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ORIGINAL ARTICLE



Narrating personal experience of living with learning disabilities and mental health issues in institutional and community settings: A case study

Paul Sutton¹ | Bob Gates²

¹College of Nursing, Midwifery and Healthcare, University of West London, Brentford, UK

²University of West London, Ealing, London, UK

Correspondence

Paul Sutton, College of Nursing, Midwifery and Healthcare (Learning Disabilities Team), University of West London, Boston Manor Road, Brentford, Middlesex TW8 9GA, UK. Email: paulsutton21@btinternet.com

Accessible summary

- This is a case study about a man with learning disabilities who has mental health issues.
- The case study describes the way that he told a researcher about his life.
- Thirty years of his earlier life were spent in a long-stay hospital in England, UK and more recently he has lived in a community setting with five other people.
- This research is important as it assists us to understand the experiences of people with learning disabilities who have mental health needs.

Abstract

Background: Historically, the emotional lives and mental health needs of adults with learning disabilities received scant attention, especially when the policy of institutionalisation was at its zenith in the UK.

Materials and Methods: This case study employed biographical narrative interviews based on a psychosocial approach. The main sources of data production were two loosely structured, audio-taped, interviews with a man with learning disabilities. This approach uses free association to elicit an individual's stories about his lived experiences. Additional information was acquired from consultations with key care staff and clinical records maintained by the man's service provider.

Results: Data revealed insights into the biography of this man who had a diagnosed mental health disorder. These data recall his personal journey through the care system which took place during an important historical period encompassing both long-term institutionalisation in segregated settings, and the subsequent implementation of the policy of community care in the UK. He recalls positive and negative experiences while residing in a long-stay hospital, and the related thoughts and feelings about his life in a community setting in more recent years.

Conclusion: This case study contributes to an increasing body of studies that perceive the use of in-depth interviewing of individuals with learning disabilities as having high ecological validity in the development of authentic knowledge, not readily available through other methods used in the co-production of data.

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**KEYWORDS**

case study, learning disabilities, mental health issues, psychosocial approach

1 | INTRODUCTION

Historically, the emotional lives and mental health issues of adults with learning disabilities have received scant attention (Arthur, 2003; Taylor & Knapp, 2013), especially when the policy of institutionalisation was at its zenith (Hatton, 2002). There was an assumption that individuals with learning disabilities lacked awareness of their social situation and hence were not affected by it (Emerson & Jahoda, 2013). Following the implementation of community care, and subsequent closure of the old long-stay hospitals, there was a growth in both clinical and research activity that focussed on the mental health needs of people with learning disabilities, and how such needs might best be met (Bouras & Holt, 2010; Hatton, 2002; National Institute for Health and Care Excellence (NICE), 2016).

People with learning disabilities are known to manifest the same range of mental disorders found in the general population (Gravestock, Flynn, & Hemmings, 2005; Royal College of Psychiatrists, 2001). The most common types of mental health problems experienced by people with learning disabilities are depression, anxiety disorder and autism. Some specific types of mental health problems, including schizophrenia (which has a prevalence rate of 3%, three times higher than the general population), bipolar disorder and dementia have been noted to be more common in people with learning disabilities than other people (Burke, 2014; NICE, 2016). Estimates of the prevalence of mental health problems in people with learning disabilities have been variously reported fluctuating between 5% and 50% (Joint Commissioning Panel for Mental Health, 2013; National Health Service Executive, 1998).

This diversity of estimates results from factors such as specific samples of participants used in studies, varying definitions of mental health problems and different diagnostic methods (Buckles, Luckasson, & Keefe, 2013; Cooper, Smiley, Morrison, Williamson, & Allan, 2007). A number of factors have been associated with an increased risk to the mental health of individuals with learning disabilities including experience of stigmatisation, limited employment and leisure opportunities, lack of self-determination, difficulties with relationships, poor economic conditions, disablism and low self-image (Beart, Hardy, & Buchan, 2005; Taylor & Knapp, 2013).

