

**ANALYSIS OF THE LIVED EXPERIENCES OF YOUNG ADULTS
WITH SPECIFIC LANGUAGE IMPAIRMENT AND/OR
PRAGMATIC LANGUAGE IMPAIRMENT TO INFORM
COUNSELLING PSYCHOLOGY PRACTICE**

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Doctor of Counselling Psychology

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Thesis Summary

Some seven percent of children in the general population are affected by Specific Language Impairment and/or Pragmatic Language Impairment with numerous cases undiagnosed. It is known that difficulty in communication affects psychosocial functioning and is likely to be a source of mental distress but the data on people's access to and benefit from psychological intervention are limited. There is also limited understanding of psychologists' capacity to meet these clients' needs although their problems continue into adulthood.

This research questions the population of counselling and clinical psychologists about their knowledge and experience of these disorders using an electronic questionnaire. Qualitative methods were then adopted with three participants with SLI/PLI and four psychologist practitioners familiar with such clients; this involved semi-structured interviews analysed using IPA and TA respectively. The purpose was to interpret and develop the clients' lived experiences into themes which were then used to look for possible connecting themes in the psychologists' transcripts. This process was termed "interconnection" and was intended to reveal the coincidence and convergence of the two sides of the client/psychologist dyad.

Results showed that whereas findings demonstrated the young men possessed a spectrum of coping and defence strategies as constituent parts of resilience, including self-esteem, self-identity and self-efficacy, the psychologists did not see the client as a congruent whole, addressing either their impairment or their mental health problem. Client resiliencies were not used in therapy and psychosocial difficulties were not recognised as a focus of distress although they did endeavour to modify their therapeutic approaches.

Finally, consideration is given to whether the research aim is met, the implications for counselling psychology and possible future research. It is proposed that this methodology of interconnection has the potential to provide a novel approach to inform any future research and service development for this and other client groups in the way it takes patients/clients into account and connects them with professional working.

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Glossary of Abbreviations

ADD	Attention Deficit Disorder	ICD	International Classification of Diseases
ADHD	Attention Deficit Hyperactivity Disorder	IPA	Interpretative Phenomenological Analysis
APA	American Psychiatric Association	NICE	National Institute for Health and Clinical Excellence
ASD	Autistic Spectrum Disorders	NRES	National Research Ethics Service
BACP	British Association for Counselling and Psychotherapy	N-SLI	Non-Specific Language Impairment
BESD	Behavioural, Emotional and Social Difficulties	PCT	Primary Care Trust
BPS	British Psychological Society	PDD	Pervasive Developmental Disorders
CAMHS	Child and Adolescent Mental Health Services	PDDNOS	Pervasive Developmental Disorders Not Otherwise Specified
CBT	Cognitive Behavioural Therapy	PLI	Pragmatic Language Impairment
CCC	Children's Communication Checklist	REC	Research Ethics Committee
CMHT	Community Mental Health Team	SaLT	Speech and Language Therapist
DfE	Department for Education	SCD	Social Communication Disorder
DfEE	Department for Education and Employment	SEN	Special Educational Needs
DfES	Department for Education and Skills	SLCN	Speech, Language and Communication Needs
DLD	Developmental Language Disorder	SLI	Specific Language Impairment
DoH	Department of Health	TA	Thematic Analysis
DSM	Diagnostic and Statistical Manual of Mental Disorders	ToM	Theory of Mind
HPC	Health Professions Council	WHO	World Health Organisation

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Chapter 1

Introduction to the Thesis

Language is universal among human societies (Pinker, 1994); it is a subset of communication and speech is a subset of language. Language involves more than speech and communication involves more than language. All spoken language can be studied in terms of four levels of description: phonology (speech sounds); semantics (meaning); grammar (formal ways of using word order and inflection); and pragmatics (use of language to communicate) (Bishop & Norbury, 2008).

DSM-IV (APA, 2000TR) categorises only expressive and mixed receptive/expressive language disorders (with phonological disorder and stuttering) as Communication Disorders recommending counselling for children with the mixed receptive-expressive disorder because of the possibility of emotional or behavioural problems. ICD-10 explains that specific developmental disorders of speech and language are followed by associated problems in reading and spelling and abnormalities in interpersonal relationships (WHO, 2007).

ICD 10 (WHO, 2007) and DSM-IV (APA, 2000TR) also specify that the child with language disorder has a selective impairment requiring a substantial discrepancy between language ability and score on a test of non-verbal intelligence (ICD 10 says equivalent to one standard deviation) so is regarded as having a “specific” disorder (Bishop, 1997a; Clegg, Hollis, Mawhood & Rutter, 2005). However, there is concern about the use of IQ discrepancy criteria because they exclude large numbers of children (Bishop & Norbury, 2008) and Tomblin (2008) concluded there is little evidence that including performance IQ criteria into a clinical diagnosis is warranted. Questions have also been raised about whether impairments can really be termed “specific” at all as conceptualising those with SLI as having intact cognitive skills is not as appropriate as once imagined (Botting, 2007).

Some researchers have adopted the terms Specific Language Impairment (SLI) and Pragmatic Language Impairment (PLI) and other terms and acronyms. It seems that

few use definitions or nomenclature from the manuals (Bishop, 2010b) and the consequences are extremely confusing for those outside of the field with ICD-10 (WHO, 2007) including a different combination of disorders.

Throughout the thesis the term SLI and/or PLI (SLI/PLI) is used unless referring to the work of other researchers, when their preferred nomenclature will be used. The “and/or” was considered necessary because of the lack of agreement about whether PLI is a subgroup of SLI (in which case the term SLI may subsume PLI) and because individuals may experience both.

SLI/PLI excludes those with autism and Asperger’s syndrome and the term is used in the absence of a hearing, medical or neurological cause. It is a developmental disorder of presumed multi-factorial aetiology with certain aspects of neuro-development selectively impaired; it is as common as dyslexia and approximately ten times as common as autistic spectrum disorder. In the UK there are 855,440 cases of SLI, 693,600 of dyslexia and 75,140 of autistic spectrum disorder (ASD). Yet whilst lay people know of dyslexia and autism, few have any ideas about SLI (Conti-Ramsden & Botting, 2008; Bishop, 2010a,b).

As many as 7% of children are affected by SLI (Burden, Stott, Forge & Goodyer, 1996) and the impairment is more common in boys than girls (Johnston, Stark, Mellitis & Tallal, 1981). Despite the high prevalence, mental health professionals seldom receive formal training in language development [or language disorders] so the deficits may continue unrecognised (Giddan, Milling & Campbell, 1996).

In a study screening 7,000 pre-school children for SLI in the mid-90s, although 7.4% were found to meet diagnostic standards for SLI (meaning a valid decision was made on whether an individual represents a clinical case), the parents of only 29% of these had previously been informed their child had a problem (Tomblin et al., 1997; Tomblin, 2008). Cohen, Barwick, Horodezky, Vallance & Im (1998) also found a

higher than expected rate of undiagnosed language impairment in their psychiatric clinic sample.

A ten-year research update review identified impairments were not always identified by Child and Adolescent Mental Health Services (CAMHS) or community psychiatric teams (Toppelberg & Shapiro, 2000; Conti-Ramsden & Botting, 2008).

However, impairment persists into adulthood and is not just a childhood disorder (Clegg, Hollis & Rutter, 1999). It becomes more pronounced with age (Whitehouse, Watt, Line & Bishop, 2009b) resulting in difficulties with psychosocial adjustment (Bishop, Whitehouse, Watt & Line, 2008) that may require psychological counselling. However, communication problems may reduce their access to support and, in any verbally-mediated counselling, create difficulties for the working alliance that will impact negatively on outcome.

People with PLI have been described as not taking account of the listener's perspective and providing conversational responses that are socially inappropriate and/or stereotyped (Rapin, 1996; Bishop, 2000). Such difficulties will have a "profound effect on ability to perform adequately at school" making it "more difficult for children to make friends and cope satisfactorily in everyday social contexts. Yet the nature of the problems is not always obvious..." (McTear & Conti-Ramsden, 1992, p.53) probably because linguistic deficits are not a hallmark of the impairment (Whitehouse et al., 2009b). There are no accurate prevalence figures for PLI (Law et al., 2002; Adams & Lloyd, 2007).

There has been a paucity of research in this field particularly when compared with autism (Bishop, 2010b). Bishop (2010a) believes autism has been pushed onto the political agenda by lobbying groups [with the publication of The Autism Act (House of Commons, 2009)] leaving SLI out-in-the-cold when there are no sharp boundaries between the diagnoses and these are closely-related conditions.

Bishop (2010 a; b) reports there were 16,071 new publications on autism over a 25-year period (1985-2009) but during this period there were only 1,140 on SLI suggesting it is under-researched. She believes one explanation for differential interest in different disorders (although saying this is unscientific) is the status of the profession most closely associated with the condition and in the source and amount of research funding attracted. Medicine/psychiatry for mental health (autism), psychology for child development (dyslexia) and speech and language therapy for SLI. This is seen as an arbitrary compartmentalisation of conditions that appears to have led to inequality in how these conditions are perceived and examined.

SLI's status as a childhood disorder means that unlike acquired adult disorders of language, it has been under-investigated in terms of quality of life or psychiatric outcomes beyond the early years (Conti-Ramsden & Botting, 2008). Whitehouse et al. (2009b) found five of their 19 adult participants in an SLI group had received a psychiatric referral for major depressive disorder and comment (pp.524-525) that "clearly the long-term mental health of individuals with developmental disorders is an important issue and identifying potential causes of psychiatric difficulties a priority of future research." Adding "there is pressing need for ongoing intervention to focus on strategies that will promote psychosocial adjustment."

A survey of 1,400 adults in the UK, conducted on behalf of the British Association for Counselling and Psychotherapy (BACP) reported that almost one person in five has consulted a counsellor or psychotherapist (Doward, 2010). There is limited evidence of the numbers of individuals with SLI/PLI presenting for psychological counselling or research into how their distress is ameliorated by psychologists. Using Bishop's (2010b) figure of 855,440 cases of SLI (not taking into account the undiagnosed cases) and Whitehouse's percentage of 5 in 19 (26.3%) of his

subjects presenting for depression suggests a figure of almost a quarter-of-a-million potential therapy cases.

There is an active debate about communication disorders and this Chapter has provided an exposition of the background to this research.

A review of the literature is conducted in Chapter 2 (p.7) concluding with the rationale for undertaking the research and the development of the overarching research aim. This aim then leads to the development of research questions for Chapters 3, 4 and 5 (Chapter 2.7, p.25). Finally, Chapter 6 (p.118) considers the outcomes of these questions in relation to the overarching aim to determine whether the aim has been achieved. The implications for counselling psychology and possible future research are also explored.

This thesis conforms to the format of the British Journal of Clinical Psychology (Appendix 1, p.165).

Chapter 2

Literature Review

Abstract

Purpose

To examine SLI/PLI and explore whether young adults with these difficulties experience problems with psychosocial adjustment and how psychologists practice therapeutically with this group.

Methods

Electronic databases including PsychLit and Medline were searched, researchers in the field were consulted, books were reviewed both in hard copy and on-line and key texts used to snowball to references found in bibliographies.

Results

This field of research is characterised by paucity of publications and complexity of both diagnosis and nomenclature. There was limited empirical evidence of practitioner psychologists' knowledge and understanding and of their experiences of providing therapeutic interventions for this group. However it was found that young adults with SLI/PLI experience difficulties with psychosocial adjustment that may require psychological counselling.

Conclusions

The review concludes with a summary followed by the rationale for, and overarching research aim of, the thesis. Research questions to meet the aim are also determined.

Keywords included: specific language impairment; pragmatic language impairment; communication disorders; developmental language disorder and impairment; specific speech and language difficulties; speech, language and communication needs; semantic pragmatic disorder; language disorders; special educational needs; psychosocial [adjustment]; counselling psychology; emotional health and mental health.

2.1 Search Strategy and Introduction to the Literature Review

Rawson (2006) suggests there are a number of main sources for the literature search starting with topic experts (those of interest for this research have their own university websites listing most recent publications and contact was also made in person). Retrieval systems such as PsychLit and Medline were used; books were purchased, viewed on-line and loaned; and key texts were used to “chain on” or “snowball” to other references through the bibliographies. To which has been added knowledge of the literature explored in a BSc dissertation on PLI.

Young adults means those aged 18-35 in accordance with Erikson’s psychosocial stage in which failure to achieve intimate relationships can lead to alienation and isolation (Erikson, 1977; Corey, 2001; Erikson, 2005).

To explore psychosocial adjustment outcomes for young adults with SLI/PLI it is first necessary to examine the field of SLI/PLI. The review then concludes with a summary followed by the rationale for, and overarching research aim of, the thesis. Research questions to meet the aim are also determined.

2.2 SLI and how this is Differentiated from PLI

SLI has been described for more than 150 years (Leonard, 2000). The biological basis is poorly understood; the problem does not seem to be the result of brain damage but of some abnormality in early neurological development before birth (leaving non-verbal IQ intact) with genetic factors strongly implicated (rather than the home-language environment) (Rapin, Allen & Dunn, 1992; Pinker, 1994; Bishop, 1997a; Rice, 2004; Newbury & Monaco, 2008). Viewed as a disorder in which genetic influences lead to a brain that is wired in a non-optimal way (Bishop & Norbury, 2008) there is growing evidence of familial aggregation (Tallal, Ross & Curtiss, 1989; Choudhury & Benasich, 2003; Botting, 2007).

SLI incorporates a range of expressive and/or receptive language problems with receptive vocabulary skills being some of the first language skills to emerge in typically-developing children and sometimes used as an index of cognitive ability (Botting, 2007). It is often accompanied by other associated neuro-developmental disorders: rates of co-occurrence of ADHD, developmental co-ordination disorder and academic difficulties are all high. Hence, cases of pure SLI are rare in clinical practice as children present with a range of co-occurring deficits and challenges that may cloud diagnostic decisions (Hill, 2001; Baird, 2008; Bishop & Norbury, 2008).

A child with a history of SLI should be considered to be at risk of literacy difficulties in terms of the cognitive processes required for learning to read. He has difficulty mastering syntax, vocabulary (with word-finding problems) and frequently phonology so struggles to express what he wants to say. Comprehension is often also impaired with the child deducing meaning from a few content words and making errors understanding spoken language (Bishop, 2000; Leonard, 2000; Snowling, Bishop & Stothard, 2002; Bishop & Snowling, 2004). It is not uncommon for SLI and dyslexia to be regarded as points on a continuum of severity rather than distinct conditions (Bishop, 2008).

The definition of SLI encompasses an heterogeneous population but there has been little agreement about whether subgroups of language impairment exist.

Conti-Ramsden and Botting (1999) supported an argument that children with SLI fall into distinct subgroups but added an important caveat. As patterns of language strengths and weaknesses change with time it might be that what is being concluded is that there are different subgroups when the same disorder might be manifesting itself at different points in development. This lack of agreement has been evident in the case of PLI (Craig, 1995; Conti-Ramsden, Crutchley & Botting, 1997; Bishop, 1998; Norbury, Nash, Baird & Bishop, 2004). However, the draft DSM-5 (APA, 2010) includes new

categories of language impairment including SLI and impairment of pragmatics (see Appendix 2, p.167) but final publication is not scheduled until May, 2013.

Children with PLI are verbose and because spontaneous speech is fluent with understanding of single words and simple phrases, the child's problems can be overlooked as comprehension difficulties can be hidden behind good or well-controlled expressive language (Rapin, 1982; 1996; Botting, 2007). Lateral thinking in adults captures this picture exactly: people "confuse fluency with substance ... so fluency of style masquerades as integrity of thought" (De Bono, 1990, p.156).

Pragmatics concern the content and use of language. Describing a picture requires linguistic knowledge but knowing what information is necessary requires an assessment of information relative to context – a complex attention-directing task involving pragmatic ability (Bishop, 1997a; 2000). Pragmatics is said to be the domain in which grammar, logic and memory interact (Wilson & Sperber, 1991; Perkins, 1998).

Adams, Baxendale, Lloyd and Aldred (2005) say there are substantial problems with over-literal use of language, impaired understanding of social inference (Leinonen & Letts, 1997) and limitations in social use of language (Bishop, 2000; Bishop, Chann, Adams, Hartley & Weir, 2000). Added to this in some individuals is a desire to talk about personal preoccupations, intense questioning style with repetition and some stereotyped speech (Bishop & Adams, 1989).

One definition concerns the *appropriate use* of language – for example, knowing when to make a more polite request because you are asking a favour, or knowing how to make an appropriate response to what someone else has said. The difficulty with appropriacy is that it is a matter of degree (McTear & Conti-Ramsden, 1992).

Not all pragmatic abilities are verbal, however, and non-verbal communication is "much more powerful than language for some purposes like expressing emotions and

attitudes to other people” (Argyle, 1988, p.308). Verbal pragmatics may be deviant in children with SLI but both non-verbal pragmatics and verbal pragmatics are deviant in children with autism/pervasive developmental disorders (PDDs) (Lees & Urwin, 1997; Rapin & Allen, 1998).

2.3 Autism and SLI/PLI: Similarities and Differences

The presence of pragmatic difficulties in children with communication problems should prompt the clinician to evaluate autistic symptomatology but it is dangerous to assume that all children with pragmatic difficulties have autism or Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS) (Shields, Varley, Broks & Simpson, 1996a; 1996b; Bishop & Norbury, 2002). The PDDNOS label tends to be used mostly in psychiatry to describe children with autistic symptoms who do not fully meet criteria for this disorder (Cox et al., 1999; Botting, 2007).

Pragmatics are hard to measure (Conti-Ramsden & Botting, 1999). The Children’s Communication Checklist (CCC) was introduced to identify pragmatic problems and indicate a need for clinical assessment (Bishop, 1998). Norbury, et al. (2004) introduced the revised CCC-2 that identifies difficulties, in a real world setting, not typically picked up by other standard language measures. Children diagnosed with autistic spectrum disorders including Asperger’s syndrome showed high levels of pragmatic difficulty as expected.

There is acknowledgement that PLI is a more common correlate of PDDs but that it may also occur in other developmental disorders affecting communication skills including SLI (Bishop & Norbury, 2002).

Children with PLI do not have a diagnosis of PDDNOS or autism using the gold standard measures of the Autism Diagnostic Observation Schedule (ADOS: Lord et al., 1997; Botting, 2007) and the CCC-2 (Norbury et al., 2004) has now been used to

identify that there are clear cases of young people with PLI without autism (Conti-Ramsden, Simkin & Botting, 2006) and there is a considerable variety of clinical pictures (Adams, 2008).

Rather than specifying a subgroup of language impairment or autistic disorder PLI may be a variable correlate of either, occupying an intermediate position between SLI and autism. Children might exhibit substantial pragmatic impairments with difficulty with social communication and yet not meet full diagnostic criteria for autism (i.e., do not have significant deficits in all three areas of the autistic triad: social interaction, communication and repetitive behaviours/restricted interests) (Botting & Conti-Ramsden, 1999; Bishop, 1997b; Bishop, 2000; Bishop & Norbury, 2002; Barrett, Prior & Manjiviona, 2004; Norbury et al., 2004; Adams, 2008).

Adams (2008) refers to numerous diagnostic debates (Bishop, 2000; Boucher, 1998) and adds that there is now reasonable consensus that children with PLI possess some of the characteristics seen in children with SLI (e.g., grammatical and word-finding problems) and that some have additional mild social problems similar to those seen in children with ASD or Asperger's syndrome and some of them have language and social and pragmatic deficits (Bishop & Adams, 1989; Botting & Conti-Ramsden, 1999; Adams, 2001; Norbury, 2005).

There were low levels of autistic symptomatology in the PLI group in a longitudinal study and findings indicated that this does not develop over time in some people with primary PLI and provides further caution against treating PLI as equivalent to ASD (Whitehouse et al., 2009b). A dimensional approach to PLI, rather than categorical, allows children to be described as having different degrees of difficulty in a combination of different areas rather than having a mutually-exclusive disorder (Bishop & Rosenbloom, 1987; Rapin & Allen, 1987; Rapin, 1996; Bishop, 2000; Botting, 2007).

It was never the intention to imply that PLI is a new and discrete disorder (Bishop & Norbury, 2008)

Individuals with SLI, PLI and ASD often show similar and overlapping sets of symptoms and there is general clinical agreement that at least some of these groups have distinct difficulties requiring different interventions and having separate prognoses (Botting & Conti-Ramsden, 2003). Practitioners concerned with SLI need to be alert to research and clinical developments relevant to autism and those concerned with autism need to be much more aware of research into SLI than they are now (Rutter, 2008).

There are no clear diagnostic boundaries between SLI and PLI and neither are there clear boundaries between PLI and autism (Bishop & Norbury, 2002; Whitehouse et al., 2009b). “Diagnostic boundaries are nothing like as clear-cut as implied by the official classifications” (Rutter, 2008, p.135) and to help children with PLI “the need for effective interventions has never been greater” (Adams, 2007, p.1).

2.4 Problems with SLI/PLI Assessment and Research

Within this field there is a degree of “confusion surrounding the use of diagnostic terminology in the area where neurology, psychology, psychiatry and speech [and language] therapy converge” (Bishop, 1989, p.108) so the picture is “complex and difficult” (Bishop & Norbury, 2008, p.797). The unclear nature of clinical descriptions is also exacerbated by the lack of accurate diagnostic “markers” (so diagnosis is made by exclusion rather than positively identifying particular characteristics) and children may be diagnosed differently by professionals with different types of training (Botting & Conti-Ramsden, 2003).

It might also be appropriate to add *education* to Bishop’s (1989) list in the opening paragraph of this section. For example, Specific Speech and Language Difficulties (SSLD) is used in education instead of SLI (Lindsay, Dockrell, Mackie &

Letchford, 2005; Dockrell et al., 2007). The DfES¹ divide populations between those with Speech, Language and Communication Needs (SLCN) and those with Autistic Spectrum Disorder (ASD) although some researchers speak of Communication Disorders defined as SLI, PLI and ASD (e.g., Botting & Conti-Ramsden, 2003).

Autistic disorder and Asperger's disorder are categorised in DSM-IV (APA, 2000TR) as PDDs.

Developmental Language Disorder (DLD) [instead of the diagnosis Communication Disorder] is a term for an heterogeneous category with deficits in speech, receptive language and/or expressive language all falling under this umbrella. Clegg et al. (1999) use the term DLD adopting the same criteria used to identify SLI (normal non-verbal intelligence, no hearing impairments and no medical or neurological cause to explain language deficits).

As a consequence of researchers not always defining their samples in the same way, it is not straightforward to determine what results are applicable to all children or only to those with the characteristics specified by the individual researcher. Results may not then be applicable to the full range of children (Dockrell, Lindsay, Palikara et al., 2007; Lindsay & Dockrell, 2008). Studies also vary in how far they explicitly include or exclude children with co-morbid conditions, with speech problems [e.g., Beitchman et al., 2001] or with autistic features (Clegg et al., 1999; Bishop & Norbury, 2008).

It had been assumed that problems with speech production and related unintelligibility of speech should be expected for children with language impairments. Recent epidemiological findings establish that by 5-6 years of age the estimated co-occurrence of speech and language impairments is less than 2%. For children with SLI, speech disorders were evident in approximately 5-8% of the children (Shriberg,

Tomblin & McSweeney, 1999; Rice, 2004).

¹ The Department for Education and Skills was later renamed The Department for Children, Schools and Families and since May 2010 it has been renamed the Department for Education.

2.5 The Impact of SLI/PLI on Psychosocial Adjustment

An exploration of the literature for a definition of “psychosocial” demonstrated that different researchers may mean different things when they use this term and a definition proved elusive. Stenner (in private correspondence, 2010) defines psychosocial in two parts. The social aspect refers to systems of communication-in-context and the psychic to modes of experience (affective, perceptual and conceptual). Hence encapsulating the interpenetration of communication and experience.

Social, cognitive and genetic risk factors [that are experienced by the SLI/PLI population] are all known to influence onset of affective disturbances (Lau, Rijdsdijk, Gregory, McGuffin & Eley, 2007). However, there has been little literature regarding the long-term impact of language difficulties on social/behavioural outcome for this group although problems with social relationships and other behavioural difficulties may be characteristic of children with SLI (Conti-Ramsden, Botting, Simkin & Knox, 2001; Clegg et al., 2005; Botting, 2007).

In the 1960s the Language Development Project recruited 20 boys aged seven who were diagnosed with a DLD and followed them into their mid-30s when they were reassessed. Subjects were assessed on various measures including expressive and receptive language and social and psychiatric functioning.

The failure of the majority of the adults with severe receptive DLD to obtain any formal qualifications on leaving school was likely to have affected their employment prospects. This subsequently limited social opportunities, increased isolation and reduced quality of life and increased the risk of psychiatric disorder in adult life.

Strikingly, a third of the group had developed mental health problems in adult life including depression and schizophrenia. All of the psychiatric problems started in adulthood and the incidence of problems increased since they were in their early

twenties. The incidence of behaviour problems was also higher than their siblings. Less than a third of the group had been consistently employed so they struggled with independence and as a result 40% were living with parents.

The psychosocial consequences of DLD were perceived by families to be more pervasive in adult life when no services were available than in childhood. Parents felt they had no tangible cause to explain their sons' difficulties due to the lack of information, services and support they had received.

The authors say there needs to be an increased awareness of the persisting social difficulties that individuals with DLD may go on to experience. Their normal performance IQ prevented access to the Community Mental Health Team (CMHT) (DoH, 2002) and adult learning disability services. So they slipped through the remit of secondary educational and social services provision. The needs of this group are complex and, although they have average non-verbal IQ, multi-disciplinary support is required as they enter adolescence and adult life, particularly with respect to improving social competence (Clegg et al., 1999; 2005).

A landmark longitudinal study was carried out in Canada between 1982 and 1996. Children (N=1655) were selected at random at the age of five, assessed for speech and language impairment and followed up at age 12, 19 and 25. The results showed that there was an association between the language profile at age five and the degree of behavioural disturbance at both age five and age 12. Specifically, initial language impairment was associated with psychiatric disorder at follow-up and was predictive for hyperactivity, anxious/passive symptoms and level of social competence.

More than a quarter of the language disorder group at age 19 had anxiety disorder (statistically significantly higher than the control); most of those also had social phobia. There was also increased substance abuse (Beitchman, Wilson, Brownlie, Walters, & Lancee, 1996a; Beitchman et al., 1996b; Johnson et al., 1999; Beitchman et al., 2001).

At aged 25 there were poorer outcomes in communication, cognitive/academic, educational attainment, and occupational status compared with peers without early communication impairments and those with early speech-only impairments (Johnson, Beitchman & Brownlie, 2010).

Social and behavioural difficulties increase with age for children with SLI and they become more likely to become a target of bullying (Conti-Ramsden & Botting, 2004). Their failure to comprehend leads to accusations of laziness, wilfulness or inattention and limits opportunities to form close relationships that would normally be protective (Bishop & Norbury, 2008). Hence, support is needed for low self-esteem, depression and social avoidance in children with long-term persistent language difficulties (Conti-Ramsden & Botting, 2004).

Wadman, Durkin and Conti-Ramsden (2008) found older adolescents with SLI are at risk of lower global self-esteem (they had lower self-esteem than a control group of peers with typical language abilities) although they want to interact socially; the relationship between language skills and self-esteem was complex with shyness potentially playing an important mediating role (they were more shy than the control group).

These results were consistent with a study of longitudinal patterns of behaviour problems in children with SSLD (Dockrell et al., 2007). This showed that raised levels of Behavioural, Emotional and Social Difficulties (BESD) continued over the period 8-12 years. BESD is related to the child's language difficulties indicating important co-morbidity. Peer relationships were also related to language development, especially pragmatic abilities.

The continuance of this study through to age 16-17 showed the increased risk of BESD persisted but asserted that subjects had the "basis for effective social adjustment and integration into the normal adult world" (Lindsay & Dockrell, 2008, p.155) where

earlier studies raised concerns (e.g., Clegg et al., 2005; Mawhood, Howlin & Rutter, 2000; Beitchman et al., 2001; Botting, Crutchley & Conti-Ramsden, 1998). Although Lindsay and Dockrell do admit that their findings present “a mixed picture” (p.145).

Educational outcomes at this age were also said to be substantially better than suggested by earlier research (Lindsay, Dockrell & Strand, 2007; Lindsay & Dockrell, 2008). There are difficulties in comparing the results across these studies, however, as there are a number of confounding variables including the comparability of samples, changes in diagnosis, the time frames and the measures used. Participants have been selected in different ways to different criteria and there have been substantial changes in the education system over the period of the studies.

A study by Conti-Ramsden, Durkin, Simkin and Knox (2009) was broadly contemporaneous with that of Dockrell et al. (2007). The majority of the 120 participating adolescents with a history of SLI were in some form of employment, education or training.

Social cognition (i.e., any cognate understanding of others’ emotional or mental state) is not a spared skill in SLI (Farmer, 2000). Botting and Conti-Ramsden (2008), in their study, propose language, social cognition and social skill need to be on the agenda for anyone involved in the functional social outcomes of young people as they reach adulthood. This is especially true for young people with a history of SLI as they are more likely to have difficulties in these areas and social cognition, that plays a larger role on social outcomes for this group, was impaired.

However, other studies have found children who do not have problems with social cognition in the form of theory of mind tasks (e.g., Shields et al., 1996b; Ziatas, Durkin & Pratt, C., 1998). Whether individuals with SLI have problems with ToM is still equivocal (Botting, 2007). Those with PLI may have more difficulty with social cognition (Shields, 1996b).

The poor communication skills of children with PLI can contribute to difficulties with peer relations and decreased opportunities for social participation, which may lead to exclusion from social groups in later life. For many this can lead on to an isolated adolescence and adulthood and mental health problems despite relatively normal formal linguistic skills such as syntax (Rapin & Allen, 1983; Cantwell & Baker, 1991; Clegg et al., 2005; Adams & Lloyd, 2007). Cuperus, Jansonius and Verhoeven (2009), in the Netherlands, found that hyperactivity and lack of pro-social behaviour reach clinical levels for this group.

However, little attention has been paid to PLI in longitudinal studies. Whitehouse, Line, Watt, & Bishop (2009a) and Whitehouse et.al. (2009b) conducted the first longitudinal study, published in two parts, to compare the language profiles and psychosocial outcomes in adulthood of 37 children diagnosed with SLI, PLI or ASD with a control.

Pragmatic ability was assessed with a Communication Checklist for adults (CC-A) (Whitehouse & Bishop, 2009). Findings replicated some of those of Mawhood et al. (2000) who found that children in the SLI group had significant pragmatic difficulties when reassessed in early adulthood. Childhood language profile persisted over time; the majority of people in the SLI group showed lasting deficits in structural language and literacy ability whilst the people in the PLI group were found to have enduring pragmatic difficulties. Intriguingly, pragmatic deficits appeared to develop over time in adults in the SLI group (the majority of the SLI group had received a childhood assessment that excluded the presence of pragmatic impairment).

Not only do DLDs become more pronounced with age (Whitehouse et al., 2009b), difficulties beyond the language domain also become apparent as children grow older e.g., susceptibility to literacy problems (Botting et al., 1998; Snowling, Bishop & Stothard, 2000) and difficulty with broader academic subjects such as mathematics

(Beitchman et al., 1996a). Those with persisting literacy impairments are more likely to be recipients of welfare benefits (Clegg et al., 2005).

In terms of psychosocial outcomes there are a number of differences between the SLI group, the PLI group and a control group. The SLI group were not high-achievers but had gained some form of vocational qualification. Achieving consistent employment was [not] a problem within professions that did not demand high language and literacy levels. Many had normal friendship levels, although a significant minority found establishing and maintaining social relationships difficult and romantic relationships proved challenging. However, individuals did show independent behaviours although five of the 19 participants had been diagnosed with major depressive disorder, three of these with a co-morbid anxiety disorder and in all cases these were severe enough to warrant a psychiatric referral and in two cases require hospitalisation.

The PLI group were more academically-able (all had achieved some form of vocational or university qualification) than the SLI group and tended to work in skilled professions but many had difficulty establishing and maintaining friendships and romantic relationships (Whitehouse et al., 2009b). Botting (2007) had also found children with PLI tend to have a higher non-verbal IQ than non-PLI peers with SLI .

Friendships require extensive use of language and initiating, managing and sustaining them are a vital dimension of child development into adolescence. Talking to each other is a natural means of communication and language is integral to most children's interactions with peers including acceptance, self-disclosure, negotiating and sharing. Those with SLI are therefore disadvantaged from their pre-school days and by early adolescence have negative views of their own social competence and low self-esteem (Jerome, Fujiki, Brinton & James, 2002; Durkin & Conti-Ramsden, 2007).

Receptive difficulties are however a key characteristic of PLI although individuals may appear not to have these when tested on formal measures of language

comprehension. They can take many forms. Difficulty in the comprehension of syntactically-complex utterances has substantial implications for accessing therapeutic inputs and as children become older it also means they are increasingly disadvantaged in adult conversation, a large proportion of which tends to consist of complex sentences (McTear & Conti-Ramsden, 1992; Bishop, 1997a; Botting, 2007).

Whilst expressive language impairments may be ameliorated, interventions for receptive difficulties are far less successful. At the same time a large number of children are presenting with increasingly complex receptive difficulties (Law, Boyle, Harris, Harkness & Nye, 1998; Botting, 2007).

Receptive language difficulties might also predict higher rates of mental health difficulties in later life (Beitchman et al., 2001; Clegg et al., 2005; Botting, 2007). Higher rates of language impairment have been identified in psychiatric samples (Cohen et al., 1998; Botting, 2007). However, it is not known whether higher rates of mental health difficulties and higher rates of language impairment are causal in either direction or whether they represent an unrelated co-morbid risk. Botting (2007) suggests the latter is true.

