Mmm. I would think for about 5 to 6 weeks. [pause] And what is the trouble with... um thioridazine and um- can I just have that, [names CNC]? And early pregnancy? What does it do?

144 P: I think it's one of the- well, of course all of them can give a problem but I think it's...

145 PR: ... One of the safest, isn't it?

146 P: ... one of the safest, yes that's right.

147 PR: That's what I understood.

148 P: I think, mind you, if the husband agreed, we'd have no problem getting a psychiatric T.O.P. [termination of pregnancy] from the gyne. department. I mean that would be straight-forward.

149 PR: Mmm.

150 P: But it's the religious issue that's the...

151 PR: ... Mmm.

152 P: ... more insuperable one.

153 PR: Unless we... Oh you can't do that; I was going to say, unless you sort of become really heavy-handed and say look...

154 P: ... for her own good.

155 PR: ... we can't give her these tablets cause it's going to damage the baby, we've just discovered, and you can't have a psychotic wife cause she go- become really psychotic, so she's got to have a termination [taps table].

156 P: The other possibility is an order and I don't think it'll stand up, wouldn't...

157 CNC: Mmm-mmm.

158 P: ... she's not bad enough for that, no.

159 SW: She'd only be bad enough if there was no medication and she was refusing to have it.

160 P: Yeah, and she's not saying that. [pause]

161 PR: She got a bit of postural hypertension, I think, on the other dose of 50mgs b.d. and 100 nocte so we've cut it back to 25mgs b.d. and 50 nocte.

162 P: Fair enough.

163 PR: She doesn't seem overtly psychotic but she's not well.

164 P: Mmm.

165 PR: Thanks [names CNC]. Plan talk to her priest...

166 P: Well, find out what church it is perhaps and [names PR] it it- in the past I've had great help from individual, even Catholic, priests in a difficult occasion like this but you've got to hand pick them. You know, they may go against the party-line in particular cases but you've got to interview them first and make sure what they're going to say cause otherwise you just trap the patient into a worse corner than they were to start with.

167 PR: So, I try and find out...

168 P: Well, the name of the church and the- the name of the church first of all, and then the name of the minister, the one who's born-again the husband or whatever the phrase is [laughter].

169 PR: So we want the husband's priest?

170 P: Well, yes I think so, yes. Really, that's what I'm on about. And then it's got to be handled on a personal basis.

171 PR: Mmm.

172 P: But I've had both success and failure along religious lines....

173 CNC: Mmm.

174 P: ... with individual people.

175 PR: So, we're really trying to bring the husband round.

176 CNC: Well, he's the one who's affecting her in making a decision.

177 P: Yeah.

178 SW: Would she really make the decision if he were agreeable to it? Or is she using that at the moment? Do you know if she...

179 CNC: I don't know.

180 PN: I think she might; she really is unhappy about the...

181 CNC: She's quite afraid of becoming ill again...

182 P: ... Right.

183 CNC: ... and and ruining not only the relationship with the 10 year old but also the new one.

184 P: Mmm.

185 SW: Which is [inaud]

186 CNC: Yeah, and she hasn't got the...

187 P: ... What age is she; 40, 30?

188 PR: 35.

189 PN: 35, 45?

190 PR: 35.

191 P: 35, 35.

192 CNC: She hasn't got those home supports so close either.

193 P: Mmm.

194 PR: And [a relative] is an old bat who wouldn't support her at all. She says; of course you'll have to have the baby...

195 P: ... Oh.

196 PR: She's never been close to the [relative].

197 CNC: Mmm.

198 P: A very dogmatic family, isn't it?

199 PR: [patient C], 21 year old, single mother, got 2 children different fathers, living with a de-facto relationship with another man and she was admitted um for... hypo-manic and um... oh no she wasn't... she- mixed features: depressed but that was shortly after an admission for hypo-mania. And she's- I, I think she's euthymic at present; I think that's normal affect, but she's full of little complaints about... feeling nauseated and lacking energy for 2 days, and she's tired. But she feels- she sleeps well, and um she hasn't got any evidence of lithium toxicity. Her interest's maintained. She said she's had glyactoria for about 12- for about one month; her breasts are enlarged, menstruation was less than usual last month. Um, she doesn't think she's depressed at present and there are no psychotic features. Lithium levels are now about .7 or .6 and have been quite steady...

200 P: ... Good, good...

201 PR: ... on her current dose. So, I thought perhaps we could um... try and reduce the haloperidol to a tiny dose and even, if she's alright, to perhaps um have her off it...

202 P: ... Mmm...

203 PR: ... and continue with the lithium and see if that- how long does it take to [inaud.] ?

204 P: Oh, it can take a couple of months to clear up...

205 PR: A couple months...

206 P: ..., I mean gradually, it's very gradual and er she may miss the next period altogether and it still won't mean she's pregnant.

207 PR: So, she'll fly into a- she's the sort of person that gets really, you know, upset if...

208 CNC: ... Yep...

209 PR: ... she has bodily things going wrong with her.

210 P: Hmm.

211 PR: I talked to [patient's de facto husband] and [he] said he's known her for 6 years and he's not going to abandon her; he wants to marry her at some stage. He's quite supportive but explained that she's the sort of person who wheedles out of jobs at home because she's got a headache or she's feeling tired. And I think in the long run that um...

212 CNC: ... And it works [laughs]

213 PR: Yes.

214 P: Lucky old her [laughs].

215 CNC: Yes [laughs].

216 PR: Well, I think in the long run she's going to be a less than adequate mother at home.

217 P: Mmm huh, true, true.

218 CNC: [sighs]

219 PR: And er that coupled with the borderline mentality... Now what did we say- decide her I.Q. was? Its [another patient] who has the I.Q. of 65 so this one must just have borderline...

220 P: ... She's 70, I think...

221 PR: ... something like that...

222 P: ... yeah, yeah.

223 PR: It makes things very difficult, and her mother is moving up to [a country town] and so is [a friend] so that both her supports that she's use to are going to leave.

224 P: Uh huh.

225 CNC: When is that occurring? [names PR]?

226 PR: I think her mother might have already gone, I'm not sure. She says she's very worried about that.

227 CNC: Hmm.

228 PR: I just wonder whether we ought to be talking to her about that family health worker and anything else you might think would be a good thing in this like of situation.

229 SW: Yes, I haven't been involved with her; [another SW] has been, and I don't know whether he has talked to her about it. I could raise it with him because there is certainly no reason why it couldn't be looked at...

230 CNC: ... Hmm...

231 SW: ... especially in view of all her supports disappearing anyhow...

232 CNC: ... Hmm...

233 SW: ... I would have thought, from what I know of her up 'til now, she'd probably be amenable to the idea... but I think she is in a bit more stable relationship than she's been in...

234 CNC: ... Hmm...

235 PR: ... and also, losing her supports might be a prime opportunity to start her on that.

236 P: Do you remember her aunt [names aunt]...

237 SW: ... Yes...

238 P: ... took the kid for 3 or 4 months...

239 SW: ... That's right...

- 240 P: ... Um... but doesn't want to again...
- 241 SW: ... No...
- 242 P: ... because she got too fond of the child.
- 243 PR: Hmm, hmm.
- 244 SW: I'll just mention it to [names other SW] anyhow...
- 245 PR: ... Hmm...
- 246 SW: ... and see if he's discussed it with her or... Where does she actually live?
- 247 P: She's [names a suburb].
- 248 SW: Oh, so there'd be no problem getting one, I don't think.
- 249 PR: [inaud.] [pause, PR looks through notes] What if I just give her 2 milligrams at night?
- 250 P: Yes, mmm.
- 251 PR: Do you think that um...
- 252 P: That's a small dose: might just be enough to keep her stable. [pause] I say [names PR] if you do discharge her before Christmas... ah, could you fit her in an early out-patient appointment?
- 253 PR: ... Oh, yes, squeeze her in. Um, I said to her I thought she ought to have a long weekend this weekend- have 3 nights out.
- 254 P: That's a good idea.
- 255 CNC: Mmm hmm.
- 256 PR: And, perhaps, be looking at discharging her early next week. [very long pause] Oh, you can't write 2 milligrams, can you? It's 1.5 or 3.
- 257 CNC: Of um, mmm.
- 258 PN: Yeah, 1.5 or 3.
- 259 P: That's right, yes. Three.
- 260 PR: Three. [very long pause] I've left the p.r.n. there, in case.
- 261 CNC: There were just a few Panadol she had last week when she had her stomach cramps.
- 262 PR: [pause] And I think continue to insist that she is active. I told her sometimes, when you're not feeling well, when you start doing things it makes you feel better. And you forget about how crook you feel, and we're going to make her do that here. [laughter].
- 263 CNC: Yeah.
- 264 PR: And she said to me; I've been good, I've been to everything. [pause] Has she?

265 PN: Hmm, reasonably.

266 CNC: She takes her body there...

267 P: ... [laughs]...

268 CNC: ... but her mind she leaves on the couch sometimes.

269 P: Oh, well.

270 SCP: [laughs].

271 CNC: But I think there was one thing that we considered; some type of ceramic project that she could spend time on and actually work on. She certainly hasn't got much self-confidence and something like would help.

272 P: No.

273 PR: [pause] I think the- when she's not high, its a sort of be depressed and- or normal- even when faced with the normal hassles of everyday life- are knocking her a bit.

274 CNC: Hmm. Like [names another patient] really.

275 P: Hmm.

276 CNC: When she's normal, she hates it.

277 PR: That's right. [pause] I do, too...

278 CNC: ... Hmm...

279 PR: ... it's much easier if you're a bit intoxicated with something.

280 CNC: Hmm.

281 PR: Now, [names patient D]. She's a 21 year old single woman of- who's mentally retarded from an early encephalitis and lives at [names an institution]. She's the daughter of [a member of the clergy] and has 3 younger siblings. She was admitted psychotic after stopping her thioridazine, and it was all precipitated by the break-up of a rather unpleasant relationship which she had with a man [a the institute]. She's been quite slow to settle but um now seems fairly reasonable. She doesn't appear to be grossly psychotic on the ward. I don't know how the nurses have felt about it.

282 CNC: It's just her- this delusion about her sister- the- the jealousy thing that- that steps into a deluded type statement. But she hasn't been creating any of those loud family arguments. So she has reduced her expression of that idea that the sister had purposely taken her boyfriend away and- and made her get involved with this other guy, and that her sister gets all the privileges at home, and those sort of things. So she's settled down on those issues.

283 PN: But it makes a bit worse- this time, with father being a [a member of the clergy], mum's really busy, and she does come and visit every day, and they're very short- very, very brief visits because she's so busy. And as soon as mum's ready to leave [D] comes up with all this again. Anything to keep mum there, cause mum- I was actually doing something yesterday, and mum went and found me and said; can you keep [D] occupied for a little while cause I have to go, cause we're just so busy and [D] is coming out with all these things about her sister again. And it just seems to be because she wants mother to spent a lot more time with her.

284 PR: Yes.

285 PN: And she coped really well at [the residential institution] on the weekend, mum said.

286 P: Good.

287 PN: And- and her only fear is that boy-friend that she had is still around.

288 PR: Yes. We practiced together this morning. I told her what to say to the boy-friend...

289 P: ... [laughs]...

290 PR: ... I was the boy-friend, and i said now this is what you've got to say. And I was being the boy-friend, and saying; give us a hug [D]. And she really- she got up off the chair [general laughter]... and then; no, no. That's not what you do. This is what you've got to say to him. [general laughter].

291 CNC: Well, that's good, that's good. That's the only way to teach her.

292 P: Oh, lovely.

293 PR: So, I said; she's got to say; I don't want to be your girl-friend any more, and I don't want to be close to you because I don't like you. But then she decided that she wanted to be a friend, so then we had to re-play it all as just a friend. But this little note was from [another professional] saying that she had a really good week-end at [the institution] and that her mum's going to ring me today at 11, and I imagine that might be about- can she be discharged back to [the institution]?

294 P: Hmm.

295 PR: And I think, probably, she could if...

296 CNC: ... Hmm...

297 PR: ... you people agree.

298 CNC: Mmm hmm.

299 PR: With a follow-up visit by- to um [names another professional] who will give her a months supply of tablets, and leave it at that. [pause, beginning to write] So, no behavioural problems for about a week really, isn't it?

