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Grounded theory and membership categorisation analysis: Partner methodologies for establishing social meaning – A research example

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Summary In this paper some of the limitations of grounded theory are demonstrated by examining the application of categories that arose in an empirical study of sexuality in special hospital settings (high security psychiatric hospitals). By looking in more depth at the ways in which the categories are applied and the meanings given to them by informants it is shown that grounded theory relies on a reconstructed logic. This logic is at once plausible but it requires a great deal of accommodative work if the meaningful behaviour of informants is not simply to be taken on 'trust of interpretation'. In facing these limitations during the study the author was drawn to ethnomethodology and, in particular, membership category analysis (MCA) as an additional approach. By working through a case example it is shown how the values of informants and their meaningful behaviour can be reached through MCA analysis.

Introduction

The following paper draws upon transcript data from 10 interviews that were analysed using grounded theory and submitted in fulfilment of a doctoral thesis. The research examined special hospital staff perceptions of the sexual health care needs of patients. Open ended interviews were used and despite the sensitive nature of issues relating to sexuality few prompt questions were required to elicit more information. Interview transcripts were made and then notated to include low inference indicators, e.g. shouting, raised voices (Silverman, 2001). They were not initially transcribed for linguistic analysis (Jefferson, 1984) but, rather, for category analysis, a prerequisite for accomplishing a grounded theory analysis (Morse and Field, 1996).

Grounded theory (Glaser and Strauss, 1967) is an interpretive research method that seeks to describe and explain human behaviour and is particularly

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useful for exploring 'relatively uncharted waters' (Stern, 1994; 1980) as is the case in relation to sexuality related care in high security settings. The approach is said to focus upon people's understandings of events and experiences within their natural and everyday settings (Glaser, 1978) and seeks to describe and understand the social psychological patterns and processes that occur within and between people, in context (Strauss and Corbin, 1998). Importantly for this paper, it is claimed that grounded theory can examine the meanings that people give to events and experiences within their natural and everyday settings, (Charmaz, 2000).

On completion of interview transcription grounded theory analysis proceeds by coding and categorising the transcript data. Glaser and Strauss describe it thus,

'Coding need only consist of noting categories on margins, but can be done more elaborately (e.g. on cards). While coding an incident for a category, compare it with previous incidents in the same and different group....The constant comparison of incidents very soon starts to generate theoretical properties of the category...its dimensions, the conditions under which it is pronounced or minimised, its major consequences, its relation to other categories and its other properties', (Glaser and Strauss, 1967: 106).

Although more formulaic and programmatic approaches to coding and categorising have been recommended (e.g. Strauss and Corbin, 1998) the general underlying principle remains the same. The process continues until all data has been included in the analytic procedure, this results in 'comprehensive data treatment' (Mehan, 1979) and is considered by some to be vital in maximising the credibility and dependability of the category analysis (Silverman, 2001).

Essentially the nature of this approach is to take datum, e.g. an observation or a few words in a transcript, and to give this datum a name, i.e. to categorise it. The researcher does not necessarily have to give it *the same* name as a research participant because the research participant is him/herself unlikely to give a name to his/her words and actions. Clearly this translation will always be necessary since analysts have to make their observations make sense to their readers. As Sacks notes,

'An unremarkable, and yet profoundly problematic truism is that when we 'look and see',..nothing we take as subject can appear as part of our descriptive apparatus unless itself has been described', (Sacks, 1963: 2).

The application of a category therefore requires interpretive and conceptual reasoning by the analyst along with a degree of inventiveness in thinking out new categories. The analysis therefore does not exist as some sort of 'pure' entity for it is inextricably linked to and the product of the analyst's thoughts, values and culture. Despite claims to the contrary (Glaser, 2002) grounded theory categories are therefore *ipso facto* preconceived and cannot therefore be dispassionate nor objective.

