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THE PALGRAVE HANDBOOK OF ADULT MENTAL HEALTH

Edited by Michelle O'Reilly
and Jessica Nina Lester

The Palgrave Handbook of Adult Mental Health

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Discourse and Conversation Studies

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Contents

Part I Reconceptualising Mental Health and Illness

Part II Naming, Labelling, and Diagnosing

Part III The Discursive Practice of Psychiatry

Part IV Therapy and Interventions

Figures

Tables

Preface

Aims and objectives of the book

The Palgrave Handbook of Adult Mental Health: Discourse and Conversation Studies is a co-edited volume that brings together empirical and theoretical chapters that examine the broad issue of adult mental health in the context of discourse and conversation studies. The empirical chapters of the Handbook focus on the interactions of adults with mental health conditions, their practitioners, and/or their families, while the theoretical chapters critically assess the dominant discourses of mental illness and offer alternative ways of conceiving the related, pertinent issues. The contributors draw upon data from a variety of contexts to illustrate the varied ways in which *language as action* can assist us in better understanding the discursive and everyday conversational practices that surround adult mental health.

In order to examine the performative nature of interaction, two language-based approaches to analysis are pertinent to this volume. Conversation and discourse analysis are useful, related approaches for the study of mental health conditions, particularly when underpinned by a social constructionist framework (Harper, 1995). Conversation and discourse research illustrates how psychopathological categories are not labels that point to an existing entity; rather, they are constructs produced within specific socio-historical conditions (Georgaca, 2012). In the field of mental health, the use of these two approaches is growing, with emergent implications for adults with mental health conditions, their practitioners, and/or their families. As such, in this volume, we synthesise contemporary research that uses and theorises these analytical approaches for the study of adult mental health. From theoretical discussions of concepts and language that surround adult mental health pathology to empirically driven chapters with an exploration of particular interactions, the contributors included in this volume adopt a critical position to the study of adult mental health, while also highlighting the practical implications.

Why a handbook now?

The World Health Organization (WHO) (2001) reported that one in four people are affected by a mental health condition, with approximately 450 million people worldwide believed to be experiencing mental health disorders. Indeed, there are a multitude of labels and clinical descriptions available to describe the lives of adults thought to be suffering from mental health disorders, with most of these labels linked to diagnostic protocols and official manuals. For instance, both the *International Classification of Diseases* of the WHO and the *Diagnosis and Statistical Manual of Mental Disorders* of the American Psychiatric Association provide language for describing the everyday performances of adults believed to have mental health disorders, with some scholars noting that the meanings attached to explain 'abnormal' behaviours ultimately determine one's past, present, and future (Crowe, 2000). We suggest, then, that the way in which adult mental health disorders are conceived of in everyday encounters, and ultimately talked about, have great consequence.

While we recently developed and published *The Palgrave Handbook of Child Mental Health: Discourse and Conversation Studies*, at present no volume exists that brings together work focused on adult mental health disorders and discourse and conversation analysis. There is also minimal work that links the everyday practices surrounding adult mental health and discourse and conversation analysis perspectives. Perhaps more significantly, there is even less work that seeks to offer practical, clinical insights positioned at the interaction of adult mental healthcare and discourse and conversation analysis. We argue that this volume, then, is both timely and needed, particularly as the number of individuals diagnosed with mental health disorders persists and raises important questions about care, clinical practice, and society more generally.

Structure of the book

We have structured the book to showcase both theoretical and empirical work that is positioned at the intersection of adult mental health and discourse and conversation analysis. With a particular focus on making explicit the clinical implications of the contributions, many of the chapters include contributions from practising clinicians. Thus, within each chapter, the contributing authors attend to the practical implications of their work, with a 'clinical practice highlights' box placed at the end of each chapter. In addition, recommended readings are offered for those who want to explore discussed concepts in greater detail. A comprehensive glossary is also included at the end of the volume, introducing central concepts highlighted throughout the volume.

More specifically, to provide a general overview of the volume, we have offered a theoretical discussion of the social construction of normality and abnormality, laying the foundation for the entire volume. The book is then divided into four parts, each part focusing on a slightly different aspect of adult mental health and discourse and conversation analysis.

1. Part I, 'Reconceptualising Mental Health and Illness', includes contributions that position adult mental health and illness as being located within everyday practices and discourses. With a particular focus on the place of discourse and conversation analysis in the study of mental health, this part reframes how mental health might be understood as being produced in and through

language. In this part of the book, the authors deal with a range of issues related to the language of adult mental health and the challenges of doing qualitative research in this area and provide interesting insights into particular disorders such as attention deficit hyperactivity disorder (ADHD), bipolar disorder, substance abuse, and Autism Spectrum Disorders (ASD).

2. Part II, 'Naming, Labelling, and Diagnosing', includes chapters that critically consider the ways in which diagnosis is fundamentally dependent upon language use. In this part, many of the authors illustrate how the diagnostic process, which results in the naming of some bodies as 'abnormal' and others as 'normal', results in the generation of an 'official' diagnosis. Here authors examine the language and labelling of mental disorders and the ways in which conditions are constructed in particular contexts such as psychiatry, counselling, support group meetings, hospitals, and online.
3. Part III, 'The Discursive Practice of Psychiatry', offers examples of empirical and theoretical work focused on the language in use that is central to the psychiatric practice. The focus of this part is on the real-world practice of psychiatric services and the mental illnesses that present to such services. Examples are given from schizophrenia and autism spectrum disorder (ASD), and attention is paid to forensic units, psychiatric hospitals, and pharmacological interventions.
4. Part IV, 'Therapy and Interventions', gives particular attention to the therapeutic practices that surround treating mental disorders. With the inclusion of both theoretical and empirical discussions, this part of the book offers insights into how to make sense of and critically study therapeutic practices. Different modalities of therapies are explored and different therapeutic contexts investigated, with an examination of therapeutic interaction, assessments, and courtroom interactions being provided.

For the purposes of easy referencing, we provide a listing of all of the chapters, along with their abstracts to give a clear overview of the content of each chapter.

Abstracts

Introduction: The Social Construction of Normality and Pathology

Michelle O'Reilly and Jessica Nina Lester

Social constructionism serves as a benchmark for this Handbook, and this chapter provides a basis for introducing this perspective in relation to mental health and mental distress. Here, O'Reilly and Lester provide a contextual background to the historical advancements of mental distress by considering its history. The authors briefly take the reader from ancient Greece to the modern day and illustrate the changing thoughts and language associated. While scientific classification systems and the related diagnostic criteria are relatively new developments, there have already been multiple revisions to the categorisations of abnormal behaviours in terms of how they are identified and defined. Thus, in bringing the reader up to the 20th and 21st centuries, this chapter illustrates the development of the main classification systems, while critically considering the role of the *Diagnostic and Statistical Manual of Mental Disorders* and *International Classification of Diseases* and pointing to the construction of the normality/abnormality binary.

Part I: Reconceptualising Mental Health and Illness

Chapter 1: The History and Landscape of Conversation and Discourse Analysis

Jessica Nina Lester and Michelle O'Reilly

In this chapter, Lester and O'Reilly provide the foundation for the Handbook by discussing the history and landscape of both conversation and discourse analysis. The authors provide the reader with a detailed overview of conversation analysis, exploring its roots and basic tenets as well as giving some practical guidance. Additionally, they recognise the different forms of discourse analysis and guide the reader through some of the more common types. This chapter serves as a benchmark for the rest of the Handbook, providing contextual methodological detail for the contributions and illustrating how these approaches have been used to study mental health.

Chapter 2: Using Discourse and Conversation Analysis to Study Clinical Practice in Adult Mental Health

Nikki Kiyimba

From the dual perspective of clinical and academic psychology, Kiyimba presents an introduction to discourse and conversation analysis as particularly appropriate and satisfying modalities of qualitative enquiry for understanding therapeutic mental health encounters. In this chapter, she skilfully outlines the domains of evidence-based practice, and the burgeoning field of practice-based evidence, guiding the reader through the terminology and debates within the current literature. The chapter provides clear up-to-date examples from empirical research of exactly how discourse and conversation analysis have been used to understand the content and processes of therapeutic mental health encounters. Kiyimba also offers accessible and practical guidance about how mental health practitioners can engage effectively in discursive research through developing mutually beneficial academic partnerships and affiliations.

Chapter 3: The Research Interview in Adult Mental Health: Problems and Possibilities for Discourse Studies

Julie Hepworth and Chris McVittie

Hepworth and McVittie directly engage with the key considerations required of any researcher in adult mental health and discourse studies. The authors highlight the breadth of practice issues from the conceptualisation of a research study through to its analytic claims. In addition to illustrating how adult mental health is represented as moral discourse, the constraints on research training for novice researchers is elaborated on with recommended strategies to address the many challenges of interviewing. Included within the chapter are several insights from the authors themselves as experienced qualitative researchers/discourse analysts that personalise the chapter. In closing, Hepworth and McVittie conclude that for all qualitative researchers the position we hold in interviewing is a privilege, and that practice is one best defined by ethics and compassion.

Chapter 4: Inclusive Conversation Analysis with Disabled People

Val Williams, Marcus Jepson, Lisa Ponting, and Kerrie Ford

This chapter is about people with intellectual disabilities, but it is also written *with* people with that label. Both Lisa Ponting and Kerrie Ford draw on their experience not only of ‘intellectual disability’ but also of carrying out research about communication. This chapter foregrounds different ways of involving ‘end users’ of the research within the actual process of the project and examines what can be gained from these diverse approaches. It will be of interest to anyone who has ever questioned the usefulness and impact of their conversation analysis, and wondered about the questions: ‘Does this analysis matter?’ and ‘To whom does it matter?’

Chapter 5: The Discursive Construction of Drug Realities: Discourses on Drugs, Users, and Drug-Related Practices

Benno Herzog

Drug realities must be comprehended as the results of a complex interaction of language, power, knowledge, practices, and material and immaterial reality. In this chapter, Herzog discusses the discursive construction of three associated phenomena: (1) drugs (i.e. substances and their materiality); (2) social actors and their identities; and (3) practices in the field of drug realities. The chapter shows that discursive constructions in this field of drug realities are highly interwoven with other, powerful discourses. Discourses on criminality, migration, and public and mental health, with their interpretations and their existing resources, influence the discourses in the field of drugs. These influences can take the form of games or struggles that are both struggles for the 'correct' interpretation and struggles for power and resources.

Chapter 6: The Construction of Adult ADHD: Anna's Story

Alison Davies and Mary Horton-Salway

This critical discursive psychology analysis of Anna's story demonstrates how an adult diagnosis of attention deficit hyperactivity disorder (ADHD) can be used to reconstruct life stories and manage stigma and troubled identities. Horton-Salway and Davies discuss some issues arising by examining the story of a mother, Anna. Horton-Salway and Davies focus on how discourse functions to construct the meaning of ADHD and events in Anna's family life. Her account transforms troubled identities and explains them in terms of biological, genetic, and familial characteristics. Anna's efforts to make sense of ADHD highlight issues that can arise for adults with undiagnosed ADHD who have a history of troubled lives, stigma, and spoiled identities. In particular, her construction of ADHD as a biological/genetic condition works not only to reinterpret life events and personal difficulties but also to manage issues of blame, accountability, and the overarching spectre of 'mother-blame'.

Chapter 7: Using Discourse Analysis to Investigate How Bipolar Disorder Is Constructed as an Object

Lynere Wilson and Marie Crowe

This chapter is concerned with how the discursive practices of psychiatry produce our understanding of what bipolar disorder is and, in the process, shape what it means to be a person with bipolar disorder. A Foucauldian-inspired discourse analysis is used to show how the psychiatric discourse used within a psycho-education intervention constructs bipolar disorder as an object that is located in the brain which only psychiatry has the authority to treat. As a result, the discourse of psychiatry produces a person with bipolar disorder in such a way that everything about the person is tied to the condition they are said to have. This discourse analysis demonstrates how discursive practices act as both a vehicle and effect of power relations with the text under analysis acting as an exemplar of Foucault's notion of pastoral power.

Chapter 8: Discourses of Autism on Film: An Analysis of Memorable Images that Create Definition

Andrea Garner, Valerie Harwood, and Sandra C. Jones

Film is a powerful influence on social discourses and consequently contributes to the popular understanding of adult mental health. Evocative images used in film often delineate distinctive categories of 'ability' and 'disability'. This practice is particularly prevalent in representations of autism on film, which have become more commonplace with films such as *Rain Man* (1988), contributing to largely unquestioned discourses about what it means to be an adult on the autism spectrum. In this chapter, Garner et al. examine the discursive practices used in three films portraying characters on the autism spectrum and constructing deficit model perceptions in the audiences. The examination employs qualitative analysis regarding the influence of memorable scenes used in film on viewer discourses about autism.

Chapter 9: Abuse Victims and High-Profile Offenders: A Discourse Analysis of Victim Construction and Adult Mental Health

Naima Fowlis, Michelle O'Reilly, and Mary Farrelly

In this chapter Fowlis et al. explore how the media constructed the sexual-abuse victims of the UK celebrity, Jimmy Savile, and relate this to issues of their long-term mental health. Jimmy Savile was a UK presenter and radio DJ who raised millions for charity, and since his death has been accused by over 450 victims. The construction of 'victim' status was investigated using five YouTube video interviews with victims, eleven newspaper articles, and the police interview transcript with Savile. Using discourse analysis, three key repertoires were identified, which were blame and responsibility, celebrity power, and victim authenticity. It appears that due to Savile's celebrity power, victims were constructed as inferior, resulting in their authenticity being questioned and the blame and responsibility shifting between the victims and Savile. Discussion about future research comparing the construction of victims of a celebrity and non-celebrity offender is also considered.

Part II: Naming, Labelling, and Diagnosing

Chapter 10: Diagnosing as an Interactional Achievement in Psychiatric Interviews

Carles Roca-Cuberes

Roca-Cuberes explores the interaction between adults with possible mental health conditions and psychiatrists. Drawing upon data from psychiatric interviews video-recorded in a large Spanish hospital, the chapter shows that from the two discursive strategies that psychiatrists might employ to elicit talk from patients, the question–answer sequence appears to be better suited to gain substantial control over the course of the interaction than an invited story. Roca-Cuberes also examines the process that leads to the production of a diagnosis, exploring a candidate patient's mental state, and proposes that it is performed on the basis of what is normatively expectable from particular membership categories. As such, the chapter concludes, it does not require much technical knowledge and basically involves the application of common-sense or lay psychological reasoning.

Chapter 11: Psychogenic Non-epileptic Seizures: How Doctors Use Medical Labels when They Communicate and Explain the Diagnosis

Chiara M. Monzoni and Markus Reuber

The communication of the diagnosis of psychogenic non-epileptic seizures (PNES) to patients presents doctors with a difficult challenge. In this chapter, Monzoni and Reuber use conversation analysis to investigate the use of diagnostic labels and formulations by neurologists. Doctors tend to employ negative formulations like litotes or similarly negatively framed attributes formulations which are used only to set up a contrast with a pre-diagnostic hypothesis (i.e. 'it's not epilepsy'). Clearer and more specific and formulations are usually avoided (such as 'psychogenic' non-epileptic seizures). The non-explicit formulations doctors employ are problematic because they amount to little more than 'dummy' diagnoses which may never be specified in the subsequent consultations, even when patients overtly request clarifications or specifications.

Chapter 12: The Process of Social Labelling of Mental Illness: An Analysis of Family Conversations

Milena Silva Lisboa and Mary Jane Paris Spink

In this chapter, Lisboa and Spink present a case study of the process of social labelling in the context of mental health. The chapter aims to show the viability and potential contributions of an association between two theoretical traditions: labelling theory and conversation analysis. It attempts to show the difficult task of conciliating singularity and the generalisation needed for developing more sensitive protocols in mental health services. Readers are thus encouraged to explore the literature regarding the processes of making sense of the world in our daily life with special regards to the negotiation of what counts as normal for people in their immediate conversational contexts, focusing on the interactional strategies used by the family to refer to different moments of the process of social labelling.

Chapter 13: Making Mental Disorders Visible: Proto-Morality as Diagnostic Resource in Psychiatric Exploration

Jörg R. Bergmann

Bergmann presents a study of intake interviews in which psychiatrists decide on the admission of candidate patient to a mental hospital. Two phenomena are studied from a conversation analytic perspective. On the one hand, the paper focuses on episodes in which a candidate patient remains silent during the interview; on the other hand, the chapter deals with certain indirect exploratory practices it is argued that the psychiatrists' practices are based on common-sense reasoning and the observation of proto-moral aspects of interaction. Proto-moral features of social interaction serve mental health professionals as a resource to make mental disorder visible and to warrant their professional judgements. It is suggested that mental health professionals take into consideration the moral implications of their practices in order to enhance their self-reflexivity and professionalism.

Chapter 14: The Role of Self-Disclosure in the Social Construction of Understandings of Alcoholism and Mental Health within Talk between Members of Alcoholics Anonymous

Matthew S. Thatcher

Thatcher shows how members of Alcoholics Anonymous develop understandings of mental health through reporting the self-disclosure of others. Focusing on different forms of rhetorical reported speech, the chapter reveals how Alcoholics Anonymous members use disclosure to persuade others that alcoholism is situated in the mind and alcoholics are insane. The chapter also addresses a current conflict within Alcoholics Anonymous regarding mental health and the use of anti-depressants and other mental health related medicine. The chapter contributes to the research on self-disclosure by showing how different forms of reported speech influence the persuasive force of disclosure and provides useful information for Alcoholics Anonymous members and professionals treating patients recovering from alcohol abuse by revealing how layperson discourse may influence understandings of mental health and appropriate treatment.

Chapter 15: 'But How Often Does This Happen?': Problem Reducing Responses by Coaches in Email Counselling

Joyce Lamerichs and Wyke Stommel

Lamerichs and Stommel explore how coaches typically reply to clients' troubles-tellings in email counselling and identify five types of 'problem reducing responses'. These responses attend to a 'neutral' reading of client emails rather than more explicitly acknowledging the client's problem. Further, counsellors emphasise the positive, cast the client's problem as something people generally deal with, and lastly, ask contrastive questions. Lamerichs and Stommel show how posing contrastive questions plays a central role in the interactional dynamic of email counselling in that they predominantly invite legitimising and accountability talk in clients' replies. Counsellors then subsequently engage in realigning with the client, for example, by reinforcing clients' legitimising claims.

Chapter 16: Does Ana = Anorexia? Online Interaction and the Construction of New Discursive Objects

David C. Giles

The pro-ana phenomenon – online communities run by people with eating disorders who do not wish to 'recover' from them – has puzzled and worried health and medical professionals and users' parents and friends for well over a decade. But are the websites a reflection of the disordered thinking of anorexia or the manifestation of a radical underground 'movement' challenging the institution of medicine? In this chapter, David Giles argues that they are neither of these things. In performing a genealogical analysis of the pro-ana phenomenon, he suggests that the discursive object 'ana' should be regarded as something new, and separate from, the psychiatric category of anorexia (nervosa) and is best understood, first and foremost, as a *media* phenomenon.

Part III: The Discursive Practice of Psychiatry

Chapter 17: Exploring the Heterogeneity of 'Schizophrenic Speech'

Lisa Mikesell and Elizabeth Bromley

This chapter brings together neurocognitive, clinical, and ethnographic data to explore the heterogeneity of 'schizophrenic speech', which has historically been treated uniformly. Recent studies, however, providing 'molar' characterisations of pragmatic engagement, highlight variation across speakers, which may reflect the growing recognition that schizophrenia is not a singular disorder. To complement these molar characterisations, we also use conversation analysis to highlight two recurring communication practices of two individuals diagnosed with schizophrenia: the first is a prosodic feature of turn design, and the second is a response to topic proffers. Mikesell and Bromley discuss how these practices may contribute to the clinical and ethnographic molar characterisations, how each practice may be framed as both problematic and skilful, and what this 'duality' means for situating communication practices within deficit and/or competency models.

Chapter 18: Mental Health Treatment Planning: A Dis/Empowering Process

Michael A. Mancini

The mental health recovery model is a process of transformation from a state of helplessness and hopelessness to a state of holistic well-being. The model requires practitioners and service users to negotiate a shared understanding of 'problems', 'goals', and 'solutions'. In the chapter, Mancini uses critical discourse analysis to explore the discursive practices that occur within a single treatment-planning meeting between a team of community mental health workers integrating a collaborative form of recovery-oriented treatment planning and a mental health service user. The team's efforts to adopt a more open and evocative interviewing genre, and to intentionally position the service user as a collaborative partner, disrupted the traditional power relations embedded within treatment planning in complex ways. Implications for practice are discussed in light of these findings.

Chapter 19: Team Work in Action: Building Grounds for Psychiatric Medication Decisions in Assertive Community Treatment

Beth Angell and Galina B. Bolden

Multidisciplinary mental health teams represent one of the most common organisational forms in psychiatric treatment for adults with serious mental illness, and this structure is considered a critical ingredient of the highly regarded assertive community treatment (ACT) model. Little research, however, has examined how team work accomplishes core functions in ACT. Using conversation analysis, Angell and Bolden examine audio-recorded consultations between clients with serious mental illness and the team psychiatrist in an ACT programme. The analysis demonstrates how non-psychiatric team co-members' diagnostic assessments of the client are strategically brought into the interaction in the course of rationalising and justifying a psychiatric treatment proposal to a client, and suggest that teams accomplish their work not simply through the additive contributions of members, but through their coordinated actions.

Chapter 20: 'Good' Communication in Schizophrenia: A Conversation Analytic Definition

Laura Thompson and Rose McCabe

In the treatment of schizophrenia, psychiatrists walk a 'tightrope': asking questions of appropriate depth and pace, while avoiding confrontation and collusion around psychotic symptoms. Thompson and McCabe explore how conversation analysis can illuminate questioning practices in psychiatry and define 'good' communication by a novel, bottom-up, approach. Using declarative questions as a case study, the chapter contextualises statistical relationships with the therapeutic alliance and treatment adherence found in earlier research (Thompson, Howes, & McCabe, 2015). A subtype of 'closed' question, declaratives are shown to be counter-intuitively nuanced – and clinically pragmatic. They may function to improve the psychiatrist–patient alliance, sequence patient narratives and display empathy, balancing tasks of assessment and treatment.

Chapter 21: 'Talk about Trouble': Practitioner Discourses on Service Users Who Are Judged to Be Resisting, Contesting, or Evading Treatment

Mike Hazelton and Rachel Rossiter

In the course of their work, health practitioners frequently come into contact with people who resist or evade treatment for mental health problems. How practitioners make sense of and respond to individuals and situations considered difficult to manage can influence the development of professional identity and whether one comes to understand the nature of mental health work primarily in terms of duty of care or duty of control. Hazelton and Rossiter report on a decade-long programme of research that has investigated these concerns using a form of discourse analysis informed by Michel Foucault's ideas on governmentality. 'Talk about trouble' concludes with a discussion of how therapeutic skills might be built, strengthened, and supported as practitioners grapple with the demands of mental health work.

Chapter 22: Conversation with an Adult with Features of Autism Spectrum Disorder in Secure Forensic Care

Sushie Dobbinson

Conversations with adults with features of Autism Spectrum Disorders (ASDs) in secure care present important data for the conversation analysis of interaction. In this chapter, Dobbinson examines talk between a patient, who has features of ASD, and his speech and language therapist (SLT) as they negotiate understanding of emotional displays and how they link to behaviour. During the talk, the SLT facilitates her ASD interlocutor's expressions of emotional understanding difficulty by following and adapting to his cues. For individuals with ASDs emotional understanding is a notoriously difficult task, and for this patient in particular, is a critical aspect of his offending. The wider context in which this conversation takes place, of ASD in forensic care, is also considered.

Chapter 23: A Critical Discursive Perspective on Psychiatric Hospitals

Claire Bone and Nichola Marchant

Psychiatric hospitals have evolved through different eras in line with the prevailing discourses of the time. In this chapter, Bone and Marchant draw on principles from critical discursive psychology to examine how current psychiatric hospitals are situated in time and context by considering their historical roots. The authors aim to engage in the debates surrounding disorder, antipsychiatry, and deinstitutionalisation from the perspective of psychologists working within a service for females with a diagnosis of personality disorder.

They discuss the challenges they face in light of these debates in order to understand how to better help those in the present, as well as looking forwards to how clinical psychology might participate in longer term socio-political change.

Part IV: Therapy and Interventions

Chapter 24: Discursive Awareness and Resourcefulness: Bringing Discursive Researchers into Closer Dialogue with Discursive Therapists?

Tom Strong

This chapter examines how discursively informed therapy can be enhanced by discursive research. Discursive therapists take up the linguistic or discursive turn, reflexively using therapeutic dialogue to deconstruct and construct client-preferred possibilities. Discursive research of mental health discourse has typically focused on dominance by particular discourses or taken-for-granted aspects of therapeutic communications. For the most part, discursive therapists and discursive researchers have talked past each other, when they have much to offer each other. Through this chapter, Strong juxtaposes the practices of discursive therapists with understandings from discourse theory and research. The chapter concludes by considering discursive therapy practice as animated and sensitised by discursive research.

Chapter 25: Therapeutic Practice as Social Construction

Kenneth J. Gergen and Ottar Ness

In recent decades, social constructionist ideas have emerged as a major challenge to the empiricist/realist paradigm long dominating the sciences and their related practices. Constructionism emphasises the origins of human meaning – including what we take to be real, rational, and good – within relational process. In this chapter, Gergen and Ness discuss some of the major implications for therapeutic practice. This includes both the implications for the therapist's general orientation to practice, as well as for specific actions within treatment venues. A constructionist orientation does not demand any single form of treatment, but sharpens critical sensitivities, and invites continuous innovation in the therapeutic process.

Chapter 26: The Value of Using Discourse and Conversation Analysis as Evidence to Inform Practice in Counselling and Therapeutic Interactions

Nikki Kiyimba and Michelle O'Reilly

There has been increasing attention paid to language and communication in therapeutic settings. Particularly, discourse and conversation analysts have become increasingly interested in institutional settings and have begun to contribute important research to the field. In this chapter, Kiyimba and O'Reilly consider the contemporary culture of therapy and the need for conversation and discourse analytic evidence. Modern therapeutic approaches are provided in an evidence-based world, and in the chapter there is a critical discussion of the contributions that can be made by this type of research. Kiyimba and O'Reilly pay attention to the different therapeutic approaches that are available to adults experiencing mental health problems to provide contextual information for the chapter. This is contextualised within discourse of evidence-based practice and the role of general qualitative evidence is promoted. The authors illustrate how discursive approaches to therapy have potential to illuminate processes within therapeutic conversations and make a case for the usefulness of this type of research.

Chapter 27: Interactional Practices of Psychotherapy

Liisa Voutilainen and Anssi Peräkylä

Conversation analysis is a method for the study of social interaction between humans in any setting. In this chapter, Voutilainen and Peräkylä discuss a conversation analysis perspective to psychotherapy in dialogue with clinically central themes. Through empirical examples from a cognitive therapy, the chapter addresses four aspects of clinical work: therapeutic collaboration, therapist's empathy, client's resistance, and therapeutic change. The chapter details interactional practices through which the participants work with the client's way to relate to disappointment, anger, and self-blame, as well as how therapeutic change in relation to these experiences emerges in social interaction. The focus is especially on the interconnectedness and possible mismatch of empathy and challenge in the therapist's ways to respond to the client's talk on problematic experiences.

Chapter 28: Finding the Middle Ground between Therapist-Centred and Client-Centred Metaphor Research in Psychotherapy

Dennis Tay

The claim that metaphorical language reflects conceptual representation is relevant to psychotherapists who seek to explore and potentially change their clients' conceptualisations through verbal interaction. The psychotherapy literature has subsequently witnessed a distinction between therapist-centred and client-centred approaches, which respectively emphasise how therapists and clients author, use, and manage metaphors. In this chapter, Tay draws from different examples of authentic metaphor use to highlight a complementary 'middle-ground' approach which acknowledges, and more accurately reflects, the complex interactional and collaborative quality of both metaphor and psychotherapy. Three aspects of this middle-ground approach – *co-construction*, *negotiation*, and *compromise* – are discussed along with some clinical implications. The importance of context in understanding the nature of metaphor in psychotherapy is emphasised.

Chapter 29: Storytelling, Depression, and Psychotherapy

Peter Muntigl

This chapter examines storytelling practices of depressed clients within the context of emotion-focused psychotherapeutic treatments. Using the methods of conversation analysis, a fine-grained qualitative approach to studying social interaction, Muntigl shows how stories convey helplessness and low personal agency and how therapists are able to negotiate the import and significance of the client's story through different types of response. The relevance for clinical practice is highlighted in this chapter. First, it is shown how different therapist responses convey different degrees of affiliation with the client's distress. Second, therapist response types tend to mobilise affiliation and empathy from clients in different ways. Third, the more empathy or affiliation therapists invest in their response, the more empathy/affiliation they get back.

Chapter 30: Using Discourse Analysis to Develop Understanding of Suicide Risk Assessment

Ric Bowl and Andrew Reeves

Discourse analysis has the potential to make an important contribution to our understanding of interventions when working with suicidal people. If we are soon to reach 'saturation' point in our knowledge of the demographics of suicide, our attention instead needs to turn to the experience of suicidal people and how they can be facilitated to talk about their thoughts in an open, non-judgemental, and collaborative way. It is in this discourse-based exploration that an individual's level of risk can be more fully understood and, in turn, informed preventative approaches developed. In this chapter, Bowl and Reeves consider the use of discourse analysis in how mental health workers respond to suicide clients, with a specific research example given of how counselling and psychotherapy approaches with suicidal clients were effectively explored.

Chapter 31: Communicative Practices in Staff Support of Adults with Intellectual Disabilities

Charles Antaki, W. Mick L. Finlay, Chris Walton, and Joe Sempik

Antaki et al. examine some of the ways in which adults with intellectual disabilities communicate with those around them – most specifically, with support staff. Support staff are not always well supported by training and may have difficult conditions of employment, thus examining the way they interact with their clients may be of benefits. The way staff ask questions, issue suggestions and directives, and support service-users' efforts to engage in social interaction can all be illuminated by close examination and some practices might be improved. But changing interactional practices is not an easy matter, and it requires an investment of time and resources, which are likely in short supply in publicly funded or commissioned services. These are real difficulties, but the real-world evidence that we have presented in this chapter may be helpful in raising consciousness about the issues involved and possible benefits of change.

Chapter 32: Discovering Mental Ill Health: 'Problem-Solving' in an English Magistrates' Court

Timothy Auburn, Cordet Smart, Gisella Hanley Santos, Jill Annison, and Daniel Gilling

People with problems of mental ill health are overrepresented in the criminal justice system. Community justice courts have established procedures for 'problem-solving' as a way of addressing these and other issues associated with pathways into crime. In this chapter, Auburn et al. examine problem-solving in one such court in England. The ways in which mental health issues are raised by members of the problem-solving team, and how signposting is implemented, are examined. Three main questioning forms are identified and the influence that these forms have on the meeting-talk trajectory is discussed. There was a continuum from eliciting 'no problem' responses to facilitating claims of mental ill health. Specific 'diagnostic procedures' are also identified as important precursors to advice delivery. The clinical relevance of these findings is considered.

Chapter 33: Discourses of Abuse and Recovery: Talking about Domestic Violence and Its Implications for Therapy

Henderikus J. Stam, Michaela Zverina, H. Lorraine Radtke, and Robbie Babins-Wagner

This chapter reviews research on domestic violence, focusing on discursive studies, namely research conducted within the frameworks of discourse analysis and conversation analysis. Stam et al. examine both research on women who have been abused by male partners and the more controversial research on men who have been abused by women partners. They present excerpts from a recently completed study on men's and women's psycho-educational groups for victims of domestic violence. A number of important conversational features emerged. Talk about responses to abuse for the men were negotiated around gender – that men should not be aggressive with women. The women questioned their responsibility in perpetuating their partners' abuse and the morality of their sometimes aggressive conduct. The women positioned themselves as accountable and challenged victim identities.

Chapter 34: When Assistance Is Not Given: Disaffiliative Responses to Therapeutic Community Clients' Implicit Requests

Marco Pino

In this chapter, Pino examines interactions between the clients and the staff members of a therapeutic community (TC). The TC clients sometimes use expressions of need ('I need X') and desire ('I would like X') to convey implicit requests for assistance. Analysis illustrates that with these expressions the clients provide the staff members with an opportunity to offer assistance, instead of overtly demanding it. This can put the TC staff members in a delicate position when, for several reasons, they may be reluctant to assist the clients in the achievement of particular goals (such as renewing a driver's licence, buying a car, and so on). The staff members sometimes deal with this problem by disaffiliating with the clients' projects to achieve particular outcomes (e.g. renewing a driver's licence) on the basis that the clients (allegedly) lack entitlement to those outcomes. This practice enables the staff members to convey that assistance will not be provided, without saying it in so many words.

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Abbreviations

ACT	Assertive Community Treatment
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychiatric Association
BBC	British Broadcasting Corporation
BPD	Borderline Personality Disorder
BPRS	Brief Psychiatric Rating Scale
BPS	British Psychological Society
CA	Conversation Analysis
CAT	Cognitive Analytical Therapy
CBT	Cognitive Behaviour Therapy
CDA	Critical Discourse Analysis
CLT	Client
CM	Case Manager
COTT	Co-Occurring Treatment Team
DA	Discourse Analysis
DBT	Dialectical Behaviour Therapy
DIU	Designedly incomplete utterance
DJ	Disc Jockey
DoH	Department of Health
DP	Discursive Psychology
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
EFT	Emotion Focused Therapy
HREOC	Human Rights and Equal Opportunity Commission
ICD	*International Classification of Diseases*
ID	Intellectual Disabilities
IPV	Intimate Partner Violence
MCA	Mental Capacity Act (England and Wales)
MCA	Membership Categorisation Analysis
MCCB	MATRICS Consensus Cognitive Battery
MCD	Membership Categorisation Device
MI	Motivational Interviewing
MSE	Mental State Exam
NICE	National Institute of Health and Care Excellence
NMHC	National Mental Health Commission
NSPCC	National Society for the Prevention of Cruelty to Children

PAR	Participatory Action Research
PII	Psychiatric Intake Interview
PNES	Psychogenic Non-Epileptic Seizures
PSY	Psychiatrist
SCID	Structured Clinical Interview for DSM Disorder
SHIP	Survey of High-Impact Psychosis
TA	Transactional Analysis
TCU	Turn Construction Unit
Video-EEG	Video-Electroencephalography
WHO	World Health Organization

Introduction: The Social Construction of Normality and Pathology

Michelle O'Reilly and Jessica Nina Lester

Introduction

Mental distress has been a focus of discussion for centuries, and, over time different views, perspectives, terms, treatments, and organisations have been utilised in response to people deemed to fit the label. In contemporary Western culture, psychological constructs in the context of mental health have been framed in biomedical terms and understood as dispositional within the suffering individual. This prevailing medicalised discourse of mental distress ostensibly offers a more legitimate and 'scientific' understanding of the problems encountered by the individual, family, and society. Importantly however, these ideas have been subject to extensive criticism from a broad range of fields, disciplines, scholars, and practitioners.