300 CNC: Hmm. Yeah.

301 P: Mmm hmm.

302 PR: [pause] Um, and that's when we started using sort of reinforcement...

303 CNC: ... Time out...

304 PR: ... and time out, and...

305 CNC: ... Hmm, and perhaps- perhaps if mum's feeling the pressure already from [D], she's going to have to promise [D] something or- or to get [D] through the Christmas time when she's so busy; that, perhaps once Christmas and New Year is over, that there's some reward.

306 PR: Well, there's- that couple...

307 CNC: ... Or some time together...

308 PR: ... that aunt that she stayed with; they might be able to help a bit around Christmas time with the promise that... later some more time with family.

309 CNC: Yeah.

310 PR: [pause] Well, I'll see if you can go either today or tomorrow depending on when mum can arrange to take her down to [the institution].

311 P: Mmm hmm.

312 PR: [long pause] And with her current medication, she's not falling asleep or anything?

313 CNC: No.

314 PR: [pause] [inaud.] [pause] And she can make that appointment, I don't think we have to, do we? [pause] Hmm. Well that's good. [names patient E] is a 45 year old woman, who can in with- er she was referred by [names another psychiatrist] for recurrence of depression- major depression, with obsessional features, which had not responded to his therapy of imipramine like it had in the past. And she's now having E.C.T.; has had er 2 I think. Written down for 6. I haven't interviewed her today, but yesterday she was still agitated and feeling depressed. And she's um, I think her depression expresses itself partly in a lot of hostility, and guilt about not being good enough and a burden, and not as good as she used to be. She's been a teacher and was quite a high achiever as I understand, and when she does get better, she gets her act together very well. She starts to become interested in things, and she makes reasonable plans and institutes them. And [the referring psychiatrist] said she's quite impressive when she's well or as she's getting well. So, I think we can expect good things as she starts to get better.

315 P: Her 6th E.C.T. is, love, is just before Christmas which is very convenient. And then you're off for the public holiday, and then you can check her the following week.

316 PR: Alright. And...

317 P: ... Oh, or- or give her more if she needs it. I mean it's up to you...

318 PR: ... Yes...

319 P: ... sort of thing, I mean that's fine. But that actually works out quite nicely; her 6th one is the Wednesday before Christmas.

320 PR: Oh, that's good. [pause] What do the nurses think about her?

321 CNC: [laughs] It's all yours.

322 PR: You don't like her?

323 PN: No, actually, I'm changing my opinion- I'm changing my opinion about the lady. When she first came in- I mean there was no way you could talk to her in the morning.

324 CNC: Hmm.

325 PN: On Sunday, [another nurse] just walked in and said; good morning. Well- got a mouthful of abuse for just saying good morning to her.

326 PR: Really? What does she...

327 PN: ... Oh she just- I've never seen anybody get so angry. She just stormed off and, you know, I'm tired and it's all your fault; it's all these medications; you're forcing me to stay because you're forcing me to stay. And she just went right off. And the afternoon; it was a totally different person. You wouldn't recognize her.

328 CNC: Yeah, you just...

329 PR: ... Isn't that amazing?...

330 PN: ... She just changes...

331 PR: ... It must be di-urnal [?] mood variation associated with depression...

332 PN: ... And she said, herself, you that um; don't talk to me in the morning, I'm shocking in the morning [laughter] and in the afternoons I'm fine!

333 CNC: Yeah, that's about...

334 PN: ... But since the weekend, the E.C.T. must be starting to work because she is changing; she's quite approachable in the mornings. She's looking for things to do, because she is bored being in here...

335 PR: ... Yes...

336 PN: ... and she's coming out as quite a pleasant lady, after all that.

337 SW: I was quite interested, when I took her home to get clothes, how she rustled around and found things to do. It's just seemed so unusual for somebody who is depressed. She brought her knitting and some books to read and things like that...

338 P: ... Ah...

339 SW: ... which, you know, was rather contrary- that was the afternoon but- And she did talk about being bored here and I've actually given her a list of recreational activities that we were using [pause] for the stress-management group, for her go through just to give her ideas...

340 CNC: ... Mmm hmm...

341 SW: ... because she is prepared to do things. So she was going to look at that and work out if there were things on there that she might like...

342 CNC: ... That she could go to...

343 SW: ... to take on. Really, I've given her the task of- of thinking back over things that she's often thought she might like to do and never got round to doing...

344 CNC: ... Mmm hmm...

345 SW: ... and what she might develop. So, you know, as you say, I think she's got the ability to do it, it's just when she feels ready to...

346 PR: ... Hmm...

347 SW: ... And she's also- apparently [another professional] referred her to STEP and she's still interested in doing that.

348 CNC: Yeah?

349 PR: STEP?

350 SW: Hmm, just to get her back to work. Cause it would be difficult at for her at that age, it's not that she hasn't got the skills.

351 PR: Yeah. So, she's already been referred there; they've got the...

352 SW: ... Yes, they've got the referral, and I think she will pick it up again once she's discharged.

353 PR: Oh, right.

354 SW: Because she would like to get back to work. She's cross that she gave up work when she went to live with this guy, I think. She can see that she did that before and she's doing it again. She said to me; I repeated the same thing and I don't have to do that. So, if she follows it through, that'll be good. Whether she will or not, we'll wait and see.

355 PR: [pause] Um medication chart alright? She should be on dothiepin 200 milligrams...

356 CNC: ... Yes, that's right.

357 PN: That started on the weekend.

358 PR: Mmm hmm.

359 CNC: Three nights [pause] of the full dose.

360 PR: [pause] What date was the full dose?

361 CNC: Started on the 12th.

362 PN: On Saturday, I think it was, wasn't it?

363 CNC: Yeah, 12th.

364 PN: Yep.

365 PR: So that we can get a record of how long it's been and just continue with ward program. [sighs] It's like dealing with a porcupine, isn't it? [pause] Handle gently.

366 CNC: She is, yeah. When you- when you say g'day or anything, you really test the water, don't you? [laughter] And wait to see what the response is.

367 PN: Wait til she says it to you first. [laughter] Now, everyone ignores her until she says something.

368 PR: The next one is [names patient F], a 70 year old woman, who was admitted severely depressed. She has a bi-polar mood disorder. And um then, before we could really do anything about that she had a small stroke with a hemi-pleger [?], and started to have fits as well. Was transferred to the medical ward and since then her mood has gradually lifted, I think from the fits; about 11 or 12 or something. And um- and the disability has- or the stroke handicap seems to have improved. She can walk around.

369 CNC: Mmm hmm.

370 PR: And she's wildly independent, and she wants to go home.

371 CNC: Mmm hmm.

372 PR: And um [names the occupational therapist] has had quite a lot of involvement. And I don't know if you want to take over from here, and tell us what's going to happen.

373 SW: You- you can tell it.

374 PR: Well, [names OT] um going to take her home. I think today, if she can organize it, or some time soon, to meet the domiciliary care worker, to have a look at her bathroom. And I don't know what else. And um to see what sort of help is available and to get [F] to see that this is what's going to happen. And then there's- because she's so insistent on going home and that like- there's nothing we can actually do, and I- we don't think we'll have any [inaud.] with the guardianship board yet, that we'll just have to let her go home.

375 SW: I was talking with [names OT] this morning and she says, and I think she's right, that actually er [F] has given- invested us with quite a lot of power, in the sense that it's; if they'll let me go home sort of statements. And er I'm wondering- we were wondering whether, you know, when she is ready for discharging, it can be made um fairly clear that we are prepared for her to be discharged so long as we are allowed to continue to give some support like I- I will visit.

376 PR: Oh, right, yes.

377 P: Hmm.

378 SW: And she's actually saying that she won't...

379 PR: ... Okay...

380 SW: ... um- won't accept any help and so I don't know what she is going to accept. She will have [names a catering service]; she's-...

381 CNC: ... Oh. Yeah...

382 SW: ... [names OT] nearly gave me heart-failure til I clarified that; she's quite happy to accept that.

383 P: Yes, good.

384 SW: But um- And I don't know that she does need things like the bathing at the moment. She's just nothing like she was before she came in.

385 PN: She does it all herself.

386 CNC: It's just that she has a history of not doing it once she's there.

387 SW: That's right.

388 CNC: If no-one's there jolting her...

389 SW: ... It's more the er shopping and [names OT] was looking at perhaps getting somebody to come in and actually doing a clean regularly. Although she's told me that she can manage that...

390 CNC: ... And washing...

391 SW: ... Well, you see that's all...

392 CNC: ... bed-making...

393 SW: ... that's all to be tested out.

394 CNC: Yeah.

395 SW: So, I think it's partly pushing with her; yes, she does have to accept some of that whether she feels she wants to or not. And that gives somebody a chance to be popping in, well, once a week maybe at the best. Er and I'll try and call in um well certainly next week. Are you thinking of discharging her this week?

396 PR: Well, er I- I was but um, if things aren't ready, we can easily hang on for a while.

397 SW: The other dilemma is going to be that between Christmas and New Year there is very unlikely to be any [meals from the catering service].

398 P: Yes, I- I was wondering about...

399 PN: ... What about the niece?

400 SW: She's not a niece; it's her sister.

401 CNC: No, no; the niece.

402 PN: There's a niece that comes, and the niece does a lot.

403 CNC: The niece lives around here. The niece is happy to- to offer um infrequent assistance when [F] phones her and asks.

404 SW: Oh, right. I hadn't caught up with...

405 CNC: ... But nothing more than that. She said; definitely won't commit herself to anything more because she's got a family and kids and she's looking after her own mother.

406 SW: Well whether she could be engaged to help between Christmas and New Year...

407 PN: ... Well, that's what I was saying; you know, if she- if anyone's had a chat to her to see what- you know, what she could provide.

408 SW: No. Have you got a contact for her at all?

409 PN: I don't know. We did have one once before...

410 CNC: ...[F]- [F] has got the phone number.

411 PN: She used to be very good; she was very um- very caring. Cause her sister lives right out in the country.

412 SW: She's at [names a country town].

413 PN: Is that what it is?

414 SW: But she's been really maintaining her. From listening to her, she's done an enormous amount.

415 PN: No it's not; it's the niece that's done it.

416 SW: Well the sister tells me...

417 PN: ... The sister tells you that she's done it. But I talked to the sister that day that [F] was really ill and I couldn't believe it. She says; I've had a stroke and I've had this and I can't do this, and my husband's got this. And apparently it's the niece that's been doing it all, and when you listen to her, you think it's the sister but it's not. The sister hardly leaves the area because she's got her own problems.

418 P: She' got angina [?], yeah.

419 SW: Well she certainly has, now.

420 PN: It's the niece; it's the niece that's been doing it all. And that's why she's sort of backing off.

421 SW: Hmm. Well maybe I need to contact her because nobody's- yeah, talked about that.

422 P: We used to be allowed to give a weeks trail leave. I think it's stopped, yes. But, I was wondering if we could cover Christmas-New Year by making it 2 blocks of trial leave, Do you know what I mean? Which would add up to a week, but with [F] fronting up [inaud.].

423 CNC: What we've done with anyone else who's been longer than the 4 nights...

424 P: ... We're no allowed- yeah...

425 CNC: ... is that, at midnight, they actually get- oh...

426 PN: ... Discharge them...

427 CNC: ... Yeah...

428 PN: ... We discharge them off the books but we keep their bed...

429 CNC: ... and then re-admit them...

430 PN: ... but we discharge them off the books and then re-admit them on the following day, or put them on leave the following day.

431 CNC: Well it all happens at midnight. Yeah.

432 P: You see, it's a bit of a worry, isn't it? To think of her er [pause] not having not having a weeks trial.

433 CNC: Well we can do that.

434 P: We can do it that way.

435 CNC: When we want to have people out there for longer periods...

436 P: ... Yeah, we don't often want to do it...

437 CNC: ... we're probably going to have to do it anyway with the Christmas long week-end...

438 P: ... Yes, yes...

439 SW: ... That's right. I'm having time [inaud.] between Christmas, New Year so I'm not going to be available...

440 P: ... Yes, oh yes...

441 SW: ... so that- if she could be maintained, you know, between here and- and as I said, there won't be any [names catering service].

442 CNC: Or that she does accept a district nurse to drop in at that time, or a dom. [domiciliary] care...

443 P: ... Would she...

444 SW: ... well, I think that's the thing; she's going to have to and I don't know what their going to offer over that period either. That'll be interesting to see.