Despite this Glaser (1992, 2002) argues that a 'true' grounded theory is able to explain, account and interpret the variation in behaviour across research participants within a field of study. This is made possible by moving beyond conceptual description (categorising and coding) to focusing upon the *underlying* patterns to be found within categories (theoretical coding). Glaser implies that this process leads to the emergence of 'meaning' and allows the researcher to **explain** rather than merely describe research subjects' views and behaviours.

In arguing her case for constructivist grounded theory Charmaz (2000) proposes a method of examining 'meaning' within talk and action. There are two parts to her thesis which are set out in an earlier article. The first is methodological. Charmaz contends that '*...the most important basic rule for a grounded theorist is study your emerging data*' (Charmaz, 1995: 36). She argues further that there should be a move away from static analyses and that an emphasis on what people are doing leads to '*...understanding multiple layers of meanings of their actions.*' (Charmaz, 1995: 35). In this sense the researcher must make analytic sense of the data as opposed to only describing it. S/he must ask themselves what their participants' actions and statements take for granted and how structure and context impact upon actions and statements. The approach seems congruent with Glaser's (1992) notion of 'focusing upon underlying patterns' within data. Both these authors therefore appear to be postulating a type of inference as analysis. Charmaz (1995) comes close to this when she states:

'What you see in the data may not exactly replicate what participants view as going on because you bring different perspectives and concerns to it. (Here I adopt the positivist assumption that it is the researcher's responsibility to find what is 'there' and that it is possible to do so because we already share or can learn to share the language and meanings of those we study)' (Charmaz, 1995: 34).

The second part of Charmaz's thesis is a practical matter requiring techniques to generate rich data and thick description in seeking out 'meaning'. For example, she warns against the researcher assuming they share the same meanings as those of participants and thus urges researchers to probe participants' responses, for example, to describe what makes a 'good' day as opposed to a 'bad' day. The approach produces narrative thick in social description. Yet, for all its inventiveness the method still requires the application of categories to talk and Charmaz still fails to provide a convincing account of a robust method to arrive at *meaning* that addresses our earlier assertion that grounded theory categories are, 'ipso facto' preconceived.

For some proponents of grounded theory the idea of 'meaning' and 'meaningful behaviour' remains buried beneath action and the content of speech and these are therefore assumed by the analyst. That this is problematic is further demonstrated below using some transcript data.

An example of a grounded theory analysis and the place of 'meaning':

In the transcript extract below Fiona, a nurse, is describing aspects of intimate relationships that occur between male and female patients in a special hospital. Here, she is talking about the circumstances in which patients meet and interact at social functions within the organisation concerned.

Fiona

248 . . . . . By and large a lot of the women ..were extremely vulnerable as a ..as a
249 . . . . . As a result of their past experiences..erm and it was almost like. . . . . They
250 were almost like sitting ducks they..they were very often . . . in large..the greater
251 majority of cases, victims. . . . . childhood survivors. . . . survivors of childhood
252 sexual abuse (sighs). Ermm..and then there we were throwing them into a
253 social environment with..with men who . . . . quite often had perpetrated that
254 abuse themselves on..on young women or girls or boys or whatever.

Categories applied using a grounded theory approach:

- *patient relationships*
  - *male patients*
  - *perpetrator of sexual abuse*
  - *abuser*
- *female patients*
  - *victims of abuse*
  - *survivors of sexual abuse*
  - *vulnerable*
  - *sitting ducks*

Fiona's orientation to patients' relationships was not unique. Informants, without exception shared a similar orientation, but all expressed it differently, for example,

Ella

I think. . . it's the same..it's the same whether you're in a special hospital or not in a special hospital, you've got to be consenting. . . We are working with some vulnerable people who don't know each other's backgrounds. . . There are a lot of people who have been through or had abusive backgrounds. . . who may be pushed into things they don't want to do.

