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‘So what brings you to the clinic today?’: talk in family intake interviews.

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DECLARATION

This dissertation has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: Signed by candidate Date: 13 04 2008

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NOTE TO READER

The references in this dissertation were executed according to the format of the American Psychological Association (5th Edition).

The Spelling used is British except where American spelling was used within quotations.

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Abstract

This research examined the ways in which families constructed presenting problems in the talk of their first session at a psychology clinic. It also looked at the ways in which they constructed individual subjectivities during the interviews. Six families self-selected for therapy and were then invited to participate in the study. The analysis was based on the clinical interviews undertaken by therapists. Interviews with the families were analysed using aspects of both discursive and psychoanalytic theory, these being interpretative repertoires (Potter & Wetherell, 1987), issues of power and ideology (Parker, 1992) and complex subjectivities (Parker, 1997). Two main themes were uncovered through the analysis. The first dealt principally with ways in which families constructed their problems and the second with defensive representations within the interviews. The themes were illustrated with several interpretative repertoires. The research demonstrates how the levels of communication and different subjectivities operating in the session serve to make what actually happens very different from what one might expect to happen, given the framework of the clinical interview. Instead of a sense of linearity and continuity within the interview, one finds fragmentation, dissonance and inconsistency.

Chapter 1: Introduction

One of the fundamental requirements of people who present to mental health facilities is that they say why they are there and speak about what ‘the problems’ are. On the basis of this initial narrative, others follow, and interventions are planned. This research focuses on talk, in initial interviews, about ‘the problems’ that have brought families to a child/family mental health facility. Its aim is to examine the talk in family intake interviews when parents and children are asked about the presenting problems. The research makes the fundamental assumption, as does the Clinical Interview (see Appendix 3 for format) that there is a problem or possibly several problems which have brought each family to the clinic.

In a clinical intake interview the therapist is always looking for the narrative into which the current presentation can be fitted (Holmes, 2000). In asking the question ‘What brings you to the clinic today?’, we immediately ‘encourage the patient to become the author of her own story – to consider what has happened to her, how she has reacted, and what she was and is feeling about it’ (Holmes, 2000, p. 94). When we ask this question, we are essentially asking the patient ‘to reconstruct a narrative chain out of an apparently disconnected series of events’ (Holmes, 2000, p. 94). The way in which ‘we organize accounts of both nature itself and our own activity into meaningful, logically organized stories is crucial in making sense of our world’ (Brown, Nolan, Crawford, Lewis, 1996, p. 1569).

The importance of narrative is highlighted in growing research on attachment which has suggested that the ability to be reflexive, in other words represent and reflect on past events in words, is correlated with the ability to develop secure attachments (Fonagy, 1999; McAdams, 1993). Conversely, in the *Adult Attachment Interview*, a research interview used to assess attachment of adults in their childhood, one of the markers of poor (ambivalent, resistant or disorganised) attachment is a reduced ability to produce a coherent narrative (Main & Hesse, 1990). In addition, it has been argued that it takes skill, judgement and experience to produce a convincing rather than unconvincing story (Robinson & Hawpe, 1986).

Another way in which the importance of narrative can be seen is in the development of narrative therapy (White & Epston, 1990), which has as its primary focus the importance of the story. Finding different ways of telling and thinking about the story is part of the recovery process. Furthermore the repeated act of writing (producing a narrative) about significant personal events using emotional language has been linked to better mental and physical health (Pennebaker & Seagal, 1999). It is not, however, the task of this research to evaluate the

mental health of these participants based on the types of narratives they produce. Rather, what is of interest is the ways in which they construct both the problems and themselves within the initial interview.

Before going any further the meaning of the word 'narrative' should be explored. The Oxford Dictionary definition of narrative (Thompson, 1995) is a tale, a story or a recital of facts, especially a story told in the first person. Within the psychological literature narrative has been defined in many different ways in different texts. It has been used as a metaphor (Riessman, 1993). It has also been viewed quite narrowly as only a story about particular chronological events (Labov, 1972) with a definite beginning, middle and end. Thematic as opposed to chronological sequencing has also been used to define narrative (Michaels, 1981). Riessman (1993) prefers a broad definition which would include narratives of different genres such as habitual, hypothetical and topic-centred narratives. She maintains that different genres 'persuade differently; they make us care about a situation to varying degrees as they pull us into the teller's point of view' (p.18). McAdams (1993) echoes this, claiming that stories are 'less about facts and more about meanings' (p. 28). Brown et al. (1996) point out that the meaning of a narrative 'may differ radically – from something that is taken to be reflective of a person's "true feelings" to a contextually co-occasioned production which is produced through interaction and does not necessarily relate to any inner mental state at all' (p. 1571). Mishler (1995) reminds us that narrative is co-created in dialogue, and is not merely intrapersonal in nature. Wolfson (1976) regards interview narratives as summaries of conversational narratives, which are real, performed narratives and are usually much more detailed. There are many other definitions of narrative, but this sample gives some idea of the variable ways of defining the construct.

Co-construction and the intersubjective nature of therapy is an important focus within this research. All participants within the therapeutic interview play a role in the type of talk which emerges in that particular context. In addition to the notion of co-construction within the context of therapeutic encounters, it is important to highlight the fact that the stories clients tell cannot necessarily be thought of as unsophisticated constructions that have not been influenced by 'versions of personhood, mental "health" and "illness" which have clear links with the versions already in use by professionals' (Brown et al., 1996, p. 1575). There are numerous existing vehicles to which people may have had access which they may use to make sense of and understand their problems and identities. The notion of the double hermeneutic (Giddens, 1976), for example, draws attention to the probability that people will make use of

psychiatric and psychological knowledge within such a sense-making process. The existence of societal discourses within conversation emphasises the way in which representation in narrative accounts may be better defined as the narrator's interpretation and not an accurate and objective description (Riessman, 1993). The role of the psy-complex (Rose, 1989) with its ideological focus on the improvement and management of individuals also deserves mention as a construct which has affected the ways in which people on a broad scale make sense of their problems. Wetherell (1999) would argue that psychoanalysis has affected the way in which people construct meaning in a similar way.

Bound up with defining what a narrative is, is the method one uses to analyse narrative. Once again much variability exists. Labov (1972) for example proposes a structural method consisting of a six-part structure, which he called the evaluation model, for analysing narrative. Narrative has also been analysed using conversation analysis which is more concerned with interactional patterns within the narrative context (Mishler, 1995) than the structure of the story. Frame analysis (Goffman, 1975) is interested in the ways in which people organise face-to-face interaction and has also been used to analyse narrative. Cortazzi (1993) shows how narratives can be analysed from a variety of perspectives, drawing on several models within each of the disciplines of sociology, psychology, literary analysis and anthropology.

The meta-theoretical framework within which the current research is situated is social constructionism. Briefly, social constructionism is a framework which focuses on the way in which life is socially constructed through language, in the way that people talk about events and feelings. Discourse analysis is a primary tool that is used to analyse talk within a social constructionist theoretical framework and will be used to analyse the data in the research.

The aim of this dissertation is to analyse the initial family intake interviews at the clinic to find out how they construct their problems in the talk. The analysis should provide a detailed and substantial description of the narratives of six such sessions. Through the use of discourse analysis the functions of the language used in the sessions will be analysed (Potter & Wetherell, 1987). The discourse analysis will also explore how individual subjectivity is constructed through the talk, making use of 'complex subjectivities' (Parker, 1997) to enrich the analysis. Lastly issues of power and ideology among the participants and researcher are of interest here (Parker, 1992). The analysis will attempt to show who has the power to talk, who

is silenced and which speakers and topics are either foregrounded or minimized (Swartz, 1996).

Of fundamental interest in the research will be what the talk reveals about narrative construction. The extent to which there is coherence or fragmentation in the narratives will be considered. Of significance will be the ways in which clients move away from or towards talking about the problems they have. The research makes the assumption that the ways in which clients' talk when asked about the problems that have brought them to the clinic will reveal much about the nature of narratives they produce.

Part of the purpose of doing this research is to provide information to clinical practitioners regarding the construction of talk within the interviews. The information obtained in these initial sessions is used to formulate and decide on clinical treatment of clients. It is hoped that the analysis will assist clinicians in reflecting on the ways in which they conduct these interviews and on the information they obtain. A focus on the ways in which talk and individual subjectivity are constructed in the interviews is likely to enrich the clinical formulation and treatment of clients.

Overview of Chapters

Chapter 2 begins with a review of the empirical literature on the doctor-patient relationship and illness narratives. This research is included because 'clinical encounters [are seen] as communication events' (Chenail & Morris, 1995, p. 2). There are clear similarities in the ways that communication research on medical interviews and therapeutic interviews has developed. Empirical research on psychotherapy encounters is also explored. The chapter then focuses on literature which describes and argues for the theoretical underpinnings of the study, both within social constructionism and psychoanalysis.

The methodology used in the research is discussed in Chapter 3, which focuses on the types of discourse analysis used within the study. The chapter also looks at discursive complexes. Methods of sampling, data collection and analysis are then examined. It concludes with ethical considerations and validation issues within the study.

Chapter 4 contains the analysis of the data. Two main themes within the talk are dealt with, the first consisting of ways in which the problems are constructed, and the second elucidating what happens when people attempt to avoid constructing the problems.

Chapter 5 contains a discussion of the results of the analysis. It continues the analysis and discussion of the interpretative repertoires found in the analysis chapter, focuses on complex subjectivities, and in this way integrates discursive and psychoanalytic theory. Another focus is the contextualization of the study. The significance and implications of the study are also explored.

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Chapter 2: Review of the Literature

The most important part of this chapter is the elucidation of the theoretical framework of the study, this being social constructionism as was mentioned in the introduction. This is followed by a review of literature integrating discourse analysis and psychoanalysis as strategies for understanding people.

However, the chapter begins by briefly examining previous empirical research done on the doctor-patient relationship and illness narratives in order firstly, to acknowledge the similarities between psychology and medicine and, secondly, to see what can be learned from this body of research for the purposes of the present study. Previous empirical research done on the psychotherapy session is also examined. While much of this research has been done in more traditional, often unitary frameworks, it has nevertheless been the research out of which social constructionist approaches to the therapeutic session have emerged. This literature is therefore important in terms of historically situating the current research on the initial session of psychotherapy.

Empirical research

Situating psychotherapy within a medical framework: research on the doctor-patient relationship and illness narratives

The discipline of medicine was the birthplace from which many psychotherapists sprang. For example, both Freud and Charcot were medical doctors before they became interested in psychology. In addition to the fact that the roots of psychology fall within biomedicine, the clinical interview (Goldberg, 1997; Pridmore, 2000), which forms the basis of the interviews analysed in this research, was created within such a biomedical framework. It is therefore important to examine biomedicine briefly, to tease out its philosophical underpinnings and also to examine research within biomedicine that has been done on the doctor-patient relationship.

Biomedicine adheres essentially to a realist ontology and a positivist epistemology (Filc, 2004) and regards 'facts' as independent of theory, and scientific research as the way of finding the truth. 'Evidence-based medicine argues that medical practice should model itself on scientific method and that all interactions with patients should be guided by the falsifiability principle: only those interventions which have been shown by rigorous tests to be effective should be implemented' (Holmes, 2000, p. 92). Furthermore within a realist

ontology there is an assumption that narrative can only be a reflection of reality (Horton-Salway, 2001). Much research and theorizing within psychology too, is positivist and empiricist in nature. And of course within both psychology and biomedicine there is a focus on the individual and individualism. It has been argued that without such a focus psychology as a discipline would not exist (Sampson, 1993) and equally that without the category of the individual patient, biomedicine as a discipline would not exist (Herzlich & Pierret, 1985). It has also been argued, however, that both its positivist/empiricist nature and its focus on the individual and individualism are problems for psychology (Crossley, 2000; Foster, 1999) because of what they prevent the discipline from acknowledging in terms of social and contextual issues.

There is a long and continuing history of research into the doctor-patient relationship within medicine. It is useful to examine this research given the proximity of psychotherapy to medicine and also because there is a parallel focus on the meanings of illness which runs through this literature. While people who present with psychological or psychiatric problems are not necessarily ill in the medical sense, they are presenting with a problem, and it may be useful to see what the literature on illness narratives could add in terms of understanding this. There are also similarities between medical encounters and therapeutic sessions in that both are tightly organized events.

Much of the research on doctor-patient relationships is based within the positivist realist framework and the attempts to improve effectiveness as discussed above, and therefore is not of much interest for this research because of its assumptions of factuality within the interview (Holmes, 2000). For example some literature focuses on assisting the doctor to do better interviews (Falvo & Smith, 1983; Shapiro, 1990). Other literature uses doctor-patient interaction as an independent variable within which to study patients' health behaviour or compliance (Heszen-Klemens & Kapińska, 1984). There is also literature which tests a model of patient-centred interactions, finding that facilitating behaviour on the part of the doctor is crucial for a successful interaction and following from that, patient compliance (Stewart, 1984). This literature with a focus on effectiveness, compliance and a successful doctor-patient interaction is generally written from within the discipline of medicine. Brown et al. (1996) maintain that, while within traditional psychiatry there is an exhortation on medical staff to listen to patients, there is no focused attention paid to the narratives of patients aside from what they reveal about the disorder, or narratives of mental illness created by those in the caring professions.

Tates and Meeuwesen (2001) are critical of the fact that studies on doctor-patient communication concentrate primarily on interactions between the adults even when the patient is a child. They found twelve such articles published between 1968 and 1998. While all the studies professed to analyse the triadic interactions only three did so unequivocally. The others analysed doctor-parent and doctor-child dyads. Tates and Meeuwesen maintain that the triadic communication differs from the usual dyadic interactions and must be studied separately. The specific findings around the contribution of the child are that a child's contribution is largely limited to the provision of medical information, maintaining a 'joking relationship' with the doctor, and that the child does not have much control in the medical conversation.

An example of literature looking at illness narratives from a psychological perspective that takes a cognitive approach is Skelton and Croyle's (1991) work on health and illness and the way in which people understand illness. This text focuses on people's 'mental representations' of health and illness, examining the illness schemata that people use to control their health behaviour. This fits best into the body of research on focusing on efficacy and improvement in general health behaviour.

There is, however, literature which regards the relationship and the situation more critically, particularly with regard to issues of power and ideology, and this is of interest here. Most of this literature has been created within other disciplines like sociology, anthropology (Armstrong, 1982, 1983, 1984) and sociolinguistics (Cortazzi, 1993). Traditional positivist psychology has been notably absent from this sort of research. Monks (2000) discusses the ethnomethodology (Abrams, 2000) and conversation analysis roots of much of this work which has been more interactional in nature, as well as the 'critique of the empiricist medical language' (p.21) of authors such as Kleinman (1980, 1995). This literature examines issues such as agency of patients, the embodied emotion of medical interviews, the concept of 'social suffering' and the differences between verbal and non-verbal behaviours (Kleinman, 1995; Monks, 2000).

A recent review of the literature on the doctor-patient relationship raises the issue of the power differential between doctor and patient as well as the frequently heightened emotional nature of the meeting (Ong, De Haes, Hoos & Lammes, 1995). This review does not examine the extensive literature prior to the 1980's however. Some of the first literature criticized doctors for not taking sufficient account of the patients' feelings and opinions (Parsons,

1952). Parsons developed a structural model of the medical interaction which was powerful because 'it conceptualised the interdependence of personal affect, motivations and responsiveness, and social structural and cultural contexts' (Monks, 2000, p. 20) and because of this, according to Monks, it remained important within sociological theorizing around the doctor-patient interaction for quite some time. It may be of interest to note that Parson's ideas had strong psychoanalytic underpinnings (Gerhardt, 1989).

One area in which psychology, although, not traditional psychology, did play a part, was in the area of a proposed change in root metaphor for psychology. Sarbin (1986) proposed the use of narrative as a root metaphor as an alternative to that of the machine which is the root metaphor of much of positivist psychology. This idea comes from Pepper's notion (1942 in Sarbin, 1986) of the different types of root metaphors which underlie work in a particular field as well as society in general. Sarbin argued that the machine metaphor with its mechanistic assumptions has dominated psychology and that a metaphor of what Pepper originally called 'contextualism', or storytelling, would be more valuable in understanding human behaviour. In the same vein Gergen and Gergen (1986) argued, for example, that several theories of psychological development are narrative in character, and rejected the assumption that these theories, i.e., stimulus-response theories, Piagetian stage theory and Freudian theory of human development, are objective (mechanistic) in nature.

Overall the theoretical frameworks of both structural functionalism and symbolic interactionism have been used in this research in the past forty years (Fife, 1995; Frankel, 1984; Gerhardt, 1989). Parsons' (1952) approach focusing on the sentiments of patients can be seen as broadly structural functionalist. Freidson's (1970) symbolic interactionism focused on power differentials between the privileged and disenfranchised. It has been argued that the aims in these earlier works were limited and practical in nature and focused on the views of patients in an effort to understand from the doctor's point of view, what the patients wanted (Herzlich & Pierret, 1985). One change has been that doctors 'now admit – a change from the prevailing attitude 20 years ago – that the "patient's illness" does not coincide with the "doctor's disease"' (p.145).

Armstrong (1982, 1984) raises the issue of why certain things that are said by the patient are heard within the medical interview and others are not. He relates what is heard to the changes in medicine and the social sciences in the 50 years before the article was written. In a post-structuralist Foucauldian analysis of medicine and patients he proposes that the interest in the

opinions and feelings of patients merely reflects the changes in perception brought about by the changes within these subjects.

At each historical point medical analysis has an object and an effect: the object is the patient's view (in its contemporary form) and the effect is the 'person' who holds those views. When the doctor searched for pathological lesions, the view was the symptom and the patient was both receptacle for pathology and unreliable translator; when the doctor acknowledged the importance of the emotions in his search for illness, the view was both the symptom and the feeling, and the patient was an emotional and somewhat less than perfect setting for pathology; when the doctor enquired of patient meanings, the view became the lay theory and the patient a subjective being (Armstrong, 1984, p. 743).

McNeilis, Thompson, and O'Hair (1995) examine the ways in which doctors and patients negotiate control within the clinical encounter. This research makes use of Bateson's relational coding to look at the control patterns within the interview. Ten Have (1991) states that conventionally the power differentials of doctor-patient communication were regarded as an effect of institutional structures, rules or resources. In more recent years however analysis has shown how these differentials are constructed within such interactions. He reviews aspects of asymmetry in the interview which produce the power differentials, for example the fact that the patient's health is being considered, not the doctor's or that the tasks in the session are consistent with interactional dominance on the part of the physician and submission on the part of the patient. His conclusion is that participants in such interviews can choose either to act or not to act in accordance with institutional expectations. This is consistent with positioning theory (Davies & Harré, 1990) which would challenge the somewhat derivationist assumptions behind such research, and argue that people can position themselves variously in conversation.

Narrative approaches to psychotherapy and psychiatry (Bailey & Tilley, 2002; Brown et al., 1996; Mishler, 1984, 1995; Murray, 2000; Parry & Doan, 1994; Rennie, 1994; Steele, 1986; West, 1984) have also been emphasized within interactional models. Some of this literature examines the structural nature of the interview or the discourses involved in the interview. Conversation analysis is one of the methods of analysis that has been used to do this (West, 1984). West does not like methods that simply classify and count certain behaviours and rejects models which reduce the medical interview to the performing of behavioural scripts. She focuses instead on the talk in the encounters and aims to discover how medical encounters are constructed within an interactional analysis.

Illness narratives have been examined more systematically in terms of the level of analysis they adhere to: personal, interpersonal, positional and societal (Murray, 2000).

Phenomenology has been the most influential and conspicuous theoretical framework used within narrative psychology (Crossley, 2000). Much of this work takes place at what Murray would call the 'personal' level where the narratives are devised in order to make sense of the body and reconstruct identity (Bailey & Tilley, 2002; Murray, 2000) which is often jeopardised by illness. This writing deals with people coming to terms with their illness and the effect that it has had on their lives. For example Frank (1993, 1995) maintains that the illness narrative often includes a central shift to a new way of thinking by the person, including a reconsideration of the way in which they live. He also considers the way in which rhetorical structures concerning the self as a 'project for change' (p. 39) could inform the personal narratives of people. This is so much so, that it has been called biographical work (Corbin & Strauss, 1987, in Frank, 1995).

Arnston and Droge (1987) identified four functions of illness accounts within the narratives. These are making sense of the problem; increasing agency and control within a framework of loss; transforming and reshaping identity and lastly, decision-making within the context of the problem. These are all situated within Murray's (2000) 'personal' level of analysis of illness narratives.

An example of work which looks at the meaning of illness and illness narratives from this level of analysis is a recent study focusing on stories about self and shame with women who suffer from chronic pain (Werner, Widding Isaksen & Malterud, 2004). In the analysis of these stories, themes of credibility, dignity and self-esteem emerge. This feminist analysis has both narrative and discourse analysis underpinnings. They found that there were ways in which these women performed versions of themselves that were consistent with the normative biomedical versions of illness. Illness was also sometimes experienced as shaming and stigmatizing.

The interpersonal level of analysis was first emphasised by Mishler (Murray, 2000) in an attempt to pay attention to the intersubjective, co-constructed nature of narrative. It is interested in topics such as alterations that take place in stories which are told within an interview situation as well as the effects of being questioned (Labov's 'observer's paradox' 1972), and the possibility of being judged by the interviewer on the production of the story. Impression management must therefore be taken into account (Goffman, 1975). Wolfson

(1976) has also emphasized these contextual factors within this sort of research. Mishler's work will be examined in more detail because of its importance to illness narratives and the doctor-patient relationship.

In this influential study of medical interviews, Mishler (1984) initially critiques previous studies on the doctor-patient interaction and then presents two different ways of examining the same medical encounter. In critiquing previous studies he directs particular criticism to standardised coding systems and an approach to the reading of transcriptions which does not 'take into account the gap between speech and text' (p.56). In his initial analysis he discusses his notion of a three-part sequence in the talk. This begins with a question by the doctor and is followed by the patient's response. The next question by the doctor serves both to close the first sequence and open the next. In analysing interviews structurally in this manner, his interpretation is that these structural units that occur throughout the interview serve to maintain the doctor's control over the interview. He refers to this as 'the voice of medicine' – the notion that a particular normative order is represented in the discourse.