Regardless, the views of people with learning disabilities concerning their mental health care received scarce attention until studies undertaken in recent times. These studies have tended to focus on experiences related to in-patient settings rather than in the community. Specialist services for people with learning disabilities have mainly been appraised more positively than general mental health services by service users with learning disabilities (Donner, Mutter, & Scior, 2010; Scior & Longo, 2005; Young & Chesson, 2006). Other research has investigated the views of service users concerning support available for people with learning disabilities and mental health issues in community settings. Research participants have highlighted

their desire to have choice and control over what they do, especially in relation to meaningful day activities (O'Brien & Rose, 2010); they have indicated the importance of care staff being aware of a service user's past history, as particular life events may have a significant influence regarding the individual's mental health, and how s/he is likely to behave in response to events or interventions (Stenfort Kroese, Rose, Heer, & O'Brien, 2013). More recently, research has focussed on the perspectives of adults with mild learning disabilities who live in community settings relating to their subjective experience of mental health issues (Robinson, Escopri, Stenfort Kroese, & Rose, 2016). In this case study, the authors describe one man's account of his life and experiences as someone with a diagnosed mental health disorder.

1.1 | Aims of research project

The primary aim of this case study of Ted (a pseudonym), who is a man with learning disabilities living in a community setting in England, UK, was to gain insights into his perspective of the care and support he had experienced in relation to his mental health issues. In addition, this research aimed to enable Ted to participate as fully as possible in the process of data production, and a psychosocial research approach to biographical narrative interviews developed by Hollway and Jefferson (2000, 2013) was employed, which offered an innovative and practicable means of achieving this.

1.2 | Research participant: Ted

At the time of the research interviews, Ted, aged 59 years, who had mild to moderate learning disabilities, and who had experienced mental health issues for the major part of his adult life, agreed to participate in the project. He lived in a staffed group home which was situated in a community setting within a busy suburban residential area in England in the UK. Ted shared this accommodation with five other adults who also had learning disabilities. He had lived in this setting for over 11 years, following his relocation from a long-stay hospital. The limited data available regarding Ted's earlier life indicated he had been admitted to the long-stay hospital during the mid-1970s when aged nearly 18 years. His parents had no longer been able to support Ted in the family home, at that time, as they could not cope with his behavioural challenges.

Ted resided in this institutional setting for 30 years and had a history of presenting behaviours that challenge during those decades. In the early 1980s, Ted had been diagnosed and prescribed treatment for schizophrenia, and he continues to be treated for this mental health disorder at the present time. In more recent years, he was reported to have suicidal tendencies and has



continued to exhibit behaviours that challenge, particularly with his mood relating to paranoia. Since resettlement to his present community setting, there have been episodes in which Ted has been both verbally and physically abusive to fellow residents and care staff at his home.

2 | METHOD

Ted was recruited, with the cooperation of a local service provider, through a purposive sampling approach. Purposive sampling allows a researcher to select a specific group, situation or person because they typify some process or characteristic the researcher wishes to investigate (Silverman, 2005). The selection criteria for potential research participants were (a) adults (over 18 years old) living in the community, (b) who had been diagnosed as having learning disabilities and experience of being diagnosed and treated for mental ill health and (c) who had sufficient verbal skills enabling them to adequately communicate with others in their daily lives. The research proposal received full ethical approval from an ethics committee established by the relevant health authority (Department of Health, 2005).

Based on the selection criteria indicated earlier, Ted was initially identified as a prospective participant for the project by a clinical manager, who knew about the research, and was employed by a local service provider. Subsequently, the researcher (i.e., the first author who had no previous knowledge of Ted) met Ted and his key carers on a couple of occasions to become acquainted with Ted and also explain the purpose of the project, as well as provide him with details about the research interviews. An information leaflet concerning the project, which employed service user-friendly language to facilitate easier comprehension, was given to Ted and his key carers, to read and discuss in between their meetings with the researcher. All practical measures were carried out to ensure Ted was enabled to make an informed decision for himself whether to participate in the research (Department for Constitutional Affairs, 2007). Following Ted's agreement to be involved in the project, the interviews were arranged and took place in a quiet sitting room area at Ted's group home; the second interview occurred 3 weeks after the first.

2.1 | Data production

The main sources of data production were two loosely structured, audio-taped, interviews that were framed by the "Free Association Narrative Interview" method, using questions which were as open as possible, and that were related to the topic areas listed in Table 1. There was also a focus on eliciting "stories" as this provides a way of connecting people's accounts to events that have actually occurred. This is an approach developed by Hollway and Jefferson (2000, 2013) that resulted from their adaption of the biographical-interpretative method (Wengraf, 2001), which is a particular method within

TABLE 1 Framework of topic areas covered in the research interviews

1. Recognition of mental ill health—By using the "life cycle" model as a concrete frame of reference (Booth & Booth, 1996), the interviewer sought to obtain the perceptions of the participant regarding when in their lives, and how, their mental health needs were first identified.
2. The care and support that was provided when the participant's mental health needs had been recognized.
3. Personal thoughts and feelings of the participant concerning their experiences of mental health issues.
4. The level of care and support that the participant currently required to live in their community.
5. Views of the participant relating to their involvement (or otherwise) in decisions about their care management.

the tradition of narrative research, and the use of free association by means of narrative interviews. Free association is a major technique that has been employed within the sphere of psychoanalytic practice to precipitate lines of thought which assist access to what is important for the individual being analysed (Rycroft, 1995).