A cohort group of more than 17,000 children born in one particular week in 1970 were followed from school entry to adulthood examining literacy, mental health and employment at 34 years. The study compared groups with SLI, non-specific language impairment (N-SLI) and typically-developing language. In this model N-SLI would simply represent the more severe end of the continuum, akin to mental retardation, with SLI at the milder end like other specific learning difficulties.

Adults in the SLI group were twice as likely to have poor literacy, twice as likely to have mental health issues and 2.5 times as likely to be unemployed than the control group. Adults in the N-SLI group were nearly eight times as likely to have poor literacy, more than five times as likely to have mental health issues and nearly three times as

likely to be unemployed than the control. Differences in time spent unemployed were significantly associated with early receptive language problems (Law, Rush, Schoon & Parsons, 2009).

Emotional health has been shown to be poorer in 16-year-old adolescents with SLI compared to peers, with higher anxiety and depression scores indicating increased risk, although there was no obvious connection between depression/anxiety and language skill or IQ suggesting a non-direct or non-causal link. The participants had a variety of different language profiles with the majority having both receptive and expressive difficulties; there is no mention of pragmatic difficulties.

The authors conclude the relationship between poor language and emotional health is difficult to interpret. Having ongoing poor communicative experiences does not appear to make a person increasingly depressed or anxious per se. Rather the association appears to be with the SLI itself i.e., with the impairment (Botting, 2008; Conti-Ramsden & Botting, 2008).

“It does not appear that emotional health is associated with language impairment in a simple way.” The association has often been assumed to be causal in that either long-term language impairment may lead to (or exacerbate) wider difficulties or psychiatric impairment may constrain communication skill. Individuals working and living with those with SLI should be aware of the associated emotional risks and have access to good support for this outcome (Conti-Ramsden & Botting, 2008, p.523).

Importantly, a further mechanism where language can affect psychiatric status is through its role in inner speech that has a self-regulatory function and is generated throughout most waking hours since childhood. It is a tool for thought as well as a means of communication and it affects how we structure our experiences, plan for the future and reflect on the past. A person with problems understanding language is rooted more in the here and now and may find it hard to delay gratification, think through

another's motivations or appreciate chains of causality (Bentall, 2006; Bishop & Norbury, 2008).

2.6 Summary of the Literature Review

This review has shown that SLI/PLI is a complex area that is challenging for researchers as within this field there is a degree of confusion surrounding the use of diagnostic terminology in the area where neurology, psychology, psychiatry, speech therapy and education converge. This means that children may be diagnosed differently by professionals with different types of training and be categorised using a variety of diagnostic labels. Additionally, the unclear nature of clinical description is exacerbated by the lack of accurate diagnostic “markers” so that diagnosis is reached by exclusion.

SLI/PLI, in the absence of autism and Asperger's syndrome, are said to be more pervasive than traditionally thought and become more pronounced with age with genetic factors strongly implicated. They are a life-long impairment with particular risks for educational difficulties, poor social functioning and psychiatric problems later in life. Those with poor social functioning have decreased opportunities for social participation, lack of independence and difficulty establishing and maintaining friendships and romantic relationships. For many this can lead to social isolation but normal performance IQ prevents access to adult learning disability services.

Social, cognitive and genetic risk factors, that are experienced by the SLI/PLI population, are all known to influence onset of affective disturbances and research has suggested that psychosocial adjustment problems may be experienced by young adults with SLI/PLI so that this group's mental health is at risk. Recent work has recommended that the long-term mental health of these individuals should be made a priority for future research and modified counselling approaches may have the potential

to help those experiencing psychosocial difficulties although empirical evidence for this is needed. Other studies, however, have suggested outcomes are improving.

There is also an expectation that the difficulties this population may experience in their comprehension and expression of spoken language and/or in their use of language will have substantial implications for their ability to engage in therapy and therefore the effectiveness of the therapeutic relationship. It has also been said that mental health professionals, whose work depends primarily on verbal interchange, seldom receive formal training in language development or language impairment so impairment may not be identified.

2.7 Rationale for the Research, Overarching Research Aim and Research Questions

The review suggests that young adults with SLI/PLI experience difficulties with psychosocial adjustment that may require psychological counselling. Counselling and clinical psychologists are well-placed to provide therapeutic input for this group but there is little empirical evidence of their knowledge and understanding and of their experiences and expectations of providing supportive intervention. One way of addressing this deficiency would be to identify in this research any important issues for those working in this field. These preliminary suggestions could then inform future research into service development.

Therefore, the overarching research aim for this thesis is:

To explore the knowledge, understanding and practice of psychologists and the lived experiences and psychosocial adjustment of young adults with SLI/PLI for the advancement of counselling psychology.

To meet this aim, studies meet the requirements of the BPS Code of Ethics and Conduct (BPS, 2006), various guidelines (BPS, 2002; 2004; 2005 & 2008) and the Data Protection Act, 1998.

A research question has been determined for each of three chapters:

Chapter 3 (p.27): What is the current level of knowledge and understanding of SLI/PLI among counselling and clinical psychologists; what is their experience of working therapeutically with this group; and would those with experience agree to participate in a face-to-face interview?

Chapter 4 (p.52): Will analysis of the clients' lived experiences enable the identification of themes that illuminate their essential qualities?

Chapter 5 (p.92): Will the exploration and analysis of psychologists' experience of providing psychological therapy to this group identify whether and to what extent there are interconnections between the themes from Chapter 4 and psychologists' practice?

Finally, Chapter 6 (p.118) discusses whether the thesis meets the overarching research aim.

Chapter 3

Knowledge and Understanding of SLI/PLI among Counselling and Clinical Psychologists and their Practice with this Client Group

Abstract

Objectives

This chapter explores the level of knowledge and understanding of SLI/PLI among counselling and clinical psychologists; identifies the experience of those who practice therapeutically with this client group, and invites these respondents to participate in a face-to-face interview.

Design

A questionnaire was developed using the Surveyor web-based application. The design was cross-sectional and in two parts. The second part was completed only by those with experience of clients with SLI/PLI. The questionnaire was completed anonymously unless respondents provided contact details for interview purposes.

Method

The questionnaire was sent electronically with a personalised letter and information sheet to 1,170 Chartered psychologists from a list generated from the BPS website. The system allowed free text to increase the richness of the data. Data analysis was conducted using descriptive statistics.

Results

There were 137 responses to the survey. 62% of counselling and 23% of clinical psychologists reported less-than-adequate knowledge for their requirements. Psychologists' experience working with young adults or adolescents with SLI/PLI was limited, with only 39 (28%) of all participants having experience. The mean number of clients seen was 13.3 and eight psychologists offered to take part in an interview and provided contact details.

Conclusions

Confusion between SLI/PLI and other conditions where language was affected, such as learning disability and ASD, was evident. Those psychologists who had

experience with this group were typically using CBT and making modifications to their therapeutic approach. Little use of flexible sessions, working with others and taking account of clients' needs were reported.

3.1 Introduction and Rationale

This chapter addresses the research question for Chapter 3 (Chapter 2.7, p.25) by conducting an electronic survey of counselling and clinical psychologists. The survey provides the means to identify among those psychologists with experience of working with young adults with SLI/PLI people who are willing to participate in a face-to-face interview as described in the qualitative study reported in Chapter 5 (p.92).

It also provides quantitative data on the extent of knowledge and understanding of SLI/PLI and of therapeutic practice across a small, broad population of counselling and clinical psychologists. This might indicate if there is consistency between the survey and interview results.

3.2 Design

The electronic questionnaire was developed using the Surveyor web-based application to determine the level of understanding of SLI/PLI among clinical and counselling psychologists and explore their experience of working therapeutically with clients. The survey allowed free text to increase the richness of the data. The design was cross-sectional (i.e., one point of data collection).

The participants were anonymous and identifiable only by a participant number generated by the survey software unless they agreed to participate in an interview and provided their contact details.

3.2.1 Measures. The questionnaire (Appendix 3, p.170) was not pre-tested. It was designed to enquire about the following topics:

- Section I: Demographics (5 questions);

- Section II: Psychologists' understanding of specific language impairment and pragmatic language impairment (3 questions). Additional terms were identified from the research literature:
 - Communication disorder(s)
 - Developmental language impairment
 - Developmental language disorder
 - Specific language impairment
 - Pragmatic language impairment
 - Specific speech and language difficulties
 - Speech, language and communication needs
 - Primary language impairment
 - Semantic-pragmatic disorder
- Section III: Psychologist's experience working with clients with SLI/PLI (for those who had experience; 10 questions). This section provided an opportunity for participants to agree to participate in a face-to-face interview.

3.2.2 Participants. Counselling psychologists and child/adolescent clinical psychologists were the disciplines most likely to have worked therapeutically with clients with a diagnosis of SLI/PLI. To maximise the number of participants and to increase the likelihood of identifying psychologists with knowledge of SLI/PLI and specific experience of working with this client group, the distribution was UK-wide to both disciplines. The participants were self-selecting and thus not a random sample of psychologists in the country.

3.3 Method

3.3.1 Procedure.

Ethical approval

The full study summarised by the overarching research aim (Chapter 2, p.7) required the approval of the University Ethics Committee. The application and research agreement letter are in Appendix 4 (p.174). Overall, the proposal is Category B as it involves vulnerable, young, language-impaired adults. The survey, designed for both counselling and clinical psychologists, did not form part of the proposal for which ethical approval was obtained. However, advice from the chair of the Ethics Board determined that an additional application for further ethical approval was unnecessary (Appendix 4, p.174).

Recruitment

The Directory of Chartered Psychologists on the British Psychological Society (BPS) website generated a distribution list of 1,263 psychologists (785 counselling psychologists and 705 child/adolescent clinical psychologists with 227 duplicates removed). All were invited to participate by personalised email (see Appendix 5, p.189) with an information sheet for those recipients wishing to participate in a face-to-face semi-structured interview (Appendix 6, p.191).

Psychologists were provided with an e-link to complete the survey. This would take less than 10 minutes. They were asked to complete the questionnaire whether or not they had experience of SLI/PLI. If they were not experienced the survey would end after nine questions.

3.3.2 Method of data analysis. Completed questionnaires from the respondents were analysed using descriptive statistics. All of the tables in Chapter 3 were verified

for accuracy using respondent numbers, which also enabled consideration of individuals' answers to different questions.

Percentage responses were calculated for counselling psychologists, clinical psychologists and the "Other" group. These were compared and, where possible, chi-square tests were used to test for significant differences.

Seven of the 14 questions in Sections II and III included free text boxes (8,10,13,14, 17, 18 and 19 for any additional comments). Content analysis was not carried out. Instead verbatim responses were included in the critical discussion (Chapter 3.5, p.41) to enhance the quantitative data.

3.4 Results

3.4.1 Respondents and demographics. A total of 1,170 psychologists received the invitation to participate in the survey (93 had inactive email addresses) and 137 (11.7%) replied.

Fifty of the respondents (36.5%) reported that they were counselling psychologists and 64 (46.7%) were clinical psychologists. 23 (16.7%) responded "Other". Ten of these were educational psychologists and were analysed separately (comprising 7.3% of the total respondents). "Other" also included occupational, occupational health, forensic and organisational psychologists and a psychotherapist. Five of the 13 in this group reported specifically that they were engaged in counselling/therapy.

Of the 137 respondents, 33% were male and 67% female. 46% worked privately only, 16% for an NHS trust only and 29% for an NHS trust and privately. 46% were aged 45 or less, 54% were aged 46 or more. 92% practiced in England, the majority in London and the South East. There were only eight respondents from Scotland, Wales and Northern Ireland combined.

Chi-square tests were used to compare the expected value by gender and discipline and by age and discipline with the observed values in the sample. There were no gender differences across the disciplines that were significant ($\chi^2=5.99$, $\text{dof}=2$, ns) but there were differences by age ($\chi^2=12.59$, $\text{dof}=6$, $P=0.05$); the clinical psychologists were significantly younger than the other disciplines.

The respondents reflected the proportion by gender and by location of the population of counselling and child-clinical psychologists in the UK. This was established by selecting and analysing a random sample of 200 of the 1,170 psychologists on the two BPS lists that were used to create the emailing list. It cannot be determined whether or not the respondents reflect the age range of this population as this information is not provided.

3.4.2 Familiarity with terminology and formal definitions. Respondents were asked (Question 6) how familiar they were with terminology used in this clinical field and with the formal definitions (Chapter 1, pp.2-3) (see figures 3.1, p.35 and figure 3.2, p.36). (Both were questioned as familiarity with the terms does not necessarily imply understanding of definitions.)

Figure 3.1 (p.35) shows that 78% were familiar with the term communication disorders but only 39% and 45% were familiar with primary language impairment and semantic-pragmatic disorder respectively. Other terminology included (including SLI and PLI) was familiar to between 60% and 72%. Overall, just 30% were familiar with all terms included and 17% were familiar with none.

For each of the terms, clinical psychologists reported more familiarity than counselling psychologists. Although there is some variation for individual terms, the clinical psychologists are overall more than twice (2.2 times) as likely to report being familiar with the terminology than the counselling psychologists. 30% of counselling psychologists reported they were not familiar with any of the terms compared to just 6%

of the clinical psychologists. This contrasts with 40% of the clinical psychologists reporting being familiar with all of the terms compared to just 8% of the counselling psychologists. Small sample sizes prevent any conclusions being drawn about the other disciplines.

Figure 3.2 (p.36) shows that the degree of familiarity with the terms contrasts with familiarity with the formal definitions. The least familiar was again primary language impairment (10% familiarity). The formal definitions of the other terms was familiar, on average, to 19.1% of the respondents (with a range of 16% to 22%). Just 4% were familiar with the formal definitions of all terms listed and 65% were familiar with none. The latter figure is 82% for counselling psychologists, 52% for clinical psychologists and 60% for educational psychologists. Figure 3.2 also shows that the clinical psychologists are 6.5 times as likely to report being familiar with the formal definitions than the counselling psychologists.

SLI and PLI were considered separately, having been mentioned in the electronic letter (Appendix 5, p.189). This showed that 80% of the respondents did not know the formal definition for SLI and 85% did not know the formal definition for PLI.

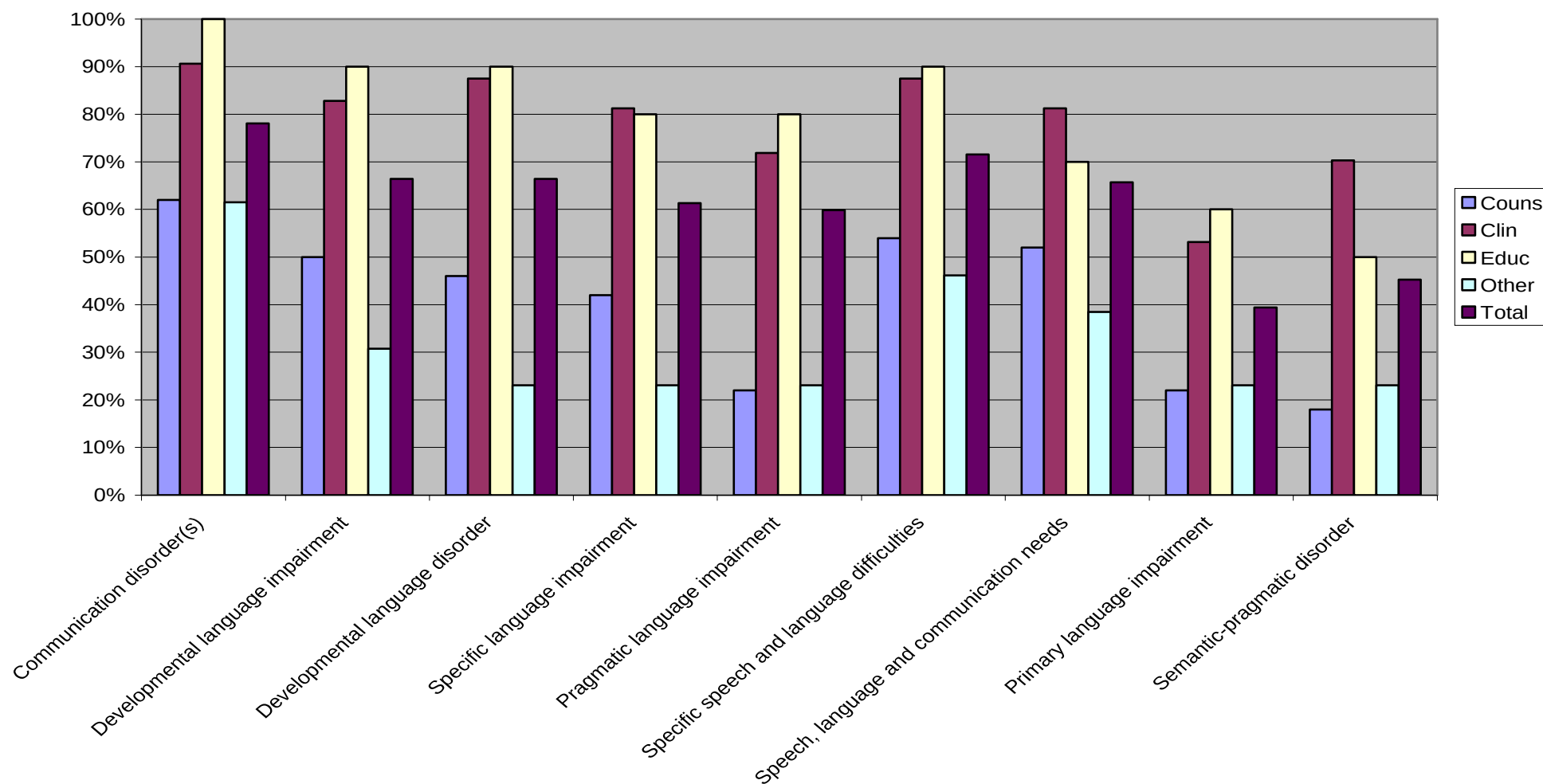


Figure 3.1: Extent to which the 137 respondents are familiar with language impairment terminology

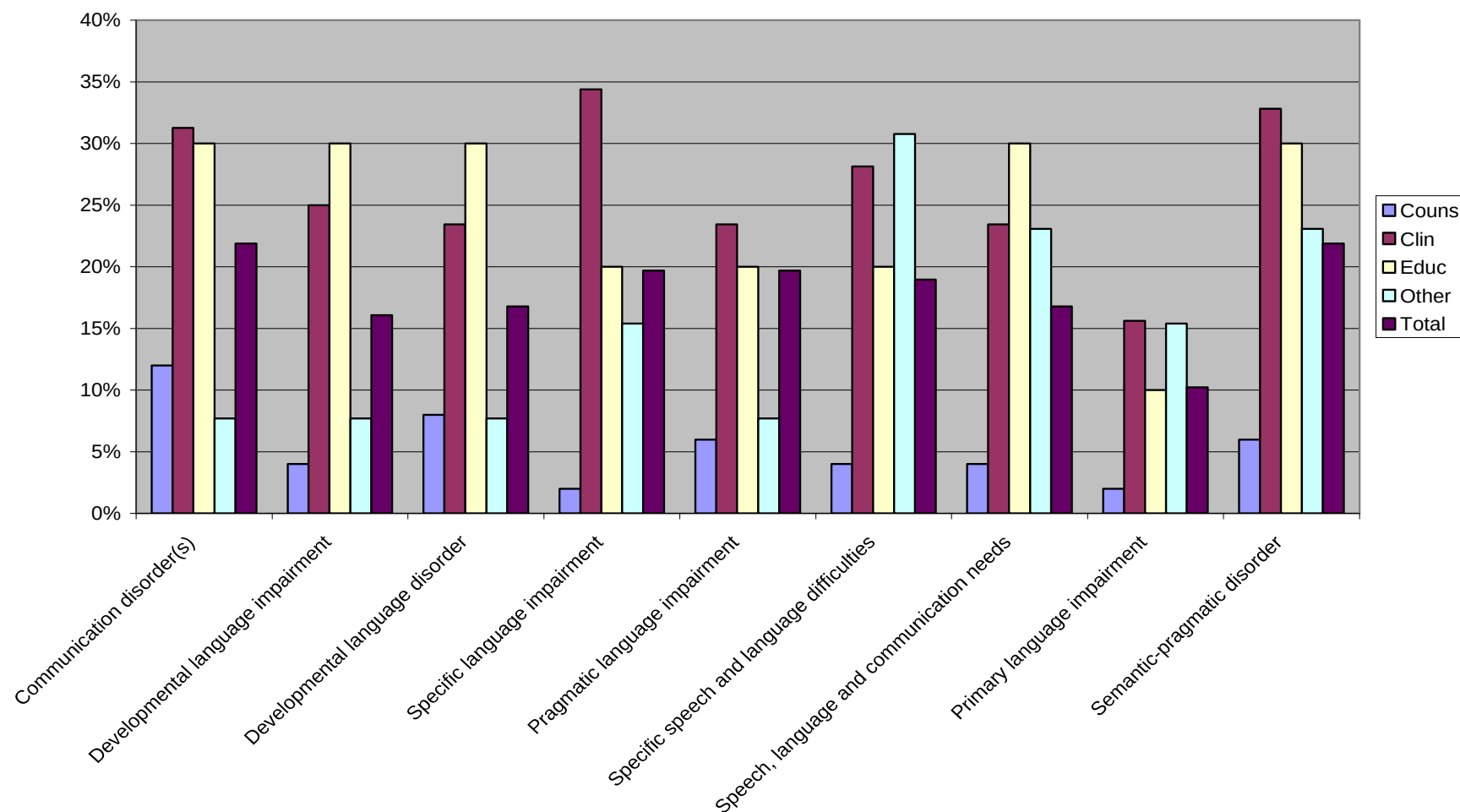


Figure 3.2: Extent to which the 137 respondents are familiar with the formal definitions

Comparing figure 3.1 (p.35) and figure 3.2 (p.36) indicates that, if a clinical psychologist is familiar with a term he or she is 3.9 times more likely than a counselling psychologist to report also being familiar with the formal definition of that term. The exception is where the term involves the word pragmatic, where a counselling psychologist is just as likely to know the formal definition if they are familiar with the term.

3.4.3 Depth and source of knowledge for each of the terms. The respondents were asked to report their depth of knowledge of these terms and where they acquired this knowledge (Questions 7 and 8).

Overall the depth of knowledge is reported as being less than adequate for all of the terms. The mean depth of knowledge was 1.2 with a range from 0.8 to 1.5 (the rating scale is 0: none, 2: adequate, 4: expert).

This applied both to counselling and clinical psychologists. However, counselling psychologists reported having less knowledge of these disorders than the clinical psychologists (mean depth of knowledge is 0.7 for counselling psychologists cf. mean 1.5 for clinical psychologists). Only 38% of counselling psychologists reported their knowledge as being adequate or better for one or more of the terms. For clinical psychologists this figure was 77%.

The mean depth of knowledge for respondents in the age group 25-35 and 56+ was 1.0 and in the age group 36-55 was 1.4.

When asked where they gained this knowledge, some disciplinary differences emerged. Most knowledge was gained from own reading and study, but whereas 24% of clinical psychologists reported having worked closely with SaLTs, only 6% of counselling psychologists had made contact with these professionals.

3.4.4 Experience working with clients with SLI/PLI. Thirty-nine respondents (28.5%) had some experience working with this group. This included six counselling, 26 clinical, six educational and one occupational psychologist (trained in counselling). However 14 (35.9%) had previously reported unfamiliarity with the formal definitions. Whilst these respondents were more familiar than those with no experience with the terms (8% vs 4.6%) and their formal definitions (3.5% vs 0.7%). This is irrespective of whether they worked for the NHS or privately. Age and gender were also non-discriminatory.

Their experience was limited. The mean number of clients was 13.3 and for 50% of the psychologists this spanned 11 years or more. (Ninety-eight respondents had no experience working with this client group so the mean number of clients overall was 3.7.)

Twenty-eight (71.8%) said their clients had a formal diagnosis. Twenty-three of the 28 reported the formal diagnoses, naming 16 in total between them. Eleven of the respondents reported only formal diagnoses consistent with this list (i.e. they did not name any additional diagnoses that were not consistent). Ten respondents reported ASD and/or Asperger's syndrome. Of those, seven individuals also reported additional diagnoses including learning disability, vague references to learning difficulties, ADHD, dyslexia and dysphasia (Appendix 7, p.192).

The experienced psychologists had a greater breadth of knowledge than those with no experience (a familiarity with a mean number of 7.5 terms compared to a mean of 5.4 terms) and also were more familiar with the formal definitions (a mean of 3.1 compared to a mean of 1.2). This was found across all three disciplines although the counselling psychologists had less breadth of knowledge than both the clinical and educational psychologist (a mean of 5.5 compared to a mean of 8.5 for clinical and educational combined). The clinical psychologists however had a greater knowledge of

the formal definitions than the other disciplines (a mean of 4.1 compared to a mean of 2.7 for counselling and educational).

Psychologists across the disciplines with experience of working with this client group had a greater depth of knowledge (a mean of 2.0 which is adequate) compared with those with no experience (a mean of 1.2 that is less than adequate).

3.4.5 Clients presenting with additional physical or psychological

conditions. Of those who had experience working with adolescents and/or young adults with SLI/PLI, 82.1% (32 of the 39) reported that these clients presented with additional physical or psychological conditions, listed in Appendix 8, p.194 (Question 13).

Forty-seven different conditions were reported, 15 of them by more than one respondent. The conditions have been organised into five groups (two conditions reported were too vague to classify); the clinical and educational psychologists reported conditions in all five groups; only one counselling psychologist reported conditions, all in Group 5. The five groups are shown in Table 3.1.

Table 3.1
Additional physical or psychological conditions

Group 1: Neuro-developmental disorders often co-morbid with speech and language problems.	Eight respondents between them reported one or more of four conditions in this group. ADHD and dyspraxia were both reported by five of the eight respondents. Neither of the other conditions (dyslexia/specific learning difficulties and Tourette syndrome) was reported by more than two respondents.
Group 2: Neuro-psychological symptoms co-morbid with speech and language problems.	There are six conditions in this group. Five of these conditions were reported by one respondent only (poor co-ordination, poor memory, poor organisation skills, communication disorders and executive dysfunction). Social skills deficits was reported by three respondents.

Group 3: Syndromes in which speech and language impairments are associated and often presenting symptoms.	There are three conditions in this group (ASD, Asperger's syndrome and learning difficulties). These were reported by 16 respondents and all conditions were reported by only one respondent.
Group 4: Neurological/physical conditions that can lead to secondary language problems.	10 respondents between them reported 17 conditions in this group. Cerebral palsy was reported by three respondents; none of the others was reported by more than two respondents. One participant reported 8 conditions in this group.
Group 5: Psychiatric syndromes or symptoms.	18 respondents between them reported 14 conditions in this. Anxiety was reported by 12 respondents and depression by 10. None of the other conditions was reported by more than two respondents.

Note. Based on Baird (2008), modified and confirmed by Bishop (private correspondence, 2010).

Considering the reports of additional conditions by discipline shows that of the six counselling psychologists only one reported additional conditions and these were in Group 5 (psychiatric syndromes or symptoms). The remaining five did not report any additional conditions. Five of the six educational psychologists reported additional conditions included in all five groups. All but two of the 26 clinical psychologists reported additional conditions. 11 reported conditions in group 3 and 12 reported conditions in group 5.

3.4.6 Therapeutic approach and modifications made. Twenty-seven therapeutic approaches were specifically mentioned (Appendix 9, p.197). Eighteen of the 39 psychologists (46%) reported that they used more than one approach and three respondents used eclectic CBT. On 19 occasions CBT was reported first (by 49% of the respondents), systemic/family therapy was reported by 8 respondents (21%) and person centred therapy by 6 respondents (15%). Three respondents reported that they did not provide therapy, they undertook assessments only.

79.5% (31 of 39) modified the assessment/therapeutic approach and 54% (21 of 39) made further modifications as therapy progressed (Appendix 10, p.199).

Modifications included: careful use of language; use of visual/non-verbal tools; flexible sessions; working with others; and the use of developmental assessment, often used in combinations (Appendix 10, p.199).

Eight of the 39 respondents who had experience were willing to participate further in the qualitative studies that follow.

3.5 Critical Discussion of the Results and how these Findings Relate to the Literature

The response rate of 11.7% was low in comparison with other web-based survey response rates: Shih & Fan's (2007) meta-analysis of 52 published surveys covering education, psychology and social science showed a mean response rate of 46% (range 10% to 90%). There are various possible explanations for this: pressure of work; lack of interest in, or knowledge of, the subject; summer holidays etc.

The word "terms" was used in the survey (Appendix 3, p.170) as the only "diagnosis" is Communication Disorder(s) from DSM-IV (APA, 2000TR) (See Chapter 1, p.2). Bishop and Norbury (2008) believe DSM-IV TR is unworkable, creating problems of categorisation.

"When you say 'formal diagnosis' it is hard to know what you mean as it may be in the notes that the client has a communication disorder or communication needs ... sometimes this is shorthand for someone not knowing what the actual disorder is." Respondent 57607.

The choice(s) of term(s) may also be influenced by the professional background of the researcher, the professional body responsible for the categorisation (e.g., APA,

2000 TR; WHO, 2007), or by the nationality, professional group or agency responsible for the study.

“I have tended to typically use those [conditions] that are agreed in formal diagnostic references such as DSM or ICD: I wouldn’t support some of these other diagnoses being formally ‘agreed’ conditions.” Respondent 57567.

In the USA the term Primary Language Impairment is preferred to SLI (which is an explanation for the limited number of respondents who recognised it) but can be confused with pragmatic language impairment and is therefore not popular in the UK (personal communication from Whitehouse, 2009); and the term semantic-pragmatic disorder has been subsumed by the term PLI (Conti-Ramsden and Botting, 1999; Bishop, 2000) although it is not clear if any of the respondents who were familiar with the former were aware of this.

The survey did not establish whether respondents also understood that the terms broadly represented the research and clinical population of SLI/PLI. Although they were not asked specifically for this information none of the respondents commented on this. All disciplines are most familiar with the term Communication Disorder(s) but it is perhaps surprising that only 22% overall were familiar with this [the only] diagnosis.

Experience of working with SLI/PLI young adults or adolescents is limited, with only 39 (28%) of all respondents with any experience. Only 38% of counselling psychologists reported their knowledge as being adequate or better for one or more of the terms. For clinical psychologists this figure was 77%.

“My knowledge is minimal but I do not need it to be otherwise since I don’t work with these presenting issues directly and

would refer on if required to someone who was knowledgeable.” Respondent 57633.

That the mean number of SLI/PLI clients seen was low could explain why some respondents are unfamiliar with the terminologies used. Yet, Bishop (2010b) says there are 11.56 million children and adolescents in the UK and of these 855,440 are cases of SLI (7.4% of the population) and only 75,140 are cases of ASD (0.65% of the population). Additionally, Beitchman et al. (2001) found that 40% of adults with a history of language problems met the criteria for at least one psychiatric disorder making the number of clients seen with SLI/PLI seem very low.

Respondents reported that the formal diagnosis of ASD and/or Asperger’s syndrome was consistent with the terms listed. They had not recalled that the personalised covering letter sent with the questionnaire specifically excluded these conditions and these were not listed as they are categorised (APA, 2000TR) as Pervasive Developmental disorders and not as Communication Disorders. There was further confusion, with a number of additional conditions (ADHD, dyslexia, dysphasia and learning disability) also being mentioned.

Thirty-one (of the 39) psychologists reported a variety of “additional” conditions in this group (Appendix 8, p.194). The term “additional” was used instead of terms such as “co-occurring”, “co-morbid”, “co-existing” or “associated” because it was felt that uncertainty about meaning could increase the risk of confusion. For example, true co-morbidity is the result of shared and overlapping risk factors with one disorder creating an increased risk for the other (Caron & Rutter, 1991; Konstantareas & Beitchman, 1996).

There was an expectation that when asked to name “additional” presenting psychological or physical conditions respondents would name, for example, depression, anxiety, dyspraxia, motor co-ordination problems, and academic difficulties/dyslexia, as

SLI is often accompanied by other neuro-developmental disorders (Hill, 2001; Baird, 2008; Bishop & Norbury, 2008; Botting, 2008; Conti-Ramsden & Botting, 2008).

However, when asked to name their clients' additional physical or psychological conditions 16 of the 39 believed that autism was additional to SLI/PLI. This is consistent with the confusion in responses to the question concerning formal diagnoses (Chapter 3.4.4, p.38).

Baird (2008) provides clarity. There are syndromes where speech and language impairments are associated and often presenting symptoms such as ASD and general learning difficulty (mental retardation/learning disability). For these clients, therefore, SLI/PLI is not the primary disorder. For the purposes of establishing criteria for a formal definition, the impairment is regarded as *primary* where it is not part of another recognised syndrome and there is no obvious underlying aetiology.

There are aetiologies leading to secondary speech and language impairment including hearing impairment; genetic disorders; acquired disorders resulting from neuro damage (e.g., stroke); motor dysfunction of central origin (e.g., cerebral palsy) and severely impoverished environment socially and linguistically (Baird, 2008).

The extensive list of additional conditions in Group 4 (conditions that can lead to secondary language problems) named by clinical psychologists may be explained by: (a) their clients were initially diagnosed with SLI/PLI and subsequently developed e.g., a brain tumour; or (b) it is symptomatic of the level of lack of understanding of the formal definition of SLI/PLI so that respondents had considered and entered all of the cases where any language difficulties were present.

*“As counselling psychologist and psychotherapist I am mindful
of how emotional, psychological, psychosocial and*

genetic/structural factors all have an influence on language development and usage.” Respondent 57512.

There are numerous debates concerning the issue of diagnosis (Bentall, 2007; Boyle, 2007; Campbell, 2007; Congdon, 2007; May, 2007; Pilgrim, 2007; Scott, 2007).

“Whether these people need to be categorised as having a medical problem I am not so sure about.” Respondent 57553.