This is contrasted to 'the voice of the lifeworld', which is what he calls the problems that patients associated with their illnesses, essentially the context within which the illness occurs. He argues that the problem with his initial analysis is that it remains within and therefore serves to legitimise the voice of medicine and does not problematise the control and dominance of the doctor. The actual 'ways of formulating and analyzing the structure of the discourse and its problems function to maintain and reaffirm the dominance of the medical voice' (p. 97). He therefore reanalyses the transcripts holding the voice of the lifeworld dominant and viewing the voice of medicine as an intrusion, and in so doing, inverts the assumptions of the initial analysis regarding the dominance of the medical voice. His finding is that the 'lifeworld' contextual view of illness is not valued within the session and that this devaluing is constructed discursively during the conversation. He underlines that this is an intersubjective process between doctor and patient, what has been called 'the creation of an emplotment' (Werner, Widding Isaksen & Malterud, 2004, p.1041) which has been extended from the philosophy of Paul Ricoeur by researchers to underline our level of action within the stories we create (Murray, 2000) and in which both the narrator and listener participate. This work is particularly interesting in that its focus is on different ways of making meaning within the interview in the broadly interactionist theoretical framework (Monks, 2000) used by several researchers.

It has been proposed that a more active patient participation is required of patients trying to engage with medical practitioners in their attempts to make sense of chronic illness experiences (Kroll, Sharf, & Haidet, 2004). They argue that this can be placed on two continua: engaging with the illness experience, and negotiating control about decisions to do with the illness. People can situate themselves at various places along each of these continua and this may change over time. They explore the extent to which it is possible to be active as a patient, particularly when one is first diagnosed and therefore probably feeling vulnerable, and when interfacing with the long paternalistic tradition of medicine.

The positional level of analysis (Murray, 2000) is interested in differences in social position of the participants in a medical interview, such as patient, physician or researcher. Mishler's (1984) notion of medicine's voice as opposed to the lifeworld of the patient provides an example of these different positions.

Murray's (2000) final level of analysis within illness narratives is that of the societal or ideological level. This level is interested in the way in which the construction and regulation of social experiences is influenced by societal or cultural assumptions. Murray explores two concepts that come out of social representation theory (Moscovici, 1984) which may be of interest in the current study: anchoring and objectification. Anchoring is the way in which meaning is made out of alien ideas or perceptions by linking them with less alien notions. Objectification takes place when abstract ideas attain meaning upon being associated with everyday events. Along these lines, Frankenberg (1986) reviewed the use of root metaphors in the performance of sickness. He proposes that sickness as a cultural performance 'lends itself to a sociology of sickness that is not reduced to the individual, the biological, or the merely textual and yet allows for the recording of personal enterprise and idiosyncrasy' (p. 625).

Illness narratives have also recently been approached from a social constructionist point of view. Sharf and Vanderford (2003) have examined health-related discourses in this way. They highlight 'the rhetorical origins of the tension between the physical world and symbolic representation, and the application of this approach to communication issues related to health and illness' (p. 29).

Within psychiatry as opposed to medicine more generally, some literature focuses on the transformation of the raw data of the clinical interview into the written case notes or psychiatric record (Barrett, 1996; Garfinkel, 1967; Hak, 1992; Swartz, 1996). Barrett, using an example of an actual case, shows how the record reduces the 'rich detail of the spoken

interaction' (p. 115) in the session. Certain elements of the narrative become invisible in the record, for example common sense notions of mental illness. Garfinkel explores the different uses to which psychiatric records are put, including both clinical and research use. Hak provides a more critical focus on the interpretation which appears in the psychiatric record and which is made from original and second-hand accounts. He details three ways in which psychiatric records are studied within the sociology of medicine. The first views the record as a repository of information. The second differentiates between the actual problem and the interpretation of that problem by psychiatry. The third is ethnomethodology which is critical of both the above approaches. 'According to ethnomethodologists as well as "critical" sociologists, the psychiatric record is a description of neither "real" mental conditions nor a patient's career' (p. 139).

Brown et al. (1996) are critical of the lack of acknowledgement of the layers of representation and interpretation within this process of transformation of data. They argue that there are different ways of reading and writing records which are partially dependent on the profession of the person doing the reading or writing, and the purpose behind what that person is attempting to do. Essentially they try to problematise the transition between talk and written document and are critical of the extent to which Hak (1992) has attempted to do so. Spence (1986), writing in the same area, highlights the process of what he calls 'narrative smoothing'. This is the process of omitting some details and enlarging others so that the case notes adhere to the theory. He goes even further than this, however, to argue that narrative smoothing also takes place within the therapeutic session, where certain questions are asked, certain stories are elicited by the analyst, and others are not. Of course there is also the matter of which stories are told by the patient and which are not!

It can therefore be seen that some of the more critical research on the doctor-patient relationship is of interest to this research in that it looks at things like power differentials and the construction of the medical interview and illness narratives, sometimes using narratives to do this, and sometimes focusing on discourses. It has, however, been argued that both the classical notion of 'listening to patients' within psychiatry and the more recent focus on clients' narratives within therapy lack an analogous focus on the narrative constructions of professionals (Brown et al., 1996). The intersubjectivity that has been highlighted by several researchers would be greatly enhanced, according to these authors, by a systematic focus on the discourse of professionals.

Work examining psychotherapy sessions

Various aspects of psychotherapy have been investigated empirically. Maione and Chenail, (1999) in reviewing the qualitative literature in the field, divide it into several categories: client-oriented factors, those concerning the therapeutic alliance, those focusing on techniques or models of psychotherapy and lastly, literature which they could not slot into one of the other categories. There is also a large body of literature examining the relationship between patient and therapist, focusing on issues like symptom change (Bottari & Rappaport, 1983) or creating better client-therapist relationships (Todd, Joanning, Enders, Mutcher & Thomas, 1990; Yalof, 1987). This literature serves a similar purpose to that examining the relationship between doctor and patient focusing on issues like compliance and patient satisfaction. While there is much relevant research in all these areas, for the purposes of the current study, what is of interest is the literature focusing only on interactions within the therapy session.

Interactions in psychotherapy sessions have been investigated in various ways in the past fifty years. Changing theoretical fashions over the years have played a large role in influencing the different techniques used to analyse sessions. Much of the work done earlier focused more on the formal structure of the session (e.g., Labov & Fanshel, 1977; Pittenger, Hockett & Danehy, 1960; Scheflen, 1973) with sociolinguistic underpinnings while later work tends to have postmodern or narrative theoretical underpinnings (e.g., Hare-Mustin, 1994; Nye, 1998, Rennie, 1994). The interest in studying psychotherapy sessions has often not been from within the discipline of psychology or even sociology, but rather linguistics, particularly sociolinguistics. This similarity with the research on the medical interview is interesting. Perhaps it is easier, or only possible to do this sort of work from outside the paradigmatic restraints of a particular field (Kuhn, 1970).

While initially the focus was much more on the naturalistic conversation and psychoanalytic interpretations (Fanshel & Moss, 1971; Frank & Sweetland, 1962), this soon moved to a structural linguistic approach (Lennard & Bernstein, 1960; Scheflen, 1973) on the one hand and an attempt to analyse content (English, 1966 in Scheflen, 1973) on the other. There were also moves toward studying other aspects of the talk besides the content (Sacks, 1972; Schegloff, 1968), for example Mahl & Schulze (1964) looked at speech disturbances such as stutters, repetitions, false starts, and slips of the tongue as measures of anxiety and developed a Speech Disturbance Ratio out of this work. Another study (Pittenger et al., 1960) attempted to look at loudness, intonation and voice quality, but here there is rather an attempt to

understand the meaning behind use of these aspects within the therapeutic conversation, instead of a focus on quantification and categorisation.

Schefflen and his colleagues spent time studying a therapeutic session and eventually produced two separate works focusing on this session. The first was aimed at psychologists (English, 1966 in Schefflen, 1973) and concentrated on clinical data and conclusions. The second focused more on the research method which grew out of a structural linguistic orientation and focused on the structured behaviour within the session, for example postural changes, gestures and other movements representing physical aspects of speech acts (Schefflen, 1973). He called this a Behavioural Systems Approach. This dichotomous split between the two works is problematic in that in the analysis of structured behaviour, there is no concomitant focus on the verbal content of the session. There is thus little focus on the fact that words and physical behaviour are together producing the narratives.

Labov and Fanshel (1977) in their seminal work on therapeutic narratives examined the linguistic forms used by the therapist and patient in fifteen minutes of one session of psychotherapy. They focused primarily on the rules of discourse within the session and tried to make sense of the interaction between therapist and client in terms of social and linguistic patterns and rules.

It has been argued that Labov's (1972) work is important because of his focus on the collection of systematic empirical data on social behaviour. Labov essentially studies the structure, as opposed to the content of narratives. He suggested that a 'complete' personal narrative will have a six-part structure, including an abstract, orientation, complication, evaluation, result and coda' (Cortazzi, 1993), but he also argued elsewhere (Labov & Fanshel, 1977) that to study only the structural elements within the sentence is not enough. Cortazzi (1993) criticises Labov's (1972) work because of his insistence on a temporal organization of clauses. Labov maintains that the way that clauses are ordered in the narrative assumes a particular sequence of events. This means that anything spoken 'out of order', such as flashbacks or embedded statements which are unexceptional in narratives, would not be permissible within Labov's model.

The later work is more interesting within the context of the current research. Winefield, Chandler and Bassett (1989) studied tag questions within a course of psychotherapy between a single therapist and client from a sociolinguistics point of view. They showed the way in which tag questions changed from early sessions to later sessions. In the early sessions they

generally served as a technique to invite the therapist to take over the conversation, while in later sessions they served to check for a reaction to the patient's opinions. 'The patient is seeking not confirmation, but an expressive sharing of her views with a person who understands' (p. 84). Their hypothesis is that the changing tag questions mirror the changing power dynamics within the therapy. Patterns of speech suggest, however, that the patient never obtained an equal status in the therapy.

The ways in which clients talk about their problems has been investigated in several studies (Buttny & Jensen, 1995; Rennie, 1994). Buttny and Jensen argue that presenting problems need to be seen not only as narratives of what has happened, but also as vehicles in which blame, accountability and justification with regard to the problem are voiced. Rennie found more than just the telling of the story in renditions of the problem within therapy. He found that storytelling can be used to avoid other issues or feelings. Nye (1998) highlights the notion of narrative co-construction within the therapeutic situation.

Saleebey (1994) proposes a Foucauldian analysis of the reasons that clients may take on a professional discourse. Essentially he says that the therapist may try to persuade the client of the veracity of a professional version of the problem, one that makes sense theoretically, but possibly not in terms of the common sense of the client. The client's own version of the story is then either yielded to this professional one or suppressed. This is how the client's story is subjugated, becomes ephemeral and is replaced by the dominant professional discourse. Saleebey maintains that if a client is socially subordinate to the therapist, it exacerbates this sort of process and makes it even more difficult to hear the client's story.

Conversational analysis (Sacks, Schegloff & Jefferson, 1974), with its focus on turn-taking, exchange structure, adjacent pairs of statements has also been used as a method of analysis for psychotherapy sessions (Sands, 1988). She concludes that therapeutic conversation is asymmetric in terms of turn-taking and repetitive, which is not negative, but rather helps the clients incorporate new ideas into their own narratives.

Peyrot (1995) found that psychotherapists engage in two types of conversation based on previously identified types of exchange (Frank & Sweetland, 1962): in the first therapists extract narrative accounts of the problem from the client and in the second they try to get clients to talk about insights into their problem or situation. The paper details an interactional analysis of psychotherapy. Peyrot maintains that conversation analysis has not often been used for analysing psychotherapy sessions.

There is also some research that has used discourse analysis as a method of analysis within psychotherapy sessions (Hare-Mustin, 1994; Madill & Barkham, 1997; Madill & Doherty, 1994). Madill & Barkham analysed a theme from an 8-session therapy of a woman with a major depressive episode. Of interest here is the way in which cultural discourses are present within the therapy as personal problems. They argue that 'this discursive analysis ... offers an understanding of therapeutic process based on a view of language use and cultural meanings rather than viewing mechanisms of change [as] hidden within the client's head' (p. 243).

This links to Hare-Mustin's (1994) argument that the therapy room 'can reflect back only the discourses brought to it by the family and therapist' (p.19). Essentially she is saying that some discourses are more likely to be brought because of their acceptability within society. Hare-Mustin (1994) argues that not all discourses have equal weight, or are seen as equally important. She maintains that dominant discourses 'are part of the identity of most members of any society, and they influence attitudes and behaviours' (p. 20). She says that therapists are guided more by dominant than marginalized discourses and that therapists generally uphold the interests and moral principles of dominant groupings in society.

The studies reviewed in this section serve to provide examples of the ways in which the interactions within psychotherapy sessions have been studied. While there is a lot of continuing research in this area, some of this literature is of little interest in a study such as this because of its broadly positivist and functionalist nature. The theoretical underpinnings of the present study are social constructionist in nature.

Social constructionism

From the literature reviewed thus far, it can be seen that there is a body of literature focusing on the talk in psychotherapy sessions which is situated within sociolinguistics and sociology more than psychology itself. Much of this work has its theoretical basis in the linguistic forerunners out of which social constructionism and discourse analysis, as a primary method of analysis within social constructionism, emerged. In this section the theoretical underpinnings of social constructionism, which is used as the meta-theoretical framework of the study, are examined. The reason for exploring the theory behind social constructionism in such detail is that in order to integrate social constructionism and psychoanalysis, the epistemological and ontological basis of each of these must be explicated.

Three contrasting ways in which to analyse narrative have been described by Horton-Salway (2001): the first falls within a realist ontology and makes the assumption that the narrative reflects the external world, in other words that it is a truth; the second is cognitivist in approach and highlights the way in which the narrator constructs the narrative; the third is discursive and takes into account both the construction of the narrative and the interactive context, in other words, intersubjectivity or co-construction. It is this third type of analysis on which this research will be based. It is therefore necessary to contextualize the research within a discursive framework.

The word discourse comes from the Latin root 'discurrere' which means, 'to run around' (Glare, 1982). It has been argued that a large part of what we do and how we act (run around) in life is performed through language (Potter & Wetherell, 1987). In examining the language that people use, one must, almost of necessity, turn to discourse. Of course there are many different types of discourse analysis; however, before discussing the use of particular methods, discourse analysis must first be located within the theoretical context from which it emerges, namely social constructionism. This will be done in the current chapter. The particular types of discourse analysis used in the study will be discussed in the methodology chapter.

Social constructionism has as its basis the belief that reality is created, or constructed in social interaction (Berger & Luckmann, 1966). It views social and psychological processes as constructed and expressed through discourse (Parker, 1992; Potter & Wetherell, 1987). Language therefore becomes something which does much more than merely represent things which already exist. It is seen as actually constructing that reality (Parker, 1992). Constructionism is difficult to define and it has been argued that it may be an inappropriate act to define it, and that doing so would imply neutrality and objectivity where there is complexity and disagreement (Potter, 1996). However it has been loosely defined as 'a concern with the processes by which human abilities, experiences, commonsense and scientific knowledge are both produced in, and reproduce, human communities' (Shotter and Gergen, 1994: p. i).

Authors such as Burkitt, Danziger, Hacking and Edwards have indicated that it would be erroneous to regard social constructionism as a unitary paradigm (Edley, 2001). Two varieties of social constructionism: ontological and epistemological, which Bunge (1993) calls cognitive, are generally referred to. The epistemological variety underlines the socially

constructed qualities of institutions and knowledge including how knowledge often 'bears the marks of its social origins' (p. 90). Ontological social constructionism makes the assertion that objects or knowledge exist only as social constructions and that it is the knower that creates the world. These varieties bear similarities to what Sayer (2000) refers to respectively as 'weak' (epistemological) and 'strong' (ontological) constructionism. They differ, however, from the approach of Edwards (1997). In his estimation social constructionism is by its very nature epistemological in the sense that it is interested in the construction of descriptions rather than the entities that exist beyond them. As can be seen from this brief description of some conceptions of social constructionism, there are a variety of different interpretations and arguments surrounding the concept, and it is difficult to simplify these.

One of the central debates is around whether constructionism is realist or relativist. Picking up on the weak/strong differentiation, Liebrucks (2001) initiates his discussion with the arguments of Berger and Luckmann (1966) concerning the nature of social constructionism, i.e. what specifically is constructed within social constructionism. The first thesis is that our beliefs regarding reality are constructed in social interactions. The second is that over and above beliefs, social institutions and people are constructed in social interactions. In the second thesis, reality itself is seen as being socially constructed, whereas in the first, only beliefs about reality are seen as being constructed.

Liebrucks (2001) differentiates between the constructionism of Gergen (1998), and like-minded theorists, who argue that reality is constructed and that of Berger and Luckmann (1966) who argue that it is beliefs about reality that are constructed. This is analogous to the differences explored above between ontological and epistemological constructionism.

Gergen's (1998) view is pertinent to explore at this point. He views constructionism as being in opposition to realism, that is, in other words, there can be no realist position within constructionism. In an attempt to counter the argument that Gergen expounds, Burr (1998) argues that there are three definitions of reality: the first is reality as truth which is opposed to falsehood; the second is reality as materiality which is opposed to illusion; and the third is reality as essence which is opposed to construction (Fuss, 1989). Burr's opinion is that constructionism is only opposed to essentialism, not to truth or materiality.

Burr's (1998) view, which contrasts constructionism on the one hand, and realism as essence on the other, is one argument around the realism/relativism debate. Willig (1999) makes another in an attempt to establish that social constructionism and relativism are not

synonymous. She argues that constructionist work must become part of the historical materialist analysis of society and that it is not sufficient merely to describe relations of power, but that one is also required to explain how these power systems are maintained and how they came about in the first place. It has been argued that 'throughout history, dominant groups have asserted their authority over language through control of the production of knowledge, of the media and publications, and of access to education and to institutions of learning' (Hare-Mustin, 1994, p. 21). Power is seen as a complex set of connections of practices, institutions and technologies that maintain both dominance and subjugation within society (Foucault, 1980). Willig invokes critical realism in order to explain the development of power systems and argues that critical realism is consistent with epistemological relativism but that it does not have to be consistent with ontological constructionism. Instead she argues for an ontological realism which implies that observable events are created by stable underlying structures.

In much the same way that Crossley (2000) is critical of the notion of an essential inward self, Sampson (1989) raises various challenges to the notion of the individual as psychology's subject. In a critical deconstruction of the notion of 'self', he argues firstly that cross-cultural work in various disciplines has suggested that this notion is not adhered to within all cultures. Feminists have, according to him, also challenged patriarchal accounts of psychology, among them the notion of the individual. Social constructionism argues that the self and psychological traits are social or historical constructions, not essences or natural objects. He argues that from a systems theory perspective, relations between people are given preference over the individual. And lastly critical theory views the concept of the individual as falling within a capitalist ideology, not as real. Potter also highlights the notion of the relation and dependence of mind and action on cultural practice (Potter, 1996). An example of this argument is that it is only recently that sickness has been constructed as an individual problem and that the category of the patient has emerged. Previously sickness was constructed as a collective affair (Herzlich & Pierret, 1985).

Willig's (1999) view is that discourse analysis, one of the primary research tools of social constructionism, is an invaluable tool for psychologists who wish to challenge the status quo in psychology. Discourse analysis can have the effect of showing how 'our customary ways of categorizing and ordering phenomena are reified and interest-driven rather than reflections of reality' (p. 94). According to Willig, in different historical periods particular discourses are

dominant and that we need to do more than just talk or write about this to bring about changes in these discourses.

So far it can be seen that there are different types of social constructionism, and that there are debates among the theorists that are broadly constructionist concerning what is socially constructed and whether constructionism is realist or relativist in position. Perhaps it is also important to look briefly at some of the problems that have been raised with social constructionism.

The first of these has to do with the avoidance of embodiment within constructionism (Cromby & Nightingale, 1999). Because the text is seen as the primary data source and it is rather difficult to fit the body into the text, bodies have generally been ignored within this framework. These authors argue that subjectivity is located within a particular body with a particular individual life history and that to ignore this fact is to ignore the experiential basis of class, race and gender and the ways in which these enter into discourse. Crossley (2000) is also critical of the lack of personal agency or subjectivity within social constructionism. She argues similarly that there is often no indication that people have an internal sense of being a self within social constructionism.

The second aspect which Cromby and Nightingale (1999) feel is missing from social constructionism is materiality, or the physical world around us. This happens for the same reason that bodies are left out, namely that it does not fit neatly into the text. They argue that materiality both provides opportunities and also limits the way we live and that it should therefore be considered within a constructionist account. To look at it more broadly, it would seem that they are criticising material relativism here. Edwards, Ashmore and Potter (1995) for example have argued eloquently for the relativist position on materiality.

Cromby and Nightingale (1999) are in fundamental disagreement with this argument, and are also critical of the decontextualised focus on power. Social constructionist authors, for example Parker (1992), have highlighted the sense in which power and institutions are important within a social constructionist account. Cromby and Nightingale argue that 'embodiment and power are intimately related and while constructionism does not adequately address embodiment and materiality it cannot include power' (p. 17). They are saying, in other words, that the one cannot be considered without the other.

In this section the theoretical underpinnings of social constructionism have been explored in order to provide an idea of how broad and varied the theoretical basis of constructionism is, and how complex the debates within the field are. Some of the criticisms that have been raised with social constructionism have also been examined. The reason that this theoretical exposition has been undertaken is partially to facilitate the discussion which follows regarding the integration of discourse analysis and psychoanalysis as strategies for understanding people. It has also been undertaken in order to situate the types of discourse analysis used in the research. These will be explored in the methodology chapter. In the next section the potential for a merger between psychoanalysis and discourse analysis will be examined. Several authors have argued that it is difficult for discourse analytic research to comment on individual subjectivity (Frosh, Phoenix & Pattman, 2003; Parker, 1997) and even more so the unconscious (Billig, 1997). Because of this gap in the approach, psychoanalysis has been utilised to combine 'a rigorous awareness of the constructive activity of social processes and an equally potent analysis of the agentic struggles of individual subjects' (Frosh, et al., 2003, p. 40) which will assist in exploring how subject positions are taken up.