The turn to science for explanations, classifications, and treatments of the mentally distressed has not always been valued, and the language associated has varied and evolved considerably over the centuries. Consider, for example, the wide range of terms available to describe those experiencing 'symptoms' that fit a label of mental disorder, including 'mental distress', 'mental illness', 'mentally unhealthy', 'insane', and so forth – not to mention those considered less politically acceptable that infiltrate everyday discourse, such as 'crazy', 'mental', 'psycho', 'nutcase', 'lunatic', 'mad', 'nutter', and so on. We argue that it is this very language and rhetoric that is important for our understanding of mental distress, a rhetoric based on the Cartesian separation of mind/body and reliant upon the use of the umbrella term 'mental'. In pointing to the problematic nature of terminology and the associated arguments, we hope to lay a foundation for the Handbook.

In this chapter, we adopt the view of mental distress and mental illness as encompassing a range of mental health difficulties and attempt to maintain a level of acceptability around the terminology we use. We thus use the term 'mental distress' when speaking generally, as this is a term that acknowledges the troubling character of the experiences but does not subscribe to a specific model of conceptualising such experiences (Georgaca, 2014). We use the term 'mental illness' when speaking more specifically in the context of health and when orienting to the corpus of work in this field.

In this chapter, we provide a contextual background to the historical advancements of mental health and mental distress by considering its rich and chequered history. We briefly take the reader from ancient Greece to the modern day and illustrate the associated changing thoughts and language. While scientific classification systems and the related diagnostic criteria are relatively new developments, particularly in relation to the rich history of mental distress, there have already been multiple revisions to the ways in which mental illnesses are categorised and abnormal behaviours are identified and defined. Thus, in bringing the reader up to the 20th and 21st centuries, we illustrate the development of the main classification systems, while critically considering the role of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and the *International Classification of Diseases* (*ICD*). To illustrate the modern unrest with diagnosing and classifying the mentally ill, we also consider the development of diagnostic practices against the backdrop of two powerful movements that have critiqued the very foundations of psychiatry. This provides a basis for introducing the broad perspective of social constructionism, which serves as a benchmark for the whole volume.

Our discussion here offers a social constructionist view of mental health and mental distress. The chapters within the Handbook adopt a range of different theoretical and methodological perspectives, but all consider language as the fundamental element of their work. Predominantly, the authors (although not exclusively) take a social constructionist perspective on mental distress and offer a more critical understanding of psychiatric labels, categories, and criteria, as not describing pre-existing conditions, but rather as being produced within specific cultural, social, and historical contexts. We explore, at a basic level, some of these theoretical underpinnings in relation to the historical making of 'mental health' next.

History of mental health and mental distress

It is inevitably difficult to write about the long and contested history of something as vast as mental distress, particularly within the confines of a brief chapter section. Further, as Braddock and Parish (2001) noted, it is somewhat challenging to offer a re-telling of the history of issues such as disability, as many published historical accounts focus on descriptions of formal services and treatments. Thus, what we recount here is a partial history, wherein we do *not* position our own interpretations as neutral or realist.

It has been suggested that 'madness may be as old as mankind' (Porter, 2002, p. 10). Some of the oldest recorded descriptions pointed to notions of mental illness. Ancient Egyptians pointed to 'hysterical disorders' (Sigerist, 1951), which dates back to 1900 BC. The oldest medical document referencing depression and hysteria is believed to be the Ebers Papyrus (the Egyptian medical papyrus) dating back to 1600 BC. There also exist ancient Greek, Indian, and Roman writings that point to descriptions of mental illnesses. For instance, Hippocrates, who is considered by some to be a pioneer in the 'treatment' of mental illness, viewed mental disorders as problems to be treated physiologically, rather than as evidence of demonic possession. This belief stood in contrast to the common perspective that demonic possession was to blame for mental differences. In contrast, Hippocrates believed that mental illness could be treated through specific measures, such as with medicines, via changing occupation, and so forth (Sigerist, 1951).

During the medieval period, mental distress was frequently thought to be the result of demonic possession or caused by some supernatural being (Clay, 1966; Neaman, 1978). A focus on 'curing' mental 'illness' was often emphasised, with Anglo-Saxons, for instance, suggesting that 'a pleasant drink against insanity' required one to 'put in ale hassock, lupine, carrot, fennel, radish, betony, water-agrimony, marche, rue, wormwood, cat's mint, elecampane, enchanter's nightshade, wild teazle; sing twelve Masses over the drink, and let the patient drink it' (Russell, 1980, p. 45). Such treatments were believed to make the patient better. With a belief that mental distress was related to demonology, it was not surprising that persecution of people believed to be insane or mentally ill occurred. For example, during the Middle Ages, France executed thousands of witches, who were thought to be demonically possessed (Russell, 1972). The Catholic Church led many of the advances against the presumably 'possessed' people, with Pope Innocent VIII declaring war on the purported witches in 1492 (Russell, 1980). In the United States (US), colonial women believed to be mentally disabled were killed for 'crimes' that they supposedly committed (Erikson, 1966), and many claimed that the word 'witch' was used to describe women who were 'insane'.

While there was a great deal of focus on mental distress in relation to superstitious beliefs, there was also evidence that some people in medieval times assumed that mental illness was associated with natural causes and could be cured. Rosen (1968) noted that some towns paid for pilgrimages to religious sites for people who were presumed to have mental illness, with the aim being to cure them. Regardless, the views held towards mental distress and differences more generally were complex and certainly varied.

In Foucault's (1965) seminal work on the history of madness, he pointed to three historic periods in the construction of madness. First, he noted that the Renaissance marked the period in which reason and madness were considered, wherein God was positioned as reasonable and madness was simply indicative of the discrepancy between what man was and what he hoped to be. During the 1400s–1600s, there was a growing focus on isolating people believed to be mad, with many such individuals being treated inhumanely.

Second, during the Classical Age (17th–18th century), a clear distinction between 'madness' and 'reason' was made, wherein madness was constructed as being the opposite of reason. Social institutions were put into place to confine people who were presumed to lack reason. Over time, madness became an object to be studied medically. In the late 1700s, there were growing concerns about the maltreatment of people believed to be mentally distressed, with some physicians in France eventually forbidding the use of chains and other tortuous practices.

Third, the modern experience of madness retained this focus on madness as an object of study. With the rise of asylums and psychiatric hospitals during the 18th and 19th centuries, mental distress was cast as something to protect society from – an illness that was best isolated and institutionally treated (see Bone & Marchant, Chapter 23, this volume, for a good overview). By the 1880s, however, mental distress began to be more commonly studied through a scientific lens, which to some extent was marked in Britain with the insanity of King George III, whose suffering raised public interest and prompted a period of humane reform (Johnstone, 1998). This was mirrored elsewhere across Europe. For example, in France there was some resistance to the typical restraining methods of treatment and a promotion of non-restraint (Johnstone, 1998). During the 19th century, there was a general promotion of the asylum to house care for those suffering, both across Europe and in the US. In the US, asylums tended to combine private and public patients and used both medical and moral therapies as promoted in Europe (Porter, 2002). Thus, the discovery of the asylum led to a growing faith in the institution, and a growth of moral therapy, which emphasised socialisation and labour, but still subjected inmates to cold showers, isolation, and electric shock treatments (Porter, 1997). The 20th century extended this promotion of moral therapies and saw a rise of psychological treatments such as psychoanalysis, but still continued some of the more radical treatments, such as lobotomies and electric shock therapies, particularly in the early part. However, by the 1940s, some mental health hospitals unlocked their doors and therapeutic communities were set up (Porter, 2002).

By the 1970s, there were attacks from within and outside of psychiatry and the start of deinstitutionalisation truly began (Mayes & Horwitz, 2005). This deinstitutionalisation saw the release of many patients who had been long-term detainees (Grob, 1995), and thus psychiatry changed from being a discipline concerned with insanity to one that was concerned with normality (Horwitz, 2002). It was during this decade that psychiatry progressed as a science and began to marginalise non-scientific approaches, including psychoanalysis (Shorter, 1997), marked most noticeably with the rise of psychopharmacology, which promoted psychiatry as a branch of medicine (Porter, 2002). By the end of the 20th century, biological psychiatry was as a science driven as other areas of medicine, and the big 'P' was no longer psychoanalysis, but Prozac, although in the broad field of mental health non-medical treatments still flourished (Shorter, 1997). This biomedical rhetoric continues in contemporary 21st-century mental health practice, an era dominated by evidence-based work.

Classifying mental disorders

Alongside the cultural and historical practices that shaped the very meaning of mental health, distinctive mental health fields such as psychology and psychiatry developed a more 'scientific' way of thinking which resulted in the development of classification systems to categorise the nature of mental illness. Not without contestation, these classification systems have been used to guide professional practice and ultimately determine and label who qualifies as mentally ill, thus defining the boundaries of normality. It is the case therefore that a patient's mental state is produced on the basis of what is normatively expected (Roca-Cuberes, Chapter 10, this volume).

The earliest classification systems were used to statistically determine the number of children born alive (i.e. not stillborn) who died prior to the age of six. An Australian statistician, Francois Bosier de Lacroix (1706–1777) is credited with the first attempt to classify diseases more broadly, publishing *Nosologia Methodical* (Knibbs, 1929). By the 19th century, the most commonly used classification system was published in 1785 and written by William Cullen (1710–1790). Like the previous systems, the focus was on classifying diseases, with the purpose of statistically tracking rates of occurrence and potentially leveraging preventative medicine. Over time, a classification system that included a list of diseases and their causes began to circulate, being modified and further developed over time. Eventually, this system became what is known today as the *International Classification of Diseases*, which, along with the *DSM*, is positioned as a toolkit for defining abnormality and normality and thereby has legitimised the pathology of certain conditions. The *ICD*, which is considered an internationally recognised 'diagnostic tool for epidemiology, health management and clinical purposes' (World Health Organization, 2014, n.p.), has been specifically used to classify and record diseases. It was not until the sixth edition of the *ICD* that mental disorders were included. In contrast, the *DSM* was specifically constructed with the intent of classifying and categorising mental health problems. The original intent of both classification systems was grounded in the desire to gather statistical information.

Prior to the Second World War, only seven categories of mental health were listed, including mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy (American Psychiatric Association, 2014). This short list stands in stark contrast to the modern-day diagnostic manuals, wherein a proliferation of mental disorders has occurred. In 1917, the American Medico-Psychological Association (which is now the American Psychiatric Association) and the National Commission on Mental Hygiene decided to gather statistical information regarding the occurrence rate of particular mental health conditions in US-based mental hospitals. The information that was collected led to the development of a classification system that became the accepted classification system in the US. Yet, after the Second World War, the US Army and Veteran Affairs put a broader classification system in place as they sought to include servicemen who had returned from the war. It was during this time that the World Health Organization published the sixth edition of *ICD*, which included mental disorders. Alongside this development, in 1952 the American Psychiatric Association created a version of the *ICD-6* that officially became the first version of the *DSM*.

These manuals were fundamentally developed from a biomedical perspective and have resulted in the construction of mental illness as an objective, ahistorical reality that resides within the 'ill' individual. In actuality, the biomedical formulation inherent in the *DSM* is a result of its historical context (Lafrance & McKenzie-Mohr, 2013). Accordingly, a main critique of the *DSM* is that it is an atheoretical document that is not value free (Caplan, 1995). In her critical discussion of the *DSM*, Crowe (2000) noted that there seems to be an assumption that mental disorders have biochemical and physiological causes which are universal. These universal causes assign fault to the individual, thus excluding the possibility that cause may be a response to external events or that 'impairment' is bound within everyday social and cultural practices. Crowe further suggested that an 'uncritical acceptance and utilization of this classification system excludes the possibility of more innovative research and treatment for people experiencing mental distress' (p. 75).

The diagnostic manuals and the boundaries between 'normal' and 'abnormal' are constantly under review, with substantive changes to the *DSM* and *ICD* occurring to this day. For example, when the third inception of the *DSM* was developed, there was a drive to make it more consistent with the *ICD*, and there were extensive political pressures regarding the status of homosexuality, which was removed in 1980, triggering a paradigm shift in how society viewed mental distress (Bayer, 1981; Mayes & Horwitz, 2005). The most recent version of the *DSM* (the *DSM-5*) has also been controversial, with concerns expressed regarding the validity and reliability of the categorisation system. Timimi (2002, 2005, 2008) and others have critiqued the suggestion that changes in understanding childhood mental disorders and therefore classifying them are due to new scientific understandings. Further, Frances and Nardo (2013) noted that the move to create more sensitive psychiatric diagnostic processes has resulted in little specificity. Frances (2013) noted that the *DSM-5*, for instance, 'developed unnecessarily complex dimensional ratings that could never be used clinically' (p. 171). Ultimately, the ongoing changes have resulted in 'the pool of "normality" shrinking to a mere puddle' (Wykes & Callard, 2010, p. 302). As Lafrance and McKenzie-Mohr (2013) noted, 'alternate perspectives are required then, to acknowledge the social and political realities of people's suffering in a way that prevents them from being relegated to the margins of theoretical understanding' (p. 134).

Opposition to psychiatry: The anti-psychiatry and critical psychiatry movements

Over time there have been several factors that have contributed to changes in the views of mental distress and the healthcare services and treatments delivered. In more modern Western healthcare systems, there have been several shifts in governmental policies and a more general emergence of the service-user movement (Thomas & Bracken, 2004). Changing trends, policies, and more critical understandings of mental distress have been politically influenced and two examples of such influence are linked and in some ways overlapping movements in psychiatry: the anti-psychiatry movement and the critical psychiatry movement.

An overview of the anti-psychiatry movement

The anti-psychiatry movement preceded the critical psychiatry movement and was a term coined in 1967 by David Cooper (Rismiller & Rismiller, 2006). This was an international movement that was promoted by the work of four key scholars:

- Michel Foucault was a French philosopher and historian who argued that social, economic, and cultural contexts have shaped our understanding of mental illness and that those who have the power have the control too (Foucault, 1965).
- R. D. Laing was a Scottish psychiatrist who considered the origins of behaviour and promoted the idea that mental illness has a social causality. He argued that mental illness was not a sign of illness but rather was an understandable reaction to the persecutory social order (Laing, 1960).
- Thomas Szasz was a psychiatrist in the US who was originally from Hungary. He argued that mental illness classifications were fiction perpetuated by psychiatry to gain power and that the state legitimised the coercive practices of psychiatry to control non-conformance and dissent (Szasz, 1960).
- Franco Basalgia was an Italian psychiatrist and neurologist. Basalgia proposed that it was necessary to dismantle psychiatric hospitals as patients

> were detained without hope of rehabilitation. He is considered to be a pioneer of the modern concept of mental health (Russo & Carelli, 2009).

Initially, this anti-psychiatry movement had some influence on practice as professionals used these ideas to develop innovative approaches to mental healthcare (Hopton, 2006). However, the anti-psychiatry movement became somewhat diffused in the 1980s as psychiatry began to address some of its fundamental concerns (Rismiller & Rissmiller, 2006). Consequently, the anti-psychiatry movement failed to establish itself as one of the mainstream ideologies embraced by mental health professionals (Hopton, 2006).

However, in contemporary times, the anti-psychiatry movement has been rejuvenated through the consumerist movement, particularly with the emergence of an anti-psychiatry consumerist coalition (Rismiller & Rissmiller, 2006). This coalition was founded on the idea that patients are consumers who have more choice and more rights than they have historically been afforded (Sharfstein & Dickerson, 2006). Thus, 'radical anti-psychiatry in the past four decades has changed from an influential international movement dominated by intellectual psychiatrists to an ex-patient consumerist coalition fighting against pharmacological treatment, coercive hospitalizations, and other authoritarian psychiatric practices' (Rismiller & Rissmiller, 2006, p. 863). This is evident in the emergence of service-user groups, with some being happy to accept the idea that they suffer from a particular disorder and accept the language of psychiatry, others rejecting completely the notion of mental illness and the language associated with it, and some others lying between the two extremes (Thomas & Bracken, 2004). These more user-centred approaches reflected a broader concern with self-advocacy, stakeholders, and consumerism (Sayce, 2000).

Additionally, the modern anti-psychiatry movement is epitomised by the Church of Scientology, which was founded in the 1960s by Hubbard, who argued that psychiatrists had committed crimes against humanity (Rismiller & Rissmiller, 2006). More broadly, the Church of Scientology has actively campaigned against psychiatry and pharmacology (Sharfstein & Dickerson, 2006). While this is considered by many to be an extreme view of psychiatry, there are some who advocate for this anti-psychiatry position. Evidently, the anti-psychiatry movement has made an impact, and while there are some differences of opinion within the broad rubric of anti-psychiatry, the prevailing view is focused on the harm that can be caused by psychiatry, pharmacology, and categorisation.

An overview of the critical psychiatry movement

New ideas in anti-psychiatry, consumerism, and the involvement of service-users in research and policy have been influential, and in the 1980s and 1990s critical psychiatry began to emerge. The notion of critical psychiatry reflected the early anti-psychiatry position in terms of how mental illness was conceptualised (Hopton, 2006) and was a term first coined in David Ingelby's book in 1981, which drew together a collection of essays drawing focusing on positivism and psychiatry (Middleton, 2007). This new ideology emerged under the notions of anti-racism, feminism, and user-centeredness that reflected theoretical and political interpretations of illness (Hopton, 2006). The general premise of this new critical psychiatry movement was that there should be some limit to psychiatry. Indeed, the new critical psychiatry movement held that the voices of service users should be heard (Thomas and Bracken, 2004) and that mental health practices and services should critically appraise the value of neurobiological, social, political, spiritual, economic, and psychological determinants of wellness (Middleton, 2007).

This new critical psychiatry movement has thus raised questions about social justice, fairness, and equality of access to services (Hopton, 2006), while also attracting a number of scholars who practised in the field of mental health. Interestingly, some scholars who had previously aligned with the anti-psychiatry movement shifted or reconceptualised their position to be in alignment with the critical psychiatry movement. For example, Thomas Szasz clarified that his position was one more of anti-coercion than anti-psychiatry per se, and he advocated in his later work that individuals should be free to choose their doctors and treatments (Szasz, 2010). Thus, the critical psychiatry movement has challenged the attempts of policymakers to extend coercive psychiatric practice (Hopton, 2006).

The modern acceptance of critical psychiatry is evidenced in the number of advocates who are practising psychiatrists (Thomas & Bracken, 2004). These practising clinicians advocate for the need for service-user perspectives and critique the ideological contamination of the discipline, which has resulted in structural inequality (Hopton, 2006). Hopton pointed to how there have been changes in how people have conceptualised the discipline, with a merging of biological psychiatry and socio-biology and behaviour being viewed as the product of the complex interrelationship between biology and the social environment. This perspective has resulted in new health initiatives that emphasise empowerment and partnerships with stakeholders.

The turn to evidence-based medicine

The anti-psychiatry and critical psychiatry movements now operate within a new paradigm of medicine – that of evidence-based practice. Evidence-based practice has produced important data about the aetiology and treatment of psychiatric conditions, and this should be contextualised against references to anti- or critical psychiatry (Hopton, 2006). In contemporary mental health practices, the evidence-based movement is probably the most influential across the Western world. It was as late as 1991 that the idea of standardising medicine emerged within emergency medicine, and most other fields have followed the modern ideal that clinical practice guidelines should be based on scientific evidence (Timmermans & Berg, 2003). This drive reflects the growing concern of professional accountability, cost-effectiveness, and resource allocation, which is especially important for the field of psychiatry, whereby there is ambiguity regarding the aetiology of conditions and many interventions are based on experience and intuition (Hopton, 2006).

This new focus is particularly problematic as randomised controlled trials (RCTs) are considered to be the most reliable form of evidence (Gelder, Mayou, & Cowen, 2001), and evidence has been organised into a broad hierarchy of importance (Marks, 2002). Yet for mental health, clinical practice tends to be based on unquantifiable humanistic approaches with a greater level of subjectivity (Hopton, 2006). Furthermore, mental distress is not confined to the realm of psychiatry and is also intrinsic to non-medical approaches, including psychology and social care. Such disciplines rely on evidence from a range of areas, and their research tends to be underpinned by a range of theoretical positions. By confining acceptable evidence to quantitative measures, there is a risk of missing important elements of the mental illness experience and potentially ignoring the influence of movements such as anti-psychiatry and critical psychiatry. More specifically, by relegating qualitative evidence to the bottom of the hierarchy, it risks excluding the very voices that earlier movements have set out to include (Lester & O'Reilly, 2015). Qualitative enquiry is considered a poor fit within the hierarchy of evidence, as it cannot evaluate the efficacy of pharmacological treatments and it has thus been dismissed as 'mere opinion' (Morse, 2006). We argue that qualitative research has a central role to play in research focused on understanding mental distress and that evidence underpinned by social constructionism has a great deal to offer. In particular, process research, especially that with a focus on language, has a great deal to offer to those in clinical practice (Karim, 2015; Kiyimba, Chapter 2, this volume).

Introducing social constructionism

Social constructionism is considered to have been pioneered in 1966 by Peter Berger and Thomas Luckman. They were influenced by a range of perspectives, including phenomenology and Marxism, and theorists Nietzsche and Mannheim, who fundamentally questioned the existence of a rational and objective knowledge (Alvesson & Sköldberg, 2010). Since its inception, social constructionism has become an influential approach across many fields. It draws attention to the idea that human experience is mediated linguistically, culturally, and historically (Willig, 2008). This challenges a more essentialist, positivist positioning of mental health that seeks to measure the dispositional attitudes and behaviours of the individual and instead considers how culture, social interaction, language, and shared meanings co-create the human experience. In this sense, it offers a view of mental distress situated within particular cultural and historical moments, wherein the language of society is viewed as part of the creation of a given 'disorder'.

There is no single version of social constructionism; rather, it serves as a frame for a range of research efforts with similar theoretical, empirical, and methodological foundations (Gubrium & Holstein, 2008). In terms of philosophy, social constructionism can be described as a loose assembly of diverse approaches (Burr, 2003) covering a broad range of views, from the view that social factors shape interpretations to the view that the social world is constructed by social processes and relational practices (Young & Collin, 2004). However, there are some key assumptions that pervade social constructionist thinking, including knowledge being viewed as historically, culturally, and socially specific and not fundamentally dependent on empirical validity but sustained by social process and explanations. Further, there is an assumption that descriptions of phenomena are never 'neutral'; rather, they constitute social actions that serve to sustain certain patterns to the exclusion of others (Gergen, 2009). Thus, there are three important aspects of social constructionist thinking, as outlined by Burr (1999):

1. Social constructionism is critical and claims that all knowledge is culturally and historically specific.
2. Social constructionism challenges individualism and essentialism, which are central to modern thinking as mental distress tends to be viewed as the property of the individual but social constructionism reframes it as being constructed socially.
3. Social constructionism emphasises that language is fundamental as it allows people to share a common currency of meanings and concepts that enable the social construction of the world.

In sum, social constructionism is primarily concerned with how knowledge is formed by social processes, particularly in terms of how meanings are generated through social interaction (Chen, Shek, & Bu, 2011). There are, however, two important distinctions. The first distinction relates to micro- and macro-social constructionism. The second distinction relates to the differentiation between social constructionism and social constructivism.

Differentiating macro-social constructionism from micro-social constructionism

An important distinction within the social constructionist perspective is between macro- and micro-approaches (Burr, 2003). These two perspectives represent an important distinction between social constructionists. Macro-social constructionism tends to be concerned with the constructed social forms and collective representations (Sudnow, 1965), focusing on the role that linguistic and social structures play in shaping the social world (Gubrium & Holstein, 2008). Those who take a macro-social constructionist position tend to be concerned with power relations and social positioning, with power and ideology being an important facet of their theoretical perspective (Gergen, 2009). As such, research grounded in a macro-social constructionist perspective may focus on broader, more macro-discourses circulating in society that function to generate and sustain inequities (Gubrium & Holstein, 2008).

Micro-social constructionism is different. It tends to be concerned with the micro-structures of language; therefore, research underpinned by this position tends to focus on talk, situated interaction, and local culture (Gubrium & Holstein, 2008). Micro-social constructionists consider reality construction within daily discourses, and enquirers advocate that there is no version of the world that is considered more real than another (Burr, 2003). They privilege naturally occurring data for their research and place less emphasis on power (Gergen, 2009).

Differentiating social constructionism from social constructivism

An equally important distinction within this theoretical position is that between social constructionism and social constructivism. These two positions, while having some similarities, are different and unfortunately have been sometimes used interchangeably in the literature (see O'Reilly & Kiyimba, 2015, for a full discussion), which reflects cultural and geographic differences. For example, in the US, scholars have talked about constructionism and constructivism typically from a child developmental perspective (Gergen, 2009), whereas in Europe constructionism has tended to focus more on dialogue and relationships (Burr, 2003). This has resulted in social constructionism and social constructivism being subsumed under a generic and undifferentiated term of constructivism, despite their differences (Young and Collin, 2004).

There are some similarities between the two in that both argue that the structures that exist cannot be grasped objectively (Franklin, 1998). However, social constructionism tends to be more pertinent in psychology, sociology, and anthropology, and social constructivism tends to occur more in science, mathematics, and technology studies (Gubrium & Holstein, 2008). This reflects broader disciplinary concerns, as social constructivists often share the commitment of positivism to a dualist epistemology, whereas social constructionists emphasise that language constitutes as opposed to reflects reality (Young & Collin, 2004). In other words, these two perspectives are different in terms of how they conceive of inner psychological structures and in terms of developmental courses versus the significance of language, culture, and social processes in the creation of one's constructions (Franklin, 1998). Thus, social constructivists see dialogue as leading to a common truth and believe in a foundational reality, whereas social constructionists do not believe in an ultimate truth (Gergen, 2009).

Social constructionism and mental health

Social constructionism has contributed to the field of health and illness in many ways. The core message of social constructionism in health and illness is that medical knowledge and medical practice are socially constructed and disease is an invention rather than a discovery (Bury, 1986). The idea that illness is socially constructed allows researchers to explore the social forces in terms of how they shape our understanding of and actions towards health, illness, and healing (Brown, 1995). The problematic nature of medical knowledge from a social constructionist perspective has been summarised as having four central issues, as outlined by Bury (1986). First, social constructionism treats medical knowledge as problematic and as a central issue in analysis. So, for contemporary social constructionism, the question of technical or scientific knowledge emerges as the primary issue. As such, the biomedical reality becomes an issue and a major problem in itself. Second, social constructionism focuses on mediating social relations. Rather than standing outside of social relations, medicine is viewed as being a social practice through which social relations are mediated. Third, the focus is on medicine and the neutrality of technique. This proposition advocated that the technical realm cannot be regarded as neutral. Fourth, social constructionism flows from the previous three propositions and suggests that a disease category should not be regarded as signalling the discovery of a natural phenomenon by the application of neutral or rational methods. Rather, it is socially bound.

Traditional understandings of medicine are thus considered to be problematic. The language associated with psychological and medical models and their disease and deficit-laden terminology arguably needs to go (Walker, 2006), with this argument being extended to our understanding of mental health and mental illness more generally. Furthermore, the four propositions outlined by Bury (1986) have important implications for the social construction of mental distress. Mental illnesses are often described in similar ways to physical ones and are also 'treated' with medication (Walker, 2006). In the 1960s, social constructionist work focused on mental health began in sociology and examined community and psychiatric understandings of mental illness in terms of the impact of labels (Mulvany, 2000). For mental health and mental illness, social constructionist research has tended to focus on illuminating the contingent, socially produced character of categories of mental distress and the associated professional practices (Georgaca, 2013), as well as on how biomedical classifications within psychiatry have provided the basis for society's definitions of abnormal behaviour.

Constructions of abnormality/normality

Historically, the process of categorisation in psychiatry provided the boundaries for normality and abnormality, while also defining who is and is not eligible for services. Yet, as psychiatrist Frances (2013) noted, constructs such as 'normal' and 'mental health disorder' 'are both extremely protean concepts – each so amorphous, heterogeneous, changeable in shape that we can never establish fixed boundaries between them' (p. 16). Further, constructions of abnormality and normality are only made possible when comparing the object of one's study to something else (Davis, 1995). Thus, to generate boundaries of abnormality and normality a comparative framework must be in place, wherein that which is 'abnormal' is only known in relation to that which is deemed 'normal' (Canguilhem, 1989). This benchmark of normality, however, is one that is historically, culturally, socially, and economically bound. 'Normal', for instance, entered the English language at a particular time in history, wherein there was a growing interest in statistics and the desire to represent the notion of a majoritarian 'norm'. Prior to the mid-1840s, 'norm' referred to a carpenter's square (Davis, 1995). Yet, over time the very concept of 'normal' was embedded within 18th- and 19th-century everyday practices and discourses wherein a 'middle way' or 'average man' was presumed to exist (Davis, 1995, p. 26), and he was what could be described as 'normal'. As Davis noted:

> [T]the social process of disabling arrived with industrialization and with the set of practices and discourse that are linked to late eighteenth- and nineteenth-century notions of nationality, race, gender, criminality, sexual orientation, and so on . . . the very term that permeates our contemporary life – the normal – is a configuration that arises in a particular historical moment. It is part of a notion of progress, of industrialization, and of ideological consolidation of the power of the bourgeoisie. (pp. 24, 49)

This view that human life can be measured according to a benchmark of normality has pervaded theories focused on childhood development and even what it means to be a 'normally functioning adult'. Children are presumed to experience an ordered progression of development, with this assumption being based on taken-for-granted theories of development (O'Dell, Crafter, de Abreu, & Cline, 2010). When a child does not experience this ordered development, they are deemed 'abnormally developing', which is particularly true in Western cultures. Likewise, normally functioning adults are presumed to experience a glitch in their 'normality' when they exhibit symptoms associated with mental illness.

Concerns surrounding looking or presenting as abnormal pervade how we go about doing life, wherein children and adults alike are socialised into acting or being as 'normal' as possible so as to avoid being deemed 'troubled' or 'crazy'. Yet Sarangi (2001) noted that 'in many societies and communities, the idea of seeking medical attention presupposes a dichotomy between the normal and the abnormal/pathological' (p. 109). Historically, for people believed to have an illness, particularly one which lives in the mind, their diagnosis has been dependent upon the established norms around what counts as 'abnormal'. While the boundaries between what counts as abnormal and normal have shifted over time (see, Decker, 2013, for a discussion of the development of the *DSM-III*), there are arguable consequences for how such boundaries are constructed and reconstructed.

With our understanding of mental health being dominated by biomedical explanations, the disciplines of psychiatry and psychology historically defined what is normal or abnormal, acceptable or unacceptable (Thomas & Bracken, 2004). Through the construction of such boundaries, a particular picture of the mental health patient is constructed (Griffiths, 2001), one which often centres on a cluster of symptoms that are grouped together to form a diagnosis (Walker, 2006). Arguably, this may result in a narrow conceptualisation of normality, which can have a negative impact on those deemed ill. It is these very constructions that social constructionists seek to study.

The aim of social constructionist work is to examine how these systems and constructions are accomplished in practice, as well as to explore the consequences for mental health institutions and individuals in distress (Georgaca, 2013). As such, social constructionist work has offered a legitimate critique of psychiatric classification systems and the diagnostic process. This critique has aimed to destabilise psychiatric knowledge and practice as ahistorical entities, thus opening up an alternative and more empowering understanding of and practice for dealing with mental distress (Georgaca, 2013).

Summary

Georgaca (2014) suggested that the central premise of social constructionism is that professional practices are not based on objective or disinterested implementation of scientific practices; rather, they are contextually and discursively bound constructions made possible by institutional and everyday discourses and practices. From this perspective, mental health and mental illness can be understood as social constructions of impairment, with language being viewed as performative and not merely descriptive (LaFrance & McKenzie-Mohr, 2013). Many of the chapters of this Handbook are grounded in a social constructionist perspective, and some being explicitly critical in their orientation, practitioners/readers are invited to reconsider how mental health discourses shape their everyday lives and practices. In implicit and explicit ways, the chapters within this volume illustrate how mental health discourses shape daily practices in ways that are often taken-for-granted, particularly as systems of mental healthcare function to naturalise the ways in which mental health and care are actualised in practice.

In order to examine the performative nature of interaction, we point to two pertinent language-based approaches to analysis: conversation analysis and discourse analysis. Conversation and discourse analysis are useful, related approaches for the study of mental health, particularly when underpinned by a social constructionist framework (Harper, 1995). This approach to research illuminates how psychopathological categories are not labels that point to an existing entity; rather, they are constructs produced within specific socio-historical conditions (Georgaca, 2014). In the field of mental health, the use of these two approaches is growing, with emergent implications for adults with mental health conditions, their practitioners, and/or their families. With these approaches being varied and diverse, the Handbook opens with Chapter 1 which highlights the landscape of this methodological approach and Chapter 2 points to the applications for clinicians.

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Part I

Reconceptualising Mental Health and Illness

1

The History and Landscape of Conversation and Discourse Analysis

Jessica Nina Lester and Michelle O'Reilly

Introduction

Mental distress has typically been examined from a biomedical or biopsychosocial perspective with quantitative evidence (especially, randomised controlled trials) being favoured. Over the last few decades there has been a growth and greater acceptance of qualitative methods and an increasing emphasis on applied qualitative research, which has been useful in the field of mental health. However, qualitative evidence has been typically, and arguably inappropriately, placed at the bottom level of evidence in the field of health and medicine (Lester & O'Reilly, 2015). Nonetheless, there is a growing acceptance that qualitative approaches offer a great deal for understanding the complexities of mental distress. More specifically, qualitative methodologies, such as conversation and discourse analysis (henceforth DA), have the added benefit of involving a close examination of the realities of individuals diagnosed with mental health conditions and the many interactions that surround their everyday lives.

This Handbook includes the work of scholars engaging with the methodologies of conversation and/or DA in a range of areas of mental distress. The purpose of this chapter is to provide a background, as this is particularly important for those who are relatively new to conversation and DA approaches. Thus, in this chapter, we provide an overview of different types of DA that may be employed by the authors included in this Handbook, as well as an overview of conversation analysis (henceforth CA). We offer a general description of CA, a brief history of the development of the approach, and some guidance regarding how CA is conducted. Additionally, we introduce some of the different types of DA to illustrate the variation in approaches, with some overview of how DA is carried out in practice. While reference is made to the field of mental distress, this is only done in passing, as the substantive emphasis of the Handbook is not our main focus here, rather we focus on the methodological approaches that are used by the authors in writing their chapters.