Given that the issue of diagnosis is controversial it was perhaps surprising that only six people raised concerns about appropriacy of working with diagnoses.

“What do you mean by ‘formal diagnosis’? I do not have any experience of this way of categorising and classifying people although ... language use is inherently problematic for all of us”. Respondent 57553

New Ways of Working for Applied Psychologists (BPS, 2007, p.9) describe the formulation being at the “heart” of a psychological approach and that this “contrasts with the diagnostic approach which is characteristic of medical models that currently represents the pervasive discourse in most healthcare organisation.” Seeming to suggest that these are mutually exclusive.

“I find the whole area of diagnosis ... very difficult indeed to distinguish so that I tend to assess people and present their individual needs rather than struggling with a formal diagnosis.” Respondent 57598.

Another respondent speaks of a young adult with high functioning autism (her quote is transferable to the SLI/PLI population) suggesting that “that part of the problem” [his autism] can be considered separately from the client rather than being central to the client presenting for therapy. This is an issue explored in Chapter 5 (p.92).

“I currently have one such client but cannot address that part of the problem as it is outside of my scope of knowledge/expertise and is inappropriate to address in this (CMHT) setting.”

Respondent 57592.

When naming approaches, only two psychologists included an eclectic approach, nobody indicated working integratively and one included eclectic CBT. It may be that these terms are being used synonymously (Norcross & Goldfried, 1992; Norcross & Grencavage, 1990).

With few exceptions (in the clinical group only) the approach was modified. The most widely adopted way of modifying the approach was with the careful use of language but it was surprising that so little use was recorded of flexible sessions, working with others and being guided by the client’s needs.

3.6 Implications of these Findings for Future Research

The questionnaire shows compromised understanding of terminology with numerous labels and terms for the SLI/PLI population co-existing with formal diagnoses from the manuals that themselves may be regarded with scepticism by both researchers and clinicians. There was also confusion about the definition of SLI/PLI and its relationship with other conditions where language is affected suggesting a need to include the current views on definitions in any paper.

To reduce confusion researchers should endeavour to ensure consistency of terminology and this may be facilitated by the introduction of revised terminology in DSM-5 (APA, 2010) if published as drafted (see Appendix 2, p.167) and researchers adhere to it.

Although undertaking research and working in this “complex and difficult area” may be seen as challenging (Bishop & Norbury, 2008, p.797) sharing knowledge

through an increased investment in research would be beneficial for psychologists and their clients.

3.7 Implications of these Findings for Policy-making, Training and Practice

Counselling psychologists are able to work with this client group in accordance with the Health Professions Council's competencies for practice (HPC, 2009) and BPS (2006). The HPC (2009) describe counselling psychologists as being concerned with subjectivity and, because of differences in training, distinctions between counselling and clinical psychologists are identifiable. NHS jobs are, however, now regularly advertised as suitable for both professions and this survey similarly has compared and contrasted the knowledge of both groups. The results showed the level of knowledge was significantly less for counselling psychologists than for clinical psychologists and this should be addressed.

The literature suggests that individuals with SLI/PLI are in danger of developing mental health problems (Clegg et al., 2005) but it has been said that mental health professionals, whose work depends primarily on verbal interchange, seldom receive formal training in language development [or language impairment] so impairment may not be identified (Giddan et al., 1996). (It was noted, however, that their study was based on DSM-III-R and excluded developmental expressive and receptive language disorders.)

Doctoral courses for counselling and clinical psychologists should include information on language development and the differences between different types of language impairment (the confusion around which is illustrated in Question 13, Chapter 3.4.5, p.39) and how clients with SLI/PLI can be helped to engage in therapy.

3.8 Study Evaluation/Critique

The survey provided comprehensive and valuable data on psychologists' knowledge and understanding of this field. This data was significantly enriched by the provision of free text.

However, there were a number of ways the questionnaire might have been improved. A pilot study to test the questionnaire was considered to improve the design that may have eliminated some of the questionnaire's limitations and improved data quality. For example, three respondents reported that they did not provide therapy but undertook assessments. Although the covering letter was clear that the survey was concerning counselling, Questions 9 asked if they had "experience working with" and question 18 asked if they had "experience with"; these were not sufficiently explicit and would have benefitted from the inclusion of the word "therapeutically".

In Question 5, more meaningful results may have been yielded by asking about the year of completion of training, rather than age group.

Question 6 on formal definitions was intended to identify whether there was an understanding of the various definitions provided in Chapter 1 (pp.2-3). There were two ways this question could be improved: firstly, respondents might have been asked to give their own explanation of the formal definition so that it might have been possible to determine whether those 4% who said they were familiar were aware of the above definition; secondly, they may have not understood the phrasing of the question, although no-one expressed this in the free text.

In Question 15 numerous references to activities in addition to therapy were made and this might have resulted from the use of the word "assessment". It was intended to refer to psychological assessment prior to the commencement of counselling but was interpreted by some to mean "care" proceedings and medico-legal/diagnostic

assessments etc. that do nonetheless require a relationship between the assessor and the assessed.

However, the second part of the questionnaire required completion by those with appropriate experience. An extensive preliminary scoping exercise had not identified sufficient experienced psychologists for IPA interviews; therefore it was unlikely that there would be sufficient participants for both a pilot study and the final questionnaire. Combined with time constraints, this made a pilot study impracticable, although the questionnaire was tested to establish the time needed for completion by a typical respondent.

When it became clear that the response rate was low, the sample size might have been increased by sending a reminder to those who did not reply. However, this was not possible as all replies were anonymous. Sending to all 1,170 psychologists would have risked respondents being irritated and/or replying twice and it would have been very labour intensive and time consuming.

The results as a whole should be interpreted with caution. There is a possibility of participant-bias as those who agreed to participate may differ from those who did not in terms of knowledge and understanding. Also results were analysed with a degree of researcher interpretation.

3.9 Conclusion

This chapter illustrates the challenges of research in this “complex and difficult area” and provides quantitative data on psychologists’ knowledge of SLI/PLI and their experience of working with this group. However, the response rate to the survey was low, counselling psychologists were under-represented and the critique suggests the conclusions should be interpreted with caution.

It was found that there was general lack of awareness of both nomenclature and formal definitions although clinical psychologists were more likely than the other psychological disciplines to be familiar with terms and definitions. Two-thirds of the respondents were not familiar with any of the formal definitions.

Confusion between SLI/PLI and other conditions where language was affected, such as learning disability and ASD, was evident. Psychologists' experience of working therapeutically with the SLI/PLI client group was limited with less than a third of the respondents reporting any experience and the mean number of clients was 13.3. Only six respondents raised concerns about the appropriacy of working with formal diagnosis.

The survey shows that although those psychologists who responded are confused about the nature and presentation of SLI/PLI they do engage both with this population, for whom language impairment is a specific/primary problem, and also the numerous other individuals with other conditions having associated language problems that create a barrier to engagement in therapy. Typically using CBT, they are individually constructing modified therapeutic approaches that they believe will be beneficial, although very little use of flexible sessions, working with others and taking account of client's needs was reported.

Previous research has shown that individuals with SLI/PLI may develop significant mental health problems and these results combined with the dearth of research in the field of psychological counselling for individuals with SLI/PLI. Overall the depth of knowledge was reported to be less-than-adequate for all of the terms suggesting a need for further research.

“I think a better understanding of these difficulties will be very beneficial to the clients concerned.” Respondent 57516.

This chapter addresses the research question and eight Chartered psychologists were willing to participate in a face-to-face interview (Chapter 5.2.2, p.96).

Chapter 4

Interpretative Phenomenological Analysis (IPA) of Interviews with Young Adults with SLI/PLI

4. IPA Interviews

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Abstract

Objectives

This chapter explores and analyses the lived experiences of young adults with SLI/PLI to identify themes that illuminate their essential qualities.

Design

The client group was a closely-defined population of young adults with SLI/PLI (diagnosed in childhood and in the absence of autism or Asperger's syndrome). They had not received psychological counselling. Interpretative Phenomenological Analysis (IPA) was the chosen methodology. A semi-structured interview schedule was designed. In addition direct questions were included on their expectations of counselling/counsellors.

Method

Three young adults were interviewed. The interviews were recorded, transcribed and analysed using standard IPA methodology. This included an iterative process of annotating and producing emergent themes. The transcripts were coded in blocks to facilitate an audit trail.

Results

Three super-ordinate themes emerged: The Identification of the Selves (with six themes); Resilience (with two themes and eleven sub-themes); and Psychosocial Adjustment (with two themes).

Conclusions

The emergent themes demonstrated a surprising level of congruency; the young men presented with a range of integrated selves and resilience mechanisms. They had awareness of the difficulties of life transitions and sufficient self-efficacy to enable change.

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4.1 Introduction and Rationale

Joffe, Cruice and Chiat (2008, p.xxiii) state that “Whilst most of us are clear about the importance of obtaining the clients’ perspective of language impairment and of the impact it has on their lives, very little has been generated in this respect particularly with developmental language disorders.” This research addresses this by putting these people at the centre of any advancement in the delivery of psychological counselling.

This chapter addresses the research question for Chapter 4 (Chapter 2.7, p.25). This age group coincides with Erikson’s psychosocial stage in which failure to achieve intimate relationships can lead to alienation and isolation (Erikson, 1977; Corey, 2001; Erikson, 2005).

Individuals with SLI/PLI have not previously been the subject of an Interpretative Phenomenological Analysis (IPA) study although the approach has been used successfully with many types of participants in health, clinical and counselling psychology. Specifically, it has been used with those with learning disability where language abilities would also be affected (Leggett, Goodman & Dinani, 2007; Macdonald, Sinason & Hollins, 2003).

Qualitative methodology is considered particularly appropriate where the field of interest is characterised by complexity and ambiguity and where, as in this case, there is limited prior theory (Richardson, 1996). Also, IPA has previously been paired with other qualitative methods such as grounded theory (Whittington & Burns, 2005). In this study it is interconnected with thematic analysis (TA) in Chapter 5 (p.92).

IPA is an idiographic approach appropriate for a phenomenological inquiry that explores in detail participants’ subjective and personal experiences [through language] (Smith & Osborn, 2003). “The participants are trying to make sense of their world; the

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researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn, 2003, p.51).

Smith has pointed out that IPA may be described as inductive, as there is no attempt to test a pre-determined hypothesis: “the aim is to explore, flexibly and in detail, an area of concern” and guidelines can be adapted by researchers based on their objectives (Smith & Osborn, 2003, p.53).

For example, individuals with childhood diagnoses reconfirmed in adulthood were recruited. This meant that they would not bring to the interview unhelpful negative emotions associated with “wasted” years having “lived without a diagnosis” (Young, Bramham, Gray & Rose, 2008, p.499).

At the time of conducting the interviews there was no awareness of the precise nature of the clients’ difficulties, only that they had been given the diagnostic term SLI, PLI or SLI/PLI in childhood research and these diagnostic terms were subsequently confirmed prior to participation in a recent research study (Whitehouse et al., 2009a; b).

4.2 Design

4.2.1 Measures. The measures (i.e., interview questions, Appendix 11, p.203) were determined to engage the young adults with SLI/PLI very generally in an exploration of their lived experiences. The areas covered were:

- How they feel about life;
- The impact of their language problems;
- Help and support they had received;
- Their diagnosis and its impact.

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Additionally they were asked specifically, as they had not received therapy, what type of help from counselling/counsellor and what type of relationship might be beneficial.

4.2.2 Participants. The client group was a closely-defined population of young adults with SLI/PLI (in the absence of autism or Asperger's syndrome). All had average non-verbal intelligence and were in the age range 18-35.

Anyone with experience of counselling/counsellors was excluded from the study, firstly to prevent good or bad reminiscences of their experience. Secondly, because determining whether their therapy had sound psychological underpinnings was likely to be difficult. Thirdly, prior counselling experience would have compromised the process of interconnection (Chapter 5.1, p.94) by influencing their lived experiences.

4.3 Method

4.3.1 Procedure.

Ethical approval

The full study summarised by the overarching research aim (Chapter 2.7, p.25) required the approval of the University Ethics Committee. The ethics application and research agreement letter are shown in Appendix 4, (p.174). Overall, the proposal is Category B as it involves vulnerable, young, language-impaired adults.

Recruitment

Professor Dorothy Bishop, Professor of Neuropsychology at Oxford University, was asked for help recruiting from her database young adults with SLI/PLI who had participated in the longitudinal study by Whitehouse et al. (2009a; b).

A covering letter from Professor Bishop (Appendix 12, p.206), a research information sheet (Appendix 13, p.207) written using the Flesch-Kincaid Index

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(readability test) at an eight-year level and a consent form with a reply paid envelope to the researcher were mailed by Professor Bishop to 10 young adults who were potential participants. Three replies with signed consent forms were received and interviews were arranged.

Semi-structured interview schedule

The schedule (Appendix 11, p.203) was drafted and amended in accordance with guidelines for semi-structured interviews by Smith & Osborn (2003) and Smith, Flowers & Larkin (2009).

Complex questions were avoided and the language was kept to a reading level similar to the information sheet to take account of receptive and pragmatic problems. Shorter and/or more explicit questions as prompts would also enable participants with expressive language problems to provide shorter answers.

A young man of 27 with SLI/PLI who was not participating in the study was shown the interview schedule and asked for his comments. No changes were made. The schedule was also seen by the supervisors.

Semi-structured interviews

The three participants were interviewed by the researcher, following an initial conversation to establish rapport (see Chapter 4.8, p.89) during which they were asked to agree a pseudonym. All of the participants were asked to confirm their pseudonym on the recorder and a number of points including that they had read the information sheet and signed the consent form (Appendix 13, p.207 and Appendix 14, p.208).

Arrangements were made with a university supervisor to ensure personal safety as the interviews were taking place in the participants' homes (see Chapter 4.8, p.89). Two

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from the client group, Atlantian and Marcus, were also asked if they wished a parent or carer to be present but both declined. The third, Snooks, was married with children.

As suggested by Smith and Osborne (2003) a process of funnelling was attempted whereby having asked an open question more specific issues were probed that were of particular concern. Combined with this, there was a process of frequently feeding back the key point(s) from a particular exchange to confirm the interviewee's and the researcher's understanding.

Each interviewee was asked at the beginning of the interview to say something about himself (not about his language impairment) and at the end to name a wish. The effects of the interviews were constantly monitored so that appropriate action could be taken if non-verbal behaviours or responses suggested discomfort (Smith et al., 2009). At the conclusion of each interview there was a private debrief (BPS, 2006, Section 3.4) to ensure that the participant was in no distress. There were no reports of distress.

As the men had no counselling experience it was unlikely they would refer to psychological therapy in their lived experiences. (The reason for this selectivity was given in Section 4.2.2, p.60). Therefore, clients were asked closed questions in respect of counselling.

4.3.2 Method of data analysis. There were a number of steps in the analysis:

- The audio recording of the interviews were transcribed and checked twice against the recording;
- Questions and responses were allocated block numbers so that an audit trail was generated;
- Transcripts were annotated with summaries of content, conceptual interpretation and linguistic observations;
- Annotations were reviewed and revised;

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- Preliminary emergent themes were developed;
- Emergent themes were generated, consolidated into Super-ordinate themes and sub-themes created;
- A final summary table was produced;
- Quotes were identified to support and illustrate the analytical process.

The process was iterative, carried out after all of the interviews and required an intensive level of cognitive immersion in the transcripts. A fully-referenced and detailed account of this process appears in Appendix 15 (p.209).

The client's expectations of counselling and counsellors were analysed separately (Chapter 4.4.3, p.79).

4.4 Results

4.4.1 Sample descriptions. Three young male adults with SLI/PLI volunteered to be interviewed. They are regarded as an homogenous group although they may not be a random selection of this population. They are described in Table 4.1.

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Table 4.1

Sample description of young adults with SLI/PLI

Pseudonym/ length of interview	Gender/ ethnicity	Age	Marital status	Domicile	Employ- ment	Education
Atlantian 130 minutes	Male/ White British	30	Single	With parents	Professional in IT (Full-time)	<i>Statement of SEN</i> <ul style="list-style-type: none"> • Specialist speech and language school • Mainstream secondary school • Further education (vocational)
Marcus 83 minutes	Male/ White British	29	Single	With mother	Voluntary work (Part-time)	<i>Statement of SEN</i> <ul style="list-style-type: none"> • Special school • Further education
Snooks 45 minutes	Male/ White British	31	Married	With wife and children. Owns his own house	Unskilled (Full-time)	<i>Statement of SEN</i> <ul style="list-style-type: none"> • Special school • Work-based training

Note. The Education Act (1996) legally defines children with Special Educational Needs as having considerably greater difficulty in learning than others of the same age. A Local Authority may decide to make a statutory assessment and produce a Statement identifying needs and provision.

4.4.2 Themes emerging from clients' interview data. Three Super-ordinate themes emerged from the data: Identification of the Selves (with six themes), Resilience (with two themes and eleven sub-themes) and Psychosocial adjustment (with two themes).

They are summarised in Table 4.2. below:

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	Atlantian	Marcus	Snooks
Super-ordinate Theme 1: Identification of the Selves			
Theme 1.1: <u>Self-awareness</u>	<i>"I'd say I'm clever, not very clever. I mean, a lot of people think you're very clever if you can Google." [A688]</i>	<i>"Sometimes I need someone to, to say things twice, another one more time, or maybe another couple of times before I can get it in my thick head at least." [M136]</i>	<i>"I just ignored that, [the language impairment] and if she doesn't like the way I am. Like that, you cannot help that, like, can you? You cannot be someone who you're not." [S209-213]</i>
Theme 1.2: <u>Distorted or incomplete self-awareness</u>	<i>"I've wondered, if in the past, there's something slightly more to the pragmatic language impairment. Such as peer relationships." [A912]</i>	<i>"when I was old enough to understand she [mother] told me but I can't remember what it [the language impairment] was." [M157]</i>	<i>"It was because of ... I dunno ... because of me ... I don't know ... No, no, I don't know, I can't remember, I would have to ask me dad [why I was at a special school." [S82-84]</i>
Theme 1.3: <u>Educated self</u>	<i>"got B in English literature, which was me worst subject I thought." [A476]</i>	<i>"they [the special school] taught me how to live life as close to normal as possible. I think they did a really good job, cause when I left I really felt I was gonna miss the place." [M244]</i>	<i>"... I was put in for NVQ Level 2 in the cooking prepping. I've just passed that. And I'm just getting my maths adult numeracy. Level 1." [S23]</i>
Theme 1.4: <u>Emotional self</u>	<i>"... having to go to, having to play out and not knowing how or what to play. [This upset him and he cried.] Well quite a bit actually, quite fairly often actually." [A500-504]</i>	<i>"It's hard. It's hard. It's hard for me to show any, any emotions especially when a when death in the family happens." [407]</i>	<i>"I feel happy. Just go to work, you know. Like everyone one I guess." [S45]</i>

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	Atlantian	Marcus	Snooks
Theme 1.5: <u>Family self</u>	<i>“long-suffering mother gets up with the dog and does the toast....” [A270]</i>	<i>“Happy to stay with mum [but] there are times when we want to kill, kill each other.” [M676]</i>	<i>“... I’ve been married last ... it wasn’t last year, the year before ... for two years next week. Three kids. I’ve bought a house.” [S39]</i>
Theme 1.6: <u>Social self</u>	<i>“either go out with me dad or, as I much prefer, to like, much prefer in most cases, to go out on me own.” [A292]</i>	<i>“[At school] I got me and two of the lads, they couldn’t separate us at all, and they say now three’s a company and four is a crowd because they couldn’t separate us, all three, all of us.” [M258]</i>	<i>“... They’ve all moved, they’ve all moved on you know, all getting older and moved on and found partners and stuff so ... You cannot do as much as that, like, you know?” [S57]</i>

Super-ordinate Theme 2: Resilience

Theme 2.1: Defence and coping mechanisms

Sub-theme 1: <i>Adapting including accepting external help</i>	<i>“actually had to get out of PE lessons completely and instead did swimming, went to, went to the local baths across the road from the school instead.” [A494]</i>	<i>“[College] taught me don’t worry about it at all if one person likes you one person does and if another person doesn’t, just at least one person does.” [M214]</i>	<i>“She [wife] helps us out on things, you know, but. Even if I ask her about spelling she’ll go right come on then spell it out and go through the alphabet and we’ll get there eventually.” [S195]</i>
Sub-theme 2: <i>Avoidance</i>	<i>“... try to avoid the playground by going into the library during dinner times.” [A506]</i>	<i>“That’s the best advise I’ve given myself over the last couple of years. I just don’t think about it.” [M397]</i>	<i>“I’m not bothering you know. I just get on with life you know. Go to work. Come home. Go to bed. Go to work. Pfft. On me computer. Play with me computer games.” [S438]</i>
Sub-theme 3: <i>Being “frozen”/ “overloaded”/ “overwhelmed”</i>	<i>“It’s almost as if ... the bucket overflows. I thought I’ve had enough.” [A349]</i>		

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	Atlantian	Marcus	Snooks
Sub-theme 4: Creativity	<i>"... some of me drawings have been likened to the works of Gilles Tréhin, the lad behind the book Urville." [A397]</i>		
Sub-theme 5: Denial	<i>"... me sister even thinks 'he's an Aspie'." [A874]</i>	<i>"I'm not bothered that they don't understand me at first ..." [M94]</i>	<i>"No-one knows, no one knows that it, even at work, they didn't know I went to a special needs' school, they don't know at all. No-one, no-one knows." [S344]</i>
Sub-theme 6: Distraction	<i>"Bumming about on the *** bus network." [A203]</i>	<i>"Since I got the bus pass I can go out on the buses anywhere." [M352]</i>	
Sub-theme 7: Flight	<i>"I would just feel better if I were able to leave, I mean. [I caught] ... the first bus I could grab." A634]</i>		
Sub-theme 8: Humour	<i>"... like a Mac user in a classroom full of Windows users." [A530]</i>	<i>"It'll probably take me another twenty or thirty years to speak properly but I'm getting there." [M126]</i>	<i>"Oh, yeah, I've been in trouble with her lots of times. Oh, on the wrong end of the stick!" [S136]</i>
Sub-theme 9: Persistence	<i>"I would say the most important thing about, about me has been the persistence given the, given the situation I've been landed in ..." [A220]</i>	<i>"Next day my luck may, may, may change. So that's what I keep thinking in my head. Next, tomorrow may change. So that's it. That's all I keep telling myself." [M315]</i>	<i>"It took us the third, it should have taken about two attempts but the first time I done it their computer crashed and I was really doing really well, and, so, I hadn't, they couldn't get it back on so ... And then the second time I failed. It took us the third attempt. But that was just because the first time you know, it would have only took us twice." [S160-163]</i>

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	Atlantian	Marcus	Snooks
Sub-theme 10: <i>Rationalisation</i>	<i>"I would say, I mean, I didn't really think I was a different thing, I mean, different perhaps, could be differently-wired differently." [A526]</i>	<i>"That's one good thing ... that's one good thing being disabled you get a free bus pass...." [M84]</i>	<i>"... I think back in my day it was like, if you had a problem, that's it: whiiiit! Into one of them schools. But it's not like that now, is it. It's like, if you've got problems they'll keep you out that school." [S181-183]</i>
Sub-theme 11: <i>Structure/ routine</i>	<i>"... everything's like done to a, done to a set routine, otherwise I feel it all falls apart, like, you miss buses." [A278]</i>		
Theme 2.2: <u>Self-esteem and self-worth</u>	<i>"Co-contributor to a book which has been published since April 2008." [A634]</i>	<i>"Now it's [speech is] coming as second, second nature to me now. Took nearly thirty years to do it [M laughs] but, but I'm getting there now." [M124]</i>	<i>"I proved them, I proved them wrong. Strange. I passed the courses. I passed all the courses. I done the weapon handling test, I done every, so I passed." [S236-238]</i>
Super-ordinate Theme 3: Psychosocial Adjustment			
Theme 3.1: <u>Self-efficacy</u>	<i>"... The second year didn't work out. [A162] I took a ninety-degree turn again and went on to doing desktop publishing." [A164]</i>	<i>"with broadband to pay, and I got a, like a, another account, like a ISA account to pay twenty quid a month [before socialising]." [M78]</i>	<i>"The hours weren't very good, like. Some days, some weeks I was working twenty hours. Some weeks ten. Various." [S33]</i>
Theme 3.2: <u>Life transitions</u>	<i>"Obviously, quite a jump for anybody, not just any, not just anyone in special school, even private school, primary, even from junior school, it's another culture shift again." [A492]</i>	<i>"About two or three months [at college] before I got to know anyone properly." [M820]</i>	<i>"... I thought I shouldn't have went to a school like that, because that was really for special needs ... and I thought I would ... I thought I could still go to like a normal school but." [S68-70]</i>

Note. Referenced definitions of themes are provided in Chapter 4.5 (p.82). All of the participants share the same Super-ordinate Themes but not all themes or sub-themes (for

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coping and defence) are shown to be shared by all participants and there are individual differences to the extent that these themes or aspects of the data are prevalent in individual participants. Quotes are used to illustrate themes; some quotes apply to more than one theme but are used only once. The absence of a quote to support the theme does not suggest there is conclusive evidence that the theme is not present for a client. Block numbers from the transcripts are in [square brackets]. There is no intention to suggest that the participants themselves are knowingly aware of these research-determined themes.

4.4.2.1 *Super-ordinate Theme 1: Identification of the selves.*

Themes 1.1 and 1.2 Self-awareness and incomplete and distorted self-awareness

Over the last seven years Atlantian has worked “*gainfully*” for internet companies. [A23] Marcus works voluntarily in a charity shop [M34] and Snooks works for a contract catering company washing pots and pans and undertaking general kitchen duties. [S19]

Atlantian alone shows considerable awareness of language impairment nomenclature/diagnosis saying he has “*semantic pragmatic disorder*” [A816] and he describes the early literature by Isabelle Rapin and Doris Allen, 1983. [A818, A820] However, evidence of his incomplete understanding of the full effect of PLI, despite his familiarity with the literature, comes later in the interview when he explains that in the past he has wondered if there is something more to pragmatic language impairment such as peer relationships. He reflects that the only peer relationships he has had have been through work, less so school. [A912]

He describes how he sometimes misunderstands and takes things the wrong way, [A532] concluding his problems seem to be far less pronounced than fifteen years ago. [A536]

Marcus by comparison struggles to explain the name and nature of his language problems saying that people have said what it is but he would need to ask his mum before being able to answer the question. [M145] He believes his language difficulties

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continue to affect his ability to find work and realises he can communicate more effectively face-face than over the phone as he knows that sometimes he tries to telephone and people do not understand the words he is trying to say. [M20]

He then describes receptive language problems, although he does not identify them as such. He struggles to find the words to describe how he sometimes needs people to say things twice or several times [M134] before he understands and can then think of the right words to respond. [M138] This is done in a self-disparaging way, describing his “*thick head*” [M136] that is concordant with his subsequent notion he is an “*idiot sometimes.*” [M165]

Snooks, like Marcus, could not remember the nature of his problems [S102] although later (when prompted with a closed question) he says expressing himself is a bigger problem than understanding although sometimes it is a little bit of both. [S128]

However, he works to ignore his language problems. Taking his wife out for the first time was not stressful for him. [S205] He said:

“I just ignored that, [his language problems] and if she doesn’t like the way I am. [S209] Like that, you cannot help that, like, can you? [S211] You cannot be someone who you’re not.”
[S213]

Theme 1.3 Educated self

Atlantian moved from a specialist language school to a mainstream secondary school. [A504] He and Marcus both attended colleges and Snooks returned to studying through employment.

Atlantian had some learning problems. English was not a problem but he needed additional support with mathematics but then he acknowledges he had difficulties with understanding the questions in textbooks and exam papers. [A474] When he left school

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and went to college he did not request help with his studies because it seemed unnecessary. [A922] He found college positive and said he learnt more after he left school. [A946]

Marcus attended a “*a special school for disabled people*” [M226] when he was six [M222] and this was a positive experience. He confirms that most of the time he was “*happy for some reason*” [M553] and that he liked “*that place*”. [M230]

Snooks attended the same school. He was totally unable to explain why he was there [S82] but says he was not happy because the level of work he was required to do was comparable to the work his daughter would have done at primary school. [S80]

Later, however, Snooks contradicts that he was “*not happy*” at the school saying that he was “*not miserable*.” [S177] However every time he went there he thought:

“... *why am I here for?*” [S175] ... *I coped, you know, but I felt as though I shouldn't have been there. I should be at a normal school, you know, with normal kids.*” [S179]

Marcus's emphasis was, and continues to be, on his speech rather than any language difficulties and it is not clear whether he is aware that he has language impairment. He explained that the only time that he had help with speech was when he was at school [M571] and that when he went to college he had to “*Get on with it.*” [M569]

Like Atlantian [A922], Marcus did not ask for help at college because he felt his speech had improved and he could be understood. [M579] At school, although he could speak, his speech had not been clear enough for people to understand him. [M581]

Now employed, Snooks reflects on his progress at school. He, like Atlantian, believes that he has made more progress since leaving school. [S364] At work he had

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just passed his NVQ Level 2 in cooking prepping and was just getting his adult numeracy Level 1. [S23] With evident pride he points to the wall at his certificates and explains that his present company is the only one that has encouraged him to work towards qualifications. [S29]

He still reflects on what might have been and how his life might have been different:

“... I would love to have all these GCSEs I would, I had all them up. I would’ve done something totally different in me life.”

[S448]

But then with a note of self-doubt he adds that he probably would not have made it. [S450]

Theme 1.4 Emotional self

Atlantian does not disguise his emotions and during the interview he was tearful. [A327] At secondary school Atlantian cried often. [A504] He describes how PE was terrible for being taunted and how he struggled to get used to the changing rooms and all the banter. [A492] He also struggled with the “*tribalness of the enforced break times*” and having to play outside and “*not knowing how or what to play.*” [A500]

When asked if there are times now when he feels “a bit low”, “a bit stressed” Atlantian found it difficult to answer and needed to think for a long time about it. [A310] He finally responds, ending with a laugh as if feeling uncomfortable:

“Sometimes I think, feel like a fish out of water if say, um,

[Pause] I’m still, still thinking.” [A312]

He also described an enjoyable weekend when he stayed overnight in an hotel and shed tears of joy. He describes how as soon as he left the hotel he broke down:

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“... thinking I’m free, thought ‘This is fantastic, this is just fantastic’ and it continued even, not so much the sobbing but the happiness continued even more.” [A367]

Marcus has worked to control the anger he directs mostly at himself so that when people do not understand him he does not get angry as he did when he was younger. He says that it has taken the last 10 to 15 years since he left school to learn how to live with it and calm himself so that he can speak properly. [M368]

When speaking about how he responded to the death of his father he says:

“It’s hard for me to let people in [M417] especially when I’m hurting.” [M419]

During the interview Snooks was most emotional when he spoke about his schooling, being frustrated by his lack of education. He explained that he did not want to tell his friends what kind of school he went to. He wanted to go to a normal school but this was refused. [S96]

Theme 1.5 Family self

Atlantian lives with his parents, Marcus with his widowed mother and Snooks owns his own house and lives with his wife and three young children.

Atlantian did not suggest a strong sense of family compared with his other selves. He said his mother was “*long suffering*” [A270] and his father had “*depression.*” [A670] He is close to his younger sister and his aunt both of whom live some distance away. [A626, A610]

Marcus has a sister and a brother-in-law. [M497] They live about three streets away from him [M501] with their son. [M499] He says he is happy to stay living with

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his mother because the rent is cheap. [M676, M672] This was despite the fact that there were times when they wanted to kill each other. [M678]

Snooks sees himself as a family man and as being:

“Happy as Larry.” [S37] “I’ve got my three kids there. I got my little boy, eventually. First off with girls. I’ve been married last ... it wasn’t last year, the year before ... for two years next week.” [S39]

Theme 1.6 Social self

Neither Marcus nor Snooks had significant social networks beyond their immediate family.

Atlantian has few friends and no intimate relationship. [A558] He acknowledges the only friends he sees *“in the flesh”* are from current and previous employment, others are from social-networking sites. [A298] He does however have his own internet sites and has a number of interests that are explored under his Creative self.

At school Marcus had two friends and they were inseparable. He described this as three being a company and four being a crowd. [M258]

He also says he had a girlfriend. [M455] The relationship lasted two months [M467] but he was unclear how long ago it was. He first said it was two years ago [M469] and then that it was over five years ago. [M474, M476] He cannot recall where he met her and does not appear to want to talk about her. [M478]

Snooks does go out with his wife on special occasions [S51] but has no friends as they have all grown older, moved on and found partners. [S57] But he recalls a time when he went nightclubbing with a friend who also had language difficulties. [S122]

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4.4.2.2 *Super-ordinate Theme 2: Resilience.*

Theme 2.1 Defence and coping mechanisms

Sub-theme: Adapting including accepting external help

At secondary school there were numerous named individuals Atlantian could contact for help with his feelings. He was also able to go to the special needs room during dinner time or to the library to avoid going to the playground. [A506]

Marcus remembers college as his best years, as there he learnt an important lesson:

“... it teached me ... that, in one sense, because it doesn’t matter how many people you know, if one person likes you, that’s OK.

[M214] ... they told me, don’t worry about it. Everyone, everyone doesn’t like everyone else, but one or two people do.”

[M216]

When Snooks was asked how having a wife had changed his life [S143] he chose to respond that she helped him, particularly with writing and spelling, [S144, S148, S195] showing a significant level of dependence on her.