Integrating discourse analysis and psychoanalysis as strategies for understanding people

It has been suggested that in retaining the dualism between individual and social, it becomes difficult for social theory to account for the process of subjective change (Henriques, Hollway, Urwin, Venn & Walkerdine, 1998). However the discipline of psychology which focuses in effect on individual subjectivity, is just as stuck within this dichotomy as other social science disciplines. Rose (1989), for example, suggests that psychology originated in and cannot be separated from the notion of individualization which essentially allows psychology to be a distinct discipline. Becoming a convert to social constructionism sometimes has the almost religious feel of having to renounce the individual in favour of the social. It is therefore quite difficult to argue for integrating discourse analysis, with its roots in social constructionism, with a system which does focus on individual subjectivity. In this section the theoretical literature which attempts to integrate these two systems will be examined. The reason for exploring links between these two approaches is to try to account for individual subject positions within the research.

It could be argued that the material uncovered by discourse analysis and psychoanalysis is quite similar in many ways. Makari and Shapiro (1994) examine the way in which linguistic

models can be used to understand the ways in which we listen to unconscious communications during psychotherapy. They speak about how one of the important achievements of psychoanalysis has been to recategorise the 'noise' of conversation, such as word choice, errors and non-coherent strands of narrative and render them worthy of serious attention as unconscious signs. Essentially discourse analysis looks at exactly these same elements of 'noise', but it does not define them as unconscious signs.

Besides the inherent similarities in subject matter, one has to consider whether discourse analysis and psychoanalysis are in essence theoretically or logically congruent. This will be the initial task of this section of the chapter. The two approaches, of course, are similar in their lack of expectation that respondents would be able to understand their own actions, motivations and feelings (Billig 1997; Frosh et al. 2003). To begin with, both psychoanalysis and discourse analysis have their underpinnings in multifaceted theoretical systems, and one cannot attempt to assess whether the two are compatible without explaining which system(s) of psychoanalysis or which type(s) of discourse analysis one is trying to draw together and where these systems are situated within broader theoretical frameworks of psychoanalytic and social constructionist theory. It has been argued, for example, that in certain ways Lacanian theory is compatible with discourse analysis, particularly in terms of its position on the unconscious. Intersubjectivist and object relations theory may have more to add to discursive theory in terms of the agentic nature of the subject which has not been highlighted sufficiently within discursive psychology (Frosh et al., 2003). These and other versions of psychoanalysis will be briefly examined here to assess their compatibility with discursive theory. Having explored the varieties of both psychoanalysis and discourse analysis, the next step is to examine whether these systems are indeed logically congruent. Several authors have tried to forge links between these powerful systems of analysis. Their arguments will be examined here.

Lacanian theory and discourse theory are often seen to be compatible (Frosh et al., 2003; Parker, 1997). This is because of their similar position with regard to the individual self: that it is socially constructed relative to those that surround it. In the case of Lacanian theory this creates 'a permanent tendency whereby the subject seeks imaginary wholeness to paper over conflict, lack and absence' (Frosh et al., 2003, p. 40). Lacanian theory also sees the unconscious as created as a result of language and this is more broadly compatible with the fundamental importance given to language within discursive theory.

Object relations theory accounts for the links between individual and culture in a different way (Frosh et al., 2003). The (m)other is seen as container of the damaging drives of the infant. Intersubjectivist theory sees the subject as 'formed through aligning oneself with the loved other and receiving back from that other an acknowledgement of one's own separate existence as a subject' (p.41). This serves to create a more agentic self than is implied by Lacanian theory. Hollway and Jefferson's (2000) work using discourse analysis falls within the tradition of object relations/intersubjectivist theorizing.

In looking at the notion of narrative in the interview and the links with psychoanalysis, one needs to think about whether the narrative is intrinsic to the individual or whether it is co-created. Brown, Nolan Crawford and Lewis (1996) call for attention to be given to the way in which psychotherapy co-constructs the narratives of the clients rather than merely exploring narratives that already exist. The notion of co-creation or intersubjectivity is important here. Recently there has been an attempt to restate Freudian repression, a classic individualist construct, in terms of discourse, or talk, which is by its very nature co-created (Billig, 1999). This was an important attempt to integrate the two systems.

While the system of psychoanalysis one uses is relevant, so too is the type of discourse analysis one employs. It is important to highlight that the co-construction between a particular variety of psychoanalysis and a particular type of discourse analysis will affect the analysis that emerges. Several different positions on the notion of a unitary concept of the self are taken. Frosh et al. (2003), taking a middle road here, argue for the concept of 'subjectivity' as opposed to 'subject'. 'Our starting point is the notion that there is no such thing as "the individual", standing outside the social; however, there is an arena of personal subjectivity, even though this does not exist other than as already inscribed in the sociocultural domain' (p.39). Wetherell (2003) would agree with this. She uses the work of Bakhtin and Voloshinov on 'voice' and Vygotsky's writing within the sphere of developmental psychology to argue that the process of internalization of the social is a discursive process. In this way she suggests that there is a porous boundary between the social and the individual. Liebrucks (2001) argues that a psychology that works within the framework of the individual will not be able to analyse meanings sufficiently because meaning is produced intersubjectively, and is not intrinsic to the individual. Crossley (2000) maintains that one of the problems with the social constructionist approaches is the loss of the subject; that within these approaches there is no self. She maintains that we need both to 'appreciate the linguistic and discursive structuring of

human psychology without losing sight of the essentially personal, coherent and real nature of individual experience and subjectivity' (p. 34).

From this basic argument about whether or not a unitary subject exists, there extends a polarized argument regarding the compatibility of discourse analysis and psychoanalysis as frameworks for analyzing discourse. Both sides seem to present fairly stereotyped versions of the other camp's arguments. The discourse analysts argue that psychoanalysis makes too much of the internal world (Parker, 1997; Wetherell, 1999) and the psychoanalysts argue that discourse analysis does not account for the particular ways in which individuals act (Frosh et al., 2003; Hollway & Jefferson, 1997). Potter and Wetherell (1987) would argue that the interpretative repertoire does allow for this more specific choice of location. Frosh et al. (2003) argue that psychoanalysis 'addresses a gap in the explanatory power of much discursive social psychology between giving an account of the discourses within which subjects are positioned and being able to offer plausible reason why specific individuals end up where they do' (p. 39). The discursive approach has been able to elucidate the process in which people position themselves in conversation often within historically constituted discourses. It has not, they argue, been able to explain satisfactorily why certain individuals choose specific positions. Frosh et al. therefore feel that it would be valuable to discursive theory to use psychoanalysis to 'gain clues to what structures discourse at the level of the "personal" ' (p.42).

One of the latest attempts to link discursive psychology with its social constructionist roots and psychoanalysis is Billig's (1997; 1999) work on Freudian repression. He uses the notion of the dialogic unconscious to show how repression can be understood discursively. He claims that repression relies on learned language skills and functions in a similar way to changing the subject in conversation. He maintains that a surface psychology which bestows a central role upon language is necessary for understanding how thinking, and therefore repression, works. Discursive psychology, according to him, can provide such an understanding. This complementary version of the story being created here essentially focuses on what discourse analysis can add to psychoanalysis.

From listening for what they call the 'intended narrative' to listening for the 'shadow narrative', Makari and Shapiro (1994) move from seeing the words as 'undistorting avenues into another's inner world' (p.38) to seeing them as only part of the story and also paying attention to indirect communications. They maintain that 'unconscious narrative is the story

that emerges recurrently despite the storyteller' (p.39). In doing this, they, like Billig (1999), place psychoanalysis within the sphere of linguistics. What is also interesting is that they use similar prerunners to the social constructionist framework within which discourse analysis may be situated, such as Merleau Ponty, Barthes and Saussure, to build a case for psychoanalysis. This suggests an 'ancestral' compatibility between the two systems.

Makari and Shapiro (1994) describe a model of psychodynamic listening specifically for unconscious communications. Using linguistic principles they divide listening into three groupings of listening. The first thing one listens to is the intended narrative of the patient, 'the meaning the speaker intends to convey' (p. 38). This is a largely conscious level of talk and concentrates largely on content. Paying attention to 'noise' instead of ignoring it as one would in normal conversation, forms part of trying to get beyond this 'intended narrative' of content. 'Directing attention to noise diminishes the normally totalizing impression of the signs in the foreground that make up the intended narrative' (p. 38). In fact psychodynamic listening would argue that there is no noise and that everything said has meaning.

They describe three ways in which the unconscious reveals itself using the linguistic categories of semantics, syntactics and pragmatics. Looking for meaning is what semantics is all about, 'the affectively charged story, desire or memory buried underneath the obviousness of a signifier' (Makari & Shapiro, 1994, p. 39). They refer to Saussure's notion of 'slippage' in which semantic meaning becomes subjectified by individuals. They describe three layers of semantic meaning, and the subjectification of meaning increases through these layers. The first relates to denotation, the signified meaning while the second relates to connotative meaning which is historical or contextual in nature and is bound up in figures of speech such as similes and metaphors. The third is the idiosyncratic meaning that the individual might have for particular words.

Here, what Katz and Shotter (1996) have called 'social poetics' is in evidence. This is about 'being "arrested", or "moved" by, certain fleeting, momentary occurrences in what patients do or say' (p. 1275). They argue that social poetics focus on the unique nature of the conversations instead of trying to fit them into a biomedical cognitive understanding.

The next way in which the unconscious might reveal itself is through syntax. While Makari and Shapiro (1994) acknowledge and syntax has to do with grammatical rules, they maintain that 'syntax can also be an individually charged matter of ordering subject, object and action and therefore can reveal unconscious meanings' (p. 40). They discuss the ways in which

latent meaning might be seen in syntax, for example the passive voice or the accusative case. This is also where what Saussure called associative relations between signs comes into play. Makari and Shapiro view this as the linguistic root of free association.

The third way in which the unconscious reveals itself is through pragmatics. This relates to 'the nonsemantic and nonsyntactic communications that structure discourse between speaker and listener' (Makari & Shapiro, 1994, p. 41). They maintain that the relationship between speaker and listener is important for this, whether it is real, imagined, or fantasized, based on historical relationships. Essentially pragmatic communication happens in the interaction, but is not based on the actual words used. It has to be inferred within the relationship. They relate this pragmatic communication to the transference, countertransference and projective identification within the psychotherapeutic relationship and comment that it allows the therapist to experience the way in which 'the patient uses language to define relationships and affect others' (p. 41). They explain how it is possible for the therapist to be seduced by the pragmatic communications of the client that would have them think and feel in a particular way. The therapist's subjectivity can, of course, prove equally seductive in a similar way in the pragmatic communication.

Possibly the most comprehensive and theoretically robust attempt to link the two has come from Parker (1997) who argues that discourse analysis runs the risk of simplifying subjectivity and that psychoanalysis can assist in providing a more complex subjectivity. He examines the way that what he called 'blank subjectivity' or 'uncomplicated subjectivity' has been used within discourse analytic theorizing.

Blank subjectivity ignores the internal world of the person or their historical relationship to language and views individual understanding as if it is an effect of language. In other words, it exists only through the discourses. Only the text exists. Anything outside the text, including individual cognition and emotion is dismissed. The interest of any speaker is reduced to those processes occurring within the conversation, i.e. only the other speaker(s). This view has been seen as deterministic by some writers (Crossley, 2000; Curt, 1994). Parker (1997) argues that rejecting all notions of internal subjectivity is tantamount to accepting a simple humanist or behavioural view of the person. 'The very refusal to explore the nature of subjectivity will lead to it creeping in again untheorised and unreconstructed' (p. 481).

Uncomplicated subjectivity returns to a humanist vision of the self as autonomous; encountering language without consideration to the context and history of that self. This

position suggests that a core self chooses which discourses or interpretative repertoires to use in talk. Parker (1997) argues that 'this is uncomfortably close to the traditional humanist fantasy of the pure subject as an active reflective independent agent' (p. 482). He maintains that this has been challenged in writing from a post-structuralist point of view as being an example of the Cartesian rational unitary subject. He says that these criticisms have used psychoanalytic ideas 'to question the way psychology reduces social phenomena to fixed qualities of individual minds' (p. 482). He does caution, however, that we should not take on psychoanalysis uncritically, but that it needs to be interrogated as a 'regime of truth' with attendant power and influence. Parker (1997) sees defences as an integral part of the structure of the text, and maintains that 'analysis helps us understand that *structure* itself rather than opening up what is hidden "underneath"' (p. 489).

Instead of a blank or simple subjectivity, he proposes a 'complex subjectivity'. He argues that 'the subject is always complicated by its enmeshment in particular dominant cultural forms pertaining to self-knowledge that circulate in the surrounding society' (p. 491). This complex subjectivity should take into account what the individual means as well as his or her needs. It should also take into account social structures and cultural elements that form the basis for the particular individuality. He takes the position that internal life is formed by the internalization of shared representations. He argues that it is at this point that psychoanalysis can play a role because it functions as a variety of self-knowledge in Western culture and complicates subjectivity. Essentially then, psychoanalytic culture is either directly or indirectly communicated and passed on through discourse. He maintains that psychoanalytic writing would need to be transformed theoretically to take into account these individual, social and cultural elements, and elaborates on several topics in which he views this as being necessary. Parker (1997) argues that French (Moscovici), British (Bocock) and American (Berger) work has sketched the 'cultural affinity' that present-day culture has with psychoanalytic categories. He says that there is a similarity between the social constructionist and psychoanalytic views of the cultural spreading of psychological knowledge.

There is an essential difference between looking at psychoanalytic performance within discourse and examining the discourses from a psychoanalytic point of view. The one is interested in whether the person is familiar with psychoanalytic terminology and world view, and the other is looking for anxiety and analyzing this from a psychoanalytic point of view. Parker (1997) does not specify whether he sees the use of psychoanalytic positions as conscious or unconscious which is a problem in terms of using his theory. Conscious choice

of psychoanalytic position would liken his theory to positioning theory, which does deal with conscious choice of position (Davies & Harré, 1990).

Wetherell (1999) makes a similar argument but comes up with a different conclusion, namely that psychoanalysis does not 'add value' to discourse analysis. She argues that one of the main differences between discursive psychology and psychoanalysis is in the way each of them view inner space. She suggests that psychoanalysis argues that the social or cultural is transformed in some mysterious way as it interacts with the subjective inner space of the individual. She maintains that psychoanalytic theorists have a notion that this reworking happens through defence mechanisms and that the result is that assuming an identity is not a simple linear process of taking in the social because of the complications inherent in the reworking of the cultural into the individual through the defence mechanisms.

Disagreeing with the above argument, she maintains that discursive psychologists do not attempt to come to any conclusions about internal subjectivity. They 'do not assume that there is a hidden reality to be uncovered' (p. 4). She maintains further that discursive theorists would follow Foucault in viewing psychoanalysis as a technology of the self, as a performance in itself, not as a system that uncovers material intrinsic to the individual. 'What analysis will uncover is the set of collective definitions available for making sense of who we are – the linguistic and institutional artefacts through which we construct selves' (p.4). Once again there is no sense of whether she thinks this happens consciously or unconsciously. This research views 'complex subjectivities' as positionings that are chosen by the individual, and which are at least partially unconscious in nature.

Billig (1997), with his notion of the dialogic unconscious, has a different argument for why discursive psychology has not engaged with psychoanalytic notions, maintaining that focusing on psychoanalytic processes is not tantamount to focusing on inner cognitive processes. He argues that 'discursive psychology has adopted practices from conversation analysis, which tend to draw attention to the presences, rather than absences, in discursive utterances. In particular, there are two principles of conversation analysis, which inform discursive psychology and which militate against psycho-analytic concerns with absences: (a) analyst should try to conduct their analyses from the participants' perspectives, as revealed in what the participants say; (b) analysts should use what participants say in order to reveal the structural organization of conversation' (p. 143).

This section has looked at the compatibility and potential for integration between psychoanalysis and discourse analysis in an attempt to provide a framework for the analysis which better accounts for the taking of individual subject positions. It has also examined previous theoretical and some empirical attempts integrate the two.

Conclusion

This chapter has reviewed empirical and theoretical literature relevant to the current research. It has considered empirical research done on the doctor-patient relationship and illness narratives as well as psychotherapeutic sessions. Theoretical concepts within social constructionism, discourse analysis, and psychoanalysis were explored in order to situate the analysis of the research theoretically, particular with regard to the interface between discourse analysis and psychoanalysis. The next chapter focuses on the methodology used in the study within this theoretical framework.

University of Cape Town

Chapter 3: Methodology

Introduction

Thus far this dissertation has explored the background literature pertinent to the study. It has focused on previous empirical studies of the doctor-patient relationship, illness narratives and the psychotherapeutic session. Social constructionism and discourse analysis were discussed to explain and justify the theoretical underpinnings of the study. Thereafter the existing literature with regard to the integration of discursive and psychoanalytic theory was examined.

Having explored the theoretical basis of the study, this chapter examines the methodology used within the research. Initially the types of discourse analysis which are used in the study and the way in which the work is analysed psychoanalytically are explored. A comprehensive description of the methods of sampling, data collection and analysis employed in the research is then given. After this, ethical considerations and the validation of the study are dealt with. Possible effects of the researcher and the theoretical underpinnings of the study will also be reflected upon.

Social constructionist methodology

As discussed in the previous chapter social constructionism through a focus on language and discourse, attempts to think about the ways in which we construct reality. Discourse analysis, which seems to be the commonly used 'method' within constructionist research (Antaki, Billig, Edwards, & Potter, 2003; Potter, 1996), attempts to investigate the manner in which this reality is constructed within the social order (Gergen 1997). It underscores the way in which discourse in talk and written material is a social practice (Potter & Wetherell, 1987). Gergen maintains that often discourse analytic studies are used to highlight the ways in which we construct the reality and in so doing, reveal the problems that can result from such constructions. Discourse analysis is not interested in the accuracy or truth contained in the content of the discourse, but in the processes through which the content is imparted as real fact and the ways in which it comes to be seen as truth (Wetherell & Potter, 1992). The content of the text therefore becomes less important than the effects which it produces. There are very many types of discourse analysis which are used to analyse language, some of which are more at home within the linguistics or rhetoric fields, and some interdisciplinary post-modernist fields, assisting to break boundaries between disciplines formally seen as

essentially separate. In terms of its philosophical and methodological underpinnings, discourse analysis is not a single entity; some versions are more influenced by conversation analysis (Potter & Wetherell, 1987) while others are more similar to critical discourse analysis (Fairclough, 1995). Given this, it is nevertheless true to say that discourse is seen as ‘the central organizing principle of construction’ (Potter, 1996, para. 8).

Two of the versions of discourse analysis which have been used to a greater extent within the social sciences, and particularly social psychology, will be used within this research and elaborated on here. They are Parker’s (1992) post-structuralist approach, and Potter and Wetherell’s (1987) interpretative repertoires. These two approaches are not often combined because of their fundamentally different theoretical roots. The most obvious of these differences is the realist (Parker) versus relativist (Potter & Wetherell) ontologies of the two approaches. Because of the limitations on space, these differences will not be explored in detail in this research. Justification for the use of both methods is, however, provided.

Parker’s (1992) approach to discourse analysis is influenced by post-structuralist theorists, including Foucault and Derrida. According to Parker, discourses are not simply descriptive; they allow us to see that which is not really there, that which is not immediately obvious. His aim in describing discourses is to highlight the way in which they shape the way we view both ourselves and the world around us. Like Foucault there is a focus on power relations, inequities and the ideological effects of the discourses.

Both Potter and Wetherell (1987; 1992) are critical of way in which Parker views discourses as real material entities independent of those who use them. Moving away from a realist ontology, they argue people use language to achieve specific ends, to do certain things. Interpretative repertoires are used to excuse, justify, blame, persuade, and so on, and in so doing, to construct the self on an ongoing basis. Interpretative repertoires are essentially the resources available within a particular setting to understand the practices in question (Wetherell & Potter, 1992). Potter (1996) defines them as ‘systematically related sets of terms, often used with stylistic and grammatical coherence, and often organized around one or more central metaphors. They are historically developed and make up an important part of the common sense of a culture; although some may be specific to certain institutional domains’ (para. 21). Potter maintains that there is a flexibility within the interpretative repertoire which means that it can be reworked in a context, and that it is this flexibility which sets

interpretative repertoires apart from the post-structuralist conception of discourses (Parker, 1992).

In the current research Potter and Wetherell's (1987) notion of interpretative repertoires is used initially to think about the functions of talking in particular ways. Potter and Wetherell do not focus explicitly on matters of power within talk, although these might be said to be implicit functions of many aspects of talk. However, because of the particular South African context where disempowerment, disenfranchisement and inequality are so marked, Parker's (1992) auxiliary criteria are used to zone in on matters of power, institutions and ideology within the talk and make sure that they are not left out of the discussion.

Psychoanalytic methodology

This research is not only interested in societal discourses, but also in individual subjective positionings and strategies employed by the parents to talk about their children's problems. Hence there has been an attempt to integrate psychoanalytic and discourse theory to do this. Psychoanalysis has as a basic assumption the notion that anxiety is an underlying attribute of all people. It would argue that in researching a topic through using interviews, instead of producing coherent consistent narratives, one needs to examine the inconsistencies and contradictions within interviews to begin to understand how anxiety might be exhibited (Hollway & Jefferson, 1997). Whether one accepts this or sees psychoanalytic theory as one way, chosen at times from an array of possibilities of making sense of the world, as in Parker's (1997) notion of 'complex subjectivity', the position taken here is that psychoanalysis can add value to the discourse analytic method. Complex subjectivity rests on the assumption that internal life as we understand it is constructed through the internalization of shared representations which must take social structures and cultural elements into account.

As well as looking at interpretative repertoires and discourses within talk, Parker's (1997) notion of 'discursive complexes' will also be examined. This provides 'a description of forms of subjectivity that circulate in a culture as a function of discourse and of the theories of self that subjects in a culture elaborate for themselves in relation to different phenomena' (p. 491). What he is saying is that making use of the concept of psychoanalysis does not necessarily mean accepting the notion of a unitary self, but that it can be seen as expanding the subject positions within Western culture.

Methods

The question posed in the research essentially revolves around the way in which parents talk about the particular problem they have when they initially present for help at a psychology clinic.

Research context

The research was carried out at the UCT Child Guidance Clinic. It forms part of a larger body of research, funded by the National Research Foundation (NRF), evaluating the clinical service. The UCT Child Guidance Clinic is the home of the Clinical Psychology Master's Programme. It is housed separately from the rest of the Psychology Department in a building that is close to public transport. Students in the programme take on a case-load of several patients at a time which they manage with the assistance of a supervisor. Each supervisor is assigned to only one student at a time. Most of the interviews in the study formed part of the June examinations for the trainee therapists. As such they were observed by the other students as well as examiners. By the time most of the interviews were done, therefore, students had completed six months in the programme.