By creating a space that allows the interviewee to have a key part in structuring the interview, and talk freely about what they "feel" like expressing, the researcher is able to obtain some indication of unconscious emotions and motivations (Clarke & Hoggett, 2009). Using a psychosocial viewpoint in research practice, as Hollway and Jefferson (2000) have contended, necessarily implies conceptualising both the researcher and interviewee as co-producers of data in the interview setting, in which unconscious dynamics operate between each of them. Moreover, Hollway and Jefferson (2000) used the concept of the "defended subject" to highlight how individuals will guard themselves against any anxieties resulting from information that is provided within a research context.

2.2 | Data analysis

Hollway and Jefferson (2000, 2013) have underscored the importance of "holistic interpretation," which consists of taking account of all the data produced when seeking to interpret part of it. In addition to verbatim transcripts of the two research interviews with Ted, information concerning his care and support had been acquired from consultations with his key care staff, clinical records maintained by his service provider, extensive field notes and record of researcher reflexivity. Data analysis of the material from the two research interviews was undertaken at two levels.

Initially, there was an analysis of the interaction that had occurred between the researcher and Ted, as Hollway and Jefferson's (2000, 2013) research approach acknowledges anxiety that may arise from the intersubjective dynamics, between the researcher and interviewee, in the interview setting. Therefore, consideration of unconscious defences, and researcher reflexivity, was critical in terms of identifying emotions and unconscious mechanisms that may have played a part in differing patterns of response while the

TABLE 2 Transference and countertransference

Within the clinical setting, the term “transference” generally refers to the unconscious, historical representations which a patient transposes to the analyst (Hunt, 1989). It involves the transference of feelings, which are often associated in some way to individuals or events from the past, and that have never been fully resolved (Frosh, 2002; Hodges, 2003). Transference responses that occur within research and clinical settings are similar in nature. The close bonds which potentially arise in the relationships between researchers and their key participants are particularly influential in regard to the operation of transference (Hunt, 1989). Thus, it seemed Ted had strongly communicated, by means of transference, his sense of desolation related to his negative perception of moving from institutional care to community living. Ted's painful feelings had been transmitted to the researcher in the interview situation, and the researcher was conscious of the feelings that had been generated within himself. Due to the researcher's insights into Ted's biography and the rapport which appeared to have grown during the course of their meetings, the researcher had evidently been enabled to experience some of the distress that Ted had felt.

Drawing on psychoanalytic concepts, the term “countertransference” is used to describe this process.

Countertransference indicates our conscious and unconscious responses to another person. To some extent, it is something that we rely on during our daily lives. Our ability to employ countertransference can assist us to comprehend the feelings of other people, along with their internal conflicts, by observing and considering the part they play in affecting how we feel (Frosh, 2002; Hodges, 2003; Young, 2001). When engaged in clinical work with people who have learning disabilities, making use of countertransference responses is an important technique. Individuals are not simply disadvantaged verbally due to their intellectual impairment, there is also a possibility they will be disadvantaged by the lack of encouragement to express their feelings (Hodges, 2003).

interviews took place (e.g., Tables 2 and 3). Following this, the substantive content of the interviews concerning Ted's responses to questions framed by the topic areas (Table 1) was analysed.

Analysis and interpretation of all the data accumulated about Ted was assisted by the use of two structured summaries, which were (a) completion of a two-page pro forma and (b) a “pen portrait.” The pro forma comprised categories that ranged from typical biographical data to notes on themes and ideas that arose from reading the whole material. While reading all the raw data, comments were written down and sometimes significant extracts from the data were highlighted, and these were used to complete the pro forma. The pro forma provided a means of communicating an overview regarding Ted's biography, along with his experiences as a service user with a diagnosed mental health disorder. The pen portrait was intended to be a narrative composition which would facilitate the research participant appearing as a real person for subsequent readers. It was mainly descriptive but provided sufficient information against which later interpretations could be appraised.