Sub-theme: Avoidance

Atlantian wisely avoids situations where he feels bullied. For example, he needed to avoid PE lessons completely because of being taunted and instead went swimming at the local baths across the road from the school. [A494]

Marcus copes and defends himself by not thinking about things. When he was asked whether he had ever felt just anger at the language problem [M392] he replied:

“... That’s the best advice I’ve given myself over the last couple of years. I just don’t think about it.” [M397]

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When mention was made of how being at the special school had made him feel Snooks too confirmed he puts it out of his mind. To illustrate the point he said that once the researcher had left, that would be it; [A436] he would not be bothering. He just gets on with life; goes to work, comes home, goes to bed. He would be on his computer, playing with his computer games. [S438]

Sub-theme: Being frozen/overloaded/overwhelmed

These are words adopted by Atlantian when he is struggling to cope with a situation that he is finding intolerable. As if he is in sensory overload. He felt overwhelmed at the christening and repeats this word several times [A343; A345; A347] concluding that:

“It’s almost as if ... the bucket overflows. I thought I’ve had enough.” [A349]

He had a similar experience in a busy pub with a lot of background noise. He said

“Sometimes I would, I would stop dead in such situations, sort of still listening, still in some way aware of what was going on but I sort of stopped dead, almost like frozen.” [A552]

Sub-theme: Creativity

This is the second sub-theme shown only by Atlantian who has a number of creative outlets. (See Self-esteem and Self-worth, Theme 2.2, p.76). He has “*created and maintained*” two websites including one focusing mostly on his own musings and any news relevant to the area where he lives. [A34; A52] He draws, he says, in the style of Gilles Tréhin. [A397] He also writes poetry and describes how important it is for him as if it is a form of self-taught therapy. With what he describes as a tickle in his throat, that makes him cough [nervously], he refers to this as “*self-disclosure*” and

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acknowledges that it has helped him [A407] although he was “*never one for self-disclosure.*” [A409]

Sub-theme: Denial

Atlantian believes he has Asperger’s syndrome rather than SPLD [A870] and this is supported by family and friends. [A874] He was reassessed by the NHS in 2004. [A864] He thought it was a “*brush off*” when the attempt to be re-diagnosed failed [A886] but he has not ruled out seeking a private option. [A882]

Marcus explains that he is not bothered when people do not understand him the first time they hear him speak because, eventually, when he has said something a second or third time they do understand

“... *Just. It’s hard to put into words all I’m thinking.*” [M94]

In a statement of what seemed to be denial rather than lack of awareness Snooks states that his language impairment has not affected him at all. [S191] He is certain that no-one knows, even at work, that he went to a special needs’ school. For emphasis he repeats that they do not know at all; no-one, no-one knows. [S344]

Sub-theme: Distraction

At his secondary school Atlantian was taunted in the changing rooms [A492] and this stopped him going to the gymnasium. However, he walked through the hills rather than “*going to a faceless gymnasium with tread mills. Obviously being gifted by the scenery around this area.*” [A496]

Atlantian [A203] and Marcus both have bus passes. Marcus says if he were stuck in the house he would be miserable, but with the pass he can go anywhere. [M350, M352] If he does not want to go to the pub he just rides the buses for a night out. [M344]

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Sub-theme: Flight

This is the third sub-theme that applies only to Atlantian. Sometimes he plans in case he has the flight response by taking his bus pass such as when he attended a family christening. [A357]

“... As soon as the service finished I wanted to go out ... I was heading towards the bus stop and thought ‘I’ve got to get out of it. I’ve had enough’.” [A321]

Other times it is unplanned. He recounted how he had found out a friend had committed suicide as he was about to leave work [A630] and he told them he just wanted to leave. [A632] He left and caught the first bus he could get. [A634]

Sub-theme: Humour

Atlantian often uses humour. With insight and a laugh he speaks about how at school he did not really think he was a different thing. He could see that perhaps he was different but it could be that he was “*differently wired*.” [A 526] He explains this by saying wittily and again with a laugh:

“So, so like a classroom, so like a Mac-user in a classroom full of Windows-users.”[A530]

Then, when asked if he is clever he quickly puts the question into context:

“Well I would say, I’d say I’m clever, not very clever. I mean, a lot of people think you’re very clever if you can Google.”

[A688]

Marcus is also able to direct his humour at himself when he responds that it will probably take him “*another twenty or thirty years to speak properly*” but that he is “*getting there*”. [M126]

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During the interview Snooks uses the phrase “wrong end of the stick” to mean that when he “*gets the wrong end of the stick*” (misunderstands) he “*gets the wrong end of the stick*” (i.e., in trouble with his wife). [S138]

Sub-theme: Persistence

Atlantian recognises his own persistence. In fact he claims that it is the most important thing about him, given the situation he has been landed in. [A220]

Marcus continues to be optimistic that he will find a job:

“In the beginning I don’t, I didn’t have any [strength to keep going] in the beginning, but now I say, well another day [indistinct] another day, next day my luck might change ... That’s all I keep telling myself.” [M315]

A snapshot of Snooks’ persistence is of him sitting an on-line exam. He made three attempts to pass. The first time the computer crashed when he was doing really well but there was nothing that could be done to make it work. [S160] The second time he failed and so he tried again. Had the computer not crashed he would have passed at the second attempt. [S163]

Sub-theme: Rationalisation

Sometimes Atlantian’s self-esteem has been at risk, but he is able to rationalise. His teacher asked the form which pupil they thought was “*different*” (see Sub-theme: Humour, p.74). He says obviously his name came up. [A514] He did not know why she asked that. It was probably, he deduced, the wording of “*different*” [A516] because:

“I don’t see meself different at all ... But then again I probably didn’t realise for the first 23 years or so.” [A laughs.] [A522]

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Then at the end of the interview, when discussing his lack of peer relationships Atlantian rationalises this by saying:

“... I don’t like that sort of thing [getting too involved with people] because I also like me own space too much. As well, as well as seeing them, and likewise they probably would too.”

[A914]

Marcus rationalises his disability by saying that he gets a free bus pass [M84] and Snooks’ difficulty with language extends to the written word although he blames being “big headed”:

“I don’t understand sometimes the, the instructions on things [S350] Yeah. I can understand some of these instructions, I just. I think with that, I know what I’m doing ... I’m just too big headed you know, I just do my own thing you know and I get it wrong.” [S352]

Sub-theme: Structure/routine

The fourth sub-theme shown only by Atlantian. He starts the day by doing everything to a set routine as otherwise it all falls apart: he misses the buses. [A278]

Theme 2.2 Self-esteem and self-worth

As already described, Atlantian is a creative individual. He is additionally co-contributor to a book published since 2008 [A634] and regularly takes part in lectures [A415] that increase his self-esteem and self-worth.

Evidence for self-esteem is not immediately apparent for Marcus although clearly he gets satisfaction from his voluntary work where he can “*have a laugh*” [M44] and he found his school experience worthwhile and productive. [M230] Speech, that is so

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important to him, is coming as second nature to him now after nearly thirty years.

[M124]

However, he felt his parents responded to his problems with what he called “*disappointment*” [M757] and this may have remained an abiding and possibly even a defining memory.

Snooks joined the Territorial Army in 1997 [S221] and left because of work in 2002 [S221] and although there was a teacher who did not want him to join [S224] he says:

“I proved them, I proved them wrong. Strange. I passed the courses. [S236] I passed all the courses. I done the weapon handling test, I done every, so I passed. [S238] I went, I’ve been to Germany, I’ve been to Kenya with them. Um. All over the place.” [S224]

4.4.2.3 Super-ordinate Theme 3: Psychosocial adjustment.

Theme 3.1: Self-efficacy

When Atlantian went to college and things did not work out he was able to recognise his abilities and difficulties and change his plans:

“Started off doing electronics but ended up doing admin in February 1997. [A158] The first year was quite good. The second year didn’t work out. [A162] I took a ninety-degree turn again and went on to doing desktop publishing.” [A164]

This was, he said, a better move. He took an easier course: a GNVQ that lasts for two years. [A168]

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Marcus is responsible about his money and his finances, putting his commitments to pay his broadband and to put £20 per month into his ISA account [M78] ahead of going socialising when he does not have the money. [M80]

Snooks was able to make judgements about employment opportunities. When he worked as a kitchen porter there was no training and in another job his working hours varied. [S33] In his present job he is being funded to gain qualifications. [S27]

Theme 3.2: Life transitions

Atlantian experienced some major difficulties around his school transition from specialist language school to mainstream secondary. Describing how he felt when he was trying to adjust to changing-room banter (see Sub-theme: Distraction, p.73) he says it would be quite a jump for anybody, whether they are coming from a special school or even a private school, because it is “... *another culture shift again.*” [A492]

However, the school staff gave positive feedback about his transition. Initially they were surprised at the jump he had made and the effort he made adjusting to the lessons. He believes he had no problems adjusting to the lessons provided everything was clear. [A472]

Neither Marcus nor Snooks had to change school at 11/12. When after 10 years in the same school Marcus went to college he did not know anyone at first [M816] and it was “*A bit, a bit hard.*” [M818]

People told Marcus not to worry at college [M216] but it was not until he had been there for some two or three months that he got to know anyone properly. [M820] He then made two or three good friends [M824] whom he sees now and again [M826] because he bumps into them (not because he contacts them). [M827]

Snooks has experienced a number of life transitions over recent years with marriage, home ownership and fatherhood and yet it is his missed educational

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opportunities that appear to be the most life-changing. However, he is concerned that one of his daughters is being assessed at school [S394] and he admits “... *That’s me most worries....*” [S416]

It was noticeable, however, that he did not articulate any concerns that her difficulties were similar to his own, preferring to cope with the situation by blaming boredom [S418] and lack of intellectual stimulation [S422] for her difficulties at school; such that might have been applicable to himself.

4.4.3 Expectations of counselling and counsellors. Table 4.3 (p.80) describes the young men’s reported expectations of psychological counselling and counsellors. The information in this table provides preliminary data that could inform future research into service development (Chapter 6, p.118). The clients’ opinions are useful as they give insight into their potential acceptance of counselling with an approach and therapeutic relationship that suits them. However, the clients were not able to make an informed response as they have no point of reference.

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Table 4.3

Expectations of psychological counselling and counsellors from young adults with SLI/PLI

Summarised questions	Atlantian	Marcus	Snooks
Is there prior knowledge/awareness?	When job searching some time ago the information shop offered counselling but he did not need it at the time. He knows there are different types of counselling. [A594, A698]		
To whom would he speak if he had problems?	He might speak to colleagues and feel more at ease rather than at home, or write to his immediate family or speak to his aunt if he needed advice. If unhappy he would talk 55% to mum and 45% to dad as well as to his sister. [A608, A610, A622]	He has someone to speak to. Prefers to talk to his sister rather than his mother if something is troubling him as he can talk to her more. His family live in the same area and they understand him [when he speaks] and how he feels. [M513, M515, M545]	His wife, father or even mother-in-law. [S254]
Has he considered seeing a counsellor?	He has thought about it and noted that there is a lady about five minutes walk from his office. His dad has seen a counsellor and was taught strategies to make his life better. Dad takes medication. [A646, A670, A672, A678]	Prefers to keep his problems to himself and says he has made this decision for himself " <i>It's how I am now</i> ". At the moment he is happy not to talk to anyone about anything, but when he does decide to talk he will find someone to talk to. [M521, M525, M527]	Nobody has ever suggested he might benefit from counselling or therapy and he has never asked to see one. He would consider seeing someone if he had a really big emotional problem. [S260, S274]
Should the counsellor have experience within this field?	He would like her to have experience of pragmatic problems " <i>as with knowledge she would probably be able to see the pattern of his existence over the last 30 years</i> " and be able to help him with where to go from where he had got to over the last 30 years. [A750, A752, A754]	Talking to a stranger even one specially trained would be a waste of time. As a stranger would have a hard time understanding the way he talks and speaks especially initially. [M543, M545, M547]	It would be useful if the person had understanding of language impairment. [S314]

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Summarised questions	Atlantian	Marcus	Snooks
What type of relationship would he want?	He wants to work in partnership and does not want to be told what to do and having to do it is “confrontational”. He wants a “consulting” approach. She should be like-minded with a creative personality. [A720, A758, A764]	He has no views about the type of relationship provided he had “ <i>that click</i> ” straight away with the person. It does not matter if they are friendly or not. [M722, M724, M726, M728]	
What would the counselling be like?	He would like counselling to involve the arts including poetry and drawing (anything involving creative endeavour). She would listen to him and help him change his behaviour. He would be happy to have counselling involving his mum and sister but not the dog. [A699, A702, A708, A710, A712, A734, A736, A738]	He says he would just want to talk and have someone listen (rejecting other suggestions) although there is the hurdle of not being understood. He does not want ideas about what he might do differently. [M694, M708, M711]	Just someone to talk to. When prompted he feels help with goal-setting would be useful (though he gave as an example “ <i>doing 100 press ups</i> ”). A preference for something project-based and experimenting with things. He was not at all interested in anything creative or artistic. Had he seen a counsellor when he was at school he would have told them he should not have been there “ <i>and stuff like that.</i> ” [S278, S318, S324, S328, S330, S334]
Any other observations?			When asked whether counselling might have been appropriate for him when he became estranged from his mother he said he couldn’t because “ <i>it was so different.</i> ” [S442]

Note. Participants were interviewed who have no personal experience of psychological counselling or psychotherapy. This table provides a summary of their responses.

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4.5 Critical Discussion of the Results and how these Relate to the Literature

The results and discussion have been generated by analysing cases within themes (Smith et al., 2009). The results have previously been summarised (Table 4.2, p.61).

Literature suggests that young adults with SLI/PLI are in danger of experiencing difficulties with emotional health and psychosocial adjustment (Bishop et al., 2008) with concerns they might develop psychiatric problems (e.g., Whitehouse et al., 2009b).

Despite the lack of recommended multi-disciplinary support into adulthood (Clegg et al., 1999; 2005) the emergent themes demonstrated a surprising and unexpected level of congruency; the young men presented with a range of integrated selves and an array of resilience mechanisms. They had awareness of the difficulties of life transitions and sufficient self-efficacy to enable change.

In this chapter the word self is being used to mean the totality of personal experiences and expression, the self as a living being (Reber, 1995). Interviews with Atlantian, Marcus and Snooks show that, like all of us, each has a number of selves that are powerful aspects of who they are. “Properly speaking a man has as many social selves as there are individuals who recognise him and carry an image of him in their mind” (James, 1890).

Resilience, including self-esteem and self-worth coupled with aspects of the young men’s selves, are necessary to achieve psychosocial adjustment. Self-esteem and self-worth reflect the overall opinion a person has of himself. At the heart of self-esteem are central beliefs about the kind of person someone is (Fennell, 2009). Rutter (1987) identified high self-esteem protects and low self-esteem puts someone at risk from stressors.

If the young men are to hope to fit in and live rewarding lives they need to be self-aware in their environment. This consuming process of bending and twisting to fit is a

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risk that might lead to rejection and isolation, hence the need for mechanisms of coping and defence.

Resilience can be viewed as a defence mechanism and as an important way of coping (Leipold & Greve, 2009; Davydov, Stewart, Ritchie & Chaudieu, 2010). Zautra, Hall & Murray (2010) say it may be “best defined as an outcome of successful adaptation to adversity” (p.4) and individual resilience by “the amount of stress that a person can endure without a fundamental change in capacity to pursue aims that give life meaning” (p.6). Some people have natural capacities to resolve their problems, bounce back from adversity and find the energy to pursue life goals although young [normally-developing] people are not always prepared to cope with the implications of stressful events and some emotional wounds may be left unhealed to invade awareness years later.

Dockrell, et al. (2007) found positive correlations between positive coping strategies and with self esteem (as well as emotional intelligence) suggesting the importance of resilience as a key factor in limiting the negative impact of adverse factors in young people first year post-16. They say it was found that coping skills are not dependent on children’s oral language and coping and the young person’s view of himself are related independent of language or behaviour. In the present study all three participants showed various coping/defence strategies. These included significant levels of persistence and a degree of humour. Additionally, Atlantian demonstrated considerable creativity. He draws and writes and reads his own poetry that he publishes on his own website.

A central task in adolescence is the definition of oneself in unique identity terms and the type and quality of interpersonal experiences plays a significant role in a person’s self-evaluation and emotional stability. Self-esteem and perception of social

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competence are affected by school experience (Downey, 1996; Sletta, Vålas, Skaalvik & Sobstad, 1996). Atlantian's secondary school experience was one that reduced him to tears. Marcus's experiences were positive because he was helped to speak and be understood. Snooks had a generally negative experience because he did not wish to be in a special school and found his education inadequate. However, there is now evidence to suggest all three are self-aware and show themselves to have functioning educated, emotional, family and social selves. All three have self-esteem, Atlantian being a co-contributor to a book, taking part in lectures as well as working full-time; Marcus perhaps less so (rewarded by his voluntary work); Snooks, although still troubled by school experience, has his own family and was an active and proud member of the territorial army.

A significant number of secondary school-age students have language and communication impairments that interfere with access to the curriculum (Larson, McKinely, & Boley, 1993; Conti-Ramsden et al., 2001; Joffe, 2008). Unfortunately, specialist support in mainstream settings is limited and almost non-existent in secondary school (Lindsay et al., 2005; Bishop & Norbury, 2008).

Atlantian did not receive specialist support, but some teaching assistance. Also, little specific help is available for young adults with SLI as they make the transition from school to a more choice-driven adult lifestyle and individuals are likely to fall short of social services or mental health provision (Conti-Ramsden, 2007). Both Atlantian and Marcus left school and went to college without support and did not ask for any.

Transitions are inherent steps in life. Traditionally, they are considered to involve stress whereas Wheaton (1990) points out that if people are already experiencing high stress levels then the transitions are less onerous. Schlossberg, Waters and Goodman

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(1995) distinguish between transitions experienced internally, in close interpersonal relationships, and in relation to work/areas of endeavour. These are somewhat arbitrary and there is considerable overlap (Sugarman, 2001).

Emotional health symptoms such as depression and anxiety have been investigated less than social skills difficulties (Conti-Ramsden & Botting, 2004; 2008). Palikara, Lindsay & Dockrell (2009) interviewed 54 participants with SLI first year post-16 who had taken part in the Dockrell et al. (2007) study. It is not clear whether those with PLI were included. The study used semi-structured and structured interviews and thematic analysis and found a quarter of those interviewed reported being worried, upset, frustrated or ashamed about their identified SEN, as Snooks had been and remains. All but one reported friendship being very important or quite important and there were friends from earlier schooling. When upset, family support was important, mostly mothers, and only one person told nobody. A large number of the young people participating in the Palikara et al. (2009) study acknowledged the supportive role that members of their family and their social networks were playing in different aspects of their lives.

It is evident that all three participants in this study depend on support within their family as a resource and this is also supported by Dockrell et al. (2007) who say this and the support of social networks lead to resilience. It has also been found in a 20-year follow-up study of subjects aged 25 that subjective well-being was primarily associated with strong social networks of family, friends, and others (Johnson et al., 2010). Whereas Botting and Conti-Ramsden (2008) found young people with a history of SLI performed poorly on both the friendship scale and the social activities measure.

Neither Marcus nor Snooks as an adult has significant social networks beyond his immediate family. Atlantian says he likes his own company and has work colleagues,

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internet ‘friends’ and contacts in the Asperger’s world but wonders whether his problems with pragmatics are involved in his lack of peer relationships.

An interesting common feature emerging from the interviews is that the clients seem not to fully understand the extent and nature of their own impairment, perhaps a defence/coping mechanism in itself or inability to comprehend the incomprehensible. Atlantian speaks knowingly of the literature but then he does not understand the full effect of PLI. It was also interesting that all of them felt their language problems had improved with age whereas research suggests that SLI becomes more pronounced with age (Whitehouse et al., 2009b) and the challenges widen to include areas of difficulty that are not directly concerned with communication skills (Conti-Ramsden & Botting, 2008).

Asked to imagine life in five years, 52 of those in the Palikara et al. (2009) study expected to have a job and 12 hoped to be running their own businesses by their early 20’s. Three quarters expected to be living independently from parents and a quarter expected to be in a serious relationship at that time. This raises the question of what happens emotionally if these expectations are not realised. Atlantian, Marcus and Snooks as resilient individuals appear to be able to bounce back from adversity (Zautra et al., 2010).

Conti-Ramsden, Botting and Durkin (2008) found adolescents with SLI are less independent than their typically-developing peers which is associated with poor early language and poor later literacy. The clinical implications of this are that a substantial number of young people with histories of SLI are at risk of personal, social and economic disadvantage. Atlantian, despite being “gainfully employed”, and Marcus both live with parents.

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Conti-Ramsden and Botting (2008) say there is a marked higher rate of anxiety and depression symptoms in adolescents with SLI but these do not appear to be a direct result of impoverished communicative experiences. Rather the association appears to be with the SLI itself (i.e., with the impairment). They conclude that the majority of adolescents with SLI in their study did not appear to present with emotional problems.

This current study has found that participants with SLI/PLI have considerable coping/defence resources and did not express experiencing emotional problems requiring therapeutic help suggesting that Conti-Ramsden's and Botting's participants may have been similarly protected.

All three participants provided evidence of self-efficacy making job choices that were beneficial for them. All experienced difficult life transitions. For example, moving from special school to mainstream school and being bullied, from school to college with loss of support and then to work (paid or voluntary) with its challenges and from being single to being married with a family. However, none of them has, or is contemplating, seeking help for psychosocial adjustment problems.

"Efficacy involves a generative capability in which component cognitive, social and behavioural skills must be organised into integrated courses of action to service innumerable purposes. Perceived self-efficacy is concerned with judgements of how well one can execute courses of action required to deal with prospective situations." (Bandura, 1982, p.122).

Finally, although issues of masculinity were not raised overtly by participants Marcus says it is hard for him to let people in when he is hurting. Men may believe feelings are unnecessary, time-consuming and better left unexplored and may conceal feelings of sadness and not seek treatment. They may believe there is a stigma

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associated with asking for psychological help that concerns not living up to a masculine image (Addis & Mahalik, 2003).

4.6 Implications of these Findings for Future Research

The sample size is small and results may not be generalisable to a larger population. Also, those with psychiatric diagnoses may be least likely to volunteer for such research.

This study shows that asking clients to talk about their lived experiences gives them power to decide what aspects they want to illuminate whilst at the same time giving psychologists a real sense of their language abilities but further research is needed.

Future research should also look at the extent to which people with SLI/PLI are made aware of the availability and benefit of psychological counselling. Neither Atlantian nor Marcus asked for support at college, suggesting that asking for help (e.g., psychological counselling) may be difficult although there was some evidence of support-seeking in their interviews. The influence of masculinity in decisions concerning accessing counselling in this group, raised in Section 4.5 (p.82), may also be a factor and this should be explored as proposed in Chapter 6.6 (p.126).

4.7 Implications of these Findings for Policy-making, Training and Practice

Clients were around the age of 30 and were therefore educated in a way that might be different today following developments in educational legislation (DfEE, 1997a; 1997b). For example, two of the three were in special schools.

It has been suggested that outcomes are now more positive post-school (Dockrell et al., 2007). Rutter (2008, p.135) says “It would be unwarranted to extend the findings

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[of his earlier studies] to all SLI” and agrees that more recent studies present a somewhat more encouraging picture but points out that they were of less severe groups.

The Autism Act (House of Commons, 2009) has been introduced to make provision about meeting the needs of adults with autistic spectrum conditions by improving the provision of relevant services by local authorities, NHS bodies and NHS foundation trusts. The Act may provide more incentive for people like Atlantian to seek diagnosis of autism; more incentive for well-intentioned professionals to shoe-horn individuals on the boundaries of autism into an ASD diagnosis to access adult resources not available for SLI/PLI.

4.8 Study Evaluation/Critique

Analysing and interpreting the interview transcripts was influenced by the researcher’s understanding of the nature of SLI/PLI and by the face-to-face experience of interviewing this client group. Whilst this may have helped understanding it may also have affected the analysis of clients’ data whilst the possibility of additional perspectives from which to interpret was provided.

Subsequent to the interviews the researcher read that “Given the language and communication needs of young people with SLI, investigating their views can be a challenging task, even for professionals trained to work with this group of young people” (Palikara et al., 2009, p.59). However, it was found that establishing a relationship with these young men to conduct a research interview was both achievable and rewarding. For each participant, there was a brief discussion before the interview began to establish rapport (Smith et al., 2009) and the interviews took place in participants’ homes where people feel most comfortable to talk about difficult issues (Smith & Eatough, 2007).

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The outcomes of this study depended on the interviewer's use of language both in terms of the questions asked, as well as appropriacy for the participants' level of expression and understanding, and in establishing an appropriate relationship with them.

Even for those without SLI/PLI outcomes also depend "on participants use of language to describe their experience and therefore the way an individual expresses his perception is shaped by the accessibility and familiarity of certain constructs that might differ from that of the researcher" (Young et al., 2008, p.499).

The IPA interview schedule formed the basis for a conversation; it was not intended to be prescriptive and it was important that the interviewee took the lead. The resulting data might be very different to what was anticipated and is harder to analyse (Smith & Osborn, 2003; Biggerstaff & Thompson, 2008).

The opinion of only one young man with SLI/PLI was sought on the IPA interview schedule (Chapter 4.3.1, p.56) as it was not possible to identify more people than the participants to enable a pilot study. However, results from the interviews did not appear to indicate that changes to the schedule would have been required.

The language impairment did inevitably impact on the interview process that like counselling is also predominantly language-based (e.g., it was challenging to keep the interviews within the interview schedule both in terms of timing and content). However, the ability to establish a meaningful relationship augurs well for the therapeutic alliance and outcome (Horvath & Symonds, 1991).

The interviews may also have been assisted by the participants finding the research objectives significant (Smith & Osborn, 2003) so that the results were sets of meaningful data that shine a light on their lived experiences.

From the outset it was imperative to consider that "our preconceptions are inevitably present ... Sometimes it is possible to identify our preconceptions in advance;

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sometimes they will emerge during the process of engaging with the new object presented” (Smith et al., 2009, p.26).

Although the work resulted in novel findings, more scope was needed to allow the young men’s voices to resonate than was possible. Verbatim extracts in the analysis help trace the analytic process but more acknowledgement of researcher preconceptions and beliefs and reflexivity might increase transparency (Brocki & Wearden, 2006).

It is noted that the recruitment information sheet for the study (Appendix 13, p.207) asked for participants who had experienced psychosocial adjustment problems and explained what these might include. However, participants had more resources than expected and they did not acknowledge, when interviewed, mental health problems requiring psychological counselling. Therefore, it may be that they were also influenced to come forward by the covering letter from Professor Bishop.

4.9 Conclusion

Although the literature review raises concerns about the emotional health and psychosocial adjustment of young people with SLI/PLI, other recent studies are said by their authors to be presenting a more positive picture. In this study, the emergent themes demonstrated a surprising level of congruency; the young men presented with a range of integrated selves and an array of resilience mechanisms. They had awareness of the difficulties of life transitions and sufficient self-efficacy to enable change. However, those in the field of resilience research have pointed out that young [normally-developing] people are not always prepared to cope with the implications of stressful events and some emotional wounds may be left unhealed to invade awareness years later. Suggesting that this caveat should also be borne in mind for this group.

This chapter addresses the research question. The following chapter, Chapter 5, is the second of the two qualitative studies.

Chapter 5

Thematic Analysis (TA) of Interviews with
Psychologists and the Interconnection of their Themes
with the Young Adults' IPA Themes

Abstract***Objectives***

To explore and analyse psychologists' experience of providing psychological therapy to this group and to identify whether and to what extent there are interconnections between the themes from Chapter 4 of those with SLI/PLI and psychologists' practice.

Design

The psychologists were regarded as a body of professionals (a nomothetic approach) rather than individuals. These were those who had reported in response to the electronic questionnaire that they had experience of working with young adults with SLI/PLI. Thematic analysis (TA) was the chosen methodology, using both deductive and inductive approaches. Additionally, a process of interconnection was adopted to assess whether there was a connection between psychologists' themes and the young men's themes identified in Chapter 4.

Method

Four self-selected psychologists were interviewed using a semi-structured interview schedule with direct questions being included on their views on a future therapeutic framework to assist working with these clients. The interviews were recorded, transcribed and analysed according to the deductive and inductive positions for emergent themes relevant to their working with their clients.

Results

The deductive themes emerging were: Client as disabled self cf. mentally distressed self; SLI/PLI interpreted as a form of ASD; client resiliencies were not used in therapy and psychosocial difficulties were not recognised as focus of distress. The inductive themes were: support into adulthood and adaptations to sessions.

Conclusions

The process of "interconnection" revealed the coincidence and convergence of the two sides of the client/psychologist dyad. The deductive themes showed the

psychologists did not see their clients as congruent whole people, either focussing on the manageable mental health problem (being unable to cure the impairment) or focussing on the impairment. The inductive themes showed that psychologists knew support into adulthood was non-existent. All made considerable effort to modify their sessions.

5.1 Introduction and Rationale

The study uses Thematic Analysis (TA) rather than IPA because it is concerned only with the professionals' expertise as practitioners rather than their lived experiences. It addresses the research question for Chapter 5 (Chapter 2.7, p.25).

Like IPA, described in Chapter 4.1 (p.54) "TA is a method for identifying, analysing and reporting patterns [themes] within data" (Braun & Clarke, 2006, p.79). TA allows the analysed themes to be pre-chosen according to the hypothesis being tested (deductive TA) and for the spontaneous identification of thematic items arising solely from the transcripts (inductive TA) and for both to be considered separately and together. This allows for maximum possibilities in identifying significances relating to psychologists working with these clients as well as contributing to greater scientific rigour (Fereday & Muir-Cochrane, 2006; Aroni et al., 1999).

The first theoretical position of this chapter (deductive TA) is that psychologists' practice is informed by a process of inclusion of the voices of clients with SLI/PLI as they describe their lives. This is relevant in two ways: Firstly, psychologists have seldom knowingly experienced the discourse of clients with SLI/PLI. Secondly, learning about the lives of these clients (who have not received/needed counselling) might reveal strategies and tactics these clients have developed and employed to navigate challenges in their lives especially during periods of significant levels of distress.

The second theoretical position is that the spontaneous responses of psychologists might produce a range of techniques that improve practice, or courses of action that resonate with the clients' discourse and themes and these become emerging inductive TA.

The process of dyadic interconnection is then used in this chapter to take emerging, significant themes derived from the responses of the adults' with SLI/PLI (Chapter 4.4.2, p.60) and connect them with professional responses (Chapter 5.4.2, p.99). This derives from methodology used in Relational Cohesion Theory (Lawler, 2001) and is rooted in Social Exchange Theory (Emerson, 1981).

A nomothetic position was taken, considering psychologists as representative of a group of professionals who also express personal views arising from their opinions and experiences. In all cases a single hermeneutic applied.

5.2 Design

5.2.1 Measures. The measures (i.e., interview questions, Appendix 16, p.211) allowed a general exploration of working therapeutically with young people with SLI/PLI. The areas covered in the interview schedule were the psychologists' views on and experience of:

- Diagnosis and its impact;
- What is understood about SLI/PLI, the word specific and the benefits of this knowledge;
- The presenting mental health problems;
- Clients' psychosocial adjustment;
- Impact of SLI/PLI on case formulation, treatment plan and therapeutic alliance;
- Deciding the therapeutic approach;

- Examples of outcomes good and bad.

The psychologists were asked specifically for their views on a therapeutic framework in this field (Chapter 5.4.2.6, p.111).

5.2.2 Participants. Thirty-nine of those Chartered psychologists who responded to the electronic survey described in Chapter 3 (p.27) (comprising counselling, clinical, educational and “other” psychologists) reported they had experience working with clients formally diagnosed with SLI/PLI. Of these eight were willing to participate in a face-to-face interview and were therefore self-selected (having volunteered) because of interest in this client group.

From the eight psychologists four were selected comprising two clinical psychologists, one counselling psychologist and one educational/neuro-psychologist. The remaining four were eliminated from further participation as one provided no contact details, two were willing to participate only by telephone and one claimed he had no knowledge and was not familiar with any of the terminology.

5.3 Method

5.3.1 Procedure.

Ethical approval

The full study summarised by the overarching research aim (Chapter 2.7, p.25) required the approval of the University Ethics Committee. (For further details of the ethics application and research agreement letter see Chapter 4.3.1, p.56 and Appendix 4, p.174).

Three of the psychologists worked for NHS Trusts and each requested to be interviewed in his/her office requiring agreement by Trust Research and Development departments (Appendix 17, p.214). The fourth psychologist worked in private practice and was interviewed in a private office.

Recruitment

The four selected psychologists were contacted to arrange a meeting using the contact details they had provided in their survey response. Each responded to the researcher having been sent an information sheet (Appendix 18, p.216) and consent form by email and returned the signed consent form at the time of the interview (Appendix 14, p.208). The information sheet was additional to the study information each had received at the time of participating in the survey (Appendix 6, p.191).

Semi-structured interview schedule

Fourteen questions (each with prompt questions) were compiled into a semi-structured interview schedule (Appendix 16, p.211) that was not disclosed to the participants in advance. (See Chapter 4.3.1, p.56 for further details of guidelines followed when writing the interview schedule.)

Semi-structured interviews

All four psychologists were interviewed in their places of work and the interviews took place after the interviews with the client group. No amendments or additions were made to the psychologists' interview schedules following the client interviews.

In the same way as for the young adults (Chapter 4.3.1, p.56), there was a brief discussion before the interview to establish rapport. Each participant was recorded agreeing to the use of a pseudonym of his/her choice, confirming that the information sheet had been read and that a consent form had been signed (Appendix 18, p.216 and Appendix 14, p.208). At the conclusion of each interview there was a private debrief (as described in Chapter 4.3.1, p.56). There were no reports of distress.

Psychologists were also asked directly for their views on a therapeutic framework and what it might include.

5.3.2 Method of data analysis. All of the psychologists' interviews were transcribed from the audio recording into a table. These transcripts were then checked against the recordings for a second time, again word-by-word because of the researcher's concerns about their intelligibility.

Analysis of the transcripts began after completion of all of the interviews to minimise bias where one interview is influenced by the analysis of a previous interview. This process involved researcher interpretation throughout.