Participants

Discourse analysis is conducive to research with a fairly small sample size. The amount of information generated in interviews with larger samples can easily become unmanageable and have a counterproductive effect on the ability of the researcher to focus on the fine detail (Potter & Wetherell, 1987). The participants in the study consisted of six families (N=29) who presented to the UCT Child Guidance Clinic between June and September 2004. The families were mostly coloured families, with one white family. They had between two and five children ranging in age from 6 weeks to 18 years. The first interview at this clinic always includes all members of the nuclear family and any other people who live or interact with the family on a day-to-day basis. In all these cases, the complete nuclear family attended the session. As can be seen from the accompanying table, the racial breakdown of the families according to how they were previously classified in South Africa is as follows: five of the families were coloured and one was white. The family members together with the education and occupation of both parents are included in the table below.

Table 1: Demographic Details of Families and Therapists.

Family 1	Therapist	White woman, age 29
	Family	Mother age 40 Father age 41 Son age 14 Son (IP*) age 9
	Race	Coloured
	Education	Both parents completed Std 8 Mother – secretarial college Father – apprentice diesel mechanic
	Occupation	Father: Diesel Mechanic Mother: Clerk

*Index Patient = the child who was referred to the clinic

Family 2	Therapist	Black man, age 30
	Family	Mother age 39 Father age 49 Daughter age 18 Son age 17 Daughter age 13 Son (IP) age 11 Son age 7
	Race	Coloured
	Education	Father completed Std 6 Mother completed Std 8
	Occupation	Father: Builder Mother: Housewife

Family 3	Therapist	Coloured woman, age 34
	Family	Stepmother age 28 Father age 33 Son (IP) age 6 Son age 2 Son age 2
	Race	Coloured
	Education	Mother completed Matric Mother – secretarial course Father – welding course
	Occupation	Father: Welder Mother: Administrative Clerk

Family 4	Therapist	Coloured woman, age 34
	Family	Mother age 38 Father age not provided Daughter (IP) age 9 Son (IP) age 7 Daughter age 3
	Race	White
	Education	Both parents completed degrees in teaching.
	Occupation	Father: Pastor in a church Mother: Home schooling children

Family 5	Therapist	White woman, age 36
	Family	Mother age 28 Father age 30 Son (IP) age 7 Son age 6 weeks
	Race	Coloured
	Education	No information obtained
	Occupation	Father: Electronics Mother: Customer Care Consultant

Family 6	Therapist	Indian woman, age 39
	Family	Mother age 39 Father age 44 Daughter (IP) age 10 Son age 6
	Race	Coloured
	Education	No information obtained
	Occupation	Father: Co-owner of small company Mother: Clothing business

Sampling

Since discourse analysis explores richly contextualized meaning and there is no attempt to generalise the results to a particular population, there was no need to find a sample representative of that population. The sample was drawn from a waiting list at the clinic. When families phone for appointments at the clinic they are placed on this waiting list and are phoned to come for an appointment when there is a therapist available to see them. Sometimes the waiting period can amount to several months. Participants have self-selected for therapy by phoning the clinic for help with a particular problem. Potential participants for this study were all families who presented for therapy between June and September 2004.

The many difficulties of representation when translating text have been eloquently explored by Zavos (2005). She argues that 'translation as equation is not possible, the different worlds we inhabit in our different languages are incommensurable; they remain separate and irreducible; they remain foreign' (p. 120). Participants were therefore all English-speaking because the discourse analysis was completed in English.

Families were invited to participate in the study after at least the first interview had taken place, and in most cases after several sessions with the therapist. Particular care was taken to ensure that they did not feel obligated to take part in the study. They were approached by the therapist assigned to their case and were informed both verbally and in writing that non-participation in the study would not jeopardize their therapeutic process in any way (see Appendix 1). The therapist assigned to each case was given a written research protocol

document (see Appendix 2) to use when discussing possible participation in this research. This was to ensure that the relevant information was made available to them. One of the parents from each family signed an Informed Consent Form (Appendix 1) if the family were willing to participate in the research after this information sharing process was complete.

Of the families who presented for therapy and were left out of the research, only one family refused permission to be included in the research. They felt that the research would be too exposing of their difficulties. The therapists for three other families neglected to ask for informed consent while the families were taking part in the therapeutic process and these families could not therefore be included in the research. Two families had to be left out of the study because they were interviewed in a language other than English – one in Afrikaans and one in Xhosa. Finally two families were left out because they were interviewed by the researcher, and it was felt that analysis of these interviews might be unduly biased because of the therapist and researcher being the same person.

Data collection

Data was collected through semi-structured interviews conducted by the therapist assigned to each case. There were five different interviewers for the six interviews. The initial interview used at the clinic is loosely based on the Clinical Intake Interview (Goldberg, 1997) and each interview lasted approximately one-and-a-half hours. Because of the fact that this semi-structured interview is followed for every family intake at the clinic, no pilot interview was conducted. It was assumed that the questions would be clear and unambiguous since this is a standard clinical protocol.

These interviews were conducted in English after it was ascertained prior to the interviews that the participants were English-speaking. The interviews took place in a consultation room at the clinic and were observed from behind the two-way mirror by other members of the clinic team. The group of interview transcripts comprises the body of material upon which the analysis is based (Parker, 1992). Interviewing the family together allows talk that is salient in the particular family to emerge.

Measuring instrument

The intake interview at the UCT Child Guidance Clinic is based on the clinical interview (Goldberg, 1997; Pridmore, 2000; see Appendix 3 for format). As such it has quite a specific structure in terms of the type of questions asked and covers the presenting problems, the

history of the presenting problems, family histories of both parents, the developmental and personal history of the Index Patient (IP). The therapist also spends time alone with the child before completing the interview with the whole family.

Data management

As is routine, the sessions were video- and audio-taped, permission being obtained during the session for the taping. The tapes were transcribed by the researcher using the slightly amended transcription guidelines of Potter & Wetherell (1987; see Appendix 4; see Appendix 5 for example of part of a transcript).

Data analysis

Potter and Wetherell's (1987) ten stages were used to guide the research. Stages 6 and 7 provide specific guidelines for the coding and analysis of the data. The data is coded as inclusively as possible with cases that seem only peripherally related being included. This differs from the coding typically done within content analysis in that borderline and loosely related instances of the category should be included (Potter & Wetherell, 1987). The analysis requires the multiple readings of the coded transcripts in order to extract the systematic patterns in the data. Within the patterning one is looking for both contradiction and consistency in the different accounts. Besides this, there is also a focus on function within the different interpretative repertoires. A focus on function is essentially interested in what is achieved by the particular language use within the context. Essentially it has been argued that language does things rather than being passive, and that strategic use is often made of language. In a strong version of social constructionism it would be argued that reality is constituted through language use (Gergen, 1997). Interpretative repertoires have been defined as systems of signification which centre around tropes, metaphors and figures of speech (Potter & Wetherell, 1987). They are seen as the building blocks for the constructions of function, action and versions of self within the talk.

Parker's (1992) auxiliary criteria were then used to examine the way in which discourses reproduce and support institutions, and power relations, and how they can sanction the oppression of non-dominant groups.

After the discursive lens had been applied to the talk, a psychoanalytic lens was applied. Both intersubjective psychoanalysis and 'discursive complexes' (Parker, 1997) were used to try to make sense of the personal subjectivity of the participants.

Ethical considerations

Involvement in the research was completely voluntary for the participants. I did not approach them directly. They were approached by their case therapist with whom it was assumed they would feel most comfortable. This was to allow them the maximum freedom to refuse participation in the study. As mentioned above, I provided each therapist with a written set of points to go through with the participants (see Appendix 2), in order that the therapist could explain the nature of the research to the participants. If they agreed to participate, they were then asked to sign an informed consent form. Names and identifying details were changed for the purposes of the research in order to guarantee confidentiality and anonymity. The participants were furthermore informed that this would be the case. Although the interviews were taped before informed consent for this research was obtained, clients do give their permission for taping for the purpose of clinical training, supervision and review of sessions at the intake interview. In addition, permission to use this material for research, as well as clinical purposes, was requested after the intake interview.

Validity

Discourse analysis has different theoretical foundations to much other quantitative and qualitative research. Because of this, the ways in which validity is assessed in other work in many cases will not work and therefore cannot be used for discourse analysis (Potter, 1996).

Several suggestions have been made for the validation of discursive work. Coherence (Potter & Wetherell, 1987; Potter, 1996) is thought to be important. Analysis is more likely to be thought of as complete if there is coherence with the way the discourse is put together and with the way in which functions are described within the structure. If there are contradictions to specific interpretative repertoires or discourses, there should be plausible reasons for the exceptions, otherwise the validity of the interpretative repertoire should be called into question. The understanding of the participants has also been argued to be important to validity (Potter & Wetherell, 1987; Potter, 1996), providing a check on interpretations. If new problems and solutions to these are created through the analysis this may offer confirmation of the use of linguistic resources in the talk (Potter & Wetherell, 1987). The special features of an unusual or as Potter (1996) puts it, 'deviant' case, may also assist in confirming the veracity of the general pattern.

Riessman (1993) speaks about facilitating the trust of others in our research. She mentions four ways in which this may be done. The first is for us to explain how interpretations were constructed. The second is for us to make what we have done visible. Thirdly we could indicate how we transform the data through the levels of representation that she specifies, namely attending, telling, transcribing, analysing and reading. These are explored further in the next section. Lastly she suggests that we make our original data accessible to other researchers.

These factors will be used to assess the validity of the analysis of the data in this research. It must be understood however that they do not 'singly or in combination guarantee the validity of an analysis' (Potter, 1996, para. 56).

Reflexivity

It is important to acknowledge that the researcher is never impartial, neutral or isolated from results of research (Mason, 2002; Wetherell & Potter 1992), but that he or she has an active and constructive role in the research process. Riessman (1993) states this point eloquently in arguing that it is not possible to represent the experience of another, only to interpret it. In a sense I am also bound by 'discursive complexes' (Parker, 1997) in that I have certain cultural and societal discourses available to me within which I am likely to interpret the world. For me psychoanalytic theory, for example, is an important discourse upon which I draw, not that it is by any means the only one. This point regarding the influence of psychoanalysis has been made by several authors (Parker, 1997; Wetherell, 1999). It is particularly important to be personally reflexive in a study such as this, and to acknowledge the personal factors that may have affected the validity and integrity of the research. While transcripts of my own therapy sessions were not used in the research, my position as a trainee clinical psychologist, studying together with the cohort of therapists who did these interviews may have affected the way the analysis was completed. It is difficult for me to distance myself from the work of my colleagues.

Riessman (1993) details five levels of representation that occur during the research process, making no claims that she has exhausted the extent of possible representation. It is perhaps useful to use these as a basis for the discussion my own reflexivity. Attending to the experience is the first level of representation described. In attending to something, certain aspects are always highlighted and foregrounded while others are minimized or go unnoticed. Meaning is attached to those things which have been foregrounded. What I choose to attend

to has also no doubt been affected by my age, gender, race and association with the Child Guidance Clinic. My exposure to and interest in psychoanalytic theory is the obvious thing that springs to mind here. The way in which I construct reality has irreversibly been affected by this theoretical framework, and it must affect what I choose to highlight in attending to experience. The Child Guidance Clinic has particular psychoanalytic leanings at any one time, and this may also have been brought to bear on my understanding of the data. I am a white South African woman in her late thirties who has lived through the demise of apartheid, of which I was critical from the time of adolescence onwards. It is however difficult to extricate myself from my background which has probably caused me to attend to certain aspects of race and gender and the effects thereof and ignore or not notice others. My own feminist leanings may have made me sensitive to gender inequalities within relationships and I might be more likely than some to notice any sign of these.

The telling about the experience is the second level of representation. 'What are you doing research on', is something that I have been asked countless times in the past two years. Every time I perform the narrative of explaining the research to someone, I re-present, in Riessman's (1993) words, the topic, my thoughts and feelings about it and my ideas of what results I hope to or think I will find. The way I describe the research changes according to the audience, and this could also have an effect on the meaning of what I am saying. For example my social constructionist theoretical basis is explored more when speaking to some than to others. Riessman (1993), drawing on Goffman, says that 'in telling about an experience, I am also creating a self – how I want to be known' by others (p. 11). My relationship with the person I am telling about the research may change way I describe it because I may want them to think of me in a certain way. The contributions of the person asking must also not go unnoted. I might change the way I describe something based on his or her questions or observations. In this way, through of the contributions of others, my description becomes co-created.

In addition to this telling, there is the performance of the stories on which the research is based during the actual interviews. This was not necessarily affected by me, but there was a 'researcher' in the form of the interviewer in the room and thus all the points spoken about here regarding the presentation of the self, in Goffman's (1975) terms, is relevant. The particular listener would have affected the type of story told, and the participation of this listener would have contributed to the intersubjective co-creation of the story in the interview.

The next level of representation described by Riessman (1993) is the transcribing of the experience. She comments on the incompleteness and selectivity of any method of transcription. The way in which the interviews are transcribed is not transparent, it is not a reflection of the reality of those interviews, but once again a representation, this time largely guided by the theoretical framework within which the research is conducted. Riessman writes that 'different transcription conventions lead to and support different interpretations and ideological positions, and they ultimately create different worlds' (p. 13). I transcribed my own material, and it was a wonderful way of getting to know the interviews, but it was also tedious at times and probably the part of the research that I most disliked and battled to give attention to. The transcription conventions I used foregrounded things like pauses, repetitions of words, places where people were more and less articulate, and I also noticed things like volume of speech. I may therefore have been particularly primed to notice signs of defensiveness and anxiety within the talk.

The analysis of experience is Riessman's (1993) fourth level of representation. This might be affected by such things as the way in which I expect the research to be received. In my case, I am aware of holding 'the examiners' in my head. Fantasies about who they might be influence my editing and reshaping of this work.

The reading of experience is the final level of representation. While my supervisor has not been 'interventionist' in the least, in that she has listened and suggested, but never insisted or pressured me into a particular direction or away from another, I hold her reading of my work in my head as I write and edit. This shapes what I write and the way in which I write it.

In these interviews one is listening to parents talking in part about their children's problems, not only talking about their own problems. Riessman (1993) raises this issue within her highlighting of the representation of experience. She says that because we do not have access to the actual experience of others, all representation is essentially interpretation. This means that if these parents were speaking about their own experience, there would be several levels of interpretation through which their narratives would filter to become the representations that might be written down. Within this research there is however, another level of representation, produced because the parent is representing, not their own experience, but the experience of the child. Riessman (1993) reminds us that 'all we have is talk and text that represent reality partially, selectively, and imperfectly' (p. 15).

Conclusion

This chapter has attempted to unpack the methodology of the research. The research question of how families talk about the perceived problem during the initial intake interview was approached theoretically from both the point of social constructionist and psychoanalytic theory, with an attempt at integrating the two. The data was gathered from interviews done with families attending the UCT Child Guidance Clinic for the first time. The participants self-selected themselves for the research by putting their names down on the waiting list at the clinic and coming for therapy. The analysis was done using discourse analysis and psychoanalysis, specifically from the point of view of discursive complexes. The ways in which validity can be assessed within discursive work were explored. Lastly, issues relating to my, the researcher's, subjectivity, and which may have influenced or shaped the research, were also discussed. The following chapter contains the analysis of the research data.

University of Cape Town

Chapter 4: Analysis

Whereas the previous chapter has focused on the methodology used in the research, this chapter deals with the analysis of the data. The analysis has uncovered two main themes in the talk, each consisting of several interpretative repertoires. The first of these is about 'telling' the problems, ways in which the problems are named, and revolves largely around attempts to move toward a description of a problem. The second theme, which has been called 'defensive representations' revolves around a movement away from the description of a problem, at avoidance, distancing, silencing, not knowing and a sense of vagueness in the talk. This chapter explores these interpretative repertoires in detail. These themes, while seemingly simplistic in nature are merely 'umbrellas' under which the interpretative repertoires can be grouped in terms of broader functions. They emerged out of the analysis of the data and were not decided upon a priori.

The current chapter does not focus particularly on subjectivities, in other words, the way in which people construct themselves within the session. Subjectivities in the form of 'discursive complexes' using a psychoanalytic lens will be discussed separately. This may seem like an artificial separation, in that whereas in this chapter the construction of the problems in the talk is discussed and in the following chapter the construction of subjectivities through the talk is discussed. However, since the presenting problem and the way in which it is constructed forms the basis of the research, it was felt that it was important to look separately at the ways in which, if at all, this is accomplished. The issue of power within the talk together with the discussion on discursive complexes can be found in the Discussion chapter.

'Telling' the problems

The ways in which people spoke about and named presenting problems were interesting. The one option was to give a summary, which very few were able to do. Sometimes the description came out gradually in the form of examples. The other way in which the problems were described was in terms of overinclusive stories. These three ways of 'telling' (Buttny & Jensen, 1995) will be described here. Thereafter the way in which parents used professional discourse in the telling of the problem will be examined.

The following excerpt shows how the mother (Family 5) is able to summarise the problems when asked. This is one of the few examples where this happened. After this excerpt they go

into more detail exploring the problems with a fairly coherent narrative. There are only two interviews where this happened to any extent at all.

- Therapist: Okay. (2) How, um how did you come to hear about the clinic. I'm interested in in how you heard about it.
- Mother: We had problems last year with his.
- Father: []
- Mother: Yes with his [] in Grade 1. He was um [].
- Therapist: Who Neville?
- Mother: Yes, um Neville. She said that he can't, he won't, he's not coping in class.
- Therapist: Okay.
- Mother: Well basically he would, he couldn't count count past 30 and (.) and he was battling with his maths. And his reading um, he only, for the first year, he only read up till level 2.
- Therapist: Okay.
- Mother: So she recommended that we see a child psychologist. And then she recommended this place and we phoned to make an appointment.
- Therapist: Okay okay. And that was some time ago. Have you seen anyone in the interim?
- Mother: No. no. because we already decided back in September, I think, that if he is really not coping whether he shouldn't stay (.) behind. He shouldn't go over to Grade 2. And then obviously in the next year we will see how it goes and then we'll. But so far (.) it's being going (.) well, and um but they still recommended that we come and see you.
- Therapist: Okay. They recommended it this year. Again?
- Mother: Yes. Um, because I mean we hadn't seen anybody but they still recommended. Although it is (.) better. It's better than last year. (Family 5)

This mother (Family 4) dives straight into the detail, without providing a summary of the problems. She describes by providing examples. In this family two children were referred to the clinic. Notice that she finds it more difficult to talk about the one that she didn't notice.

- Therapist: Okay. And did you, is this the first time that you've come (.) to seek assistance for whatever the problems are. I'm not sure yet =
- Father: = Besides, besides going to Julia.
- Mother: David, we took the kids to an OT. And they were assessed. And we brought the report. I just would like to Photostat. I didn't manage to Photostat it before I came. It's the only one I've got. And then um Julia lectured Father. I don't know if you know the National Institute of Learning (Father: are you familiar with it) so she did a (.) rough assessment.
- Father: I don't know if you want to look at these now?
- Therapist: No. I'll look at it afterwards.
- Mother: Anyway so she. I was, I was needing help. Um so I kind of went back to her. Cash is (.) fairly limited. So Um (.) you know like the OT's were recommended, but I haven't followed up because they really pricey but I tried to (.) incorporate her suggestions in what we do.
- Mother: Ya and just seeing. But um I think (2) ya to specifically know what expectations to. The more I know, the better I can (.) help them. Ya the better progress we can make. I kind of wasn't really aware of (.) anything out of the norm. Till probably about a year ago with the older one. With him I often suspected that there might be something. His development kind of goes (.) in big leaps. So he'll plateau for a long time and then suddenly [shows a jump with her hand].
- Therapist: Who you talking about?

Mother & David.
Father:

Mother: So he'll go from not drawing (.) at all (.) to drawing fine detailed (.) you know his first (.) he used to paint colours and stuff but not do representation. His first representation drawing was a landscape with people with the whole details of a house and all the details of the stuff. And then you know kind of sat at that for probably about two (.) three years and then suddenly (.) started drawing faces in perspective with (.) all the features and stuff. So it's a difficult thing to track. You know just on that which is an example of (.) his drawing. So. (Family 4)

In the following extract, the stepmother (Family 3) begins an extremely over-inclusive story about the reason they are at the clinic. She has already previously said that the problem is that he can't concentrate at school, but this appears to be a different problem for which she had sought help at a different time. The summary of the problem she is attempting to describe is as follows. The boy was having difficulty both at school and at home. At school he had problems concentrating in class and learning his work. At home they were having behavioural difficulties with him. He was lying and stealing, and also behaving in strange ways at times, like aggressively breaking toys and he also once jumped off a third floor balcony. However, providing this sort of summary appears to have been difficult for these parents.

Therapist: Okay. Do you want to tell me a little bit about what is the problem is? What the problem is?

Father: What?

Therapist: What has brought you here today?

Father: Um. Let she explain she.

Mother: She want you to talk, she said. I'm talking the whole time.

Father: Let she explain.

Mother: Um beginning of the year, or was it last year, um my cousin was still looking after them cos I didn't want to take them out of the house cos it was quite difficult when they were smaller, and to take them. My cousin used to come to the house and look after them. And then um I left a R10 and I asked her if she want to go buy bread for him for school holidays, it is December, yes. Cos there was nothing, beside the porridge and she can buy bread and he can make himself some sandwich or she can make them sandwiches. And then she phoned and she said she didn't open the window and when she woke up cos they were sleeping, Cameron wasn't in the house. He was outside. And um she said she pulled the table away and she moved the cupboards and whatever to look for the money but she couldn't find the money. So I said okay fine. That's impossible but she said she didn't open the window cos um they were sleeping. But then she woke up Cameron wasn't there. And then um Cameron never came in the house. He was outside the whole day. And then um he came. And I don't know what. He came to fetch me halfway and he said he was outside and did he now say [] any rate, and then I asked him, didn't you see the money so he said no. and then his daddy. I dunno his daddy said it's just the look on his face that he took the money. And then he said that he didn't take the money. He said that um Auntie Sheila gave him money. The lady that lives in front. She gave him money to buy sweets. And then again he said his friend Robert gave him money to buy sweets. (Family 3)

Discourse of profession

The discourse of profession was also one in which parents attempted to ‘tell’ the problem. Parents sometimes spoke only about professionals they had been referred to or consulted when asked to describe the problems and some transcripts were saturated with professional terms. It is important to think about what the functions of this discourse of professionalism are within this context. First, however, there are several examples of this discourse which will be described here.