An introduction to conversation analysis

Underpinned by a micro-social constructionist position, CA is a qualitative approach that focuses on the study of interaction. With a variety of influences in the background – including ethnomethodology, Goffmanian sociology, linguistic philosophy, ethnography, and others (Maynard, 2013) – it is an emic and inductive methodology, which prioritises empirical evidence that involves the participants' orientations (Bolden & Robinson, 2011). That is, conversational materials are assumed to exhibit orderliness for the participants and is made visible through the ways in which they assemble actions together (Sacks, Schegloff, & Jefferson, 1974; Schegloff & Sacks, 1978). In other words, CA aims to 'describe, analyze and understand talk as a basic and constitutive feature of human social life' (Sidnell, 2010, p. 1). Those using CA attempt to explore what kinds of social organisations are used as resources in interaction (Mazeland, 2006), with a focus on how participants within an interaction negotiate meanings between them on a turn-by-turn basis (Hutchby & Woofit, 2008; McCabe, 2006).

The history and development of conversation analysis

CA was pioneered by Harvey Sacks who originally trained in Law and began to develop this approach, in part through the influence of Harold Garfinkel (Maynard, 2013; Schegloff, 1992) during his investigations at the 'Center for the Scientific Study of Suicide' in the 1960s (Drew, 2015). His early work focused on telephone calls to a suicide prevention center, and he explored how the callers' accounts of troubles were produced through the interaction with call-takers (Drew, Heritage, Lerner, & Pomerantz, 2015; Silverman, 1998). Through this, he began to investigate the generic practices of interaction, and the general elements of what CA is began to develop (Drew, 2015). Notably, the work on suicide prevention calls did not have an analytic interest primarily on suicide, or even on troubles-talk, but rather was focused on the organisation of talk-in-interaction (Drew et al., 2015). Also, Sacks (1984, p. 26) did not begin working with recordings because of 'any large interest in language or from some theoretical formulation of what should be studied', but because the tapes could be replayed and others also could review the data and Sacks' analyses to see or hear how well analytic assertions would hold up.

Despite the popularity of CA today, at the time of his premature death in 1975 (from a car accident), his papers had tended to be published in relatively obscure outlets (Silverman, 1998); yet, over time the value of CA began to be recognised. In part, this recognition was due to the fact that during his time 'inventing' CA (Silverman, 1998), Sacks worked alongside Emanuel Schegloff and Gail Jefferson in developing the approach and making observations regarding the nature of interaction. It was through his work with Schegloff and Jefferson that Sacks began to view talk as an object of study in its own right (Drew, 2015), with the continued work resulting in CA becoming a readily acknowledged qualitative approach.

Sacks et al. were influenced by ethnomethodology, with the origins of CA being traced back to the work of Goffman and Garfinkel[1] (Schegloff, 2003). Thus, CA is grounded in ethnomethodology, which is a 'bottom-up' approach that views social organisation as an 'emergent achievement' resulting from the efforts of social members who act within a local situation (Maynard & Clayman, 2003). Ethnomethodology explores the principles upon which individuals base their social actions (Seedhouse, 2004). Hence, ethnomethodology is a label used to capture a range of phenomena linked to the knowledge and reasoning techniques of ordinary people (Heritage, 1984). Indeed, it was described by Heritage (1984) as the study of particular subject matter; that is,

> the body of common-sense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves. (p. 4)

For CA, claims are made in the observable orientations that participants display to one another. CA has a distinctive interest in how orderly characteristics of talk are accountably produced on a turn-by-turn basis (Maynard & Clayman, 2003). Therefore, CA reflects a fusion of Goffman's and Garfinkel's approaches through the creation of an empirical method in order to explore how people produce social order (McCabe, 2006). Because of the focus on interaction and the sequential organisation of talk, CA has been described as focusing on 'talk-in-interaction' (Drew & Heritage, 1992), with this understood to entail focusing on what talk is *doing* rather than what talk is *about* (Schegloff, 1999).

Conversation analysis and interactional linguistics

Recently, interactional linguistics has become a prominent part of CA for many scholars. This is because contemporary anthropologists, conversation analysts, and linguists have realised the value of coming together to combine their respective disciplinary strengths with the focus on language (Couper-Kuhlen & Selting, 2001). Interactional linguistics (different from interactional sociolinguistics, discussed later in the chapter) is an interdisciplinary approach to interaction and grammar in linguistics, anthropology, and the sociology of language. Scholars using this approach utilise CA, functional linguistics, and linguistic anthropology in order to describe the ways in which language features in normative interactions (Ochs, Schegloff, & Thompson, 1996). This is a perspective on language structure that goes beyond grammar and prosody to examine all aspects of language structure, phonology, phonetics, syntax, lexis, morphology, pragmatics, and semantics, as well as language acquisition, language variation, loss, and disorder (Couper-Kuhlen & Selting, 2001).

An important step in the development of interactional linguistics was the seminal work of CA, and the analytic tools of CA were instrumental to this development. Thus, interactional linguistics combines the approach of CA with linguistics and contextualisation theory and forms an interface between linguistic analysis and the study of social interaction (Kern & Selting, 2012).

Interactional linguists see linguistic forms as affected by interaction in speech and language, unlike dominant approaches to linguistics which traditionally focused on the form of language or the user's language competencies (Couper-Kuhlen & Selting, 2001). In other words, interactional linguistics is founded on the premise that language ought not to be studied in terms of context-free linguistic structures, but instead should be examined as a 'resource' for accomplishing social actions (Kern & Selting, 2012).

Conversation analysis and data

Those who utilise CA favour naturally occurring data. That is, conversation analysts have a preference for data that have not been deliberately generated by the researcher for the purposes of research. Rather, they record (in some format) interactions that occur in the 'real-world' as they would happen naturally, without the researcher intervening. In other words, naturally occurring data would still occur if the researcher had not been born (Potter, 2004) or if the researcher was unable to collect it (Potter, 1996). Conversation analysts favour naturally occurring data because it captures actual interactions while retaining the situated nature of the conversations. Thus, it is presumed to illustrate how participants orient to their setting without the abstraction of the researcher's agenda (Potter, 2004).

When analysing this naturally occurring data, researchers either develop a large corpus of conversational data, choose to share analysis from a single case or document practices of social action based on a collection of cases (Schegloff, 1987). Analysis of a single episode brings findings from the body of CA work to bear on the case; analysis of collections has the purpose of explicating a single phenomenon (Mazeland, 2006). That is, the analysis of collections draws upon a large corpus of data and aims to explicate or account for something specific within the data.

Ordinary talk, institutional interaction, and applied conversation analysis

In contemporary literature, there has been a distinction made between ordinary and institutional CA. Ordinary CA refers to the analysis of commonplace conversations, and institutional CA refers to investigations of legal, medical, and other professional settings (McCabe, 2006). Ordinary CA is epitomised by the work of Sacks and his colleagues. This form of CA investigates conversation as a domain in its own right and specifies the normative structuring and logics of particular courses of social action and their organisation into systems (Heritage, 2005). Second, as noted by Heritage (2005), institutional CA builds on the findings of basic CA in order to examine the operation of talk in social arenas that sociologists have called 'formal organisations'. Institutional CA requires a shift in perspective, as talk and discourse in institutional settings may be historically contingent and subject to the processes of social change under the impact of power, culture, social ideology, economic forces, and intellectual innovation. Still another form of CA fits the category of 'applied' analysis. Applied CA has different meanings, which are described in Table 1.1, as they were outlined by Antaki (2011).

It is essential to have an understanding of the basic principles that underlie ordinary conversation in order to analyse talk within institutional settings (Seedhouse, 2004). There are several distinctions between institutional talk and ordinary conversation, as outlined by Heritage (2005):

1. First, the turn-taking organisation of the interaction is often quite different. Although some types of institutional settings use the same turn-taking procedures as mundane conversations, many institutional settings involve very specific and systematic transformations of interactional procedures.
2. Second, the overall structural organisation is often quite distinct. It is typical for interaction to have some overall structural features. In ordinary conversations, these structural features include specifically located activities, but the complex structural organisation of talk is not found in all forms of institutional talk.
3. Third, the sequence organisation is often unique. This is particularly pertinent, as conversation analysts argue that it is through sequence organisation that the tasks central to interaction are managed. For example, in institutional talk there is often a range of question–answer sequences, which are less commonly found in mundane talk.

CA has investigated institutional interactions from its inception, but it was not until the 1970s with the work of Don Zimmerman and his students at

Table 1.1 Meanings of applied conversation analysis

Type of applied CA	**Description**
Foundational applied CA	This form of applied CA helps to re-specify an understanding of any given discipline to provide a different framework for understanding core concepts. See, for example, Edwards and Potter (1992) and their work on discursive psychology.
Social-problem-oriented applied CA	This form of applied CA is designed to help us better understand social problems. CA offers an alternative way of looking at social organisation and social problems such as conflict, power, and so on. Although what constitutes a social problem varies, CA does recognise macro issues, while focusing mostly on the micro-concerns. See, for example, Kitzinger's (2005) work on heteronormativity.
Communication applied CA	This form of applied CA has focused on 'disordered' talk to understand the features of such talk and in some cases to challenge the picture of disorder and deficiency. CA has strength in being able to look at the interactions of these groups and to see how they actually engage with the world. See, for example, Ray Wilkinson's (2015) work on aphasia and Stribling, Rae, and Dickerson's (2009) work on autism.
Diagnostic applied CA	This form of applied CA is one of the more contentious applications of CA, as this has attempted to correlate features of the organisation of a person's speech with some underpinning psychological or organic disorder. Theoretically, this form has the potential to correlate speech features to medical diagnosis, which may be attractive to those working in medicine. See, for example, Schwabe, Howell, and Reuber's (2007) work on diagnosing epilepsy.
Institutional applied CA	The application of CA to institutional talk is not usually related to solving an institution's problems, rather it looks at how institutions manage to carry out their institutional work successfully. Thus CA illuminates the routine work of the institution. See, for example, O'Reilly, Karim, Stafford, and Hutchby's (2015) work on child mental health assessments and also consider how members resolve problems and/or conflicts. See, for example, Stiver's (2002) work on paediatrics.
Interventionist applied CA	This form of applied CA has a number of core characteristics, including that it is applied to an interactional problem that existed before the arrival of the analyst. It assumes that a solution will be identified through the analysis of the sequential organisation of talk. See, for example, Heritage's work on problem solicitation in medical encounters (Heritage & Robinson, 2006). Also see Maynard's (2003) study of delivering bad and good news; a coda in that book, mostly directed at clinicians, specifies the 'how to' for such tasks.

Source: Antaki (2011).

the University of California, Santa Barbara (Maynard, Clayman, Halkowski, & Kidwell, 2010), and of Atkinson and Drew on courtroom interactions that researchers began to examine institutional interactions as having distinctive features (Heritage, 2005). Importantly, the application of CA to institutional settings explores how institutions manage to carry out their institutional work successfully (Antaki, 2011).

How to carry out conversation analysis

The main aim of CA is to identify the ways in which talk is organised and to appreciate how interlocutors make sense of the unfolding interaction. Patterns in the talk are identified through an analysis of the sequential patterns that occur with respect to turn-taking, repair, and turn design (McCabe, 2006). The structure of a turn is built around 'turn construction units' (TCUs), with a turn being incomplete until the speaker has finished speaking (Sacks et al., 1974). While undertaking CA can be a complex task, and one that requires training to perform effectively, there are some practical steps offered for examining the sequential turn-taking interactions that unfold. Seedhouse (2004) outlined five practical stages:

1. The 'unmotivated looking' on the part of the analyst. Unmotivated looking means that the analyst is open to the discovery of patterns or phenomena without having preconceptions that guide their 'looking'.
2. Once the analyst has identified a candidate phenomenon, it is usual to engage in an inductive search through the data corpus to establish a collection of the phenomena.
3. This stage requires the establishment of the patterns in relation to the occurrences of the phenomenon, and also illustrates how these are methodically produced and oriented to by the participants.
4. Detailed analyses of single instances of the phenomenon are produced, with attention given to deviant cases.
5. A generalised account is produced in terms of how the phenomenon relates to the broad matrix of interaction; thus, a social action is identified.

The practical implementation of CA can be quite a complicated process, and there are a series of steps that the analyst should undertake, from the inception of the analysis to writing it up. Drew (2015) outlined these in detail, and these are summarised in Table 1.2.

The Jefferson convention of transcription

Since its beginning, extensive attention has been given to transcription in CA, with the Jefferson system designed specifically to reflect the analytic stance of

Table 1.2 Practical steps of CA

Step	**Description**
First stage	The useful starting point for any analyst is to consider the ways in which the interlocutors are not just 'talking' but are actually engaged in their social activity. Thus the analyst should ask 'what they are doing'. The first step therefore is to explore what activity or activities the speakers are engaging in: for example, inviting, excusing, justifying, accounting, questioning, and so on.
Second stage	The analyst should now pay attention to the sequence of turn that preceded the initiated action so that they can investigate how the identified activity has arisen from that sequence.
Third stage	At this point, the analyst should examine the detail in the design of the turn whereby the action was initiated in the talk.
Fourth stage	The analyst should examine how the recipient responded to the prior turn of the initial speaker. In other words, the researcher can analyse what each of the participants in the interaction are making of each other's talk and conduct.
Fifth stage	To this point, the analyst has explored the ways in which, through a series of turns at talk, those in the interaction have managed their activities, with a focus on social conduct. The point of this is to explore how conduct is constructed through what participants are saying and the design of their talk.
Sixth stage	This is a more implicit stage. That is the observation of the construction of the turns at talk, and the understanding or response to them, are not idiosyncratic to those speakers. Thus while every interaction is unique, there are systematic properties of talk-in-interaction and as such the common or shared forms of language can be identified.
Seventh stage	Once the phenomenon has been identified it is time to explore the sequential pattern. At this point, the analyst collects several cases of the phenomenon, and begins to explore the features that the cases have in common.
Eighth stage	The final stage of analysis is to provide an account for the pattern. This stage thus requires the analyst to determine whether the collection has any features in common, and where and how the object or pattern in question arose. Once the analysis is completed, it should be written up. It is important that the steps taken for accounting for the phenomenon are clear, and relevant literature should be discussed. It will be necessary to identify which data examples will be used and to decide how many are needed to establish the analytic point for transparency.

Source: Drew (2015).

the approach (Jefferson, 2004). The key conventions were designed to build on familiar forms of literary notation. The symbols were designed to illustrate how words and phrases sound, while making no correction for grammar or pronunciation (Hepburn & Bolden, 2013). Many of the authors in this Handbook utilise the Jefferson system of transcription, and we illustrate the most common of these symbols in Table 1.3.

For those practising CA, the process of transcription is viewed as a core analytical activity and the first step in developing a deeper understanding of the communicative process (Roberts & Robinson, 2004). The transcription process is considered an integral part of CA and is argued to be part of the analytical endeavour (Atkinson & Heritage, 1984). However, those practising CA are also aware that the transcription process is time consuming. Estimates vary from it taking approximately one hour to transcribe 1 minute of talk (Roberts &

Table 1.3 Jefferson transcription symbols

Symbol	**Explanation**
(.)	A full stop inside brackets denotes a micro-pause, a notable pause but of no significant length.
(0.2)	A number inside brackets denotes a timed pause. This is a pause long enough to time and subsequently show in transcription.
[ ]	Square brackets denote a point where overlapping speech occurs.
> <	Arrows surrounding talk like these show that the pace of the speech has quickened.
< >	Arrows in this direction show that the pace of the speech has slowed down.
( )	Where there is space between brackets denotes that the words spoken here were too unclear to transcribe.
(( ))	Where double brackets with a description inserted denote some contextual information where no symbol of representation was available.
<u>Under</u>	When a word or part of a word is underlined, it denotes a raise in volume or emphasis.
↑	When an upward arrow appears, it means there is a rise in intonation.
↓	When a downward arrow appears, it means there is a drop in intonation.
→	An arrow like this denotes a particular sentence of interest to the analyst.
CAPITALS	Where capital letters appear, it denotes that something was said loudly or even shouted.
Hum(h)our	When a bracketed 'h' appears, it means that there was laughter within the talk.
=	The equal sign represents latched speech, a continuation of talk.
:::	Colons represent elongated speech, a stretched sound.

Robinson, 2004) to 1 hour of talk taking approximately 30 hours to transcribe (McCabe, 2006). In reality, the time taken is likely to be influenced by the quality of the sound, whether the data is in the form of video or audio, whether paralinguistic features are captured, the transcriptionist's level of experience, the number of members in the interaction, the frequency of overlapping talk, and the level of detail used in the transcription.

Introduction to discourse analysis

'Discourse analysis' is an umbrella term (Harper, 2006) that refers to qualitatively oriented methodologies that can be broadly characterised as attending to talk and text in social practice (Potter, 2004). Generally, the basic assumption of DA approaches is that through language people accomplish things. For instance, through language an individual might offer a complaint, give advice, build a case for a particular position, classify someone as 'abnormal', and so on. Language, then, is presumed to be the vehicle by which social life is ordered and sustained.

More specifically, some forms of DA look primarily at the content of the language used, or the issues being discussed within a given conversation. On the other hand, other approaches to DA attend to the structure of language and how this structure functions to create particular understandings or perspectives about a phenomenon of focus. There are also some approaches to DA that are more descriptive, arguing that the goal is to describe how language works or functions. Other approaches to DA are fundamentally critical, meaning that their primary goal is not just to describe how language works but to consider and intervene in social and political issues (Gee, 2011). The diversity of DA approaches is due to the simultaneous focus on discourse in varying disciplines, and thus the term 'discourse analysis' can be thought of as a generic term (Potter & Wetherell, 1987) and different approaches to DA will utilise different methods of data collection (see e.g. Hepworth & McVittie, Chapter 3, this volume). Relatedly, it is difficult to offer a single description of the 'steps' or procedures for carrying out a DA study; rather, it is perhaps most useful to consider analysis as being informed by the particular assumptions of the approach to DA being employed, while also centred on common principles related to the study of social action in talk and text (O'Reilly, Dixon-Woods, Angell, Ashcroft, & Bryman, 2009).

While it is difficult to provide a single definition of DA, it can be broadly characterised as a commitment to studying discourse as talk and text in social practice. As noted, it is generally considered an umbrella term that encompasses a number of techniques for analysing discourse in practice. Across DA perspectives, there are three shared features or perspectives: (1) a focus on language, (2) an acknowledgement of the variability in how people go about accounting for things; and (3) a focus on the broad ways in which accounts are constructed.

Indeed, there are many approaches to DA, with each underpinned by different theoretical assumptions and therefore serves to answer unique research questions. However, common across many DA traditions is an alignment with a social constructionist epistemological perspective. While there is no single definition of social constructionism, across perspectives there is an explicit recognition that knowledge is historically, socially, and culturally contingent. Thus, across DA perspectives, there is an assumption that knowledge is produced and sustained through social processes.

While there are similarities between CA and DA, with some approaches to DA explicitly drawing upon principles of CA (see, for instance, discursive psychology), there are some key differences. One of the primary differences is that CA examines how participants manage interaction as it unfolds in relation to the sequential structures through which activities are accomplished. CA, then, gives particular attention to the micro-details of an interaction. On the other hand, many approaches to DA emphasise the action orientation of language at a much broader level, with the analysis of the sequential organisation of talk focused on how these structures function in relation to the broader social structures.

A brief history of discourse analysis

While discourse-oriented research can be traced back to writings in the early 1900s (for a further discussion of this, see Lester, 2011), it was not until the 1980s that many of the most dominant discourse research traditions began to develop. The view of language as constitutive rather than merely reflective of inner thought is not new, as linguistic philosophers, such as Wittgenstein (1958), Winch (1967), and even the writing of Berger and Luckmann (1967), discussed it at length. With the linguistic turn, however, there was an even greater shift in how language was understood and eventually studied, with Rorty (1989) and others claiming that language was 'a useful tactic in predicting and controlling . . . behavior' (p. 15) and constitutive of meaning and practice. As researchers began to negotiate a crisis of representation across many research traditions (Clifford & Marcus, 1986; Geertz, 1988; Marcus & Fischer, 1986), they avoided the notion that language corresponds with a given reality. Rather, reality is a feature or outcome of the assumptions to which participants in social life orient and the practices they enact. This shift in perspective shaped how a variety of DA perspectives were developed and applied across disciplines.

In the 1990s, discourse research became more specialised. For instance, analysts drawing upon discursive psychology (discussed below) began to examine how mental states were worked up in language, with a gradual and growing focus on CA as well. Those analysts using critical DA (discussed below) began to attend to broader political and social structures. More traditional approaches to DA focused on analysing discursive resources by which the truth of a claim could be considered. Thus, post-1990, there were very explicit ways in which the varying approaches to DA began to develop and focus their analytical orientation.

Different approaches to discourse analysis

While a variety of traditions and approaches to DA have been developed, we highlight seven distinguishable approaches to DA, including: (1) discourse analysis model, (2) traditional discourse analysis, (3) discursive psychology, (4) critical discourse analysis (CDA), (5) Foucauldian discourse analysis, (6) interactional sociolinguistics, and (7) Bakhtian discourse analysis. Across the approaches, there is some degree of overlap, with some approaches informing others.

Sinclair and Coulthard's Discourse Analysis Model

In the 1970s, a group of scholars developed an analytical model for the study of spoken discourse referred to as the Discourse Analysis Model, which is also referred to as the Birmingham model. Initially, this model was informed by Sinclair and Coulthard's (1975, 1992) work around classroom discourse, wherein they noted that classroom discourse follows a specific and somewhat rigid structure. They referred to this as the initiation-response-evaluation (IRE) structure, with a particular focus on the interaction between the student and teacher. The IRE structure was described as involving a teacher initiating a turn (e.g. posing a question), a student responding (e.g. a student offers an answer to the question posed), and a teacher evaluating the student response (e.g. a teacher evaluates the accuracy of the student's response). Sinclair and Coulthard (1992) described their model of DA as a tool for the study of classroom talk, but It has since been expanded and applied to the study of less structured talk (see e.g. Coulthard & Montgomery, 1981; Sinclair & Brazil, 1982).

The Discourse Analysis Model uses a rank scale to describe the nature of the structure of the discourse, with no rank given priority over another (Sinclair & Coulthard, 1992). The five ranks initially used to describe discourse were lesson, transaction, exchange, move, and act. Within this rank scale 'lesson' was conceived of being the 'top' rank, which is reflective of the uniqueness of the nature of classroom discourse. Sinclair and Coulthard (1992) claimed that the lower four ranks would likely be found in other types of discourse, not simply classroom interactions. This particular model is grounded in Halliday's work around categories of grammar.

Table 1.4 The three core concepts of traditional discourse analysis

Concept	**Description**
Interpretative repertoires	Interpretative repertoires are the common sense (but contradictory) ways that people talk about the social world. They are common knowledge, the cultural ideas, and explanations that everyone knows. Interpretative repertoires are used to build explanations, accounts, and arguments (Potter & Wetherell, 1987). A 'repertoire' is a more or less coherent way of describing something. It can be a set of words and expressions, perhaps with associated images, and so on.
Subject positions	This is the discursive process of locating the identity of others and oneself. In conversation, we position others using adjectives or categories and position them in a certain way. We may position someone as a 'bad mother', which constructs the identity of that person in a particular way. This can then be accepted or rejected by others including the talked about person. We can position ourselves in the same way. Discourse analysts views identity as fluid and produced through discourse. Subject positions are culturally available categories that define a person and their identity.
Ideological dilemmas	The concept of an ideological dilemma was developed by Billig et al. (1988) as a concept relating to the fragmented and contradictory nature of everyday common sense. Ideological dilemmas relate to common knowledge and cultural wisdom as being full of contradiction, and many beliefs and expressed values are not fixed, rather they are lived ideologies. In other words, they are ways of explaining and interpreting flexible rhetorical resources. For example, a modern father may have the ideological dilemma in a research interview of showing the interviewer that he is a good father who spends time with his children while managing the contradiction that he works 60 hours per week.

Traditional discourse analysis

A more traditional form of DA is grounded in ethnomethodology and draws upon a social constructionist framework (Potter & Wetherell, 1987). Such a form of DA uses three core concepts, as outlined in Table 1.4.

Discursive psychology

Discursive psychology reflects the key concerns of ethnomethodology and Wittgenstein's theory of language use, and is increasingly influenced by CA.

This form of DA is concerned with how people report their mental states and suggests that mental state reports are social actions (Edwards & Potter, 1992). As such, discursive psychology provides a general critique of cognitive theory and criticises the traditional methods used to study mental states. This is a particularly useful orientation to DA for mental health research, as this analytic approach argues that adult's mental health problems are constituted in and reflected by language, rather than being fixed biological states.

Discursive psychology grew from discourse analytic work that was focused on the ways in which speakers draw on cognitive concepts such as memory, cognition, and attention and make them relevant as a way of constructing facts (Wooffitt, 2005). A DP perspective to DA challenges how analysts orient to phenomena like identity and memory (see e.g. Lester, 2014), asserting that these are not entities in themselves but are constituted in and through language. Discursive psychology, then, considers how psychological matters, such as identity and memory, 'are produced, dealt with and made relevant by participants in and through interaction' (Hepburn & Wiggins, 2005, p. 595). Specifically, discursive psychology draws upon both the principles of discourse and CA. The key scholars working in this area include Derek Edwards, Alexa Hepburn, Elizabeth Stokoe, and Jonathan Potter.

Critical discourse analysis

Critical discourse analysis grew out of linguistics, semiotics, and other traditional forms of DA. This approach to DA is mostly focused on theorising and researching about social processes and social change, with a particular focus on political and social issues. With roots in linguistics, critical discourse analysis has a primary focus on the role of discourse in the production of power within social structures. As such, analysts using critical discourse analysis attend to how language functions to sustain and legitimise social inequality (Wooffitt, 2005). Specifically, critical discourse analysis emerged in relation to other approaches to DA and CA, but offers a more critical orientation, with an explicit commitment to demystifying dominant ideologies. Further, the purpose of critical discourse analysis is typically conceived as involving some kind of positive political social change (Morgan, 2010).

Some critical discourse analysts, such as Norman Fairclough, aim to identify how conflicts and/or inequality arise from capitalist modes of discursive production. Others, such as Teun van Dijk, have considered the role of social representation and social cognition in understanding inequalities that inform specific discursive acts. Critical discourse analysts, such as Wodak, have argued for a broader contextual base of discourse, wherein analysts consider the operation of dominance and power across (1) the actual use of language or text, (2) the relationship between utterances and genres, (3) the impact of sociopolitical elements, and (4) the place and role of the historical context. In the case of adult mental health, a critical discourse analyst may be interested in examining power differences between clients and therapists or between those with mental distress and those without and would thus examine how the subordinate position of 'client' or 'mentally distressed' was produced, sustained, and legitimised through language. Central scholars who have greatly contributed to the development of critical discourse analysis include Teun van Dijk, Norman Fairclough, and Ruth Wodak.

Foucauldian discourse analysis

Foucauldian discourse analysis analyses how discourse informs and shapes one's understanding of the world, particularly an understanding of political and social relationships. While critical discourse analysis emerged in relation to issues surrounding social and political inequality, Foucauldian discourse analysis developed in relation to critical perspectives in psychology and clinical practice. Drawing from philosophers such as Foucault and Derrida, Foucauldian discourse analysis focused on the historically based ideological underpinnings of the dominant discourses in society to identify the vocabularies which shape the ways in which we think about the world (Wooffitt, 2005).

Foucauldian discourse analysis tends to focus extensively on how people are positioned and how such positioning is taken up, with a very explicit focus on subject positions. Further, such an approach to DA typically focuses on historical analyses of how particular discourses are developed across time and space. For instance, there may be an explicit focus on a historical analysis of the development and legitimation of mental health discourses. Another critical concept in Foucauldian discourse analysis is deconstruction, which was shaped by Derrida's work and aims to elucidate taken-for-granted assumptions within a text. For instance, Derrida (1981) noted the structuralist idea that meanings are always constructed in and through a system of signs resulting in each meaning being constructed in relation to something else. In other words, every word, idea, or concept brings with it all other words, ideas, or concepts that are different from it. However, Derrida, like other post-structuralist went beyond such structuralist ideas, and suggested that in order to reify a particular meaning, positioning it as a superior representation of reality, all of the words, ideas, or concepts that shape its meaning are subordinate (Hepburn, 1999). In the context of mental health or the notion of 'abnormal' mental health, the idea of 'health' or 'wellness' does not even make sense without the concept of 'unwell' or 'mental distress', with its very meaning differing from and being evaluated against, while still incorporating, its opposite, in situated and contextually specific ways.

Foucault's work and conceptualisation of discourse has deeply informed this approach to DA, wherein he asserted that nothing exists outside of discourse (for a fuller discussion of how the concept of 'discourse' is conceived in Foucauldian discourse analysis, see Foucault, 1972). Key scholars in Foucauldian discourse analysis, apart from Foucault and Derrida, are Erica Burman, Ian Parker, and Wendy Hollway.

Interactional sociolinguistics

Interactional sociolinguistics (which is different from interactional linguistics, a more CA-related enterprise, see earlier in the chapter) entails an analysis of power within linguistic practices. More particularly, this form of analysis considers the ways in which certain linguistic features are produced for a specific context, recognising that common grammatical knowledge can be mobilised by different social or ethnic groups. Interactional sociolinguistics attends to patterns of language as a system and thus shares some similarities with CA. However, different from CA, interactional sociolinguists argue that member's interpretations of language form methods of dominance, rather than the words themselves achieving this dominance. In this way, a focus on power is far more emphasised than one would see in a pure CA study. Key scholars working in the area of interactional sociolinguistics include Deborah Tannen and Sydney Gumpertz.

Bakhtian discourse analysis

Bakhtian discourse analysis is grounded in the work of Bakhtin (1981) who conceptualised language as dialogic; that is, he argued that utterances serve to contribute to meaning making in a fluid way. In this way, language is conceived as fluid, with a response to an utterance viewed as a response to other utterances. Maybin (2003) suggested that Bakhtin viewed language as always pointing to a particular position, as it is never neutral. In fact, Bakhtin oriented to language as a site for ongoing struggle around issues of power and ideology. Further, Bakhtin suggested that reported speech can be linear (i.e. reported verbatim) or that speech can be pictorial (i.e. infiltrated with the voice of the speaker).

Within this form of DA, there is an explicit focus on social conflict and ideology, with these constructs being believed to be evidenced in evaluative judgements conveyed through language (Morgan, 2010). In addition, Bakhtian discourse analysis views every-day speech as being patterned into speech genres or themes. Evidently, the key scholar within this particular approach to DA is Mikhail Bakhtin.

Using conversation and discourse analytic research as evidence in the field of mental health

> In practice, it is in the interaction between the clinician and patient that the signs and symptoms of mental illness are manifested, identified and treated.

> Moreover, studying interaction directly has distinct advantages in identifying how a particular skill, as operationalised and tested in experimental situations, can be generalised to everyday reasoning and interaction.
>
> (McCabe, 2006, p. 42)

The scope of CA and DA for addressing research problems in the field of mental health and mental illness is vast, and there are many different types of questions that CA and DA can answer. Indeed, Sacks' own work started in the context of a suicide prevention center. Both CA and DA are well suited to any research question that asks how people do things in a natural context and the role of language in this process, as opposed to experimental contexts (McCabe, 2006). Specifically, CA is a useful method to explore the language of mental distress and related interactions in this field, as psychiatric categories are produced through and within language (Harper, 1995). The notions of sanity and insanity, normality and abnormality, health and illness are typifications that begin with interaction and observation (Roca-Cuberes, 2008). Importantly, the work from CA has helped to reframe conceptualisations of mental illness and the way in which it is managed by changing the emphasis from biomedical to interpersonal and socio-cultural (Georgaca, 2012). However, there are only a few studies that have applied CA to the study of mental distress and mental health services, and yet CA has great potential to make a significant contribution to the supervision and training of mental health professionals in communication skills (McCabe, 2006).

DA is also an important approach for mental health research and could be used more than it is currently used (Harper, 2006). While DA is becoming more accepted in mental health research, there remains a need to explore how findings from DA studies might impact policymakers, as well as clinicians, particularly those who may be less familiar with or open to questions framed within social constructionist perspectives.

Indeed, both CA and DA have much to offer research in relation to mental health services and treatments (see e.g. Gergen & Ness, Chapter 25, this volume; Kiyimba & O'Reilly, Chapter 26, this volume). This type of research has already examined how clinical processes are interactionally constituted in the course of therapy and has explored the role of the therapist in shaping the interaction (Georgaca, 2012). Furthermore, there is increasing recognition that conversational evidence can be useful as a resource for enhancing practice, with the recordings of actual practices offering rich opportunities to see how outcomes are shaped by therapeutic dialogue (Strong, Busch, & Couture, 2008) and for offering practical recommendations for professionals (Parker & O'Reilly, 2012).

Of course, those practising CA and DA still have to compete on the evidence-based stage for recognition as part of the qualitative evidence set. This is a stage that has relegated qualitative evidence generally to the bottom of the pyramid

(Lester & O'Reilly, 2015). However, CA and DA are considered to be robust methodological approaches and, in some ways, scientific methods. Thus, these approaches may be able to play a part in the rhetoric of evidence. After all, the notion of evidence relates to how we substantiate propositions and raises questions of reliability and validity of findings (McCabe, 2006). CA and DA espouse both reliability and validity in that sense (although we are not fully subscribing to the notions of reliability and validity as suitable terms for quality in qualitative research; see O'Reilly & Kiyimba, 2015, for a full discussion). Thus, for CA and DA reliability is addressed through the selection of recordings and the adequacy of the transcripts and texts, and validity is addressed through transparency of the analytic claims and validation through 'next-turn' and deviant case analysis (Peräkylä, 2004).

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Note

1. For example, Goffman (1955) argued that conversational interaction represents an institutional order, and within this there were interactional obligations and rights, which are linked to personal face and identity. Furthermore, Garfinkel (1967) recognised that analysing conversation in terms of practices and rules imposed moral obligation, which needed to be supplemented by recognising the importance of shared understandings.

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2

Using Discourse and Conversation Analysis to Study Clinical Practice in Adult Mental Health

Nikki Kiyimba

Introduction

The discipline of clinical psychology has emerged from a largely positivist approach to understanding human behaviour (Kiyimba, 2015), and applied research for clinical psychologists has, for the most part, followed the quantitative tradition. Psychology, in the wider sense, historically positioned itself within the sciences, and as such the quantitative approach to measuring phenomena has tended to predominate (Peters, 2010). Thus, the move towards using qualitative approaches within psychological research has been relatively recent, despite the rich pedigree of this paradigm (Howitt, 2010). One of the aspects of this new appreciation of qualitative research has been an acknowledgement of the important role that understanding the processes in therapeutic encounters plays. This line of enquiry has facilitated an integration of the scientific ideals of good-quality research with actual clinical practice (Rhodes, 2011).