Categories applied using a grounded theory approach:

- *patient relationships*
  - *potential for exploitation*
  - *ignorance re partner's past history*
  - *staff concern re patients' capacity to consent*
- *partners*
  - *survivors of abuse*
  - *vulnerable*
  - *exploitative*

Although each informant's quote is different they and their applied categories had sufficient 'family resemblance' (Miller and Fredericks, 2000; Wittgenstien, 1958) to be subsumed under a larger, overarching category of 'inappropriate imbalance of power', an overarching perceived characteristic of patients' relationships consisting of one partner exploiting the other. Yet, none of the informants *stated* this. Rather, this applied category reflected the analyst's understanding of the meaning inherent within informants' talk. How did the analyst hear it this way? How can a family resemblance be detected and understood within speech acts of differing content? The answer to these questions lies in understanding that it is only in the sharing of a language and culture that the underlying meaning and values within talk are given to members of that culture or 'natural attitude' (Schutz, 1962: 209).

Grasping these meanings in the talk is contingent upon the researcher grasping the **meaning underlying the content of categories** (Wittgenstien, 1958). In everyday social situations Schutz (ibid) argues that the mutual intelligibility of con-

tent between interactants (or interviewer and interviewee) comes as part of sharing a 'natural attitude', i.e. a shared culture. We hear informants' distaste about patients' relationships in what they say because we have a socio-moral understanding about what it means, for example, to be a 'victim of abuse', 'perpetrator of sexual abuse' and, indeed, a 'sitting duck'. The socio-moral values in the talk remain unspoken and submerged, yet understood by the hearer within a shared culture. Grounded theory categorisation does nothing to intercept this and its analysis therefore remains 'flat'.

In the above we are dealing with *words*, with our understanding of their meaning. This is not inconsequential. Sacks (1972;1972a) argues that language is contingently accomplished to establish social meanings within the overall structure of the story or sentence (Sacks, 1972;1972a). The problem here is that coding the content of ***what*** has been said is not necessarily concomitant with a coding of the intended ***meaning*** of using words in a particular order. The creation of overarching categories representing the preponderance of smaller categories is acceptable in *descriptive* accounts but when dealing with social meanings it becomes less robust. This is because the content (the talk) within the smaller categories becomes removed from the speaker's individual situated meanings and motives when placed in a broader category by the researcher. It is here that findings can be accused of 'anecdotalism' since the social validity of the overarching categories, i.e. the social meanings claimed by the researcher to be inherent within the data lack a systematic, robust, demonstration (Silverman, 2001). Such anecdotalism may serve to undermine studies' claims to credibility, transferability and dependability, (ibid: p. 222).

Given the above arguments and, despite the arguments of Charmaz (1995; 2000) that grounded theory accesses to social meaning, grounded theory procedures cannot facilitate a demonstration of the accuracy of the analyst's interpretations. Any applied or understood meanings therefore gained from the categories necessitates the presence of '*interpretive trust*' (Schutz, 1962a,b; Garfinkel, 1967; Heritage, 1984). The method of analysis proposed within grounded theory assumes the 'correct' transfer of first order constructs (the meanings intended by informants) by the analyst into an accurate, generalised social position, induced theory or, even hypothesis. Yet above it has been demonstrated that they are in fact 'second order' constructs, i.e. constructs made by the analyst out of the prior existing constructs of 'actors'. Clearly then grounded theory's power remains at the level of *description*, not *meaning*.

Repair for the link between first and second order constructs

The intention of the research upon which this paper is based was to influence future sexual health policy and practice initiatives within high security care. From the category analysis yielded by the grounded theory approach it became apparent, for example, that **all** informants were unsure as to hospital policies regarding patient marriages and were negative about all patients having the right to marry whilst detained in hospital. Informants also disagreed with policies that prevented a patient from being informed about their intended spouse's offence histories viewing such non-disclosure as a means through which known perpetrators could continue to deceive and abuse others. For those with a view to policy and practice it might seem a reasonable conclusion that a change in policy which upheld patients' 'right to know' about their partner's past history of perpetrating abuse would significantly contribute to overcoming staff disaffection towards the marriage policy. Additionally a training package would enhance staff's knowledge and ability to engage with the policy.

Whilst the above position is plausible it is also flawed.