The deductive themes emerged from the super-ordinate themes of the IPA interviews (Chapter 4.4.2, p.60) seen from the perspective of the psychologists. This necessitated reviewing the psychologists' transcripts for examples of where their comments were interconnected with the adults' themes: identification of the selves, resilience and psychosocial adjustment. Quotes illustrating their perspective were woven into a narrative with block numbers to facilitate an audit trail.

The inductive themes were identified by reviewing the transcripts for comments made by the psychologists that developed from their own previous experience and their opinions on working with this group. These were either woven into a narrative or tabulated with block numbers.

The psychologists' views on a therapeutic framework were analysed separately.

5.4 Results

5.4.1 Sample descriptions. Four Chartered psychologists who responded positively to the survey described in Chapter 3 (p.27) of this thesis were interviewed.

Table 5.1

Sample descriptions of psychologists

Pseudonym/length of interview	Gender	Discipline	Employment
Dylan 53 minutes	Male	Clinical psychologist	Child and Adolescent Mental Health Service (CAMHS)
Chris 73 minutes	Female	Counselling psychologist	CAMHS
Matt 62 minutes	Female	Clinical psychologist	CAMHS
T 74 minutes	Female	Educational- and Neuro- psychologist	Private practice

5.4.2 Analysis of deductive and inductive interview data.

5.4.2.1 Deductive Theme 1: The identification of the selves.

The impaired self cf. the mentally-distressed self

The first interview question asked psychologists how they became initially aware of the language impairment and the effect of that. Dylan comments that the main reason clients come to him is that they are not sure whether their problems are because of a deficiency in language or because of a mental health problem. [D10] It does not seem to be a possibility for him that these two are indivisibly connected. Inability of a client to distinguish between internal and external possible sources of their problems can be distressing in itself. Dylan responds to this situation by conducting assessments to identify whether they have autistic characteristics or not. [D22] He says he does not diagnose mental health [D140] because the clients are coming to him with a particular query in mind and ask him:

“Is this ... why I’m failing socially, is this why I’m failing in my occupational life and I’m not happy about that.” [D142]

However, Chris explains it is the language impairment diagnosis that brings clients to her. [C44] But she makes it clear to her clients that she is not there to deal with the part of them that is language impaired, but only the key presenting mental health issue. [C46] She seems to think that because of the language problem the best

that can be done is for the client to focus only on “*managing*” their mental health problem. She says she is clear to them that she cannot perform “*miracles*” by removing their language disorder. [C48]

Matt is similarly careful to differentiate between the language impairment and the mental health issue even to the extent of referring on for a language assessment if she suspects a problem. [Mt12] Of one in-patient client she said his breakdown was more the result of mental health difficulties than language difficulties and that these are quite separate. [Mt46]

T is the only person who seems to have a holistic view of her clients and says she likes to use initially a “*normative*” assessment. [T12] She actually carries out many of these assessments but as says she is not bothered about IQ. What she is bothered about is looking to see where the young person’s strengths are. [T12] She seems to be seeing the whole person but she emphasises that she does not work as a counsellor – that is she never takes people in to work on, “*in a quote, talking therapies.*” [T80]

SLI/PLI seen as autism/ASD

The difficulty in recognising and understanding language impairment has resulted in three of the psychologists using autism/autistic spectrum disorder (ASD), with which they are more familiar, as a default position. Dylan was acutely sensitive to what he called “*markers*” characteristic of ASD such as being uncomfortable with other people. [D52] He also identifies that PLI is a part of ASD. [D84]

Chris identifies the need to be cautious with the client’s presenting diagnoses, as:

“poor social communication skills can also look like autistic spectrum disorder, ADHD, ADD and all sorts of other things.”

[C76]

She admitted she had more experience of PLI than SLI and says perceptively that if someone comes with PLI it could be part of another diagnosis or standing alone.

[C90]

Matt also struggles to distinguish between the various disorders. She is asked specifically about clients coming with SLI/PLI and instead responds that:

“they might have a diagnosis of speech disorder ... [or] ... usually around autistic spectrum disorder.” [Mt8]

She describes her training as a clinical psychologist with some experience of assessments for autistic spectrum disorders adding that her knowledge of speech and language is pretty much non-existent. [Mt90] She had read about speech and language problems but if she does not use it a lot she forgets it again. [Mt94] However, she is able to report that there is an expressive and receptive part and that comprehension is really important. She understands how difficult it must be for children because people struggle to understand what this means and lack awareness. [Mt16]

T has understanding and is aware of the confusion in her own mind when she says it is very difficult to distinguish ASD and language impairment:

“... all the literature will tell us lots about the ASD group who have lots of problems with pragmatics. Um, but, pragmatics is also really about understanding deep structure of language, and I think that comes into SLI as well as a lot of other ones.” [T68]

5.4.2.2 Deductive Theme 2: Resilience. In general for all psychologists there are scarce references to their client's positive coping resources and resilience or lack of them. Dylan described his working with a language impaired client who had “*low mood*”. He could only conceptualise the client negatively in terms of his language impairment and/or autistic difficulties. He asked himself whether and to what extent the

impairment/autism contributed to the low mood. [D162] He then provides a list of possible ways, including intolerance of others' agendas and exam problems, that low mood may result. [D164] He attempts therefore to see beyond the diagnosis to find the cause of distress but does not mention any positive resources shown by the client that can be developed.

When asked for essential skills to employ with this client group Chris named unconditional positive regard because this group has probably had a number of experiences of being misunderstood. [C110] Seemingly not aware of the confidence- and resilience-building underlying UPR she sees her counselling as problem-solving rather than an overall resilience-building:

“If it’s a problem that’s quite entrenched and ... almost becomes part of their lifestyle, then, you know, that obviously needs to be negotiated with what element of the problem would they like to address, and when would they see the right time to stop.”

[C130]

Matt, on being asked if her clients seemed resigned to a difficult life, sees them as having very low self-esteem although there were many issues, adding:

“... But again I think that probably the language difficulties were not necessarily the most important factor in that.” [Mt147]

She makes the attempt at increasing self-esteem by commenting on a photo of the client with the observation that she looked “cute” [Mt149] but does not describe the intention of her intervention. She notices in one client that some people get quite good at covering up – particularly if they are quite placid and pleasant [Mt46] but does not interpret/acknowledge it as a coping strategy that is integral to resilience and can be developed.

T, however, seems to be the only psychologist who looks for positive resources. She explains that what she is concerned about is looking to see where the strengths of the young person are. [T12] Although she says she does not know how to assess mental health [T14] she takes parents' views into account but also sees the client alone and in their usual surroundings to get an overall picture of their operating. For another client T recognised attack as a negative coping strategy against his frustration at school and explained it to him as a reasoned argument. This rationalisation then has the potential to become a positive means of coping:

“And um, when I sort of went through what we had done together ... he cried. And said, not because he was upset that I was saying that but because it made sense to him.” [T26]

Typical of T is her taking little heed of pre-existing opinions, but liking to make up her own mind, and in particular she starts with an assessment of the recognisable skills the person has for her own benefit; so she knows what she needs to be aware of. [T80]

5.4.2.3 Deductive Theme 3: Psychosocial adjustment. The literature suggests that psychosocial adjustment is a potential major source of stress for people with SLI/PLI. Dylan says all his language disordered clients were living with parents. However, some of them managed to show considerable self-efficacy in holding down jobs. He names one who was taking an horticultural course and another who was working in a university payroll office but who was having to deal with students who got him down by asking stupid questions. [D192]

He expresses this as:

“He got quite down about his agency if you know what I mean.”

[D196]

Chris believes that while there are many psychosocial maladjustments in this client group, the greatest problem is moving away from the specialist school where suddenly you are responsible for things that you have never been responsible for before and this means speaking up and explaining yourself. [C236]

This straining of self-efficacy is underpinned by low confidence because where the person is the only one struggling their self-esteem drops, leading to such problems as depression and drug and alcohol abuse. [C236]

Matt describes serious psychosocial adjustment problems in one client with language impairment, a one-time victim of child sexual abuse, discharged from psychiatric inpatient care into a non-existent adult service, and who consequently did very badly. She refers to this as a *“nightmare”*. [Mt52] She also said that had she been involved he would never have been admitted. [Mt52]

T recognises how difficult life is for these young people with SLI. Throughout childhood and into adolescence they usually find that they can get on with older people or young children because both groups will make allowances in different ways for their language – but never with peers. Then once they leave school it is peers that they have to get on with and that is very difficult. [T92]

She describes the possible consequences of this as a high level of depression, concerns about suicide and not feeling life is worthwhile and so on. [T94]

5.4.2.4 Inductive Theme 1: Adolescence into adulthood with SLI/PLI. The psychologists knew this research was specifically about their working with young adults (18-35) with SLI/PLI, however it was difficult to be sure of the ages of mentioned

clients. Table 5.2 is a simple measure of the number of mentions of clients as children or young people cf. adults.

Table 5.2:

References to non-adults and adults

	Dylan	Chris	Matt	T
Number of mentions of child or children	18	24	32	46
Mention of young person	7	24	11	45
Total non-adult	25	48	43	91
Mention of adult	18	4	15	2

Dylan was unclear about what happens in adult services generally [D188] but he was aware that the adults he was assessing were going to have difficulties finding the help they needed because it does not exist. [D288]

Chris thinks special allowances must be made for young adults with SLI/PLI because it cannot be taken for granted that they will automatically know what is OK and not OK to say. [C103] She is also aware of a particular difficulty:

“... when they become adults they’d use the same script, they ask for help and the help isn’t there.” [C242]

Matt says that those with speech and language disorders “*tend to be otherwise young ones*” [Mt22] and Dylan agrees. He believes:

“SLI sort of disappears, doesn’t it, after, once the child’s started talking. And unless there’s any residual difficulty. I think even then it would still be ignored you know ... There is a feeling that language development is done in the first five years of life or even earlier.” [D252-254]

But SLI/PLI persists into adulthood. What happens to these individuals when they are older is answered later when Matt says of a client:

“People settled for depression with psychotic symptoms in the end, but also, there was a lot of pressure from me that they said it because that’s the only way he would get a service in adult services.” [Mt86]

T also worries what happens into adulthood believing the reality is that there will possibly be even more isolation than ever for people with language impairment. [T92]

5.4.2.5 Inductive Theme 2: Session adaptations for clients with SLI/PLI. Table 5.3 provides a summary of the second inductive theme and shows that the psychologists made considerable efforts to adapt their therapy sessions for clients with SLI/PLI. They were careful in their use of language and where possible used visual aids rather than talking. They gave their clients emotional support and used role-play and suggested activities out of the clinic where appropriate. In addition they were flexible in the timing of their sessions and believed that there was an occasional need for long periods of silence and non-activity.

Table 5.3

Inductive Theme 2: Session adaptations for SLI/PLI

Dylan	Chris	Matt	T
Use of language			

<p><i>"I might have to rephrase."</i> [D44]</p> <p><i>"... one has to be sensitive to the need for perhaps visual cues and for the amount that one's saying so that it's clear and that it's simple language."</i> [D164]</p> <p><i>"attention and memory are more of a really common co-occurring."</i> [D180]</p> <p><i>"Be sensitive for the need for reframing, not to jump to conclusions about the length of someone's utterances, about their ability to articulate their thoughts, feelings, intentions, etc."</i> [D206]</p>	<p>No <i>"abstract thinking."</i> [C20]</p> <p>No <i>"jargon and alternative words."</i> [C92]</p> <p><i>"avoiding metaphors."</i> [C96]</p> <p><i>"check" "both on the same wavelength."</i> [C96]</p> <p><i>"being clear as to, what the rules are."</i> [C102]</p> <p><i>"aware of their rigid thinking and not make any promises that, that we later can't keep."</i> [C138]</p> <p><i>"do a narrative"; "retell the story."</i> [C168]</p> <p><i>"Frequently naming exactly what's going on."</i> [C208]</p> <p><i>"allows silence in the room and thinking space."</i> [C110]</p>	<p><i>"... explaining things differently ... I need to use certain language."</i> [Mt14]</p> <p><i>"... he had major comprehension difficulties" but "... when did he not feel able to express what he felt and thought? And when did he not dare to say it?"</i> [Mt32]</p> <p><i>"adjust my language"; "be less surprised if they struggled."</i> [Mt102]</p> <p><i>"not to use metaphors."</i> [Mt14]</p> <p><i>"I ask a lot more."</i> [Mt122]</p> <p><i>"I'd also take into consideration that they sometimes really struggle to explain their thoughts and feelings and might need to find different ways of eliciting that."</i> [Mt16]</p>	<p><i>"short sentences."</i> [T166]</p> <p><i>"... also I deal with people where it's more difficult to gauge where the understanding starts and finishes and what bits they won't understand. I feel much more wary because I feel, um, a responsibility to try and get it right ..."</i> [T138]</p> <p><i>"... I've never liked my voice, and I worry about things like, er, is my voice the right timbre and tone, is it an easy voice to pick up, should I project it more, or less?"</i> [T138]</p> <p><i>"Sometimes I will actually speed up my language, er, but not, not, not so often. Trying very hard, and this is the thing that I find most difficult, to think of the vocabulary that I use so that if I can say it in the most simple way I will."</i> [T166]</p>
Dylan	Chris	Matt	T
Visual assistance			
<i>"sensitive to the need for perhaps</i>	<i>"whiteboard" for information and</i>	<i>"drawing things."</i> [Mt14]	<i>"Visual schedules."</i>

<i>visual cue.</i> " [D164]	setting timing to reduce anxieties. [C28]	[T160]
<i>"I'd be ready to use some sort of visual assistance."</i> [D46]		<i>"visual materials"</i> geared to interests. [T162]
<i>"visual strategies."</i> [D240]		

Emotional support

<i>"If they were available then yes"</i> [Parents present]	<i>"pleased when a carer or parent was there."</i> [C26]	<i>"Raise self- esteem."</i> [Mt149] <i>"make lists and multiple choice and pick emotions out of these."</i> [Mt263]	<i>"Have a session with parents where I explore ... things that they're concerned about."</i> [T14] <i>"not to have whole goldfish- bowl sessions."</i> [T102] <i>"Go into school and /or college."</i> [T104] <i>"getting environmental variables right in terms of, um, the supports, changing parental attitudes."</i> [T112] <i>"Help to see themselves in a wider perspective than just that uni- dimension of language impairment."</i> [T106]
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Dylan	Chris	Matt	T
Activities			
<p><i>"Going ten-pin bowling ... going out for a meal."</i> [D248]</p> <p><i>"shopping"; "structured experience."</i> [D246]</p>	<p><i>"using homework tasks"; "visual as possible."</i> [C100]</p> <p><i>"the parent-child game"</i>[if the parent has a language impairment.] [C170]</p> <p><i>"sat and played dominoes for the first two sessions."</i> [C286]</p>	<p><i>"No homework."</i> [Mt130]</p> <p><i>"Play so people can express themselves rather than all verbal."</i>[Mt202]</p>	<p><i>"art therapy."</i> [T124]</p> <p><i>"imagining that they're behind a camera"</i> [T112] to learn about different perspectives.</p> <p><i>"learning to play golf - little conversation ;not a team game."</i> [T106]</p> <p><i>"Ordinary practical stuff."</i> [T106] like how to get around town shop etc.</p> <p><i>"role play can be extremely useful"; "board game ... [can] create an awareness of different strategies."</i> [T183]</p>
Timing and length of session			
<p><i>"shorter sessions."</i> [D165]</p>	<p><i>"set the timing of the session."</i> [C28]</p> <p><i>"allow quite a bit of time."</i> [C38]</p> <p><i>"be very aware of my timing."</i> [C96]</p>	<p><i>"I would shorten it"</i> [the length of the session]. [Mt118]</p>	

Dylan	Chris	Matt	T
Assessments			
<p><i>“Pervasive developmental disorder of a kind. The provision of that kind of assessment is not great in the UK and I will see people for that kind of assessment.”</i> [D16]</p>	<p><i>“For the assessment I, I felt it was quite difficult because, you know, obviously it was a talking therapy, and I wanted to tease out information that probably required them to use some abstract thinking.”</i> [C20]</p>		<p><i>“I always liked to, um, a fairly detailed um, normative assessment.”</i> [T12]</p> <p><i>“a place for standardised assessment”</i> [T88] to reveal hidden capabilities.</p>

Note. Quotes are used in this table to illustrate the second theme. The absence of a quote to support the theme does not suggest there is conclusive evidence that the theme is not present for a psychologist. Block numbers from the transcripts are in [square brackets].

5.4.2.6 Psychologists' views on a therapeutic framework. The psychologists' views on frameworks were sought during the interview and these were produced in table form (Appendix 19, p.217). Broadly the word framework was explained to them to mean ideas from their practice that could be shared with others in the field.

Nobody was averse to the idea. Matt initially was unsure of the value of a framework, but changed her mind. They all have suggestions for practice, and are aware of service limitations:

“Asperger's teams are starting to appear but SLI teams for adults are unlikely. For people with SLI to get some form of help they would have to be diagnosed with Asperger's syndrome.” [D252]

5.5 Critical Discussion of the Results and how these Relate to the Literature

5.5.1 Deductive themes. The issue of the focus of counselling is a defining one in this study and is articulated by Smart and Smart (2006, p.29) who say "... When counselors dismiss or ignore the disability, a critical part of the client's self-identity must remain unexplored. On the other hand, counselors may tend to over-emphasize the salience of the disability and automatically assume that the disability is the 'presenting problem' or the cause and source of all the client's concerns."

Clients are told by one psychologist that no attempt is being made to address the language problems (rather they will be helped to focus on and manage their mental health problems as there is no magic cure for the impairment) although she makes pragmatic efforts to adapt her methods to allow for assumed incapacities arising from the language difficulties.

However, two of the clinical psychologists see these clients primarily in terms of their language impairment. They too are focussed on how the clients might have reduced capacity to understand their questions and/or limited ability to express answers and various other difficulties that will interfere with therapeutic outcomes.

It appears the psychologists fail to think of language impairment as being at the core of the person so that it forms part of who he is (inextricably linked to his "self"). Instead they take a modular approach - seeing him as someone with an [incurable] language impairment and [separate and manageable] mental health problems.

Psychological counselling requires a connection between the self of the client and therapist, another way of viewing the working alliance. To achieve this, all aspects of the client must be recognised and acknowledged. Language impairments are hidden disabilities i.e., not immediately apparent. The ability to positively encompass a client

with a language impairment, mental health issues and their environment is instrumental in the therapeutic process.

Only one psychologist sees the client overall, their difficulties and their abilities, but says that she does not practice therapeutically (although she provides psychological intervention). Inability to see multiple aspects in a congruent whole inevitably diminishes the quality of the working alliance. Rather the psychologist will become stuck in a one-coat-fits-all model that dictates "I have to use visual material for these clients" when what is needed is a bespoke approach that can be decided in the moment.

Three of the four psychologists described their SLI/PLI clients in autism-related terms that will have impacted on treatment choices. This is perhaps why they want to know the diagnosis in advance. However, the lack of clarity that exists in the literature concerning the relationship between SLI/PLI and ASD is evident (e.g., Adams, 2008).

One psychologist used the parameter of IQ as a yardstick, but then put it aside and was able to connect more on a relational level with the client as an individual, with strengths and weaknesses (i.e., she looks for inherent resources in her clients). This view is strongly supported in the literature. Resilience is well established as a primary defence against psychosocial risk factors (Rutter, 1999; Davydov et al. (2010); Zautra, 2009; Leipold & Greve, 2009) and there is literature on harnessing this capability especially in vulnerable people (Luthar & Cicchetti, 2000). Specific psychotherapy techniques have been developed to improve positive adaptation in the face of significant difficulties (Fava & Tomba, 2009).

Writing about disability generally, Smart and Smart (2006, p.29) state "Typically, the disability is not the single defining characteristic of the individual; rather the disability is one of several important parts of the individual's self-identity...."

5.5.2 Inductive themes. Psychologists in this study mostly support children/adolescents with SLI/PLI, but for about half the children with language difficulties at five years of age continuing lifelong impairment appears to be a reality (Conti-Ramsden & Botting, 2008). Neither Matt nor Dylan is aware the problems are lifelong. However, in general psychologists were aware that adult services are non-existent and were concerned; one skewed a diagnosis in an extreme case to enable access to an adult service.

One psychologist speaks of seeing young people with undiagnosed language impairment in a sex offenders' unit. Children seen in psychiatric clinics for behavioural problems or in offender environments in the UK often have language impairments with many children and young people having *unrecognised* language difficulties (Botting, 2008).

The psychologists use a variety of adaptations to sessions for SLI/PLI clients (Table 5.3, p.107). For example, visual assistance was generally accepted as useful, the length of sessions modified and two types of assessment were described, with one psychologist saying these are difficult if they require abstract thinking.

Whilst the focus was on the language impairment, with little information on psychotherapeutic approach, CBT, psycho-education, integrative, personal construct and person centred approaches are all mentioned by the psychologists. However, although numerous modifications are made when counselling clients with SLI/PLI, it appears there is a lack of theoretical content suggesting individual experiential underpinnings for their practice.

5.5.3 The psychologists' interview results in relation to the electronic questionnaire. In the absence of statistics, the inclusion of a quantitative measure (an electronic survey) for the psychologist body offers at least limited confirmatory data. The results from the small population of psychologists who participated in Chapter 5 are

broadly consistent with the results from the larger population who participated in the electronic survey (Chapter 3, p.27). For example, those who said they had experience in the survey and those taking part in the interviews were typically making modifications to their therapeutic approach (Chapter 3.4.6, p.40). Significantly, despite the high prevalence of SLI/PLI (Bishop, 2010a,b; DfE, 2010) in both studies psychologists were confused between SLI/PLI and other conditions where language was affected, such as ASD.

5.6 Implications of these Findings for Future Research

Research should be conducted to explore the ways in which psychologists can help clients with SLI/PLI identify and enhance their own resources and guide them in utilising these to find their own strengths and solutions with particular emphasis on work to improve resilience/coping.

5.7 Implications of these Findings for Policy-making, Training and Practice

Training in language development, including impairment, should be included in doctoral courses for applied psychologists and more training on disability issues where communication is affected. The introduction of DSM-5 in 2013 should (if published as drafted) have implications for those in the field of SLI/PLI including practitioners as new/renamed categories of impairment are introduced.

The Autism Act (House of Commons, 2009) may provide more incentive for well-intentioned professionals to shoehorn individuals on the boundaries of autism into an ASD diagnosis to access adult resources not available for SLI/PLI.

More multi-professional working between psychologists and other involved disciplines might be beneficial. In Chapter 3 (p.27) of this study 6% of counselling psychologists gained knowledge by making contact with speech and language therapists and 24% of clinical psychologists reported working closely with them.

Additionally, this research might lead to consideration of a new approach to inform research into service development (not only for language impairment) in the way it takes patients/clients into account and connects them with professional working. This is discussed further in Chapter 6.5 (p.123).

5.8 Study Evaluation/Critique

The psychologists who were contacted to take part in the survey were listed by the BPS as child/adolescent psychologists. This was because this group was believed to be those most likely to have understanding of SLI/PLI. At interview their focus was therefore primarily on children despite the study being on young adults/adolescents.

In Chapter 3.8 (p.48) it was noted that the wording of the survey did not make it sufficiently clear that “working with” meant working therapeutically. One of the four people selected for interview did not work therapeutically although she subsequently said she saw counselling as a “*psychological intervention*”. [T96] She too works face-to-face. [T100]

A pilot of the interview schedule was considered. However, there was an insufficient number of suitable psychologists to support both a pilot study and the resultant interviews.

The difficulties experienced in the group differentiating between autism and SLI/PLI meant the researcher had to question them regularly to confirm diagnosis. Also, the psychologists were asked for their views on a “therapeutic framework”. The word “framework” had to be defined as its meaning was unclear to participants.

The process of dyadic interconnection used in this chapter appears unproven and this was a risk. However, it is derived from methodology used in Relational Cohesion Theory (Lawler, 2001) and no literature was identified that provided a standardised method for interconnecting themes from two separate groups.

5.9 Conclusion

The process of interconnection revealed the coincidence and convergence of the two sides of the client/psychologist dyad. (See Chapter 6.4, p122.)

The deductive themes showed, in contrast to the clients' preferences, that psychologists did not see their clients as congruent whole people, either focussing on the manageable mental health problem (being unable to cure the impairment) or focussing on the impairment. The inductive themes included that psychologists knew support into adulthood was non-existent and all made considerable effort to modify their sessions in response to their clients' perceived needs.

The research question for Chapter 5 has been addressed and Chapter 6 will bring together Chapters 2-5 and considers each of the research questions in relation to the overarching research aim (Chapter 2.7, p.25).

Chapter 6

Thesis Discussion

6.1 Introduction

This chapter considers the outcomes of the research questions in relation to the overarching aim to determine whether the aim has been achieved. The implications for counselling psychology and possible future research are also explored.

It was initially thought necessary to undertake a comprehensive literature review to provide an account of the nature of SLI/PLI and current arguments and discrepancies. This includes the lack of diagnostic power in SLI/PLI, the existence of a spectrum of severity as well as complex combinations of deficits, and lack of evidence-based therapeutic interventions.

The literature review demonstrates that the field of SLI/PLI is complex, controversial and under-researched. Yet language is argued to be what largely defines us as humans. Chomsky (2006, p.88) describes human language as “the ‘human essence’, the distinctive qualities of mind that are as far as we know unique to man and that are inseparable from any critical phase of human existence, personal or social.”

The review provided empirical evidence that individuals with deficits in language are subject to distresses especially with respect to psychosocial adjustment. Therefore, the highest priority, from a psychological perspective, is the alleviation of these individuals’ unhappiness. Yet emotional health symptoms such as depression and anxiety have been investigated less than social skills difficulties (Conti-Ramsden & Botting, 2004; 2008).

6.2 Critical Discussion of the Research Question for Chapter 3 in Relation to the Overarching Aim

The questionnaire results (Chapter 3.4.3, p.37) inform that 62% of counselling and 23% of clinical psychologists reported that they had less than adequate knowledge for their requirements. Most knowledge was gained from own reading and study.

Additionally, the questionnaire includes many of the interview questions of Chapter 5 with a larger but equivalent participant base. The questionnaire results and the psychologists' interview results are not inconsistent. However, those clinical and counselling psychologists participating in the second part of the questionnaire were those who considered themselves experienced with this client group.

As communication disorders are more commonplace than generally recognised but poorly understood, this research has implications for psychologists practising in this field.

6.3 Critical Discussion of the Research Question for Chapter 4 in Relation to the Overarching Aim

The client interview outcomes were a series of themes that emerged from the transcripts interpreted by the researcher as having particular significance. By interviewing participants phenomenologically these elements of their lived experiences, including coping with psychosocial adjustment, will inform those working with them. Any psychological practice with this client group has an improved chance of successful therapeutic alliance, and hence effectiveness, once the client's formative characteristics are recognised.

A key point is that the clients agreeing to be interviewed may have coped with life's challenges reasonably successfully. However, because one group of clients has been able to withstand life with a language impairment relatively well, does not mean others will be similarly able. Numerous factors relating to their family, demographics, severity of their impairment, schooling, etc. will be influential. The clients interviewed here, with demonstrable difficulties and distresses, describe their survival mechanisms. This gives the opportunity to look at the self-strategies they have developed to inform counselling psychologists working with similarly disabled clients who have less resourcefulness.

One of the most significant achievements of this study involved hearing the actual voices and stories of the clients in their own words. This approach is similar to the concept of narrative medicine (Greenhalgh & Hurwitz, 1999) in which it has been established that doctor/patient communication, vital in clinical medicine, is improved by the physician hearing the patient's "feelings, expectations, wishes" and understanding of his illness (Coaccioli, 2011, p.91).

For example, there is little overlap between the way psychologists see their clients and the way the clients see themselves. None of the young adults wanted to be "cured" (the word used by Chris) but rather accepted for who they were (an unique and non-standard whole). Atlantian provides a seminal example when he says:

"Well, I said I never saw meself as different at all. I mean, Atlantian. [A laughs] ... I don't see meself different at all ... I mean, different perhaps, could be differently wired differently."
[A laughs]. [A520-526]

Only T sees the clients overall, their difficulties and their abilities, but does not practice therapeutically.

Whittington & Burns (2005) conducted IPA interviews with care-givers in a care home and have adopted an approach designed to identify new ways of professional working, as in this study, but did not interview their service-users and therefore missed the opportunity to hear their voices.

There is a significant literature on the importance of consulting patients about their care, in both physical and mental health contexts, and this usually takes the form of feedback surveys post-treatment or shared decision-making (Cleary, 1999). However, in

the field of mental health, once given the therapeutic treatment, the patient will be conditioned by his experience.

In this study, it was important that the participating clients had not received previous psychological counselling as this would have influenced their lived experiences. They were however asked directly for their expectations of counselling and counsellors and provided a meaningful account of these (Chapter 4.4.3, p.79 and Table 4.3, p.80).

6.4 Critical Discussion of the Research Question for Chapter 5 in Relation to the Overarching Aim

Thematic analysis has the advantage of two forms of analysis, the inductive approach reminiscent of IPA and a deductive approach which uses a predetermined hypothetical position as the starting point for theme development. Using the themes from the client IPA analysis as hypotheses, complementary positions were sought in the psychologist transcripts connecting the clients' experience with psychologists' practice. This was termed "interconnection" whereby dyads (e.g., teacher/student) are analysed for their points of connection. In this study, however, the principle was modified so that group dyads of clients and psychologists were used rather than individuals. This offers a systematic and semi-objective way to evaluate how important aspects of clients are shared with, impact on or resonate with, in this case, psychologists.

Although young adult clients may have survived adversity in childhood and adolescence with varying levels of success, none of the psychologists looks for existing coping and defence strategies that they can develop or enhance, although one does look for capabilities. This is even more surprising in psychologists working with children and adolescents, a situation where the client lacks agency to change his/her circumstance. Such work could be the goal for therapeutic development.

Any individual caught in a distressing situation where he has no personal agency has only coping and defence mechanisms to protect against the annihilation of the spirit. North (2007) states that the resilience of the human spirit under extreme duress is often under-appreciated. If the therapist does not identify and understand the client's resources he cannot access them for therapy. The opportunity for the psychologist to congratulate, acknowledge, enhance, develop or initiate aspects of resilience is missed (e.g., Kuyken, Padesky & Dudley, 2009) whilst they focus on modifying their therapeutic approach seemingly experientially rather than theoretically. In some part, this may be connected to their difficulties differentiating between SLI/PLI and autism.

6.5 Implications for Counselling Psychology

The current level of knowledge and understanding of SLI/PLI and of counselling people with these difficulties appears low from both the electronic survey (Chapter 3.4.3, p.37) and the psychologists' interviews (Chapter 5.4, p.98), especially as the psychologists who volunteered to be interviewed had said they had experience in this field. In terms of fundamental knowledge and understanding it would, for example, be advantageous for psychologists to know that a client with SLI/PLI is not categorised as learning disabled i.e., having an IQ of 70 or less (Morrison, 2001) and that PLI can exist without autism (Conti-Ramsden et al., 2006). Also there is a development need for psychologists in their knowledge of language development and impairment generally and in their perception of disabilities through training and the professional competencies. (Professional competencies are explored in Chapter 6.6, p.126.)

It has been reported that counsellors will be required to become proficient in disability to meet minimum standards of practice. Both the American Psychological Association and the Canadian Psychological Association have revised their guidelines to attend to disability issues (Hays, 2001).

Disability, in general, is a vast unmet need within counselling (LoPresti & Zuckerman, 2004). This is illustrated in Chapter 3, p.27:

“I currently have one such client [high-functioning autism] ... but cannot address that part of the problem as it is outside of my scope of knowledge/expertise and is inappropriate to address in this (CMHT) setting.” (Respondent 57592)

“As does everyone, the client with a disability has multiple identities and multiple roles. Disability is not the ‘master status’.” Furthermore, a deeper and more complete understanding of the client’s varied identities, functions, and environments will facilitate counselling (Dembo, 1982; Higgins, 1992; Smart & Smart, 2006, p37).

In this study the voices of the three client participants demonstrated a remarkable spectrum of coping and defence strategies, including humour, as constituent parts of resilience and in the face of a difficult childhood and adolescence (Van Agt, Verhoeven, Van Den Brink & De Koning, 2011; Arkkila, Rasanen, Roine, & Vilkinen, 2008; Arkkila et al., 2009; Arkkila et al., 2011). In fact resilience is a powerful resource for a wide range of problems (Pratyusha, 2007; Cárdenas & López, 2010; Lloyd & Hastings, 2009.)

Whitehouse et al. (2009b) state there is a need for ongoing intervention to focus on strategies that will promote psychosocial adjustment. This study shows that three individuals from their study already have these resources (Chapter 4.4.2, p.60) and psychologists need to harness a client’s strengths when planning the therapeutic approach.

Clients see themselves as a congruent whole, the language being an integral part of their overall persona, with sometimes levels of distress from life events. This study has the integrated narrative of the clients versus the modular/fragmented narrative of

psychologists. The psychological construction of the professionals seems to be underpinned by a very modular view of cognitive and emotional processing when it would be more beneficial not to compartmentalise aspects of experience as though they are not mutually influential.

Conti-Ramsden and Botting (2008, p.523) say “Those receiving referrals need to be aware of the possible association of emotional health and language disorder as this may inform assessment of developmental history and emotional disorder and the efficacy of any verbally-mediated therapy”. However, this research casts doubt on any general assumption of efficacy problems, both in terms of the young men’s level of engagement in the interviews and of their expressed expectations of counselling and counsellors (Chapter 4.4.3, p.79).

Therefore, results from the process of interconnection (Chapter 5.1, p.94) are supported by evidence from the clients that they are receptive to counselling (Chapter 4.4.3, p.79 and Table 4.3, p.80) and the psychologists’ views that they are not averse to the development of a therapeutic framework (the word used and interpreted by the interviewer) (Appendix 19, p.217).