One of the drivers for this turn towards qualitative enquiry has been an interest in research questions which seek to understand the processes involved in psychological change that occur during talking therapies (Burck, 2005). In particular, researchers have been interested in discovering what the role of the therapist is in the application of therapeutic techniques that makes the crucial difference in the client's recovery (Duncan & Miller, 2005). This shift in focus away from just asking whether treatments appear to be effective, but also to ask *how* they are effective has precipitated an opening of the parameters of research methodologies to address issues of both outcome and process. Process research focuses on what is the observable between the client and therapist during the work (Orlinsky & Howard, 1986). It has not yet been conclusively demonstrated that any one approach to psychotherapy is definitely better than any other in terms of accurate measurement of clinically significant change (McGlinchey, Atkins, & Jacobson, 2002). Thus, there is a growing interest in learning about what is transformative about the therapeutic relationship itself (see e.g. Brown, Dreis, & Nace, 1999; Imel & Wampold, 2008). Asking questions about how therapy works allows room for investigating what the dynamic features are in the process of change. While there is value in quantitative outcome studies, what is not captured is the range of different responses to treatment among clients (including deterioration in symptoms), and as a result individual change is not adequately considered as a way of evaluating the effectiveness of that treatment (Lambert & Ogles, 2009).

This chapter explores how discursive approaches to quantitative enquiry can be useful mechanisms for explain both the social processes (largely through the application of discourse analysis (DA)) that occur in therapeutic interactions as well as the nuances of the micro-level dynamic features of adult mental health therapeutic conversations (largely through the application of conversation analysis (CA)). Rhodes (2011) submitted a challenge that clinical professionals would benefit from being better informed about process methodology in research. This chapter goes some way towards demonstrating how the application of discourse analytic approaches can illuminate the processes that occur within therapy to either aid or hinder the therapeutic progressivity of the sessions. This is achieved through the presentation of examples from recent empirical CA and DA papers that look at therapeutic process. The overall aim of this endeavour is to suggest ways in which the insights gained from discursive research can inform applied clinical practice in adult mental health settings.

The previous chapters in this volume have already discussed the social construction of normality and pathology, as well as the philosophical basis of conversation and discourse analytic traditions. In the context of mental health and illness, therefore, these concepts are treated as dynamic and socially constructed, and the position adopted here is to recognise the indexical and situated nature of all discourses, including those that occur in therapeutic settings. From this foundation, rather than to reiterate the deconstruction of dominant discourses about illness and pathology, the focus will be on the usefulness of discursive methodologies in illuminating good clinical practice to facilitate the well-being of clients.

My particular contribution I believe is to consider how clinicians can involve themselves in research at a time when pressures for clinical intervention often outweigh opportunities for empirical evaluation and reflection. In the current socio-political and economic climate in the United Kingdom (UK), especially within the National Health Service (NHS), constraints on therapists' time often prohibit all but the most tenacious from engaging in research work in addition to their clinical workload. However, I firmly believe that practice-based evidence is a hugely important area that can be developed within the area of mental health and would wholeheartedly support the efforts of clinicians to engage in research activity of various kinds. Some of the ways that this may prove possible are to build collaborations with academics in research institutions, to engage in postgraduate study which affords the opportunity for research as part of a dissertation, and to initiate small-scale 'action research' groups within the local mental health context.

The starting point for this endeavour, however, is to consider the implications and applications of evidence-based practice and to compare these with practice-based evidence. As these terms of reference are now becoming common parlance in applied psychology, I will attempt to demystify what these two approaches mean in the course of this chapter. The reader may be aware of the difficulties that academics have in translating their research into meaningful outcomes that can be applied to mental health settings. Similarly, I have already alluded to the challenges that clinicians and therapists in mental health setting have in prioritising empirical work amidst other competing demands on time. However, beyond the pragmatics of resources, there is also the issue of communication and language. For those academics used to research and teaching within the institutional parameters of their university, there is often also a conceptual and experiential distance from applied mental health settings. Historically, those involved in psychotherapy research have been largely remote from those who practice it (Rowan, 1992). Similarly, for those practitioners for whom their academic acuity has become a little hazy after years focused predominantly on their therapeutic efforts with daily client-work, the challenge to return to academic research can feel daunting.

A comparison of evidence-based practice and practice-based evidence

At this point in time, there is a growing emphasis on evidence-based practice within psychology and therapeutic practice (Brown & Lloyd, 2001; Stiefel, Renner, & Riordan, 2003). With commissioners of mental health services keen to ensure that they supply the best possible provision for their clients, decisions about the quality of services purchased are usually based on whether the services provided are 'evidence-based'.

Evidence-based practice

Evidenced-based interventions are those practices which have a basis of consistent 'scientific evidence' to demonstrate improvements in client outcomes (Drake et al., 2001). In the UK, the National Institute of Health and Clinical Excellence (NICE, 2012) provides advice to mental health professionals about the kinds of interventions that have been found to have the most robust and substantial empirical evidence of their efficacy. On this basis, clinicians and therapists are strongly recommended to adhere to the guidance about which interventions should be used for particular mental health difficulties. Guidance is provided on the basis of the categorisation of mental health difficulties following the *Diagnostic and Statistics Manual of Mental Disorders Fifth Edition* (*DSM-5*) (American Psychiatric Association, 2013) and *International Classification of Diseases* (*ICD-10*) (World Health Organization, 1992) frameworks for diagnostic criteria. According to these descriptive categories, certain types of therapeutic intervention are prioritised over others, and in many settings commissioners specify that only these interventions should be utilised.

The principles and aspirations of this system are commendable and do mean that there is a clear structure to how treatment paths are managed. It is acknowledged that there have been improvements in the quality of research design, which have provided the basis for systematic reviews and meta-analysis of mental healthcare literature. In turn, this has helped to provide a foundation for best-practice directives driven by the needs of policymakers (Barkham & Margison, 2007). However, there are a number of shortcomings within this evidence-based model of mental healthcare provision. Some researchers argue that most evidence-based models do not fully capture the complexity of the relationship between the client and the service provider (Williams & Garner, 2002). Additionally, there are still many questions still unanswered relating to issues such as the length of therapy, the particular components that increase efficacy, and the therapy itself (Barkham & Margison, 2007).

Although there is now more recognition of qualitative research by medical researchers and funding bodies, there remains a hierarchy within the evidence-based practice framework that relegates qualitative evidence to being less valuable than its quantitative counterparts (Lester & O'Reilly, 2015). One of the problems with the adoption of hierarchies of evidence and the prioritisation of quantitative methodology is that it has tended to sideline the issue of appropriateness. This raises the important matter of relevance of research to practitioners in routine clinical settings. Aarons (2004) contended that if evidence-based practices are to be effectively implemented in community-based mental health settings, then a better understanding of the service providers are required. There is also the issue of how to fully capture the outcomes of therapy. For example, there are outcomes that may be valued by the clinician and the client that can be difficult to measure accurately or even to adequately summarise in words (Holmes & Lindley, 1998) such as the more intangible aspects of therapy that include feeling validated, understood or being 'held' in the mind of another. However, difficulty in measuring outcome does not make the outcome less desirable (Barkham & Margison, 2007). In terms of research, a distinction has been made between *effectiveness* research and *efficacy* research (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lambert & Ogles, 2004). A report by the US (NAMHC) Clinical Treatments and Services

Table 2.1 Key domains of research activity

Type of research	**Description of aims**
Efficacy research	To examine specific, measurable effects of particular interventions; to address issues of feasibility, safety, side effects and dose levels.
Effectiveness research	To identify the extent that effective treatments have measureable, beneficial effects across broad populations and different settings.
Practice research	To consider and examine variations in care rather than to generalise; to evaluate improvements in service delivery or treatment by examining which treatments are provided and by what means.
Service systems research	To address, large-scale policy, financial, or organisational issues including the economic impact of certain treatment options to the whole system; to monitor the impact of policy changes, legislation, and regulation on service delivery.

Source: From NAMHC (1999).

Research Workgroup (1999) identified four categories of research activity that are described in Table 2.1.

Efficacy research has been considered to be the gold standard with regards to making decisions about client care. However, in a strategic review of psychotherapy services in the UK by the Department of Health (NHS Executive, 1996), it was identified that links should be made between clinical practice and research. This review emphasised the need for evidence to be collected from routine clinical settings (effectiveness data), compared with outcome data from randomised controlled treatment trials (efficacy data). Conceptually, while evidence-based practice fits within the realm of efficacy research, practice-based evidence research sits within both the effectiveness and practice research domains (Barkham & Mellor-Clark, 2003). Bower (2003) argued that while the evidence-based practice efficacy research is necessary, it is not sufficient as the only evidence base for the delivery of interventions in clinical practice settings. It is recognised that no matter how good the evidence base is for a particular intervention, this must be combined with clinical expertise as even the best external evidence may not be entirely applicable to an individual client (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996).

Practice-based evidence

The term 'practice-based evidence' is used to refer to evidence that is collected from routine clinical settings (Barkham & Mellor-Clarke, 2000; Margison et al., 2000). Practice-based evidence focuses on the client and is often used to predict the likely trajectory of a client's progress in therapy. It has been argued that practice-based evidence is a necessary adjunct to evidence-based practice (for a summary, see Parry, 2000). Therapeutic practice that is based on practice-based evidence involves the 'conscious, explicit, judicious use of current evidence drawn from practice settings in making decisions about the care of individual patients' (Barkham & Margison, 2007, p. 446).

Practice-based evidence being rooted in routine clinical settings is a naturally occurring 'bottom-up' model of gathering evidence. The advantage of bottom-up approaches to research are that it grows from clinical observation rather than being based on past research findings, thus increasing the likelihood of discovering relevant and important phenomena (Lampropoulos et al., 2002). Some advocates of practice-based evidence in psychological therapy have argued for the use of quantitative outcome measures such as Clinical Outcomes in Routine Evaluation (CORE – OM) (Barkham et al., 2001; Evans et al., 2000). These outcome measure scales can be used in practice either as triage tools or to measure an individual client's progress against their own scores in order to make clinical decisions (Lutz et al., 2006). Process feedback during therapy can thus be useful to clinicians as a way of improving outcomes.

A relatively new practice-based approach which to date has mainly been used in education is action research. In educational settings, action research has been used to evaluating teaching effectiveness and for considering improvement in schools. Action research is a systematic enquiry that is engaged in for the purpose of gathering information about how a particular institution operates. Various methods can be used to collect data, which is then analysed with the specific intention of informing best practice within that environment. The value of taking an action research perspective from a practice-based evidence point of view is that the knowledge generated is presented from multiple perspectives of how reality is experienced by different individuals. This means that both the 'dominant' discourses of those who have more institutional power and the views of service users and less experienced or qualified staff members can be captured. In action research, it is the participants and their personal experiences that are the central source of validity (Kemp, 2013). The primary process for gathering information in this methodology is to record the normal everyday encounters of people in the setting that is being studied, such as supervision sessions, team meetings, and informal interactions. These meetings and interactions are often audio-recorded in the process of the action research methodology. Other data collection methods are written accounts, such as participants' diaries of their personal observations, interpretations, and accounts. The audio or audio-visual capture of normally occurring meetings constitutes naturally occurring data, and it is thus appropriate for discursive and conversational analytic approaches to data analysis. There are also a number of discursive analytical approaches that can usefully be applied to textual data such as the data that might be collected in a reflective diary.

Using DA and CA to develop practice-based evidence in adult mental health

There are a number of areas that CA and DA can be very helpful methodologies to employ with regard to the development of qualitative practice-based evidence. The onus of practice-based evidence is on taking a bottom-up or inductive approach to research enquiry, in order to provide scope for new ways of thinking about and understanding current practices to emerge. Practice-based enquiry also prioritises the participants in the research process. While it has been shown that gathering quantitative data at a practice level can help to inform and subsequently direct clinical interventions, there is also much scope for gathering qualitative naturally occurring data. Naturally occurring qualitative data is deliciously rich in depth and fullness. It is also a fantastic resource to tap into in order to answer specific research questions about the process of therapeutic change, as well as to examine what the factors or ingredients are within it that are either detrimental to or enhancing of therapeutic progressivity. The following section offers some empirical insights from recent CA and DA work that demonstrates how these qualitative approaches utilise naturally occurring data.

CA evidence from adult mental health

Rather than just offer a theoretical discussion about the way that CA research can be beneficial to informing clinical practice in mental health settings, I have instead summarised two recent CA empirical papers. In doing this, I have sought to demonstrate very practically exactly how CA has already been used as a very strong qualitative approach to provide practice-based evidence about effective therapeutic practices.

Keeping the session on track

Antaki and Jahoda (2010) conducted a study of cognitive behavioural therapy (CBT) sessions using CA. Knowledge of how turns of talk are constructed has been carefully documented throughout the growing literature that scrutinises talk-in-interaction using CA. This rigorous technique has demonstrated that particular types of turns of talk create a greater likelihood of certain other types of turns of talk to follow. A simple example would be that when one person asks a question, the most likely and interactionally relevant next turn from the addressee is to respond in their subsequent turn with an answer to that question. These utterances where there is a clear link between what is said and the expected response are called ‘adjacency pairs’ (see Schegloff & Sacks, 1973).

In this piece of CA research by Antaki and Jahoda, they demonstrated that in the context of the CBT therapy encounter there were certain effective strategies that therapists engaged in that redirected clients onto discussion of the therapy-relevant agenda when they began going 'off-track' by discussing other unrelated topics. These were

- minimal receipt of otherwise be newsworthy announcements in 'off-track' talk;
- not requesting further clarification of confusing 'off-track' narratives;
- selective repetition of only the relevant part of the client's 'off-track' talk;
- the use of formulation to close down 'off-track' topics; and
- explicit orientation to stay 'on-track' with the therapy relevant topic.

The usefulness of this specific research is clear not only for therapeutic practitioners, particularly those working in more directive therapeutic modalities, but also for both trainee and more experienced clinicians who may be faced with a similar issue. In this instance, CA has provided a clear protocol for therapists to use to keep a session 'on-track' with the therapeutic agenda. Clear tools have been identified that that have been shown to be effective in a real-life practice-based situation.

Negotiating agreement about topics of conversation

Sutherland and Strong (2011) analysed the therapeutic interaction of a couples counselling session using CA to examine the mechanisms used by the consultant to manage topic-focused agreement with the clients. Therapy work is inherently difficult in the sense that for clients it is an extremely challenging situation in which their core beliefs and unconscious psychological defence mechanisms are necessarily being challenged by the therapist. In this environment, it is very common for clients to introduce material into the session that is a conscious or unconscious attempt to subvert the topic of enquiry. In this piece of research, the authors demonstrated using CA, a particular strategy that the consultant used to take control of the trajectory of the session, while not cutting across or invalidating the points of view expressed by the clients. In the face of refusals, minimal agreements, and disagreements from the clients, the consultant persisted in attempts to achieve consensus using a form of talk called 'pre-sequences' (see Schegloff, 1980). This is a common strategy used by speakers to alert their listeners that there is an upcoming discursive action. Some examples in this data set were

- 'I just wanted to mention…'
- 'Well let me begin then and ask you…'
- 'Can I shift a bit here in terms of ask you uh a general question'

- 'Can I (interrupt for a second? Do you) think...'
- 'Before we wind up for today...'

(Sutherland & Strong, 2011, p. 17)

Rather than directly introducing a topic shift that was clearly disjointed from the previous talk, the consultant in this data used pre-announcements as a strategy to allow clients the option to disagree with the proposed change before it fully occurred. However, it also served to gain a temporary agreement from the clients about the possible topic shift. Therefore, in this environment characterised by resistance and disagreement, the authors demonstrated that there were particular, regularly observable, and consistently effective practices that could be used to garner agreement as a basis for proceeding (in this case pre-announcements). Thus, in quite a different therapeutic environment to the example from the CBT session previously, CA has been used very helpfully to demonstrate that a micro-analysis of actual turns of talk in a naturally occurring therapeutic encounter can generate extremely helpful information about the local conversational aspects of affective therapy talk.

DA evidence from adult mental health

As with the previous section, I have provided the reader here with two examples of how DA can be used to illuminate underlying structural interactional features in therapeutic talk.

Identifying features of therapeutic change and rupture

Martinez, Tomicic, and Medina (2012) used dialogic DA to analyse 60 sessions of psychotherapeutic dialogue. They discovered two particular episodes of therapeutic change and two ruptures in the therapeutic alliance in different sessions. From these they were able to identify the linguistic features that characterised change and rupture. In episodes of therapeutic change, features of talk that indicated a point had been reached of significant change were identified as being characterised by the client using self-referential language that positioned him or her as author of his or her change. In episodes of rupture of the therapeutic alliance, certain linguistic markers were found to demonstrate a connection between the rupture and the particular verbal interventions used by the therapist to re-establish the relationship.

The authors pinpointed the change moment in the session as that moment when the client used the first-person singular pronoun in relation to the therapeutic topic:

> This is what **I want** (2) deep down, the life **plan that I, I (.) need** and **I:: I want** (2) to have.
>
> (Martinez et al., 2012, p. 109)

In this example, the client's utterance in this form marked the moment of change by fulfilling the criterion of being present tense, self-referential, and in the first-person singular (see also Reyes et al., 2008).

In relation to the management of rupture episodes, dialogic markers were identified which demonstrated the methods used by the therapist to overcome the rupture. In this example, reference to a third party operated as a mechanism to introduce objectivity, in the service of repairing the therapeutic relationship. The following extract was part of an episode of rupture, in which the client had expressed not wanting to feel better and the therapist responded:

> I would have to be honest to tell you that, **in this jo::b (.) we sometimes see** with a certain frequency that, **when somebody** feels better, just **like in medicine when one** feels better one says it's ENOUGH, so to speak, right?
>
> (Martinez et al., 2012, p. 111)

In this example, the authors illuminated the discursive action of drawing a third party into their turn of talk (achieved through the phrases 'this job' and 'in medicine'). This was used in conjunction with the modaliser 'to be honest' which had the effect of positioning the therapist as a trustful person. The use of DA in this piece of research enabled close inspection of the naturally occurring data to scrutinise actual sequences of talk to identify the actions performed within them. As a result, it was possible to illustrate specific details of the practices of third-party talk that therapists used to manage therapeutic ruptures.

The identification of changes in interpretative repertoires

Öster, Magnusson, Thyme, Lindh, and Åström (2007) investigated the question of what changes occurred in the use of beneficial cultural interpretative repertoires among women with breast cancer who participated in art therapy, compared to a control group. In the context of critical DA, there was an interest in the ways in which identities were constructed and presented in different social contexts. The authors reported in this study that the most dominant repertoires used by the women related to the following categories:

- Gendered boundaries
- Breast cancer as a challenge and a learning opportunity
- Stoicism in the face of adversity
- Confusion and uncertainty about adequate repertoires

(Öster et al., 2007, p. 282)

The results of this study showed that there were large differences between the women in the art therapy group and the control group on the dimension of gendered boundaries talk. It was found that by using a form of critical DA called critical discursive psychology (Wetherell, 1998) to analyse this data, the interpretative repertoires that the women used with regard to themselves did change as a result of the process of engaging in art therapy. This example is included here to demonstrate that DA can be used helpfully to reveal the qualitative aspects of outcome data as well as process data. It also shows the discursive frameworks used to verbalise the changes that occurred in the clients' lives as a result of therapeutic input. In this instance, the authors suggested that art therapy was a mechanism that helped the women to recognise and distance themselves from traditional gendered ways of thinking about their limits and boundaries.

Discussion

The previous four empirical examples of recent DA and CA research into the processes of therapeutic change demonstrate that there are aspects of therapeutic change that can only be observed through careful line-by-line analysis of the dynamic flow of interaction between therapist and client. In the CA instances, the actual mechanisms of talk to mitigate against 'off track' talk were revealed, as were linguistic techniques to agree conversational topic focus. In the DA examples, identity constructs were seen to change through the women's art therapy group, and the features of therapeutic rupture and repair were highlighted. These examples demystify some of the elements of how the core ingredients of successful therapy are built and maintained. One of these core ingredients which has hitherto been difficult to pinpoint is the alignment between therapist and client, also known as the therapeutic relationship. Further research into the specific interactional aspects of how this relationship is dynamically positioned and oriented to throughout therapy would be very beneficial in adding to the current literature in this field.

There has been a growing interest in the psychological literature about the 'special something' that some therapists seem to have compared to their counterparts working within the same therapeutic modality. Since the 1970s, the concept of the 'supershrink' (Ricks, 1974) has started to be used to describe therapists who display exceptional outcomes from their interventions. This interest has found there to be significant differences in the outcomes of therapists working within the same therapeutic modality with similar client populations, a difference that cannot be accounted for by considering the therapy alone. For example, Okiishi, Lambert, Nielsen, and Ogles (2003) found in their study of 91 therapists over a two and a half year period that therapists whose clients showed the most improvement saw an average change that was ten times greater than the mean for the whole sample. The argument presented was that a research focus on just the therapy misses the vital factor of the specific features that individual therapists bring to their work. Okiishi et al. (2003) suggested that rather than simply investing in theory-based training 'it may make more sense to study the effects of particular therapists and then develop interventions to enhance patient outcomes' (p. 362). The evidence points to the conclusion that the person providing the treatment is more likely to determine its success than which treatment approach is used.

Miller, Duncan, and Hubble (2008) have studied the supershrinks phenomena in an effort to understand what it is that these therapists do differently than their rather more average counterparts. Their findings suggest that the formula for successful therapy is:

(1) determine your baseline of effectiveness;
(2) engage in deliberate practice; and
(3) collect feedback.

Miller et al. (2008) found that exceptional therapists were more likely to ask for and receive negative feedback. Additionally, although the top 25% of clinicians consistently achieved lower scores on standardised measures of therapeutic alliance at the beginning of therapy, they then actively worked on addressing problems in the relationship. In doing so, these therapists were better able to avoid client dropout than average therapists. In terms of how this research is important to the focus of this discussion, it seems that a better understanding of the strategies that successful therapists use to maintain and improve client engagement is likely to be a very profitable endeavour. During the reflection phase of Miller et al.'s (2008) research, they found that the therapists who performed best identified specific strategies and alternative approaches for improvement compared to the more general approach of their average colleagues. What this finding indicated was that as practising therapists, it was much better to reflect very *specifically* on particular strategies for improving performance. The use of detailed qualitative research to aid this learning process is proposed to be an excellent way forward for identifying particular areas for improvement.

Clinical relevance summary

In this chapter, I have demonstrated the value of using DA and CA in the qualitative practice-based research in adult mental health. As detailed approaches that use naturally occurring audio and textual data, they are an excellent resource for answering the 'how' questions with regard to the therapeutic process. Indeed, both DA and CA can be useful for examining therapeutic processes in situ (see e.g. Gergen & Ness, Chapter 25, this volume; Tay, Chapter 28, this volume; Voutilainen & Peräkylä, Chapter 27, this volume). In terms of application, I have broken this section into four parts that relate to practical ways in which mental health professionals can become more involved in qualitative practice-based research. These sections consider the roles of the scientist practitioner and the reflective practitioner and also discuss opportunities for continuing professional development and building affiliations between academic institutions and clinical practitioners.

Scientist practitioner

An enduring dichotomy in applied clinical research is that of the scientist practitioner which is debated as an ongoing issue in clinical psychology (Lampropoulos et al., 2002) and counselling psychology (Chwalisz, 2003). Within these professions in particular, there is an expectation that the practitioner will also remain active in scientific research, in order that their clinical practice is informed and enhanced by ongoing learning. However, there are a number of practical limitations that affect psychologists operating as scientist practitioners and continuing to be actively involved in research. These may include lack of research funding, limited research training, lack of time, limited motivation and limitations imposed by the work setting (Lampropoulos et al., 2002). Often these significant factors will limit practitioner's ability to engage in large-scale research projects, and Lampropoulos et al. (2002) suggested that their research must therefore necessarily take a different form. In this chapter, I have discussed some of the characteristics of practice-based research and have outlined briefly the current trend in some settings towards action research, which is research conducted in real-life settings with the goal of having real-life application. There are different forms that this kind of research can take, and for clinicians working in mental health therapeutic settings, small-scale qualitative research is a pragmatic as well as extremely beneficial approach to take. As Maletzky (1981) observed, 'It is a lonely and sometimes frightening task to face of patient and try to help; what comfort it would be if our colleagues experiences could always accompanied us!' (p. 287).

Reflective practitioner

The changing context of healthcare delivery places increasing demands on practitioners' expertise. As a result, within the field of medicine there has been an increasing emphasis on doctors developing the ability to critically reflect upon their decisions (Arnold, 2002; Swick, 2000). To varying degrees depending on the particular modality of training and therapeutic intervention, within the field of mental health, the concept of reflective practice is something that has been recognised for some time as an essential part of the professional work. The premise has its roots in the work of Dewey (1933), who proposed the idea of 'reflective thought' as a way of finding explanations or solutions for situations in life that raised doubt or uncertainty. Dewey (1933) conceptualised a five-stage process:

1. doubt or uncertainty due to difficulty in understanding an event or solving a problem;
2. definition of the difficulty by thoroughly understanding its nature;
3. a possible explanation or solution arrived at through inductive reasoning;
4. elaboration of ideas through abstract and deductive thinking by focusing on the implications; and
5. hypothesis testing through either direct or imagined action.

(as cited in Mamede & Schmidt, 2004)

More recently, Schön (1983) proposed the idea of reflective practice. In this conceptualisation, Schön differentiated the processes of reflection-on-action which is a mental review that occurs later on after an event, and reflection-in-action which occurs in the moment that the decision is made. As mental health practitioners, engaging in DA and CA research can afford the opportunity for practitioners to reflect on action at a later date by reviewing and analysing data collected during therapy sessions. While the process of simply listening back or watching recordings of sessions can be highly beneficial for a practitioner to review – either alone or during supervision – the additional benefit of engaging in-depth analysis, means that sequences, patterns, and turn-by-turn dynamic responses can be more closely studied, revealing another layer of learning.

Continuing professional development

The third area that affords opportunity to engage in meaningful research while still continuing to work in clinical practice is through continuing professional development. Although economic constraints are an unfortunate reality for many, for some it may be possible to engage in postgraduate study in a specialist area of mental health that is relevant to your current clinical work. Under these circumstances, as part of an academic qualification, a research project is a requirement of most courses. The advantage of undertaking research via this route is that for those who have not been involved in research for a while, it provides the structure and support that can facilitate the opportunity to gain confidence in producing empirical work.

Developing partnerships with academic institutions

There is immense benefit on both parts for the establishment of clinical–academic partnerships for the purpose of developing practice-based research. On a practical note, practitioners applying for funding for research may find that an affiliation with a university department may give the funder greater confidence in the viability and success of the project. Additionally, where practitioners have access to naturally occurring data, and have the

Table 2.2 Clinical practice highlights

1. Despite the pragmatic constraints that are inevitable as a mental health professional, the possibility to maintain a scientist practitioner status by conducting small-scale CA and DA qualitative research is possible.
2. CA and DA can be very helpful tools for engaging in more in-depth reflective practice for the purpose of ongoing professional development.
3. Continuing professional development is one route whereby practising mental health professionals can undertake postgraduate-level study, including a research project.
4. Developing mutually beneficial partnerships between clinicians and academic departments is an excellent way to ensure methodological rigour for your CA or DA practice-based research.

expertise and knowledge to translate research findings into formats that are meaningful within the therapeutic community, academics are well placed to offer advice and support on methodological matters to ensure that the project is of a high quality and that the analysis is robust. For both parties, publications that result from the research partnership will be beneficial. Opportunities for a wider variety of dissemination channels are also increased, and information learned from the research may reach a wider audience and be translated into a format that is accessible to their particular needs. Additionally, from an ethical point of view, the participants who have given their consent to involvement will have the comfort of knowing that their input has been used effectively to help others.

The emphasis in clinical psychology training on working as a scientist practitioner and reflective practitioner is an excellent foundation for continuing to engage in research during a clinical career. The argument of this chapter has been that the qualitative approaches of DA and CA can be excellent tools that lend themselves extremely well to answering some of the most pertinent and pressing research questions that many therapists ask. These include understanding what it is about the therapeutic interaction and relationship that can make or break a treatment intervention, and how the therapist affects the application of therapeutic techniques in ways that make all the difference in facilitating a client's recovery. More research is invited that focuses on asking questions about *how* therapy works and takes an active interest in the specific details of the dynamic features in the change process. For a simple summary of the practical implications, see Table 2.2.

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3

The Research Interview in Adult Mental Health: Problems and Possibilities for Discourse Studies

Julie Hepworth and Chris McVittie

Introduction

The aim of this chapter is to critically discuss the research interview in adult mental health by examining the ways in which discourse studies can further contribute to the understanding of research practice. Importantly, research practice is conceptualised here as an object of study in itself, in that it produces subjects and has effects. In other words, the practice of using the research interview simultaneously enacts a method of data collection and creates a re-presentation of interviewees' accounts that reproduce, maintain, or transform dominant psychological thinking about humans and health (or adult mental health). The ways we practise as researchers, therefore, are inseparable from the findings that are produced. In this chapter, we explore existing critical considerations about the research interview, several problems and possibilities that discourse studies encounter in health research, and what implications there are for education and research practice to inform the research interview in adult mental health.

Objectives

(1) Provide a summary of key critical considerations about the research interview in discourse studies;
(2) Discuss the problem of mental health as a moral issue: health as the preferred state, ill-health as an accountable matter; the difficulties in providing an account for what is not visible, and the implications of this for the research interview and discursive research; and
(3) Identify the implications for teaching and research practice of using the research interview in discourse studies and adult mental health.

Critical considerations of the research interview

We set out five key critical considerations about the use of the research interview in discourse studies, and argue that researchers' practices engage to various extents with these critical considerations. In doing so, while the focus is clearly on discourse studies, we also engage with broader scholarly debates about the research interview more generally in order to provide a more comprehensive and detailed exploration of the place of the research interview for researchers to ponder as they make decisions about its use in the field of adult mental health.

Ubiquity of the research interview as a default option for data collection

The ubiquity of the research interview is clearly seen in its deployment across multiple disciplines and fields including politics, media studies, medicine, public health, social sciences, health sciences, and others. In this chapter, we critically discuss the research interview within the particular contexts of the social sciences and health sciences where the majority of research about adult mental health and discourse studies takes place. First, it is important to point out that the research interview, while involving multiple issues in discourse studies, also has commonalities with the use of interviews across other social contexts of interviewing such as political and news media interviews. 'Put simply, interviewing provides a way of generating empirical data about the social world by asking people to talk about their lives' (Holstein & Gubrium, 2003, p. 2). Unlike these other social contexts, within the social sciences and health sciences there are several types of research methods available, but the research interview has become a default option for qualitative data collection. Indeed, research interviews have become so widespread that, as noted by Gubrium, Holstein, Marvastii, and McKinney (2012), they have been identified as 'interview research'. Here, we concur with the view espoused by Taylor and Francis (2013) 'that interviews are not a *research approach per se*' (p. 213), but a *method* of data collection. In other words, we do not conflate the ubiquity of the research interview with a methodological approach. Rather, interviews are understood here to be one of several different methods of data collection in studies that are informed by various possible epistemological, theoretical, and methodological approaches and paradigms.

In terms of their composition, research interviews are structured to varying extents and developed in ways that are considered to most appropriately collect data to answer the research questions of specific studies. Interviews that are termed 'in-depth' or 'unstructured' are often time consuming and commonly used to find out about illness narratives (see Mishler, 1984), and examine how people make sense of illness (Radley, 1994). In contrast, 'structured' interviews can be relatively short in duration, typically include closed answers and can be quantified such as in research about health status (Askew et al., 2011). In the social sciences and health sciences, the research interview is most often 'semi-structured' with preformed research questions and/or interview schedule. Prior to the recent emphasis on 'naturally occurring data', which we discuss later in the chapter in Section 'Issues of Power', the semi-structured interview format has also been widely used in discourse studies such as in research about anorexia nervosa using semi-structured focus-group interviews (see McVittie, Cavers, & Hepworth, 2005) and individual interviews with women and men about gender and constructions of type 2 diabetes self-management (Hepworth, 1999). Here, it is also important to note that while we refer to a health condition – type 2 diabetes – that is predominantly regarded as being about physical health, women and men are also commonly diagnosed with mental health co-morbidities, particularly depression. The prevalence of depression is significantly higher in women and men diagnosed with type 2 diabetes (Ali, Stone, Peters, Davies, & Khunti, 2006) and involves a bi-directional relationship (Siddiqui, 2014). The complex interrelationship between depression and type 2 diabetes also illustrates how approaching adult mental health in terms of discrete categories is problematic because of the construction of the categories themselves and the notion that they are separable from the health of the whole person.

Research interviews are also used as just one among several methods of data collection in the same study in multi-method or mixed-method research. The analysis of multiple sets of data obtained from different methods and their combination is argued to enhance validity through 'data triangulation' (Cresswell, 2014). A common approach in public health and primary healthcare research, multi-method research design aims to provide a broader representation of phenomena such as the 'patient journey' of populations diagnosed with multiple chronic conditions and their need to navigate and regularly access mental and physical healthcare services over many years. As Funk and Stajduhar (2009) argued in terms of caregiving research, there are limits to using only the research interview, and greater integration of observational and longitudinal methods is required. The increasing popularity of multi-method or mixed-method research designs means that researchers need to carefully consider when the research interview is most appropriately used by itself or in multi-method research. In doing so, consideration of 'technical and epistemological intricacies' (Taylor & Francis, 2013, p. 217) is required by researchers.

Epistemological critique

The epistemological assumptions that inform a research study where interviews are a method of data collection are important to understand and should be made explicit in study design because of the implications for research conduct, data analysis, and interpretation of findings. Epistemology is a theory of knowledge – or how we know what we know. For a detailed critical discussion of epistemology, see the work by Irene Vasilachis de Gialdino (2011). Epistemology is inextricably linked to particular research designs, how a research interview is employed, and determines the parameters of the research study's claims. Take, for example, a study about type 2 self-management (Hepworth, Askew, Jackson, & Russell, 2012) based on a post-positivist epistemology, which is an understanding that although a totally objective truth cannot be achieved, researchers can aim for knowledge that goes some way towards objectivity. The outcomes of such a study therefore are not taken to be dependent upon the particular context within which the research is conducted. In this study, such an epistemological approach was combined with an interpretive framework of primary healthcare, and thematic analysis of semi-structured interviews with interviewees selected via critical case sampling who had significantly improved their self-management of type 2 diabetes. The study aimed to find out what phenomena had contributed to improve their self-management by identifying aspects of the individuals' descriptions of health-related change, healthcare providers' practices, and the healthcare setting in which themes reflected tangible features, a *realist* position that took the outcomes to reflect quasi-objective phenomena, and that in turn could be used to inform policy and future primary healthcare practice regarding improved health outcomes.

In contrast, let us return to the discourse study we referred to in the previous section (Hepworth, 1999) about women and type 2 diabetes self-management. This study used a post-structuralist epistemology that foregrounded the effects of power and social structures on what is treated as knowledge and combined this with feminist theory and discourse analysis of data collected by semi-structured research interviews. Through this approach, it was possible to examine women's accounts about self-management that demonstrated the ways by which their self-care was not simply a reflection of individual decision-making but embedded within particular familial, social, and economic structures involving caring for partners, husbands, and children and participation in the labour force that impacted the time available to women to put in place medical regimens for effective self-care. The study findings claimed that these women's accounts were one example of the multiple meanings about type 2 diabetes self-management that may be available, a *relativist* position that viewed knowledge as relative to one or more features of the context of its production, and expanded the perspectives taken to this topic beyond individualistic notions of patient decision-making.