The usual link between research and policy suggests that operationalising findings for policy and informing staff both through training and in other ways will act to resolve their misapprehension of policy. However, this view assumes a compliance, that the intended actions of staff will follow policy exhortation with appropriate training. What the data seemed to be suggesting however, was that staff were 'findings ways' of ignoring policies with which they disagreed, one of which related to patient sexuality and its expression. All that can legitimately be claimed at this point is that there exists some sort of problem or deficit in relation to staff acceptance of current policy. Any apportioning of blame to individual practitioners for their views at this point fails to acknowledge the role of the social, historical and cultural contexts in which clinical practice concerns are constructed and maintained in the first place (Mercer et al., 2000; Purkiss, 1994). Thus, we may now know that a problem exists but without understanding the meanings and intentions of staff it would be premature to claim to know the cause and thus inappropriate to make recommendations for policy and

practice. In order to understand the problem some form of analysis that moves beyond description, and which facilitates demonstrable 'first order' meanings was therefore clearly required for the study in question. It was for these reasons that grounded theory as a sole analytic approach was supplemented by membership category analysis (Sacks, 1972a; Lepper, 2000; Silverman, 2001).

Membership category analysis

According to Garfinkel (1967) speech accounts (talk) are part of the world that they describe and according to Giddens (1987) to know a language is not only to know syntactical rules but is also

'..to acquire a range of methodological devices, involved both with the production of utterances themselves and with the constitution and reconstitution of social life in the daily contexts of social activity.'

(ibid: 79–80)

Given the above we not only use language categories but we have to understand the rules and conditions of their application. To be a part of a particular culture (this may be a country, a sub-culture or in this case staff in a special hospital) requires that the rules and conditions of application are **mutually** understood. Language categories are therefore suffused with cultural significance and morality; they therefore demonstrate value positions.

In reading and re-reading transcripts it was clear that the 'stories' about sexuality and patients were constructed to 'make sense' in a particular way. The stories therefore reflected informants' value positions. If we revisit Fiona's data extract above we can see that it is 'a story'. It is a story in the sense that it is a 'boundaried' description of her values within a particular context. It should be noted that examples of contexts in this study related to a number of situations, for example communing of staff at social gatherings, access to rooms, in terms of an informal economy of exchange and so forth. Fiona's values in the above transcript are brought into relief through 'contrast structures' (Smith, 1978).

According to Smith (1978) contrast structures contain two parts. The first part sets up instructions for the hearer about how to perceive social categories and what to perceive as fitting (moral, socially acceptable) behaviour associated with them. The second part shows behaviours perceived as not fitting with those categories and this provides a basis upon which social judgements about those categories and behaviours can be justifiably made (Smith, 1978). In Fiona's talk the main contrast structure concerns the categories of **victims** of abuse and **perpetrators** of abuse. Fiona's statements appeal to the rationality and values of the hearer as if they were the same as her own. Fiona, therefore, intentionally provides for the hearer to understand that **fitting (moral) behaviour would be to protect victims from perpetrators**. This is the first half of the contrast structure.

The second half of the contrast structure reveals the behaviour that did occur, that is that victims were 'thrown' into a social environment with perpetrators. Fiona intentionally provides for the hearer to understand that protection was not provided and thus to see that the placing of victims and perpetrators together was anomalous with that seen as fitting (moral) behaviour. This contrast structure serves to communicate that Fiona's value position is that priority must be given to **protection of the vulnerable** and it follows that the best way to do this is to not allow contact between abused and abuser.

By identifying contrast structures and reading the text in this way it was possible to identify value positions and therefore move beyond flat category description towards 'meaning'. However, although these initial interpretations of Fiona's categories are plausible they have not, as yet, been demonstrated. Membership Categorisation Analysis, MCA, (Silverman, 2001; Lepper, 2000; Baker, 2004; 2002; 1997; 1987; Jayyusi, 1984) has been used in these circumstances. The seminal work in MCA is that by Harvey Sacks (1972) with his story from a child:

'The baby cried. The mommy picked it up'.