Based on the findings from this research as a whole, the following preliminary suggestions are identified as important issues for those working in this field:

- The client to be seen as a whole person, with the psychologist accepting his abilities and understanding his difficulties;
- Bespoke therapy provided based on individual clients’ needs and expectations (including of the alliance) – not a one-coat-fits-all approach;
- Psychologists can help SLI/PLI clients identify and enhance their own resources and guide them in utilising these to find their own strengths present and future;

- The client informing research into service development with his voice at the core;
- The need for psychologists to keep up-to-date with new developments and ways of thinking.

A confounding factor of this research is that a bespoke approach is contrary to the current practice where therapy is prescribed based on diagnosis (NICE, 2008) and raises questions on training that currently may not include language development (and impairment) that is at the heart of therapy and of the self.

6.6 Future Research

Whilst issues of masculinity are not a theme in this study there are two considerations worthy of note: SLI is more prevalent in boys than girls (Conti-Ramsden & Botting, 2008) and it is known that psychological difficulties may result from adherence to male gender roles including emotional inexpressiveness and negative attitudes toward seeking psychological help. Depression remains undiagnosed and untreated and they do not understand the impact of these roles on their mental health (Good, Dell, & Mintz, 1989; Betz & Fitzgerald, 1993; Good, Robertson, Fitzgerald, Stevens & Bartels, 1996; Brooks, 1998; Levant, 1998; Englar-Carlson, 2006). Masculinity issues should not be ignored in this client group and may unknowingly impact on the research results. (See Chapter 4.5, p.82 and 4.6, p.88).

The results and conclusions reached through the process of interconnection of themes from Chapters 4 and 5 can be tested and either substantiated or refuted by introducing other elements of the research in addition to the electronic survey. For example, the psychologists' transcripts were considered in relation to the current professional competencies (BPS, 2008; HPC; 2009; BACP, 2010) to make a preliminary appraisal of instances where the professional competencies were met, or not met or considered. This is especially important for the HPC Standards (Chapter 3.3.7,

p.47) as these form the first examples of competencies within statutory regulation.

Copies of the abridged and annotated documents appear in Appendix 20, p.219.

It was identified that psychologists did not appear to consider alternative ways of working (to progress from current practice) (HPC, 2009, 2a.2) and did not consider SLI persisting across the client's lifespan (HPC, 2009, 2b.2). This process raised the possibility that the competencies might be made more relevant to disabilities if they were to include what the clients in this study imply (through the client themes and direct questioning detailed in Chapter 4, p.52) are factors important to them.

However, importantly, what the annotations in the professional competencies identified was the absence of considerations important to the participants with SLI/PLI when their voices should be, and are able to be, heard as this study shows.

Existing professional competency standards could be re-evaluated in collaborations between researchers, practitioners and the regulatory authorities and professional bodies to include clients' voices.

If it can be proved that client involvement has the potential to inform research into service development, especially for client groups with complex and unseen disabilities, there remains the difficulty of how to incorporate their phenomenological data in a systematic way with professional practice. This study shows the adopted methodology (i.e., IPA, TA and the process of interconnection) has the potential to be instrumental in service development for this and other client groups. This novel strategy prioritises patients' accounts and maximises their input in conjunction with professional working and allows for connections in an infinitely flexible way.

The preliminary findings emerging from this research are suggestive of new approaches for service development and will need to be validated in an evidence-based context before potentially influencing policy and practice. They have emerged from an

exploration of data provided by an electronic questionnaire completed and returned by a limited number of applied psychologists and by interviews with a small number of experienced psychologists and clients with SLI/PLI. Different themes might have been found with different participants or with a different researcher (Rizq & Target, 2008) and results may not be generalised to a larger population.

Findings could also be extrapolated to other disabilities where communication is impaired e.g., major forms of developmental language disorder found in childhood broadly parallel types of acquired communication deficit associated with left and right unilateral brain damage in adults where phonology, syntax and semantics (left) and pragmatics (right) are affected (Shields et al., 1996b).

Finally, there is a need for training in language development (including impairment) in doctoral courses for applied psychologists and for training on disability generally, particularly where communication is affected.

6.7 Conclusion

The research identifies deficiencies in knowledge and understanding of language impairment among counselling and clinical psychologists. Clients are not seen in the way they see themselves (as integrated, resilient individuals with idiosyncratic difficulties and an array of coping and defence mechanisms) but as people with an incurable impairment and manageable mental health problems or primarily in terms of their language impairment.

The research aim was:

To explore the knowledge, understanding and practice of psychologists and the lived experiences and psychosocial adjustment of young adults with SLI/PLI for the advancement of counselling psychology.

This has been achieved by “hearing” the voices of young adults and developing a novel approach to interconnect these with the practice of psychologists. This approach may inform any future research into service development for this group, resulting in additions to psychologists’ education and training and hence enabling the advancement of counselling psychology. Also, as suggested, the approach of interconnection may be suitable for informing service development research with other client groups.

These preliminary findings could then inform any future research into service development with the client’s voice at their core.

Whilst the outcomes from this research are based on limited samples, they pave the way for confirmation and testing in future research that should be guided by collaborations between researchers, practitioners, the regulatory authorities and professional bodies.

Chapter 7

Critical and Reflective Appraisal of the Research Process

“Reflexivity means we can intervene into ourselves, make decisions and change ourselves” (Rennie, 1998, pp.2-3)

Life as a psychologist-in-waiting charged with undertaking research has been a roller-coaster of despair and elation and of difficulties to be overcome and culminates in the creation of a thesis that has surpassed my initial expectations.

I began the “ride” by thinking of the research project as a further step in a life-long process of self-actualisation that was merely intensified when I returned to university to train as a counselling psychologist. I therefore entered into the research with optimism having been “chosen” by the university to study for the doctorate.

I was also reassured by the fact that my well-received BSc dissertation had 10 years previously enabled me to research pragmatic language impairment from an educational perspective. (At that time my son, a young man with SLI/PLI, ADHD, dyspraxia and specific learning difficulties, was in school.) This meant I would be starting the project with prior knowledge. I had also been extensively involved in third sector work and conference organisation in this field so I knew many of its professionals. The backdrop, however, was that I had never carried out qualitative research of any kind and this created a lack of confidence and self-doubt that entered into an unhelpful mental dance with my initial optimism.

Although I did consider possible claims of researcher bias because of my son’s difficulties, my decision to proceed was based on the perception that my experience and training meant that I was exceptionally well-placed to undertake this research. Perhaps the fact that despite prior knowledge it took me several weeks to establish what name I should give the impairment before settling on SLI and/or PLI (SLI/PLI) should have provided a warning but my doubts were pushed aside.

My second warning came with the literature review detailed in Chapter 2, p.7.

There was no qualitative research identified in which individuals with SLI/PLI were interviewed using Interpretative Phenomenological Analysis (IPA) so there was no accessible reassurance of the wisdom of attempting to undertake this research and one recent study suggested investigating the views of these individuals would be challenging. Then despite an extensive and lengthy scoping exercise to identify psychologists to participate in an interview and making contact with all of the most-published researchers in the field and specialist schools/colleges, I was unable to identify any participants with experience working with my client group.

That I had no participants was quite telling. It was tempting to replace psychologists with other professionals who work with these clients or parents but I wanted to persist as I had been told by one major researcher that there were potential participants. Therefore in discussion with my supervisor it was agreed that I would circulate an electronic survey that would both explore experience across respondents and ask for people to come forward. I subsequently had to decide whether I should include information on the scoping exercise in the thesis and originally did so. Eventually however it was removed to save words and because it did not add information of value to the content.

I had to check if the survey needed agreement by the university as it was not part of my initial proposal and to design and distribute the survey; not something I had done before. It did not. But this thesis journey would, throughout, take me to territory previously unknown to me. It was pleasing that I included some free text to enrich the data although this did require additional time for Chapter 3 analysis. On reflection, there were improvements that could have been made and with more time I could perhaps have made more of the opportunity. The response rate was disappointing but I felt this was consistent with my experience during scoping for psychologists for interview.

At the same time that I was trying to recruit psychologists for interview I was also concerned about identifying clients. For a time it looked as if nobody would be coming forward but then there was the overwhelming joy of receiving three responses from the ten contacted on my behalf by Oxford University and the survey also identified the four psychologists. I had also spoken to Manchester University, as they also have a client list from their research studies, but they were disinclined to help citing data protection. That had meant having all my client eggs in the Oxford basket.

My interviews with the clients involved travelling to the North of England. My interview schedule needed to take into account their particular difficulties whilst meeting IPA requirements and I found the experience extremely stressful at many levels. Afterwards I continued to reflect on them and eventually conceded that I could probably not have done significantly better. Because the interview was a conversation it was necessary to hold in my mind what the client had said from my schedule and what remained to be covered. This gave me a sense that my brain was too limited in capacity to hold and manipulate the input. I also had to work very hard not to be too directive by asking open questions as much as possible whilst acknowledging in each moment that this is quite difficult with people who may have receptive language problems and who may find it difficult to stay on topic.

Interviews with psychologists took place from the Midlands to the South. Perhaps because I had already conducted the client interviews I did not find these as stressful but they provided their own challenges. For example it was extremely difficult to maintain and further the interview where a psychologist appeared to be describing individuals with autistic spectrum disorder who were not the subjects of my research. I did feel that on occasions I was a little too interrogative and not sufficiently facilitative as I tried to remain neutral whatever their response.

I made the decision to produce a comprehensive contents page early in my work to guide my planning and kept all of the chapters and their sub-sections open so that I could place information identified day-to-day in appropriate chapters and move information between chapters. This has helped me to think of the “separate” chapters as part of the whole recognising that this is larger than the sum of its parts. Over time I built a picture of the finished work in my mind and have been mindful at all times of where the research was taking me and where I was taking it – sometimes an uneasy alliance during which the picture lacked clarity and I stumbled but regained my footing.

I noted that during this time, although I had no paid work, I was also struggling to cope with the pressure of university assignments, my placement and associated work and major problems at home. Looking back, I know that I had to prioritise my workload and the deadlines for the research suffered a little not just because I had made changes to my proposal (although this added to my pressure) but because I did not want to compromise work standards elsewhere and I had no idea at that time of the amount of work that would be required by the research. My supervisors tried to keep me on track and were largely successful but the hand-in date seemed a long way off. My personal standards may also have been set too high (childhood schema in play) and on reflection I spent too much additional time in my placement, time that could have been used for my research.

The process of transcribing the seven interviews was onerous. In both groups it was not always immediately possible to understand what was being said because of accents and impairments and so they were transcribed twice; this made a great amount of work and of course prompted the inevitable self-doubt about my interviewing competencies. Having transcribed the interviews the work needed to move to the IPA analysis; I felt paralysed by this step and read “the book” (Smith, et.al., 2009) and highlighted most of it in the hope that I would learn by osmosis. I then found numerous

IPA published papers to assist with this. Why, I asked myself, am I using IPA on a study of this complexity and importance without having practised the approach?

Eventually, having struggled with analysis, particularly making the transition between initial annotation and identification of emerging themes, I knew I needed to find my own way through this without being overly reliant on the “book”. I managed to overcome my fears and found a way to move forward through the audit trail by introducing some extra steps and checked the validity of these with my supervisors. In fact I did report to them that linguistic analysis was difficult as a consequence of the underlying language impairment but focus was anyway on experiential themes. I subsequently had to resist the temptation to attempt to identify and explain language difficulties by comparison with the literature review when this would not be me trying to make sense of the person trying to make sense of experience.

Then, increasingly during the lengthy process of analysis, I became concerned that the psychologists’ interviews did not lend themselves to IPA (not being primarily about their lived experiences but about their professional practice). I did not immediately understand the validity of these worries because I felt disempowered by my initial unnecessary fears of the IPA process and whilst my focus was on just trying to get to the narrative stage within my deadline.

When I finally recognised my concerns were justified, I felt traumatised and the task ahead seemed overwhelming. However, having decided and agreed with my supervisors that I needed to use Thematic Analysis (TA) I did eventually accept that there was solace in the fact that I had actually recognised it (on a better-late-than-never basis). Therefore, having grappled with IPA in Chapter 4, I then had to research and understand the TA methodology before undertaking the analysis. It helped me that I could build on the existing IPA transcripts. As I searched the literature I found that I could use deductive and inductive approaches and this would suit my research perfectly

but it would also create more work. Having thought in circles, not for the first time, and based on the richness of my data, I decided to choose this way forward despite the additional pressures.

It was also at this stage that I recognised the difficulty of writing up this change to methodology. I had used a chronological approach, referring to it where it happened, believing this to be more “honest” but numerous problems were created throughout Chapter 4 that confused the reader, beginning with the title. I therefore asked for input from supervision and was advised to rewrite those aspects of the study in the here-and-now i.e., as if this were the intended approach from the outset. I felt my schedule was significantly set back by this need for rewriting but knew that it was sensible and necessary and used my raised level of anxiety to drive the rewrite forward, reassuring myself that what was happening was merely research as an evolutionary process and an (even greater) increased opportunity for personal growth.

There was a further setback when it became obvious that Chapter 4 was both too large and also confusing having changed methodology. I needed to make two separate chapters and time was ticking by remorselessly. However, as the research had progressed and developed I was also understanding more clearly the potential value of this work as it applies to disability where communication is affected.

At the same time, I began to become very concerned about my imminent hand-in deadline and disconcerting word limit and spoke to my course director and supervisors about some extra words and time. Whilst I was waiting for the agreement that I would be allowed some additional time, having previously taken a short retrospective leave of absence, I made a frightening discovery when looking at one of my appendices and my heart sank to my feet. I saw a reference to seeking NHS approval (if any interviewee worked for the NHS) in the letter that had been electronically sent to psychologists with my survey. I had no memory of this and nothing had been done about it; this was the

only mention of it. I was distraught and convinced myself that my doctoral dreams had ended.

I had believed I did not need to contact the NHS as I had not recruited participants through them but according to the National Research Ethics Service (NRES) website I needed to seek permission. Having spoken to the University about my concerns I decided to speak to the Research and Development (R&D) department at the PCT where I currently work and they were understanding and supportive telling me to contact the other two trusts involved and speak to their R&D people. I had to send a copy of the ethics form and they then sent me an email for the thesis appendices clarifying their position on the matter. One said as it is an exploratory assessment of need rather than “research” as defined by the DoH formal REC approval is not required and encouragingly included an invitation to present my results to the PCT. However, I should have known what was required of me.

Bringing the thesis together during the final weeks was a massive challenge and unfortunately, whilst the extra time was agreed no extra words were allowed and this was very disappointing. Should I be aiming at achieving a good enough thesis or something closer to excellent in the time available? Good enough was going to have to be the goal. Even this modified goal meant working long hours and tirelessly to complete chapters and references and meet style requirements but I felt I could and should be doing more. However, despite my many set-backs, I could see with the benefit of hindsight that the final design was how the study should have been planned originally.

Finally, the support of supervisors is of paramount significance. Initially I found building a relationship with them surprisingly difficult. I believe this was because I felt that at my advanced age and with my life and work experience I should have been more knowledgeable and confident than I was. Instead I wrestled with a strange mix of

maturity and competence (in life, business and university course work) combined with a sense of inadequacy (in research).

I do feel that experimenting with two new research methods for a doctorate may have been a little too ambitious and time was my enemy. So, although the thesis was completed and handed in, my self-doubt will only be eradicated if and when my doctorate is conferred.

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Appendices

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

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Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

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All manuscripts must be submitted via our [online peer review system](#). The Journal operates a policy of anonymous peer review.

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- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose,

Methods, Results, Conclusions. Please see the document below for further details:

- [British Journal of Clinical Psychology - Structured Abstracts Information](#)
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
- For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Publication ethics

All submissions should follow the ethical submission guidelines outlined the documents below:

[Ethical Publishing Principles – A Guideline for Authors](#)

[Code of Ethics and Conduct \(2006\)](#)

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the [British Library Document Supply Centre](#). Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

8. Copyright

On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form. To find out more, please see our [Copyright Information for Authors](#)

Disorders usually first diagnosed in infancy, childhood or adolescence

Childhood disorders not currently listed in DSM-IV

Specific Language Impairment (SLI)

- A. Specific Language Impairment (SLI) is a form of [Language Impairment](#) that is diagnosed when language abilities are below age expectations but non-linguistic developmental abilities are within age expectations. The child's first words are likely to be delayed, early grammatical and morphosyntactic forms may be late to appear, vocabulary size can be smaller and less varied than expected, awareness of the phonemic and morphemic structure of words can be delayed well into the school-age years, and utterances can be shorter and less complex than expected. Language performance must be below age expectations as measured by an individualized, standardized, culturally and linguistically appropriate psychometric measure. Nonverbal cognitive performance is not impaired.
- B. The low language abilities result in functional limitations in effective communication, social participation, academic achievement, or occupational performance, alone or in any combination.
- C. Criteria are not met for [Intellectual Disability](#).
- D. Symptoms must be present in early childhood (but may not become fully manifest until language demands exceed limited capacities)

Social communication disorder (SCD)

- A. Social Communication Disorder (SCD) is an impairment of pragmatics and is diagnosed based on difficulty in the social uses of verbal and nonverbal communication in naturalistic contexts, which affects the development of social relationships and discourse comprehension and cannot be explained by low abilities in the domains of word structure and grammar or general cognitive ability.
- B. The low social communication abilities result in functional limitations in effective communication, social participation, academic achievement, or occupational performance, alone or in any combination.
- C. Rule out [Autism Spectrum Disorder \(ASD\)](#). Autism Spectrum Disorder by definition encompasses pragmatic communication problems, but also includes restricted, repetitive patterns of behavior, interests or activities as part of the autism spectrum. Therefore, ASD needs to be ruled out for SCD to be diagnosed.
- D. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities).

Language Impairment

Language Impairment

- A. Language impairment (LI) is diagnosed based on language abilities that are below age expectations in one or more language domains; LI is likely to persist into adolescence and adulthood, although the symptoms, domains, and modalities involved may shift with age.
- LI affects acquisition and use of spoken language (sound-, word-, sentence-, and discourse-level comprehension, production, and awareness), written language (reading decoding and comprehension; spelling and written formulation), and other modalities of language (e.g., sign language).
 - LI can affect the domains of vocabulary; grammar; narrative, expository and conversational discourse; and other pragmatic language abilities individually or in any combination.
 - Language impairment should be diagnosed based on multiple sources of information, including naturalistic observation and individualized, standardized, culturally and linguistically appropriate psychometric measures.
 - A regional, social, or cultural/ethnic variation (e.g., dialect) of language is not an LI.
 - LI may occur as a primary impairment or co-exist with other disorders (e.g. [Autism Spectrum Disorder](#), [Learning Disability](#), [Selective Mutism](#)).
- B. The difficulties with language result in functional limitations in effective communication, social participation, academic achievement, and occupational performance, individually or in any combination.
- C. If LI is present, it should be determined whether the criteria are met for [Late Language Emergence](#) or [Specific Language Impairment](#), or other related disorders such as [Social Communication Disorder](#) or [Selective Mutism](#), in order to formulate appropriate diagnostic testing and treatment plans. LI may be a provisional diagnosis to initiate treatment and further investigation. LI may be the primary diagnosis if criteria are met for LI but not for any of the other LI diagnostic categories.
- D. Symptoms must be present in early childhood (but may not become fully manifest until speech, language, or communication demands exceed limited capacities).

Late language emergence

- A. Late language emergence (LLE) is a delay in language onset with no other diagnosed disabilities or developmental delays in other cognitive or motor domains. LLE is diagnosed when language developmental trajectories are below age expectations for toddlers and preschool children up to 4 or 5 years of age based on age-referenced criteria (e.g., less than 50 words at 24 months, inability to follow verbal instructions, limited use of gestures and sounds to communicate, limited symbolic play, and few word combinations at 30 months). Children with LLE are at risk for Specific Language Impairment, [Social Communication Disorder](#), [Autism](#)

Language Impairment

[Spectrum Disorder](#), [Learning Disability](#), [ADHD](#), [Intellectual Disability](#) and other developmental disorders, and therefore need to be identified as toddlers, referred for early intervention, evaluated for more general cognitive problems, and monitored for a change in diagnosis as they approach school age.

- B. The low language abilities result in functional limitations in effective communication, social participation, or emergent literacy skills and pre-academic achievement, alone or in any combination.
- C. Criteria are not met for Specific Language Impairment, [Social Communication Disorder](#), [Autism Spectrum Disorder](#), [Intellectual Disability](#), or [Learning Disability](#).
- D. Symptoms must be present in early childhood and identified before 4 or 5 years of age.

From APA (2010)

Section 1 - Demographics

1 Please confirm whether you are a:

Counselling psychologist ☐ Clinical psychologist ☐

Other ☐ Please state

2 Do you work for an NHS trust? Y/N

If so, which one?

3 Do you work privately? Y/N

If so, in which area(s) of the country?

4 Gender: Male/Female

5 Age range: 25-35 ☐ 36-45 ☐ 46-55 ☐ 55+ ☐

Section 2 – Your understanding

6 and 7 Are you familiar with any of the following terms and their formal definitions and what is the depth of your knowledge about each?

Key:

- 1 Minimal
- 2 Adequate for my purposes
- 3 More than adequate
- 4 Expert

	1	2	3			
	Have you heard of the term?	Are you familiar with the formal definition?	What is the depth of your knowledge?			
			1	2	3	4
Communication disorder(s)	Y/N	Y/N				
Developmental language impairment	Y/N	Y/N				
Developmental language disorder	Y/N	Y/N				
Specific language impairment	Y/N	Y/N				
Pragmatic language impairment	Y/N	Y/N				
Specific speech and language difficulties	Y/N	Y/N				
Primary language impairment	Y/N	Y/N				
Speech, language and communication needs	Y/N	Y/N				
Semantic-pragmatic disorder	Y/N	Y/N				

- 8 If you have knowledge of any these terms, where did you gain this knowledge? You may check more than one.

Key:

- A University course
- B Own reading
- C Training session
- D Collaboration with a speech and language therapy team
- E Prior to meeting a client with a relevant diagnosis

	A	B	C	D	E	Other (please state)
Communication disorder(s)						
Developmental language impairment						
Developmental language disorder						
Specific language impairment						
Pragmatic language impairment						
Specific speech and language difficulties						
Primary language impairment						
Speech, language and communication needs						
Semantic-pragmatic disorder						

If applicable (e.g. a course completed at a university or within a health care trust), where (in which region of the country) did you gain this knowledge?

Section 3 – Working with clients

9 Do you have any experience working with adolescents and/or young adults (aged 18-35) whose problems could be categorised as any of the terms listed in question 8? (Please note that you can use the back button to review the list of conditions.)

Y/N*

If no, thank you very much for taking the time to complete and return this questionnaire. If you have any further comments please add them to the space provided at the bottom of this questionnaire.

10 Did any of these clients have a *formal* diagnosis consistent with the terms listed in question 8?

Y/N What was their formal diagnosis?

11 Approximately how many clients who presented for assessment with a formal diagnosis have you worked with?

1-5 ☐ 6-10 ☐ 11-20 ☐ 21-25 ☐ 25-30 ☐ 30+ ☐

12 Were these clients seen within the last:

0-5 years ☐ 6-10 years ☐ 11+ years ☐

13 Did these clients present with any additional physical or psychological conditions? Y/N
If Yes what were they?

14 What therapeutic approach did you use? (e.g., CBT) _____

15 Did you have to modify your assessment/therapy in response to the diagnosis? Y/N

16 Were you required to make any further therapeutic modifications during your time working with this client?

17 In what way(s) did you modify your approach?

18 If you do have experience with clients who have a formal diagnosis, would you be willing to undertake an interview as explained in the information sheet for Stage II?

Y/N*

If you are willing to participate in an interview, please provide contact details below:

Name: _____

Address: _____

Contact telephone number: Work: _____
_____ Mobile: _____

Email: _____

19 Are there any additional comments? Please continue on a further sheet if necessary.

Many thanks for taking the time to complete this questionnaire

School of Applied Sciences Ethics Committee: submission of project for approval

- **This form must be word processed – no handwritten forms can be considered**
- **ALL sections of this form must be completed**
- **No project may commence without authorisation from the School Ethics Committee**

CATEGORY B PROJECTS:

There is identifiable risk to the participant's wellbeing, such as:

- significant physical intervention or physical stress.
- use of research materials which may bring about a degree of psychological stress or upset.
- use of instruments or tests involving sensitive issues.
- participants are recruited from vulnerable populations, such as those with a recognised clinical or psychological or similar condition. Vulnerability is partly determined in relation to the methods and content of the research project as well as an *a priori* assessment.

All Category B projects are assessed first at Divisional level and once approved are forwarded to the School Ethics Committee for individual consideration. Undergraduates are not permitted to carry out Category B projects.

Title of Project:	Developing an understanding of the psychological counselling needs of young adults with specific language impairment and/or pragmatic language impairment who are experiencing problems with psychosocial adjustment
Name of Supervisor: (for all student projects)	Dr J. Chen-Wilson and Mr N. Hulbert-Williams
Name of Investigator(s):	Val Harrington
Location of Research: (Module code, MPhil/PhD, Staff)	PS5011
Qualifications/Expertise of the investigator relevant to the submission:	<u>Val Harrington</u> BSc (Hons) - Brunel University – Psychology University Advanced Diploma - University of Derby - Cognitive Behavioural Skills and Studies Currently studying for Practitioner Doctorate in Counselling Psychology – University of Wolverhampton

Participants: Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.	There are two populations of participants: Population A Counselling- or clinical psychologists
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	<p>Number of participants</p> <p>5-8</p> <p>Nature of the participant group</p> <p>Must have experience counselling young adult or adolescent clients who have been formally diagnosed as having SLI/PLI.</p> <p>How they will be recruited.</p> <p>An advertisement will be placed in the BPS magazine, 'The Psychologist', and Divisional publications; contact will also be made with colleges for adolescents with SLI, the registered charities for language-impaired children, ICAN and AFASIC, and through personal contact/referral. Psychologists who have the most relevant experience with this client group will be preferred.</p> <p>Population B</p> <p>Young adults with SLI/PLI (see Appendix I for information on this client group)</p> <p>Number of participants</p> <p>5-8</p> <p>Nature of the participant group</p> <p>Participants will have a formal diagnosis of SLI/PLI (in the absence of autism or Asperger's syndrome) with, for no known reason, a substantial discrepancy between average non-verbal intelligence and specific language difficulties. Because of their normal non-verbal intelligence they do not fit into adult learning disability services. They are vulnerable because they have a life-long impairment and are at risk of poor social functioning and psychiatric problems later in life. None of those invited to participate will have had psychological counselling as this study is designed to develop an understanding of psychological counselling needs rather than to evaluate an individual's experience of counselling that may or may not have been underpinned by psychological principles.</p> <p>How they will be recruited.</p>
--	--

	<p>Research centres in Oxford (Oxford Study of Children with Communication Disorders), Manchester (Clinical Neuroscience and Language Disorders) and London (Centre for Developmental Language Disorders & Cognitive Neuroscience) as well as the registered charities for language-impaired children, ICAN and AFASIC will be contacted and agreement sought for their help in recruiting young adults with SLI/PLI for the study. If requested they will be sent a copy of the agreed ethics application form. Assistance will be given with copy for their internal communications or the provision of recruitment posters and flyers.</p>
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Continued overleaf

Appendix 4: Ethical Approval for the Study (continued)

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Please attach the following and tick the box provided to confirm that each has been included::

Rationale for and expected outcomes of the study	✓
Details of method: materials, design and procedure	✓
Information sheet* and informed consent form for participants <i>*to include appropriate safeguards for confidentiality and anonymity</i>	✓
Details of how information will be held and disposed of	✓
Details of if/how results will be fed back to participants	✓
Letters requesting, or granting, consent from any collaborating institutions	n/a
Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16	n/a
Is ethical approval required from any external body? If yes, which Committee?	NO
<i>NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.</i>	

Signed:

Date

(Investigator)

:

Signed:

Date

(Supervisor)

:

Except in the case of staff research, all correspondence will be conducted through the supervisor.

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Divisional Approval

Date

Granted:

:

 (Chair of Divisional Ethics
 Committee)

School Approval

Granted:

Date

 (Chair of School Ethics
 Committee)

Rationale for the study

Social, cognitive and genetic risk factors are all known to influence the onset of affective/emotional disturbances (Lau, Rijdsdijk, Gregory, McGuffin, & Eley, 2007). It has therefore been suggested that the long-term mental health of individuals with specific language impairment (SLI) and/or pragmatic language impairment (PLI) should be made a priority for future research (Whitehouse, Line, Watt & Bishop, 2009a and 2009b).

SLI incorporates a range of expressive and/or receptive language problems and is diagnosed when, for no known reason (in the absence of a hearing, medical or neurological cause) a child's language development does not follow the normal developmental course. The impairment is seen as language specific as there is a substantial discrepancy between the child's average non-verbal intelligence and language difficulties (Bishop, 1997a; Clegg et al., 2005).

People with PLI have impoverished or inaccurate representations of others' mental states, and social and behavioural problems similar to those with autism but milder, and experience psychological adjustment-related difficulties that vary over time (Bishop, 1989, 1997a, 1997b, 1998).

These impairments have been shown to persist throughout childhood and become a life-long difficulty with particular risks for poor social functioning (including problems with friendships and romantic relationships) and psychiatric problems later in life. Research has identified major depressive disorders, anxiety disorder and social phobia in this population, severe enough in some cases to warrant psychiatric referral. Young people with histories of SLI are at risk of personal and social disadvantage often still

living with parents due to lack of financial independence. Their complex needs require multi-professional support (Clegg, Hollis & Rutter, 1999). Yet, no provision is formally available because their normal non-verbal intelligence excludes them from adult learning disability services. The psychosocial consequences were perceived by families to be more pervasive in adult life when no services were available than in childhood when some services were available (Clegg et al., 2005).

Regarding UK mental health policy, there is currently no indication that individuals with SLI and/or PLI who are in need of psychological support will benefit from the increased resources initiated by the Increased Access to Psychological Therapies initiative (Layard, 2004). This is despite evidence demonstrating that there are twice as many school-age children with speech, language and communication needs compared to those with autism (DfES, 2007).

There have been suggestions from within this academic field that a modified counselling approach may have potential to help individuals with SLI/PLI (Personal correspondence from Professor Bishop, Professor of Developmental Neuropsychology at Oxford University, 2008), although evidence is lacking on this matter. It is clear that further empirical enquiry is required into the psychological needs of those with SLI/PLI and how best they can be supported in clinical/counselling services.

Expected outcomes of the study

This research aims to raise awareness of the psychosocial adjustment difficulties in those with SLI/PLI from both client and psychologist perspectives. Additionally, the study will highlight the specific psychological support needs of this client group which may need to be addressed at both an individual intervention and at a policy-setting level. The work is also expected to provide guidelines for how a counselling psychology-based therapeutic model may be developed and implemented. To achieve these ends, it will be necessary to address such questions as 'What are the experiences of clinical/counselling psychologists working with individuals who have SLI/PLI?', 'What psychosocial difficulties present in this client group and how do they differ from other demographic groups?', 'What are the approaches and challenges specific to young adults with SLI/PLI?', 'What are the expressed needs of these individuals?'

Details of design and procedure

Qualitative research is considered particularly appropriate where the field of interest is characterised by complexity and ambiguity and where, as in this case, there is limited prior theory (Richardson, 1996). Interpretative phenomenological analysis (IPA) has been selected as the methodology for this study. IPA is a form of phenomenological inquiry that explores in detail participants' personal experiences (Smith & Osborn, 2003). The choice of IPA was based on the requirement for an idiographic approach, in which the meaning of psychologists' subjective and private experiences of counselling clients with SLI/PLI can be explored. Young adults with SLI/PLI, all of whom will have average non-verbal intelligence, will also be interviewed to gain a deeper understanding of their personal perspective of the research questions. IPA has been used successfully with many types of participants in health, clinical and counselling psychology and as such seems appropriate for both of these groups (Leggett, Goodman & Dinani, 2007; Macdonald, Sinason & Hollins, 2003).

In accordance with IPA principles, the interview will not be strictly regimented to cover the areas of investigation in any particular order – instead, the interviews will be guided principally by the participant and any of these areas which are not discussed naturally will be initiated by the researcher.

Very general, non-leading questions will be used to initiate the discussion in each area (for example, 'Can we talk about the clients you have worked with?' and 'Can we talk about your diagnosis?') and supplementary questions will be used to elicit more information in particular areas.

There will be three phases in this research:

- **Phase I** is the collection of data from psychologists who have experience of counselling young adults with SLI/PLI;
- **Phase II** is the collection of data from young adults with SLI/PLI who have not had psychological counselling as this study is designed to develop an understanding of psychological counselling needs rather than to evaluate an individual's experience of counselling that may or may not have been underpinned by psychological principles;
- **Phase III** acts as both a validation phase of the psychologist interviews, and as a follow-up study whereby the psychologists who participated in Phase I will be invited to comment on some of the issues highlighted in the interviews with the young adults with SLI/PLI.

Phase I**Participants**

Five to eight counselling- or clinical psychologists (population A on RES20B form) will be recruited. These participants must have prior experience of counselling

young adult or adolescent clients who have been formally diagnosed as having SLI/PLI in the absence of autism or Asperger's syndrome. Psychologists who have the most relevant experience with this client group will be preferred. An advertisement will be placed in the BPS magazine, 'The Psychologist', and Divisional publications; contact will also be made with colleges for adolescents with SLI, the registered charities for language-impaired children, ICAN and AFASIC, and through personal contact/referral. The information sheet for the psychologists is in Appendix III and the consent form is in Appendix IV.