445 P: [names PR], would she choose to come here for Christmas day, or something. Would she- would she like that, or is that an anathema?

446 PR: I haven't asked her.

447 P: It's just a thought, I mean she could have a bite to eat...

448 CNC: ... Whether she'd bother to use the bus...

449 SW: ... Whether the family might be having her for the day...

450 P: ... Somebody might just bring her in here for the day. I mean there'll be a few people in at Christmas. There always are, and she- I mean it might actually suit, or- or it might not. I don't know.

451 SW: Look, I'll try and get in touch with the niece cause that's...

452 CNC: ... Yeah, I spoke to...

453 PN: ... See, if the niece is willing or even if the niece would be willing to drop her off here...

454 P: ... Yes, that'd be alright...

455 PN: ... for the day, cause transport's pretty dicey on- on Christmas day.

456 P: It is, very dicey.

457 SW: Well yeah- see she's, for 4 months, not gone out of the house.

458 PN: Yeah.

459 SW: That's the sister's story. Now, you know, that's been put all in- [laughs] into question. But that was her story; that she could never get her to go in the car.

460 CNC: We- yeah. I guess it's the wrong time to send her home, in a way.

461 [general agreement]

462 PN: She's getting more and more depressed being in here.

463 CNC: Yeah. The inevitable thing is that she won't cope at home. So, does it matter when she goes home? Really.

464 SW: Except that it- yeah, it'd be nice to think that she was getting what support is available. I mean to send her home and know that she's not going to get any meals for 2 weeks is a bit...

465 CNC: ... Domiciliary contact...

466 SW: ... Well, yes, we'll wait and see what they're offering.

467 CNC: They have frozen meal; she could heat them up.

468 SW: Well, yes, that- I don't know whether that's what [names catering service] are doing. It depends which kitchen she's attached to.

469 CNC: Hmm. Well dom. care people know where you can get those frozen meals.

470 SW: Oh, I see.

471 CNC: For people who need them on weekends.

472 PR: So, wait for feedback from dom. care.

473 P: Frozen meals over Christmas; is that a kind of arrangement?

474 SW: Over weekends as well.

475 CNC: Yeah, well I know- there are different er sections of dom- of [names catering service] who offer frozen meals for people who need meals on weekends.

476 P: Oh, right.

477 CNC: So that you actually buy a freezer full of food once a fortnight, once a month...

478 P: ... Oh, I get you...

479 CNC: ... whatever.

480 P: Right.

481 CNC: But she's certainly mentally well enough. It's all those services that she- and she's denying it all, so um.

[OT enters]

482 PR: Okay, I'll write those out. [pause] Um are you coming to the meeting [names OT] or just taking that away?

483 OT: No, just taking this way [removes tea-trolley].

484 PR: Oh, right, that's fine. And the last one is...

485 OT: ... Does anyone want a cup of coffee before I take it away?
[OT leaves]

486 P: No, no.

487 PR: [names patient G], 36 year old single woman who lives alone, and was admitted hyper-manic- manic- [pause] manic-...

488 CNC: ... Manic...

489 PR: ... Um [pause] was detained for 24 days and has just come off detention. Now voluntary. Said she didn't have- she cut her Stelazine down by 20 milligrams each day while she was away on the last week-end.

490 P: Did she, indeed?

491 CNC: She's hopeless.

492 PR: Yes, because she didn't wake up in time to take the morning dose. So she didn't think she ought to take it all at lunch-time. So she just took the 10 milligrams at lunch-time, and not the 20 for the morning. And then [pause].

493 P: That's just like her.

494 PR: I told her off.

495 P: [laughs]

496 PR: You lose control when they're not detained.

497 PN: True.

498 CNC: She does it- she's got a history of it, though, all through her notes. She- as soon as she's out of our control, she's on no medication. [pause] And it was observed- her behaviour was more hyper-manic.

499 PN: It's been um more hyper-manic since she's come back from the week-end

500 CNC: More dis-inhibited; more getting over-involved with other patients.

501 PN: We had the carol-singers in last night and she lead the singing.

502 P: [laughs] Now, [names PN], that is not necessarily a sign of psychosis [laughs].

503 PN: Well, in 8 years in this place, I have always copped those carol-singers.

504 CNC: Have you? [laughs]

505 PN: Never fails. And it's the first time I've ever- they've turned around and said; now you can- you lot can sing us a Christmas carol. It's the first time in 8 years.

506 P: Oh, yeah.

507 CNC: And you loved it [laughs].

508 PN: I hated it [laughs].

509 PR: So the plan is to...

510 PN: ... And she's back to- because she's getting her medication regularly here, she's back to sleeping all day.

511 P: Yes, yes.

512 PN: Which had stopped last week because she'd started to get a regular dose. She now back to sneaking up stairs and sleeping.

513 PR: Shall we cut out- or reduce the morning dose by 10, so she's on 10, 10, and 20? [very long pause whilst writing] And continue with the rest of her things; lithium and carbamazepine, I think she's on. Isn't she? [pause] Yep.

514 CNC: She had- what did you say? Reduced her morning- all of her morning dose at home?

515 PR: Yes; didn't take it.

516 P: [pause] Isn't she [names another psychiatrist] follow-up, in the ordinary way? On discharge, I mean? Doesn't she always see [names other psychiatrist] over at [names a general hospital]?

517 PR: I don't know.

518 P: Oh, maybe not. I...

519 PR: ... I think she comes here. I think she's one of my out-patients, that's right [laughs].

520 P: I'm behind the times.

521 PR: Psycho-genic abnesia.

522 P: Quite right. [general laughter]

523 CNC: Can- if she doesn't want to have that morning dose, can you load the doses up later on in the day?

524 PR: When would you like me to load it?

525 CNC: Well, I don't know, I'm just thinking; if she's going to control it anyway, by not having medications in the morning, do we need to give them in the morning?

526 PN: But then she'll say she couldn't get up til after lunch. [pause] Well, she was here Sunday morning because she was going to visit some friends.

527 CNC: Right.

528 PN: Cause she had to go and pick up her piano-accordion, cause they'd asked her to entertain them.

529 PR: I think we ought to say to her; look there's not got- going to be any bargaining about this medication. [pause] This is how it's going to be. [pause] If you don't like it, go home.

530 P: [laughs]

531 PN: If you don't like it, you can't go to [another state] in 2 weeks.

532 CNC: She won't get there if she keeps cutting her drugs down.

533 PR: Well, I think that's what we need to keep saying to her.

534 CNC: Yeah.

535 PR: We know what's best for you. She'll say; but no, you don't. And we'll say; yes, we do, that's why- you thought you knew and you got sick, and you had to be detained. We want you to go to [names another Capital city] as much as you do, and if you cut your drugs down you won't get there because you go high.

536 CNC: Mmm hmm.

537 PR: [pause] Continual [inaud.]. [pause, writing] Continue to encourage to stay as a voluntary patient [pause]. Is that all?

538 P: Uh huh, at least that's all our list.

[formal conference ends]

Appendix 7

Interview Schedule:

The following questions were used as the basis of the interviews analyzed in chapters 7 and 8. The first interview was conducted using the entire list. The second interview was conducted using those questions indicated with an asterisk (*).

Transcripts of the interviews are contained in appendices 8 and 9.

1. How long have you worked in clinical psychology? *
2. What academic training have you had? *
3. What academic specialization/thesis topic?
4. How long did you/ have you been working at [the institution at which this study was carried out, S]? *
5. What activities would you normally perform? *
6. Who sets these tasks ?
7. Do you initiate any of these activities? *
8. How many patients would you normally see? *
9. Over what period would you normally see a patient? *
10. In seeing a patient, how often do you come to rely on your training, and how much common sense is involved? *
11. What standard psychological theories are relevant to what you do? *
12. What current theories affect practice ? *
13. Do you think there are a number of standard ways in which to approach every patient?
14. Do you have the opportunity/interest to engaged in research projects?
15. Could you describe them briefly?
16. Do you see any relationship between the research you engaged in, and your role as practitioner?
17. How do you see your role as being different from other mental health professionals? *
18. Could you contrast clinical psychology with, say, social work and psychiatry? *
19. What position do you see clinical psychology having in relationship with psychiatry? *
20. If it were possible, what changes would you make to the way psychology is taught?
21. Have you had to become skilled in the areas you described?
22. How much do you gain from discussions with colleagues? *
23. Is there much of a consensus between the clinical psychologists you work with?

Appendix 8

Clinical Psychologist Interview No. 1:

001 INT: Well, some basics first. How long have you worked in clinical psychology?

002 CP: How long have I worked in clinical psychology? I've worked for- since May 1986 at [names large psychiatric hospital, hereafter, L] and I did a er- an apprenticeship in a clinical work kind of practice in er- when I was actually teaching at [names a tertiary institution], that would have been for about 2 years, from 1983-84.

003 INT: Would that have been part of registration?

004 CP: Yeah.

005 INT: And what academic training before that?

006 CP: Um before that I did a 4 year degree in psychology, an honours degree... majored originally in maths, honours in psychology and er during that time- after honours I did a Ph. D.

007 INT: In what area?

008 CP: In... the area of memory research.

009 INT: Could you give me the title?

010 CP: [gives title] Which, if your interested, mainly dealt with looking at the way in which people store numbers and looking at the difference between visual number storage, auditory number storage, and how that effects both information storage and speed of processing; how you can measure it, how it varies between individuals, and how one can develop a simulation model which can compare performance of visual and auditory [inaud.]

011 INT: So, was that with [names a researcher in the field]?

012 CP: [briefly discusses supervision, but that is not relevant to the present investigation and may affect anonymity]

013 INT: So um, how long, and how much work were you doing work at [names a smaller psychiatric institution, hereafter, S]?

014 CP: At [S] I was just doing one day a week, er one morning a week, really.

015 INT: Yes.

016 CP: Um really, er not very much at all. Most of my time was spent working at that time with er the emergency unit at [L].

017 INT: So, what tasks would you be performing with the emergency unit, and what tasks at [S]?

018 CP: Very, very similar tasks. Um with the emergency unit I was part of the team involved in the initial assessment of patients when they came to the hospital and er [a bell and an announcement is broadcast in the corridor. The CP briefly explains what it means] Yes, anyway, where was I? In the emergency team my job was, part of that team, to assess patients who came in and er following them up in the context of short-term treatment programs. And I guess mainly the [S] situation was more ah, more an assessment based orientation than any treatment based one.

019 INT: So who would be setting the tasks in both those situations?

020 CP: Well, again, both of them were relatively unstructured. I mean it was up to the individual to some extent although the guide-lines were er... I guess, established from one's predecessors to some extent. Um you fulfilled the role that er they had done before you. But I think there was an element of, once you became familiar with the job, of having a degree of flexibility. I was not really associated with [S] long enough really to do anything different. I think that er what I did with the emergency team, because of my research background and my orientation towards tha sort of area, and the fact that clinical load was small, I developed a very strong interest in quality-assurance work. And er I would say that realistically half my time was spent um on evaluating um the work that was being done in the er in the emergency team. And er...

021 INT: ... By the other professionals?

022 CP: Yep, and generally how the unit was operating and um and proposing different ways in which- also that related to the hospital as a whole, in terms of information collection, storage, and usage; that sort of thing.

023 INT: So, would you describe that as a program evaluation?

024 CP: Well it was a number of- I mean, what had- what hadn't been done up until then was that the way in which information was collected, or data, was collected about the unit; it was just nonexistent, or if it was there the data that had been collected was very erroneous. So what I tried to do was systematically er begin a process of evaluating the data; so, working out what sort of people actually came in, what were the problems, demographic background of the patient, and what happened to them when they were assessed; ah whether they were um sort of statistical ah- what numbers of people were admitted, if they weren't admitted, what happened to them. And er just that sort of information so that er really that the unit could define its role more clearly.

025 INT: So did you initiate that study?

026 CP: Hmm.

027 INT: And the assessment things? Would you initiate who you would assess, or would that be set by somebody else?

028 CP: Well in- initially what happened is that everyone did a roster round the- this is at the emergency team- every one had a roster and er my roster was Monday afternoons and anyone that came though then, they saw me; I was the duty officer. Um and I had to determine the nature of that person's er- well whether the person would be admitted or not admitted and what should logically be that course of treatment the person has. And er... everyone- or the medical officers and the psychologists basically did that task. And er every morning we had a ward round to discuss the people from the previous day that had come in and the management, generally, was reviewed.