The researcher was able to refer to various sources of data, such as Ted's key carers, pertinent clinical records, extensive field notes (including meetings with Ted and visits to his community home) and record of researcher reflexivity, in order to ensure the authenticity and accuracy of information gained through the research interviews

TABLE 3 Recognition and containment

Hollway and Jefferson indicate that conceptualisation of “aspects of unconscious intersubjectivity in the concepts of recognition and containment” offer a useful way of “understanding what it is in the research (or other) relationship which helps trust to develop” (Hollway & Jefferson, 2000: 49). Recognition between individuals is necessarily mutual and begins “with the other's confirming response, which tells us that we have created meaning, had an impact, revealed an intention” (Benjamin, 1995: 33). In the case of strong emotions emerging in an interview situation, such as had occurred with Ted, the interviewer needs to let the interviewee know that s/he, and the emotions they expressed, are accepted; and also confirm that they should not avoid feeling these emotions due to apprehension about upsetting the interviewer (Wengraf, 2001).

In the second research interview, Ted revealed deeply personal material regarding the reason for his exclusion from the day centre that he previously attended. This had taken place after the researcher had managed to contain the painful feelings that Ted voiced regarding his experience of community living. An examination of the transcript for the interview showed that an endeavour had been made to acknowledge the pain Ted had communicated to the researcher. Ideally, in this kind of situation, it has been suggested that the interviewer should say as little as possible (Wengraf, 2001). In fact, the researcher's response had been fairly minimal: “Really...That is how you feel (i.e., sad)?”

The majority of communication is nonverbal (Wengraf, 2001), and this was highlighted during the interviews with Ted. It was crucial that the researcher demonstrated nonverbal expression of active listening; this was partly shown by maintaining an attentive listening stance, a level of eye contact and using sounds such as “hmm” to indicate he was listening to all that was being said to him.

with Ted. The following process was undertaken to achieve a consensus in terms of research findings: (a) the second research interview afforded a means of engaging Ted in dialogue about emerging hypotheses or findings (from the first interview); (b) interview transcripts, live recording of interviews, data extracts and other relevant material were discussed with an independent panel of academics who had knowledge of mental health issues, and a background of clinical and research experience in learning disabilities; and (c) different perspectives regarding the data were examined and discussed, along with a detailed review concerning holistic analysis of data; the researcher and independent panel came to a general agreement on research findings, drawing from all available evidence.

Consistency has been identified as a criterion for evaluating the validity of data obtained from research participants with learning disabilities (Perry, 2004). The two interviews with Ted, and analysis of all the material acquired about him, as well as comparative analysis with data obtained from other participants involved in this project, provided a structure for consistency checks and thus enhance the validity of data.

3 | RESEARCH FINDINGS

The main findings from the research with Ted, extracts from the research interviews and issues regarding the co-production of data are encompassed in the following sections.



3.1 | “Schizophrenic” and “Subnormal”

When Ted had been asked about recognition of his mental health needs in the early stage of the first research interview, he indicated his mental ill health had initially been noticed by his parents (“me dad...and me mum”). He also recalled being examined by a doctor who had asked him a “lot of questions,” and written things in a note book. This all apparently took place in Ted’s late teens, and shortly before he had been admitted to a long-stay hospital. Ted related his recollection of these events to “sleeping problems” which he had experienced intermittently over the years. He had then gone on to disclose that he heard “voices” and that he also experienced “horrible thoughts.” In response to a query as to whether he was able to tell the interviewer any more about what he had experienced, Ted referred to painful thoughts and feelings that he endured regarding “anger” and “suicide”. At a later stage in the interview, Ted acknowledged he continued to have mental health problems.

Interviewer: Do you still have mental health... problems?

Ted: Mental health problems...I do have mental health problems, yeah, I hallucinate.

Interviewer: Oh, right. What, that’s mainly you hear voices?

Ted: I hear voices, yeah. I’m schizophrenic... schizophrenic.

Interviewer: Right...

Ted: I’m subnormal...I’m subnormal in myself.

Interviewer: Right. And you see, um, a doctor that helps you, do you?

Ted: Yes, I see Doctor (name of psychiatrist)

Interviewer: Right...

Ted: At his clinic, in... (name of local health service setting)

As the first research interview progressed, the interviewer became increasingly aware that Ted’s responses frequently tended to be phrases and short sentences; or a single word on some occasions. He had not replied by providing extended periods of narrative.