Procedure

Data will be collected through one-to-one interviews with the psychologists, each lasting 60 to 90 minutes. The interviews will be semi-structured to ensure that all aspects of the subject are covered and questions will be prepared and phrased carefully to avoid leading the participant. The areas of investigation are shown Appendix II. In accordance with IPA guidelines, the structure of the interviews will develop constantly and be informed by the earlier interviews.

The interview will take place in the psychologist's office, or another setting where he or she feels comfortable if preferred.

Interviews will be audio recorded and notes will be made of any non-verbal signals in a notebook. Data will be collected with the primary purpose of understanding their experiences of, and/or personal opinions and attitudes towards, providing psychological counselling to this specific client group.

Verbatim transcripts will be produced, incorporating verbal and non-verbal elements for analysis. In accordance with IPA guidelines, the transcripts will be analysed systematically and in detail to develop issues, themes and sub-themes. Themes will be connected and clustered providing in-depth analysis of the shared data.

Phase II

Participants

Five to eight young adults with SLI/PLI (Population B on RES20B form) who have not had psychological counselling will be recruited. Research groups in the UK that focus on SLI/PLI will be contacted and, through them, potential participants will be identified and approached. The information sheet for the young adults is in Appendix V and the consent form is in Appendix VI.

Procedure

Data will be collected through one-to-one 60 to 90 minute interviews with the recruited young adults with SLI/PLI. These will again be semi-structured and follow the interviews with the psychologists, possibly with some discussion of issues raised by them. The areas of investigation are shown in Appendix II. As in Phase I, the structure of the interviews will develop constantly and be informed by the earlier interviews.

These will take place in the participant's home as this is typically where participants feel most free and comfortable to talk about difficult issues (Smith & Eatough, 2007). Although it is usual for interviews to be conducted on a one-to-one basis (to avoid biased responses) due to the vulnerable nature of the sample a parent, friend or carer may be present if the participant wishes. However, we acknowledge that this may introduce some minimal level of bias into the data collection. It will be noted in the discussion when a third party is present in the interview. The interviews will be recorded and notes will be made of any non-verbal communication in a notebook by the researcher. Data will be collected with the primary purpose of identifying their psychosocial needs and attitudes towards psychological counselling.

Verbatim transcripts will again be produced and analysed to refine the issues, themes and sub-themes developed in Phase I.

Phase III

This final phase acts as both a validation phase of the psychologist interviews, and as a follow-up study whereby psychologists will be invited to comment on some of the issues highlighted by the interviews with the young adults with SLI/PLI. This is an additional step that, although not inherent in the standard IPA approach, was felt to be valuable in this study as it would give psychologists access to the perspective of this client group and enhance the research (Rizq & Target, 2008).

Participants

The counselling- or clinical psychologists who were interviewed in Phase I will be invited to participate in Phase III. It is anticipated that a minimum of 50% would be willing to participate in this further interview. The information sheet for this phase is in Appendix VII and the consent form is in Appendix VIII.

Procedure

The thematic interpretation derived from Phase I and Phase II interviews will be presented to the participants. Participants will be invited to comment on the accuracy of the analysis according to their own experiences and opinions and to

contribute any further data that reading the analysis may initiate. The following prompts will be used to guide the discussion.

- Do the themes and sub-themes adequately summarise the experiences we discussed previously?
- Do the themes and sub-themes reflect your clinical experience?
- Are there themes that you feel need to be added, removed or enhanced?

Any further issues or recommendations highlighted by the client interviews with the young adults with SLI/PLI will also be presented, allowing the therapists to discuss these in reflection of their own clinical practice and experiences.

Phase III interviews are expected to last no longer than 60 minutes. These will also be recorded, transcribed and analysed in accordance with IPA guidelines.

The final analysis will integrate themes from all phases of data collection to create a consolidated list of important issues, clients' needs, examples of good practice, and future recommendations. These will be used to develop a basis for a therapeutic model which could be empirically and clinically tested.

Details of how information will be held and disposed of

Throughout the study the researcher will take steps to ensure that the identity of participants is kept confidential unless permission is given specifically to reveal a participant's identity as detailed on the informed consent forms (Appendices IV, VI and VIII).

Two secure locations will be identified, accessible only to the researcher and her supervisors. Paper records will be stored in a locked filing cabinet at the University of Wolverhampton and some electronic records will securely held by the researcher.

When an informed consent form is received the participant will be allocated a code and this code will be used consistently throughout the study in place of the participant's name. The consent forms, and any other paperwork concerning the participants, will be kept in the secure location and the researcher will not allow anyone, other than her supervisors, access to a list of the participants in the study.

The interviews will be recorded on a digital voice recorder as an MP3 file. On completion of the interview a copy of the file will be made onto a DVD and the file on the recorder will be deleted.

A duplicate of the DVD will be held securely whilst the researcher produces a verbatim transcript of the interview. The file containing the verbatim transcript will be copied onto the DVDs containing the interview and these will be held securely. No paper copy of the transcript will be made at this stage, which means that the interview and the transcript will be held securely together on one DVD, with another secure copy.

At this stage the researcher will make any amendments to the verbatim transcript that are necessary to ensure the confidentiality of the participant is maintained to produce a working transcript (for example, the participant might say something during the interview which might allow his or her identity to be determined; this will be amended). In most cases it is anticipated that no amendments will be required but doing this will ensure that anyone can access the working transcript without the identity of the participants being inadvertently revealed. At this stage any non-verbal data noted during the interview will also be added.

The working transcript will be used for the analysis of the data.

The informed consent forms and the DVDs containing the interviews and the verbatim transcripts will be kept securely for five years from the end of the study and then will be physically shredded and disposed of as confidential waste.

For security, any electronic records will be password protected for both read-only and read-write access. Only the researcher and supervisors will know this password.

Details of how results will be fed back to participants

Individual participants will not be provided with transcripts of their own interviews in any phase of the study unless specifically requested. If provided, this will not include any notes or analysis made by the researcher on language, content, or non-verbal behaviour.

Both participant groups will be sent a research summary on completion of the work at the end of 2010 with a covering letter formally thanking them for their participation.

For psychologists

The confidentiality and anonymity of the psychologists and that of their clients will be maintained throughout. It is recognised that reflecting on practice may raise some anxiety/stress issues but it is not anticipated that this will be a major concern or last beyond the end of the interview. However, if they express anxiety at the conclusion of the interview it will be suggested that they discuss this with their clinical supervisor.

For young adults with SLI/PLI

Advice will be sought on the wording of any materials for the client group and to ensure that the interviews are conducted in a way that enables full participation. Particular care will be taken to communicate clearly the purpose of the consent form (Appendix VI) and how the ethical principles are to be followed with the potential participants.

The researcher is aware of the potential for emotional distress within this study but the study has been designed to minimise this where possible. For example, the clients will

be offered the opportunity to have a parent, friend or carer present during the interview if the participant wishes due to his or her vulnerable nature.

In cases of upset and distress, the interview can be paused, and participants retain the right to withdraw at any time in accordance with British Psychological Society guidelines for research. In the unlikely event that it is apparent that distress has been caused, access to supportive resources would be offered. However, the involvement here would be primarily signposting to available help, unless it is specifically requested by the participant that contact is made on his or her behalf.

For the researcher

A 'lone worker' policy will be devised by the researcher and her supervisors to ensure her personal safety. In particular, care will be taken to ensure that a supervisor is aware of any visits to personal homes and workplaces and that contact is made on completion of each interview as an assurance of the researcher's safety.

Ethical concerns will be discussed with supervisors during regular meetings

Letter from University of Wolverhampton, School of Applied Sciences granting permission to continue with the proposal



UNIVERSITY OF
WOLVERHAMPTON
School of Applied Sciences

Dean of School: Professor Patrick W J Robotham BSc PhD

Psychology Division
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24th July 2008

Valerie Harrington
Bromley Corner,
4 Orchard Dene,
Buckinghamshire.
MK18 1PX

Dear Valerie,

**Doctorate Proposal for Counseling Psychology
Special Student Management Board Meeting held on 8th July 2008**

The Board made the following comments on the submission of your RES1P:

Title: Developing an understanding of the psychological counselling needs of young adults with specific language impairment and/or pragmatic language impairment who are experiencing problems with psychosocial adjustment.

Research Area: Appropriate and topical area of research.

Methodology: Appropriate for this level of research.

Supervisor Availability: Two supervisors have been proposed. It was noted that one of the supervisors with specialist knowledge in this area had not yet obtained their doctorate and in the meantime should be referred to as a 'specialised advisor'.

It was agreed that the student may continue with this proposal.

Yours sincerely,

**Dr Nicola Hart
Module Leader
Doctoral Thesis (PS5011)**

Copy: Dr. Yvette Lewis

Vice-Chancellor
Professor Caroline Gipps MSc PhD ACSS FRSA

-----Original Message-----

From: Manktelow, Kenneth I (Prof)

Sent: 14 May 2009 14:42

To: Hulbert-Williams, Nick

Cc: Morris, Neil G (Dr)

Subject: RE: Val Harrington

Nick,

I see no problem with a new recruitment strategy, since the potential participant group will be the same.

KM.

-----Original Message-----

From: Hulbert-Williams, Nick

Sent: 13 May 2009 11:19

To: Manktelow, Kenneth I (Prof)

Cc: Chen-Wilson, Josephine

Subject: Val Harrington

Dear Ken,

Further to my last email about **, I'm also supervising a Counselling Doctoral student who also needs to slightly ammend her project.

Val's application was accepted on the basis that she would identify eight clinical or counselling psychologists who have experience of working with adolescents or young adults with specific language impairment and/or pragmatic language impairment (in the absence of autism or Asperger's syndrome). These professionals were then to be interviewed using IPA. Following these interviews people with SLI/PLI would be interviewed. The intention being to develop a framework for the development of a therapeutic approach suitable for this client group who have been shown to develop mental health problems as young adults. The proposal anticipated that if these professionals were to be identified they would be known to the specialist language schools, to researchers in the field or through the BPS. Having explored these sources, indications are that there may be few of these people and she has, therefore, undertaken a scoping exercise within CAMHS to try to identify whether these individual do actually exist. This has proven unsuccessful and so we have been forced to explore other options. Jo and I (as joint supervisors) have advised Val to conduct a short e-

survey. This will be circulated to clinical- and counselling psychologists to investigate their knowledge of these impairments and whether they've ever had clinical contact with them. It is possible that this will identify participants for the interviews. If it proves impossible to recruit, it will be necessary to identify a different professional group (which we will submit as a separate application if and when the need arises). Even if this survey does not identify participants for the interview study, the information gathered will still prove a valuable contribution to her thesis, and indeed the current literature, providing evidence to support the initial dilemma around the difficulties of recruitment of psychologists!

Can you please confirm whether or not this change can go through as a Chair's action or would require a new application. If a Chair's Action is possible, we'd be very grateful as this would speed up progress on the project. Can you please also let me know what further details you may need, if any.

Many thanks,

Nick.

Nicholas Hulbert-Williams B.Sc. (Hons)

Lecturer in Applied Psychology

Department of Psychology, School of Applied Sciences University of
Wolverhampton MC Building, City Campus Wulfruna Street Wolverhampton
WV1 1LY

Tel: 01902 321329

Fax: 01902 321380

Dear

Supporting young adults with developmental language impairment: a scoping exercise to identify awareness among clinical- and counselling psychologists

I am currently studying for a practitioner doctorate in counselling psychology with the University of Wolverhampton and for my thesis I am undertaking research into the counselling needs of young adults with Developmental Language Impairment. This refers to people formally diagnosed with Specific Language Impairment (SLI) and/or Pragmatic Language Impairment (PLI) (in the absence of autism or Asperger's syndrome).

A comprehensive literature review indicates that these individuals may experience problems with psychosocial adjustment leading to mental health problems and social difficulties. Furthermore, there is limited evidence of the availability of appropriate therapeutic interventions as these individuals do not have a learning disability and may be falling through a gap in service provision.

The overall aim of this work is to develop the basis for a psychology-based therapeutic model to meet the needs of this group which will then be tested in future work to develop an effective framework specific to this client group. Firstly, I need to identify psychologists who have experience of working therapeutically with this client group.

From initial investigations, I believe it is likely that there are relatively few of these individuals and, hence, I am undertaking a scoping exercise to identify psychologists' awareness of these impairments. Additionally, I hope to identify how many have direct client experience.

I would be extremely grateful if you would please complete the questionnaire whether or not you regard yourself as having this experience. If you do not have this experience the survey will end after nine questions and this contribution will be extremely valuable.

If you do have relevant experience you will be asked to give more details of this experience and you may wish to participate in the next stage of the study and an information sheet on this is attached. You should read the attached information sheet before completing the survey.

**Appendix 5: Personalised Email sent to Counselling and
Child/Adolescent Clinical Psychologists**

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Completion of the full questionnaire should take no longer than 10 minutes. On completion, your responses will be submitted automatically. Unless you have relevant experience and have agreed to take part in Stage II of the research (and have provided your contact details) the results will be anonymous. Any data you provide will be treated in a strictly confidential manner.

Please click on this link to take you to the on-line survey [*link to on-line survey here*]:

Thank you for your interest in this study and for your co-operation.

Yours sincerely

Val Harrington, Trainee counselling psychologist

Practitioner doctorate in counselling psychology, University of Wolverhampton.

August 2009

Appendix 6: Attachment to Email Linking to Electronic Questionnaire

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Supporting young adults with developmental language impairment: a scoping exercise to identify awareness among clinical- and counselling psychologists

Information sheet for Stage II of the study

If you have experience working with clients with Developmental Language Impairment and have indicated in the scoping questionnaire that you would be willing to agree to be interviewed for the study then my intention would be, subject to appropriate ethical agreement, to invite you to be one of five participating psychologists in Stage II. If more psychologists volunteer to participate than we require, we will select appropriate participants based on those demonstrating the most extensive and relevant experience.

The study has been granted ethical approval by the University of Wolverhampton; if any of the participating psychologists work in the NHS then the study will also be submitted to an NHS ethics committee for scrutiny before the interviews would take place.

Each psychologist participating in Stage II will be asked to take part in a one-to-one, tape-recorded interview of between an hour and an hour-and-a-half. This would take place in a location convenient for the individual which could be your place of work or your own home. If a face-to-face interview is not possible we can explore the option of conducting the interview over the telephone.

The interview will be semi-structured and will seek to explore the psychologist's experiences of supporting adolescents or young adults with developmental language impairment. The methodology we will be using for these interviews is Interpretative Phenomenological Analysis, a psychologically-based qualitative approach.

Val Harrington

Trainee counselling psychologist

Practitioner doctorate in counselling psychology, University of Wolverhampton.

September 2009

Supervised by

Nicholas Hulbert-Williams BSc (Hons) PGCert PhD

University of Wolverhampton

Appendix 7: Response to Question 10: Did any of these clients have a formal diagnosis consistent with the terms listed in question 8?

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Counselling psychologists						
Answer to Q10	57520	57548	57553	57557	57571	57690
Yes						
Developmental Language Difficulties (participant felt this was inappropriate as client came from specific ethnic origin)						
No						
Not answered						

Educational psychologists						Other
Answer to Q10	57565	57567	57597	57645	57662	75588 57552
Yes, but only accepts DSM-IV or ICD diagnoses						
ADHD						
ASD						
Asperger's syndrome						
Communication Disorders						
Developmental Language Disorder						
PLI						
Semantic Pragmatic Difficulties						
SLI						
No but vague references to learning difficulties						

Appendix 7: Response to Question 10: Did any of these clients have a formal diagnosis consistent with the terms listed in question 8? (continued)

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[illegible]

Appendix 8: Response to Question13 Listing the Physical or Psychological Conditions that were Additional to the Language Impairment.

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Counselling psychologists						
Answer to Q13	57520	57548	57553	57557	57571	57690
Group 5: Psychiatric syndromes or symptoms						
Anxiety						
Depression						
OCD						
Too vague to classify						
Problems in their relationships with being						
No						
No answer given						

Educational psychologists							Other
Answer to Q13	57565	57567	57597	57645	57662	75588	57552
Group 1: Neuro-developmental disorders often comorbid with speech/language problems							
ADHD							
Dyspraxia							
Group 2: Neuro-psychological symptoms comorbid with speech/language problems							
Poor coordination							
Poor memory							
Poor organisation skills							
Social skills deficits							
Group 3: Syndromes in which speech and language impairments are associated and often presenting symptoms							
ASD							
Asperger's syndrome							
Learning disabilities							
Group 4: Neurological/physical conditions that can lead to secondary language problems							
Cerebral palsy							
General developmental delay							
Group 5: Psychiatric syndromes or symptoms							
Addiction							
Anger							
Anxiety							
Behavioural problems							
Not specified							

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[illegible]

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<i>Group 5: Psychiatric syndromes or symptoms</i>
Anger
Anxiety
Behavioural problems
Depression
Eating disorder
EBD
Low self esteem/confidence
Mental health problems
Mood problems
Parenting difficulties
Personality disorder
Psychosis
<i>Too vague to classify</i>
Sensory difficulties
No
No answer given

Appendix 9: Response to Question 14: Approach used in the Therapy and Question 15: Did you have to modify the assessment/therapeutic approach?

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Counselling psychologists						
The approach was modified in all cases.	57520	57548	57553	57557	57571	57690
CBT						
Eclectic CBT						
Person centred						
Expert witness assessment						
CAT						
Narrative therapy						
Solution focused						
Anything beneficial						
Existential phenomenological						
No answer given to Q14						

Educational psychologists							'Other'
The approach was modified in all cases.	57565	57567	57597	57645	57662	75588	57552
CBT							
Rarely CBT							
Person centred							
Eclectic							
Solution focused							
Involving others							
Many and varied, including TEACCH, visual timetables etc.							
Self regulation strategies							
Social stories							
Visualisation							
Not doing therapy, modified assessment							
No answer given to Q14							

Appendix 10. Participants Response to Question 17: In what way(s) did you modify your approach?

Resp. No.	Participant's response to question 17: In what way(s) did you modify your approach?	Careful use of language	Visual/ Non-verbal	Client's needs	Work with others	Developmental assessment	Flexible Sessions
Counselling psychologists							
57557	I learned how to communicate and make appropriate interventions according to the ethnic form of language expression.						
57548	Thorough research and understanding of cultural differences in verbal expression						
57690	Visual presentation approach - art therapy and drama therapy.						
57553	I always monitor the way I work with my clients and make changes as necessary generally in consultation with my client.						
Educational psychologists							
75588	Become more aware of body, eye contact, delivery of speech						
57645	In terms of the number of steps required. In all cases, allowing time for processing. Sentences simple in construction. Vocabulary familiar. Allow for working memory difficulties.						
57597	Visual rather than verbal during PCP.						
57567	According to the needs of the client, but not able to exactly specify						

Table continued on next page

Appendix 10. Participants Response to Question 17: In what way(s) did you modify your approach?

Resp. No.	Participant's response to question 17: In what way(s) did you modify your approach?	Careful use of language	Visual/ Non-verbal	Client's needs	Work with others	Developmental assessment	Flexible Sessions
Clinical psychologists							
57637	Careful monitoring. Reviewed person's comprehension levels, simplified language, visual approaches, attention to sequencing. Working with others to learn from them.						
57575	Visual aids beneficial. Language modified and parent or friend can be present. (Clients are learning disabled).						
57604	Using visual aids, pictorial formulations, shorter sessions, simplifying information.						
57636	More reformulation. Cognitive differences assumed, e.g., more concrete thought than expected developmentally that cannot be quantified immediately.						
57618	Shorter, more frequent sessions, written or visual prompts, more work with family and carers						
57666	Visual representations of concepts. Establishing shared meanings of words. No access to a SaLT.						
57610	Simplifying communication. Remain literal. Use more visual material.						
57574	More time, slower pace, more collaboration with parents.						
57594	Developmental approach, assessed developmental level of the young person in terms of semantics used and proposed treatment plan.						
57680	Modified assessment to suit child						
57568	Mindful of overuse of verbal complex material and communication.						
57560	Simplify language and length of utterances. Repeat and rephrase. Use more concrete language.						

Appendix 10. Participants Response to Question 17: In what way(s) did you modify your approach?

Resp. No.	Participant's response to question 17: In what way(s) did you modify your approach?	Careful use of language	Visual/ Non-verbal	Client's needs	Work with others	Developmental assessment	Flexible Sessions
57598	Adaptation of communication depending on difficulty presented during assessment.						

Table continued on next page

Resp. No.	Participant's response to question 17: In what way(s) did you modify your approach?	Careful use of language	Visual/ Non-verbal	Client's needs	Work with others	Developmental assessment	Flexible Sessions
Clinical psychologists							
57569	Introduced more creative non-verbal tools.						
57641	Used lots of hands-on and visual approaches e.g., mind maps.						
57563	Visually, mainly.						
57544	Adapted to the client's needs at the outset so they can engage in text-book therapy after about three to six months.						
57639	Ensuring individual work was appropriate to their needs.						
Other							
57552	No one model ever fits a client. I always adapt my approach using CBT and CAT related techniques.						
Total		15	12	7	4	4	3

Appendix 10. Participants Response to Question 17: In what way(s) did you modify your approach?

Very general questions will be used to begin the discussion in each section of the interview. I'm interested in your story in your own words.

The interview will be guided principally by you and any matters which are not discussed naturally will be raised by me. There are no right or wrong answers.

Can I check a few things? Check you have not had counselling. Check whether you have any questions on my letter sent by Dorothy Bishop describing the research – will refresh his memory if he has forgotten what it said (have copy with me). Can we agree a pseudonym. Would you find it helpful for your mum/wife or someone else to sit in?

Introduction on tape

Thank you so much for agreeing to take part in my study. As you know the interview is being recorded and you can ask to stop the interview at any time. It will be between one and two hrs. If you want a break please say and I will pause the tape or I will just suggest a break at some point about halfway through

I want to concentrate on the experience you've had in your life as someone with a diagnosis of specific language impairment and/or pragmatic language impairment. I have checked that you understand what my research is about and that you have not had counselling in the past. You have signed and given me the consent form. Can you please confirm that is right? You also know broadly how the interview will be done? Yes?

I am going to keep the questions short and use everyday words. Please tell me if you do not understand my question and I will ask in different words. Is that OK? Please tell me if you need more time to think about them. Is that OK? Is there anything you would like to ask?

1. Something about you, the young man

I would like to know something about you. What would you like to tell me about yourself that is not about your language difficulties?

- Perhaps you can tell me about your job or what you are interested in? Or similar
- What are you proud to have achieved?
- Can you tell me the most important one thing I should know about you?

2. Something about your feelings or emotions

How do you feel about your life at the moment?

- When you get up in the morning how do you feel?
- Are you happy most of the time?
- What sort of things make you happy?
- Do you go out and laugh and smile and have a fun time?
- Is that often?
- How do you feel if you don't feel happy?
- What would be the best words to use to describe it?
- Would you say you sometimes feel stressed/very worried/or bad about yourself?
- What sort of things make you unhappy, worried or feel bad about yourself?
- How do you try to make yourself feel better?

3. Living with SLI/PLI

What does having language problems mean to you?

- Does having a language impairment change how you live your life now?
- Has it been easy to grow up and move into work/being an adult?
- How do you get on making and keeping friends?
- Do you have any special friends or romantic relationships?
- Do you live with other people Who?

- Are you pleased to live with them or would you prefer to be somewhere else?

4. Help and support

Can you tell me about any times when you wanted to talk to someone about how you were feeling?

- Have there been people to help you when you wanted help? Who?
- Do you feel OK talking with family and friends about how you feel?
- Has anyone told you that you sound so unhappy or worried or have such a big problem with how you feel about yourself that you need special help?
- Has anyone ever suggested that you should discuss how you are feeling with a psychologist or someone else like a therapist or counsellor?
- Who was this person ... and what was the reason they said this?
- Have you yourself ever considered asking for counselling or therapy because you are unhappy, worried or feel bad about yourself? Or can't cope?
- Can you remember what was happening that made you feel unhappy?
- If you have been unhappy or worried, or felt bad about yourself is there any reason you didn't ask for help?
- Sometimes people use alcohol or drugs to make their difficulties go away? What do you think about that?
- Have you ever needed to talk to the police about anything?
- Did you find this helpful?
- If you have been offered counselling but decided not to go, why?
- Have you requested counselling and not been able to find any ... or for other reasons had your request declined?
- Can you think of a time when someone tried to help you feel less unhappy, worried or bad about yourself and it was really successful?
- Tell me about what happened?
- Has there been a time when someone tried to help you but it didn't really work out very well?
- What happened?
- Do you think that counselling is something you might consider now or in the future?
- Are you struggling with any particular difficulty now?
- Are you feeling miserable, stressed, worried or bad about yourself?
- Do you have less problems with language as you get older or do you just cope better?
- If you have more problems with language as you get older – do they all seem to pile on top of each other?

This might be a good place to take a break if you would like.

5. What sort of help would you want from a counsellor?

There are different types of counselling. If you were stressed, unhappy or felt bad about yourself what sort of help would you want?

- It might include help with changing your thinking and behaviour. Would that be helpful?
- Or would you prefer to just have someone trained to listen?
- Or perhaps a mixture of listening and helpful ideas?
- It might for example include some work to help you make friends - in a programme just for you and your difficulties. Would that be good?
- It might include using a computer. Would that be OK?
- Or how would you feel about involving members of your family?

- Can you think of any other ideas that have helped you in the past. Drama for example?
- Should a counsellor have some knowledge about language impairment and therefore have a better understanding of your problems?
- Have you ever been aware that someone was changing the way they were doing things to help you understand better?
- What works for you?
- Have you ever been aware that someone was changing the way they were saying things to help you understand better?
- What works for you?
- When the counsellor is talking to you, how could he change his approach to give the best possible help?
- Would it help to keep sentences short and avoid long difficult words, checking understanding as you go along, giving you time etc.?
- What sort of relationship would you want to have with the counsellor so you could feel better for talking to her/him?
- Would you want the counsellor to be in control or would you want to work together as a team? Or perhaps a bit of both?

6. Diagnosis and its impact

Can we talk about when you first knew you had a language impairment?

- Do you know what sort of language problem or problems you have?
- Has anyone given it or them a name?
- Do you remember the words expressive, receptive or pragmatic? Or some other name?
 - How did that make you feel?
 - How did your family feel about it?
 - Do you know who made the diagnosis?
 - Do you know how old you were at the time?
 - When did you begin to understand what it means to have a language impairment?
 - Do you have any other problems in addition to the language impairment?
 - If so, what is it – or what are they - and how much does it/do they affect you?
 - What special support did you have at school – mainstream school, language unit, language school or other special provision?
 - Did you take exams?
 - How did you get on?
 - Was education a happy experience ... or were you pleased to leave school?
 - Are you happy where you are now?

7. Close

- Are there any other areas that we haven't covered during this conversation?
- I have one final question. If you could make a wish what would it be?

Thank you ... I am going to turn off the tape now and then we can have a short informal debriefing if you would find it helpful.

**Dorothy Bishop FMedSci, FBA
Professor of Developmental
Neuropsychology
Wellcome Principal Research Fellow**

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<http://www.psy.ox>

E-mail: dorothy.b@psy.ox.ac.uk



**Oxford Study of Children's
Communication Impairments
Department of Experimental Psychology
South Parks Road
Oxford
OX1 3UD**

<<address>>

29 September 2009

Dear <<name>>

We are writing to people who took part in the research study that Andrew Whitehouse did a couple of years ago. This is to let you know about another study that you may be interested in. This is explained in the information sheet in the enclosed envelope. If you would like to take part, please contact Mrs Harrington directly.

Andrew and the team send you their best wishes

Yours sincerely

Noël Orpen (Ms)
Research Co-ordinator
OSCCI

University of Wolverhampton, School of Applied Sciences**Research into psychological counselling for young adults with SLI and/or PLI****Participant information sheet**

We are getting in touch with you because we want to find young adults with specific language impairment (SLI) and/or pragmatic language impairment (PLI) and to ask for their help. We would like to talk to people who may have struggled with problems of psychosocial adjustment. This can mean different things to different people. Some people might perhaps find it very difficult to cope with the stress of having to make changes in their lives. These changes might have been when they left school, or found a job. Some might find it hard to cope with problems with work, a lack of work, or having to live with parents. Some might find it stressful having no proper friendship group and being lonely.

We would like to invite you to join this study if you believe you have had some of these problems but if you have **not** had any experience of counselling. This is whether or not you have thought about, or been offered, counselling in the past. This study is to look at psychological counselling approaches for young adults with SLI and/or PLI who do not have autism or Asperger's Syndrome. Findings from this study will help to improve psychological counselling for young adults with these language impairments in the future.

The research is an assessment study only and not a treatment study. Your involvement is entirely your own choice. You will be interviewed by a researcher for no longer than an hour-and-a-half. The interview will take place in your home, or another place where you feel comfortable if you like. A parent or friend can be present if you want. The interview will need to be audio recorded but you will be free to stop the interview at any time and drop out of the study. This will not be a problem. You do not need to give any reason. If you do drop out, the audio recording will be rubbed out.

Any information about you given during the research will be kept safe and confidential. It will be held following rules given by the Data Protection Act 1998 and British Psychological Society guidelines. Your identity will not be revealed in any way in connection with this study.

The finished research may appear in scientific journals. Researchers should make their finished work known to others. This is required by the BPS Division of Counselling Psychology Guidelines (2005). Any information will be held for no more than five years after the date of publication of any results of this study. After this, the recordings will be destroyed. Any paper-based materials will be torn up and thrown away in confidential waste. You will need to sign the attached consent form prior to the interview.

We do not believe there will be any risks or benefits for you if you take part in this study. However, in the unlikely event that you get very upset, you will be told how you can get help.

The person doing this work, and who will interview you, is Val Harrington. She is a post-graduate student. Her work is approved by the University ethics committee. Val can be contacted at the School of Applied Sciences, University of Wolverhampton, Wulfruna Street, Wolverhampton WV1 1SB. Telephone: 01902 321000.

Or you can email her at: valharrington@gmail.com.

Val is supervised by Dr J. Chen-Wilson and Dr N. Hulbert-Williams who can be contacted at the university.

University of Wolverhampton**School of Applied Sciences****Research into psychological counselling for young adults with SLI/PLI****Participant consent form**

I agree to participate in the research study into counselling approaches for young adults with SLI and/or PLI. My participation in the study is entirely voluntary and will involve a one-to-one interview with a researcher. This conversation will be recorded.

*Please tick
or initial*

I confirm that:

- 1 I have read the information sheet provided for this study ☐
- 2 I have been given the opportunity to ask questions about the research. ☐
- 3 I am clear on the aims of this research. ☐

I understand:

- 1 An audio recording will be made of the interview. ☐
- 2 That I am free to halt the interview and withdraw from the study at any time, without penalty or reason in which case the audio recording will be erased. ☐
- 3 How my responses to the interview will be used. ☐
- 4 That any information about me obtained during the research will be kept secure and strictly in confidence. ☐
- 5 That anonymised quotes from my interview may be used in subsequent reports and papers but these will in no way enable anyone to identify me. ☐
- 6 That all information will be held in accordance with the Data Protection Act 1998 and British Psychological Society guidelines. ☐
- 7 That my identity will not be revealed to any other participant or in any subsequent publication of this study without first obtaining my specific consent in writing. ☐
- 8 That any information will be held for a maximum of five years after the date of publication of any results of this study. After this time the recordings will be destroyed and any paper-based materials will be shredded and disposed of in confidential waste. ☐

Name (please print)

.....

Signature

.....

Date.....

All of the clients' interviews were transcribed from the audio recording. All transcripts were then checked against the recordings for a second time, again word-by-word because of concerns about intelligibility. Analysis of the transcripts began after completion of all of the interviews to minimise bias where one interview is influenced by the analysis of a previous interview. Additionally, to ensure an idiographic approach each transcript was examined fully before analysing the others (Young et al., 2008).

Each interview was re-read and annotated in the right hand margin with, where required, brief summaries of the transcript (black type). Conceptual (red) and linguistic (blue) observations were then added and any initial quotes (blue) that have apparent significance were also identified during this stage of analysis (Smith et al., 2009).

As a consequence of the underlying language impairment linguistic analysis was difficult and comparatively limited. However, the focus of this research was always intended to be the more important extraction of experiential themes.

When the annotation process was complete each transcript was re-analysed revising some of those initial annotations and using this information to enter what was classed as pre-thematic interpretations (green) in the left hand margin. This process assisted familiarity with the script and thoroughness of interpretation to enable engagement in the identification of preliminary emergent themes.

The preliminary emergent themes again reflect both the participant's words and thoughts as well as the interpretation and various authors suggest there is encouragement to be innovative in terms of organising the analysis (Smith et al., 2009; Biggerstaff & Thompson, 2008; Willig, 2004). Therefore, a separate process was conducted with the pre-thematic interpretations being considered chronologically in the context of the transcript as a whole. During this process the resultant preliminary emergent themes and super-ordinate themes were entered onto individual tables (with block numbers to assist identification).

This necessitated an intense level of cognitive immersion in the transcript so that it was possible to challenge, reappraise and develop previous understanding, mindful of psychological considerations. The frequency of a theme does not necessarily suggest it should be selected as super-ordinate to, or more important than, other themes. The richness of the selected text and how the theme might inform other parts of the account must also be considered (Biggerstaff & Thompson, 2008).

To convert the preliminary emergent themes and super-ordinate themes into final emergent themes and super-ordinate themes the individual tables of preliminary emergent themes were subjected to a further interpretative process of reassessment and reorganising by working across all of the available data including the transcript. This final thematic data was entered onto a second table for each individual in parallel continuing to use block numbers for identification and introducing sub-themes where these add clarity to the theme of defence and coping mechanisms and therefore to the results. There was also adherence to an additional requirement to include overt relationships to psychological concepts and terms evident in the literature (Smith et al., 2009; Biggerstaff & Thompson, 2008; Willig, 2004).