029 INT: So you'd be working with the medical officers who would be trainee-psychiatrists?

030 CP: Well they were yeah, mainly trainee-psychiatrists. There were also some psychiatrists that were doing- who were involved, and er there was also a social worker who also had the same sort of function. And the team also consisted of a number of nurses as well.

031 INT: Would you- would you be assessing people as they came in separately or as a team?

032 CP: Oh separately, I guess, although I could only do a certain degree of the assessment; there was also a medical examination just after everyone was admitted. Obviously, that wouldn't be my job. But I was there, as were all the other people who were involved with the

duty officer roster, um to er see what the person's problem was. Some of the time people would be detained and I didn't have the authority to release a detention order, so I didn't really have a choice in those sorts of situations. The person had to be admitted; it was a matter of seeing if one could get the necessary details to fill out the appropriate forms initially. If not, then the person would go to a more secure area, in this case [names a ward in L], usually.

033 INT: Yes. So, would the medical officer see the patient before you would see them? Or were you the first point of contact?

034 CP: Usually, in that case, I'd be the first point of contact.[pause] If the- if I had decided then- I don't know, on occasions usually there would be a sort of- if there were any queries about it would be a collaborative sort of effort. But if it was agreed at that time that the person should be admitted, then the medical officer would do a formal medical assessment. Usually, ah the way the system operated, there would be some indication that a person was coming in. Either, well usually a referring person would phone the [L] nurse and then you'd have a bit of background and you'd expect- you'd have an idea of whether you think the person is likely to be admitted or not. So really that's if you making- if it's fairly straight-forward. The more difficult decision making was er how you perceived the long-term treatment program. I guess as er- it was a very competitive area in terms of, ironically, in terms of getting um patients. And er um many of my own cases actually came from the ones I had assessed at casualty. It was a way of getting your own cases so to speak. You see, so it was a bit of a er... it was a bit unfortunate that that has- that was how it worked.

035 INT: So if um a medical officer was the first point of contact then how likely would it be that they would refer them to you?

036 CP: Yes, very unlikely.

037 INT: Very unlikely.

038 CP: Which was unfortunate. Now there's a problem in the system there- there wasn't- we did try and also do a lot of ground work as far as providing in-service training to give them an idea of what psychologists did and er what sorts of areas that er psychologists would er specialize in. And they offered, perhaps, better programs of treatment in some ways- preferred choices of treatment. But er it was very very difficult; most of them were very much in the er model of drug-based treatment programs and er they were there to learn to a large extent and they want to do as many patients as possible.

039 INT: Yes. And how much referring would go the other way? If you had received a patient who was going to be one of your patients, then how often er would you have to refer to psychiatrists?

040 CP: Well I er had no worries- no qualms about that sort of issue. I found that- I wouldn't- I can't actually say the- the actual frequency, but I would say that I had no worries about it. Especially if the person was er... obviously um psychotic or possibly- I mean that wouldn't be the case; I wouldn't take on a person like that, so it didn't happen very often. But if- if there were any doubts I wouldn't have any qualms at least in terms of asking somebody to have a second look at a person I might be working with, especially if they were quite obviously very depressed...

041 INT: ...Hmm...

042 CP: ... and what I was doing wasn't very helpful. So they may need medication.

043 INT: So how many patients would you be seeing under those circumstances?

044 CP: In the assessment situation, or in the normal clinical load?

045 INT: Well let's take them both.

046 CP: Okay. Normally, in an afternoon, I can actually almost tell you exactly, but I think it was, on average, about 4 patients in the afternoon I'd be assessing. And during the week, I guess at that time, my clinical load was about- probably about 2 patients a day. So you'd be looking at about 8 to 10 patients a week.

047 INT: And over what period would you see those?

048 CP: Well, the- the er time that one would normally provide a clinical service would be between 1 and 10 weeks or- no, sorry, 1 and 10 sessions. And my usual program or my sort of formula was largely; I would usually see the person possibly once or twice in the first week er and again in the second week, and then I'd try and break it down so I'd normally see the person in another fortnight. And, depending on the development, assuming that the person is getting um whatever- usually it's a crisis situation that gets resolved, then I would extend it to a follow-up for a month or another fortnight. So you gradually extend the period.

049 INT: So how is that different to what you were doing at [S] when you were over there for one morning?

050 CP: [sighs] Well um [pause] that- that degree- in many respects there was a strong similarity except that [S] didn't have any neuro-psych ah component and so, whereas here- that's when I was at the emergency team, I didn't do any of the neuro-psych assessments so they were immediately referred to the neuro-psych section or department here; which, I might add, I'm more involved with now, but at that stage I really only dealt with er with affective disorders, personality disorders, that clinical group, largely. Whereas er at [S] I would often do neuro-psych evaluations or assessments. So, I mean, the treatment program wasn't so important. Also at [S] they wanted more er formal personality testing which was the other area I was involved in, which I didn't do very much of here.

051 INT: So they'd be the things that um [names SCP] would normally be doing? And you were doing things similar to what he was doing?

052 CP: Very much so.

053 INT: Um and at- at [S], would you be initiating who you would see?

054 CP: Er no; that was totally referral based system, so that er...

055 INT: ... From?

056 CP: From the psychiatrists.

057 INT: Right. And that was always for assessment...

058 CP: ... or from [names SCP]. All in all, I mean I'm assuming that I'm saying that...

059 INT: ... Yes...

060 CP: ... it was er- there were a couple of situations which were for a treatment program but largely for relaxation programs but um the er majority of people I saw were for some for of assessment or write-up.

061 INT: In seeing a patient, how often do you come to rely on the training you've had, and how much do you think is based on common sense?

062 CP: [pause] Um [pause] Well I hope the- that er common sense over-rides training although I have been aware, in the past, of sort of down-grading some components of my training, and realizing with more maturity that er some learning theory and so forth has a lot of relevance in the clinical context. So I've changed my view to a large extent as far as knocking some areas that I've thought were a waste of time before.

063 INT: But you did see it in those terms?

064 CP: Well I think my- my feeling was really, when I was teaching some of those areas and relating it in applied settings, and thought; well that's a lot of rubbish. When I've come here I've often sort of found myself religiously adopting it because I knew it was the process that, especially working in terms of helping people with phobias and so forth. And I've- to my sort of shock and horror, I've found that's it's very effective, works very well. Plus I've also found that er having people keeping diaries is an invaluable way of ensuring one can er assess what's happening and er and so, I'm getting off the point a bit here but I, you know, this sort of gear which I though was sort of rather the weak side of psychology, and I realize now is very important side, a very important component of clinical work. And it has a very er- I wouldn't say that ah to- to try and answer your question, the inference, almost, is that's not common sense; I guess it's just my- my er theoretical bias away from learning theory but I've found that er it has a very strong practical relevance to working with patients. Um but yeah, common sense, I think, over-rides generally er most- most of what you do. And I guess there a- there is a sort of a theory which, to a large extent, makes up common sense. So it's very much an interactive type of thing.

065 INT: So then what standard psychology- er psychological theories would be relevant to what you are doing in the clinical setting?

066 CP: [pause] Um [pause] That's a bit of- of a broad question. Um, well, as I've mentioned, a lot of learning theory in treatment of er um particular phobias and anxieties sort of... Um er Not quite sure what other theories you- I would say that a lot of personality theory doesn't have much relevance for me as a clinician. Certainly psycho-analytic theory, I find not terribly relevant at all. [pause]

067 INT: Whereas, some psychologists here would?

068 CP: Oh I don't think so, I mean, I'd be very surprised. I mean I think people dabble in it form an historically interesting point of view, and one does also come across some- quite a few psychiatrists who are that way inclined but I would say very few psychologists.

069 INT: So on the- on the theories, would there be any um current research which is having an effect on the way clinical practice goes on here? I- I...

070 CP: ... Yeah...

071 INT: ... don't mean current research going on within this institution, but within the literature in general.

072 CP: Well that depends. I mean, again I'd be changing to the area I'm working now. It's a bit hard- I'm not quite sure whether you mean when I was working with the emergency team or where I'm working at the moment which is largely with the geriatric team...

073 INT: ... Right...

074 CP: ... and um from a research point of view, I feel for comfortable in the area where I'm working now which is very much involved with the assessment of dementia and um generally problems associated with memory.

075 INT: Right.

076 CP: And er obviously, because of my background in the area, I'm very familiar- relatively familiar with research and feel quite comfortable in terms of er keeping up with the relevant research...

077 INT: ... Hmm...

078 CP: ... and er I don't- I think probably in other areas of clinical work my level of commitment to keeping up with the relevant research is superficial.

079 INT: So you have a current um research program going on the side with your clinical practice with the geriatric unit.

080 CP: Well and- well yes, and also with other teams in the hospital. There's the schizophrenic unit, for example, which I've got very er little clinical involvement with, I've got quite significant research involvement with. So that's er- the two don't necessarily go together... In some ways, I think that's not such a bad thing.

081 INT: Do they go together more with the geriatric unit?

082 CP: Well [pause]. To be honest, I- I think my involvement with the er research with the geriatric unit really um [pause]. I'm really sort of helping or facilitating others, also really focusing on material which particularly interests me. Um that's largely what my role in the hospital generally has been; co-ordinating most of the quality-assurance work that now goes on in the hospital, and being associated with the research committee, and generally um helping people who want to do research. And um, I'm probably getting off the topic. I personally don't find a great deal of overlap between my particular research that I've been doing and it's relevance to my clinical work.

083 INT: Hmm.

084 CP: Directly, anyway. [pause] I might also add, though, that my perception of the way I do er a clinical- or my work with a patient, is very a model of how I'd approach a research problem. And I try and basically follow the same write-up in terms of um, to give you an example; recently I had a schizophrenic woman who was referred to me who was obsessive-compulsive. So obviously- well what I did in the first case was try and find out as much as I could about obsessive-compulsive disorders and um and treatment. And um the next stage- so that was your sort of literature review, so to speak, and developing a program I thought, on the basis of the literature review, appropriate. The second stage was um keeping a diary and using it in terms of collecting your data, developing treatment so that there's reinforcers and so forth. Um and evaluating the program as it was going along; graphing it and showing the person the results it- as she was- with the behaviour. Um and then at the conclusion [inaud.] was affected by the amount in terms of a report. And that- that format, I think, is very consistent with the way one would normally attract-attach- approach um a piece of research. So I always try to think of my clinical work, to some extent, with the same model- the same framework as I would a research problem.

085 INT: So you have um one standard way of approaching the majority of the patients you see?

086 CP: [pause] Well, I guess so. I guess so, I mean I look at the problem, and I see well, you know, what are my hypotheses about this particular problem and er- this is when you're dealing with a treatment program, I guess, as opposed to a pure assessment situation. Once you're dealing with a treatment program, then you- you choose your best measure, hopefully you're got some preliminary measure so you can evaluate whether or not what ever your appro- your treatment program is going to do; whether it's changing the behaviour or not. And evaluating; you set your self sort of limits in terms of time and er very much a structured- structured treatment.

087 INT: [pause] Um I suppose the next question relates both to what you were doing at [S] and the assessment...

088 CP: ... at er the emergency team...

089 INT: ... How would you see your role as being different form other mental health professionals?

090 CP: [pause] Well it's is very clearly defined in some...

091 INT: ... So you're not really ruling out the geriatric component?

092 CP: Well- well okay...

093 INT: ... Well let's talk about the three, if you like.

094 CP: Okay, okay. Well um primarily er where my role differed was in terms of providing an assessment service of psycho- psychometric tests. They could be personality tests or intelligence tests or memory tests, which was usually given to the psychologist not- the psychologist was deeply involved in that assessment component. In terms of therapeutic approaches, or treatment programs, I should say, I guess a lot of the time there was a fair overlap and er work that involves say relaxation training perhaps there was some. One was just er part of a- a bit of a team which was involved in that sort of area. The other area of expertise that I think a psychologist particularly contributes is er the- the area of being able to adopt a scientific, research-based orientation to problem solving. I think, more that anything, that's the area which er I found I could fit most easily into, and er I think, from the point of view of others, that was the area that most other people also appreciated. When one tends to provide er similar services to others there does become a potential for conflict um and if you can actually find an area er and say this is where I'm- this is where I am um then people feel comfortable. It just makes working in a team a lot easier: your- your situation's clearly defined.