This comparison of two research scenarios about type 2 diabetes self-management clearly illustrates the importance of considering the epistemological position of any qualitative study. That is not to say, of course, that research that adopts a realist position has the potential to inform 'real-world' practice, while relativist research cannot inform practice in similar ways. Rather, what this comparison demonstrates are the possibilities for the researcher's practice, the claims made by particular studies and their relationship to understanding health phenomena. Whereas post-positivist studies seek to identify 'real' phenomena that promote or impede health and effective healthcare practices, post-structuralist research can show how patients make sense of themselves and of the salient issues relative to and located within the structures and contexts in which they are positioned. In their different ways, then, both types of study potentially can inform understanding of present health-related experiences and the development of future practices.

Issues of power

The research interview as a practice is constituted by different sets of relationships and assumptions regarding power and socio-political structures. Here, we critically discuss three ways in which the research interview involves power to illustrate debates at various levels of practice. First, there are issues of power between the interview participant and interviewer. Typically, power within the research relationship has been recognised in terms of class, gender, and race, as well as 'other issues of marginalized groups' (Cresswell, 2014, p. 64). Research practice that is informed by these issues of power is deemed to be more effective if both the interview participant and interviewer share the same or similar demographic characteristics (corollaries of this argument can also be found in the literature about clinical interviews, counselling, and therapy relationships; see e.g. Suzuki, Ahluwalia, Arora, & Mattis, 2007). The underlying notion is that these similarities provide the opportunity for interview participants to experience greater equality in the research encounter, and, in doing so, participants are enabled to talk with increased openness and authenticity. For example, Ghane, Kolk, and Emmelkamp (2010), in a study on the effects of ethnic characteristics of the interviewer and interviewee on explanations of mental illness, found that in interview pairs with similar ethnicity interviewees perceived victimisation and religious/mystical causes as more important than medical causes. Achieving such equality, or moving closer to it, is however by no means straightforward. Somewhat ironically, attempts to establish similarity can all too easily backfire and demonstrate more clearly whatever differences already exist between the interviewer and interviewee. Alternatively, even where interviewer contributions might point to such similarities, the effect can be to disempower further the interviewee in conferring upon the interviewer greater authority to discuss the topic at hand (Abell, Locke, Condor, Gibson, & Stevenson, 2006). For such reasons, the role of the interviewer merits as much attention as that of the interviewee in examining the consequences of relative power for the production of interview data.

Second, there are issues of power between types of data/analyses and their relationships with specific theoretical approaches. The relationship between language and power is especially important to consider in, for example, feminist research because of the possibilities for transformative social change and women's empowerment. As such, we observe how issues of power are critically considered in feminist qualitative research because of the tension between relativism and feminist politics. Taking the example of 'incest', Hepburn (2000) made several salient arguments that relativist analyses of 'talk' are capable of both demonstrating the ways in which claims are constructed about objects and engaging with the socio-political context in which those descriptions embedded in practices take place. Hepburn (2000) wrote:

> Relativists are not persuaded that there is a simple brute reality of 'incest' or 'child sexual abuse' outside of, and separable from, those complex practices. However, to claim that such things are not simple freestanding objects is not to treat them as any less important or shocking. (p. 98)

The relative separateness of 'talk' from 'reality', the articulation of power, and the use of the interview in feminist qualitative research are further taken up in a recent methodological debate about feminist conversation analysis (FCA) (Griffin, 2012; Speer, 2012; Wetherall, 2012; Whelan, 2012). Whelan (2012) maintained that the collusion of FCA with the argument in discursive psychology in favour of 'naturally occurring data' (see Potter & Hepburn, 2005) may be privileging and prioritising particular research methods. Prior to this, Griffin (2007) critically examined the preference for 'naturally occurring data/talk' above other data obtained through the research interview by drawing on examples of historical research involving direct engagement with people 'in the field' and current research about youth – both based on interviews – to demonstrate the benefits and problems of direct engagement with participants. She clearly argues that this engagement in research involves the inclusion of 'something else' or 'other events' that are neither part of what was initially thought to be included within the research nor result from the researcher, but involves systematic observation requiring her/him to be an active reflexive participant rather than having minimal involvement in the research process. Further to this, in the case of FCA, Griffin (2012) argued that, not least, '…FCA research tends to pay relatively little attention to the cultural, political and economic context in which such studies are embedded' (p. 299). As these feminist scholars demonstrate, the tension between relativism in discourse studies and reality in some theoretical perspectives such as in some feminism(s) is a key consideration for researchers in order for research to inform issues of inequality and injustice. This is a pertinent issue for certain types of discourse analysis (see Lester & O'Reilly, Chapter 1, this volume for a discussion).

Third, there are issues of power involved with how the research interview is conceptualised within the design of a study when the purpose of the interview is also one of empowerment. The research interview as empowerment is widely discussed from various perspectives. At a micro level, empowerment can be conceived as being made possible through interview conditions that are conducive (i.e. empathy, rapport, building trust) and the telling of stories where interview participants' stories are understood to reflect their authentic experience as seen in early work on illness narratives (Mishler, 1984). Although, as the 'turn to language' in the social sciences increasingly emerged in the 1980s and was adopted more widely in research using interview data, the notion that chronic illness narratives revealed authentic, real experience was contested (Miczo, 2003). Alternatively, empowerment may be enacted at a broader community level through direct engagement with participants to develop and agree on the research agenda, research conduct, and interview questions, as in the community psychology work of David Fryer (1987) and through the co-authorship of research illustrated by the article published with community activist Cathy McCormack (Fryer & McCormack, 2012). As a widely adopted approach in public health, 'research partnerships' or 'collaborative research' between researchers and communities co-construct the definition of the problem, research conduct, and the interpretation of data to varying extents and, in doing so, aims towards a more equitable form of research practice.

Interactional production of 'data'

The interactional production of 'data' in the course of the research interview has attracted researchers' attention particularly in terms of the co-construction of data between interview participants and interviewers within the interview exchange and by the involvement of two interview participants in the same interview such as found in research on couples. Indeed, in their seminal text on the theory and application of discourse analysis, Potter and Wetherell (1987) argued that interviews cannot meaningfully be treated simply as data-gathering instruments but rather fall to be considered as 'conversational encounters'. Attention, consequently, must be paid not only to the descriptions that an interviewee provides but also to the local interactional contexts within which these are to be found.

More recently, in a comprehensive critical discussion about analysing interviews, Rapley (2001) convincingly demonstrated how interview data are co-constructed by the interview participant and interviewer, and because of that, it is therefore necessary to include verbal and non-verbal communication (i.e. pauses, silences) by both parties in the analysis, as well as in the explicit presentation of research data. As Rapley (2001) described, 'the "data" obtained are highly dependent on and emerge from the specific local interactional context which is produced in and through the talk (and concomitantly identity work) of the interviewee and interviewer' (p. 303).

Similarly, in research with heterosexual couples accounting for men's illness, the co-construction of interview data emerges from the local interactional context involving 'identity space' and 'positioning dances' illustrative of the ways in which this talk extends beyond that which would have been otherwise available if the interviews had been conducted with only men (Seymour-Smith & Wetherell, 2006).

What we see, then, in interviews that are conducted specifically for purposes of discussing issues of health or ill-health is that the 'data' that result will inevitably reflect the contributions of both interviewer and interviewee. How both parties orient to what is said, and what is not said by way of absences, pauses, and so on, is consequentially relevant for the outcome. Indeed, particular interview contexts are especially conducive to production of the very health limitations that they are designed to study. For example, individuals who produce momentary confabulations are particularly likely to do so in response to the questions and other interactional features found in an interview setting (McVittie, McKinlay, Della Sala, & Macpherson, 2014). Thus, how questions of health and ill-health are presented and perhaps resolved can have as much to do with the interaction itself as they have to do with the interviewee's state of health as demonstrated elsewhere.

Researcher-focused concerns

The fifth and final critical consideration is that of researcher-focused concerns where the position of the researcher may reside anywhere along a continuum from the adoption of a perceived invisible, neutral stance to an explicit reflexive engagement with how gender and/or personal experience and/or other features inform the interpretations of the research. While the impossibility of a researcher adopting an objective or neutral stance in the interview has become widely agreed in the social sciences, the problematic notion of neutrality is also increasingly being recognised in qualitative research in the health sciences (Taylor & Francis, 2013) even though it continues to have a heavy reliance on post-positivism and objectivism.

Imagining the subjects behind the interview, Holstein and Gubrium (2003) traced the movement in the literature about interviewing from when typically both interview participants and interviewers were regarded as passive in collecting data through to the increasing focus on the production of meaning taking place through the process of interviewing and the possibilities for empowering respondents.

Research relevance 1: Dominant understandings of adult mental health and problems for discourse studies

Consideration of the features of the research interview, as outlined above, becomes all the more pertinent when taken in the context of discussions relating to adult mental health. For, interviews on these topics provide the sites for discursive negotiation of individual health or ill-health against a backdrop of broader social understandings as to what is to be recognised as comprising health and ill-health (McKinlay & McVittie, 2008, 2011). A major element here is the issue of accountability: people are morally accountable for being healthy or being 'properly' ill. As Radley and Billig (1996) pointed out:

> the need to legitimate one's position extends from those who consider themselves in robust health to those who are severely ill or disabled. For the healthy, illness talk carries with it the threat that one might be seen as a potential malingerer, or even a habitual complainer. For the sick, the same threat applies, although this must be balanced against the possibility that . . . one will be dismissed as unfit to participate, as being essentially different from the norm. (pp. 225–226)

The question arises then of what is to count as evidence of a particular state of health or ill-health.

Although accountability is relevant to any talk of health or ill-health, it becomes all the more relevant in relation to mental health/ill-health. Indeed, mental health professionals do consider the moral implications of their practices (Bergman, Chapter 13, this volume). Mental health and ill-health are inevitably, in some sense, private matters in that usually any description provided cannot be warranted by reference to the physical body. The interactional task facing a person claiming mental ill-health is one of warranting any such claim in ways that will be socially recognised and accepted but without resort to descriptions that might lead to one being dismissed as socially unfit. If and how, then, interviewees account or fail to account for mental health or ill-health is a central concern for researchers who conduct interviews that are designed and conducted with the specific aim of exploring these issues. Adopting this focus, let us turn to the question of how adult mental health or ill-health and attendant issues of accountability are worked up in the context of the research interview. On this question, opinions among researchers are divided as to whether or not interview constructions can tell us anything useful about adult mental health more generally.

On one view, the versions of mental health and ill-health (or indeed of anything else) produced in interviews will have little resemblance to those found in everyday life. For example, Potter and Hepburn (2012) argued that particular features of the interview context, specifically the power imbalance between interviewer and interviewee, will almost inevitably result in the interview being 'flooded' by the researcher's agenda. Thus, the interviewee's concerns will receive less attention than the interviewer's focus on production of certain forms of 'knowledge'. On a related note, Stokoe (2010) argued that, for research participants in research interviews, 'the stakes are low'. This stands in contrast to real-life encounters in which an individual will have greater stake in the outcome of the encounter. Thus, whereas in, for example, consultations with health professionals or discussions with family members people will attempt to legitimate their own positions, there is rather less requirement for them to do so in the context of the research interview. On these arguments, research interviews potentially will tell us little about the subject at hand: a more useful understanding of adult mental health could be derived from analysis of naturally occurring data such as patients' consultations with health professionals, assuming that these data can be made available for research purposes. On the opposing view, however, other researchers argue that there is no sound basis for forgoing the use of interviews in favour of other methods. Rather, interviews fall to be treated as specific forms of 'social practice' where both interviewer and interviewee contribute to interactional outcomes (Talmy, 2011). This requires attention to the turns of all who are involved in the interaction to the understandings that result from the discussions (Condor, Figgou, Abell, Gibson, & Stevenson, 2006). In particular, it calls for close examination not just of what the interviewee says about adult mental health but also of how the interviewer negotiates the detail of the interview as it unfolds. Discursive research thus treats seriously all interactional elements of the interview and does not treat it simply as a means of collecting data on the topic at hand. In looking to understand how interviewees make sense of potentially sensitive topics, we need to consider if and how interviewers respond to their descriptions, for example by providing minimal responses, by signalling clear agreement with what is being said, and by withholding talk for whatever reasons (Kirkwood, McKinlay, & McVittie, 2013). Each of these interviewer contributions will have its consequential relevance for the interaction. Specifically in relation to adult mental health, the form of account that an interviewee offers and how it develops is likely to reflect in part how it is treated by the interviewer, whether it is encouraged, challenged, or goes without comment, and how this, in turn, is taken up by the interviewee.

Research interviews, then, potentially might tell us much about issues relating to adult mental health. The extent to which what results from an interview encounter reflects everyday life more generally remains an open question. Regardless of whether we view interviews as untypical of what is to be found elsewhere, or as a meaningful form of social practice in their own right, for a discursive researcher an understanding of the outcomes of interviews requires consideration of all the features specific to the research interview and how these are reflected in the fine-grained detail of the talk. What this requires on the part of the researcher is, above all, reflexivity as to his/her contribution to the entire process from design of the interaction to participation in the interaction and analysis of the results that have ensued. The extent to which researchers are fully equipped to engage in this process of reflexivity will be discussed later in the chapter.

Research relevance 2: Implications for education and research training in conducting discourse studies

Limitations and variability of education and research training in discourse studies

Thus far we have considered a number of challenges that face discursive researchers who use research interviews to study adult mental health. At the same time, however, we have also seen some of the possibilities that interviews make available, allowing researchers to engage with participants in discussing these issues and to derive findings that meaningfully reflect the interactional aspects of making sense of mental health or ill-health. To arrive at this point requires sensitivity and reflexivity on the part of the researcher. Whereas in other traditions and/or other approaches interviews are commonly treated as little more than procedures for collecting data, this does not hold in discursive research where interactional aspects of research interviews come to the fore, both in terms of participation in this as a form of 'social practice' and in careful analysis of what results from that.

Therefore, one question that we might ask at this point is, to what extent are researchers equipped to undertake such studies? While this might well vary from one researcher to the next, and reflect varying degrees of experience and sensitivity to the subtleties of the approach, there can be little doubt that in order to take the initial steps into what might be viewed as highly unfamiliar territory, those that embark on this journey will require prior education and training.

The extent to which such education and training is available is uncertain. Historically, many of the most popular textbooks on the subject of psychology have had little or nothing to say on the topics of interviewing and/or discourse analysis. For, psychology is often described as a scientific discipline that aligns itself primarily with the conduct of research that uses quantitative methods. Indeed, for some authors, this position still holds, for example, 'Psychology is now defined as a natural science that uses experimental methods to study mental processes and behaviour' (Comer, Gould, & Furnham, 2013, p. 27). Recent decades however have seen an ever-increasing popularity in the use of qualitative methods in the discipline generally. This rise in popularity has led to recognition of qualitative methods as a central part of the discipline, as reflected in the formation in 2005 of the Qualitative Methods in Psychology Section of the British Psychological Society and the formation in 2013 of the Section for Qualitative Methods in Psychology as part of Division 5 of the American Psychological Association. Alongside this, we have seen an ever-increasing number of research method texts that either take qualitative methods as their sole focus or now include coverage of these topics along with material related to quantitative methods.

This growing use of qualitative methods within psychology has, to at least some extent, been taken up in developments in the training and education that universities provide to undergraduate students. For example, in the United Kingdom, The Quality Assurance Agency for Higher Education (QAA) has since 2002 recognised in its benchmark statements the importance of qualitative methods for psychology. In its 2010 benchmark statement, the QAA provides that students 'need to be aware of a range of the new developments in the field, for example, in ... discourse analysis and critical theory'. It also provides that

> 4.8 It is expected that all the following main sub-areas will be covered: ... quantitative and qualitative methods.
>
> 4.9 It should be noted that qualitative methods are understood broadly here, and might include consideration of procedures of data gathering, such as interviewing and participant observation, as well as associated methods of analysis; for example, discourse analysis, grounded theory and conversation analysis.

These requirements have also since 2004 been reflected in the standards set out by the British Psychological Society (2014) for the accreditation of psychology programmes, most recently repeated in 2014. The extent to which and manner in which the QAA and BPS requirements to deliver training and education in qualitative methods are implemented in practice is however less certain. A recent study of qualitative research methods teaching in UK HE psychology departments (Hugh-Jones, Madill, Gibson, Keane, & Beestin, 2012) found that information as to the qualitative methods teaching provided was unavailable from the websites of approximately 50% of 114 departments offering psychology degrees. Of 33 people who subsequently agreed to be interviewed about the teaching provided by their department, a majority reported that training was provided in the use of interviews in collecting data and in the use of discourse analysis for analysing data. What is clear however is that the availability of expertise required to deliver effective education and research training in discourse studies varies markedly across the departments for which data are available. The form and content of education and research training elsewhere remain unknown.

What all of this suggests is that the increasing use of research interviews and discursive approaches within psychology has to some extent been recognised more broadly by those responsible for benchmarking and setting standards for the discipline. These developments have, at least in part, filtered down and led to changes in education and training. Lack of full information and lack of visibility of qualitative methods in university curricula suggest that there might still be some way to go, but there are signs that current provision offers greater scope than existed previously for training students in these methods.

Time demands and time constraints in discourse studies

As will be clear at this point, applying a discursive approach to research interviews in the context of adult mental health can be a time-consuming process. This is necessarily so, given the close and careful consideration that is required to examine the nuances of the data that are collected. In this, however, the topic of adult mental health is not unique: applying discursive techniques to any research interview data will take time. And, just as the conduct of such research takes time, so too does learning the skills involved.

Making available the time required for appropriate education and training presents a specific challenge for psychology departments. In the 2012 study of teaching in UK HE psychology departments described above (Hugh-Jones et al., 2012), those who participated in interviews identified time as a barrier to this teaching. Moreover, the time allocated to qualitative methods teaching varied considerably across departments. For example, all 33 interviewees reported that their departments provided qualitative research methods training at UG2 level. The form and amount of time allocated to this training ranged from online learning (n = 1), to one or two lectures (most typical) to full modules (n = 1). It is interesting to note that interviews comprised the most common element of training in data collection (n = 20), while discourse analysis provided the most common element of data analysis (n = 23). Given however the wide variation in time made available for qualitative methods in itself, it is difficult to be certain of the time provided for either of these (or any other) part of that training.

One development in recent years, however, is education and research training within the curriculum. The upsurge in interest in the use of discourse analysis and similar methods has been accompanied by an increase in the resources that are potentially available to support curriculum provision. Thus, for example, the Teaching Qualitative Methods at Undergraduate-Level Group funded by the UK Higher Education Academy Psychology Network developed a set of interview-based resources (audio and visual interview recordings, complete and abbreviated transcripts) that can be used with or without an accompanying book to support curriculum provision. In a similar vein, the Discourse and Rhetoric Group at Loughborough University made available online a range of their resources designed to support teaching of discourse analysis and related approaches. Other websites and resources are also available. While none of these can properly compensate for a lack of sufficient time being given to these methods within every psychology programme, availability and use of publicly available resources can assist departments in maximising the effective use of the time that is available to them to educate and train students in using research interviews and in developing familiarity with discursive approaches.

Novice versus experienced interview researchers

Finally, a key limitation of conducting research interviews is around the problem faced by novice researchers and supervisors in that research training and research experience cannot fully equip *any* novice researcher to face the possible challenges that may eventuate in the field. Disconcertingly, the constraints on research training and allocated time constitute a problem where few, if not any, solutions can be easily found. Realistically, research training and allocated time simply cannot support the extent of practical experience that is desirable prior to undertaking interviews in the real world. Further to this, given the breadth and depth of issues involved in research interviews, how can we possibly expect a doctoral student – let alone an honours student – to be sufficiently competent to meet these challenges effectively when they go into the field as a research interviewer? In practice, fortunately the various issues that researchers may face conducting research involving interviews do not usually occur simultaneously, and, largely, novice researchers 'get by' and do not violate ethical principles of research. However, researchers who are in the beginning years of the interviewing journey may not participate as fully in research encounter, be aware of the richness of data, or the 'something else' or 'other events', as referred to Griffin (2007) and discussed earlier in the chapter.

Interestingly, postgraduate students' accounts of their concerns, worries, and hesitations in research practice are some of the most pertinent articles about interviewing as a novice researcher. What is noticeable, however, is that the focus of their shared concerns is about the *relationship* between the (novice) interviewer and interviewee. In her analysis of 'voicing the interview', Mallozzi (2009) refers to the 'interviewer–interviewee relational energy' (p. 1052) that she describes as existing on a scale and involving various characteristics of rapport and bonding. Further to this, she highlights the complexities involved in women interviewing women including 'social status', 'self-disclosure', and 'voice'. Similar to Mallozzi (2009), in her reflections on interview pairs that are women, Tang (2002) also focused on the interview relationship arguing that it is not simply the quality of the interview conduct that impacts the power relationship but the different social, cultural, and personal differences that constitute the *dynamics* of the interview.

While frameworks have emerged to support novice researchers, such as Roulston's (2010) typology for novice researchers to learn about quality in qualitative research, it is striking to observe the interest by graduate students in the experiential dimension of interviewing. In terms of the challenges faced by novice researchers, some of these include 'unexpected participant behaviours, dealing with the consequences of the interviewers' own actions and subjectivities, constructing and delivering questions, and handling sensitive research topics', and being confronted by the emotional aspects of interviewing (Roulston, deMarrais, & Lewis, 2003, p. 643). As experienced researchers ourselves, we can strongly relate to these aspects of interviewing and, in many instances, can still recall the experience of conducting particular interviews and interviewees' stories even many years later. For example, one of us (Chris McVittie) conducted some years ago a number of interviews with individuals who were unemployed and registered as looking for work. From the researcher's perspective, the aim of this study was to explore issues of employment and non-employment. It quickly became clear in the course of many of these interviews, however, that the interviewees did not share this aim: rather, their main concerns were with narrating personal accounts of individual problems, family difficulties, and harrowing unforeseen events, all of which had impacted upon their mental health and well-being. One interviewee described her recent problems arising out of divorce and family breakup, life events that put issues of employment or non-employment into a rather different perspective from that of the interviewer. In contexts such as these, previously carefully designed questions have to take second place to the moment-by-moment encounter that is under way. There is little by way of education or training that can equip the researcher for a situation such as this: what is required is continual awareness and sensitivity to the context that has emerged. For a simple summary of the practical implications, please see Table 3.1.

Summary

In this chapter, we have critically discussed the research interview in adult mental health by drawing on key considerations about interviewing generally and also specifically related to discourse studies. In doing so, several areas have been

Table 3.1 Research practice highlights

1. The use of the research interview in adult mental health involves researchers' consideration of epistemology, issues of power, and local contexts in the production of 'data' and analytic claims.
2. One particular consideration for researchers is how adults account for mental health and ill-health, and the role of the researcher in producing such accounts, within the research interview.
3. Constraints on research training and allocated time means that it is unlikely that novice researchers can be fully prepared for what they may face 'in the field', therefore, self-directed additional study and practice to develop interviewing skills is recommended.
4. Notwithstanding the challenges involved, research interviews provide rich opportunities for exploring issues related to adult mental health provided that researchers are aware of and sensitive to the features of the interview context.

highlighted, including the importance of epistemology, power, local contexts, the constitution of adult mental health as moral discourse, and the constraints on research training. The journey of the qualitative researcher who chooses to use the interview is one that involves immense scholarly, practical, and ethical challenges. As experienced qualitative researchers and discourse analysts, we can strongly relate to what may appear to the novice researcher, as well as some experienced researchers, to be the enormity of this research practice. However, in many instances, the problems and challenges that have to be overcome may not even be realised, and it is only during the journey and many years later that the realisation of the complexities of interviewing/engagement with people 'in the field' unfolds as learning about our practice also evolves. We would like to conclude this chapter by making clear the view that interviewing is a privilege, that it has the potential to reward researchers both professionally and personally, and that, above all else, it is a practice best informed by both ethics and compassion.

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4

Inclusive Conversation Analysis with Disabled People

Val Williams, Marcus Jepson, Lisa Ponting, and Kerrie Ford

Introduction

Disability Studies (DS) approaches lie at the heart of this chapter, which concerns itself with an analysis of interactions in which people with the label of intellectual disabilities (ID) engage with social care workers. An intellectual disability, by definition, is a lifelong impairment, which involves cognitive limitations as well as difficulties with social functioning, and coping with everyday life (Emerson & Heslop, 2010). However, the category is very broad, differentiated, and often blurred (Williams, Swift, & Mason, 2015), and there are strong reasons for avoiding a prior impairment-related definition. In Disability Studies, the very notion of disability is critiqued and questioned, with social model adherents following Oliver (1990) in viewing disability as the product of a disabling society which fails to include disabled people. While not denying the embodied reality and impact of impairments on the individual (see Shakespeare, 2006; Shakespeare & Watson, 2001; Thomas, 2004), this chapter is simply more interested in the way in which categories of disability emerge from particular social circumstances, contexts and interactions. In conducting the research, we have worked closely to include people with the label of ID as active participants in the research process, and we aim to explore some different ways in which this can be achieved in research about interaction.

In common with other chapters in this volume, we use conversation analysis (CA) (see Lester & O'Reilly, Chapter 1, this volume) to examine naturally occurring data (Ten Have, 2009; Wooffitt, 2005). CA is rarely used in disability studies, and yet the two areas of study are well matched, since this type of analysis can reveal how disability itself is reinforced in the flow of talk. The essential tool for analysis is the turn-by-turn examination of talk, looking for evidence as to how each speaker has taken the previous turn and how mutual understanding is maintained. As with other forms of 'institutional CA' (Heritage & Clayman, 2010), the analytic interest turns towards inequalities in the distribution of turns, the types of turns taken, and what may be done with those turns by various parties in the talk. This is a particularly useful approach for examining the interactions of adults with disabilities (Antaki, Finlay, Walton, & Sempik, Chapter 31, this volume).

Unusually for CA, the current chapter is also framed by an inclusive approach to research; indeed, the chapter is written inclusively, with people with intellectual disabilities as co-authors (Ford & Ponting). A word or two are in order then about what we mean by 'inclusive research'. Disability Studies are strongly associated with an 'emancipatory' paradigm in research, where disabled people themselves define their own theoretical stance, and where research is controlled by people representing the disability movement (Oliver, 1992). People with ID however were not at first included in these notions of emancipatory research, and the strides they took towards joining the research community took place largely because of support from non-disabled allies (Chappell, 2000; Walmsley, 2001; Williams, 1999). Nevertheless a large movement of what is often termed 'inclusive research' involving people with ID now exists (Bigby, Frawley, & Ramcharan, 2014; Walmsley & Johnson, 2003), and encompasses a wide variety of different formats and models (Marriott & Williams, 2011; Nind & Vinha, 2014), including team approaches as in the current work, where people with ID are supported to initiate their own ideas and to take on active roles as researchers. In summary, inclusive versions of conversation analysis aim to involve people with ID, not just as objects of our gaze but also as co-producers of knowledge.

Examining data from three different sources, our focus in this chapter will be on interactional contexts which are ostensibly about people with ID exercising 'choice and control'. This liberal principle of individual autonomy lies at the heart of the policy shift towards personalisation in English social care (Lymbery, 2012), but can be contentious in practice when applied to people with ID. We therefore bring in here the voices of Lisa Ponting and Kerrie Ford, our co-authors, who are people who have the label of 'intellectual disability'. What do they feel about making their own decisions? Lisa and Kerrie both feel that making choices is good, even if you make a bad choice, because you learn from it. Taking control of your own life is much better than relying on other people. You've got to make mistakes in order to learn from them. However, there have long been concerns that some groups of disabled people fall short of the ideal of an 'autonomous citizen' (Dowse, 2009; Redley & Weinberg, 2007) and that they will need greater levels of protection and support to become involved in decision-making (Goodwin, 2011; Kendall & Cameron, 2013).

What is of interest here is to see how these tensions about power, identity, and choice play themselves out in the ebb and flow of talk. In this chapter, we will explore different ways in which people with the label of ID have been actively involved in collecting data, advising research studies, and in creating research impact by applying findings to their own lives. In Lisa Ponting's own words, ‘We can get the inside of what they’re saying out’. This chapter will examine some of the ways in which this may happen, and the resulting effect on the analysis about the interactional accomplishment of ‘choice and control’.

Overview of projects

We draw on three studies in this chapter, which are outlined in Table 4.1.

All three studies received ethical approval, the first and the third from national research ethics committees, since they included arrangements under the Mental Capacity Act to include participants who lacked capacity to consent to the research. All three also developed accessible and iterative forms of informed consent to ensure people were aware of the use of their data in video formats, especially when that data were taken forward into training materials as in ‘Skills for Support’.

Who decides?

Consideration of whether or not a person has made a ‘bad’ choice is of particular significance for people with ID, as we have mentioned in our opening remarks, and this has been brought to prominence in England and Wales under the Mental Capacity Act (MCA). One of the key principles of the MCA is that a person’s capacity to make a decision is not to be judged solely on the basis of the supposed wisdom of any decision that they make. In the language of the MCA:

> A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> (Mental Capacity Act, 2005. Part 1,1 [4])

Our first extract features Miriam – a woman with an ID, and Wilf – her personal assistant (PA). They are in Miriam’s flat, preparing a shopping list for the week ahead.

Extract 1

```
 1  Wilf  err Saturday what would you like for your lunch
 2  Mir   (3.0) ((Miriam shrugs after 3 seconds))
 3  Wilf  do you like beans on toast↑ (0.8) or another sort
 4        what about a sandwich o:r what kind of things do you like
 5  Mir   po chop
 6  Wilf  pork chops↑
 7  Mir   yeah
 8  Wilf  you could have that as your dinner one evening
 9        what about Friday evening you could have pork chops for
10        dinner
```

Table 4.1 Three studies

	Who Decides? 2008–2011: Jepson (2011)	**Skills for Support 2004–2007: Williams et al. (2010)**	**Support Planning in Practice 2010–2012: Williams and Porter (in press)**
Funder and scope of study	PhD study funded by Economic and Social Science Research Council	Partnership study in four UK sites, with disabled people's organisation, funded by the Big Lottery	Five site study, across England, funded by the School for Social Care Research.[1]
Goal	To examine how the Mental Capacity Act was being applied in everyday interactions with people with ID	To analyse what made 'good support' at the interactional level, from the point of view of people with ID	To find out how support planning is conducted with personal budget users with complex needs.
Data (only the naturally occurring data are mentioned here, as that is the focus of this chapter)	Nine hours of video data of discussions focusing on everyday choices	Over 20 hours of video data of people with ID interacting with support workers during everyday routines	Just over four hours of audio recordings from four support planning sessions, involving person with ID, worker, and parent.
Involvement of people with ID	Participants offered opportunity to review data	Two people with ID employed as researchers. They collected data, selected extracts for analysis, and commented on the analysis.	Five people with ID reviewed parts of the data, to recommend own solutions to interactional problems.
Products with people with ID		Training pack with DVD, showing clips of original data with commentary from team members with ID (Ponting et al., 2010)	DVD based on scenes role-played by people with ID and social work students, to help people with ID understand support planning (details from lead author)

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[1] The School for Social Care Research (SSCR) is part of the National Institute of Health Research in England, and is the major national funder for research about social services. The views expressed in this chapter are those of the authors, and not necessarily those of the SSCR.

The first part of Extract 1 follows the typical sequential progression seen in much of the 'Who Decides' data, and these opening steps provide a context for what is to follow, with Wilf introducing the decision-making act in line 1, Miriam displaying a sign of interactional trouble (although not necessarily a lack of capacity to make the decision) in line 2, and Wilf attempting to resolve the interactional trouble in his next turn.

In response to a question about 'what kind of things' she likes, Miriam responds in line 5 with a response interpretable to Wilf as 'pork chops', which Miriam confirms in her next turn. It is interesting at this point to note the way Wilf subtly appears to both endorse the suitability of 'pork chops' as a meal choice for Miriam but also reject it as suitable for lunch on Saturday; the meal decision-making act which he had initiated in opening this sequence. Instead, he makes a counter suggestion to Miriam, 'you could have that as your dinner one evening'.

We will now look at how this exchange progresses.

Extract 2

1	Wilf	yeah? we can buy some pork chops *((writing))* pork chops
2		pork chops what would you like with the pork chops
3	Mir	mash
4	Wilf	and mash pork chops and mash er:m so-
5	Mir	and two mash *((holds 2 fingers up))*
6	Wilf	two mash
7	Mir	yeah
8	Wilf	so buy some potatoes to make mash
9	Mir	mmm
10	Wilf	what about some vegetables
11	Mir	*(exhales)*
12	Wilf	don't forget those like little frozen packs of vegetables
13		(.) peas or something
14	Mir	I'm not too not too keen
15	Wilf	not too keen on vegetables?
16	Mir	no
17	Wilf	what about erm gravy or something with them
18	Mir	*((shakes her head))*
19	Wilf	no? (.) sweetcorn?
20	Mir	*((shakes her head))*
21	Wilf	peas?
22	Mir	*((shakes her head))*
23	Wilf	carrots
24	Mir	*((shakes her head))*
25	Wilf	nothing like that *((both shake their heads))* okey dokey

Between lines 4 and 8, Wilf and Miriam establish that she will have 'mash' with her pork chops, understood by both parties as mashed potato, with Wilf then reporting the need to 'buy some potatoes to make mash'. Hereafter, Wilf introduces a new suggestion for inclusion with the meal, asking: 'what about some vegetables' in line 10. Miriam's immediate reaction is to display an indication of trouble with a long exhalation of air in line 11. Wilf persists with the idea of vegetables, reminding Miriam about 'little packs of frozen vegetables' which he embellishes adding a suggestion of 'peas or something'. Miriam gives a dispreferred response (Pomerantz, 1984) in line 14, which could relate to either peas or vegetables in general. However, following Wilf's checking turn in line 15, Miriam's response is unequivocal: she is not too keen on vegetables. It is perhaps unusual therefore, that after Miriam rejects 'gravy or something...' as an accompaniment to her pork chop and mash Wilf suggests an alternative type of vegetable in each of his three self-initiated turns that follow in lines 19, 21 (particularly notable as he suggests 'peas' again here), and 23.

In this interaction, Wilf has twice undertaken to influence Miriam's decision. In the first instance, he has successfully taken Miriam's selection of pork chops as a meal preference and subtly transferred it from a possible lunch on Saturday, to a dinner choice on Friday evening. Wilf may consider 'pork chops' to be an inappropriate meal for a (Saturday) lunchtime. This assertion may be supported by looking back towards the start of this exchange and Wilf's initial introduction of 'beans on toast', or 'a sandwich'. Perhaps he has considered these 'snack-like' meals choices more appropriate for lunchtime.

Secondly, and less successfully, he goes to great lengths to persuade Miriam to select a vegetable to accompany her meal. Once more there was no explicit statement as to why he might consider it a good idea for Miriam to have vegetables. Plausibly he might have suggested that 'it's considered healthy to have vegetables'. However, without any such qualification the sequential progression could be viewed as Wilf ignoring or disregarding Miriam's stated wish – effectively a decision on her part – to not have vegetables with this meal.