When the second IPA table had been produced for each participant in the client group a provisional summary table to show the super-ordinate themes, themes and sub-themes for the group and in whom they were present. During this process block numbers were again checked against the original transcripts. This enabled the identification of key aspects of the data, supportive quotations for the results and an audit trail back to the original transcript.

Finally, in this iterative process, the quotes of each of the three clients that support each block number on their individual second tables were coded and classified into separate narratives by themes and sub themes, one for each client. These were then combined into a single document that allows confirmation of recurrence and impact and indicates broad similarities and differences (Smith et al., 2009)

Introduction

Thanks for completing survey etc. Sign the consent form. We need to agree a pseudonym.

On tape

This is a semi-structured IPA interview - that should take between one and one and a half hours. General questions will be used and I'm interested in your experience in your own words. This means the interview will be guided principally by you and any matters which are not discussed naturally will be raised by me. There are no right or wrong answers and if you would like me to repeat a question please say.

We will consider such issues as the diagnosis of specific language impairment and/or PLI, the clients, assessment, the therapeutic approach, formulation, treatment plan and so on and finally the outcome and therapeutic relationship. Please confirm on tape that you have read the information sheet, signed the consent form - having agreed to take part in this interview - and that you have agreed to be recorded. We will have an informal debrief off tape at the end.

Thank you.

When you met your clients, how were you made aware of this diagnosis and how did it impact on the initial assessment and case formulation?

- Did you have a letter, look at medical records etc
- Were you able to find out what you wanted to know?

What information was the client able to give you about their diagnosis of SLI and/or PLI and any other diagnoses they might have been given?

- Did clients have a Statement of Special Educational Needs for specific language impairment and where were they educated (language unit, specialist school, mainstream with support) if you know?
- Did the client have additional/co-morbid problems e.g. dyspraxia or ADHD?
- If there were other problems, did you take these into account and if so how?

Can you tell me what you know about SLI and/or PLI and what you understand the use of the word 'specific' to mean?

When offering counselling is it important to know the client has SLI?

- May prefer to focus on need based on formulation than diagnosis.

Was the SLI central to the case formulation or was it overshadowed by what the client believed were more significant issues?

Did the SLI impact on how many sessions you would need and were you able to implement the treatment plan as you wanted?

- Did the client's language difficulties prevent the client from understanding how therapy would proceed.
- Did the plan involve setting goals and homework and did this work?

What were their presenting mental health problems and any history and can you recall their family circumstances (living with parents, married, employed etc?)

- How did this/these problem (s) develop over time and what was the impact on the client and significant others?
- Did the client feel these problems were somehow inevitable given his history of language impairment?
- Had they ever had counselling before and did they provide information about it?

Were you able to explore how they had coped with any psychosocial problems resulting from life transitions and other stressful situations?

- Were they referred to you because you have experience with this group?
- If they had not made these associations for themselves, would you say they had experienced psychosocial adjustment problems?
- What were these problems? (leaving home, starting work, having a girlfriend or not and being lonely)

Is it helpful for a counsellor to have some knowledge about SLI and/or PLI and therefore have a better understanding of their problems from the outset?

- If the person had pragmatic language problems what did you do differently, if anything?
- Have you worked with autistic clients? Have you found that the approach used with the autistic clients works with clients who have pragmatic language impairment?

Did you feel confident to practise with these clients and how did you decide what therapeutic approach you were going to use?

- Have you found that some approaches work better than other approaches with these clients?
- Did you adjust your way of working and relating to take into account the client's language problem? If so, how?

Do you feel there is a need to develop a new therapeutic framework for the SLI/PLI client group and what additional features or considerations might it include?

- Features: (e.g. art, drama, social skills work)?
- Considerations: e.g. chunking information, checking understanding of language, regular summaries to check understanding and ensuring the client is processing all of the content of the session?
- If you have used these, how important were they to the success of the therapy?
- Have you thought about asking or actually sought advice from other professionals (e.g. speech and language therapists)? And if no why?

Can you think of a time when the therapy went particularly well and another when it went particularly badly and identify what made the difference?

- Did you consider using a different approach with future clients? What approach?
- Were you able to measure outcome?
- Were the clients able to give you feedback?

Were there ways in which the SLI influenced the therapeutic relationship both from your perspective and from the client's?

- Did you find the client uncommunicative, unwilling or unable to engage, or difficult to help for other reasons?
- Have you updated your knowledge of this field from current literature?

Are there any other areas that we haven't covered during this interview?

Thank you

Appendix 17: NHS Ethical Approval

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From: **Baxter Sinead (SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST)** <sinead.baxter@nhs.net>

Date: 18 January 2011 11:56

Subject: RE: further to our conversation

To: Val Harrington <valharrington@gmail.com>

Dear Val,

Thank you for contacting the Research and Development Department to notify them of your study. As the research activity has already occurred we are unable to issue R&D Approval retrospectively. We have looked at the study documentation, and with the information you have provided us, concluded that this is a low risk study as the meeting only occurred once within the Trust and with one NHS Staff member, and it will not be happening again.

I would like to highlight that these issues should have been discovered much earlier in the process by your University Supervisor, so that you would have been able to address them and proceed appropriately. Universities receive funding to provide support and guidance to students, and the University of Wolverhampton are signed up to the National Institute of Health Research (NIHR) Research Passport System which provides information and guidance for students to gain access to NHS Trusts.

I have also noted that although the Psychologists are on the BPS, they are still NHS Employees, and have signed up to the BPS as NHS employees. Therefore research involving visiting them on NHS Premises during their NHS time is classed as research within the NHS. This leads onto a second point, any research conducted within an NHS Trust needs to have been reviewed by an NHS Research Ethics Committee. Your study has been reviewed by the University Ethics Committee but not an NHS Committee, which could potentially pose problems when it comes to publishing your research – I am unsure whether this will pose problems but I thought that I should mention it for consideration in the future.

All the best for the completion of your study.

Kind regards,

Sinead

Sinead Baxter
RM&G Manager
Research & Development
SWBH NHS Trust
Tel: 0121 507 4092
Mobile: 07976 499420
Email: sinead.baxter@nhs.net

From: **Taggart Shelagh (5CQ) Milton Keynes PCT**

<Shelagh.Taggart@mkpct.nhs.uk>

Date: 1 February 2011 09:02

Subject: RE: Your Study

To: Val Harrington <valharrington@gmail.com>

Hi Val

The only response I have had so far from CAMHS is that they were aware you'd interviewed a member of staff. I did reply to say I ideally needed retrospective approval but no response as yet. As you have already undertaken the study with no issues and are working to a strict deadline, I think you can take this email as confirmation we are aware and happy that it went ahead.

Good luck

Shelagh

Val Harrington
Postgraduate Counselling Psychology
School of Applied Sciences
University of Wolverhampton
Wulfruna Street
Wolverhampton
WV1 1SB
16th February 2011
Dear Ms Harrington,

Re: Developing an understanding of the psychological counselling needs of young adults with specific language impairment and/or pragmatic language impairment who are experiencing problems with psychosocial adjustment

I am writing in relation to the above project which you have recently completed as part of your postgraduate counselling psychology course. I understand that you are anxious to have discovered that you should have sought NHS permission to undertake your project as it involved interviewing psychologists on NHS premises.

The Research Governance Framework for Health and Social Care (2005) governs research being conducted in NHS Trusts. This includes any research which is being undertaken with its staff, patients or their carers, and/or on its premises. Wolverhampton City PCT research and development department has specific duties under this framework, which it was not able to fulfil in this instance.

As the Chief Investigator of the research, you are responsible for the conduct of the project in accordance with these guidelines, particularly in terms of ensuring that participants are properly treated, that data is protected and that adverse events are reported to us and the ethics committee who originally gave approval for the research. As an R&D department we appreciate that research governance can be a challenging process at times and consequently we are always pleased to provide advice and guidance to applicants on what is required with regard to NHS approvals procedures.

I am sure that this has been an important learning opportunity for you and hope that it has not deterred you from undertaking research in the future.

May I take this opportunity to wish you well with your studies.

Yours sincerely

Sue Marshall
Director of Governance and Risk, Wolverhampton City PCT.

Copy to: R&D Office, Wolverhampton City PCT
Research and Development
The Beeches
Penn Hospital
Penn Road
Wolverhampton
WV4 5HN
01902-444609

University of Wolverhampton**School of Applied Sciences****Research into psychological counselling for young adults with SLI and/or PLI****Information sheet for psychologists**

Thank you for agreeing to participate further in this study. We understand that you have had experience of working with clients who have Specific Language Impairment (SLI) and/or Pragmatic Language Impairment (PLI).

The intention of this study is to consider the therapeutic needs of young adults with SLI and/or PLI, in the absence of autism or Asperger's syndrome, and to develop the basis for a counselling psychology-based therapeutic model to meet such needs. If the research is successful the model would be tested in future work to develop an effective framework specific to this client group.

Following the electronic scoping survey completed by psychologists, this 'interview' phase of the study will gather and analyse data from a number of psychologists who came forward from the survey and from a number of young adults with SLI and/or PLI using Interpretative Phenomenological Analysis (IPA). As you may already know, IPA involves a one-to-one interview that lasts between an hour and an hour-and-a-half and which will be audio recorded. The interview will take place in your office, or another setting where you feel comfortable if you prefer. You will, of course, be free to halt the interview at any time, and withdraw from the study, without penalty or reason, in which case the audio recording will be erased.

During the interview you will not be asked to reveal the identity of any clients you have worked with and you will not be expected to do so. The purpose of the interview is to explore your experiences in working with clients who are young adults or adolescents with a diagnosis of SLI and/or PLI. We will, of course, send you a copy of the conclusions at the end of the study (that is likely to be Spring, 2011).

The research has been approved by the University Ethics Committees and is being conducted in accordance with the BPS Code of Ethics and Conduct. Any information obtained during the research will be kept secure and strictly in confidence and held in accordance with the Data Protection Act 1998 and BPS guidelines and it is hoped that the completed research will be published in peer-reviewed journals. All data will be completely anonymised and your identity will not be revealed in any publication relating to this study or to the other psychologists participating in the research unless you specifically give your permission. You will need to sign the attached consent form prior to the interview.

Any information will be held for a maximum of five years after the date of publication of any results of this study. After this time the recordings will be confidentially destroyed and any paper-based materials will be shredded and disposed of in confidential waste.

The person conducting the research and who will interview you is Val Harrington. She is completing her Practitioner Doctorate and her contact information is:

Val Harrington

Postgraduate Counselling Psychology, School of Applied Sciences

University of Wolverhampton

Wulfruna Street, Wolverhampton WV1 1SB Telephone: 01902 321000

Appendix 19: Psychologists' Views on a Therapeutic Framework

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Dylan	Chris	Matt
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Alternatives to verbally-mediated approaches

Be open to other (non-verbal) modes of therapy [D236], including using visual strategies [D238] that might include video. [D268]

Social skills

Social skills training, including structured experience, e.g., going to the shopping centre. [D246] There may be staffing level issues. [D252] Conduct social skills training in the clinic room and explore social opportunities outside of the clinic. [D248]

Homework tasks relating to social interactions. [D240]

Psychologists in adult services do not know how to know how to work with people with social difficulties. [D262]

Perceptions and involvement of other agencies

Speech and language therapist to inform therapeutic work, [D230] decode information [D232] and give ideas about prognosis. [D234] However, they see speech and language as a child problem. [D270] He confirms that he really does not have contact with them. [D272]

Therapeutic approaches

An integrative approach, rather than one theoretical approach, is best. This should be explained to the client so they know what you are doing when you change direction. It needs to be structured, easy to explain and not involve a lot of abstract thinking or complicated use of language. They leave with a number of scripts that they can use throughout life. [C292] This provides psychological education. [C294] You need to be flexible [C310], creative [C312], client-driven. [C314] with lots of opportunities to be reflective. [C296]

T

Environmental factors

Start by considering how to change or modify the environment that might reduce any major hurdles for the client. [T110]

Are there useful gadgets, like, for example, a watch that will remind the person with SLI/PLI to do something. [T110]

Change parental/family attitudes to make a difference. [T112] Works to change the family dynamics as a client will be unable to become a different person whilst the family dynamics remain the same. Sometimes the parents need the client to remain the same. [T114]

T

Concept of a framework

With a framework you often narrow a person's options in terms of what they can say. That's what happens in ASD with adult services. It's difficult to get people in there because there's an exclusion criterion because they don't have the skills to work with them. [Mt207]

Would hate to say we need a specific way of working with people with that problem because it makes it easy for people to say it's not my area and not to do it. People can adapt the skills that they have once they know and they should be flexible and skilled enough to do it. [Mt207]

Would not wish to say always be more structured because you might want to use art, but some people might hate art. You need to make an assessment of that individual and decide on that basis, with knowledge, that that's a difficulty. [Mt207]

On the flip side, reports written about people with learning difficulties have recommendations about how they should be supported in education. These need pointing out so in that context guidance could be useful. [Mt217]

Don't make it [the framework] too specialised so that people would feel they don't want to do it but it would be good to have something out there so people could look it up. [Mt233] On reflection, probably nobody would tell someone how to work with a client. You just find your way by being with people for a while. [Mt247]

Dylan

SLI/PLI and ASD

HPC Standards of Proficiency, 2009	General Psychologist's Adherence
1a.1 Understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing.	This is called into question by the psychologists finding it helpful for a carer or parent to be present.
	Understand the power imbalance between practitioners and clients. There was no indication that psychologists did not understand their relationship to the client.
1a.4 Understand the importance of and be able to obtain informed consent.	Consent was never mentioned, but the acceptance of parental input was considered, seemingly, without consent .
1a.6 Be able to practise as an autonomous professional, exercising their own professional judgement- be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem.	Admission of poor knowledge of language disorders generally and this was seemingly not rectified.
	Know the limits of their practice and when to seek advice or refer to another professional. There were occasional attempts to refer on for formal diagnosis plus a little collaborative working.
	Be able to initiate resolution of problems and be able to exercise personal initiative. Tendency to skew diagnosis for client access to services.
	Recognise that they are personally responsible for and must be able to justify their decisions. All the psychologists did what they felt was right for this group and went to considerable lengths to adapt their sessions seemingly based largely on previous experience.
1b.1 Be able to work, where appropriate, in partnership with other professionals, support staff, service users and their relatives and carers.	Helpful to involve parents as easier and clearer, but working with other professionals minimal both in the psychological dimension and in the "duty of care" concept of ongoing support. In the TA it was mentioned that colleagues in adult mental health services struggle with people with social communication problems.

1b.3	Be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users and others.	All the psychologists made strenuous efforts to modify their communication style including visual aids.
	Understand how empathic understanding can be helped by creativity and artistry in the use of language and metaphor.	Specific mention of non-use and use of metaphor, and some effort into creative approaches.
1b.4	Recognise the need to use interpersonal skills to encourage the active participation of service users	Limited evidence of working alliance with this client group.
2a.2	Be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment.	Much talk of assessment, but aimed at the 'disorder' primarily.
	Be able to choose and use a broad range of psychological assessment methods, appropriate to the client, environment and the type of intervention likely to be required.	Mention of assessment (psychological) largely interpreted to mean diagnostic assessment.
	Be able to conduct psychological assessments and make formulations of a range of presentations.	Compromised by lack of understanding and existing opinions.
	Be able to reflect critically on their practice and consider alternative ways of working	The psychologists reflected critically but alternative working not evidently considered.
	Be able to assess social context and organisational characteristics.	This is an important aspect for the language impaired but there was little indication it was under consideration
2b.1	recognise the value of research to the critical evaluation of practice	Some of the psychologists were aware of some research on SLI and had read papers, but this seemed not to influence their methods. One said she/he read but forgot.
	Be able to engage in evidence-based practice, evaluate practice systematically, and participate in audit procedures.	No evidence of research outcomes incorporated into practice, nor audit.

2b.2	Be able to decide how to assess, formulate and intervene psychologically from a range of possible models and modes of intervention with clients and/or service systems	Few instances of psychological interventions with this client group.
	Be able to draw on knowledge of development, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities.	Development across lifespan is important in language impairment, but the psychologists seemed inaccurate in their understanding. Suggestion SLI always disappears age five.
	Understand therapeutic techniques and processes as applied when working with a range of individuals in distress including those who experience difficulties related to anxiety, mood, adjustment to adverse circumstances or life-events, eating, psychosis, use of substances, and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.	Language disabled clients are still vulnerable to all other life difficulties, but there was no indication from the psychologists that they looked beyond the impairment.
2b.3	Be able to formulate specific and appropriate management plans including the setting of timescales.	Not known
	Understand the requirement to adapt practice to meet the needs of different groups distinguished by, for example, physical, psychological, environmental, cultural or socio-economic factors.	All the psychologists made adaptations for this client group, though their anticipation of their requirements may not have been accurate. Asking the client seems infrequent.
2b.4	Be able to implement therapeutic interventions based on a range of evidence-based models of formal psychological therapy, including the use of cognitive behavioural therapy.	Two of the psychologists mentioned CBT as a possible approach with SLI/PLI for specific presentations.
2c.1	Be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly.	There was no mention of review used to assess progress.

3a.1	Know and understand the key concepts of the bodies of knowledge which are relevant to their profession-specific practice.	The psychologists came forward for interview because they had experience with language impairment, yet their knowledge was to some extent inaccurate and/or outdated.
	Understand psychological models related to a range of presentations including: problems with mainly psychosocial factors including problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic physical and mental health conditions.	Psychosocial factors are known to be associated with difficult times for people with language impairment. Although the psychologists knew this there was very little harnessing or assessing resilience or coping skills.
	Understand psychological models related to clients: with communication difficulties.	The psychologists used ASD as their default position but seemed not to involve psychological models. E.g. no mention of theory of mind, but limited use of metaphor or abstract thought.
	Understand the therapeutic relationship and alliance as conceptualised by each model.	Working alliance was not mentioned.
3a.2	Know how professional principles are expressed and translated into action through a number of different approaches to practice, and how to select or modify approaches to meet the needs of an individual, groups or communities	The psychologists enquired little of the young adult clients what their needs were, and seemed not to have a variety of approaches in mind, rather were absorbed by the SLI difficulties.

BPS Generic Professional Practice Guidelines 2nd Edition	General Psychologist's Adherence
Assessment	
1. the development and use of psychometric tests in best-practice ways.	The educational psychologist routinely used tests for IQ, which was useful as the SLI/PLI clients might have appeared low IQ. The only other tests used related to the language disorder, as there was anxiety among psychologists that the comprehension might be too poor.
2. The application of systematic observation and measurement of behaviour in a range of contexts and settings.	The educational psychologist observed these young adults within the family and college contexts if appropriate. The others only saw the client in their office.
3. The use of a range of interview processes with clients, carers and other professionals.	The psychologists were able to use a range of interview approaches according to their perception of the clients, however, this perception seems clouded by their experience of autism
Formulation – based on the assessment	
1. The summation and integration of the knowledge that is acquired by the assessment process, which may involve a number of different procedures.	Psychologists have a confused picture between the language disorder, the mental distress and autistic traits in a poorly diagnosed background.
2. Draw on psychological theory and research to provide a framework for describing a client's problem or needs.	The confusion from above made any kind of framework development difficult. On being asked the psychologists were in favour of guidance but not at all sure what it would be like.
3. Using the relationship of theory to practice, applied psychologists will be able to draw on a number of models to meet needs or support decision-making	CBT, integrative, Person- centred, and personal construct were all mentioned - there were indications they had to be more directive than usual for clarity.
4. Ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a psychological perspective.	There were problems in assessing the language impairment from a clear psychological perspective.
Intervention – based on formulation	
1. Use of psychological models or approaches to facilitate change, or solution of a problem or improvement of the quality of relationships.	Formulation tended to be skewed and obscured somewhat by a level of perception of language impairment as a mild form of autism. Little understanding of SLI.

Appendix 20: Psychologists' Professional Competencies (continued)

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BPS Generic Professional Practice Guidelines 2nd Edition	General Psychologist's Adherence
2. Training or coaching of others (such as professional staff, managers, relatives and carers).	One psychologist who considered herself particularly effective with this client group, had not attempted to disseminate this.
3. These interventions, or implementation of solutions, are tests of the provisional hypotheses contained in the formulation and are subject to iterate modification in the light of experience and new data.	The psychologists attempted to learn by experience with these clients, but seeing very few and the complexity and variability of their presentation made this difficult.
Evaluation	
1. All activities and interventions need to be evaluated both during their implementation and afterwards	No evidence of evaluation or follow up.
2. Assessment of the stability and security of change.	No evidence for this.
3. Whether needs are met appropriately.	No evidence of consulting client or being clear what the needs were.
4. Is decision-making is supported adequately?	Little attempt at second opinions.
Research	
1. Ongoing evaluation of assessment, formulation, intervention or implementation in relation to specific services provided.	No.
2. The development and testing of psychological theory explorations of psychological processes and outcomes (basic research).	No.
3. The development and evaluation of specific psychological interventions (primary research).	No.
4. The consolidation and evaluation of primary research (secondary research).	No.
Contracting	
1. obtain valid consent prior to undertaking any assessment or intervention.	No evidence of explicit consent.
Valid consent	
1. Before intervention.	No evidence.
2. Before communicating with family or carers.	No evidence.
3. Timely – informed of waiting lists, etc.	No evidence.

Appendix 20: Psychologists' Professional Competencies (continued)

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BPS Generic Professional Practice Guidelines 2nd Edition	General Psychologist's Adherence
4. Provide with relevant information to inform consent in a format that is designed to meet any specific needs, taking account of any sensory, cognitive or communication difficulties they might have, their language and culture.	No evidence.
5. Invite questions.	No evidence.
Information type for consent 1. What the psychological activity involves, as far as this is consistent with the model of interaction, e.g. there will be limits in the use of some non-directive therapies and psychometric assessments.	There was a concern the client might have expectation they would alleviate their language problem. However, lifelong disabilities especially in language are unlikely to be apparent to the client – how can they be cured of who they are? No evidence that they communicated this to their clients.
2. The benefits of this activity, either directly to the client in the case of assessment or intervention, or indirectly in the case of systemic intervention, or to potential theoretical advances in the case of research.	The psychologists did not seem to include the client in their deliberations on how to modify or assess therapeutic working.
3. The role and function, areas of expertise and qualifications of the psychologist, refraining from laying claim to affiliations or skills that they do not possess.	They came forward to be interviewed because they had experience of working with the group.
Issues of power and control 1. take into account any power imbalances which may reduce the voluntary nature of valid consent	Complicated by parental involvement and the language problem. No explicit evidence in terms of redressing power imbalance
Nature of therapeutic interventions 1. Unique to each client and his or her life circumstances, which cannot be precisely predicted in advance. So general consent only.	Confused picture – no evidence client consulted.
Disability when unable to consent 1. Special case – give full information anyway.	This is a grey area – where ability to consent is unclear and asking might exacerbate problems and damage working alliance

Appendix 20: Psychologists' Professional Competencies (continued)

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BPS Generic Professional Practice Guidelines 2nd Edition	General Psychologist's Adherence
Working with other professionals 1. Contribute to the development of integrated, comprehensive plans of direct and indirect work with clients.	Attempted with SALT but difficult to achieve in low resource context.
2. Contribute to and benefit from consultation, support and training to increase understanding of the needs of clients.	No evidence of collaboration or consultation on the mental health aspects.
3. May also experience concerns about the competence or ethical practice of individual colleagues involved - raise according to local procedures.	This is a difficult issue as there is no standard language impairment framework against which anyone could be judged.

BACP Ethical Framework for Good Practice in Counselling and Psychotherapy	General Psychologist's Adherence
<p>Being trustworthy: Honouring the trust placed in the practitioner (also referred to as fidelity)</p> <p>Being trustworthy is regarded as fundamental to understanding and resolving ethical issues. Practitioners who adopt this principle: act in accordance with the trust placed in them; strive to ensure that clients' expectations are ones that have reasonable prospects of being met; honour their agreements and promises; regard confidentiality as an obligation arising from the client's trust; restrict any disclosure of confidential information about clients to furthering the purposes for which it was originally disclosed.</p>	<p>Trust may be an issue when dealing with the parents of a language disordered young adult as the psychologists made no mention of asking permission to disclose or whether the clients wished parents' presence.</p>
<p>Autonomy: Respect for the client's right to be self-governing</p> <p>This principle emphasises the importance of developing a client's ability to be self-directing within therapy and all aspects of life. Practitioners who respect their clients' autonomy: ensure accuracy in any advertising or information given in advance of services offered; seek freely given and adequately informed consent; emphasise the value of voluntary participation in the services being</p>	<p>This is problematic in language impairment if the therapist isn't certain the client can express their autonomy. There was no evidence that the psychologists sought to encourage their clients in decision-making about themselves.</p>

BACP Ethical Framework for Good Practice in Counselling and Psychotherapy	General Psychologist's Adherence
<p>offered; engage in explicit contracting in advance of any commitment by the client; protect privacy; protect confidentiality; normally make any disclosures of confidential information conditional on the consent of the person concerned; and inform the client in advance of foreseeable conflicts of interest or as soon as possible after such conflicts become apparent. The principle of autonomy opposes the manipulation of clients against their will, even for beneficial social ends.</p>	
<p>Beneficence: A commitment to promoting the client's well-being</p> <p>The principle of beneficence means acting in the best interests of the client based on professional assessment. It directs attention to working strictly within one's limits of competence and providing services on the basis of adequate training or experience. Ensuring that the client's best interests are achieved requires systematic monitoring of practice and outcomes by the best available means. It is considered important that research and systematic reflection inform practice. There is an obligation to use regular and on-going supervision to enhance the quality of the services provided and to commit to updating practice by continuing professional development. An obligation to act in the best interests of a client may become paramount when working with clients whose capacity for autonomy is diminished because of immaturity, lack of understanding, extreme distress, serious disturbance or other significant personal constraints.</p>	<p>The psychologists clearly all held their clients best interests at heart. What is not so clear, however, was how they knew what those best interests were. With limited knowledge of SLI/PLI, by their own admission, and limited evidence they consulted the client, their direction towards the client's interests were decided by their own assumptions, for example that the language impairment was the primary problem. No evidence of monitoring.</p>
<p>Empathy: The ability to communicate understanding of another person's experience from that person's perspective.</p>	<p>This is thought by the psychologists to be difficult with language impaired clients. However, that may be due to the assumption that their problems are equivalent to autism.</p>

Appendix 20: Psychologists' Professional Competencies (continued)

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BACP Ethical Framework for Good Practice in Counselling and Psychotherapy	General Psychologist's Adherence
Competence: The effective deployment of the skills and knowledge needed to do what is required.	The psychologists were not clear or did not realise that it was disability generally in which they perhaps lacked knowledge.
Courage: The capacity to act in spite of known fears, risks and uncertainty.	One of the psychologists made a "skewed" diagnosis such that the client could access a needed adult service.
Good quality of care 1. Practitioners should give careful consideration to the limitations of their training and experience and work within these limits, taking advantage of available professional support. If work with clients requires the provision of additional services operating in parallel with counselling or psychotherapy, the availability of such services ought to be taken into account, as their absence may constitute a significant limitation.	Psychologists knew their training was somewhat inadequate in communication disorders but did not know what they did not know with respect to language impairment. There was also understanding that in adult services there were colleagues who did not know how to work with this client group.
2. Practitioners are advised to keep appropriate records of their work with clients unless there are good and sufficient reasons for not keeping any records. All records should be accurate, respectful of clients and colleagues and protected from unauthorised disclosure. Any records should be kept securely and adequately protected from unauthorised intrusion or disclosure. Practitioners should take into account their responsibilities and their clients' rights under data protection legislation and any other legal requirements.	The psychologists seemingly had not consulted their records prior to this interview but that does not indicate lack of record keeping and there is no information on this requirement
Maintaining competent practice A commitment to good practice requires practitioners to keep up to date with the latest knowledge and respond to changing circumstances. They should consider carefully their own need for continuing professional development and engage in appropriate educational activities.	Some of the psychologists had read the literature but generally were very out-of-date in the SLI/PLI field and with so few clients it could be forgotten.

Appendix 20: Psychologists' Professional Competencies (continued)

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BACP Ethical Framework for Good Practice in Counselling and Psychotherapy	General Psychologist's Adherence
<p>Keeping trust</p> <p>1. The practice of counselling and psychotherapy depends on gaining and honouring the trust of clients. Keeping trust requires: attentiveness to the quality of listening and respect offered to clients culturally appropriate ways of communicating that are courteous and clear respect for privacy and dignity careful attention to client consent and confidentiality</p>	<p>The psychologists were respectful of their SLI clients, but there is a suggestion that inclusion of parents (even for a young adult) made their life easier and so they may not have been strict about consent procedures.</p>
<p>2. Clients should be adequately informed about the nature of the services being offered. Practitioners should obtain adequately informed consent from their clients and respect a client's right to choose whether to continue or withdraw.</p>	<p>The clients seem not to have been consulted about what they would like from their therapist. Had they had this conversation psychologists might have discovered the clients did not want to be 'cured'. SLI clients are not low IQ and have been found able to communicate their preferences.</p>
<p>3. Practitioners should ensure that services are normally delivered on the basis of the client's explicit consent. Reliance on implicit consent is more vulnerable to misunderstandings and is best avoided unless there are sound reasons for doing so. Overriding a client's known wishes or consent is a serious matter that requires adequate and reasoned justification. Practitioners should be prepared to be readily accountable to clients, colleagues and this Association if they override a client's known wishes.</p>	<p>There is no indication consent was sought from these clients or that it was not.</p>

Appendix 20: Psychologists' Professional Competencies (continued)

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BACP Ethical Framework for Good Practice in Counselling and Psychotherapy	General Psychologist's Adherence
<p>4. Working with young people requires specific ethical awareness and competence. The practitioner is required to consider and assess the balance between young people's dependence on adults and carers and their progressive development towards acting independently. Working with children and young people requires careful consideration of issues concerning their capacity to give consent to receiving any service independently of someone with parental responsibilities and the management of confidences disclosed by clients.</p>	<p>SLI clients may seem as a result of their difficulties to have non-average non-verbal IQ, although this is not correct. In this case assessing the balance in terms of their independence is difficult. Parents worry about their children's/adolescent's social difficulties and may also not have knowledge about SLI/PLI.</p>
<p>Respecting privacy and confidentiality</p> <p>1. Respecting clients' privacy and confidentiality are fundamental requirements for keeping trust and respecting client autonomy. The professional management of confidentiality concerns the protection of personally identifiable and sensitive information from unauthorised disclosure. Disclosure may be authorised by client consent or the law. Any disclosures of client confidences should be undertaken in ways that best protect the client's trust and respect client autonomy.</p>	<p>It is not known if the psychologists' inclusion and involvement of parents may have touched on their young adult clients' rights to be consulted before this decision was made.</p>
<p>2. Exceptional circumstances may prevent the practitioner from seeking client consent to a breach of confidence due to the urgency and seriousness of the situation, for example, preventing the client causing serious harm to self or others. In such circumstances the practitioner has an ethical responsibility to act in ways which balance the client's right to confidentiality against the need to communicate with others. Practitioners should expect to be ethically accountable for any breach</p>	<p>The psychologists may judge it is so important to have the parents input in conjunction with the perceived low communication skills, that consent becomes a lower priority in their concern to give an effective service.</p>

Appendix 20: Psychologists' Professional Competencies (continued)

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of confidentiality.	
<p>Teaching and training</p> <p>All practitioners are encouraged to share their professional knowledge and practice for the benefit of their clients and to promote awareness of counselling and psychotherapy in the public through providing information and education.</p>	<p>At least one of the psychologists considered she had special expertise with SLI and although others might benefit from her experience she had not apparently taken steps to disseminate it.</p>
<p>Researching</p> <p>The Association is committed to fostering research that will inform and develop practice. All practitioners are encouraged to support research undertaken on behalf of the profession and to participate actively in research work.</p>	<p>Very few of the originally approached psychologists responded, and few agreed to be interviewed that determined the scope of the research. They understood the research was about young adults with SLI/PLI of whom they saw relatively few clients and they were inclined to want to discuss people with ASD. However, this reflects very low service provision for this vast potentially 'needful' group, and only as a result of these psychologists volunteering was this research able to continue.</p>
<p>Responsibilities to all clients</p> <p>Practitioners have a responsibility to protect clients when they have good reason for believing that other practitioners are placing them at risk of harm.</p>	<p>There were instances where the psychologists felt a client with SLI had been put at risk, in one instance by admitting to hospital when he/she thought it inadvisable. No evidence this was pursued.</p>

Appendix 20: Psychologists' Professional Competencies (continued)

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<p>Working with colleagues</p> <p>The increasing availability of counselling and psychotherapy means that most practitioners have other practitioners working in their locality, or may be working closely with colleagues within specialised or multidisciplinary teams. The quality of the interactions between practitioners can enhance or undermine the claim that counselling and psychotherapy enable clients to increase their insight and expertise in personal relationships. This is particularly true for practitioners who work in agencies or teams.</p>	<p>There were some expressions of successful working with SaLTS, but this did not seem to be actively pursued – only welcomed if available. Also an opinion was expressed that SaLTS are concerned only with children with these impairments.</p>
<p>Making and receiving referrals</p> <p>Prior to accepting a referral the practitioner should give careful consideration to the appropriateness of the referral; the likelihood that the referral will be beneficial to the client; the adequacy of the client's consent for the referral. If the referrer is professionally required to retain overall responsibility for the work with the client, it is considered to be professionally appropriate to provide the referrer with brief progress reports. Such reports should be made in consultation with clients and not normally against their explicit wishes.</p>	<p>The psychologists did what they could to consider appropriateness, but this diagnosis requires multi-professional assessment. There was evidence of trying to look behind the diagnosis to see what might be hidden there.</p>

Note. These annotations provide a preliminary appraisal of psychologists' practice with people with SLI/PLI. (Annotations supported by the psychologists' transcript block numbers would have better-supported the observations.)