The interviewer’s central objective had been to create an informal setting which would enable Ted to feel at ease, and valued, in his role as a research participant. In spite of the lack of verbal fluency regarding Ted’s responses, this had not resulted in being a major impediment to

eliciting stories from him. Drawing on the information gained from Ted, it was possible to build an account of his experiences concerning the care and support that he received throughout the years he spent in the long-stay hospital. For instance, he recalled being given medication regularly while in hospital, primarily in tablet form and sometimes by injection.

Ted had spoken about being visited and examined by medical staff that regularly visited the Male Ward where he resided. He recounted that his Ward had been “for high grades,” whereas another Male Ward situated nearby had been “for low grades”. Ted also recollected attending the Occupational Therapy Department and being engaged in activities such as cutting and trimming paper, and wine making. Furthermore, he recalled that he and other residents had been taken “out to pantomimes at Christmas”. In the course of examining the text of everything Ted had told the interviewer, it became evident that he had actually provided a potent insight into his life while in that long-stay institutional setting.

3.2 | Memories of institutional care

Ted continued to recount his experiences while in a long-stay hospital for three decades. He recalled a number of “good memories” such as a carnival which took place annually at the hospital. The hospital residents that were more able were given “a bit of pocket money” when they went to the carnival, where Ted said “you could... buy anything you wanna buy”, which included “a pouch of tobacco... and just keep it on you”. Ted also recalled negative experiences during his time in institutional care. For example, he alluded to his feelings of bitterness about the power relationships which had then prevailed between staff and residents in the long-stay hospital. Subsequently in the second interview, Ted had gone on to state that “the staff... were not too bad, but they have their reasons for being nasty”. He indicated some staff had at times used somewhat oppressive techniques to physically manage residents who exhibited behaviours that were challenging.

From his recollections, Ted intimated that he had personal experience of being restrained by such physical interventions. He indicated he had sometimes “gone...off the wrong side of the handle” and “let off steam”. The interviewer ascertained, at this point, whether Ted felt comfortable talking about his experiences of being a resident in the long-stay hospital, and he had affirmed he did not “mind talking about (name of hospital)”.

Although Ted indicated earlier in the interview that he still felt “bitter inside” regarding some aspects of his life in the long-stay hospital, he evidently felt a great sense of sadness at its closure. The interviewer checked with Ted whether his sadness was related to having become used to living in an institutional setting. Ted replied by declaring the long-stay hospital had been a “home” for the residents, and gone on to state:

Ted: That’s the way it should be...nowhere else...The outside world is too much for people like me.

Interviewer: Really, Ted?

Ted: It's too much pressure...too much...The outside world is a madhouse...the outside world (indistinct)... We ask a question...they just ignore you...just walk by...without saying a word...The outside world is like this...No use feeling alive sometimes...You just want to be dead.

The interviewer had been conscious of the intensity of feelings communicated by Ted when venting this negative view about his present life in the community. The distress which Ted apparently experienced was palpable at this particular point in the interview.

3.3 | Life in the community

When the interviewer sought to obtain further information about Ted's viewpoint of community living, he responded by expressing some discontent regarding the community home where he resides. He stated "I can't bear this place... It gets me down sometimes... the way people look at yer". When the interviewer asked Ted about where he would have liked to live, Ted replied that he would rather live in "a smaller place... with no carers...just meself". However, when the interviewer checked whether Ted felt he would be capable of managing on his own, Ted had conceded he would need "someone to come and cook me food". The research interview had subsequently taken an unforeseen turn when the researcher sought to attain an insight into the level of care and support Ted needed to live in the community, focussing on activities which occupied him in his everyday life.

3.4 | Attendance at a community Day Centre

Ted no longer attended the Day Centre where he had gone for some years after he had been discharged from the long-stay hospital. Provisional arrangements had been made for Ted to attend a project run by the local Social Services Department which offered work opportunities for service users with learning disabilities. Nevertheless, his attendance at this project had been inconsistent and, when the research interviews were undertaken, Ted had not been attending for a number of months. Therefore when the researcher asked Ted about his current situation regarding work, he responded;

Ted: I don't work... no... that's a... see... (indistinct) ... I should work really... somewhere to go... But I done some things in me past... some things wrong in the past... to other people...Things that're un-hygienic... things that're wrong...serious...