Membership Categorisation Analysis: Concepts and Application

In the 'story' above Sacks (1972) was led to ask how was it that we hear the story as we do? Why are we likely to hear the 'mommy' as the mother of this 'baby' (Sacks, 1992: 248) and why do we hear that the baby's cries are the reason that the mommy picks it up? (Sacks, 1992: 236).

According to Sacks (1972, 1992) our hearing or reading of the story is informed by the way in which we make inferences about the categories of 'baby' and 'mommy' (Baker, 2004; Silverman, 2001). These categories come from a collection of categories that we subsume under a larger category of

'family' (Sacks, 1972a; 1992). A collection such as this is called a **membership categorisation device** (MCD). This device consists of a collection of linked categories (e.g. mother + father + daughter + son) that make a larger category (family). These may of course vary between cultures or, today within a single culture. But generally speaking we recognise the device as consisting of these people. Sacks suggest that for MCAs there are rules of application that are central to understanding the basics of MCA.

In the child's story above 'baby' and 'mommy' are single, named categories. As Silverman (2001) notes we are told nothing about the characteristics of those individuals incumbent within the categories or their relationship to each other but we have no problem in understanding them and their activities as a plausible, non-problematic description of events. This intelligibility is due to what Sacks (1972; 1992) terms as the **economy rule** defined thus:

'A single category from any membership categorization device can be referentially adequate' (Sacks, 1992: 246).

However, a category can sit in more than one collection. For example 'baby' can belong to the MCD 'stage of life' as well as 'family' (Sacks, 1992) and can also be used as a term of endearment or love and could therefore come from the collection '*romance*' (Silverman, 2001: 142). So how do we hear the baby as an infant from the same device category as the mommy, this being 'family'?

Sacks (1992) explains this through a **consistency rule corollary.** When two or more categories (baby and mommy) are used to describe two or more members and it is possible to hear those categories as belonging to the same MCD (family) then we hear them that way. As Silverman (2001) explains this is why 'mommy' and 'baby' are heard as part of the same MCD of 'family'. In Sacks' terms we therefore create a 'hearer's maxim', a form in which we can only 'hear what is said in this way'.

Using the concepts above we can now return to Fiona's data extract introduced earlier. We can see that Fiona uses a number of categories within her talk but there are three central categories, 'women' (line 248), 'men' (line 253) and 'we' (line 252). The other categories used serve to embellish these central categories. However these central categories are not in this instance referentially adequate (Silverman, 2001; Sacks, 1992). By this it is meant that we cannot from the text alone identify the MCD from which each category is derived. Yet, if we remember the context or the contingent nature of the talk we remember that Fiona has been asked to talk about **staff** action and **patients'** sexuality and relationships within the special hospital context. From this we can take the three categories identified by Fiona and by applying the **consistency rule corollary** take them as reflecting members from the MCD '**people to be found in special hospitals**'. This is perfectly legitimate for as Jayyusi argues this method is not about:

*'... where one **decides** what device these two membership categories (or any co-selected) categories **are drawn from**, but rather to see what device-category they could, strictly or conventionally, imply **for the task or relevance at hand** that is displayed in the talk within which this category is embedded.'*(Jayyusi, 1984: 62, bold in original)

Thus, it is the task at hand in the talk that implies the categories to be heard and not the researcher's presuppositions (Lepper, 2000). Given this it should be remembered that Fiona has been invited to speak about patients' sexuality from her standpoint as a **staff** member at a special hospital with a responsibility for the care of patients. Thus when Fiona uses the category 'we' she invokes herself, and the category 'we' can be heard also as the category of '**staff**' from the MCD '**people to be found in special hospitals**'. When Fiona therefore speaks of the categories 'men' and 'women' she speaks of the categories of '**men patients'** and '**women patients'** respectively, from the MCD '**people to be found in special hospitals**'.