What did Miriam herself make of this video? When we replayed this clip to her and to Wilf, the session resulted chiefly in Wilf reflecting on his actions. Miriam herself enjoyed seeing her data, but her contribution to the 'meaning of choice' was made chiefly through what she did during the actual interaction. Not only did she verbalise the fact that she was 'not too keen' on vegetables, but she actively maintained her resistance to Wilf's several persuasive attempts between lines 17 and 25. Thus, an active strategy of resistance is one important way in which a person with ID can assert their own autonomy. As Lisa and Kerrie remarked earlier, the right to make mistakes, or to make a 'bad choice', is important. However, if we want to include the voices of people with ID in shaping these ideas, then we clearly have to go further than enabling them to revisit their own data. That may be the first step, but in the next section, we will explore a more fully 'inclusive' approach to the research process itself.

Skills for Support

Extract 3 is one of several chosen from our 20 hours of video data by Lisa and Kerrie, co-researchers on 'Skills for Support'. In this part of the video, Fred's personal assistant (PA, or support worker) is seen sitting close to him, on the sofa in his flat. He is composing a letter to send to his aunt, and his PA, Penny, is helping him by writing down what he wants to say. As they are doing that, they mention the lunch club where Fred goes regularly, and Penny makes a joke about everyone coming to the lunch club with Fred. Then, the following snippet of conversation ensues:

Extract 3

1 Pen we'll all come (LF) what did you have today (.)
2 *((looks up towards N, who is looking at letter))*
3 Fre cottage pie
4 Pen mm (.) ooo (.) shall we put that down .hh do
5 you want to write that↑ (3) yeah no
6 Fre mm er
7 → Pen (LF) you don't have to (1)*((looks at N again))*
8 Fre °good°
9 Pen yeah
10 Fre I think (he) not interest what you get
[Video extract can be seen on Ponting
et al., 2010: 'Choices']

Kerrie Ford and Lisa Ponting originally picked out this extract because they felt that it was about a support worker helping someone to get more 'confident'. The extract features on the training DVD (Ponting, Ford, Williams, Rudge, Francis, 2010) which they produced, and on it, we can see Kerrie and Lisa watching the film. As they say on the DVD, 'we are doing this project to make the support better for everybody, so that they do have choices'. They point out that Fred had lived previously in a long-stay hospital, and like many others, he was used to being told what to do, rather than choosing for himself. It was therefore important that he had asked his PA to help him write the letter, and Lisa says: 'In that way, it's a good communication'. They also comment on the body language and particularly the close physical proximity of Penny and

Fred, sitting within touching distance of each other. Kerrie comments on the DVD that she would find that closeness intrusive ('I would be, get back!') but admits that everybody's different.

What of the talk itself? Lisa points out that the support worker, Penny, asks questions of Fred, and she characterises these as 'prompts' which help him through it, 'because sometimes you get stuck on various words'. From a CA perspective, the extract is a clear example of a couple of linked adjacency pairs, with the first part in each pair offered by Penny (lines 1 and 4). Although both these turns are formulated as questions, they do very different things: line 1 is a question which succeeds at eliciting a preferred response, when Fred supplies the information that he had 'cottage pie' today. Penny then uses that information, in order to formulate her subsequent, very positively tilted question, 'Shall we put that down?'; with pen in hand, she is clearly suggesting that she could write about the cottage pie in Fred's letter to his aunt. That too seems to be how Fred takes the suggestion, as he is looking down towards the letter throughout this extract. However, there is a three-second pause, followed by some hesitation as Fred says 'mm' and 'err'; from the evidence of line 7, 'you don't have to', it seems that Penny has taken Fred's hesitation as meaning that perhaps he disagrees with her suggestion, and so she swiftly mitigates her proposal, foregrounding Fred's right to choose.

This extract was included in our DVD, partly on the basis that it was picked out by Kerrie and Lisa, but also because it was typical of a pattern in the data, where support workers specifically foregrounded 'choice making' as a right, something that the person with the label of ID should engage in. This frequently happened after the person had hesitated (as here), had appeared to accept a suggestion too readily, or had sought advice or guidance about what to do. This strategy suggests that, without their reminder about choice, Fred would be likely to defer to others' decisions and to seek direction rather than exercise his own autonomy. There is ample evidence elsewhere that this assumption is well founded, with people routinely deferring to their support workers, seeking approval for their own actions, and showing that they expected their staff to take responsibility for decisions. In the 20 hours of data we collected, it was rare for a person with the label of ID to initiate and choose a course of action which they defended and insisted on. Although Lisa and Kerrie, like other participants in the project, assumed that choice was important, they were quite shocked when they engaged with the videos which showed how rare choice making really was.

One of these rare examples is given at length in Williams (2011, pp. 99–100), where Charles is trying to organise a party. He wants to hire a hall, which could be expensive, while the manager of his services is trying to offer a counter-suggestion of a more informal and cheaper option with a friend who would run a disco within the service setting. Like Miriam and Fred, Charles actually sticks to his own plan, and the extract finishes like this:

Extract 4

1 Sue um you know you're probably talking about 50 or 60
2 [pounds all in so-
3 Cha [yes OK yeah
4 Sue that's a lot cheaper
5 Cha alright
6 Sue I'll leave it entirely up to you
7 Cha OK I'll see what happens and I'll let you know
8 any changes I'll let you know
9 Sue all right Charles
10 Cha nothing to it is it
11 Sue absolutely right Charles *((shakes head, smiling))*

Sue presents Charles with the information about costs in line 1 of Extract 4, and underlines that the option she suggests is 'a lot cheaper'. However, instead of conceding to her, Charles simply says 'alright', and it is at that point that Sue issues the familiar focus on choice making: 'I'll leave it entirely up to you'. Framing the person with ID as an independent choice-maker is a common tactic for support workers, but the take-up by Charles in lines 7–8 is rare. Not only does he take on the responsibility for making the decision, but he offers to put his plan into action and let Sue know 'any changes'.

Doing choice-making turns out to be not simply a matter of one person offering options and another person choosing between them. Instead, it is very tightly interwoven with the construction of an ID identity. Even Charles acknowledges that his right to decide on his party is 'noteworthy', as he comments in line 10, 'nothing to it is it', implying that he is countering the assumption that choice-making may be difficult. One can speculate that his service manager might well have felt that what was at stake here was Charles' ability to make a sensible decision about budgeting his money and spending a large amount on a birthday party (Williams, 2011). Sue follows the routine tack of agreeing and encouraging Charles' decision-making in Extract 4, but then immediately switches to a protective mode of talk, warning Charles of the likely consequences, and proposing a far more 'sensible' solution for him.

What then did we make of this sort of debate in the 'Skills for Support' project? One of the points Kerrie and Lisa make on the DVD is that support workers should be there to advise and guide people like themselves, but that this advice and guidance should be given to people only when they ask for it. In order to make their point, the DVD also contains 'stories from the past' to illustrate problematic encounters and bad practice among support workers, chosen by Lisa and Kerrie from their own experience. One of those stories shows two women with ID having a drink in the living room; when they ask a support worker to open another bottle for them, the worker refuses, and says that they have had plenty to drink already! She goes further in complaining that it is not her role to sort out the drinking habits of another person, who she is not paid to work with. While this is a fictional scene, nevertheless, the themes on which it is based would be familiar to anyone working in this sector. Do support workers have a duty of care, and thus should they prevent service users making bad, or unwise, choices? The Mental Capacity Act would say that the women's choice to get drunk should be respected, unless they lack capacity. However, the notion of capacity is at best a blurred one (Williams, Swift, & Mason, 2015). Further, does the support worker's responsibility extend to people beyond her 'charge'? There are frequent debates about professional boundaries in the support worker role. Yet, Ponting et al. (2010) challenge support workers to see the task of support from the point of view of service users themselves. In the introduction to the section on 'Advice', Andy Pullin (Ponting et al., 2010) comments on how he sees his own right to choice and advice

> [m]ake choices, be independent, what stuff you want to do and you can talk to the PA, if I needed any help with anything. And if they're there, and I'm doing anything stupid, they'll advise me on that.
>
> [Ponting et al., 2010: Advice section of DVD]

In the 'Skills for Support' project, we pushed the limits of this team approach to research. Instead of making assumptions about what the PA role entailed, we developed ways of listening to the views and explanations of people with the label of ID. They did not carry out a detailed CA analysis, yet their comments helped to guide the questions we pursued. What, for instance, does it mean to 'make choices' and 'be independent'? More subtly, how is advice given, and what happens if someone makes a bad choice? Some of these questions were explored further in the very different context of the audio data from support planning meetings in our final project in this chapter.

Support Planning in Practice

The policy of personalisation in English social care is enacted chiefly via the mechanism of a personal budget, which is intended to give people choices about how to manage their social care funding and to plan what types of support they would like, in order to meet their agreed 'outcomes'. That is the activity known as 'support planning' (DoH, 2008). However, some citizens may be assessed as lacking capacity to consent (specifically to a direct payment), and thus are assigned a 'suitable person' (DoH, 2009), normally a family member or close friend who will act in their best interests. Both the people who took part in recordings of support planning sessions in our study were in that situation. Although they were both encouraged to discuss low-level choices, their parents would have had the final say over allocation of budget. Thus, the talk in support planning sessions was conducted between three parties: a practitioner, the focal person with ID, and a family member. We have considered elsewhere the supportive strategies used by family members, and the resultant shape of these three-way conversations (Williams & Porter, 2016). For the purposes of this chapter, we are interested in just the few rather problematic stretches of talk, where the parent's interventions ran counter to the expressed wishes of the person with ID. For us, they raised some questions about how we interpret data like this, and what implications the data may have for different parties in the talk – including for people with the label of ID.

First, a short extract from 'Kia's' support planning session, to illustrate some of the lengths these practitioners and family members went to, simply to foreground choice and to encourage participation. In Extract 5, Natalie the support planner was trying to encourage Kia to choose photos to display in her support plan. Kia however is unresponsive:

Extract 5

```
 1  Nat  ookay↓ well ehmm have you seen this Kia (2) you
 2       haven't seen this one have you I've got a
 3       [picture quite a few pictures here that's
 4       an old one
 5  ?    [LF
 6  Nat  like (.) this one I took like (.) when I first met
 7       you that photo in the car I can't remember
 8       where we were going
 9     ((gets up during this, takes photos over to kneel
10       by K's side, shows them to her))
11  Mum  o:h yeah we went for a milkshake didn't you=
12  Nat  = yeah (.) erm (.) so that that's a really old one
11       but that's (.) em Liverpool isn't it=
```

From lines 1 to 8, Natalie does several things to bring Kia into the conversation; she uses her name in line 1, she asks her a tag question (which should produce a 'no'); she refers to photos which she is sorting through (and which feature Kia herself), and she does 'forgetting' (Goodwin, 1987), a device that privileges Kia's knowledge. Despite all this, Kia does not answer, and her mum aligns with Natalie's efforts at line 11, with a second part turn that both deals with Natalie's 'not knowing', and then turns it back to Kia with a 'didn't you'. In Heritage's (2012) terms, Kia's mum exercises an epistemic privilege over Kia's affairs, and she uses this close personal knowledge to do a prompt; as Bolden (2012) explored, language competence and incompetence can be exposed via this type of repair activity, undertaken by parties who know each other well. Given Kia's silence, it is all too easy for the other two parties to start addressing each other, and there is certainly a danger of that at the end of this extract. Despite all this, choice is clearly on the agenda here, and there are many other examples in these data of family members promoting choice and supporting their relative to say what they want, doing subtle repair work, anticipating support needs, and clarifying their relative's turns.

Once the third party in these interactions has a turn, they can use that slot to start challenging what their relative is saying. One particular conflict in support planning is given in Extract 6, where a young man, 'Karl', is meeting with Simon (a social worker) with his mum Asma to review a plan for his placement at a day centre. Extract 6 occurs at the point where Karl intervenes and disrupts matters by stating that he wants to go to the same place as his girlfriend.

Extract 6

```
 1  Karl  I want the same place (as) Shirley before
 2  Si    Shirley
 3  As    °no Shirleys not going to the same place Karl
 4  Si    eerr I don't know who Shirley is is that a friend
 5        of yours
 6  Karl  it's my girlfriend =
 7  Si    = your girlfriend↓ and where does she go to I
 8        thought the last time we met you had a girlfriend
 9        - a new girlfriend at college did you not
10  Karl  °no°
11  Si    = no
```

Following Karl's words his mum's quiet instruction at line 3 comes over very much as a repetition and a reminder to Karl, building on a shared understanding between herself and her son about this matter. His talk about his girlfriend has clearly been rehearsed within the family, and so his mother is 'knowledge plus' about Karl's affairs. In a sense, this closeness can be seen as a type of epistemic trap, from which it is hard for Karl to escape. Simon the support planner is however knowledge deficient about this matter, and so his question in lines 4–5 about the identity of Shirley gives Karl an opportunity to upgrade his claim to be together with Shirley, using the term 'girlfriend'. However, Simon subsequently starts supporting the family position, by questioning the long-term status of this girl – maybe Karl was swapping from one girlfriend to another rather rapidly. That at least is how Karl takes it, with his denial at line 10.

There follows an extended sequence of persuasion where Karl is reminded of the many benefits of the day centre, which sounds very much like a top-class leisure and sports club. Finally, Karl concedes that he remembers visiting the day centre, and has seen a swimming pool there. This detail is taken as confirmation of his agreement to go there, and the girlfriend is not mentioned again.

Karl's dilemma stood out from the rest of the data about support planning. Although they were not frequent, conflicts were interesting, since they underlined the limits of 'choice' for both Kia and Karl. Rather than leave the analysis where it stood, the questions in our minds were 'why does this matter?' and 'to whom does this matter?' The first author therefore took these extracts to a small group, which included Kerrie Ford and Lisa Ponting. After reading through a slightly simplified version of the transcript, we allocated roles and played the different parts, pausing to ask the group members what could have happened differently. Extract 7 occurs at the point when the group are role-playing Karl's problem about his girlfriend, with Val taking part:

Extract 7

1	Ker (playing mum)	ok no shirley's not going to the
2		same place
3	Val (playing Karl)	why:: (2)
4	Ker (playing mum)	why (0.5) I don't know Karl
5		shall we ask Shirley ourselves (1)
6	Val (playing Karl)	but Shirley's not here (1.5)
7	Ker (playing mum)	we could perhaps phone Shirley's
8		carers and ask them why

The point made by group members in this exercise was that Karl bore some responsibility himself for challenging what was happening in his support planning meeting. They first suggested that he needed an advocate, and that he should stop the meeting until he had one there. They then thought about the possibility of challenging Karl's mum, in the way played out in Extract 7. Interestingly, instead of Karl's mum being in possession of the facts about her son's private life, the challenge posed by Karl at line 3 puts her in a position of relative ignorance: in this role-played version, she does not in fact know about Shirley's decisions, and admits this, following up by a suggestion to ask her. This effectively introduces another set of conversations with Shirley and her carers, which has not yet taken place, but which might have a bearing on Karl's own decision. We felt that this suggestion was particularly important because it played precisely on the analytical point about 'who knows what' and the power of finding out and being in possession of insider knowledge.

Following our role-play session on these extracts, the same data were presented at two different seminars, where other research colleagues, practitioners and family members were present. Although the data from those sessions were not recorded, it is fair to say that none of these people reacted in the same way as the group of people with the label of ID. It was pointed out, for instance, that a support planning meeting does need to follow an agenda, and the issue about Karl's day centre placement was important, and had already been pursued in previous meetings. Therefore, his objections were not useful at this point in time. Further, his mother was acting as a good advocate for him, effectively speaking up in Karl's 'best interests'; given that he would lack capacity to make this big decision in his life, he would clearly need some guidance here. In fact, elsewhere in the data, Karl's mother had explained to Simon that Karl often pursued random, spontaneous lines of conversation and had great difficulty in really 'answering the question' or understanding the import of what was going on.

It seems therefore that there is never an absolute answer to 'what matters' in the data, however much we can deploy the neutral gaze of the CA analyst in working out what is going on in the talk. In fact, the repeated discussions on this extract led us to the conclusion that we should question some of the premises behind Karl's dilemma. The conflict in this extract is based on the fact that it is assumed that a relationship with a girlfriend or boyfriend can only be pursued in the context of a common day centre placement. However, most of us would question the wisdom or necessity to work in the same place as a partner on a daily basis! It was this idea that was taken forward into the final product from this research, which was a DVD entitled 'How to Speak up about your Support Plan', acted out by group members, together with social work students. Instead of being forced into a day centre placement, in the DVD the service user chooses to attend part-time, and to see their partner on a different day of the week.

Practical relevance summary

This chapter set out to explore the different ways in which our understanding of interactional data could be enhanced by the inclusion of people with the label of intellectual disabilities. Therefore, the first point of practical relevance relates to the way in which we can productively include people with this label in the research process itself. Three different modes of inclusion have been explored; firstly, in the 'Who Decides?' project, it was clear that simply taking back data to the participants does not always draw out a considered or revealing response. People may be interested and engaged in re-exploring the issues they pursued in the talk, but in our case, participants in 'Who Decides?' did not really offer further insights through this method. By contrast, the 'Skills for

Support' project offered two people the opportunity to engage over a period of time as analysts of others' data. Although they could not be seen as technical CA analysts, nevertheless they did engage in some detailed noticing, tracking back over DVDs and thinking in detail about the exchanges. As Lisa Ponting remarked earlier, 'We can get the inside of what they're saying out': because of their own positioning, it was possible for Kerrie and Lisa to offer some guidance and direction based on the perspective of people with the label of ID.

The second area of practical relevance in this chapter relates to the actual findings of the three projects. All three projects produced detailed knowledge about how support interactions could be more effective in enabling people with ID to engage with everyday tasks in a more 'autonomous' manner. However, all three emphasised the fact that this autonomy is not an individual matter, with people abandoned to their own resources to make an isolated, individual decision. By contrast, the whole point in 'Skills for Support' was about relational decision-making and the emergence of decisions from sensitive interaction (Williams, Ponting, Ford, & Rudge, 2009a, 2009b, 2010). This chimes very much with the turn towards ideas of relational autonomy (Wehmeyer & Bolding, 2001); Kerrie Ford and Lisa Ponting defined five outcomes of good support in their lives, which they listed as 'respect, choices, friendliness, advice and support to speak up'. These headlines are used as section headers for the practice DVD which they produced (Ponting et al., 2010), and in respect to choices, for instance, practitioners are urged to consider practical ways to allow people with ID to access information which they will need in order to manage their lives. Guided by Lisa and Kerrie's comments, we can conclude that it is helpful for support workers to set out the nature of the choice to be made, intervene only when asked, and define the issues together with their conversational partner.

The third and final way in which this chapter contributes to practice is through its consideration of the varying perspectives on defining a successful outcome. The final project discussed here, 'Support Planning in Practice', challenged us to think afresh about the validity of different points of view. In the end, there is no objective way to decide how an interaction can be most effective, since that effectiveness can be challenged from the point of view of the different social actors involved in it. Interventionist CA (Antaki, 2011) must thus be cautious since it often positions itself on the side of the practitioner, assisting with the accomplishment of tasks such as the personalisation of jobseeker interviews (Toerien, Irvine, Drew, Sainsbury, 2011) or an appointment in an audiology clinic (Egbert, 2011). What one party wants from an encounter might be different from another. From the professional point of view, these encounters were matters of balancing the viewpoints of several parties, notably the family and the service user. However, the suggestions made on our practice DVD, based on the insights of Kerrie Ford and others, included the fictional

Table 4.2 Disability studies and social care practice highlights

1. Interactions with support staff are key to the everyday experience of people with intellectual disabilities. Relational autonomy for people with ID depends on having respect, choices, friendliness, good advice and support to speak up. People with ID who want to train their own support staff can use the training DVD produced by Ponting, et al. (2010), available on Youtube.
2. With forward planning and funding, researchers with ID can be selected and supported to take on meaningful roles in the study of interaction. This requires enough time, support roles in a study, and a flexible research design. Video data are generally accessible, and a team approach to the research enables the insights from conversation analysis to be discussed within a mixed team. More details about the process of inclusive research are given in Marriott & Williams (2010) and in Williams (2011).
3. People with ID who are developing their own support plan for social care often have a family member present at meetings. The success of the interaction depends on how the family member's self-selected turns are taken up by the practitioner, who can treat those turns as prompts, clarifications, or support. Allowing time for good preparation of the person with ID is as important as managing the meeting, and the 'knowledge deficient' or naïve stance of a practitioner can be effective in enabling the person with ID to reach a considered decision.
4. The success of a social care interaction may be seen differently from the point of view of service users, family members and practitioners. It is helpful to take back key extracts of data to representatives of these different groups, and using role-play techniques, to work out possible solutions to the interactional problems. The outcomes of one attempt to do this can be seen in the DVD 'Speaking up about your support plan'.

person with ID using her tablet computer to plan her life and discuss it with others before her encounter with the social worker. The conclusion was that it was important to take time for preparation, obtaining advocacy and challenging the 'knowledge plus' status of the parent. For a simple summary of the practical implications, please see Table 4.2

Summary

Research that offers a focus on the detail of everyday interaction helps us to discover much about how categories such as intellectual disability are constructed in the live to-and-fro of talk. However, if we are to move beyond the academic understanding of discourse, into debates about practice, this chapter has suggested that we need to engage more with those who are most affected by those practices. By that very engagement, we change the terms of the *research* interaction, as is explored in Williams (2011). Instead of being the respondent, Lisa and Kerrie took on the interactional rights to ask questions, determine the agenda, and decide what counted as relevant data. These are powerful things to do for people whose lives and identities may have been defined by being treated as interactionally incompetent (Antaki, Walton, & Finlay, 2007; Williams et al., 2009b). Therefore, through their inclusion in research, people with intellectual disabilities can and do challenge and change the very terms of reference which define their own status as people with intellectual disabilities.

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5

The Discursive Construction of Drug Realities: Discourses on Drugs, Users, and Drug-Related Practices

Benno Herzog

Introduction

Drugs are substances, that is, material realities with specific, describable chemical characteristics. Therefore, it is unsurprising that the scientific literature about drugs is dominated by bio-medical viewpoints. This scientific literature is based upon 'hard facts', chemical or neuronal reactions independent of the researcher's viewpoint, and – of course – not the result of discourses. However, discourse and discourse analysis encompass more than text and talking. Discourse analysis can be used to better understand even apparently 'objective' realities.

The concept of 'discourse' as it is used here refers to a structured and institutionalised approach to speaking that has creation rules that can be identified and become the object of social analysis (Foucault, 1972, 1981; Link, 1986). These rules limit and structure how subjects use language. In the sociological discourse model, it is assumed that discourses and non-discursive reality (e.g. social action or institutions) influence each other. Discourse theory describes *how* social realities are constructed and allows researchers to use *discourse analysis* to study this process and analyse the results.

Therefore, reality is no more considered in singular as if social researchers expected to discover only one 'objective' reality. Rather, we must disentangle diverse discourses about the same object and recognise the different realities of different social groups. However, this does not mean that there are as many realities as subjects. Social perceptions are usually shared by members of a group. Moreover, there are often hierarchies and hegemonies that make one discourse or interpretation of social reality dominant. However, the discursive approach has a limitation; namely, it causes social researchers to focus on the dimension of reality that is constructed through discourse (Keller, Hirseland, Schneider, & Viehover, 2005, p. 8).

This limitation leads us to ask, 'What aspects of social reality are *not* constructed through and by discourse?' In the last two decades, scholars have offered various answers to this question. It might be helpful to elucidate the extreme positions in this debate. Ernesto Laclau and Chantal Mouffe (1985) assert that everything is discourse or, more precisely, that objects cannot constitute themselves outside of discursive conditions. In other words, although many phenomena may exist independent of discourses, they are already included in the discursive game when we constitute them as objects of knowledge. At the other extreme, some authors argue for a clear differentiation between the discursive and the non-discursive (e.g. Fairclough, 1992; Wodak, 1996). These authors, most of whom have linguistic backgrounds, typically focus on language and its use when conducting discourse analysis. Therefore, especially in the Anglo-Saxon world, 'discourse analysis' and 'conversation analysis' are often synonymous, whereas in the sociological, Foucaultian tradition, there are clear differences between the two.

In what follows, I do not engage in this scholastic debate. Nevertheless, for *analytical* purposes, I assume a distinction between discourse and non-discursive reality even though in practice it seems impossible to clearly differentiate these concepts. I understand materialities, such as material substances in the case of drug realities, as part of a non-discursive reality. Actors and their identities (e.g. an addict or drug user) are also considered part of a non-discursive reality. Furthermore, practices are treated analytically, in contrast to discourses. However, these three aspects of non-discursive reality must be understood in relation to the study of language and discourse. Analysing discourses in the field of drug realities therefore requires analysis of both language and non-discursive realities. Discourses must be understood in the context of actors, practices, and materialities. The characteristics and effects of these discourses extend beyond the academic analysis of language. Discourses not only represent the world; they give it meaning and signify it (Fairclough, 1992, p. 64). For example, there are several discourses related to drug consumption. Although judiciary and police discourses of criminalisation and rejection are prevalent in social representations of drug users (and indeed many other types of mental disorder, see Auburn et al., Chapter 32, this volume), there is also a relationship between drug dependence and concepts of illness, weakness, and the need for help. This relationship leads to discourses with medical-sanitary and socio-cultural frameworks (Berjano Peirats, Pons Diez, & Llopis Goig, 1996; Romaní, 1997).

The concept that realities are discursively constructed implies that drugs, drug experiences, and drug users should not be considered 'objective' starting points for researchers working in the field of drugs. Rather, they must be approached as the results of a complex interaction of language, power, knowledge, practices, and material and immaterial realities. Any activities in this field, such as drug consumption, policing, or intervention by health professionals, are the result of socially constructed knowledge, power, and resources. To understand drug-related activities and the knowledge, power, and resources that shape them, we must understand the process of their discursive construction. The Foucauldian model of discourse analysis and its contributions to linguistics and social science help us understand the social or discursive construction of these phenomena and their social implications.

In this chapter, I use relevant empirical research findings to discuss the discursive construction of three associated phenomena: (1) drugs (i.e. substances and their materiality), (2) social actors and their identities, and (3) practices in the field of drug realities. Using case studies, I will show how knowledge about these phenomena is socially constructed and how it affects (and is affected by) social structures such as power relationships, materialities, and practices. Far from being a simple chemical composition (drugs) that creates a specific consumer (drug user) who, due to a biological reaction, behaves in a certain way (practices), drugs and drug use are shaped by *social* relationships and are not defined by 'natural' distinctions stemming from the object itself. Finally, I discuss the implications of the findings for professionals working in this field and ask how reflexive knowledge about the social embeddedness of our knowledge and practices changes our attitudes towards them or even changes the way the mentioned phenomena are discursively constructed.

This chapter reveals that discursive constructions in this area are tightly interwoven with other, powerful discourses. Discourses on criminality, migration, and public and mental health, with their interpretations and their existing resources, influence discourses about drugs. These influences can take the form of games or struggles to establish the 'correct' interpretation and, with regard to the relationship between knowledge and material realities, struggles for power and resources.

Materialities: Substances

When talking about the materiality of drugs, we immediately step into the battle of definitions and meanings. The term 'drug' itself is not clearly defined, and its definition is embedded in an entangled web of discourses from the legal, medical, and moral spheres (Escohotado, 2000). Its current definition often refers to the term 'addiction', although this medical term is itself an innovation of the modern age. In older discourses, the abuse of substances had been considered more of a moral fragility (Bailey, 2005; Hammersley & Reid, 2002). The lack of coherence in the use of concepts in discourses on drugs and drug use manifests underlying social conflicts (Brook & Stringer, 2005). Thus, an analysis of the use of these terms can help in understanding these subjacent conflicts. For that purpose, we can differentiate roughly four meanings of drugs.

The first meaning, drug as medicine (i.e. a substance that alters the metabolism), cannot be found in European languages other than English (see also Tupper, 2012). From this first meaning, we can differentiate a second one: a drug as a substance that alters consciousness. This meaning is highly influential in medical and academic discourses. In social and public discourses, however, a 'drug' is mostly understood as a substance that alters consciousness and 'has been subjected to the most rigorous forms of control – typically criminalization – under the international drug control regime' (ibid., p. 467). We can even find a fourth notion of drugs that does not concentrate on substances. In this use, other practices that can have effects on humans similar to drug consumption – whether gambling, sex, or football – are equally considered drugs.

For discourses on drugs, it is important to note that a set of connotations accompanies the way drugs are discussed and defined. Only the third form of drugs is criminalised and persecuted in our societies. Its use is seen as pathologic, usually as 'abuse' or as addiction. Due to the important consequences of interpreting a substance as a drug in this sense (i.e. as an illegal drug), we should closely examine the specific discourses on these (illegal) drugs. It is this third notion that can be seen as a shared epistemic model that guides politics, as well as academic research on drugs.

If we start at the end of discourses about drugs as illegal substances, we can first note that these drug discourses have powerful *effects*. Prohibition, moralisation, criminalisation, pathologisation, and treatment, as well as the 'war on drugs', drug policies, drug advice, and education on drugs are the results of discourses on the danger of specific substances. Defining a substance as an illegal drug also has economic effects. The profit margins of those involved in drug production and distribution rise at the same time that those who produce, offer, distribute, and advertise legal drugs (e.g. alcohol) are protected against illegal competition. Police, private security companies, health workers, and social assistants are hired to fight against illegal drugs. Sensational news about the drug threat sells, and politicians are elected or not according to their stance on these illegal substances.

Regarding the *content* of these discourses, we can note that (illegal) drugs are seen as substances with specific characteristics. The differences in the treatments (i.e. the differences in the effects of drug discourses) are ascribed to the substances themselves. It seems as though these substances not only are objects of consumption but also have in themselves powerful capacities that turn them into social agents. Tupper (2012) mentions two metaphors that are commonly used to describe the characteristics of drugs: 'drugs as malevolent agents' and 'drugs as pathogens'. Drugs often are personalised as having a will over their users: 'By this conceptualization, a substance is understood as a kind of intrinsically evil force, like a demon or wild creature, possessing its own nefarious volition and the capacity to subjugate or override the free will of “weak” or “immoral” individuals' (ibid., p. 475). The drug-as-malevolent-agent discourse is closely related to discourses and practices of morality, criminality, or policing. The drug-as-pathogen discourse, in contrast, is related to discourses and practices of health, hygiene, and risk.

However, not only do drugs in general exist, but a diverse range of substances also exists that are considered drugs. Different substances are usually seen as having different personalities. However, even the same substance can be interpreted in different ways depending on how and when it is consumed and by whom. Reinarman and Levine (2004) mention understandings of crack as having characteristics that are essentially different from those of cocaine, although it is a simple freebase form of cocaine. However, the discourses about cocaine and crack are fundamentally different. Whereas the discourse on crack is that of a dangerous drug that leads to criminality, cocaine is socially seen as a drug for creative and hardworking people, such as artists or managers. We can understand these differences in discourses as the result of differences in the discursive infrastructure. Whereas those who use cocaine are usually the more powerful members of society, crack users – especially in the United States, where more social alarmism about crack has been created – classically were not only poor people but also ethnic minorities.

Thus, in the discourses about substances, their characteristics and dangers depend on their material (e.g. people, practices, institutions) and ideal infrastructure (knowledge or relationships to other discourses). As the infrastructure changes over time, so do discourses. The discovery in the mid-1980s that injection drug use is an important infection route for HIV changed the discourses about heroin as the most important injected drug, as well as discourses about the most reasonable counterstrategies (Campbell & Shaw, 2008).

Furthermore, not only are diverse substances shaped by discourses, but the very fact of naming a substance also affects how people approach it. Especially in the case of ‘modern’ drugs such as ecstasy, the naming can be understood as giving a symbolic value to a particular substance similar to the case of other commodities. Names and, in the case of ecstasy (Fitzgerald, 2002), commercial logos can create relationships among drugs, consumers, music, and lifestyle and therefore can confer social status. ‘A drug name could be a site for a whole set of discourses that offer subject positions and perhaps produce the bodies/subjects of which they speak’ (ibid., p. 202). In this context, we can understand drugs not only as discursively created material substances; the discourse also confers on the commodity drug a symbolic value and offers specific subject positions. Drugs are ‘cultural artefacts’. They are surrounded by meanings. Consuming drugs means not only introducing a substance into one's body but also expressing oneself in a specific manner. The relationship between a drug and its use as cultural artefact is produced and reproduced by discourse, which can even be the result of an obvious marketing strategy.

In the context of both lifestyle and health issues, the perception of material reality depends on the discursive infrastructure. In her research about discourses on safe (medical) drug consumption, Fainzang (2010) analysed the fear among different cultural-religious groups about the secondary effects of prescribed drugs. In discourse-analytical words, we discuss different discursive infrastructures because there is a diverse cultural knowledge background. For Muslims, it is quite common to express fear that a drug would negatively affect the heart. When reasoning about secondary effects, Muslims draw on their belief that the heart is the seat of moral sense and reason and of moral and spiritual life. The Jewish discourse is influenced by other knowledge; Jews are especially worried that drugs may have negative effects on their memory. Remembering is a typical Jewish cultural practice, and memory is a cardinal value for Jews. Thus, the infrastructure, with its knowledge and practices, substantially influences the discourse, which, again, has effects on risk-avoiding strategies and practices of the individuals embedded in culturally specific discourses.

For the analysis of the discursive construction of these drug discourses and of what the materiality of specific substances means, it is important to emphasise that ‘there are no properties inherent in a substance that allow one to infer that it is, or should be, regarded as *medicine*’ (Tupper, 2012, p. 472). In fact, the common definition and, therefore, the legal status of substances change and have changed over time. Some products that were originally introduced to western cultures as medicine are now considered food (e.g. tea or coffee), and other products used as medicine in different contexts are now considered (illegal) drugs, such as cannabis, cocaine, and LSD. The dominant discourse in a specific time and place is the result of a specific discursive constellation. This discursive constellation includes diverse actors such as politicians, mass media, medical experts or companies, as well as diverse social knowledge available at that time (e.g. about health or criminality). It includes power relationships, institutional settings, and interrelationships with other discourses. These parts are structured and held together by *dispositifs* that can be understood as ‘the material and ideal infrastructure’ of discourses (Keller, 2005) or the ‘net’ between these diverse elements (Foucault, 1978, p. 120). In other words, the materiality of substances is *not* a somehow objective biochemical reality but instead is the result of discourses that depend on what we can call a specific discursive constellation. Hence, substances are discursively constructed social categories and not ontological states. Additionally, as the infrastructure of discourses creates discourses, these discourses again create new material and ideal infrastructures. New knowledge about prevention strategies is created, new institutions such as drug agencies are founded, practices are justified, and identities are constructed for individuals and groups involved in the field of drugs.