095 INT: Yes. So you'd be the one who um delineates your area, if you like, within the team you work in?

096 CP: Yes.

097 INT: So how would you contrast, then, um what you would do with say what a social worker and/or what a psychiatrist would do?

098 CP: How did I?

099 INT: Er how do you see those- your role as being different from those two did? Purely in terms of assessment procedures or would there be a fair amount of overlap?

100 CP: Well to me they all compliment each other.

101 INT: Right.

102 CP: That- so that one doesn't er duplicate unnecessarily um- I er [pause] It's probably not a bad thing; some degree of duplication, I mean, obviously, in terms of history taking and that sort of stuff, but one often get similar sorts of backgrounds. But er as I saw it, the social worker, as a general rule, tended to work as well with the family and was involved in terms of er a lot of the legalistic side of things in terms of organizing the person's er- the patient's basic resources; their finances. And that was completely foreign to me. I had very little- [names SCP] on the other hand, I might say, was much more involved in terms of family therapy programs; that wasn't an area I was um... oh I had some familiarity with it but it was not an area I'd say I'd jump at. Um but er I saw the social worker principally there to help with the social areas of the

person which included the family and er- and their relevant legal side. Obviously, the psychiatrist, in any context, was there again from a legalistic point of view in case the person was detained, and had to make certain judgements about the person's mental state from the legal side of things. If medication was obviously appropriate then it was the psychiatrist's jurisdiction. [pause] But, apart from medication, [pause] most of the time I think with some- with many psychiatrists, one tended to work on a similar level er. Perhaps they would have different perceptions of the psychologist, I'm not sure.

103 INT: Would there be many patients who would not be on medication?

104 CP: Er well that all depended- Here, if I assessed them initially through emergency, and decided that I could help this particular person um who was in particular crisis at that stage but wasn't on medication, yes I would- If for some reason that- that person didn't respond to what ever the treatment was, maybe then I would seek um further advice; I would refer the person. It never happened in the majority of cases, but that could be the follow-up but most of the time when one saw the person and took control of the person, so to speak, then medication wasn't an issue. But er, some of the time anyway, if I was referred a patient who was- whose treating officer was the psychiatrist, usually, they would be on some medication.

105 INT: And in [S] they would almost always be on medication?

106 CP: Er yeah, a lot of the time. I mean, there would be some cases, in fact out-patients, I'd see at [S] who wouldn't be on medication. But as a general rule it's usually psychiatrists who [inaud.].

107 INT: So the relationship, then, between psychology and psychiatry would be one where er, if you had decided you could treat this particular person, then psychiatrists would not over-ride it and um prescribe certain medications?

108 CP: As a general rule, that would be the way. I mean there was a bit of common sense that also some people- I mean most of the psychiatrists that I dealt with had- were fairly common-sensical about things, and respected one's professional opinion. But I am aware that there would probably be other psychiatrists that would be quite obstinate and er ignore what I would have to say. But that hasn't personally happened to me. But I'm sure there are probably obnoxious psychologists around.

109 INT: [pause] Surely not.

110 CP: No, no, no. Scrub that [laughter].

111 INT: [INT checks that recorder is still working] Well, um now for a very general couple of questions.

112 CP: General? I've been general all the time [laughter].

113 INT: Well even more general.

114 CP: Okay.

115 INT: Given your experience of coming up through the academic system of psychology and then getting quite a lot of clinical experience, er the clinical face of psychology, if it were possible, what changes would you make to the way psychology is taught?

116 CP: Ah! [pause] Um yes, well let's er- let's start um say the way it's taught at [names a particular university, hereafter X] and I- I think that's particularly relevant. I think there's a difference between the way psychology is taught in some institutions as opposed to others. Now my feeling as far as [X] is concerned is that it tends to select the subject areas according to the areas of expertise the staff have or the areas of interest the staff have. One thing I would

very strongly be arguing for, as a general point, would be that one covers what are the recognized areas of psychology irrespective of the whims of particular staff. And especially in the first year, I think that a sort of a er [pause] a good general range [pause] a fair range of area should be taught, probably using a standard psychology text as the basic reference. To me er there is, at [X] anyway, um an implicit sort of bias towards somewhat more exotic areas of psychology far too early. I'd like personally to see that um be more evenly taught. I must say that er the [names a different tertiary, hereafter Y] where I did a lot of my teaching um adopted that philosophy of trying to provide um what I call a fair sort of coverage of psychology without individual preferences or biases, and er I felt more comfortable in that sort of situation.

117 INT: So would you then be loading more clinical sort of components in the undergraduate courses? Is that what you mean by a...

118 CP: ... Well, no...

119 INT: ... more general sort of...

120 CP: ... I think you need a balance. I think you need a balance and I think it's very difficult for er people to often decide, you know, where the balance should be, and this is why I'm er arguing probably what people can agree is that some standard introductory texts, in the initial stage, are often recognized as providing a balance of a range of areas. And rather than try and debate whether one should do one or the other, I would try and sort of follow that as er- certainly there are a range of texts to choose from, so I'd see that the role, in the first instance, would be to select what most people sort of consider to be a fair text and to try and follow that, in the first year, anyway. Then they can sort of um, once er, depending on the nature of the course is- I mean [X] traditionally was very experimentally biased er so it's not surprising that a lot of their did develop more that line but er [pause] That's a much, er I don't know- do you want me to go on about that?

121 INT: Well that- that clears up about differences to first year components, but would you then um have what you called a more balanced approach onwards up through honours?

122 CP: Well certainly I'd like to think that you'd become more systematic so there was a logical structure, depending on the subject areas and the value of the subject areas, rather than individual preferences or esoteric topics. And I think that recognized in the field of psychology are some major areas that should always be given some coverage, especially one area that I think, in the clinical context, is very much ignored in this state is the neuro-psych component. And er that my own area is, I think, very relevant is memory research or memory, which makes up a large component of um experimental work er is also to some extent neglected, or has been. But er I'd like to think that er there would be a systematic sort of way of selecting what are the most important topics and make sure that that theme is covered from the beginning through to the end of the third year, er with the opportunity for my more er specialization in option topics, rather than necessarily following or having every one doing one line, so that if a person wants to become um [pause] orientated towards clinical work that- that sort of option of psych can be taken. And er if someone wants to be more orientated towards clinical work that option can be taken, but there's a main stream that everyone does and er I think that's important that the main components are there.

123 INT: So when you came into clinical practice, were there then areas which you then had to go and study up on your own because the academic side didn't provide it?

124 CP: Oh very much so. Very much so. Um, I knew very little about er [pause] anything associated with psychiatric disorders; very little about schizophrenia, very little about er [pause] depressive disorders. So that- that [laughs] I more or less had to catch up that whole area. It wasn't really, from my recollection, covered at all in my course.

125 INT: So in doing that, how much would you come to rely on um colleges you'd have say in this situation? Is there a lot of knowledge passed around in your own environment about what

sort of things would be expected of you, or did you select these areas and go out and get better at them?

126 CP: Well I probably relied a bit more on my reading to er become more familiar. And when I found I didn't um understand or agree with relevant issues er I would then discuss it with colleagues and others in the clinical field. They didn't have to be psychologists necessarily.

127 INT: Who else would they be in that case?

128 CP: Oh, in some cases social workers, er in some cases psychiatrists. I mean areas like grieving and so forth; variation in terms of theories associated with it. Things like that came up and I talked to a social worker who'd probably often be a er person... [the tape finishes and is turned over]

129 INT: So er the social worker would then what? Introduce you to the theories concerning grieving, or would they discuss those er in question more in terms of practical application?

130 CP: Well, I guess, largely it would be a balance of theory of the person's er reflection of her understanding of the theory, and er in- in practice; how she's found- she may have come across 50 or 60 patients that she's dealt with who have been er um severely affected- er say, for example cases of still-birth or things- issue- things like that and what sort of experiences she's found. So er I think that er- a lot of that information you don't find in books, and er it's very much a thing- I er respected those sorts of opinions and directions.

131 INT: So would grieving then be part of er the areas you talked about where duplication happens between say, what a social worker does and what a clinical psychologist does?

132 CP: Well it could be, it could be. I mean I chose not too er work in that area because at the time the particular social worker, who's er very competent, and wasn't over worked, if I can put it like that, um was quite happy to have referrals of that type. So we worked in balance, you know, in harmony sort of thing. But if- if the situation were that er I didn't have that option, then I'd be happy to probably um [pause].

133 INT: So um I don't quite understand how the referral system works. How do you know that there is a er social worker who's much more experienced in grieving? How do you know where these um more personal specialities come from, rather than say- If I were a psychiatrist, how would I know what specialities were there in psychology, rather than say I think psychology does so and so?

134 CP: I think there's a strong component of being a sales-person after a fashion. And in terms of the emergency team, at that time, the social worker was a very articulate woman and er she was involved with er a number of in-service training programs. Certainly one of them wasn't er- was in relation to grieving and er she presented in that area um. In the same way, psychologists also spoke about sort of the areas that they sort of have expertise and I think that was a very effective sort of channel for telling people what- what you can do and what you can't do; what areas you want to do and those you don't. It was er fortunate in many ways the fact that er, at the time, um the staff ratio was very- relatively high in terms of patients, and so er the stress of er the work-load anyway- stress was minimal, and one had the advantage and the good fortune to be able to er be flexible with patients. It was very much a- a situation of, if the patient was free, everyone grabbed- went for her- him or her. So er one had no trouble in terms of er [pause]. The hardest thing was to get patients, it wasn't to get rid of patients, which, you know, I think is probably different in different organizations.

135 INT: You put all that in the past tense; has it changed since?

136 CP: Well I'm- I'm no longer working with the emergency team.

137 INT: Right.

138 CP: My role is a lot different now. My role is very much more defined in terms of working in the geriatric area.

139 INT: Right.

140 CP: I guess the person who does the formal assessment, and er largely it's er very much more structured.

141 INT: And was it structured because you took over the roles that er a previous psychology-er psychologist had had? Or did you come in with those sort of intentions?

142 CP: No; in the geriatric area it was simply because I have taken over- I took over from a neuro-psychologist.

143 INT: Right.

144 CP: And he had probably exclusively um involved himself in assessment. What they want me to do now also is extend, I guess, the level of service from more than just simple assessment to also looking at treatment, and that's something I'm trying to er develop at the moment. But er just at this stage I'm finding that er most of my time is taken up purely with assessment and um...

145 INT: ... When you say 'they' what do you mean? Who's 'they'?

146 CP: Oh well, I guess, you can always work with nursing staff and medical staff and, when somebody new comes on the scene, people want to get to know you and er so it's both the medical staff and the nursing staff er and social workers. One tends to er get on with these people, it makes life easier and er they're- I- I'm very impressed with the level of competence in that particular unit and certainly I think it's very rewarding work with people I find have a lot of credibility.

147 INT: So you're being guided, then, by the members of an inter-disciplinary team?

148 CP: [pause] Ah, well [pause] very, very gently, yes. I mean, they're encouraging me to do my own thing to- to a large extent. Obviously, in that unit, er more than any other unit in the hospital, er the neur- neuro-psychological is er is fundamental. But er one thing that they haven't really had before was er the opportunity of having a psychologist working in a treating component, whereas they've always had just simply a person working in a- an assessing component- in an assessing position, should I say. And er the scope is- is er- is very er- very large for having a psychologist working in a treating capacity.

149 INT: And you're initiating the treating side of it?

150 CP: Well yes. Yes, but, as I say, um at the moment it's er- it's- it'll take, I think, a couple of years before it's established. And probably, at the moment I'm still [pause] feeling around to er work out really what resources that we've got there. I don't want to jump in and find that er [pause] things are going to become to demanding. I want to be able to provide a service er that I can- I can er keep going. And er I don't want to provide a service that I'm not going to be able to do properly. At the moment, my time is actually balanced between half-time working er with the geriatric team, half-time with living-skills team which is another area.

151 INT: This is um two halves of your clinical side rather than the research your doing or...

152 CP: ... Well the...

153 INT: ... does the research get excluded from that?

154 CP: Well um [pause] research is always constant. I mean I fit that in when I'm not doing clinical work...

155 INT: ... Right.

156 CP: ... in pragmatic terms. But in terms of the way the hospital perceives where I am, so to speak, half the time I'm allocated for the er- well actually it's 2 days a week, I'm allocated for the geriatric team, 2 days a week for the social skills er living skills training, and er um 1 day a week of purely research.