The categories assigned to people are of vital importance for they lay the foundations as to how their identities and actions will be constructed and perceived by talkers and hearers (Baker, 2004; Lepper, 2000; Baker, 1997). For example we have no problem with the fact that from the MCD 'family' that the 'mommy' picked up the crying 'baby'. This is because each category of persons has culturally imbued within it **category-bound activities**, which are behaviours associated with that category (Sacks, 1992; 1972a). Thus 'picking up crying babies' is a culturally accepted category-bound activity for incumbents of the category/identity 'mommy' and 'crying' and is an accepted category-bound activity of those incumbent in the category/identity 'baby'.

Now if we return to Fiona's data extract we can begin to examine the activities of patients. In lines 248—252 we see that Fiona has described the women patients as vulnerable to abuse because of being sexually victimised in the past. From lines 253—254 and with reference to 251—252 Fiona describes men patients as perpetrators of sexual

abuse who victimise the vulnerable. The hearer is left to ask what kind of men engage in such behaviours? By contrasting the professed activities of these men to those category-bound activities socially expected and accepted of men we come to understand that Fiona's talk has provided us with the understanding that these men are not honest, trustworthy men. They are men from which the vulnerable (the women patients) require protection. This is central to understanding Fiona's utterances about staff action.

If we return to the child's story of the 'baby' and the 'mommy' we see the 'mommy' as the mother of the 'baby' because the MCD 'family' is one of a number of collections that can be heard as constituting a team of members (Silverman, 2001; Sacks, 1992). This is known as duplicative organisation (Sacks, 1972) which allows us to see the 'mommy' and the 'baby' to come from the same 'family'. Indeed, Silverman (2001) suggests that this is not just likely but necessary in order to view the activities engaged in by each member as unremarkable and accountable. This is the rule for the **hearer's maxim for duplicative organisation**, defined by Sacks as follows (our additions and emphasis in bold).

*'If some population **('woman' and 'infant')** has been categorised **('mommy' and 'baby')** by use of categories from some device('**family**') whose collection has the 'duplicative organization' property, and a member is presented with a categorized population **('mommy' and 'baby')** which CAN BE HEARD as co-incumbents of a case of that device's unit **(from the same family)** then hear it that way'*

(Sacks, 1992: 248, cited by Silverman, 2001: 142).

Going back to Fiona's data extract we can use the principles above to have confidence that what she speaks of concerns a collection of persons i.e. staff, men patients and women patients from the same organisation (special hospital). However, the 'baby' and the 'mommy' in the child's story are more than members of the same 'family' just as Fiona's staff and patients are more than members of the same hospital. They are also standard **relational pairs** (SRP) (Lepper, 2000) constituent of a set of rights and obligations to each other (Silverman, 2001; Sacks, 1972a). The baby and mommy are a SRP of the **Collection R** (Sacks, 1972a). Collection R obligates the mommy to give help to her baby e.g. picking it up when it cries, feeding it when it is hungry. The staff and patients however in Fiona's data extract are of the **Collection K** (Sacks, 1972a). Collection K contains categories of 'experts' e.g. opticians, who offer help with specific troubles when paired with a person with such troubles e.g. a short sighted man. In Fiona's data extract the Collection K is constituent of 'staff' (nurses) with a duty of care towards 'patients' (people with mental health problems).

Collection R and K therefore imply the *right* and *proper* activities of particular categories of people. In essence they frame the expected and acceptable category-bound activities such as professionals and family members. Implicitly we establish moral assessments of people according to how their behaviours are congruent with their social identities (Baker, 2004; 2002; Silverman, 2001; Lepper, 2000; Baker, 1997; 1987; Jayyusi, 1984). For example, it is usually acceptable for a mommy to pick up her crying baby. It will usually be viewed in a negative light however if a mommy refused to feed her baby for this would not be associated with the category-bound activities of a 'good' or 'caring' mommy. It is therefore the absence or existence of category-bound activities that facilitate a moral assessment of the mommy's parenting activities. These constructs are relevant to Fiona's values about staff action.