Actors and identities

Similar to substances with characteristics created by discourses, social actors in the field of drugs are also shaped by discourses. Actors do not only produce discourses about drug realities; their own assumed identity as well as the identity that is socially given to them as others (alterity) are the result of discourses. In our field of interest, we can find a high number of social actors: institutions, institutional actors, users, and related actors. Institutions include governments, public health institutions, mass media, and drug agencies. Examples of institutional actors are police officers, social workers, and nurses. Users are described in discourses in quite varied ways, as junkies, addicts, or criminals. As related actors, we can find a range that includes dealers or pushers, on the one hand, and family or friends, on the other. The existence of some of these actors is only thinkable in the context of drugs (e.g. drug agencies, drug users, and drug dealers), whereas other actors exist independently but receive a specific shape in relation to drug discourses (e.g. police, hospitals, and friends). In what follows, we are concerned mainly with two questions: how are identities created, adopted, and used in and by drug discourses?; and how do previously given identities shape discourses about drugs and the material and immaterial infrastructure of the drug discourse?

Effects of discourses on actors

As everyone must 'learn' about their own identity, so must social actors in the field of drugs. This learning process can take place as an ordinary adoption of identities offered by discourse. However, in some cases, it also takes the form of strategic 'games' (Foucault, 2002, p. 670) in a power field. Institutional actors, users as well as related actors, must 'learn' about drugs, about their uses and treatments, and about themselves. They must learn what is normal and what is considered pathological. Sometimes, the learning process is quite obviously forced upon an individual. In discourse-analytical terms, this means that the material infrastructure of discourses is able to create settings where individuals must reproduce the dominant discourse. Campbell and Shaw (2008) and Reinarman (2005) describe such practices of forcing self-definitions on drug users through constant repetition or therapeutic practices.

It is important to note that the hegemonic definition can change quite rapidly depending on the immediate context. Illegal drug users can be seen as criminals in a legal context but, almost at the same time, can be identified as patients suffering from a disease. Whereas the suffering patient is a more-or-less helpless victim of 'drugs as pathogens', the criminal is a person who is morally (and legally) responsible for his or her actions. However, even in a legal context, it can be of strategic value for drug users to adopt the identity of drug victims, as Jock Young (2009) notes. Media and court discourses about drug dealers as 'pushers' can have positive effects regarding the sentence for drug users, who can present themselves as 'victims'. Here, we have a discursive strategy that leads to the creation of two social identities: that of the drug victim and that of the evil, seducing drug dealer who is only interested in his own economic benefit.

Campbell and Shaw (2008) report similar findings in discourses of intravenous drug users about harm reduction strategies. Harm reduction can be understood as a very powerful *dispositif* that relates drug discourses, social actors, and knowledge, as well as social and criminal policies. The authors wondered about their field experience in which drug users adopted a harm reduction discourse, for example, stating that they always bleached or used new needles, when it was obvious that this was not the case. However, the harm reduction discourse offered very attractive subject positions to the drug users. They could identify themselves as morally responsible social agents. Nevertheless, this subject position is also connected with burdens of responsibility. Responsible drug users (i.e. drug users who are identified by society and who identify themselves as moral agents) are now to blame for drug-related behaviour or for the health consequences of their drug use (Maskovsky, 2005).

In relation to the discourse of drugs as disease, Reinarman (2005) argues that specific ideas about drug consumers also depend on the cultural context. He argues that understanding addiction-as-disease is only possible in the context of the Protestant Reformation and capitalism, which gave rise to the idea of the autonomous individual (ibid., p. 310). Drugs now can be understood as an evil force that deprives individuals of their free will. In relation to alcoholism, he states that before the end of the 18th century, drunks were seen as people who 'just loved drink too much' (p. 310). After that time, with the ideal of the 'renunciation of pleasure for the sake of piety and productivity' (ibid.) that depends upon self-control, alcohol consumption has been seen as an addiction-creating disease that steals the volition of its consumers.

Identities or subject positions created through discourses are not an 'objective' reflection of reality; subject positions are offered by discourses and create realities. People often come to fit the categories offered to them by discourses. These categories are not value neutral; they are the expression of dominant discourses, which means that they are also the expression of dominant value systems. Neoliberal discourse, with its value of individual responsibility, shapes the identity of the 'addict' as a responsible agent, such as in the case of harm reduction. These identities are sometimes adopted due to an almost omnipotent discursive structure, but they can also be merely strategic assertions.

Effects of actors on discourses

Discourses affect the subject positions of those involved in a specific discursive field, and subjects influence the discourses. In fact, discourses are produced and reproduced by subjects. Subjects have interests, strategies and competences when using language and often know quite well the effects of their language use. This is true not only for subjects with high cultural capital, such as politicians, industrial spokespersons, academics or doctors, but also for those who use drugs and engage in discourses of justifying, apologising or explaining their situation.

Every discourse is created under specific historical and social conditions and is promulgated by different individual, collective, and institutional actors. As an example, we can cite Alcoholics Anonymous as a very powerful actor with an important tradition of creating discourses (see Thatcher, Chapter 14, this volume). Producing discourses also means creating social reality, interpretation schemes, and, again, social actors. The first step of the famous 12-step programme says, 'We admitted we were powerless over alcohol – that our lives have become unmanageable' (Alcoholics Anonymous, 2014). Here, we can see how a powerful actor – often the first, the only, or the most visible organisation in helping people with a 'drinking problem' – forces upon its members a creed. Members must not only accept the belief that alcohol is a stronger force then they are; they must also accept the identity of powerless alcoholics and addicts. The acceptance of alcoholism as a disease can then spread from the religiously motivated Alcoholics Anonymous to the alcoholics, who now promote that concept via a self-identification as addicts. The idea of addiction-as-disease was consciously introduced later in science; therefore, it was not science but a religiously motivated group that 'inculcated' the disease concept to the broader public and made it popular (see also Reinarman, 2005).

On a local level, we can observe the power of institutions to inculcate a dominant discourse about drug therapies. The therapeutic discourse tries first to break down the denial of addiction (Reinarman, 2005; Weinberg, 2000). In discourse-analytical terms, this means that with the power of the material and omnipresent ideal infrastructure, a discourse is created that forces upon individuals a self-concept as addicts, thus creating a coherent narrative or identity for drug users. After this process of discursively mediated 'learning' about being addicts, these individuals can be used as first-hand witnesses regarding the addictive potential of drugs. Whereas it may be degrading for their self-esteem to consider themselves not persons with free will but persons under the command of a substance, in the legal discourse, this could help – and could be used strategically – to minimise their criminal responsibility.

'Secondary effects' of actors on discourses

Social actors can also influence drug discourses involuntarily. Their subject position external to the drug discourse can shape discourses and their infrastructure in the field of drug realities. For example, in the United States in the late 1970s, crack was mainly consumed by 'stock brokers and investment bankers, rock stars, Hollywood types, and a few pro athletes, [...] Congress passed new laws to extend health insurance coverage to include drug treatment' (Reinarman & Levine, 2004, p. 182). However, when crack use in the 1980s was mainly identified with African Americans and Latinos, 'Congress passed new laws to extend the length of criminal sentences for crack offenses' (ibid.). Here, the social status of the consumers (i.e. their racial and class identities) clearly shapes the discourse about the drug as a substance and about drug-related behaviour. The authors mention five myths, or popular discursive formations of knowledge, that contradict the scientific standard (or scientific discourse). These myths stem from the material infrastructures of the discourse, which here implies mainly the low power status of an actual crack consumer: crack as different from cocaine, as instantly and inevitably addicting, as spreading to all sectors of society, as causing crime and violence, and, finally, as producing crack babies when used during pregnancy.

Similar findings could be observed in differences in alcohol consumption and binge drinking in Spain. Herzog, Gómez-Guardeño, Agulló-Calatayud, Aleixandre-Benavent, and Valderrama-Zurián (2008) found two different discourses depending on whether consumers were young autochthonous or Latin American migrants. In the former case, discourses acknowledged the negative aspects of public drinking, such as noise pollution and small-scale vandalism, but underlined the responsibility of society, which must offer alternative ways of spending their leisure time (e.g. building sport facilities). In the case of alcohol consumption by Latin Americans, the behaviour was interpreted as an ontological cultural quality of these migrants, and the negative aspects of this consumption for the natives were stressed. The responsibility was ascribed to the migrants. More and harsher police controls were presented as the solution to the problem (see also Herzog, 2009).

Provine (2007) describes for the case of North America different relationships in public discourses in the last century with ongoing effects. He explicitly cites the relationship of Mexicans and marijuana, African Americans and crack, and Chinese and opium. Regardless of the factual basis of these assumed relationships, the supposed characteristics of drugs now could be brought together with the supposed characteristics of races. Ideas about aggression, sexual behaviour, and intelligence are widely used to explain the supposed relationship between drugs and minority groups in the United States.

Studies on the social perception of immigrants and ethnic minorities all over the world show that negative representations often link immigration with criminality, social problems, lack of civic safety, and drug dealing or drug abuse (Aramburu Otazu, 2002; Maneri & ter Wal, 2005). The areas with negative connotations are used openly or implicitly in discourses as an argument to convey rejection of the migrant population. Because of these discourses, specific legal and material consequences are created. Legalisation and illegalisation, healthcare, and criminalisation depend on both who the social actors are that promote a certain discourse and who the supposed consumers of a specific substance are. Racist and racialised discourses also find their way into drug discourses (Herzog et al., 2008), and the more powerful in society, such as governments, pharmaceutical industries, or hegemonic groups, have more resources to shape the discourse than do the less powerful. The same idea of discourse refers to the fact that discourses pre-exist individuals as structures, categorisations, and identities. The lower the cultural and educational capital, the fewer the possibilities of actors to be deliberate producers of discourses and the more they find themselves constrained by available discourses. Marginalised social groups find themselves more often as dehumanised and discriminated subjects in public discourses in general, as well as in drug discourses. However, even the relatively powerless have the possibility to relate intentionally and strategically to the categories and identities offered by the dominant discourses. 'People [...] can become aware that they are classified as such. They can make tacit or even explicit choices, adapt or adopt ways of living to fit or get away from the very classification that may be applied to them' (Hacking cited by Tupper, 2012, p. 480f).

Practices

When talking about practices rather than isolated actions, we usually refer to conventions of behaviour (i.e. to typical models with repeating patterns). Individuals 'learn' practices in interactions with others. However, practices are not only repeated but also creatively appropriated, modified and adapted to the concrete social situation. For our analytical purpose, we can differentiate four types of practices (for the first three practices, see also Keller, 2005). First, we can identify practices of discourse production. These include all practices in which text and talk are produced directly, such as political declarations, news reports, the writing of academic papers, and talking in self-help groups. Second, we can identify practices produced by the discourse. For example, the practice of bleaching needles could be understood as a result of risk-avoiding discourses or discourses on personal responsibility. Similarly, policing practices in the field of drug realities are directly related to political discourses on strategies against drugs, such as the discourse of the 'war on drugs' in the United States. Third, we can identify practices independent of specific drug discourses, such as cooking or cycling. Finally, there is a fourth set of practices that do not produce discourses and are not produced by a specific drug discourse but are nonetheless part of drug discourses. I am referring here to practices that are not produced by a specific discourse – although they may be produced by other discourses – but to which discourses give a specific social sense. There may be cases in which stealing a handbag is interpreted socially as drug-related crime. Stealing a handbag is not producing text or talk; it is not the result of a drug discourse, but it is interpreted by society as part of drug realities (i.e. as drug-related behaviour).

Practices of discourse production are quite diverse. We can find discourses produced by drug users to justify their behaviour (e.g. Campbell & Shaw, 2008), which could be seen as a classical example of discourses of justification. Powerful discourses are produced in practices of conversation between medical doctors and their patients or by the pharmaceutical industry and its corporate associations with their practices of publishing scientific and popular material (Fainzang, 2010). As we have seen in the case of Alcoholics Anonymous, ritualised forms of talking can reinforce specific ways of understanding a social phenomenon and can offer attractive subject positions for those involved in the practice.

Harm reduction practices can be understood as an example of practices *produced by discourses*. As the result of a specific neoliberal discourse of individual responsibility for health (and due to other factors, such as knowledge about the transmission of HIV), harm reduction discourses became popular. These discourses were highly successful in creating practices of 'intervention', such as by social or health workers and by creating practices of 'risk reduction' or 'harm reduction'. Campbell and Shaw (2008) interpret these practices as practices of self-governing. Additionally, drug consumption can be understood as a practice produced by a certain discourse, as Fitzgerald (2002) shows with regard to the important underground marketing discourse about ecstasy. Ecstasy consumption is the logical consequence of a lifestyle discourse that includes practices such as dancing or wearing specific fashion items. Commercialisation is equally a practice produced or shaped by the drug discourse. Whereas alcohol and tobacco may be produced and commercialised quite freely (with some restrictions), in the field of illegalised substances production and commercialisation must follow other strategies. In other words, discourses about the danger of substances influence the legalisation or illegalisation of certain practices. There is also an obvious relationship between discourses about the materiality (i.e. the characteristics) of the substance and the practices produced by discourses. If drugs are seen as 'malevolent agents' (Tupper, 2012), then the logical socio-political practices are those of policing and punishment. Tupper (2012) shows the logic of this relationship using the power of metaphors. If drugs are like 'malevolent agents', then one must solve the drug problem as one would solve a problem of criminality. Discourses, therefore, are a powerful tool insofar as they help to find – and to justify – a set of practices from the contingent variety of possible practices.

As examples *of practices to which discourses give a sense*, we can mention the same practices mentioned previously. However, when talking about the *social* sense, we are analytically switching the perspective away from those who perform a specific practice towards those who evaluate it. Therefore, whereas drug consumption could be related to an underground discourse of lifestyle for the individual, the same practice could be interpreted in quite different terms by society. Reinarman (2005) shows how the social meaning of a consumption practice can change over time. Drugs in public discourses are seldom 'used'; they are usually 'abused'. Abuse is a normative rather than a scientific concept because it relates to socially undesirable or 'cultural-alien' behaviour.

Moreover, with the discourse of addiction, we can identify something like a *non-practice*. People identified as addicted do not take actions by themselves; they are supposedly somehow remote-controlled by a substance. Although, sociologically speaking, these people perform practices (because there are socially learned patterns in their behaviour), to society, it is not they who perform the actions but the drugs. Instead of non-practices, we could therefore also speak of *practices performed by objects*.

The way society understands a practice depends on the material and ideal infrastructures. The questions here are the following: which discourses are at hand to interpret a specific practice in the field of drug realities? How are the materialities to which practices refer constructed? What type of social actors are involved in the practices? Similar to the interpretation of a substance, the interpretation of a practice can vary depending whether the social group performing it is of low or high social status (see also Herzog, 2009; Herzog et al., 2008; Reinarman & Levine, 2004).

Practical relevance summary

Although bio-medical scientists and politicians, in particular, prefer to approach drug realities through 'hard facts', we should remember a pun by Bruno Latour: '*Les faits son faits'* – 'the facts are made'. The facts presented here – material reality, social actors, and practices – are the result of strategic discursive games of producing, reproducing, adopting, and adapting discourses in a specific social field. Drug realities are the product of discourses; at the same time, these realities create the necessary conditions for further discourse production.

For professionals and researchers working in the field of drugs, it is important to understand that discourses about drug realities are powerful mechanisms of reality production. The reality, with its inequalities, injustices, and justifications, depends on the existence of certain discourses and what I have called the discursive (i.e. the material and ideal) infrastructure. We must consider how certain social inequalities are latently reproduced in discourses; how material reality, instead of being an objective necessity, is the result of contingent possibilities of discourse and reality production; and how certain social actors benefit from these discourses and realities while others are marginalised. For a simple summary of the practical implications, please see Table 5.1.

Table 5.1 Clinical practice highlights

1. When working in the field of drugs, consider why people are speaking the way they do. Do they strategically use discourses? Have they internalised a certain discourse? What are the material and ideal reasons for that internalisation? These questions may help you to better understand the people you are working with and to understand their embeddedness in social relations.
2. What do you think about drugs, the people involved, and their practices? Why do you think that way (i.e. which discursive infrastructure led you to think that)? Can you imagine living in another society where people do not think as you do? What discursive infrastructure would that society have? Questions like this help you become aware of your own prejudices. Being able to consider our own knowledge as only one among many socially constructed realities helps us question incorrect but deeply rooted assumptions.
3. Never take any knowledge for granted!

Summary

The approach to 'discourse analysis' presented here shows both practitioners and researchers how to step back and engage in a second-order reflection. This term refers to the possibility of understanding the assumption that a specific social problem (e.g. addiction, drug-related crime) is a given fact into an object of social research. This research allows us to ask the following questions: why does society consider this specific phenomenon a problem? What 'facts' are taken for granted and therefore not debated? Who (and how and why) is involved in the production of our knowledge about that phenomenon? These questions allow practitioners, researchers, and society to gaining reflexivity about our own – everyday and often unconscious – actions.

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6

The Construction of Adult ADHD: Anna's Story

Alison Davies and Mary Horton-Salway

Introduction

The diagnostic category of attention deficit hyperactivity disorder (ADHD) has only recently included criteria relevant to adults. Consequently, qualitative studies about the personal experience of adults who have a diagnosis, or believe they have ADHD, are uncommon. This chapter briefly introduces adult ADHD, identifying common issues arising from the literature. We apply discursive psychology to examine the construction of adult ADHD in the personal narrative of one mother. Anna's narrative about her two adult sons who have a diagnosis of ADHD is multilayered and open to interpretation. We show how she constructs the meaning of ADHD and the identities of herself and her sons as examples of ADHD life stories. Our discursive psychology approach examines how her narrative is embedded in the socio-cultural context.

Project overview

Anna's story follows an interest in how mothers are positioned in relation to their children's health and behaviour and how ADHD may be a hidden disorder in women. Alison Davies's (2014) study of parents' experience of ADHD and Mary Horton-Salway's (2011, 2013) work on ADHD in the media showed how cultural representations and discourses rendered mothers as the accountable parent in relation to the health and behaviour of their children (mostly boys) with ADHD. Davies noted how parental accounts of their children often involved complex biographical work based on their own lives and those of their extended family members and ancestors. A common theme identified was ADHD 'in the family' – parents frequently comparing themselves with their children. Indeed, it is useful to recognise how people make sense of daily life and, in particular, what counts as normal for them in their immediate social context (Lisboa & Spink, Chapter 12, this volume). Anna's interview was audio recorded as part of Davies' research and refers mainly to an account of how ADHD was diagnosed in Anna's sons in adulthood. The story not only constructs how her sons were diagnosed but also constructs Anna's own life as a retrospective example of ADHD. This single case chimes with other stories of parents of children with ADHD, further pointing out the relevance of 'hidden' ADHD in girls and women. Discursive psychology is applied to examine Anna's story showing how the meaning of ADHD is a 'worked for' category, achieved through complex biographical narrative work.

Adult ADHD

Recently, the UK criteria for diagnosing ADHD expanded to include between 3% and 4% of adults (National Institute for Clinical Excellence, 2009, p. 27). Despite a gendered bias in diagnosis towards boys with childhood ADHD, the NICE report states that men and women are equally affected by adult ADHD. Davidson (2008) suggests the prevalence of adults with ADHD is 4–5%.

Research has discussed the persistence of ADHD into adulthood since the 1980s (Dunne and Moore, 2011; Henry and Jones, 2011; Nussbaum, 2012; Quinn, 2005; Rafalovitch, 2001; Singh, 2002; Wender, 1987, 1995, 1998, 2000). The symptoms of undiagnosed adults have been misdiagnosed as anxiety and personality disorders or have led to substance misuse (Young, Toone, & Tyson, 2003). This is partly due to the practice of using the criteria of *DSM-III*, originally designed for diagnosing childhood ADHD (American Psychiatric Association, 1980). Difficulties in diagnosis can, however, result in barriers to care for both children and adults (Davidson, 2008). Adults are more often diagnosed with inattentive-type attention deficit disorder (ADD), which can easily be overlooked (Davidson, 2008, p. 629). Adults with ADHD suffer impairment in areas such as marriage, family, relationships, and occupation. However, these categories were not originally included in the criteria for diagnosing childhood ADHD, so adults' symptoms were more likely to be associated, or confused, with other psychiatric conditions such as antisocial behaviour disorder, bipolar disorder, and psychotic disorder (NICE, 2009, p. 37). Successive versions of *DSM* used diagnostic criteria not applicable to adults, leading to adult misdiagnoses (NICE, 2009, p. 21). The redefinition of ADD to ADHD and wording changes to *DSM-IIIR* (American Psychiatric Association, 1987) allowed the expansion of the category into adulthood and the social context of employment (Conrad & Potter, 2000). Later, the Conners ADHD adult diagnostic interview for *DSM-IV* (American Psychiatric Association, 1994) was used, and the diagnosis of ADHD as a lifelong disorder is reflected in the latest revision, *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders*, fifth edition; American Psychiatric Association, 2013). *DSM-5* provides guidance on the diagnosis of adults offering examples of how older adolescents and adults might behave and widening the criteria to incorporate more 'adult' contexts, such as employment.

It is claimed that the recognition of adult ADHD is further complicated by gendered symptom criteria (Ohan & Johnston, 2007). Taylor and Keltner (2002) gave three reasons why ADHD might be overlooked in girls and persist into adulthood: (1) late onset of ADHD linked to a later surge in dopamine receptors (related to increase in oestrogen). This is contrasted with a reduction in dopamine receptors in adult males after puberty, (2) inattentive-type ADD is more common in girls and more likely to be overlooked (Solden, 1995, p. 46 describes symptoms of 'non-hyperactive ADD' that are 'subtle, quiet and invisible'), (3) *DSM* criteria previously overlooked girls with symptom emergence after the age of seven. Although *DSM-IV* (APA, 1994) finally allowed for diagnosis after the age of seven years, when this is recognised in adulthood, diagnosis could be partially dependent on a credible retrospective account of an 'ADHD career'.

Besides the difficulty of obtaining a referral for adult ADHD, women's accounts of childhood problems are less likely to be identified as ADHD since inattention and underachievement are less likely to be interpreted as symptoms of ADHD in girls and women. Recognition is strongly influenced by gender-biased cultural norms and expectations for girl-appropriate behaviour and stereotypes of women's mental health. Taylor and Keltner (2002) argued that girls with ADHD avoid negative attention by trying to 'pass as normal'. Magnusson and Maracek (2012, p. 140) contrasted girls' 'internalizing' behaviours leading to anxiety and depression with the more disruptive behaviours displayed by boys with hyperactive-type ADHD. Consequently, women's symptoms of ADHD have frequently been overlooked or treated as mental illness or neurosis (Nussbaum, 2012; Quinn, 2005). Nussbaum (2012, p. 88) described '*DSM-IV-TR* criteria that were more appropriate for males', arguing that 'females who have significant difficulties with attention are being misdiagnosed with other forms of psychopathology' (see American Psychiatric Association, 2000). Women with ADHD are claimed to suffer more psychological distress than males, often resulting in alcohol and drug abuse (Rucklidge & Kaplan, 1997). Solden (1995, p. 49) describes 'secondary emotional effects' that 'take on a life of their own' in women with ADHD.

Adults with ADHD might cope less well as parents (Johnston, Mash, Miller, & Ninowski, 2012) and in relationships, at work, and in the home. This is a 'significant public health concern' (Quinn, 2005, p. 582). A recent study of college women (Fedele, Lefler, Hartung, & Canu, 2012) revealed higher levels of impairment in family and social life, education, handling finances, and coping with daily life. Solden (1995) suggests this is because women have to multitask, bear more responsibility for home and children, and may not have so much organisational support at home and at work. Solden highlights the unequal cultural frameworks that shape what is expected or tolerated from men and women.

The recognition of ADHD as a lifelong condition has led to a number of recent lifespan studies. For example, Dunne and Moore (2011) applied narrative methods to the transition from boy to man; Fleischmann and Miller (2013) adapted Labov's textual analysis to online life stories of adults with ADHD; Henry and Jones (2011) looked at the accounts of older women with a diagnosis of ADHD; Waite (2010) focused on women from ethnic minorities; and Young, Gray, and Bramham (2009) investigated the personal experience of adults with ADHD using phenomenology. The adults in these studies share common stories of failure, difference, rejection, work, and relationship difficulties and self-blame. They were not, however, all focused on negative outcomes, and there is much to be learned from accounts of coming to terms with difficulty, self-understanding, and acceptance (Solden, 1995).

In this chapter, we argue that to understand what ADHD means for adults, we need to understand how the category of ADHD is socially, culturally, and historically constructed and subject to gendered and societal norms (see also Conrad & Potter, 2000). Much of the qualitative research in the 'experience of illness' tradition (Conrad, 1990) indicates that people with ADHD making the transition to adulthood lack continuity and support in health services. Adjusting to work after school is problematic, and this is especially acute for girls who have faced gendered barriers to care (Groenewald, Emond, & Sayal, 2009) and for undiagnosed boys whose ADHD remains troublesome in adulthood. While these matters are documented by research, there are few studies that document personal accounts of undiagnosed ADHD and none that focus on how a credible account of an ADHD life story is accomplished. Anna's story, represented below, describes her experience of being the mother of two boys later diagnosed as adults with ADHD. Anna's own life story and family background are inextricably linked with her efforts to explain the nature of her sons' ADHD, managing her own accountability as their mother and reinterpreting her own problems as ADHD.

Anna's story: The construction of adult ADHD

In telling her story, Anna has constructed her own identity and that of her two adult sons and other members of the family through the retrospective lens of the past and her current knowledge of ADHD. We were interested to see how the meaning and validity of adult ADHD is accomplished through Anna's use of constructed explanations and how the identities that populate her narrative are associated with moral risk.

ADHD in the family

This section of the narrative depicts an account of ADHD drawing on a biological explanation.

Extract 1

```
Well my children are grown up now and I have two sons
who've been diagnosed with one with ADD and one with ADHD
which is as you will know slightly different [mm] uhm
I believe it's in the family I believe it's genetic now
I know more about it I can look back and see [...] there
were definitely traits in my mother and [...] in her sister
and you know that's quite a long time ago we're talking
about of course we didn't know that there was a diagnosis
for it then and I wouldn't be surprised if my father had a
had some symptoms.
```

Anna describes herself as an objective, empirical observer, 'I can look back and see', presenting the adult diagnoses as medical fact. Her use of diagnostic labels ADD and ADHD indicate a distinction between them. As with several participants in Davies' study (2014), Anna draws on the biological explanation of ADHD as a genetic condition, with 'traits' 'in the family'. This has the credentials of a knowledge claim informed by facts and experience, 'now I know more about it'. The lack of formal diagnoses might undermine her claim but she manages this by observing an historical lack of awareness of ADHD, 'we didn't know there was a diagnosis for it then'. This not only accounts for the lack of evidence but also constructs a phenomenon ('it') that might have been common to members of the family.

Tracing the origins of ADHD

Anna's account of her sons' story begins when they were of school age. The starting point of a story is a significant aspect of constructing one version rather than another (Horton-Salway, 2001, 2002) and dating ADHD to primary school age builds the trajectory of adult ADHD as a life-long condition.

Extract 2

```
the behaviour was picked up at school [...] I have six
children [...] so I have got two three four normal children
[...] so R's behaviour was picked up at school [...] but it
wasn't diagnosed because we you know we are talking forty
years ago well thirty-five years ago.
```

Although Anna constructs a deficit account of her two sons with ADHD, she does this implicitly in contrast to her other 'normal' children. She constructs difference and demonstrates her ability to discriminate normal from abnormal. Resonating with McKeever and Miller's findings (2004), this evidences her ability to raise 'normal' children, contrary to any suggestion that parenting failure might be the reason for her sons' ADD/ADHD. The lack of medical diagnosis in childhood could challenge Anna's story, but this is explained away in retrospect because '40 years ago' ADHD was not a common diagnosis. Tracing her sons' problems to childhood is vital in constructing an ADHD trajectory and attributing causes. The lack of difficulties prior to school and her description of how her son's ADHD behaviour was 'picked up at school' suggest that ADHD first became noticeable to teachers rather than to her. Taken at face value, this supports research suggesting the school environment as the most typical context for identifying ADHD behaviour (Hjorne, 2005; Singh, 2008). Anna's account of her sons' ADHD moves back and forth between past events at school and an adult trajectory to establish a body of evidence leading to the recognition of adult ADHD.

Accounting for addiction

Anna describes how a diagnosis of adult ADHD was made for her elder son during his treatment for alcoholism. The phrase 'behaviour was picked up' refers to the serendipitous way that clinical observations of ADHD were diagnosed by a psychiatrist.

Extract 3

> I uhm paid for him at the time to go into private treatment and it was in there that his inattentive hyperactive uhm behaviour was picked up and there was a very good psychiatrist in there who diagnosed him as having ADHD and as soon as I started to read more about it it all fell into place [...] I didn't realise that he was on drugs as well now the drugs were amphetamines [...] in retrospect it falls into place and I didn't realise he was on drugs because they'd had the most amazing calming effect on him. [...] it soon came to a uhm uhm and it was obvious that he was self-medicating [...]. When he was in treatment he was put on [...] Ritalin. [...] he's been much more stable on that however he's struggled to remain sober because as soon as his emotions rock around a bit he wants to calm himself down with alcohol and Ritalin alone doesn't seem to be the [...] whole answer to it. I would love him to have had

> some behavioural uh cognitive behavioural-behavioural some support groups but uhm I had (pause) there are none in the area.

The elder son's ADHD diagnosis is embedded in Anna's account of rehabilitation for addiction. Anna claims his inattentive and hyperactive behaviour was 'picked up' and a diagnosis of ADHD was made by 'a very good psychiatrist'. Referencing psychiatric expertise chimes with Malacrida's (2001) observation that mothers draw on superior knowledge to strengthen the credibility of their claims to the diagnosis of ADHD. Serendipity adds to the credibility of this account since her son had not pursued a diagnosis of ADHD prior to rehabilitation for addiction. This lack of 'stake' in an ADHD diagnosis is a common feature of parents' accounts of children's ADHD (Davies, 2014), and, more widely, it is characteristic of how people talk about diagnoses such as myalgic encephalomylelitis (ME) or chronic fatigue syndrome (CFS), which also have a controversial history (Horton-Salway, 2001, 2007). 'Stake management' is a common discursive strategy that works to deny personal interest or prior motivation that might undermine the credibility of a preferred version of events (Potter, 1996). Here, it works to emphasise how her son's past problems, interpreted as addictions before the ADHD diagnosis, 'fell into place'. Anna's use of a retrospective lens to make sense of her son's past drug and alcohol abuse helps construct amphetamine and alcohol use as 'self-medication'. This echoes the 'self-medication' claims of drug users in Schubert, Hansen, Dyer, and Rapley's study (2009), who constructed an adult ADHD identity in rejection of an amphetamine-addict identity. Despite the strength of Anna's genetic explanation for ADHD, her demonstration of a balanced view in this extract indicates Anna's awareness of complex causes for her son's problems, 'he wants to calm himself down with alcohol and Ritalin alone does not seem to be the [...] <u>whole</u> answer'. Anna's suggestion that cognitive behavioural-support groups could be useful for her son demonstrates her open-mindedness to complex causes and solutions and a willingness to acknowledge that her son might have long-standing psychosocial problems that cannot be explained away by ADHD. This open-mindedness functions to indicate lack of bias and provides credibility to Anna's account of a version of events that is morally risky.

Substance abuse as self-medication

The 'self-medication' account is further evidenced in Anna's description of her second son in Extract 4.

Extract 4

> [...] my other son who has a different type of the ADHD of ADD he was never hyperactive he was born second very-we

> `(pause) both very normal births [...] went to school didn't have any problems but one of his first school reports [...] said how much he dreams he stares out of the window [...] and it's only comparatively recently with sort of talking about this because we've had him assessed er [...] and uhm he's definitely assessed him as having ADHD, ADD [...] he had a spell of really abusing alcohol and he also tried er s-speed and this was after my husband died and I think it was probably (sigh) you know just a kind of self-medication again to help them through.`

Anna's 'proto-professionalism' (Shaw, 2002) in using these two labels (ADD and ADHD) is supported by close experience of her son's character and behaviour as a child. Although she does not identify any major behavioural problems at school, her second son's adult diagnosis is traced back to school when reports that 'he dreams and stares out of the window' match the prototype for inattentive-type ADD. Anna's gathering of evidence scripts up a recognisable prototype for ADD in the manner of 'the documentary method of interpretation' (Garfinkel, 1967). Drawing on examples of evidence from the past Anna warrants a diagnosis which had only been sought 'quite recently'. Her narrative then takes a surprising turn, with a revelation about the younger son's alcohol and drug abuse. Anna explains this behaviour using two more morally excusable reasons, his father's sudden death and a form of 'self-medication' for ADHD. Anna's switch to the third person plural includes both sons in the 'self-medication' explanation, which was interpreted as something 'to help them through' a sad bereavement.

Here, a clear tension is emerging in Anna's story. A competing psychosocial explanation for her sons' problems, one of bereavement, grief, adolescent problems, addiction, and the struggles of a single mother, could have threatened to overwhelm her preferred biological/genetic version of the meaning of ADD/ADHD. While psychosocial influences are understood to be commonly involved in all manner of illness, disease, and disability profiles, in common parlance, psychosocial explanations are frequently used to make moral judgements. For example, ADHD can be explained in terms of poor parenting and environmental influences and children who are out of control (Davies, 2014; Gray, 2008; Horton-Salway, 2011, 2013; Rafalovich, 2001; Singh, 2004). In the public discourse of ADHD, diagnosis and drug treatment are often referred to as an opting-out strategy for the parents of naughty children. There is an underlying threat to the credibility of Anna's account posed by this 'bandwagon' of cases that are not genuine cases of ADHD (Horton-Salway, 2007). To manage the risk to her own identity as good parent, and her sons' potentially 'spoiled identities' as drug and alcohol abusers, Anna works to resolve the dilemmas raised by these alternative explanations. She does this through the working up of a genetic and medical explanation for their early troubles at school combined with an account of how the medically sanctioned diagnosis of ADHD came about unexpectedly. Such 'tales of the unexpected' are a common linguistic device to manage possible accusations of prior motive or disingenuous claims (Wooffitt, 1992).

Anna's self-diagnosis

Anna's son's diagnosis led her into an account of self-diagnosis (below). This reinforces the genetic explanation for the problems experienced by her sons, and, for a while, the story becomes about Anna.

Extract 5

> `think I would say that we were actually quite similar as personalities and in fact I think I could be diagnosed with having it [...] I'm sure I've got it. [...] I remember I was always [...] full of energy but it always felt like a kind of er anxious energy [...] and uhm having all this hyperactivity uhm attention I've always been worried about attention my attention span re-the ability to read. I was a great reader but I could never recall things you know.`

Anna's self-diagnosis is achieved through comparison with her younger son who has a diagnosis of ADD. Echoing Latour and Woolgar's (1979) observations of how scientific facts are established through the gradual elimination of modality, Anna's claim becomes incrementally stronger starting with tentative suggestions 'I would say…', 'I think I could be…', and moving to assertion 'I'm sure…'. Interpreting her childhood behaviours as also being symptoms of ADHD, 'anxious energy' and 'hyperactivity' combined with 'attention' problems and difficulty in 'recall' establish the recognisable symptoms of ADHD. Identifying with their children with ADHD is quite a common aspect of parental accounts (Davies, 2014) and functions to reinforce the genetic explanation of ADHD over the psychosocial explanation of environment and poor parenting. However, a retrospective claim to ADHD can be difficult to validate as exemplified in Extract 6 (below), where the interviewer queries the warrant for Anna's diagnosis.