157 INT: What's the social skills training?

158 CP: Um, living skills, I should say...

159 INT: ... Living skills...

160 CP: ... um it's a er- part of the er hospital is involved with er [pause] developing programs for patients in basic living skills which may be catching buses; which may be cooking, speaking English. [pause] The area which I'm most interested in is er rehabilitation, industrial therapy. And er my role with them, with the living skills group, has been two fold. One, ah looking at all the various programs. They have outside people come in who are involved with putting on the programs, and my role has been to examine the present level of assessment that's involved [inaud.] and to try and develop better ways assessing, evaluating particular programs. That's on one hand, on the other side ah [pause] I've had sort of some clinical involvement developing programs for transport training- [inaud.] [laughs] I won't go into that. Um but what I'm hoping to do is er- is er initiate some new programs in the industrial therapy area. Especially the two areas I want to develop; one is a data processing with industrial therapy, and the other is developing a er- a er centre for producing psychology resource kits that can then be um [pause] commercially sold.

161 INT: When you said um- when you talked about the assessment procedures a moment ago, you said you wanted to um- to re-define those. Did you make them more formal- did you mean make them more formal?

162 CP: Well, a lot of the time there was no formal assessment.

163 INT: Hmm.

164 CP: And er what I wanted to do initially- what I did initially was er try to get an idea- a breakdown of the courses involved and er what current level of assessment was involved.

165 [INT checks tape is still running]

166 CP: So, and in most cases, the formal assessment was non-existent, and most of the courses actually did lack structure. So, to some extent, it was a bigger load than I anticipated because what I also tried to do, in the context of developing an evaluation prog- or component to the courses, is actually to try and organize some structure and influencing them to some extent. So it hasn't been as simple a process as I thought it would be.

167 INT: Um your 1 psychologist in how big a department here?

168 CP: I think we're 14 or something- maybe 13.

169 INT: How similar do you think you are? You've described what you're doing, how similar do you think that is to the rest?

170 CP: Um [pause] Well I guess, er- I guess I'm similar to er- I have a sort of mixed role which some- most of er the people here tend to be, I guess, more confined to er one area. I guess my

role has been, in terms of research, together with neuro-psych assessment, together with um clinical treatment programs, together with cognitive rehab programs, together with- Um they're- I guess they're the 4 main areas; research and quality assurance together. Um whereas most of the others are in er sort of one of those areas almost exclusively. I find that by er involving myself more diversely, er one doesn't get so bored because- I enjoy it; it's stimulating. And I also feel that, as a clinician, um as a therapist, I'm probably no better or no worse than some of the others, er think my er sort of background abilities in the research component is probably a bit better than others. So er I'm happy with where I am. And I certainly think that er ultimately what seems to happens with psychologists, and it's very fortunate, is that they do-they are generally in positions to let the er- their positions be moulded by their- by their degree of personal preference.

171 INT: Hmm.

172 CP: And I think that's very good from the point of view of your job giving you satisfaction.

173 INT: So there's a fair degree of flexibility um in what they choose to end up doing.

174 CP: Yeah, yeah. [names SCP], for example, probably [pause] principally a clinician-based psychologist; orientated towards clinical evaluation and treatment programs associated with the evaluation. [inaud.] Whereas you might have somebody like [names two other psychologists] who are exclusively neuro-psychs, their orientation is simply to looking at er that assessment. Other people like [names another three psychologists] are almost exclusively involved in research components. There's a- there's a balance in all the- there is a balance I share with most, if not all, the members of the department. But er unlike most members, I interact with all of the sections.

175 INT: So you don't think there's a um standard face that psychology puts on to the rest of the hospital?

176 CP: No, no, I think there are definitely a lot of different faces. And I think it's flexible too; you can change faces [pause] depending on the moods. Realistically, at the moment, um- the thing is when- the thing I found actually with er working in the emergency team, because of the intense vying for patients and so forth, many of the people who are pure clinicians got very bored and very angry with the fact that their work-load, if you like, was small. They didn't have anything to do. Um they didn't know how to occupy their time constructively. The thing is- what happens- I- I dread that sort of exercise.

177 INT: Hmm.

178 CP: So, I think being able to er- involve different roles productively is a very important part of the balance.

179 INT: So, unless you do that, that is what happens? You do end up with a small load, is that what you're saying?

180 CP: Well, I mean, you can at different times in different places. And if you're working- there are obviously er some areas er where the demands are much much greater. If your working with probably with adolescents or with child-abuse cases, I'd say that er you have a never ending supply of sort of er cases. I think some situations that are operating in the state at the moment are going through a 4 month backlog of people waiting. Er now we don't have anything like that, in fact our services are almost immediate. And er so we've got er- at the moment on staff we, [pause] unless you just twiddle your thumbs, I think most people who- who have gone through the formal training have got more ability than that; they want to do something constructive when they're not er actively involved in the duties they're employed for. To me the two areas of greatest expansion are research, and educa- or training- teaching [inaud.]. I think that er they are the areas that er do get most people, who can provide a service, teaching. Teaching I might talk about, in a hospital context especially.

181 INT: Teaching other professional or trainee psychiatrists?

182 CP: Other professionals.

183 INT: About what it is that psychology does, or increasing their own skills?

184 CP: Well, er particular areas. Another area that I'm involved with is providing services to country areas, particularly [names a country town]. Now what I did there was to evaluate what- what sort of patients and so forth the community nurse was seeing.

185 INT: Hmm.

186 CP: And seeing- well, you know, how much of the time- if I got there once- once a month, what good is it going to see some of these people. And really, a lot of the time the problems were long term problems, people who were quite chronic; depressed and so forth. And the problem of isolation. Anyway cerfice to say that some of the best help that we could provide was giving them better um background about the areas, and provide er more education as well. So what- what we did them was develop a seminar program that went to er the country areas. That, in the first instance, we looked at 3 topics; anxiety, depression, and suicide. And er sort of spent a day workshop discussing, presenting those topics. And I think about 40 workers came along to those. I mean that's what I meant about education really.

187 INT: Were you giving them [pause] skills in order to deal with things, or theoretical background on those issues?

188 CP: Yes. Yes.

189 INT: [laughs] Yes to both?

190 CP: Yes to both. The most difficult thing, I guess- um we weren't sure at the time what the background of some of the people was going to be. Um I think, in true psychology fashion, we ploughed into this group- we ploughed in sort of using the standard format we were familiar with in terms of providing the theory- providing the theory then providing the data, then the conclusions. Probably um the majority of people we were talking to didn't have much education; were often volunteer helpers. So I think what we should do in future probably make it a bit more concrete; make it a bit more applied in practice. But also I think that what we've got to make sure that we don't do is make- make cook-book recipes sort of thing. So that people feel that- some inappropriate- in some cases they may er be taking on more than they should. So there's sort of a fine balance in actually working out what the best sort of package is. The others side of things that I have time to develop at the moment is resource kits er that'd be particularly appropriate for country centres.

191 INT: And is that a bit more like a cook-book?

192 CP: Well er it could be, but I'm hoping that it will be related to areas that are not going to be sort of dangerous. Where I say cook-book; if people feel comfortable about dealing with suicide er patients- er I think that could be a bit much if they haven't had any training or experience. So really, many of them- it -it just worries me that some of them think they can do more than they can. But in terms of basic, say, stress-management, some components of that, I think there's very good evidence to say that they could be able to run those sorts of programs given the appropriate resources. And er what I'd like to do is to put together resources and er, because of the facilities that we have here through industrial therapy, we can manufacture and, to some extent, that can generate moneys that can continue to generate more activities. And the money can also be refunded to areas of research in the hospital.

193 INT: You seem to cover an enormous number of bases.

194 CP: Well one thing leads to another and you can't- I think that's the nice thing about it is that er one just continues to grow in different directions and er that's sort of the comforting thing I think, if one does get sort of restricted to a er- a singular area then, I think, I would get bored out of my brain and I don't think I'd be terribly productive. To me, I guess, the excitement of life is the growth, variability, flexibility.

195 INT: And all of that is up to you?

196 CP: Very much so. Very much so. And the other thing which I try to do is to er [pause] develop some of these ideas outside of the hospital per se. I'm doing um [pause] a study with the [names a sporting clinic] er which er covers a lot of the similar material I'm doing here in the research context. But it- it- it's sort of initially I think it might appear that- er what's the relevance of that to the hospital? But I think that when you can make comparisons especially between psychiatric patients an elite sports people and make- show the fact that they are very similar in many respects um then I think er you can actually do a lot of value to the sports- er for the ath- sorry for the er psychiatric patient. The model- the model of being normal is very important.

197 INT: So you've been doing these things outside of the hospital perhaps because the hospital is more restrictive?

198 CP: Well because I've [pause] well largely I guess because there is that flexibility with an institution like this; it does have- it doesn't- you don't feel everyone's looking round and- where's [names himself] today? so to speak. It has almost I think almost university sort of flexibility and freedom about it. And er the situation came up that I was invited by a college from [the sport clinic] to er to do some research there and er [pause] one thing leads to another.

199 INT: If it is that flexible then, is there some assessment procedure on what it is that you do?

200 CP: [pause] Well...

201 INT: ... Because...

202 CP: ... yeah...

203 INT: ... there isn't um one in- there isn't very much of one in a university situation as to which particular interest you pursue, but I wonder whether it's different context.

204 CP: Um.

205 INT: I mean, if they don't say; where is [names CP] today, do they at all?

206 CP: I think that what is er critical, and what one does find, is that if you do something badly, then people start to [pause] make noise. But if what you do is good, and if people are happy with what you are doing, then you don't really get much feed back. Or you don't get feedback that's um favourable um, so that's um- I guess...

207 INT: But there's no formal way?

208 CP: There's no- there's no formal way, really. [pause] Well [pause] there maybe technically a for- a formal way, but in practice there is no formal way really of [pause] controlling what a person does to some extent. I mean, there is- I mean there are basic guide-lines you have; one is employed with a duty-statement which covers everything. Um and what happens is that the person sort of usually er develops their own er niche in the institution that- that, one would hope, would make most people happy. [pause] And also, obviously, makes the clinician happy.

209 INT: Hmm. Well that about does it.

Appendix 9

Clinical Psychologist Interview No. 2:

001 INT: Just a few basic questions first. How long have you worked in clinical psychology?

002 SCP: Oh, about 12 years.

003 INT: And what academic training did you do before you started work?

004 SCP: Well, I did my first degree in psychology, ah, an honours degree, then I went on to do my Masters in London. Um the decision- I went to the [names a famous institution] and I worked toward a Master of Philosophy degree which in fact is a professional degree which qualifies me to work in clinical psychology.

005 INT: Was there a thesis component?

006 SCP: Yes, it is part course work and part thesis. [briefly discusses the particular aspects of the M. Phil. course which involved both academic and practical components over two years]

007 INT: How long have you been working at [S] in particular?

008 SCP: About 3 years. [pause] I think I started- yes it was September '85

009 INT: And did you start at [L] at the same time, or were you there before that?

010 SCP: Um, I started at [L] at the same time.

011 INT: Right.

012 SCP: But part of my duty was to do one session at [S], so in fact from September '85 I only did one session at [S] for about 12 months before I started to work here on a half-time basis

013 INT: Okay, well we can talk about what you are doing at [L] as well if you like...

014 SCP: ... Yes...

015 INT: ... but for the moment; what activities would you normally perform here?

016 SCP: Well, in the broad sense, my duty is to provide a psychological service to [S] which is the psychiatric unit of [names a large general hospital]. And to perform this duty I have to have very close liaison with the other workers of the unit like the psychiatrists, the social workers, and the nurses. And one venue of maintaining this communication is to go to the conferences, the morning meetings to familiarise myself with what's going on within the unit; the type of patients that are being serviced by the unit. And I also take referrals from the other professions, and this is where the bulk of clinical work comes in.

017 INT: Through referrals?

018 CP: Through referrals. But of course when I go to the meetings and there are um times when I do pick up cases which I- well I think that could benefit from some form of psychological investigation or intervention then I often indicate to the team that er this particular patient may benefit from some form of psychological input. So really it works both ways; I take in referrals from the other professionals, and at the same time I also um sort of actively try to look for the appropriate cases to work on.