In the following example (Family 1) one of the children demonstrates this knowledge. He was not the Index Patient in this case, but an older brother. Words like ‘concentrate’, ‘easily distracted’, form part of the Attention Deficit/Hyperactivity Disorder (ADHD) discourse. This interpretative repertoire could serve the function of depersonalising what the person is talking about. To describe something in professional terms suggests, perhaps, that you do not personally have to think about what the meaning is of the words you are using.

- Therapist: Okay. And can you tell me a bit about why you were put on Ritalin.
 Joseph: Cos I couldn't concentrate in class in class.
 Therapist: Couldn't concentrate. And was it just that you couldn't concentrate or were you also like moving around and.
 Joseph: Easy distracted. I got distracted easily. (Family 1)

A similar discourse of ADHD from Family 1 can be seen in the following extracts. Instead of a description of a problem, this mother uses the professional discourse, in which terms such as “Occupational Therapy”, “concentration” and “reversal of letters” feature. A possible function of this could be proving that they had attempted to do things about the problems, proving that they had consulted professionals.

- Therapist: Okay. So right. And so are you, is everyone okay to be here. (.) Okay alright. Um and so, now I'd like to just move on to you know what has brought you here and what your concerns are?
 Mother: Um Adam has been to Occupational Therapy.
 Therapist: Okay.
 Mother: Which they found that his concentration. He tends to wander off.
 Therapist: Okay.
 Mother: And um. He's finished with Occupational Therapy now.
 Therapist: Okay. (Family 1)

Therapist: (.). Okay so you went for a year. Okay. And the reason you went to the occupational therapist in the first place. Was that to do with concentration or.

Mother: Concentration, um reading, reversing of letters. (Family 1)

And here it appears again (Family 3).

Therapist: Was that the only point that you sought assistance?

Mother: I asked the school.

Therapist: Okay.

Mother: Because he how can I say not have a problem but his concentration span and that is a little bit um short. And um he's very busy, active in class. He doesn't pay attention and so forth. (Family 3)

The mother in the following examples (Family 4), which are taken from several places in the interview, makes frequent use of professional discourse. In this instance she is a professional herself. However, it is nevertheless interesting to consider her use of professional language. It may serve as a defence for her. She may be using professional language in order to position herself as one of the professionals, in a sense to legitimize herself, to defend against the anxiety she feels about being responsible for her children's education. Her children are all home-schooled and she is the teacher. She may feel that she has to perform the fact that she knows what she is talking about.

Mother: But um (.) sequencing beyond that. Is (.) um something that hasn't come naturally. (Family 4)

Mother: So she was writing cursive big and that was very laborious. So she actually had to think about each. So. And because of, she reversed quite a lot. (Family 4)

Mother: Um yes and and directionality's been a thing. Left and right and. Um coordination. (Family 4)

Mother: So its not that she doesn't know the word. So I think it's a neurological thing. Not so much that she doesn't know. Just a thing of the brain putting it in the. (Family 4)

Defensive representations

Aside from the ways of describing the problems that I have explored above, there were several interpretative repertoires which appeared to serve a defensive function in the talk. These included functions such as: vagueness; a problem which continually disappeared during the session; fighting back on the part of some family members; and attempts to distance

themselves from the problems on the part of others. These will be described in the rest of this chapter.

Vagueness – not knowing

What strikes one in several of the interviews is a sense of what might be called ‘not knowing’ regarding the problems. The way the problem is spoken about is vague and the parents often find it difficult to define their problems. One of the first questions asked when families come to the clinic is why they have come for assistance, what the nature of the problems are. The following example shows how one mother (Family 1) answered the question using the rhetorical device of indirectness in an attempt to talk around the problems without actually saying what they are.

- Therapist: Okay. So right. And so are you, is everyone okay to be here. (.) Okay alright. Um and so, now I'd like to just move on to you know what has brought you here and what your concerns are?
- Mother: Um Adam has been to Occupational Therapy.
- Therapist: Okay.
- Mother: Which they found that his concentration. He tends to wander off.
- Therapist: Okay.
- Mother: And um. He's finished with Occupational Therapy now.
- Therapist: Okay. (Family 1)

Within conversation analysis this insertion sequence would usually prepare the listener for the answer by talking about the context, but this does not happen here without the therapist quite actively questioning the mother regarding the reason for the occupational therapy intervention.

This next example also speaks of vagueness. The child had been kidnapped or disappeared through neglect of his mother, but at no point in the discourse does either the stepmother or father name this. They describe what happened in quite a roundabout manner. The way they tell the story gives one the sense that they were quite overwhelmed by what happened. The stepmother (Family 3) introduces the topic saying “we got married in March and then we got, or we found him in about July.”

- Mother: Three. Cos that was the time when. We got married in March and then we got, or we found him in about July.
- Therapist: So he came to live with you a few months later. And how did that happen. You know that he came to live with you. What was the process, um, around it? What happened? Why did he come and live with

you?

Father: Well. This, this. He was actually gone. I go to the mother and ask, ask if I can see him and she say no, she doesn't know where the child is. And I say, what do you mean you don't know where the child is. So the lady next door, she gave the child to the lady next door, so when she come from work the lady and the child was gone. So they don't know where the child is. So I met her boyfriend and then I ask him. He say no he doesn't know where the child is. He met the, the child of that lady.

Mother: From Woodstock.

Father: Ya and he said she was staying somewhere in Woodstock. But he's not sure where. So me and Camilla go take a walk through Woodstock. (Family 3)

The theme of not knowing comes across in the same interview within the father's life too. When asked about his brothers and sisters being in foster care, he does not know which of them were in care.

Therapist: And so, were, were all of you, all eight of you in foster care.

Father: Ya. I think so. No not all. Only the brothers I think. I'm not sure. (Family 3)

Here is another example of the vagueness interpretative repertoire. In this case, in response to a question about medical history, the father (Family 3) describes the way in which his ex-wife volunteered the baby for experimental medical treatment. What he says is difficult to understand, as can be seen by the fact that the therapist asks him what he means. His sense of being overwhelmed by what happened comes across in the interview in the fact that he does not mention whether the child was sick or not, or what the particular drug was for.

Therapist: Has there been any medical kind. Any medical problems or anything.

Mother: After the three years he was there [with his mother] he was never sick.

Father: When he was a baby I don't know what programmes they or new medicine they test. I was very upset.

Therapist: Say that again. They tested new medicine on him?

Father: Ya they. I dunno what it is and they gonna give him a prize. They never give him a prize. Anyway. To see if it's working. And the mother volunteered him. No I was upset. (Family 3)

In the following extract (Family 4) the therapist asks what the difficulties are that the family is experiencing. She begins by mentioning the concentration difficulty which had been raised earlier in the interview. However before beginning to talk about the difficulties, there is a long digression by both parents in which they explain firstly the type of material and curriculum they have been using in the classroom, the fact that they read a lot as a family and their

television-watching habits. It is a long passage but worth including to show the extent of the avoidance. While this is slightly different to the interpretative repertoire of not knowing and vagueness, it nevertheless seems to suggest a defensive avoidance of talking about the problems.

- Therapist: Okay so just. Maybe take me through the difficulties, what what it is you're experiencing with both of them. (.) David did say that he struggles sometimes to concentrate. (David: nods). What what do you struggle to concentrate on?
- David: My reading and my maths.
- Therapist: What?
- David: My reading and my maths.
- Mother: I've done um, we've been studying, just call it the core curriculum because I've integrated everything else. Reading and maths okay is (.) age appropri, well stage appropriate you could say, and then I've done (.) together, but its been a verbal thing, I haven't required them to do much writing with it, just because it takes so long, did ancient history, which they loved and were more than able to to. So the curriculum I use is the international one. We use a lot of Usborne books. Just to give you an idea. You know the [] so that's what I did, just the last year and a half.
- Therapist: Okay.
- Mother: Um so that. Neither of them have been required to do (.) lots of writing cos they read and then sit down and study it.
- Therapist: Okay.
- Mother: And then I do a lot of. We read quite a lot as a family. So they love books. They always have. At the moment we're reading Laura Ingalls Wilder. So they're able to concentrate quite well.
- Father: We don't watch, they don't watch, we don't watch television. The only time we bring out the TV is (.) to watch a video so that's never been an influence in their lives.
- Therapist: Okay.
- Father: We we we binged on the Olympics and they gained quite a lot of (.) action out of that.
- Therapist: Uhh
- Father: But um (.) ya its not been one of our priorities. In some cases it's been one of our priorities not not to watch.
- Therapist: Television.
- Father: Ya. We've wanted to emphasise a healthy love for (.) reading, you know.
- Therapist: David. You say that you can't concentrate. What do you mean by that? (Family 4)

Here is an example of when the mother (Family 1) refers the therapist to the report. The therapist asks about the nature and history of the difficulties and the mother refers her to the report without answering the question. This could be an example of avoidance or not knowing and may suggest fear on the part of the mother of being exposed as not understanding the nature of the problems. It could serve several functions, for example 'I don't know about these things. Read the report' or possibly, 'this is no concern of mine'. On the other hand it may be saying 'I'm scared of professional talk' or 'I'm not sure my own understanding is allowed here'.

Therapist: Okay, and was that okay or were there already difficulties?

Mother: It's all in his report. (Family 1)

It is interesting to think about what the use of the word 'we' does in the following example (Family 6). It seems to serve the function of avoiding locating the problems within the children. Saying 'they can't get up' would firmly place the problem in the camp of the children, and both parents are avoiding doing that in a systematic way for some reason.

Father: Lets start in the morning. We can't get up. First of all. Then there's a whole fight = (Family 6)

The mother uses the same strategy later in the session.

Therapist: Um is there any other concern that you'd like to tell me about Penny.

Mother: Basically just attitudes and behaviour and the fact that we don't listen. (Family 6)

The following example shows the confusion that can underlie the not knowing or vagueness. After extracting all sorts of professional terms that describe the problem from these parents, such as 'concentration', 'distractibility', 'phonics', 'reversals', the mother (Family 1) finally says that they just don't understand the problem.

Therapist: What other areas of difficulty are there?

Father: We just don't understand what is Adam's difficulty in class. (Family 1)

How can this be understood? Is it just a lack of understanding or knowledge? Is it the juxtaposition of the professional discourse and informal family descriptions of the problems? While these are possibilities, we do not really know enough about these people to come to one conclusion.

Playing down problems – or 'the disappearing problem'

The difficulty of disappearing problems occurred most noticeably during one of the interviews. It was very difficult for the therapist to get a sense of why the family had come to the clinic.

The parents (Family 6) were initially very reluctant to talk about why they had come to the clinic. After a while, because they were not raising any issues after the therapist had asked them why they had come to the clinic, she started asking them about specific things which had been written on the referral card. There are several examples here of these specific problems 'disappearing' when she asked about them.

Therapist: But you also had concerns specifically about Fiona. And um you're your mom said that she was a bit worried about you um because you had health problems. Is that true?

Fiona: I don't know?

Mother: Uuuu um She had, she went through a stage where she used to have headaches and tummy aches every day. But that seems to have cleared up very nicely since then. Hey you hardly get headaches these days. (Family 6)

This happens again later in the session when the therapist asks about clinginess.

Therapist: Okay. um one of the things that um you mentioned Penny [mother] was about [], about clinginess on the referral card.

Mother: Ooh but that was a long time ago. (Family 6)

And it disappears again.

Therapist: Um. There's one other thing that you mentioned um and that is that Fiona was stuttering. You mentioned that on the referral.

Mother: But now. She she goes through phases. Now it's fine again, but then suddenly Fiona hits a patch and there she goes stuttering. Even this year. Before school closed you were stuttering. (Family 6)

By this time in the interview the therapist was desperate to find the disappearing problem.

Therapist: Mhhh. Okay. Um I suppose we, we have to be very open right now because this is what we are here for. So both of you have used the words attitude problems and I think now is about time to expand a bit on what you mean by that.

Father: Maybe not attitude. [] a better word. Conflict.

Therapist: Okay.

Fiona: What does that mean daddy?

Father: I'll explain later. (Family 6)

In the above extract from the same interview the therapist tries to get the father to explain what he means by 'attitude problem', but instead of explaining it, he just uses another word which is equally as abstract, i.e. 'conflict'. Then when his daughter asks him to explain the meaning of the word, he says he will explain later. These strategies could be serving an avoidance function. The avoidance could be either one of avoiding talking and thinking about problems, or of avoiding having to deal with problems. Here instead of talking about how he understands the attitude problem, the father avoids this by restating the problem.

In terms of resistance, euphemism is discussed as mitigating device in the literature (Labov & Fanshel, 1977). This last example may serve as an example of a rhetorical attempt at euphemism. Stating the problem as ‘attitude’ serves to position it as the problem of the ‘other’. However, conflict implies two legitimate partners, either of whom might have a problem.

Silencing and fighting back

There were several cases during the interviews where a member fought back with regard to something that one of the other family members had said.

In the following example the mother (Family 1) complains that she has no time for hobbies which could be pragmatic communication (Makari & Shapiro, 1994) of an implied criticism of her husband who soon reveals that he has several time-consuming hobbies, including keeping tropical fish and racing pigeons of which he has over a hundred.

- Therapist: Uhuh. Okay. And have you. Have you got any hobbies or.
 Mother: Not at the moment.
 Therapist: Not a lot of time...
 Mother: No time for it. [both laugh]
 Therapist: Okay. Peter.
 Father: [] doing okay.
 Therapist: Okay
 Father: I'm doing diesel mechanicing on boats.
 Therapist: That's. Uhuh. That sounds exciting. Or is it not exciting.
 Father: No. its okay. Better than being stuck in a boring job in an office. (Family 1)

He responds by saying that his work is ‘better than being stuck in an office’, with ‘like my wife’ possibly being implied the end of the sentence.

This rhetorical use of indirect criticism by both these parents could suggest that they have problems to work out that do not include the child. This sort of exchange may therefore provide the therapist with a clue regarding other potential problems in the family.

In the following two extracts which both come from the same interview (Family 6), the daughter reveals that her parents fight, and more specifically that they had a fight the previous

night. The parents are highly embarrassed about this and try to silence her. This could be seen as an active attempt to fight back on the part of the daughter. It had become apparent in the interview that she was being positioned as the person with the problem. She does not allow her parents to position her without attempting to resist this dominant discourse by revealing their fight.

Father: Um. I think its, we have our ups and downs like all marriages, but I think we get along pretty well. Um We do have our fights over [] naturally.

Fiona: Oh, do you. Mmmmmm.

Mother: Sh.

Father: And (7). Quiet. Okay. Good. (Family 6)

Therapist: And and do the two of you (.) so you saying that your only disagreement is around (.) the two of them. Why? Having a fight or

Father: Mostly. Yes.

Therapist: Mostly.

Father: Yes. Yes. [something about money]

Therapist: Okay.

Fiona: And the idea problem. Cos I heard you were screaming at each other last night.

Father: And my smoking.

Fiona: "When last did you come up with ideas?" [laughs]

Mother: No, you mustn't listen. (Family 6)

In the following three brief extracts from an interview (Family 5), one can see the husband quite directly fighting back about the topic his wife has brought up, namely the problems that she feels exist between the two of them. It is clear that he does not want to talk about these issues during the session and that that argument is something which has come up for them several times before. To contextualise briefly, she feels that the relationship is falling apart because they do not spend enough time together as a couple. She thinks that they should be working on the relationship by going out together, having conversations and generally spending time maintaining the relationship.

Father: Not about the [] I don't see why do we have to talk about it. (Family 5)

Father: Ya. Its, I won't say I can't relate or I can't act on what she wants, what she wants me to do in our relationship like she said. I'm not scared anything is going to happen. I know nothing is going to happen. I'm trying to (1) build this marriage. I know, I won't say I'm trying, but I'm planning to (1) I'm making plans. I know she doesn't know what I mean but I'm thinking of (.) keeping it together. (Family 5)

Father: If she leaves, if she can, if she can leave me alone now. Stop (.)

Mother: Whining

Father: Whining. I think I will (.) be a better (.) person. (Family 5)

This may be an indication that the problem does not lie with the child. Sometimes families present a child at the clinic and the child becomes the repository of problems in the family. This could be a defence against the parents seeing that the problem is with them or within the family. It becomes easier to scapegoat one particular child. Sometimes shades of these other problems become evident in the discourse.

Distancing

Discourse often has the function of distancing the person from problems. One technique to distance the self from the pain is abstraction. In the following example the father (Family 4) does this by talking about the problem as “the nature of what what we working with”.

Abstraction functions as a mitigating device (Labov & Fanshel, 1977) and it could be argued that it masks problems through using language that is not direct.

Therapist: I just wanted to check with you. How did you (.) hear about the clinic?

Father: The lady who's doing (.) um the discovery lessons with them said that (.) this facility, or this (.) opportunity) might be something we could use. And that we should just just give it a shot. See if we can understand the nature of what what we working with. So. [shrugs] (Family 4)

The way in which people refer to themselves and others is not new to discussions that look beneath the ‘intended narrative’ (Makari and Shapiro, 1994) of talk. They refer to ‘the individually charged matter of ordering subject, object and action’ (p. 40) which can reveal unconscious meanings. A commonly noted distancing technique is to use the second person, as happens in this next extract. This mother (Family 6) also refers to ‘it’ being hectic, which also does not situate her complaint anywhere. Essentially it allows her to distance herself from the complaint because she doesn’t complain about a specific person.

Mother: But. You it gets. You don't need, you don't want all that drama early morning [] and its everything. You do A then its B that is wanted. So it gets a bit hectic. (Family 6)

Another common distancing technique is the use of the passive voice, which can be seen in the following extract (Family 1). It may serve the function here of assisting the father to appear neutral, instead of him having to take responsibility for removing the lunch money.

Therapist: Okay. And how and how do you as family handle discipline? What happens if you want the children to do something and they don't do it?

Father: Well his lunch money disappears. (Family 1)

Here the mother (Family 6) uses both the second person and the passive voice when talking about getting angry with the children. 'Action happens' is the way she describes this.

Mother: You need to speak a couple of times. You know and then eventually you need to get really upset and then then action happens, but that point, you, I'm already in a state = (Family 6)

Distancing is also used in the following example. When asked what the problem is, the mother (Family 2) refers to the teacher, the doctor, and a psychologist at Groote Schuur Hospital with whom she had an appointment. There is no sense in which she attempts to describe the problem herself or give her own understanding of it.

Mother: His teacher was concerned because he's [] and reading. He can read a bit but when it comes to like big words then he he um can't spell it and he finds it difficult to read.

Therapist: Okay

Mother: And because of that he's got difficulty in writing as well. And um the teacher called me in and then um she said to me I must take him to the doctor and the doctor mos referred me to a psychologist.

Therapist: Okay. When was this?

Mother: That was about a month ago.

Therapist: Okay.

Mother: And um. So um I took him to the doctor and she referred me to Groote Schuur and I got an appointment um with []. And she tested him. And then she said to me um. She phoned me. She said to me I must phone you people to get an appointment and she'll fax the report through. (Family 2)

This is highlighted further later in the session where the interviewer asks about the results from the assessment at Groote Schuur.

Mother: Yes. She she phoned me with the results.

Therapist: Okay okay and how did you understand them?

Mother: Ya. I understand what she told me.

Therapist: Okay.

Mother: Um that's why she referred me here.

- Therapist: Okay. Okay. Can you perhaps snare maybe from your ...
- Mother: = Okay. She she said to me that um he didn't do well with the um questions that she asked him.
- Therapist: Okay.
- Mother: And um. That's basically what she told me. But she said I can phone anytime with if I've got any concerns. (Family 2)

Once again the mother makes no attempt to explain these results or give her own understanding.

Conclusion

This chapter has examined the interpretative repertoires found in the analysis of the interviews in the study. It has focused specifically on the ways in which the nature of the problem or problems has been constructed in the talk. The next chapter, concluding the study, will focus primarily on the integration between these interpretative repertoires and psychoanalytic theory within this particular study.

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Chapter 5: Discussion

This research has brought to light an interesting contradiction in the talk of families, particularly parents, when they presented at a psychology clinic with problems. Paradoxically even though they expect to talk about their problems when they come to the clinic, and are indeed asked about the problems when they do come, they nevertheless find it extremely difficult to produce coherent linear narratives regarding the problems. The research has shown how difficult it is to get a straight answer to the question 'so what brings you to the clinic today'. All the levels of communication and different subjectivities operating in the session serve to make what actually happens very different from what one might expect to happen, given the framework of the clinical interview. Overall two main themes were found in the transcripts. The first was made up of interpretative repertoires in which descriptions of the problems are structured in a variety of ways. The second was a defensive theme made up of interpretative repertoires of avoidance, evasion, distancing, ambiguity, and elusiveness.

The particular stories which were told during these interviews could only have emerged within these particular interviews. The questions asked by the therapists, the fantasies of the parents regarding what the therapists wanted to know, the fact that parents were discussing their children who were in the room have contributed to the co-construction of these particular narratives. Mishler (1986) calls this process 'narrative smoothing'. If these parents had been asked while walking on the beach or sitting at home over a meal about the problems they were experiencing with their children, the stories are likely to have been told in significantly different ways. The study brings to light the functions, performatives and positionings involved in talk during these interviews. It shows how active the various participants are within the framework of the session. The activeness suggests a co-construction of the particular narrative. Given the context of the research, it is not surprising that defensiveness, suspicion and a lack of trust prevailed in the sessions. The knowledge that you as a family have problems that you cannot cope with without outside assistance is likely to be anxiety-provoking in itself. To compound this, the levels of surveillance with the mirror, the video camera and the necessity of telling the story in front of strangers would probably raise anxiety levels in anyone, let alone these families who have come with problems.

This chapter extends the discussion of the interpretative repertoires presented in the previous chapter. It focuses more closely on the psychoanalytic possibilities suggested by the integration of discursive and psychoanalytic theory paying particular attention to the

construction of subjectivities. It then examines issues of power within the research. More than this however, it both seeks to contextualise the study and to comment on the significance and implications of the study. My reflections on the research are also included.

Complex subjectivities

It will have been apparent in the previous chapter, that instead of constructing the problems during the interviews, many families tended to avoid constructing them as could be seen in the defensive representations theme. Instead of constructing a problem, many were constructing themselves in a particular way when asked to describe a problem. This may also be seen as a defence, however it is interesting to look more closely at the ways in which subjectivities are constructed in the talk.