Interviewer: Really...? What you've done?

Ted: (Indistinct)... Yeah, not much going on... I was doing something I shouldn't be doing... Someone else, sexuality, sexuality... something was going on with a man and me.

Although the researcher managed to retain his composure, Ted's disclosure had been unexpected. Sexuality, as a specific issue, had not been considered in much depth before this research commenced. Opportunities for sexual expression and the development of intimate personal relationships are integral parts of human experience that, until more recent times, were denied to individuals with learning disabilities (Oakes, 2007). Research has shown many contemporary service providers did not include the issues of sex, sexuality and relationships, in their work supporting service users unless queries about these issues were generated by service users themselves (Abbott & Howarth, 2005). The staff at the Day Centre regarded the incident involving Ted in a very serious light and were concerned that an offence may have been perpetrated. According to what Ted disclosed, he was apparently aware he had not behaved appropriately with a male co-worker, whom he referred to as a "friend". After the second research interview, a senior staff member at Ted's group home was able to confirm the incident occurred as Ted had recounted and that local police investigated the matter but no formal action had been deemed necessary.

4 | DISCUSSION

The terms which Ted employed to describe himself offered an understanding of his perceptions about personal identity. He referred to having resided on a ward "for high grades" during the years that he was in the long-stay hospital. When the interviewer checked what Ted meant by the term "high grade," he confirmed it was a way of describing residents who were capable of doing many tasks independently. In reality, "high grade" residents were often involved in work that aided the "low grade" residents, who were intellectually less capable and also frequently had coexisting physical or sensory impairments (Potts & Fido, 1991). Moreover, Ted indicated that he was "subnormal." Historically, this is a term that at the time meant "less than normal," "below normal" (Sinason, 2010: 40). It is a term that is clearly outdated, and today some would see it as derogative, but it reflects the terminology concerning legislative and clinical classification which prevailed at the time Ted was a boy and young man. However decades later, this was a label that he still continued to use when defining himself.

Ted also revealed he was "schizophrenic". After decades of his lived experience as a service user, Ted displayed his awareness that this additional diagnostic label had been allocated to him by qualified medical practitioners. Diagnosis of this psychotic disorder would generally be founded on a psychiatric assessment indicating symptoms of schizophrenia, which are recognised by standardised criteria (American Psychiatric Association, 2013; Royal College of Psychiatrists, 2001). Ted recalled receiving medication through



different modes during his years spent in the long-stay hospital; and he continues to be given prescribed psychotropic medication daily at the present time. Additionally, he was aware that he currently had a person-centred care plan and confirmed he attended an annual meeting where this plan was reviewed and he had opportunities to voice his views about aspects of the plan.

4.1 | Living in a community setting

The researcher's personal supposition that living in a community setting would be the preferred option, when contrasted to experience of residing within a long-stay institutional environment, had been challenged by Ted's view about his experience of community living. Nonetheless, his view reflects findings from other studies which revealed life in the community for some people with learning disabilities lacks fulfilment and that they are more likely to experience social exclusion and abuse (Gravell, 2012; Myers, Ager, Kerr, & Myles, 1998; Wilkinson, 1989). Ted had affirmed that the long-stay hospital, where he previously resided, was a "home" for its residents and disclosed he felt marginalised in the "outside world" of the community which was inclined to "ignore" individuals like him. Moreover, Ted divulged a painful recollection of an incident relating to his sexual behaviour which had affected his attendance at a community Day Centre.

4.2 | Power dynamics within the research interview

Power is a significant aspect of the interaction within the interview setting (Wengraf, 2001). Historically, individuals with learning disabilities have experienced devaluation by society and consequently have also experienced a lack of control regarding their lives. They became subject to other people who gained power over them and often made decisions on their behalf (Wolfensberger, 1998). When an individual has been diagnosed as having learning disabilities or a mental health issue, s/he become the object of professional attention. Qualified professional practitioners such as psychiatrists, psychologists, nurses, social workers and educationalists are "experts" who will specify a person's needs and the means by which these should be met (Barnes, Mercer, & Shakespeare, 1999).

During his past and present life, Ted has been subject to the attention and interventions of diverse health and social care professionals who possess power. For most people with learning disabilities that require support, and reside in staffed accommodation, the choices and opportunities accessible to them in their everyday lives depend on the benevolence of care staff (Dowson, 1997; Svanelov, 2019). Research has investigated the balance of power in the context of therapeutic interactions with individuals with learning disabilities, through a process of interactional analysis. The study indicated that collaboration in a therapeutic setting does not solely refer to the therapist being able to communicate effectively in their capacity as an "expert," it also refers to ensuring that the client feels s/he has been fully heard and understood (Jahoda et al., 2009).