019 INT: And that's just in the case-conferences or do you come across cases in the word in general?

020 SCP: No, it comes mainly from the case-conferences.

021 INT: So how many patients would you normally see here?

022 SCP: Well on average it's about er 5 cases per 2 session, on average.

023 INT: And what's a session? Is that a day or?

024 SCP: A session is half a day.

025 INT: Half a day.

026 SCP: Yes, so it's about 5 clients per day.

027 INT: And over what period would you be seeing one patient?

028 SCP: How do you mean?

029 INT: Well would you, say, be seeing them once for an assessment, or would you be doing some follow-up?

030 SCP: Oh, right, I'm with you. It really depends on the type of service that I provide to the patient. If it were a- say a neuro-psychological investigation, er it may be a one-off thing, or it may take up two or three sessions at the most. When I believe the investigation is complete then I just write up the report, there is no follow-up unless um- there are occasions where I think a re-assessment is necessary is say 3 months or 6 months time. But with the- say the treatment-oriented cases, um again it depends on the type of problem the patient has, but I would say um as a rule I- I would prefer to see the patients on a time-limited basis; say, not more than 10 sessions for the so-called triple regime. I think that its- if we don't get any results after say 5 or 8 or 10 sessions, then we really have to stop and think over case and see if we should adopt a different approach.

031 INT: So, how much of your clinical load is to do with one-off assessment things, like the neuro-psych, and how much is some treatment program that would extend over a number of sessions?

032 SCP: Right, I can give you an approximation of the proportion. I would say- say about one third is on the psychometric or psycho- neuro-psychological investigations, and two thirds is on treatment.

033 INT: And most of- both of those are done by referral?

034 SCP: Yes.

035 INT: Right. [pause] In seeing a patient, how often do you come to rely on the training you've had, and how much do you think that common sense is involved?

036 SCP: Oh I think training is very important. Um [pause] If we get a patient- Um, personally, I really do not believe that common sense alone can enable someone to um provide an adequate professional service to a client. And I think the er clinical training is tremendously important because training provides the- the clinician with the basic er theoretical expertise. Um and it is only with this theoretical and practical expertise that we get from the training courses that we feel confident in approaching any particular problem that the patient presents. And I think again the other important factor which [pause] guarantee an adequate and professional service is that of the experience of the clinician. Now without the training and experience I don't think [pause] the clinician would be in a position to er- to give a er an adequate service. I'm not playing down the importance of common sense um because I still think what makes a good psychologist is

the psychologist's ability [pause] of exercising a lot of common sense in quite a number of quite diversified situations [pause] but I still would like to put training and experience above that of common sense.

037 INT: So um what standard psychological theories would be relevant to what you do in clinical practice?

038 SCP: [pause] A lot of people have- may answer this question by sort of straight- ploughing straight into the er different orientations in psychology like psycho-analysis or behaviourism or the more humanistic approach and so on. But personally I like to take one step back um and consider a sound knowledge of basic psychology as important because I think it is from a sound knowledge and understanding of the basic psychological principles that all these different orientations er branch out. And so um I think a- a good psychologist should have a sound knowledge of general psychology. He or she should be knowledgeable about abnormal psychology er [pause] and the next step would be for the psychologist to decide on an orientation or an approach which suits his own, not so much personality, but his own philosophy of life. Because I think um in a lot of cases the reason why a particular psychologist is drawn towards any particular theoretical orientation has a lot to do with his own philosophy in life. For example, a lot of people just cannot accept the um, what do you call it- the mechanistic um approach or behaviourism. Personally, I think it is a misunderstanding of behaviourism. But um I know a lot of people who simply cannot um get themselves to accept behaviourism because of a philosophical belief that they have.

039 INT: So how would you describe your theoretical orientation in that case?

040 SCP: I consider myself a behaviourist, there's no doubt about it. [pause] Although may I may qualify this statement by saying that I'm- [pause] in a way I'm [pause] a softer behaviourist than say I was 10 or 12 years ago [pause] because I think my clinical approach, although still it's still deeply rooted in behaviourism; like I believe we need to deal with the here-and-now problem without- without um getting back into speculation of childhood experiences um, and I don't believe in making any sort of unsubstantiated conjectures about what goes on inside the organism, and I still believe that the most pragmatic way of approaching any problem is to consider the observable. [pause] And I also believe um that the only way we can evaluate whether our approach is effective is through some reliable measure of the variables concerned. So my approach I would call um scientific and behavioural but I- when I say soft- a softer approach is because um I can say that I'm more aware of the prevailing emotions and attitudes [pause] presented by my clients then I was about 10 or 12 years ago.

041 INT: So um, what theory would have influenced your softening of the behaviourist approach or is that softening to do with practical experience?

042 SCP: Um I would say it is [pause] more clinical experience than any prevailing psychological theory that has softened up my um what used to be a very radical behavioural approach. [pause] The- say back in the early 1970s when I did my training, everything was very well laid down; like when you're presented with this problem all you need to do is use this approach. And every treatment which the clinician follows was a very er stringent er procedure; like flooding, or cessation, or assertive-training. Each and every individual treatment regime is so well laid out that all the clinician needed to do is to follow these procedures in steps and the patients- the clients would get better. But as you really um moved into the reality of the clientele, then apart from the presenting problem they also have these other concerns like the family, like er mood-state, like their attitude of how they perceive er of the therapist and how they perceive of themselves. And all these other what once- they called extraneous variables, becomes so important, I feel I cannot sort of negate it as the extraneous variables. And so um- and I feel that it became important to try to address some of these issues, and from experience I- I sort of discovered by trial and error that if I acknowledged some of these prevailing emotions and attitudes, and how they perceive of the situation and so on, um there was a dramatic improvement in the kind of rapport that I had with the clients. And that was very rewarding because it contributes toward a very positive therapeutic effect which I think adds something on

to the traditional behavioural approach. So say if I approach someone from a very traditional behavioural um oriented procedure, I am not get as much a positive therapeutic result as when I acknowledge some of these prevailing emotions and attitudes, and try to um clarify some of the perceptions or perceived ideas of the therapist, themselves and their family and so on. So I get um- be drawn sort of more and more into the ones they called the unspecific factors in treatment, and um begin to look at some of these very important areas. I think this is where um I think common sense comes in.

043 INT: So it sounds like er the training gave you a number of standard ways...

044 SCP: ... Oh yes...

045 INT: ... to approach every- every client.

046 SCP: Yes. Ah, I think I have reiterated at this point to a lot of my colleagues and some of the students. That a training course only provides you with a basic theoretical framework, um where you can have a sound footing um on one aspect of a psy- psychological discipline. And with this basic framework, I think it is up to the clinician or the student to try to expand their knowledge because, after all, what a training course can provide er are a number of theoretical concepts, er a number of possible theoretical alternatives um, and ways of say looking up relevant er references, and be communicative. And I think it is up to the clinician to try and catch up with the er fast expanding knowledge in psychology.

047 INT: Mmm, well we've talked about the er theoretical orientations, but are there aspects of the current research going on in the journals at the moment which have affected the way you are working in practice?

048 SCP: [pause] That's a um difficult question because there are so many things happening in the academic journals that it's really hard to say that um I've been affected or influenced by any prevailing um [pause] series of advances. [pause] I mean I- no I- I find it difficult to answer that. [pause] Again that- this feeling of um stuckness; I would put it down to the rather, I would say, stagnant position of clinical psychology of the past decade or so. Um there are always um- there are times when we feel quite uncomfortable um because I don't think psychologists or clinicians now have a clear direction of where they are heading or where they are going. And like say in the early 1950s or 1960s when there was some sort of a boom of behavioural therapy and behaviourism and everyone was drawn into this big empire of treatment [inaud.] technique-wise and theory-wise as a boom in all parts of the world. And er when you asked the psychologists, say in the early 1960s, about their orientation they would be quite happy to tell you; oh, yes, I'm a behaviourist and I follow say the Skinnerian approach or the Walshian approach or what have you. And they feel confident and comfortable in using techniques like cessation or flooding or even, in some cases, aversion therapy and so; and they feel quite- quite comfortable and happy in using more these sort of techniques. And then came the early 70s um where there was a shift from the behavioural approach to the more cognitive orientated approach. And people still feel comfortable about that saying that now we are beginning to acknowledge the importance of cognitive variables and er and we have shown that by modifying the cognitive structure we can bring about some quite desirable behavioural change. But I think between the early 1970s to the 1980s I can not pin-point any er major break-through in clinical psychology. And I think people at the moment are sort of clinging on to um what they've had in the 1960s and 1970s, namely the behavioural approach, and the er cognitive- behavioural approach. And they are still sort of using that as the basis of their clinical work. [pause] And there hasn't been any sort of [pause] major innovation in the field that um- that is significant for us.

049 INT: What about minor innovations?

050 SCP: Sorry?

051 INT: What about minor innovations? Have there been say er particular small research things which have had an effect?

052 SCP: Um [pause] from an innovation point of view, um it has been about [new batteries are put into the cassette recorder] Now, where were we? Um minor innovations.

053 INT: Yes.

054 SCP: I don't know whether you would call um family therapy a minor innovation. I don't. It had a long history er- I think as long as behaviour therapy, but I think it's only in the recent say 5 or 7 years that people- a lot of workers in the field are- begin to- to take family therapy more seriously. Certainly I think family therapy has a lot of er useful techniques in the interview situation. But I think family therapy is always hampered by the fact that it hasn't got a very coherent and workable theoretical framework. Um [pause] and there's such- I don't think it- in a way it doesn't qualify as a scientific approach [pause] treatment. But, again, you cannot deny the fact that er in the United Kingdom and certainly here in Australia, that more and more traditions, not necessarily psychologists but psychiatrists and especially social workers, um well, are head over heels about the systems theory- the systems approach. And family therapy becomes um a very fashionable approach, I would say, in treatment. But personally, I can see a lot of inadequacies in the approach, and certainly a lot of dangers in this approach, in the sense that the- well a lot of the family therapists haven't got a firm er clinical background. And certainly they do not have the adequate basic knowledge in general psychology, and abnormal psychology, and psych-pathology to enable them to er have a um balanced view of [pause] their client's problems. And unfortunately quite a number of the er family therapists will look upon their techniques as the um- the panacea for all problems which- I feel that it is a- an inherent danger in this particular approach. But personally- I mean I- I cannot profess I am an expert in family therapy, but I- personally I do feel that there are a number of quite useful er techniques that we can borrow from family therapy to enhance our- our interviewing procedure. And certainly the way that we try to illicit information from the different members of the family and so on. But as um [pause] a system of- or as a theoretical system, I don't think family therapy will stand up terribly well. So that's on the treatment or intervention side. The other [pause] feeling that I- say that I have in the last 8 or 10 years is that quite a number of psychologists are gradually shifting back to assessment. When I say assessment, I um- I mean er now a fairly sort of specialized branch in clinical psychology which is called clinical neuro-psychology. Um it is a science on its own; its got its own theoretical framework, its own er scientific data to support all its [pause] hypotheses and assertions. Um but it seems that- my suspicion is that possibly a number of clinical psychologists or clinicians working in the psychological area do not feel comfortable working um with either the behavioural approach or the cognitive-behavioural approach. And they may begin to get the feeling that they are now working in sort of a theoretical vacuum. Ah, and a more safer alternative is to go back to something which is a more scientific, more data based, or unequivocal. And of course clinical neuro-psychology is one of the areas um which can provide this sort of security to the clinician. Because, after all um, you have your psychometric protocol to rely on and, as long as you are experienced enough at looking at the test data and, through a process of er pattern-recognition learning, you can er draw some fairly well founded conclusions, and form quite um appealing sort of conclusions about [pause] the patient. So it seems that the wheel has come full circle; that in the 1960s and 70s psychologists had been trying so hard to break away from this image of a mental-tester, and to do away with all the psychometric equipment. And now in the 80s more and more psychologists are slowly being drawn back um to psychometry.

055 INT: And what do you think the cause for that is?

056 SCP: For drawing back to...

057 INT: ... to the testing.

058 SCP: Well, as I mentioned, because they do not feel comfortable with this er theoretical vacuum; because they no longer er possess the kind of er security er that was offered to them by behaviour therapy in the 60s and the 70s...

059 INT: ... Yes...

060 SCP: ... and er [pause] so.

061 INT: If- if I can just go back to um what you mentioned about family therapy for a moment...

062 SCP: ... Mmm...

063 INT: ... when you say that there are some techniques there which you can borrow...

064 SCP: ... Mmm hmm...

065 INT: ... How did you come to be aware of those techniques form family therapy? [pause] Was it through um discussions with other clinical psychologists or...