The first question that comes to mind when thinking about interpretative repertoires is one of function (Potter & Wetherell, 1987). As already mentioned, one of the functions of talk such as this, is to create distance. It serves to distance the narrator from the problems.

Psychoanalytically one might say that this is done as a defence to protect the self from the anxiety associated with owning the problem or as a resistance to the therapy. Labov and Fanshel (1977) refer to 'vague reference' as one of the mitigating devices used in the therapeutic situation they analyse as part of masking and resistance in the therapy. Thinking more intersubjectively however, it also keeps the therapist distanced from both the client and the problems. This may be a function of the fact that they have just met, that this is the first interview, or possibly that clients are protecting themselves against being judged.

Interpretative repertoires suggestive of avoidance and distancing were most evident in the analysis of the interviews. There was little sense in which most of the parents were either able or willing to describe the problems when asked. This avoidance was accomplished in different ways. In some interviews there was a sense of 'not knowing' regarding the problems. For example parents would describe what they had done to deal with the problems instead of detailing what the problems were. In one interview there was a sense of 'disappearing problems'. Every time the therapist tried to pin down a problem, that particular issue had already resolved. In another interview, when asked about the problems, the mother, who was home schooling her children, started describing the sort of curriculum and teaching methods she was employing. These interpretative repertoires have avoidance in common.

If one thinks of the distancing or avoidance as a defence, psychoanalytically this would be in place in order to avoid anxiety (Malan, 2001). The anxiety would be an indication of an intrapsychic battle that the person is fighting. The anxiety might relate to the feelings of helplessness, for example, that arise in the parent at the thought of having a child with problems that the parent cannot solve. However in this attempt to integrate discourse and psychoanalytic theory, perhaps there is a different way in which to explain this anxiety.

As has already been explored, Frosh et al. (2003) argued that psychoanalysis could make a valuable contribution to discourse theory in terms of assisting to explain how discourse is structured 'at the level of the "personal"' (p. 42). So using this theory, one might explain the interpretative repertoire of the parents who are home schooling their children, for example, as an attempt to justify themselves, to say in a sense that 'this is the best we could have done' before explaining what the problems are. They do say, later in the interview that it is important to them to be good parents.

Mother: And we put quite a lot of work into (.) being the best parents we can. And we realise that no nobody's perfect. Try and [] each other. You know I wouldn't say, wait till dad comes home drdrdrdrrrrrr.
(Family 4)

Parker (1997) on the other hand would argue that psychoanalytic theory could add to an understanding of what he calls 'complex subjectivity'. This might explain the position taken within the previous example by referring to the internalisation of a sense within in these parents of having to justify that one has done one's best. This could be as a result of a particular cultural, family or even personal history of either or both of these parents. Perhaps, for example, there was opposition from their own parents to the fact that they wanted to home school their children. On the other hand it could be because these parents have internalised particular notions of self-sufficiency and are loath to give up control of their children's education. They might think that they can only justify that they have done their best if they do it themselves. Yet again, it could be because the mother, in struggling with her own schooling, has internalised a sense of pain around schooling and seeks to prevent a similar struggle and similar pain in her children. There are obviously other versions of subjectivity which could be at play here. Without having more information about the historical and cultural context of this family, it is not possible to be more specific.

Looking at another example of avoidance, the interpretative repertoire of disappearing problems, it is clear that there is resistance to discussing the problems. These parents simply do not want to say what the actual problems are. So, even though they have brought their children to the clinic, they are unable at the very least to say which child has problems. The only reason it becomes clear which child is the Index Patient is that the therapist makes this obvious because of her prior knowledge of the case.

There is also an element of rhetorical displacement within this interpretative repertoire. There is no sense in which there are core problems to be solved. Instead the problems move from health problems to clinginess to stuttering to conflict. Psychoanalytically this could be described as a defence against the anxiety provoked by naming problems. This could be because they are afraid of the reaction of their children or the Index Patient child if they do name a particular problem. It could be because they are not actually sure what the problems are, and therefore cannot be more specific. They may also be ambivalent about getting help for their problems and therefore unwilling to name them. In terms of complex subjectivity (Parker, 1997) this could be seen as a tool possibly chosen unconsciously from a repertoire of tools with the specific goal of not revealing too much in the interview. This could be because these parents are embedded within social or cultural circumstances in which privacy and not revealing too much are desired ways of functioning.

In looking at the vagueness interpretative repertoire, this may be the defensiveness of individuals who are trying to deflect close examination of their private lives within a situation that is quite threatening – in front of their children, in front of a stranger and with fantasies about what is occurring behind the mirror. Certainly the sense of surveillance (Foucault, 1980), of being watched, must be palpable. Or are we seeing parents that are overwhelmed by their problems, and simply unable to begin describing them. We may be seeing what Shakespeare (1996, in Wetherell, 1999) or Parker (1997) might term an inability to perform the psychoanalytic version of self. On the other hand we may be seeing individuals who through lack of education or lack of opportunities to reflect in this way as they grew up and developed into adults, simply do not have the competence to perform in this way? Crites (1986) argues that without a sense of personal continuity or identity, people produce self-narratives that are confused, inconsistent and may even seem chaotic. Is this also a part of what is happening in these interviews?

There is certainly a considerable amount of vagueness or ‘not knowing’ in which these parents perform a sense of having little certainty or clarity regarding the nature of their problems. This may be related to class, education and to a certain extent, race issues. It has been argued that the ability to present the self is related to competence. ‘It is a matter of being competent in the fine-grain methodic practices involved in telling, first, stories in general and then, second, stories about oneself’ (Wetherell, 1999, p. 4). These parents mainly come from working-class coloured families. Under apartheid they would have had poor educations and many of them did not complete secondary education. Furthermore the Cape Flats is an extremely violent place (Haefele, 2003; Standing, 2005) and with families living in such circumstances it is possible that these would have been affected by crime and gangsterism. We know that trauma negatively affects the ability to produce a coherent narrative. Shakespeare’s (1996, in Wetherell, 1999) point is essentially that not everyone may be competent to position themselves freely, that there may be some ways of talking about oneself which one cannot access because one has not had the opportunity to develop the competence.

The discourse of professionalism was evident in several of the interviews. While avoidance has been seen in several of the other interpretative repertoires, here it is a distancing which seems to be happening. There may be several reasons for using a professional discourse. On the one hand it could be to avoid thinking about the meaning of the words one is using. Is this because parents are trying to avoid engaging with the realities of the difficulties – therefore if they use professional discourse will it seem that they know what they are talking about and will this result in us leaving them alone? On the other hand could be an attempt to perform a competence in previous attempts to deal with the problems. It could also be an attempt to position oneself as one of the professionals which in psychoanalytic terms might be performed because one feels inadequate because one is not one of the professionals. Coming back to Shakespeare’s idea again, is the use of professional discourse simply an example of the ‘performative’ that these parents have been able to learn and are therefore performing because they have access to it.

Ochs (1996) has delineated two necessary components for co-construction of narrative meaning. The first of these is the value and time the listener places in listening and the second is the speaker’s capacity to risk being vulnerable within the situation. In these interviews, from the amount of avoidance, distancing and blaming that occurs, one could conclude that these parents definitely do not feel comfortable with exposing themselves and being

vulnerable within the situation. If Ochs is correct, this suggests that the creation of narrative meaning cannot even begin.

Looking at the 'fighting back' interpretative repertoire, in which one family member generally tries to silence another, this could be understood in different ways. Perhaps it takes talking in front of other people to avoid being silenced. Perhaps these interactions could not have taken place at home at all, or perhaps the silencer could more effectively silence the other family member at home, for example by leaving the room, becoming angry or threatening the other member in some way. This interpretative repertoire certainly shows how Harré's positioning theory works in the interviews (Davies & Harré, 1990). People are quite active in taking positions and do not simply acquiesce to whatever positions are offered to them in terms of questions asked, or topics raised, either by their family members or by the therapist.

Aside from looking at this content in terms of its function of silencing within a discourse analytic framework, if one considers the psychoanalytic analysis there are other implications of this type of silencing. Billig (1997), in writing about the dialogic unconscious, maintains that one 'needs to investigate how routines of talk can prevent the utterance of themes/accounts/questionings, which might seem reasonable to outsiders but which are collaboratively avoided by the particular speakers as a localized form of politeness' (p. 151). Psychoanalytically silencing could be seen as a way of avoiding talking about something, of defending against content which is disturbing to the person in some way. It could also be seen as an aggressive action with the same motive, that of avoidance. Equally it could be seen as an attempt to deal with what has been projected into another.

It could also have to do with power. Who has power in a family to silence? It is interesting to note that in these examples there is a gendered silencing that occurs. It is largely the fathers who make these active attempts to silence the mothers. The exception is the example where the parents silence one of the children. Is this because they are the most powerful members of the families? One would probably have to feel powerful to make this sort of attempt at silencing, particularly under the circumstances where there is so much surveillance by the therapist, the videotaping, and those behind the mirror who are all observing the family. In the South African context in terms of gender relations, it has been argued that men generally have more power than women within relationships (Maharaj, 1999) and it is likely that men are more powerful in these families, which, as discussed previously, generally have working class roots.

If one looks at this in terms of Parker's (1997) complex subjectivity, instead of seeing this power and ability to silence as something innate, as might happen within traditional psychoanalysis, it can be thought of as a subjectivity that is available to these men because of where they are situated by social structures and the cultural positions available for their use. In terms of intersubjectivity this interpretative repertoire also suggests how the story might be different given the particular circumstances. The fact that this silencing took place often so actively suggests that under different circumstances, possibly where there is less scrutiny, the stories that needed to be silenced may not have seen the light of day. They may have been too difficult or dangerous to tell without the 'protection' that the surveillance of the clinic offered.

Power and Ideological Effects

Aside from looking at interpretative repertoires and discursive complexes, the matter of broader societal discourses in the work is also important. Parker (1992) delineates three criteria on which a discourse analysis should focus, these being that discourses support institutions, reproduce power relations and have ideological effects. The role of power in the 'silencing' interpretative repertoire has already been explored. Parker makes the point that discourses tend to replicate power relations, which is the case here in terms of gender relationships between the couples. However Parker also distinguishes between coercive power and resistance power. In this interpretative repertoire it could be argued that both are present. If the silencer has control over the dominant story, the very fact that the other person needed silencing suggests the presence of a discourse of resistance.

In addition to the gendered silencing there is also most obviously silencing of children within the interviews which is consistent with Tate and Meeuwesen's (2001) finding within medical interviews. In the one interview where the child makes a comment about her parents fighting, both of them move in to silence her immediately. It is very seldom that the children are asked to describe the problems. There are a couple of examples, notably in family 4, where the therapist tries to get the child to describe the problems because the parents are not providing the description.

Therapist: David. You say that you can't concentrate. What do you mean by that?

David: []

Therapist: Sorry?

David: I don't know what you mean?

Therapist: You don't know what I mean, okay. Cos you said um you (.). Cos I'm trying to figure out what you mean when you say (.) you can't concentrate. (Family 4)

Obviously the talk and the discourses that are employed are affected and complicated by matters of race and gender between therapist and family which may be related to power in terms of who feels free to speak and who does not. Families may not feel as free to talk where the therapist is 'other' (Sampson, 1993). 'Not only do "identities" such as ethnicity/ "race" (as well as gender and class) entail categories of difference and identity (*boundaries*), they also construct social positions (*hierarchies*), and involve the allocation of power and other resources' (Anthias, 2001, p. 634). In much literature on race a structural hierarchy is identified (Bonilla-Silva & Forman, 2000; Duncan, 2003; James & Tucker, 2003; Van Dijk, 1992, 1993). This suggests that in interviews where the families perceive themselves as being 'lower' on this hierarchy, they could have felt less power to speak.

Therapists are not always neutral in the ways in which they summarise and formulate the information they obtain during therapy sessions. Hare-Mustin (1994) has argued that 'the efforts of most therapists represent the interest and moral standards of the dominant groups in society. Therapy is typically well-regarded by elite groups for the goodness of its principles and practices' (p. 20). She maintains that the 'goals of most family therapies (for example, maintain the family, avoid divorce, keep the children in school, differentiate) reveals that we as therapists are engaged in social control more than social change' (p. 20). She argues that marginalized groups may have other subordinate discourses which tend to be kept out of the therapy room or sometimes co-opted by dominant discourses. So the institution of the family is likely to be reinforced (Parker, 1992) through the process of coming to the clinic and the discourses that are allowed would speak to family values, obedience by children, and the protestant work ethic (Furnham, 1990).

Along these lines, it has been found that in the process of formulating presenting problems and creating a therapeutic intervention, there may be an attempt on the part of the therapist to persuade (or coerce) the client into accepting a certain interpretation of the events and their meanings (Davis, 1986). Similarly, the ways in which therapists manage sessions could also be seen to be persuasive and may at times verge on the coercive. Peyrot (1987) examined how the use of what he calls circumspection on the part of the therapist during therapy sessions was used to avoid altercations with clients so that the clients would remain in therapy. Stancombe and White (1997) showed ways in which therapists and clients attempted to control the creation of meaning rhetorically within sessions. Similar factors have been identified in the way in which written case records affect the way in which psychiatric

patients come to think about and describe themselves (Barrett, 1996; Swartz, 1996). It can thus be seen that the co-creation process may at times have an agenda attached to it, on the part of both therapist and client.

Interrogating 'the presenting problem'

An assumption was made at the beginning of this study that there is a problem or possibly several problems that have brought each family to the clinic. However, this assumption cannot go un-interrogated.

The clinical interview can be thought of as having a modernist vision. What is asked for is a cohesive chronological and linear story, a recognition and understanding of symptoms, an ability to reflect on family and personal history. In a sense, these interviews suggest a postmodernist answer to this modernist task. It is noteworthy that the themes found mirror the postmodernist task of the deconstruction and replacement with fragmentation, dissonance and inconsistency of a sense of linearity and continuity (Crossley, 2000; Swartz, 1996) – or the cohesive story narrative as Labov (1972) might envision it. In terms of asking people to tell and possibly expecting fully-formed coherent stories, this fragmentation and the absence of cohesive narrative is interesting.

The clinical interview (Appendix 3) makes the assumption that there is either a problem or problems which cause the family or individual, should that be the case, to present at a clinic for psychotherapy. One of the most important sub-headings of this interview is 'The Presenting Problem'. It has been suggested that the current research provides a postmodern answer to this modernist task. The assumption that there is a problem or problems that need to be solved is part of such a modernist vision. Neophyte therapists are taught to look for 'the problem', to ask about 'the problem' and to formulate around 'the problem'. This research suggests that there may be no neat coherent problem waiting to be discovered, but that the clinical interview rather reveals extremely rich information about the ways in which families function and the ways in which they construct problems and themselves in relation to perceived difficulties. Perhaps the attempts to elucidate the 'presenting problem' should be seen rather as a strategy which draws attention to the ways in which the problems are constructed for each family, rather than an uncomplicated description of what the problem is.

On the one hand therefore, is the finding in this research that when descriptions of problems are sought during the initial interview, defensiveness emerges. On the other hand there is the

possibility that searching for a problem that can be solved is problematic in itself, and that what one needs to attend to is the way in which problems are constructed by families and the way families are constructed in problem. Parker's (1997) assertion that defences are an integral part of the structure of the text, and that 'analysis helps us understand that *structure* itself rather than opening up what is hidden "underneath" ' (p. 489) lends credence to such an interpretation. Instead of searching for the elusive 'problem' which is hidden beneath the defences, it may be more useful to examine the construction of the defences themselves.

Perhaps the most important result to emerge from this research is the calling into question of the nature of the Clinical Interview. It may be the case that what we need to do is interrogate the expectation that there is a 'presenting problem' to be found. This may merely be a defence against and attempt to gain control over and 'tame' a problem where it is simply too difficult to do this.

The value of the research

One way of assessing the value of research is to see whether the research could have consequences for either the theory or practice in a particular research area.

In terms of clinical practice, the results problematise the narratives within the interview. They systematically show that therapists are likely to have to put in effort to get an idea of what the problems might be, and that the first suggestion of what the problems might be by parents is likely to require further investigation. What must remain highly significant is that it was exceptional to obtain a coherent account of the problems, for a family to be able to 'tell their story' of the problems.

The results demonstrate that what is obtained within the intake interview is not necessarily what one first thought would be brought to light. It could be argued that this has value and utility both theoretically and clinically. The information that one obtains from an analysis such as this is useful in terms of making hypotheses and attempting formulations in order to develop treatment plans around presenting problems precisely because of the complexities that surface. This is because of the layers of knowledge one is able to access when thinking about people in terms of complex subjectivities instead of just the facts of the case. The results could highlight for other trainee therapists, the possibility that these sorts of interpretative repertoires may be found.

The extent of the information it is possible to extract from the interviews could also possibly remind one that there is a tendency in case records to effect a significant reduction from the spoken to the written information, and that the latter is likely to be the remembered information (Barrett, 1996). It must always be remembered that manifest content is only one aspect of the interview and that there are many other layers of communication taking place at the same time. It is these other layers that have been explored in this research.

This research did not bring to light the neat interpretative repertoires or the societal discourses that were expected. Instead the gaps and psychodynamic indications of defence against anxiety (Billig, 1997) were found. As Gergen (1997) has argued, building on the work of Gadamer, Kuhn and Fish, interpretation will without doubt be bound up in the prior assumptions and understandings which the interpreter brings with him or her. Kuhn (1970) called this the 'paradigm of understanding'. Gergen reiterates the argument of Fish that interpretations are likely to sustain the typical understandings of the community from which they emerge.

It must also be remembered that these parents are likely to have wanted to appear in a good light. Goffman's (1975) notion of impression management within the presentation of the self is important to remember here. Maintaining the 'face' necessary for continued social interaction would probably be high on the agenda of these parents. This is something which needs to be taken into account within practice in the field in terms of formulation around a case when thinking about what parents say about their problems, or their histories.

Limitations of the study

There are some limitations in research such as this. Crossley (2003) argues that the subject or unitary self may often be missing from a social constructionist methodological framework since such studies are often distinguished by their focus on interpretation, variability and relativity and avoidance of universal assertions. It is hoped that this criticism has been addressed through the use of a methodology which integrates discourse analysis and psychoanalysis.

This type of analysis is also not useful for large-scale studies, as it is so detailed and nuanced. Furthermore there is a possibility that a narrative approach to analysis may reify language and favour the linguistic (Riessman, 1993). The criticisms made regarding the exclusion of embodiment and materiality from much social constructionist work (Cromby & Nightingale,

1999) may apply to this work since the talk in the sessions was focused on to the exclusion of other factors.

Conclusion

This chapter has attempted to examine the ways in which individual subjectivities were constructed in the talk in the context of a discussion which aimed to extend the findings on the construction of the presenting problem examined in the previous chapter. Both intersubjective psychoanalysis and Parker's notion of discursive complexes (1997) were used in order to do this. Moreover, the broader societal discourses implicated in the study and the value of the research were also examined. These include issues of power and ideology. An attempt was made to question the nature of the clinical interview with its focus on the presenting problem.

In conclusion, this research demonstrates above anything else how difficult it was for all these parents and families to tell their stories. The defensive representations which emerged in so many of their stories testify to these difficulties. The way in which these interviews reveal the details of these difficulties they construct both the problems and themselves talk is one of the most important findings in this research.

References

- Abrams, M. (2000). 'Jesus will fix it after awhile': meanings and health. *Social Science & Medicine*, 50, 89-105.
- Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: a critique of six analytic shortcomings. *Discourse Analysis Online*, 1. Retrieved August 20, 2005, from <http://www.shu.ac.uk/daol/previous/v1/n1/index.htm>
- Anthias, F. (2001). New hybridities, old concepts: the limits of 'culture'. *Ethnic and Racial Studies*, 24, 619-641.
- Armstrong, D. (1982). The doctor-patient relationship 1930-1980. In P. Wright and A. Treacher (Eds.), *The problem of medical knowledge* (pp. 109-122). Edinburgh: Edinburgh University Press.
- Armstrong, D. (1983). The fabrication of nurse-patient relationship. *Social Science and Medicine*, 17, 457-60.
- Armstrong, D. (1984). The patient's view. *Social Science & Medicine*, 18, 737-744.
- Arntson P., & Droge, D. (1987). Social support in self-help groups: the role of communication in enabling perceptions of control. In T. Albrecht & M. Adelman (Eds.), *Communicating social support* (pp. 148-171). Newbury Park, CA: Sage.
- Bailey, P. H., & Tilley, S. (2002). Storytelling and the interpretation of meaning in qualitative research. *Journal of Advanced Nursing*, 38, 574-583.
- Barrett, R. J. (1996). *The psychiatric team and the social definition of schizophrenia: an anthropological study of person and illness*. Cambridge: Cambridge University Press.
- Berger, P. & Luckmann, T. (1966). *The social construction of reality*. New York: Doubleday.
- Billig, M. (1997). The dialogic unconscious: psychoanalysis, discursive psychology and the nature of repression. *British Journal of Social Psychology*, 36, 139-159.
- Billig, M. (1999). *Freudian repression: conversation creating the unconscious*. Cambridge: Cambridge University Press.
- Bonilla-Silva, E., & Forman, T. A. (2000). I am not a racist but . . . : mapping white college students racial ideology in the USA. *Discourse and Society*, 11, 50-85.
- Bottari, M. A., & Rappaport, H. (1983). The relationship of patient and therapist-reported experiences of the initial session to outcome: an initial investigation. *Psychotherapy: Theory, Research and Practice*, 20, 355-358.
- Brown, B., Nolan, P., Crawford, P., & Lewis, A. (1996). Interaction, language and the 'narrative turn' in psychotherapy and psychiatry. *Social Science and Medicine*, 43, 1569-1578.