While reflecting on the power dynamics in the interviews with Ted, the researcher considered the inherent power imbalances that Ted had potentially experienced in his relationships with professional practitioners and care providers. Despite Ted appearing well disposed to the researcher in his role as interviewer, the feelings experienced by the researcher indicated Ted may actually have viewed him as an authority figure, to whom Ted had conveyed some of his innermost anguish.

4.3 | Strengths and limitations

This case study was rooted in a real-life service setting and therefore is notable in regard to its ecological validity. The psychosocial research approach employed in the study proved to be a positive means of addressing the power asymmetry in the relationship between the researcher and participant (Wengraf, 2001). It offered Ted opportunities to make choices about where to commence his narratives and enabled him to actively participate in the process of data production. Ted's narratives relating to his life, however, only represent one person's experiences, and other individuals would narrate different stories. Due to the collective case study design of the research project, data produced by Ted's case study could be compared with all the data accumulated from other case studies. Hence, although generalisability would be limited as data analysis was based on a comparatively small sample of participants, their experiences are likely to represent the experiences of a broader population of adult service users with learning disabilities.

4.4 | Implications for practice and research

This research involving Ted, and other participants in the project, underlined the importance of the roles of direct care staff and service providers in supporting service users in their everyday lives. Nevertheless, a problem that has been highlighted in meeting the mental health needs of individuals with learning disabilities is the lack of training that staff, who are employed in services for people with learning disabilities, receive regarding mental health issues (Stenfert Kroese et al., 2013). Therefore, it is crucial that staff, especially those without recognised qualifications in health or social care, have sufficient training in mental health issues (Costello, Hardy, Tsakanikos, & McCarthy, 2010).

Additional points noted during the research with Ted, and other participants, were the importance of daytime occupational activities (O'Brien & Rose, 2010), and person-centred planning in relation to mental health care (NICE, 2016), in supporting service users with learning disabilities and mental health issues.

Researcher reflexivity is central to the psychosocial research approach developed by Hollway and Jefferson (2000, 2013), and is congruent with the requirement within Disability Research for the subjectivities of the researcher and those being researched to be acknowledged (Oliver, 1992, 2009).

Psychosocial studies has “emerged as an embryonic new paradigm in the human sciences in the UK”, and “uses psychoanalytic concepts and principles to illuminate core issues within the social sciences”, especially, for example, “the experiences of the powerless” (Clarke & Hoggett, 2009: 1–2). The evolution of psychosocial research approaches in the past two decades has given rise to some creative innovations in the way researchers produce data (Clarke & Hoggett, 2009), and narratives and individual testimonies are significant resources for these approaches (Woodward, 2015).

The current literature, however, indicates minimal use of these methods in research involving people with learning disabilities, although a psychosocial research approach (i.e., Biographical narrative interpretative method) was employed in research involving a 34-year-old woman's experience of living with a learning disability (Horn & Moss, 2014); and free association narrative interviews were previously used in a study that involved eight staff members who worked with people with learning disabilities and complex mental health needs (Storey, Collis, & Clegg, 2012). It is hoped that researchers will consider the use of psychosocial research approaches in future studies involving participants with learning disabilities, particularly as a means of seeking greater insights into their lives and views of their experiences as service users.

5 | CONCLUSION

Overall, this research with Ted has produced data regarding the biography of one person with learning disabilities and diagnosed mental ill health whose individual journey through the care system took place during an important historical period, which encompassed both long-term institutionalisation in segregated environments, and implementation of the policy of community care. The use of free association in the research interviews provided Ted with opportunities to talk about what he felt he wished to talk about. Generally, the experience of this approach to narrative interviewing with Ted has demonstrated its capacity to sustain a power symmetry in the research relationship, as it gave precedence to him in the role of research participant. It is felt that this case study contributes to an increasing body of studies which perceive the use of in-depth interviewing of individuals with learning disabilities as having high ecological validity in the development of authentic knowledge, not readily available through other methods used in the co-production of data.

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ORCID

Paul Sutton  <https://orcid.org/0000-0001-8429-0583>

Bob Gates  <https://orcid.org/0000-0001-7822-6905>

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