066 SCP: ... Oh I see yes...

067 INT: ... was it on the basis of some publication on family therapy that had come out?

068 SCP: Right, right. The standard sort of training procedure for family therapy um is to participate in many, many therapy sessions with a supervisor. And er almost all the [inaud.] the trainee will observe the sessions through a one-way screen. You know, a one-way mirror. And so it is more a process of role-modeling on the er supervisor and, of course as the sessions proceed, there will be a lot of discussions generated behind the screen amongst the trainees and possibly the supervisor. And through these observations and role modeling procedures that say, for myself, I began to discover that there are alternative ways of questioning, for example. Um in a more sort of traditional, orthodox behavioural or behaviour therapy approach, I don't think it's any different from a standard sort of medical examination approach. That you ask quite specific questions to the um- to the clients er and we want fairly effectual answers from them. Ah but in family therapy, there are more um round about ways of getting at the same answer without er the unnecessary feeling of being interrogated.

069 INT: Yes.

070 SCP: And I think it's a very important aspect in the technique of the interviewer. And of course there are a number of very standard behaviour therapy- er no; family therapy type of questions. Like questioning the client of their own perception of um what they expect form a change and how they perceive er say um certain parameters; how they compare their own perception with that of another person. And I don't think this sort of information was emphasised in a behavioural approach. So I've- I found that this technique of say questioning a comparison between different perceptions um, and the questioning the persons own idea of what the change is, and so on, is very useful in getting um relevant clinical information.

071 INT: How would you see your role as different form other mental health professions working in, say, this unit?

072 SCP: Hmm. Sort of um- I perceive myself as an applied scientist. Um we work with a well defined area of theoretical expertise plus um the adequate clinical skills and experience. And we possess the knowledge of psychology which would be beneficial to the other disciplines like psychiatry and social work. Um and I think the major role of an applied scientist is to reduce the uncertainty in say the more ambiguous clinical situations. I think this is exactly what the clinical psychologist should be doing.

073 INT: Mmm.

074 SCP: Um, in psychiatry for example, very often they rely on subjective judgments and um in a lot of situations, they have to make a decision on the basis of inadequate data. Which I think in many circumstances is not justified on the part of the client. And a psychologist can help the team or the other professions to try to reduce the amount of uncertainty by providing more objective data. Whether it could be a self-rating questionnaire or behavioural rating um or some other tools or instruments, or even a second opinion from the psychologist can help to reduce this ambiguity in clinical decisions. Of course on top of that the psychologist also has the kind of skill and expertise and experience um to deal with a number of well defined or specific problems that the client may have. And to offer some alternative treatments er to some form of disorder. A good example is say obsessive-compulsive disorder; the psychiatrist will tend to say prescribe a drug - clomipramine - which they feel that could be- er would help the obsessive-compulsive disorder but er from a psychological point of view, the same disorder can be tackled by [pause] some behavioural approach which is just as effective.

075 INT: And how would you contrast, then, clinical psychology with social work, seeing you've already done it with psychiatry?

076 SCP: Mmm, well, I um- I think with all the different professions, there are over-laps in their roles. That holds true between psychology and psychiatry, and between psychology and social work. Um but again I have to sort of amplify the the fact that er, apart from these over-laps, there are distinct um contributions and differences um in the approach among different disciplines. Say between psychology and social work, [the (90 min) tape finishes and is turned over] The most common overlap will in the areas of say family therapy. A lot of treatment- of social workers see themselves not as social workers but as family therapists. And some psychologists tend to do the same thing, and that also holds true of some psychiatrists, they see themselves as family therapists. Um and a lot of social workers run groups, like stress management groups, er assertive training groups, communication groups. A lot of psychologists do the same, also a lot of nurses do the same thing. And um occupational therapists. So there are areas in day to day clinical management that each and every profession tend to chip in. [pause] And I don't think it is a um- a problem of sort of one profession acting to the detriment of another profession. I'm quite receptive to the idea that er any person who is er professionally qualified or confident in er [pause] running these groups and providing this sort of service, and who has a fair degree of common sense. They should do very well. But with the more specialized approaches in intervention, right, like the behavioural approach or um [pause] seeing a certain patient for a cognitive-behavioural intervention; techniques like cognitive restructuring, I think that should be left with somebody who is well trained, well skilled, and well experienced in the field. And should remain within the realm of clinical psychology. And if, say social workers or different teachers or parents would like to initiate something from behavioural programs say, I think it would be advisable if that particular program could be um monitored or supervised by someone who is skilled in this area, namely a psychologist.

077 INT: So um how important, then, do you think is psychology's role as a testing discipline? [pause] Things like the EPQ and IQ scores.

078 SCP: [pause] I- right- I'm not a hundred percent happy with the term 'testing'. Er I seldom use the word 'testing' er even if I do 'testing', or even if give a WAIS or the personality questionnaire, whatever, I would tend to use 'investigation'. Because 'testing' implies a very mechanical execution or administration of a particular procedure. And it also sort of implies that it is a- that it will yield a score um which can pigeon-hole someone according to a particular category. But if you can get away from this concept of 'testing', and you perceive your- your um procedures as 'investigations', alright? They- it gives you a totally- a new dimension of meaning, because what you are doing in an investigation, and not a testing, alright?...

079 INT: ... Mmm...

080 SCP: ... is that first of all you have to what is wrong or what the problem is, and from your expertise, your knowledge, your theoretical background, your experience; then you should be able to [pause] postulate some hypothesis about this problem. And once you have a hypotheses, alright, you can investigate, you can test, alright? You can investigate the hypotheses, through some of those formalised procedures.

081 INT: Right.

082 SCP: And once the investigation is finished, alright, then again it is up to the person's um knowledge, skill, experience to make some sense out of the data [pause] what shall we call- interpretation. [pause] Try to draw up a er conclusion on the basis of the investigation. Alright? And I don't think it should stop there. Once you get the data; once you get some either conformation or rejection of your hypothesis, it gives you, the clinician, er the basis um to modify your original hypothesis. And to go on to investigating other areas that may be relevant to the um situation. It's more like a series of detective work; that you proceed from one hypothesis to the other until you are satisfied that, yes, this is a er all the data or the information that I need for me to draw a conclusion. [pause] And that is I think the basis of [pause] a scientific investigation, and I think it is different from what people construe as a 'test'...

083 INT: ... Yes...

084 SCP: ... a one-off type of activity.

085 INT: So it's- it's more like an experiment.

086 SCP: Yes.

087 INT: That sort of approach.

088 SCP: Sure, yes.

089 INT: But um I wonder how psychology is perceived, and whether the role of the psychologist is perceived by, say, psychiatry as the testing discipline.

090 SCP: [pause] Oh, it is up- I suppose it is up to the psychologist to- to sell his image to the other professions. Er some psychologists do it very well, some don't. Um it's pretty hard to make any sort of generalized statement about how er the psychiatrists perceive the role of a psychologist or- because it- really it differs from institution to institution, from psychologist to psychologist, from psychiatrists to psychiatrists. And I think it all depends on how broad-minded the psychiatrists are, and I think the, so called, the new generation of psychiatrists; they are, on the whole, quite good in the sense that they are less dogmatic about the medical model, and they are appreciative of the contribution of the other professions. And er- if but you er come across psychiatrists say of the 1930 or 1940 vintage, then you may get quite a different picture; that they would expect you to kiss their feet before you do anything.

091 INT: Mmm.

092 SCP: [laughs] So [pause] but um [pause].

093 INT: So when you're- [pause] when you get referrals, when you're working here...

094 SCP: ... Mmm...

095 INT: ... what are they referring for; what are they calling for?

096 SCP: What are they calling for?

097 INT: Mmm.

098 SCP: Um, if it is a referral for intervention um [pause] the referral usually specifies the problem area. Sometimes the referral may give an indication of the type of [pause] a service that the referring person would like to happen for example; relaxation training um, increase the person's assertiveness, or some social skills training. Um but as a rule I think what the psychologist should do is not to [pause] get his approach sort of coloured by the request, but the psychologist should go about looking at the situation from his point of view and decide for himself what would be the most appropriate mode of intervention. [pause] So the majority of the referrals that say we get from this unit is for the psychologist to provide an alternative form of therapy [inaud.], or um to see the client on a supportive basis which serves as an adjunct to the say the chemotherapy the patient is already getting. Or the other sort of social-network therapy that the patient is getting. So the- to um provide the patient with the necessary psychological support, so that a much more comprehensive um service could be provided. Um with the more psychometric orientated referrals; they usually um ask a fairly specific clinical question; like is so and so suffering from dementia, is so and so's drinking problem affecting his memory functioning; if so which area, how bad it is. And of course all this ties in with the very important and relevant decision, and that is [pause] what is the best way of managing this patient given the cognitive status of the person whatever it is. One very important clinical question that had been sort of overlooked by- by a lot of clinicians, and we- we can find it in many cases, that a psychiatrist may make a neuro-psychological referral to the psychologist, and the psychologist will see the patient um before investigations, or 'testings'; come up with the conclusion, yes, so and so's short-term memory is poor but his long-term memory is intact and so on. And, in many cases, it- the whole thing seemed to stop there which I don't think is right. I think um the- the importance of the investigation, really, is to try to shed some light on to how this particular person will manage in his life given the- the results; the psychologist's findings, and what will be the best alternative for this person; whether he should stay at home, whether he should, for his benefit, go to an institution or a nursing-home or what.

099 INT: Right. I take it the- the referrals are from the psychiatrists here.

100 SCP: Yes.

101 INT: Um how do the psychiatrists know what it is you do, or what it is that psychologists who attend here do?

102 SCP: Uh huh. Oh, [pause] in this unit, I would put it down as the result of a continual process of mutual feedback between the psychiatrist and the psychologist. Um and say when a psychiatrist has been working with a psychologist for [pause] a reasonable length of time, the psychiatrist will get a pretty good idea of the areas of it- expertise of the psychologist; what areas this particular psychologist is good at, um and what sort of referrals will be handled adequately and professionally by the psychologist. And of course on the part of the psychologist, again it is a process of communication with the psychiatrist, say; oh, I don't think this referral is appropriate. And then the psychiatrist will know that- [pause] the psychiatrist will refrain from making the same mistake next time.

103 INT: Mmm.

104 SCP: Some psychologists like to lay down [pause] a list of the areas that they would [pause] like to get into, alright? But I think it is more important, that if there is an on-going or flow of communication between the psychiatrist and the psychologist [pause] rather than laying it down in black and white.

105 INT: I wonder how much of your role was influenced by the role taken by the psychologist who was working here before you?

106 SCP: Er, I don't think this is happening. [pause] We'd have to admit that, although psychologists tend to share basically the same sort of expertise, knowledge, and experience,

different psychologists tend to have different emphasis on their line work. As for myself, I don't think um I have been sort of influenced by the line of work that had been done by my predecessor. Say, just to highlight, the situation is that um my predecessor is really into family therapy; so much so that about 3 sessions a week um is devoted entirely on- on family therapy and nothing else. When I started to work here um the number of family therapy sessions had been curtailed quite dramatically, and I only see clients on a family therapy situation when I am convinced that this is the best alternative form of treatment. Then I will offer them a family therapy session, but not for every referral like what's happened in the past.

107 INT: Mmm.

108 SCP: And I have- well, I still maintain my um style and belief um [pause] that, in the majority of cases, um I still think a one to one, individual therapy is much more beneficial then drawing the whole family together [inaud.]

109 INT: So um [pause] when you came in here, there had been a family therapist working...

110 SCP: ... Mmm hmm...

111 INT: ... so you were then given referrals that were family therapy orientated...

112 SCP: ... that's right, yes...

113 INT: ... and, over time you changed the approach, or um was it something that you did...

114 SCP: ... No, I- I won't say that because it was a um [pause] very peculiar situation, because when I started to work here on a half-time basis it was, again, the time that coincided with a change-over of the medical staff. Um so in a way, I was new here when I started on a half-time basis, and so were the psychiatrists...

115 INT: ... Ah...

116 SCP: ... so it was possible for me to sort of um start from scratch without sort of- [pause] to worry about the old tradition. [pause] So it's different.

117 INT: Well, that about does my list.

118 SCP: Oh, right.

119 INT: [pause] Wonderful. [tape-recorder is switched off and the interview is completed]

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