- Bunge, M. (1993). Realism and antirealism in social science. *Theory and Decision*, 35, 207–235.
- Burr, V. (1998). Overview: realism, relativism, social constructionism and discourse. In I. Parker (Ed.), *Social constructionism, discourse and realism* (pp. 13-25). London: Sage Publications.
- Buttny, R., & Jensen, A. D. (1995). Telling problems in an initial family therapy session: the hierarchical organization of problem-talk. In G. H. Morris & R. J. Chenail (Eds.), *The talk of the clinic: explorations in the analysis of medical and therapeutic discourse* (pp. 19-47). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Chenail, R. J., & Morris, G. H. (Eds.). (1995). *The talk of the clinic: explorations in the analysis of medical and therapeutic discourse*. Hillsdale: Lawrence Erlbaum Associates.
- Cortazzi, M. (1993). *Narrative analysis*. London: The Falmer Press.
- Cromby, J., & Nightingale, D. J. (1999). What's wrong with social constructionism? In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: a critical analysis of theory and practice* (pp. 1-19). Buckingham: Open University Press.
- Crites, S. (1986). Storytime: recollecting the past and projecting the future. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 152-173). New York: Praeger.
- Crossley, M. L. (2000). *Introducing narrative psychology: self, trauma and the construction of meaning*. Buckingham: Open University Press.
- Crossley, M. L. (2003). Formulating narrative psychology: the limitations of contemporary social constructionism. *Narrative Inquiry*, 13, 287-300.
- Curt, B. (1994). *Textuality and Tectonics*. Buckingham: Open University Press.
- Davies, B., & Harre, R. (1990). Positioning: the discursive production of selves. *Journal for the Theory of Social Behavior*, 20, 43-63.
- Davis, K. (1986). The process of problem (re)formulation in psychotherapy. *Sociology of Health & Illness*, 8, 44-74.
- Duncan, N. (2003). 'Race' talk: discourses on 'race' and racial difference. *International Journal of Intercultural Relations*, 27, 135-156.
- Edley, N. (2001). Unravelling social constructionism. *Theory & Psychology*, 11, 433-441.
- Edwards, D. (1997). *Discourse and cognition*. London: Sage.
- Edwards, D., Ashmore, M., & Potter, J. (1995). Death and furniture: the rhetoric, politics and theology of bottom line arguments against relativism. *History of the Human Sciences*, 8, 25-49.

- Fairclough, N. (1995). *Critical discourse analysis: the critical study of language*. London: Longman.
- Fanshel, D., & Moss, F. (1971). *Playback: a marriage in jeopardy examined*. New York: Columbia University Press.
- Falvo, D. R., & Smith J. K. (1983). Assessing residents' behavioral science skills: patients' views of physician patient interaction. *Journal of Family Practice*, 17, 479-483.
- Fife, B. L. (1995). The measurement of meaning in illness. *Social Science & Medicine*, 40, 1021-1028.
- Filc, D. (2004). The medical text: between biomedicine and hegemony. *Social Science & Medicine*, 59, 1275-1285.
- Fonagy, P. (1999). Psychoanalytic theory from the viewpoint of attachment theory and research. In: J. Cassidy, & P. Shaver (Eds.), *Handbook of attachment: theory, research and clinical applications* (pp. 595-624). New York: Guilford Press, 1999.
- Foster, D. (1999). Racism, Marxism, psychology. *Theory & Psychology*, 9, 331-353.
- Foucault, M. (1980). *Power/knowledge*. Edited by C. Gordon. New York: Pantheon Books.
- Frank, A. W. (1993). The rhetoric of self-change: illness experience as narrative. *The Sociological Quarterly*, 34, 39-52.
- Frank, A. W. (1995). *The wounded storyteller: body, illness, and ethics*. Chicago: University of Chicago Press.
- Frank, G., & Sweetland, A. (1962). A study of the process of psychotherapy: the verbal interaction. *Journal of Consulting Psychology*, 26, 135-138.
- Frankel, R. M. (1984). From sentence to sequence: understanding the medical encounter through microinteractional analysis. *Discourse Processes*, 7, 135-171.
- Frankenberg, R. (1986). Sickness as cultural performance: drama, trajectory, and pilgrimage root metaphors and the making of social disease. *International Journal of Health Services*, 16, 603-626.
- Freidson, E. (1970). *Professional dominance. The social structure of medical care*. Chicago: Aldine.
- Frosh, S., Phoenix, A., & Pattman, R. (2003). Taking a stand: using psychoanalysis to explore the positioning of subjects in discourse. *British Journal of Social Psychology*, 42, 39-53.
- Furnham, A. (1990). *The protestant work ethic: the psychology of work-related beliefs and behaviours*. London: Routledge.
- Fuss, D. (1989). *Essentially speaking: feminism, nature & difference*. New York: Routledge.

- Gergen, K. J. (1997). Social psychology as social construction: the emerging vision. In C. McGarty and A. Haslam (Eds.), *The message of social psychology: perspectives on mind in society* (pp. 113-128). Oxford: Blackwell.
- Gergen, K. J. (1998). Constructionism and realism: how are we to go on? In I. Parker (Ed.), *Social constructionism, discourse and realism* (pp. 147-155). London: Sage Publications.
- Gergen, K. J., & Gergen, M. M. (1986). Narrative form and the construction of psychological science. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 22-44). New York: Praeger.
- Gerhardt, U. (1989). The sociological image of medicine and the patient. *Social Science & Medicine*, 29, 721-728.
- Giddens, A. (1976). *News rules of sociological method*. London: Hutchinson.
- Glare, P. G. (1982). *Oxford Latin Dictionary*. Oxford: Oxford University Press.
- Goffman, E. (1967). *Interaction ritual: essays in face-to-face behavior*. Chicago: Aldine Publishing Company.
- Goffman, E. (1975). *Frame Analysis*. Harmondsworth: Penguin.
- Goldberg, D. (1997) *The Maudsley handbook of practical psychiatry*. Oxford: Oxford University Press.
- Haefele, B.W. (2003). *Gangsterism in the Western Cape*. Department of Community Safety. Crime Information Centre.
- Hak, T. (1992). Psychiatric records as transformations of other texts. In G. Watson & R. M. Seiler (Eds.), *Text in context: contributions to ethnomethodology* (pp. 138-155). Newbury Park: Sage Publications.
- Hare-Mustin, R. T. (1994). Discourse in the mirrored room: a postmodern analysis of therapy. *Family Process*, 33, 19-35.
- Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1998). *Changing the subject: psychology, social regulation and subjectivity*. London: Routledge.
- Herzlich, C., & Pierret, J. (1985). The social construction of the patient: patients and illnesses in other ages. *Social Science & Medicine*, 20, 145-151.
- Heszen-Klemens, I., & Kapińska, E. (1984). Doctor-patient interaction, patients' health behavior and effects of treatment. *Social Science & Medicine*, 9, 9-18.
- Hollway, W., & Jefferson, T. (1997). Eliciting narrative through the in-depth interview. *Qualitative Inquiry*, 3, 53-70.
- Hollway, W., & Jefferson, T. (2000). Biography, anxiety and the experience of locality. In P. Chamberlayne, J. Bornat & T. Wengraf (Eds.), *The turn to biographical methods in social science* (pp. 167-180). London: Routledge.

- Holmes, J. (2000). Narrative in psychiatry and psychotherapy: the evidence? *Journal of Medical Ethics: Medical Humanities*, 26, 92-96.
- Horton-Salway, M. (2001). Constructing the 'self' and 'M.E.': a discursive psychology approach to illness narrative. *Journal of Health Psychology*, 6, 247-259.
- James, A. D., & Tucker, M. B. (2003). Racial ambiguity and relationship formation in the United States: theoretical and practical considerations. *Journal of Social and Personal Relationships*, 20, 153-169.
- Katz, A. M., & Shotter, J. (1996). Hearing the patient's 'voice': toward a social poetics in diagnostic interviews. *Social Science & Medicine*, 43, 919-931.
- Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley: University of California Press.
- Kleinman, A. (1995). *Writing at the margin: discourse between anthropology and medicine*. Berkeley: University of California Press.
- Kroll, T. L., Sharf, B. F., & Haidet, P. (2004). "What story am I in?" times two: narrative as a foundation for active patient participation. Paper presented at the Psychoanalysis and Narrative Medicine Conference, University of Florida, Gainesville, 19-22 February 2004. Retrieved September 23, 2005, from <http://web.english.ufl.edu/pnm/kroll.html>
- Kuhn, T. (1970) *The structure of scientific revolutions* (2nd ed.). Chicago: University of Chicago Press.
- Labov, W. (1972). The transformation of experience in narrative syntax. In W. Labov (Ed.), *Language in the inner city: studies in the Black English vernacular* (pp. 354-396). Philadelphia: University of Pennsylvania Press.
- Labov, W., & Fanshel, D. (1977). *Therapeutic discourse*. New York: Academic Press Inc.
- Lennard, H. L., & Bernstein, A. (1960). *The anatomy of psychotherapy: systems of communication and expectation*. New York: Columbia University Press.
- Liebrucks, A. (2001). The concept of social construction. *Theory and Psychology*, 11, 363-392.
- Mahl, G. F., & Schulze, G. (1964). Psychological research in the extralinguistic area. In T. A. Sebeok, A. S. Hayes & M. K. Bateson (Eds.), *Approaches to semiotics* (pp. 51-124). London: Mouton & Company.
- Madill, A. & Doherty, K. (1994). 'So you did what you wanted then': discourse analysis, personal agency, and psychotherapy. *Journal of Community and Applied Social Psychology*, 4, 261-23.
- Madill, A., & Barkham, M. (1997). Discourse analysis of a theme in one successful case of brief psychodynamic-interpersonal psychotherapy. *Journal of Counseling Psychology*, 44, 232-244.

- Maharaj, Z. (1999). *Gender inequality and the economy: empowering women in the new South Africa*. Keynote speech at Professional Women's League of KwaZuluNatal, August 9, 1999. Retrieve 24 September, 2005, from <http://www.africaaction.org/docs99/gen9908.htm>
- Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in preschool years: theory, research, and intervention* (pp. 161-184). Chicago: University of Chicago Press.
- Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: the role of common factors in psychotherapy* (pp. 57-88). Washington, DC: American Psychological Association Press.
- Makari, G. J., & Shapiro, T. (1994). A linguistic model of psychotherapeutic listening. *Journal of Psychotherapy Practice and Research*, 3, 37-43.
- Malan, D. H. (2001). *Individual psychotherapy and the science of psychodynamics*. London: Arnold Publishers.
- Mason, J. (2002). *Qualitative researching*. London: Sage.
- McAdams, D. P. (1993). *The stories we live by: personal myths and the making of the self*. New York: The Guilford Press.
- McNeilis, K. S., Thompson, T. L., & O'Hair, D. (1995). Implications of relational communication for therapeutic discourse. In G. H. Morris & R. J. Chenail (Eds.), *The talk of the clinic: explorations in the analysis of medical and therapeutic discourse* (pp. 291-314). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Michaels, S. (1981). Sharing time: children's narrative styles and differential access to literacy. *Language in Society*, 10, 423-442.
- Mishler, E. G. (1984). *The discourse of medicine: dialectics of medical interviews*. Norwood NJ: Ablex Publishing Corporation.
- Mishler, E. (1986). The analysis of interview narratives. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 233-255). New York: Praeger.
- Mishler, E. G. (1995). Models of narrative analysis: a typology. *Journal of Narrative and Life History*, 5, 87-123.
- Monks, J. A. (2000). Talk as social suffering: narratives of talk in medical settings. *Anthropology & Medicine*, 7, 15-38.
- Moscovici, S. (1984). The phenomenon of social representations. In R. M. Farr and S. Moscovici (Eds.), *Social representations* (pp. 78-93) Cambridge: Cambridge University Press.

- Murray, M. (2000). Levels of narrative analysis in health psychology. *Journal of Health Psychology, 5*, 337-347.
- Nye, C. H. (1998). Power and authority in clinical practice: a discourse analysis approach to narrative process. *Clinical Social Work Journal, 26*, 271-280.
- Ochs, E. (1996). Linguistic resources for socializing humanity. In J. Gumperz & S. Levinson (Eds.), *Rethinking linguistic relativity* (pp. 407-437). Cambridge: Cambridge University Press.
- Ong, L. M. L., De Haes, J. C. J. M., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: a review of the literature. *Social Science & Medicine, 40*, 903-918.
- Parker, I. (1992). *Discourse dynamics: critical analysis for social and individual psychology*. London: Routledge.
- Parker, I. (1997). Discourse analysis and psychoanalysis. *British Journal of Social Psychology, 36*, 479-495.
- Parry, A., & Doan, R. E. (1994). *Story re-visions: narrative therapy in the postmodern world*. New York: The Guilford Press.
- Parsons, T. (1952). *The social system*. London: Tavistock.
- Pennebaker, J. W., & Seagal, J. D. (1999). Forming a story: the health benefits of narrative. *Journal of Clinical Psychology, 55*, 1243-1254.
- Peyrot, M. (1987). Circumspection in psychotherapy: Structures and strategies of counselor-client interaction. *Semiotica, 65*, 249-268.
- Peyrot, M. (1995). Therapeutic preliminaries: conversational context and process in psychotherapy. *Qualitative Sociology, 18*, 311-329.
- Pittenger, R. E., Hockett, C.F., & Danehy, J. J. (1960). *The first five minutes*. Ithaca: Paul Martineau.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: beyond attitudes and behaviour*. London: Sage Publications.
- Potter, J. (1996). Discourse analysis and constructionist approaches: theoretical background. In J. T. E. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences*. Leicester: BPS Books. Retrieved November 25, 2004, from Virtual Faculty Web site <http://www.lboro.ac.uk/departments/ss/depstaff/staff/bio/JPpages/Richardson%20Handbook%20Chapter%20for%20web.htm>
- Pridmore, S. (2000). *Psychiatric interview: a guide to history taking and the mental state examination*. Amsterdam: Harwood Academic.
- Rennie, D. L. (1994). Storytelling in psychotherapy: the client's subjective experience. *Psychotherapy, 31*, 234-243.

- Riessman, C. K. (1993). *Narrative analysis*. Newbury Park: Sage Publications
- Robinson, J. A., & Hawpe, L. (1986). Narrative thinking and a heuristic process. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 111-128). New York: Praeger.
- Rose, N. (1989). Individualising psychology. In J. Shotter & K. J. Gergen (Eds.), *Texts of identity* (pp. 119-132). London: Sage Publications.
- Sacks, H. (1972). On the analyzability of stories by children. In J. Gumpertz and D. Hymes (Eds.), *Directions in sociolinguistics* (pp. 325-345). New York: Holt, Rinehart and Winston.
- Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking in conversation. *Language*, 50, 696-735.
- Saleebey, D. (1994). Culture, theory and narrative: the intersection of meanings in practice. *Social Work*, 39, 351-359.
- Sampson, E. E. (1989). The deconstruction of the self. In J. Shotter & K. J. Gergen (Eds.), *Texts of identity* (pp. 3-19). London: Sage Publications.
- Sampson, E. E. (1993). *Celebrating the other: a dialogic account of human nature*. Series: Theoretical imagination in Psychology. New York: Harvester Wheatsheaf.
- Sands, R. G. (1988). Sociolinguistic analysis of a mental health interview. *Social Work*, 33, 149-154.
- Sarbin, T. R. (1986). The narrative as a root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 3-21). New York: Praeger.
- Sayer, A. (2000). *Realism and social science*. London: Sage Publications.
- Schegloff, E. (1968). Sequencing in conversational openings. *American Anthropologist*, 70, 1075-1095.
- Schefflen, A. E. (1973). *Communicational structure: analysis of a psychotherapy transaction*. Bloomington: Indiana University Press.
- Shapiro, J. (1990). Patterns of psychosocial performance in the doctor-patient encounter: a study of family practice residents. *Social Science & Medicine*, 31, 1035-1041.
- Sharf, B. F., & Vanderford, M. L. (2003). Illness narratives and the social construction of health. In T. L. A. Dorsey & K. I. Miller (Eds.), *Handbook of health communication* (pp. 9-34). Mahwah, N.J.: Lawrence Erlbaum Associates.
- Shotter, J. and Gergen, K. (1994). Series blurb. In T.R. Sarbin and J.I. Kitsuse (Eds.), *Constructing the social*. London: Sage Publications.
- Skelton, J. A., & Croyle, R. T. (Eds.). (1991). *Mental representation in health and illness*. New York: Springer-Verlag Inc.

Spence, D. (1986). Narrative smoothing and clinical wisdom. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 211-232). New York: Praeger.

Stancombe, J., & White, S. (1997). Notes on the tenacity of therapeutic presuppositions in process research: examining the artfulness of blamings in family therapy. *Journal of Family Therapy*, 19, 21-41.

Standing, A. (2005). *The threat of gangs and anti-gangs policy*. Policy discussion paper. Occasional Paper 116, Institute for Security Studies. Retrieved September 21, 2005, from Institute for Security Studies Web site
<http://www.issafrica.org/Pubs/Papers/116/Paper116.htm>

Steele, R. S. (1986). Deconstructing histories: toward a systematic criticism of psychological narratives. In T. R. Sarbin (Ed.), *Narrative psychology: the storied nature of human conduct* (pp. 257-275). New York: Praeger.

Stewart, M. (1984). What is a successful doctor-patient interview? A study of interactions and outcomes. *Social Science & Medicine*, 19, 167-175.

Swartz, S. (1996). Shrinking: a postmodern perspective on psychiatric case histories. *South African Journal of Psychology*, 26, 150-156.

Tates, K., & Meeuwesen, L. (2001). Doctor-parent-child communication. A (re)view of the literature. *Social Science and Medicine*, 52, 839-851.

Ten Have, P. (1991). Talk and institution: a reconsideration of the 'asymmetry' of doctor-patient interaction. In D. Boden & D. H. Zimmerman (Eds.), *Talk and social structure: studies in ethnomethodology and conversation analysis* (pp. 138-163). Berkeley: University of California Press.

Thompson, D. (1995). *The concise Oxford dictionary of current English*. Oxford: Clarendon Press.

Todd, T. A., Joanning, H., Enders, L., Mutchler, L., & Thomas, F. (1990). Using ethnographic interviews to create a more cooperative client-therapist relationship. *Journal of Family Psychotherapy*, 1, 51-63.

Van Dijk, T. A. (1992). Discourse and the denial of racism. *Discourse & Society*, 3, 87-118.

Van Dijk, T. A. (1993). Analyzing racism through discourse analysis: some methodological reflections. In J. H. Stanfield & M. D. Rutledge (Eds.), *Race and ethnicity in research methods* (pp. 92-134): Sage Publications.

Werner, A., Widding Isaksen, L., & Malterud, K. (2004). 'I am not the kind of woman who complains of everything': illness stories on self and shame in women with chronic pain. *Social Science & Medicine* 59, 1035-1045.

West, C. (1984). *Routine complications. Troubles with talk between doctors and patients*. Bloomington: Indiana University Press.

Wetherell, M., & Potter, J. (1992). *Mapping the language of racism: discourse and the legitimation of exploitation*. New York: Columbia University Press.

Wetherell, M. (1999). *Discursive psychology and psychoanalysis: theorizing masculine subjectivities*. Paper presented at the Millenium World Conference of Critical Psychology, University of Western Sydney, 30 April - 2 May 1999.

Wetherell, M. (2003). Paranoia, ambivalence and discursive practices: concepts of position and positioning in psychoanalysis and discursive psychology. In: R. Harré and F. Moghaddam (Eds.), *The self and others: positioning individuals and groups in personal, political and cultural contexts* (pp. 99-120). New York: Praeger/Greenwood Publishers.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionist work. In D. J. Nightingale, & J. Cromby (Eds.), *Social constructionist psychology: a critical analysis of theory and practice* (pp. 37-51). Buckingham: Open University Press.

Winefield, H. R., Chandler, M. A., & Bassett, D. L. (1989). Tag questions and powerfulness: Quantitative and qualitative analyses of a course of psychotherapy. *Language in Society, 18*, 77-86.

Wolfson, N. (1976). Speech events and natural speech: some implications for sociolinguistic methodology. *Language in Society, 5* 189-209.

Yalof, J. A. (1987). Client perceptions of the intake-referral process in a college walk-in clinic: monitoring the latent content. *Journal of College Student Psychotherapy, 1*, 59-68.

Zavos, A. (2005). (Im)possible translations: challenging therapeutic authority through textual practices. *Group Analysis, 38*, 115-128.

Appendix 1

Informed Consent Form

To the participant in this research

This research will examine the ways in which families talk in the initial session about the reasons why they have come to the clinic.

During this research your information will be protected and kept anonymous and confidential.

The transcript of the interview will not have your names or any other identifying characteristics on it.

No information will be used by anyone other than the researcher, and for any purposes other than this current research.

Please sign below to show that you consent to the above conditions.

Name: _____

Signature: _____

Date: _____

Name: _____

Signature: _____

Date: _____

Appendix 2

Research Protocol for Therapists

1. Please start by informing the participants what the research is about:
 - It will look at the ways in which people describe their problem in the initial session when they come to the clinic. It is concerned with how people make sense of the problem before they start any therapeutic process.
 - If they want more information, I will be happy to phone them

2. Please make sure that the following points are made clear to the client:
 - They will *not have to do anything* to participate in the research. It will be based purely on the initial interview which they had when they came to the clinic.
 - The research is *completely voluntary*.
 - The research will be *confidential* and *anonymous*. (please explain what these terms mean)
 - Any *distinguishing information* and *names* that are given in the interview will be changed.
 - If they choose *not* to allow their interview to be used for the research, this will *not* prejudice the service they receive from the clinic in any way.

3. Please hand the Informed Consent form to the client and ask either or both parents to sign.

Appendix 3

Clinical Interview Format

World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1995/1997/1999
Downloaded from http://www.nelmh.org/page_view.asp?c=1&did=1481&fc=001002

The purpose of the psychiatric history is help with decisions about diagnosis, will increase understanding of the factors that may influence symptoms or problems, and to help determine the most appropriate treatment and management plan.

It will be important to inform individuals that the psychiatric history notes belong to the health service and that others with a duty of care or other legitimate role, now or in the future, will have access to the notes. The steps involved in taking a psychiatric history are outlined below.

Identify the individual

- Name
- Age and Sex
- Present address and phone number
- Languages spoken
- Name and phone number of the individual's regular general medical practitioner
- Marital status
- Education
- Occupation

Identify the presenting problem

Obtain a brief description of the principal complaint and the time frame of the problem in the individual's own words. The individual's concerns need to be taken seriously. Respect and empathy will enhance trust. The individual's description of the problem will also enable the clinician to assess the individual's insight or perception into his or her situation. Specifically, find out:

- What is the nature of the problem?
- Why and precisely how has the individual presented at this time?
- What events led up to this presentation?

History of the present illness

It will be important for the clinician to identify information that is relevant and useful and to bypass information that is not as useful. An important part of history taking involves probing for useful information that the individual does not mention spontaneously.

Some individuals (e.g., those who are brought into the centre by others) may deny the existence of a problem. In these circumstances it may be necessary to obtain a history of the illness from a family member or close friend.