We have already established that, according to Fiona, 'women patients' are in need of protection from the sexual victimisation that the 'men patients' are known to have perpetrated. Yet Fiona tells us that the male and female patients socialise (lines 252—254). Her use of the description 'throwing' in line 252 serves as a negative connotation about staff action in relation to the well-being of women patients. What her talk does is to provide a hearer's maxim to tell us that perpetrators of abuse should not be placed with victims who remain vulnerable to abuse for they become 'bait'. She is therefore complaining that staff action is morally suspect for if the women patients are placed in potential danger through staff action then staff are not fulfilling their category-bound activity of 'duty of care' as required by the SRP of staff and patients within the collection K category. Fiona's moral position is therefore revealed. Women patients need to be protected from abusive men patients. It is the duty of staff to ensure protection since they have a duty of care and the best way to prevent abuse from occurring is to prevent male and female patients from forming relationships.

From the above it can be seen that MCA, like grounded theory analysis, is firmly grounded in the data. But, unlike grounded theory approaches MCA can **demonstrate** social values which are at work in talk and which are often hidden but nevertheless reflected in clinical contexts. The combina-

tion of grounded theory methods and MCA gives us a set of tools to enable a move beyond the assumption of meanings inherent within language towards a systematic method of demonstration. Others have termed the use of multiple methods 'triangulation' (Silverman, 2001; Seale, 1999; Lincoln and Guba, 1985). Triangulation tends to be used in order to confirm what has been found. However, in this study it was thought of as layers of 'meaning'. In other words, MCA offers a rigorous, systematic and transparent method through which to ascertain and demonstrate informants' logic in use (Baker, 2004), the meanings behind their talk (Lepper, 2000), a means of identifying the moral precepts underpinning talk and therefore, by extension, social and cultural order (Jayyusi, 1984).

By organising analysis by using MCAs it was found that staff used a number of mechanisms to ensure that they could legitimate actions that were not in line with the policy on sexuality. For example staff cited other policy they claimed was of a higher order in order to prevent some expressions of sexuality; they acted in groups to provide protection in making decisions about their practice; and, where they could, they organised the setting to avoid having to deliberately avoid pursuing sexuality policy. In these circumstances they were able to *maintain* their own values *despite* policy. They would no doubt be able to do the same in situations of policy change implying the inadequacies of simple recommendations for policy change and training as the repair to systems of personal values.

Conclusion

What has been shown from the analysis is that public pronouncements of values within policy that move towards liberal attitudes to the expression of sexuality by patients in secure settings stand in contrast to staff values and actions in the lived context of secure hospitals in which they work. This dissonance is based upon profoundly held staff beliefs which make policy change impossible through training nor exhortation. There is something in here about the fundamental morality of human relationships and it must be at that level that the basis for the debate must be enjoined. Whilst disappointing for a study not to be able to meet its aims of promoting new policy, it remains more honest to identify the reality disjunctures in the values of staff and those who write policy as being the starting point for future policy development. Room does not, unfortunately, favour more discussion of this here.

Not examined in this paper are a number of difficulties with using MCAs. For example, MCA analysis requires much time and effort to be expended on small extracts of data. It is therefore only possible to analyse snippets of data from much larger transcript data sets, raising issues about how the data for MCA analysis is chosen. In the present study this was resolved by taking 'flat descriptions' of the grounded theory approach and selecting for MCA those which showed a preponderance, i.e. those that needed to be explained. It is in this sense that we use the term 'partner' in the title of this paper to describe the relation between the two methodological approaches.

It has been demonstrated that grounded theory categorisations yield descriptive categories of the second order that require 'interpretive trust' to accept the meaning attributed to respondents talk and actions. By employing MCAs it is possible to examine more closely the central morality, values and intentions of each respondent in ways that explicate meaning as a first order construct.

Establishing such a knowledge base opens up new possibilities in working with staff to understand policy, its implementation and how best to work with the meanings people have in relation to patient care. It also opens up a partnership of methodologies that is less about the confirmation inherent to 'triangulation' and more to do with the 'elaboration' of the meaning, values and intentions of social actors.

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