You will need to obtain the following information:

- Identify specific symptoms that are present and their duration.
- Note time relationships between the onset or exacerbation of symptoms and the presence of social stressors/physical illness.
- Note also any disturbance in mood, appetite, sexual drive and sleep.
- Obtain information about any treatments given by other doctors or specialists for this problem, and the individual's response to treatment.

Personal history

The personal history covers many aspects of the individual's life, from childhood through to adulthood. Obtain information about:

- Infancy (drug treatments during pregnancy; emotions and temperament; level of activity; nourishment; general development). This information is generally only important if the index individual is a child. You will need to obtain this information from the child's parents or guardians.
- Childhood and adolescence (emotional adjustment; relationships with peers, siblings and parents; play; trait anxiety; physical illnesses; sleeping behaviour; mental and motor development; early loss of close family members; sexual or physical abuse; belonging to a group; relating to peers and adults; school history; extent of sexual activity).
- Work history (jobs held; reasons for changing jobs; level of satisfaction with employment; ambitions).
- Marital history (number of marriages; duration; quality of relationships; personality of spouse/s; reasons for break-up of relationship/s).
- Relationships with others (intimate or sexual relationships; presence of someone in whom to confide).
- Children (name; sex; age; mental and physical health).
- Illegal activities/violence (ask about criminal record and any previous episodes of violence such as pub brawls, violence at home, or other acts of aggression).

Previous medical history

Obtain information about any physical, psychological or emotional disorders for which professional help has been obtained. Find out about the response to treatment.

Drug history

Find out about present or previous drug or alcohol use (prescribed medications, self-prescribed, or illegal) and responses to each of these drugs. Are there any adverse (including allergic) drug reactions?

Premorbid personality

How does the individual describe his or her personality before becoming unwell? Note:

- Overall mood or temperament
- Character traits
- Confidence
- Religious and moral beliefs
- Ambitions and aspirations
- Social relationships with family, friends, workmates

Family history

Ask about the individual's close family (i.e., spouse, children, parents, siblings). For each member of the immediate family, obtain information about:

- Age
- Health
- Occupation
- Personality description
- Quality of relationship with that person
- Psychiatric and other illnesses (including alcoholism and other substance abuse)
- Treatment for these illnesses
- Response to treatment

It may also be helpful to ask about the presence of psychiatric illness in grandparents, aunts, and uncles.

Appendix 4

Transcription conventions

Potter and Wetherell (1987)

- () Round brackets where there are doubts about the accuracy of material
- [] Empty square brackets when material has been omitted from the transcript
- [] Square brackets when you need to clarify something – explanation
- = = Equals signs at the end of one and beginning of next utterance where there is an absence of a gap between one speaker and another with
- (.) Indicate pauses in the speech with seconds in round brackets (5) and a full stop for small pauses less than a second (.)

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Appendix 5

Example of part of a transcript.

The full transcripts are available from the researcher.

*All names have been changed in the interests of confidentiality.

- Therapist: Okay. Well I'm [name]. So um I've spoken to (.) your mom on the phone. Um. Now I'd like to just explain a bit about today and how the clinic works and that kind of thing. Um. The. [] We work, um as a team here, so this is the shocking part of the information. As you can see there's a one-way a one-way mirror here. So there's actually. We we work as a team. So a couple of my colleagues sit behind the mirror and watch, um what's going on. The reason for that being that sometimes, you know, um they'll notice things that I don't notice. You know you'll always like two two heads are better than one. That's the sort of [laughs]. Okay. But I'm. Does that feel weird.
- Adam*: No.
- Therapist: Are you alright with that. You're smiling Joseph. Looking as if, as if, does it feel like you're in a movie.
- Father: []
- Therapist: Ya it is. I know. It takes a bit of a while to get used to. Also, um, if somebody knocks on the door, that will be one of those couple of people who might knock on the door. And that might be that they've thought of something that they think would be important to know and they might just want to speak to me to say, you know, what about this or, why don't you ask that or something. So, don't get alarmed if somebody knocks on the door. Um, but that said. Um everything that we talk about is confidential here. Um between the team, the couple of them and myself and it won't go beyond us. Okay. So anything that you do speak about you can rest assured it doesn't go beyond the people that are here now and its not a sort of free open door that anyone can wander in and out but its just the team allocated to this case. Um. The other thing which you guys can see, more and more like the movies, Uh, is that um we have a camera. We videotape our sessions. The reason for that being that I try and write notes while you're talking but quite often you know you don't get everything down. So if I actually have it on video then I can go back and check the video and just check have I got all the information I need or you know, so we just find that that's a more efficient way of um you know storing information cos otherwise if its just relying on my bad handwriting then it doesn't work so well. Um. So how does that feel boys. Being videotaped and being watched from behind the mirror. [laughs]. Is it a bit weird. Ya. Okay. I think people normally get used to it and ignore it. I think you probably will ignore it. Um So that's, that's um the the way we work in terms of the room. What I'd like to do today is to spend probably about an hour with the whole family. I know I mean I said we'd finish at ten thirty but that was but that we would start at nine. So is it, it everyone okay to stay longer cos I'm lucky I don't have another appointment at ten thirty so I can stay for the full hour and a half.
- Mother: Yes.
- Therapist: Is it okay with Joseph. Yeah. Okay. [no laughs] So what I'd like to do is spend an hour as a whole family just finding out about the, you know what brought you here, what your concerns are. And then I'd like to spend some time, about twenty minutes with Adam maybe by himself. But we'll see how it goes. we might decide not to do that. But normally that's the way things would work and then we'd meet together with the family and make a plan about what happens next.
- Mother: okay
- Therapist: [] So. Have you had a chance to look at the the that folder and all the information here. Okay so that will. We're going to talk about the the problem in a minute um and you've signed. Um Just in terms of um what I'll probably need to do is consult with with Adam's teacher
- Mother: Yes that's fine.
- Therapist: Is that okay. [] Um and then did you. You've read the information about what I've explained about the mirror and everything. Um and you've had a chance to look at the the the payment. (
- Mother: Yes.
- Therapist: Is that okay. Okay. And would you like to pay um, oh so on your way out. So it [] Right. Okay. All done. Paperwork and stuff out the way. [laughs]. Um so um just maybe. I'd like to just get to know you a little bit to start with. So I don't know maybe you can just tell me a bit um, about yourselves, your interests, work and things, We can go round.
- Mother: I work at [compnay's name] as a receptionist. And (4).
- Therapist: Do you enjoy. How's work going. Is it alright =
- Mother: = I enjoy work.
- Therapist: Okay. Is it a fulltime job.
- Mother: It's a fulltime job yes.

- Therapist: Okay. Okay. And its. I'm just writing down what you say. (Mo: okay) No weird and wonderful things. [both laugh]. Um. Okay, so you you work as a receptionist and how. Have you been there a while or =
- Mother: = I've been there four years now.
- Therapist: Okay. Right. And before that where =
- Mother: I worked at um [company's name]
- Therapist: Okay. Also doing receptionist =
- Mother: = No I was doing um credit clerk.
- Therapist: Credit clerk. Okay. So that's a sort of. And do you enjoy being a receptionist
- Mother: Yes
- Therapist: more or less than the credit clerking.
- Mother: Well it doesn't matter. I enjoy a job of everything. You know. A real all-rounder.
- Therapist: Uhuh. Okay. And have you. Have you got any hobbies or =
- Mother: = Not at the moment.
- Therapist: Not a lot of time.
- Mother: No time for it. [both laugh]
- Therapist: Okay. [father's name].
- Father: [] doing okay.
- Therapist: Okay.
- Father: I'm doing diesel mechanicing on boats.
- Therapist: That's. Uhuh. That sounds exciting. Or is it not exciting.
- Father: No. its okay. Better than being stuck in a boring job in an office.
- Therapist: So do you actually work like in the harbour. Or =
- Father: = Ya. []
- Therapist: Okay. And is, is diesel mechanicing on boats is it similar to cars or is it [].
- Father: You just have less to do actually.
- Therapist: Less to do. And you get in the sun.
- Father: [] in the sun [] work what ever time you want.
- Therapist: Okay. And is it. Do you work on big ships or.
- Father: No. Up to [] metres.
- Therapist: That's quite big isn't it. It sound big to me. [both laugh] okay.
- Father: I also do fitments, wheels [] and then I []
- Therapist: Okay. And um what. Have you been doing that for a long. Do you work for a company or =
- Father: = No for myself.
- Therapist: Do you work freelance. Freelance. Oh and so that's. So you're your own boss. So you can organize your time how you =
- Father: []
- Therapist: Okay. And have you got any hobbies or anything =
- Father: Yes. I keep tropical fish and I keep racing pigeons.
- Therapist: Oh wow. [] And trop. What do you do. How does racing pigeons.
- Father: []
- Therapist: Oh. And how like where do you race them or is there. Are they like racers like.
- Father: []
- Therapist: Okay. And how far do racing pigeons race.
- Father: How far do we go. They start at 160 km and end up at 1088. [mo and fa laugh]
- Therapist: Gosh. So they could like race from here to Joburg, well not quite.
- Father: [] which is next week.
- Therapist: So do you and do you let them, do you take them away from their home and then they race back to.
- Father: Ya.
- Therapist: That's how. Gosh. That sounds very interesting. And so have you got your pigeons at home.
- Father: Mhm
- Therapist: Okay. And how many do you =
- Father: = [] about a hundred.

Therapist: And do you boys are you interested in the racing as well.

Both boys: Yes

Therapist: Do you go with your dad. Oh. Yeah.

Joseph: []

Therapist: Oh. So have you got your own.

Joseph: There's three that are half my daddy's half mine.

Therapist: Oh okay. It sounds like a fun thing. And didn't you go along [to Mo].

Mother: No.

Therapist: No. its not fun for you. [both laugh] Okay. Adam. What can you tell me about yourself. What what grade are you in.

Adam: Grade 2

Therapist: Grade 2. and you're at Plumstead, you already told me. What's your teacher's name.

Adam: Miss Ball.

Therapist: Miss?

Adam: Miss Ball

Therapist: Miss Ball. Like a bouncing ball. Okay. (mo laughs). And what's she like.

Adam: She's quite nice.

Therapist: Quite nice. As teachers go she's not too bad. [Adam laughs]. And how's school for you?

Adam: Alright.

Therapist: Alright. Okay. And have you got any hobbies?

Adam: I do skateboarding.

Therapist: Skateboarding. Wow. So with skateboarding do you do races and stuff with that? No. you just play.

Mother: He wants to skateboard all the time.

Therapist: Oh really.

Mother: Mhh.

Therapist: I see. So you really love your skateboarding. Okay. Um so, skateboarding. I need to write important details like that down. Okay. And Joseph. You.

Joseph: I also do skateboarding.

Therapist: Also skateboarding. Let me write this down. Also skateboarding and then you do the pigeon um racing. Sorry can you just tell me again, Grade 8 did you say.

Joseph: Grade 8

Therapist: So you're in grade 8 okay. At Plumstead High. Were you at Plumstead Preparatory as well?

Joseph: Yes. And John Graham.

Therapist: And John Graham.

Joseph: []

Therapist: Okay. So you're now at Plumstead High. And John Graham. Okay. Right. And apart from skateboarding and pigeons have you got any other....

Joseph: Um I like driving beach buggies []

Therapist: Ooh. Gosh you sound like quite an active family. [Mo laughs] Doing lots of things. So driving beach buggies. Okay. Okay well that's, it's good to just get a bit of a sense of who you are. Um before we start. Um I want to move on now to just finding out. First thing I want to find out how did you find out about the clinic or how. Who, did you come through the school?

Mother: I found out by one of my colleagues at work.

Therapist: Oh, okay.

Mother: She told me about this clinic.

Therapist: Okay and she. So has she have been here before.

Mother: Um, her daughter has been here.

Therapist: Oh. Okay so and so were you just saying that you were, had some worries and concerns and then she said why don't you =

Mother: = Yes.

Therapist: Okay. Okay. Um. Do you. Your coll. Who was your colleague?

Mother: Um \$\$\$\$\$.

Therapist: Okay. I'm just going to write that down. So she had suggested and then you phoned here

Mother: Ya.

Therapist: Um okay. Right. Is everyone, can I just check is everyone okay to be here cos, um cos I mean, what did your mom say to you boys when you were told you were coming here this morning.

Joseph: My mommy said we were coming here.

- Therapist: Uhuh. Did she say why?
 Joseph: No
 Therapist: No. Did you. What. Did you just say that we were coming, that we had an appointment.
 Mother: Yes.
 Therapist: Okay. So right. And so are you, is everyone okay to be here. (.) Okay alright. Um and so, now I'd like to just move on to you know what has brought you here and what your concerns are?
 Mother: Um Adam has been to Occupational Therapy.
 Therapist: Okay.
 Mother: Which they found that his concentration. He tends to wander off.
 Therapist: Okay.
 Mother: And um. He's finished with Occupational Therapy now.
 Therapist: Okay.
 Therapist: (.) Okay so you went for a year. Okay. And the reason you went to the occupational therapist in the first place. Was that to do with concentration or.
 Mother: Concentration, um reading, reversing of letters.
 Therapist: Okay. (5) And did that start right from um (.) from when he went to school.
 Mother: Um from grade 1, ya.
 Therapist: Okay. And you so. And did the school say that it would be good for for Adam to go to an Occupational Therapist.
 Mother: Yes. [] which the Occupational therapist knew.
 Therapist: Oh okay alright. So you went to.
 Father: []
 Therapist: Okay and what's what's her name?
 Adam: \$\$\$\$\$
 Therapist: And you'd be okay for me to contact her.
 Mother: Yes. I brought a letter of you know when he was finished with her.
 Therapist: Oh, so she wrote a letter (yes) to say a summary of what happened.
 Mother: Yes.
 Therapist: Okay. That would be would be very useful. So one of the big difficulties that you're worried about is that that Adam is struggling with letters and everything. But did the Occupational Therapist do any tests. Do you know? Did did you get a report of any actual assessment tests or not.
 Mother: Um no.
 Therapist: No. it was just that he was sent at the school sort of in the school. (
 Mother: Yes.
 Therapist: Okay so that hasn't. because what I'm trying to check cos one of the things that I would be looking at doing with Adam is doing a sort of formal assessment of um all sort of different areas to try and identify his strengths and weaknesses so that we can work out what sort of help he might need, but I just want to check that I'm not repeating something that's already been done.
 Mother: Okay. And then I took him to Dr \$\$\$\$\$\$ who is the school doctor.
 Therapist: Oh okay.
 Mother: Okay, and um she put him on Ritalin.
 Therapist: Okay, when when was this now.
 Mother: Well I started.
 Therapist: Was it recently?
 Mother: Um two weeks ago taking half a tablet in the morning.
 Therapist: Okay. And how has that been going.
 Mother: Um Well we didn't get any report. I'm going to see her on the 14th September. So the school is probably in contact to tell her how he was at school.
 Therapist: Okay, And but I mean has anyone, have you noticed anything in the family or Adam have you noticed do you feel any different with Ritalin or does it make you feel the same.
 Adam: Mmmmh
 Mother: How does the Ritalin make you feel?
 Adam: Alright.
 Therapist: Has it made a difference to your concentration at school or you can't really tell at the moment.

- Adam: It makes a difference.
- Therapist: It does make a difference. How can you tell me more about that?
- Adam: Like if I used to walk around in class now I just sit at the table.
- Therapist: Okay. And do you think. And and you're finding it easier to sit sit down with the Ritalin. [Adam nods]. Okay. And in terms of concentrating on what the teacher says. Or you don't really know.
- Adam: Its different.
- Therapist: It's different. Okay. But but you are sitting down more with the Ritalin. Okay. Can I just check Dr ???????? what assessment did she do before she gave the Ritalin. What um what did she do to check.
- Mother: She um obviously took his weight and he had to listen through the earphones to the sounds.
- Therapist: Okay. So she checked his weight.
- Mother: And his eyes.
- Therapist: And hearing and sight.
- Mother: Sight.
- Therapist: Ya. It is important to check those those things. But did she um because there there are sort of like um behavioural tests that that one would normally do before giving Ritalin and I'm just wondering if. She didn't give you a sheet of things to um like tick about Adam's behaviour like over a week long period.
- Mother: No.
- Father: Maybe to Adam's teacher.
- Mother: I don't know if she sent that to the school.
- Therapist: Okay.
- Mother: [] to see if =
- Therapist: = See normally what would happen before a doctor would give Ritalin is that they would um take they would give you, there's a a special kind of rating scale thing which has a lot of questions for you and what you.
- Mother: After watching for a week.
- Therapist: You would fill in that form and they'd also give it to the school and then look at it together before they would decide about Ritalin, but I I don't know. But you didn't get anything like that.
- Mother: No.
- Therapist: Um Okay. Cos that might be something that we we might need to look at.
- Mother: Because she wasn't quite sure if she should put him on Ritalin or not.
- Therapist: Uhu. But the school suggested it. Is that =
- Mother: = That's right yes.
- Therapist: Okay so um and as far as you know. Do you know if the teacher had anything to that she was ticking, like a thing with lots of boxes to tick off while she was watching you. You didn't didn't know anything about that [Adam shakes his head]. Okay. So I think that's one of the things I'll need to find out from the teacher and um because its quite important that that process happens otherwise um you know otherwise its not really clear about whether Ritalin should be =
- Mother: = Given to =
- Therapist: = given or not. Um but anyway I mean, it is making you sit down. That's one thing. Yes? [Adam nods]. Okay. So that's. That might be a good thing [Therapist & Mo laugh]. But it would make probably most children sit down. So [laughs]. And how do you feel about him being on Ritalin.
- Mother: Well Joseph was also on it.
- Therapist: Oh okay. And Joseph how long were you on Ritalin for.
- Joseph: From Grade 2 to um Grade 3.
- Therapist: Okay. And can you tell me a bit about why you were put on Ritalin.
- Joseph: Cos I couldn't concentrate in class in class.
- Therapist: Couldn't concentrate. And was it just that you couldn't concentrate or were you also like moving around and.
- Joseph: Easy distracted. I got distracted easily.
- Therapist: okay. So um. So then you had Ritalin, and how much Ritalin did you take. Can you remember?
- Joseph: One a day.
- Therapist: One a day. And...
- Father: You were on it till Grade 5 man.
- Joseph: No I wasn't it was just till Grade 3.
- Mother: Yes and you took it at John Graham.
- Therapist: Oh. And at John Graham he stayed with it so what till Grade 5.

- Father: & Grade 5.
 Mother:
- Therapist: So about three years, um on Ritalin.
 Mother: Joseph's problem was his behaviour,
 Therapist: Okay.
 Mother: concentration, easily distracted in class.
 Therapist: Uhu.
 Mother: Couldn't sit still at all.
 Therapist: Okay.
 Mother: Um he was a very hyper child
 Therapist: And is is Adam the same or is =
 Mother: = No. Adam's much different to him. He's more calm in that way. But what it is about Adam is he tends to wander off.
 Therapist: Like daydream. So so both of them have had concentration difficulties but Joseph was like hyperactive..
 Mother: That's right, yes.
 Therapist: Whereas Adam you're not not hyperactive.
 Father: And he was with Dr ??????? as well.
 Therapist: Okay
 Father: And what was that other doctor that we took him to as well.
 Mother: Now I can't remember now.
 Father: []
 Mother: []
 Therapist: Okay, and but he and he suggested that.
 Father: No he didn't want to put Joseph on.
 Therapist: He didn't want to.
 Mother: Ya.
 Therapist: Oh, but then.
 Father: That's why we went back to him and said he must put him on.
 Therapist: Oh okay. Alright. So he didn't he didn't want to put Joseph on Ritalin the psychologist said what did the psychologist =
 Father: = She suggested putting him on. She actually assessed him.
 Therapist: Uhu
 Father: And then he didn't want to put Joseph on and then we decided to go to this other doctor.
 Therapist: Uhu
 Father: And he assessed Joseph as well and he came up with the same conclusion.
 Therapist: With Ritalin.
 Mother: Ya
 Therapist: And did it help.
 Mother: Yes.
 Therapist: Did it make a big difference
 Mother: It did.
 Father: It made a big difference.
 Therapist: Big. Okay.
 Mother: Even with his hand writing. Everything improved.
 Therapist: Everything. Okay. And then what about the decision to stop taking Ritalin. What how did you stop, I mean why did you stop giving
 Mother: Because he found that he could cope on his own without taking Ritalin.
 Therapist: So did you do like a trial period without and see.
 Mother: Yes. And he did very well in Grade Grade 7.
 Therapist: Oh okay. And and so, and now how how are things. Are you calmer than you used to be or.
 Joseph: Yes I'm calmer.
 Therapist: Ya. [both laugh] not jumping around so much. And you're okay without the Ritalin. You don't need it any more.
 Joseph: No I still get distracted in class.
 Therapist: But distracted in a normal sort of way like other kids might be.

- Joseph: Like if the teacher's teaching and my friend calls me then I look I look at them (
- Therapist: Uhu.
- Joseph: And then I get in trouble.
- Therapist: And do do you get in trouble quite a lot or not too =
- Joseph: = Not too much now.
- Therapist: Not. So when you were smaller it was much more of a problem.
- Joseph: Yes.
- Therapist: Okay. Um and and so, okay so it would be useful to know that, you know that that Joseph, that the Ritalin helped a lot for Joseph. It helps us to sort of understand with Adam. Um so. Adam. Can you just tell me a bit more about Adam. You you said he's his behaviour. How is his behaviour at school and at home.
- Father: Well he just generally doesn't listen.
- Mother: He tends to ignore you. You'll talk to him and he'll be completely somewhere else.
- Therapist: Okay. So he just goes into sort of his own world. Does that Do you agree with that. Yes, cos he's smiling. Okay. And you say you find he just doesn't really listen.
- Father: Ya. You'll tell him to do something and he'll look at you and two minutes later you just have to tell him to do it again.
- Therapist: Does he forget things. Or =
- Mother: = No. he does know that he must =
- Father: = He knows what he's got to do. He just does not.
- Therapist: Okay. And how and how do you as family handle discipline? What happens if you want the children to do something and they don't do it?
- Father: Well his lunch money disappears.
- Therapist: His lunch money disappears. [laughs] uhu and does and does that work. How =
- Father: = Ya sometimes. For a day or two but after that its its back to where we started from.
- Therapist: Okay. Anything else happen as a disciplinary =
- Father: = He gets banned from going out with me.