Extract 6

> `[Int: so uhm you don't have a diagnosis is that right but you suspect that you probably?] well my <u>doctor</u> strongly suspects yes (smiles) [Int: and do you think that?] oh and`

> I was always interrupting as well when I was in class uhm I was either very quiet in class or later on when I got a bit older I didn't mean to interrupt but I wanted to ask a question before and not realising that the person had finished you know one of my sons T is very like that.

Mothers of children with ADHD draw on expert warrant to legitimise their own truth claims (Malacrida, 2001). Here, Anna bolsters her speculative claim for a personal diagnosis by emphasising that her 'doctor strongly suspects'. Behaviours such as interrupting, not realising that others were speaking, or being very quiet and dreamy also match the prototype for inattentive-type ADD, and this evidences symptoms similar to that of her son. Anna works to manage the risks of making a tentative claim to a diagnosis of ADHD by demonstrating a reluctance to admit it.

Extract 7

> [Int so do you find ADHD a useful label?] no I'm ashamed to tell people (smiley voice) [...] that I'm-I'm-I've just been discovered (laughs) I mean honestly! [...] I just see myself as a batty old woman (laughs) [...]. I did actually talk to somebody [...] doing some research [...] I talked to a Professor [...] and I said 'I feel a bit silly at my age'[...] He said 'you're not the oldest of my patients' he said. So you you'd almost think people wouldn't bother by the time they got to this age but there-there feels to be something unfinished you know with your brain and I think that's a good way of describing it.

Here, the grounds for diagnosis are accomplished using a biological explanation, and this is underwritten by the authority of medical expertise as 'something unfinished with your brain'. Her account displays reluctance and embarrassment about the possibility of an adult diagnosis. It performs the function of a discovery story where Anna reinterprets her own childhood and the events and experience of her life story in terms of an ADHD diagnosis. The doctor's remark about the age of his patients normalises her claim to a diagnosis in later life. Anna works hard to maintain her position that she had no motive to obtain this diagnosis and, as the following extract reveals, that should be set in the context of her own life difficulties.

Anna's disclosure

The following disclosure evidences further similarity to her sons and is used here to explain some of the past difficulties of her life and reinvent them. Her strategy here is a risky one because her story could be interpreted as evidence for an alternative and more morally threatening explanation for her own problems and those of her sons.

Extract 8

`I'd like to tell you that I'm a recovering alcoholic uhm again genetically alcoholism is on my mother's side of the family and er I was fortunate I got into recovering [...] before they really got through their teenage but it-it didn't do any favours. The kids were brought up in chaos frankly so I'm-I mean I know that didn't help and some people might look at the family circumstances and think duh duh duh duh duh. But I know genetically now that my aunt [...] definitely had all the symptoms I can kind of see it-see symptoms in my father and it's not that I was actually looking for it but it's just that it kind of all fell into place the more I read. [...] now my mother was funny because I mean she was sadly sort of a heavy smoker she was an alcoholic but she stopped drinking and she was-she just was a very heavy smoker [...] and also she always used to drink a lot of coffee now these are self-I've just been reading recently you know they help the dopamine receptors [...]`

Anna's disclosure of alcoholism was offered as a confessional account of possible psychosocial influences. This morally risky account works to demonstrate self-knowledge, a balanced point of view, an awareness of complexity, and willingness to engage with an alternative interpretation. The events she describes link the lives of her family members, their alcoholism, and a chaotic family life. However, her disclosure also contributes to the credibility of the genetic explanation of ADHD traits in the family. The diagnosis of adult ADHD is not itself the issue at stake in Anna's story. Even if it is medically supported, the meaning of ADHD and its causes remain controversial. A bio-psycho-social diagnostic model assumes a combination of multiple factors are causes of, or influences on illness or disease and this model is (in theory) preferred by health practitioners. However, in discourse and interaction bio-psycho-social reasoning does not always operate in quite this way (Horton-Salway, 2002). Psychological explanations can be used as a moralistic device (Yardley, 1996), or they can be treated as imaginary (Kirmayer, 1988). Additionally, physical conditions have historically received greater understanding and priority within the medical model (Stimson, 1976).

We argue that Anna's version of the meaning of ADHD is alert to the moralistic function of psychosocial explanations. It rests primarily on a biological explanation to reiterate her claim that the troubles affecting three generations of family were genetic in origin and that alcohol abuse was self-medication, resulting from the lack of a formal diagnosis of ADHD. Dunne and Moore (2011, p. 353) argue that narrative research on ADHD allows the 'voice of individual experience' to counter the dominant discourse of medicalisation. Anna does indeed portray a sensitive account of her experience of parenting children with ADHD, but she also favours a medicalised biological explanation. This is common when lay people make claims about controversial diagnostic categories (Horton-Salway, 1998), and it works here to mitigate the impact of a potentially more morally risky psychosocial explanation for the troubles and trauma that have been evident in her family life. The spectre of 'mother-blame' is never far from the surface in mothers' accounts of their children's health and behaviour, especially with regard to ADHD. Within Anna's story one can discern the voice of personal experience combined with the voice of expertise as she endeavours to strengthen her version of events and explain her personal understanding of the meaning of ADHD. She achieves this by scripting behaviours, experiences, and narrative identities for herself and her family members that fit the prototype for ADHD. Anna's confessional story reveals her awareness of an alternative psychosocial interpretation, and she embeds her management of 'troubled identities' associated with addiction and substance abuse (Gubrium & Holstein, 2001) in her constructions of their lives with ADHD.

Discussion

There are significant themes in common with previous research on narratives of ADHD. Dunne and Moore (2011) described teenage Jake's story of alcohol and drug abuse and relate this to lack of support at high school and the transition from school to work. This is echoed in Anna's sons' troubled adolescence and attributed to ADHD being overlooked when they were children. Like the young men in Schubert et al.'s (2009) study, Anna draws on ADHD to explain her sons' alcohol and drug use as self-medication and construct an ADHD identity in preference to that of drug addict or alcoholic. In Anna's narrative, ADHD is the less morally risky category transforming her own problems as a 'recovering alcoholic', risking and acknowledging her vulnerability to blame or condemnation. She weaves this admission into an account of undiagnosed familial ADHD, projecting the consequences of this through her own and the lives of other family members. Adults with ADHD are reported to cope less well as parents and in relationships and are more chaotic at work and in the home (Johnston, Mash, Miller, & Ninowski, 2012; Solden, 1995), so Anna's claim to have had undiagnosed ADHD provides a credible alternative to counter the riskier one of alcoholic, single mother and bad parent. Anna's story supports the claims of Singh (2004) and Davies (2014) that the mothers of boys diagnosed with ADHD are concerned about parenting failure and being positioned as 'blameworthy mothers' (see also Bennett, 2007; Blum, 2007). Rather than detracting from the credibility of these mothers' accounts, these observations underline the micro-politics of talking about their children's health.

Anna's account of embarrassment about her realisation that she has ADHD as a mature adult resonates with the women in Henry and Jones's (2011) study, who experienced chaotic lives and late diagnoses. Solden (1995) observed the shame that women with ADHD feel about their disorganisation. Anna's account of embarrassment also provides a discursive and contextual explanation for her lack of motive in seeking a diagnosis of ADHD. Anna's reluctance to admit to ADHD indicates she did not wish to use ADHD as an excuse for her own 'self-medication' with alcohol when her children were young. Indeed, her narrative is less focused on justifying the events of her own life than on how she makes sense of her sons' ADHD. Her personal account is part of an effort to story a credible genetic link between the older generation, herself, and her sons that supports a biological explanation for her sons' alcohol and drug consumption. Anna demonstrates considerable insight into 'how the story might look' and orients to this at various points in the interview. Had the focus of the interview been her own life story, no doubt she would have attended to different or additional interactional concerns. It is therefore important to see Anna's retrospective narrative and the analysis here as a snapshot of an adult ADHD narrative, raising issues of identity and stigma management and interpreted through the lens of discursive psychology.

Clinical relevance summary

Existing research highlights an association between undiagnosed ADHD, low self-esteem, and generally poor outcomes in adult life. This may be particularly relevant for women, such as Anna, who may have had undiagnosed ADD/ADHD in childhood. A discursive psychology analysis of Anna's story of adult ADHD has helped us understand the issues arising for such adults with undiagnosed ADHD, what it means for them, and its possible consequences and confusions. Anna's story provided insight into what having an adult diagnosis means and what that implies for undiagnosed boys, girls, and women. Greater, and earlier, recognition of ADHD as a 'hidden disorder', especially in girls and women, might result in fewer negative outcomes.

Our analysis highlighted some interactional and moral dilemmas confronting adults in talking about ADHD. Adult diagnoses are based on retrospective accounts set in the context of clinical observations of current symptoms and behaviour. So, it may be useful for practitioners to consider

Table 6.1 Clinical practice highlights

1. Anna's story suggests timely diagnosis and more training are needed about the impact of entrenched patterns of gendering in the recognition and diagnosis of ADHD (Groenewald et al., 2009).
2. Both biological and psychosocial explanations are relevant to the diagnosis and treatment of ADHD. However, a greater understanding of how these explanations position people within the cultural context of moral condemnation or social stigma would be helpful, especially when dealing with retrospective histories (Horton-Salway, 2013).
3. Where a diagnosis of adult ADHD is appropriate, 'talking therapies' could help to address past chaotic behaviour patterns and issues of self-esteem and to reformulate more positive life narratives and trajectories that are enabling rather than disabling.

how interactional or moral dilemmas and power relations impact upon these accounts and their interpretation. We suggest such accounts be attended to in the context of entrenched patterns of gendered inequality in the discourse and diagnosis of ADHD. Anna's story illustrated how mothers orient to the unequal and gendered apportioning of blame in families and how, consequently, the biological (genetic) explanation is often a preferred one to manage 'spoiled identities' in clinical contexts. A 'gender-sensitive' approach to diagnosis, social support, and social, psychological, and medical research would be helpful to support mothers when they tell stories of their family troubles (Quinn, 2005, p. 579). For a simple summary of the practical implications, please see Table 6.1

Summary

In this critical discursive psychology analysis of Anna's narrative, we have made three main observations:

1. Anna uses a biological explanation of her own problems and those of her sons as genetically inherited.
2. Her construction of inherited traits rests on a story populated with three generations of family members. ADHD identities are scripted as a familial characteristic through anecdote. Anna's identity is relational with family and sons, and individual ADHD identities become interdependent.
3. She manages the risk that a psychosocial explanation could undermine her preferred biological/genetic explanation. A defence against 'troubled identities' is an integral part of her construction of the recognisable scripts of ADHD.

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7

Using Discourse Analysis to Investigate How Bipolar Disorder Is Constructed as an Object

Lynere Wilson and Marie Crowe

Introduction

The experiences now known as bipolar disorder have a long history as a focus of attention for psychiatry; from *la folie circulaire* (circular disorder) to manic depressive insanity to present day bipolar disorder (Goodwin & Jamison, 2007) psychiatry has worked hard to know, define, and claim expertise in the treatment of the disorder. As with many other health conditions which are understood to be incurable and relapsing, in contemporary mental healthcare there is an expectation that people can learn to live a life that is conducive to limiting relapse and, when a relapse does happen, an expectation that the person can learn to see the early signs of impending illness and take appropriate action (Colom & Vieta, 2006; Suto, Murray, Hale, Amari, & Michalak, 2010). As part of this movement towards greater self-management by individuals with long-term health conditions, mental health clinicians have led the development of psycho-education as an intervention. Psycho-education seeks to integrate a psychotherapeutic and educational approach to the way information is shared with people living with long-term conditions so that they learn more about the condition they are understood to have and how best to live with it (Ryglewicz, 1991). It is an intervention that is now recognised as an essential part of mental healthcare for people with bipolar disorder (Poole, Simpson, & Smith, 2012; Stern & Sin, 2012) to the point where it seems 'common sense' to expect that a person can learn to manage their own condition and to do so offers the possibility of a greater sense of control over one's own life. Who would not want this?

As a complex set of health practices that rely upon language and specialised knowledge, mental healthcare is an ideal practice for discourse analysis. People who are understood to have a mental disorder become part of psychiatry's discursive practices, and, as such, they are called to understand themselves as a patient often with an incurable disorder. Such notions of mental disorder are often challenging to communicate (e.g., Monzoni & Reuber, Chapter 11, this volume), particularly as the discourse of mental health recovery aspires to help the patient move to a state of 'holistic well-being' (Mancini, Chapter 18, this volume). It appears that by engaging in this process (whether with agreement, ambivalence, or resistance) the subjectivity of diagnosed people is being transformed by psychiatric discourse and practices (Estroff, 1989; Terkselsen, 2009). This chapter is concerned with investigating the practice of psycho-education for bipolar disorder as a way to ask questions of an intervention that seems to have reached the status of 'taken for granted' in order to consider if it might be having broader effects upon people beyond knowledge acquisition.

By applying a discourse analysis methodology based upon Parker (1992) and the writings of Michel Foucault, this chapter will investigate how the discursive practices of psychiatry produce our understanding of what bipolar disorder is and, in the process, shape what it means to be a person with bipolar disorder. The *Psychoeducation Manual for Bipolar Disorder* (Colom & Vieta, 2006) has been chosen as the text for analysis because of its place as one of the few published, evidence-based guides for clinicians that provides high levels of detail about the content of a psycho-education programme for bipolar disorder. As such, it provides an example of the psychiatric discourse about the nature of bipolar disorder and how people are expected to live with it.

After providing an introduction to the experience known as bipolar disorder, we will discuss the theoretical concepts of discourse, power relations, and subject positions that are central to our approach to discourse analysis. Then, using illustrations from the chosen text, we will show how the discursive practices of psychiatry construct bipolar disorder as an illness located in the brain that only psychiatry and science have the authority to treat. When constructed as an illness, the experiences associated with it have no meaning beyond being symptoms, and it is imperative that it must be treated with medication. In the text, a person with bipolar disorder becomes a 'bipolar patient' with attributes of reflexivity and deference to experts.

Bipolar disorder

Bipolar disorder is constructed as a disorder of mood in which people experience recurrent episodes of moods constructed by psychiatric discourse as mania, hypomania, depression, or mixed episodes. Mania is constructed as episodes of 'abnormally, persistently elevated, expansive or irritable mood and persistently increased activity or energy' that results in marked impairment in functioning or hospitalisation (American Psychiatric Association, 2013, p. 124). Hypomania is constructed as a similar state but of a lesser intensity, thus not requiring intervention in a person's life, either through hospitalisation or by stepping in to take over a person's day-to-day responsibilities. Depression is constructed as periods of persistently low mood, often associated with a loss of pleasure in usual activities causing impairment in day-to-day functioning. Mixed-mood episodes are constructed as occurring when a person experiences symptoms of mania or hypomania at the same time as symptoms of depression (American Psychiatric Association, 2013).

To date, psychiatry has no cure for bipolar disorder, so those diagnosed with it are required to learn skills to manage it over the long term. Psycho-education is an accepted practice to enable the person to manage their disorder, and there are now a significant amount of claims to support its use in mental health services for a range of conditions (Bauml, Frobose, Kraemer, Rentrop, & Pitschel-Walz, 2006; Chien & Leung, 2013; Lucksted, McFarlane, Downing, & Dixon, 2012). The most prolific authors on psycho-education for bipolar disorder have been Francesc Colom and Eduard Vieta (Colom & Lam, 2005; Colom et al., 2003a; Colom et al., 2003b; Colom et al., 2009; Vieta, 2005), and they have used their research to produce a text for mental health clinicians called *Psychoeducation Manual for Bipolar Disorder* (Colom & Vieta, 2006). Henceforth referred to here as The Manual, it provides detailed instructions on how to run a psycho-education programme for people with bipolar disorder. The Manual was developed out of the research work of the University of Barcelona Hospital Clinic Bipolar Disorders Program, which, according to its website, is 'devoted to generating, disseminating and applying knowledge on outcome, treatment and prevention of bipolar disorder' (http://www.bipolarclinic.org).

The intention of The Manual is very explicit: 'common sense' clinical knowledge of the disorder, according to research, reduces relapses of the condition and therefore mental health professionals should be encouraged to teach 'your patients how to manage their disorder better, live with it, progress with it, take their medication more effectively and understand why the medication needs to be taken' (p. xvi). While written for clinicians, it contains information about how psychiatry constructs the condition, how psychiatry treats it, and advice written specifically for the person with the disorder about how they should conduct themselves in relation to bipolar disorder.

Discourse, power, and subject positions

Discourse analysis is concerned with how human experience is structured by language. Rather than language being seen as able to represent reality, in discourse analysis it is assumed that how we can think about ourselves and our experience of the world is determined by the language, ideas, concepts available to us; they shape what it is possible to say or not say about a particular thing, and they do so within both social and historical contexts. Discourse analysis is perhaps best described as a sensitivity to language and its productive nature such that analysis of text is focused upon what is done by language rather than what is meant (Crowe, 2005; Willig, 2001). In this methodology, language is understood as one mechanism by which people come to think and know themselves.

Our approach to discourse analysis has been shaped by Ian Parker's work (1992), and he in turn has been influenced by the work of Michel Foucault. Discourse analysis is notorious as a research methodology without a set of 'rules' to follow, and Parker is at pains to point out that his approach is not a step-by-step guide. What he does provide is a broad theoretical framework for understanding the nature of discourse and its role in human life which is then used to shape the questions that can be asked by the analysis. Foucauldian-inspired discourse analysis is concerned with '*what kind* of objects and subjects are constructed through discourse and *what kinds* of ways-of-being these object and subjects make available to people' [italics in original] (Willig, 2001, p. 91).

Discourse is understood here as '*a system of statements which construct an object*' [italics in original] (Parker, 1992, p. 5). This includes practices or things that are done that use discourse. For example, the discourse of psychiatry constructs the object of mental illness in particular ways. One of the ways that these ideas are reproduced and 'put to work' is through the text known as the *Diagnostic and Statistical Manual*, of which *DSM-5* is the most recent edition (American Psychiatric Association, 2013). Through the discursive practice of a comprehensive assessment, clinicians use this text to decide how best to make sense of a person's difficulties and give a diagnosis. This diagnosis is then shared with the person and their family, recorded in their file for others to refer to, and used to construct a letter to the person's family doctor. Through this assemblage of processes, discourse can be seen to be shaping what can and cannot be said about the person's experience.

As well as constructing objects, discourses also make available particular ways of being in the world or subject positions (Willig, 2001). To further our example, the person who sees a clinician for a comprehensive psychiatric assessment can occupy the position of 'patient' or 'client' or 'service user' or 'consumer'. Each of these terms 'call' to the person in a particular way, such that a person comes to understand (not necessarily consciously) that particular attributes go with each of these positions. In order to make sense of what is being 'said', a person must come to see themselves in a particular way (Parker, 1992), and the psychiatric discourse makes available a space for different sorts of selves to step in.

We also understand discourses as reproducing relations of power. The discourse of psychiatry dominates our contemporary understandings of what it means to be 'mentally ill', and people who do not use psychiatric discourse to make sense of their difficulties are often named as lacking in insight. In this sense, discourse is understood to be productive as it makes things happen while at the same time people can reshape it, challenge it, and resist it.

With these theoretical underpinnings in mind and the methodological steps offered by Parker (1992), the following questions acted as the starting point for analysis:

1. How does the text construct bipolar disorder as an object? What knowledge is used to construct bipolar disorder as an object? Complete the statements 'bipolar disorder is...' and 'a person with bipolar disorder is...' as a means to explore the use of metaphor in construction of both object and subject.
2. What ways of being in the world does the text make available to people understood to have bipolar disorder?
3. What sort of relationship are people with bipolar disorder expected to have with the object?

Findings

Bipolar disorder as an object to be medicated

Bipolar disorder as constructed in The Manual is first and foremost a biologically based illness that is located in the brain.

> Try to explain the bipolar disorders by focusing in particular on its biological aspects; in other word, starting by its definition as a brain disorder: the bipolar disorder is a disorder that affects the limbic system, neurotransmitters, and the endocrine system. In this case, even though this is an oversimplification, we will avoid any comment about the interaction of these causes with others, or a rather psychological or social nature, because this may add confusion. (p. 55)

The understanding of bipolar disorder as a brain-based disorder is a necessary pre-requisite for enforcing the need for medication as the only treatment option. As a brain disorder, the experiences of bipolar disorder are constructed as having no meaning for either patient or clinician beyond being symptoms of an illness. The psychiatric construction of the disorder is the only permitted construction within psycho-education sessions. Alternative constructions are dismissed or derided.

> What often happens is that mystic or religious exaltation presents itself in the context of manic episode and it is nothing more than one of its symptoms, so that it goes away when the mania is treated. To explain this point easily and amicably, we usually joke about it and say that 'we don't have a problem with you talking to God through prayer, but we would be worried if you actually heard Him answer you'. (p. 82)

Any attempt to understand mania or hypomania as a positive or purposeful experience is a myth to be dispelled.

> During the session we should stress the pathological nature of both mania and hypomania, since many of our patients see hypomania as 'a blessing' or 'a gift'. In these instances it would be useful for us to remind them that: (a) during hypomania people usually make the wrong decisions, (b) not all the symptoms of hypomania are pleasant . . . and (c) hypomania almost always leads to another immediate episode that involves greater suffering . . . . (p. 80)

When experiences such as these can only be spoken of as symptoms of an illness that episodically recurs, it becomes vital to be able to 'differentiate normal emotions from pathological ones' (p. 85) so that thoughts and feelings can be scrutinized for evidence of a relapse. Psychiatric discourse is reproduced in psycho-education sessions by marginalizing any alternative explanations.

As an 'illness', bipolar disorder must be treated by medication and psycho-education is an intervention that reinforces to people this 'fundamental aspect of their treatment: its biological nature and the need for drugs' (p. 53). While The Manual is in the business of persuading people that psychological interventions for bipolar disorder are important, this cannot in any way be seen to be at the expense of medication. Psychological treatments 'must always be combined with mood-stabilizer treatment and many times with an antidepressant' (p. 123), and 'it is absolutely necessary for the therapist to . . . make it clear that the medication is absolutely necessary, including writing it on the blackboard if necessary . . . ' (p. 54).

Significant time is dedicated in the programme to medication-related issues, and the problem of non-adherence to medication regimes is addressed in a section of The Manual dedicated to defining forms of non-adherence, the reasons for it, and how to combat it.

> Chart 1. Types of poor treatment adherence
>
> 1. Absolute poor adherence. This refers to the complete negligence of the patient in following the indications of the responsible therapist . . .
>
> 2. Selective partial adherence. Certain patients selectively reject a certain type of treatment but not another . . .
>
> 3. Intermittent adherence . . . Many patients do not completely abandon the treatment but neither do they take it as prescribed . . .
>
> 4. Late adherence . . . some patients show initial resistance to admitting the need to receive treatment and decides to start taking the medication prescribed after a few relapses . . .

> 5. Late poor adherence. After 2 or 3 years of good adherence, some patients start abandoning their mood stabilizers without apparent reason...
>
> 6. Abuse... Taking more medication is also a rather common form of poor adherence among bipolar patients...
>
> 7. Behavioural poor adherence. The term 'poor adherence'... also includes aspects concerning the attitude and behaviour of the patient... obeying clinician's instructions as to the regularity of sleep habits and other advisable behaviour that may facilitate euthymia, such as not consuming alcohol or other toxics.... (p. 105/106)

Treatment of bipolar disorder with medication is an imperative, and a great deal of time and text is dedicated to making this point.

The process of subject construction

Ensuring the authority of a psychiatric discourse to know bipolar disorder and the people understood to have the condition is central to the psycho-education practices described in The Manual. To ensure adherence to these constructions, the text can be seen to use some specific discursive tactics.

Firstly, The Manual often uses interdictory flavoured language when describing the role of patients within psycho-education; 'patients *are allowed* to get involved freely when they think it is necessary...' (p. 49), 'we will warn them that *failing* to respect some of these rules may lead *to expulsion*...', 'any patient who *fails* to attend five sessions will be *forced* to leave the group' (p. 58), and 'the mood-chart technique, that the patient *must* master by the end of the session' (p. 93).Secondly, it makes no space for debate about the nature or treatment of bipolar disorder:

> It is absolutely necessary for the therapist to present, from the beginning of the group sessions, both treatments not as opposed but as complementary, and to make it clear that the medication is absolutely necessary, including writing it on the blackboard if necessary. Otherwise, 'an antipsychiatry' type of thinking may immerge [*sic*].... (p. 54)

Thirdly, whenever The Manual does refer to alternative views on the nature or treatment of bipolar disorder, there is often what can be read as a disparaging tone to the text:

> [T]he first contact between a patient and a psychological treatment can be crucial in explaining the subsequent response to treatment. We are not now going to digress into mysteries of other paradigms about whether or not to shake hands with our patients and look them in the eye. In principle, they

> are your hands, your patients and your eyes, so do whatever common sense tells you. (p. 40)

As with the process of excluding any other possible explanation for the person's experiences, the need for medication is positioned as the only possible response.

And finally, the overt disapproval of alternate constructions of bipolar disorder is complemented by a tone of address to patients that suggests the knowledge of the psy-sciences is necessary but complex and therefore requires simplification for patients. The need to keep things simple for the patient is exemplified in the way the fairy tale of The Three Little Pigs is converted into the story of The Three Little Bipolar Pigs as a way to illustrate the biological nature of bipolar disorder and the importance of a person's attitude towards it.

> The first one simply did not believe what his veterinarian told him and thought that bipolar disorder was an illness that had been made up by psychiatrists or was a fairytale, so he never changed the way he behaved... The second little pig is the story agreed to take the medication his psychiatrist suggested, even more so at his family's insistence... The mistake he made was in thinking that medication alone would help keep his mood stable... The third little pig joined a psychoeducation group for little bipolar pigs. This activity... led him to take all the necessary precautions to avoid the dreaded relapses: he took his medication and paid attention to this doctor's orders and those of his psychologist... he tried to get enough sleep... [h]e paid attention to his wife's comments... he even learned to identify the signs of relapse in time... Out of all the little pigs in this story, he was the wisest pig of all, and there are some who say that some pigs are smarter than people.' (pp. 69, 70)

While the use of this story comes with a caveat that clinicians need to be able to walk a fine between 'comical and disrespectful comments' (p. 68), it is still nonetheless presented as one way to educate people about bipolar disorder, and it does so in a way that uses simple, almost childlike methods to instruct. It is as if no one with bipolar disorder would have the capacity to understand the details of expert knowledge which, in turn, begs the question of what would happen if a clinician had bipolar disorder and attended a psycho-education group.

Constructing the surveilling self

At the same time as the nature of bipolar disorder is discursively produced as a recurring brain disorder that must be medicated, The Manual makes available particular subject positions or ways of being in the world for the person who is understood to have this condition. As a person under the jurisdiction of psy-sciences, the person with bipolar disorder becomes a ‘patient’ and a ‘bipolar patient’ in particular. As a bipolar patient, they are called to be reflexive, to work upon their thoughts, and to defer to experts.

Reflexivity

A crucial attribute of a bipolar patient is their capacity to examine themselves and, in the light of this examination, make changes to what they do and think. The first stage in being able to do this is the ability to separate the normal for abnormal. Firstly, for hypomania and mania:

> We always recommend differentiating between hypomania and non-pathological happiness. (p. 80)

And then again in the next session on understanding the symptoms of depression:

> We will again insist on the need to differentiate normal emotions from pathological ones. (p. 85)

Then, group members are expected to learn to recognise their unique version of bipolar disorder

> always emphasize the need to individualize the knowledge of the disorder: I am trying to learn not about *the* illness of bipolar disorder but about *my* bipolar disorder. (p. 163)
>
> [italics in original]

These skills are particularly pertinent to the process of learning to predict and respond to signs of relapse. A patient who can individualise can take the generic information about bipolar disorder they have been given and apply it to themselves.

> Step 2: Individualization – identification of one’s own warnings or operational warnings. The goal of this step is to individualize, that is adapt the information from Step 1 to everyone’s particular case. We try to have the patients to identify which warning signs appear regularly in each type of episode.’ (p. 158)

A patient who can specialise can take their ability to examine themselves one step further.

> Step 3: Specialization – prodromes of prodromes, or early warning signs . . . in this step the patient claims ‘specialization’ in their own case, beyond

> knowledge of their own relapse signs. The point is to identify the signals that precede the warning signs – 'warnings of warnings'. (p. 159)

Each of these steps now needs to be completed for each abnormal mood state so that a list can be created and used daily as a means to examine oneself and determine what needs changing.

> If after reviewing the list, you match one or one of the items, do not do anything to change behaviour.
>
> If you match two items for 3 days in a row, you should consult with your support person.
>
> If you match three or more items in a single day, it is time to put an emergency plan into effect. (p. 162)

A bipolar patient becomes a prudent planner, who can separate the normal from the pathological, name, list, and rank symptoms by their importance, monitor themselves via their lists of warning signs, and plan for the inevitable relapse.

This self-surveilling subject position also requires the bipolar patient to recognise both the problems and potentials associated with their thoughts and attitudes. Thoughts are problematic due to the way they indicate the presence of actual or potential illness.

> The handling of depressive or negative cognitions, which also appear in some euthymic patients, is extremely delicate during a group psychoeducation session, because having the patients begin to sympathize with such cognitions must be avoided, especially those that have to do with the disorder ('we're a bunch of losers', 'what lousy luck – we'd be better off dead', 'we'll never do anything good,' etc.). (p. 42)

While thoughts are a problem, they also offer the way to bring about change in a person.

> The attitude toward the disorder and the health beliefs of each patient play a highly significant role in the emergence of poor adherence; obviously, bipolar patients who firmly believe that they can control their mood by themselves will have a worse degree of adherence. (p. 107)

Bipolar patients are therefore called upon to intervene in their thoughts.

> We can propose that the group debate blame vs. responsibility, by contrasting how thoughts of blame are useless and unproductive, and how useful, on the other hand, feelings of responsibility are. (p. 74)

And change their attitude towards themselves:

> He was aware that this attitude involved scarifies [spelling mistake in original], but since he was a smart little pig, he understood that it was worthwhile to live a moderate life in exchange for something as important as his happiness and personal stability. (p. 70)

Surveillance of one's thoughts and attitudes is a central aspect of this subject position. The bipolar patient becomes both a prudent planner and someone who understands the way their thinking can both act as means to measure illness and as a means to bring about change in themselves. Despite this, the bipolar patient doesn't always act as he or she should so this requires them to be able to recognise their mistakes and then tell others;

> This session, and one of the previous ones, is rather propitious for confessions of poor adherence by the patients, which is very positive both for patients who speak sincerely and for their group mates. If this happens, we will try to have patients explain their reasons without being interrupted by the rest of the group and we will not adopt under any circumstances an openly critical attitude. Our first reaction must always be to thank the patient for their sincerity and for showing us enough trust to explain such a significant problem both to (we) therapists as well as to the other members of the group. (pp. 140, 141)

The importance of the admission of wrongdoing and the opportunity it offers people with bipolar disorder to come to know, examine, and change themselves is underscored by the strong directive given to clinicians about how they must act in this situation. Through the practice of confession the group member takes 'the role of the self-examinatory, self-reflective subject who needs both [to] tell and recognize the truth' (Hook, 2003, p. 612) of their self.

While the capacity for reflexivity can be understood as an attribute of contemporary subjectivity for all people (Giddens, 1991), for bipolar patients it is a central attribute to be cultivated, especially if psycho-education is to be successful. There appears to be an intensified expectation that a bipolar patient can and will examine their thoughts, emotions, and behaviours in line with the doctrine of psychiatry, confess mistakes, and then adjust themselves accordingly.

Deferring to the expert

As a bipolar patient, the person is also called to see themselves as someone who defers to expert knowledge on what it means to have bipolar disorder, and there are a number of ways that this subject position can be taken up.

People who defer to the experts comply with a psy-science way of understanding what bipolar is and voice this to others.

> Participation in this group implies ‘confession’ in front of the other member’s own diagnosis, in this case bipolar disorder. (p. 62)

They take medication and encourage others to do so.

> Once again, it will be very positive if it is not the psychologist or psychiatrist who appears to be the only defender of the need to take medication, even though obviously he would already have taken this position in front of the group; it is appropriate for patients themselves to advise good adherence. (p. 140)

If psycho-education has been successful, they will recognise themselves as the third little pig in The Three Little Bipolar Pigs tale.

> The third little pig joined a psychoeducation group for little bipolar pigs. This activity, in addition to reasonable behaviour and being highly motivated not to relapse (he knew he enjoyed life a lot more during periods of euthymia), led him to take all the necessary precautions to avoid the dreaded relapse; he took his medication and paid attention to his doctor’s order and those of this psychologist. (p. 70)

The bipolar patient who resists the knowledge of bipolar as a brain disorder that needs medication and therefore does not defer to psy-expertise becomes instead a rebellious patient.

> These are more ‘open’ session; in other words, sessions in which the patients are invited more to give their opinion concerning the topic discussed. The purpose of this approach is merely for us to get an idea of which beliefs and attitudes are being handled by our patients in order to find out exactly on what point we must emphasize, and to understand what prejudices they have in connection with the disorder, since they are often dominated by guilt. Certain patients react [to] explanations with resistance; in this case, the better strategy is to allow the members of the group to discuss between them the contents of the sessions rather than for us to act as defense [spelling in original] lawyers for the medical model, since if we do so quite a few patients will accuse us of having corporate-like attitudes. In exchange, if it is another patient that defines the biological character of the bipolar disorder and the need for treatment, the ‘rebel’ patient is left without weight arguments. (p. 54)

The rebel patient is constructed as someone who simply needs to be persuaded of the error in their thinking, and psycho-education is presented as the means by which this lack of understanding will be rectified.

> Incomprehension is an opportunistic illness that exacerbates the course of psychiatric disorders... [p]atients who do not know their disorder do not know their lives.... (p. 27)

A lack of understanding is constructed as something to be cured by medicine, just like an illness. At the same time, lack of awareness of one's bipolar disorder is also constructed as part of the disorder itself.

> Subjects suffering a manic episode *do not recognize that they are ill* [italics in original] and they might resist attempts at treatment. (p. 83)

As is a lack of trust,

> problems such as irritability or lack of trust that often arise from the psychopathology itself, which can be an obstacle to receiving proper treatment. (p. 26)

Everything about the non-conforming patient is to be explained by the brain disorder they are understood to have such that people who resist the knowledge of psy-experts are no longer complex creatures with multiple and conflicting motivations and beliefs; they are simply displaying the characteristic 'high rates of illness insight' (p. 53).

Clinical relevance summary

With psycho-education now a recognised education-based psychological intervention that promotes the self-managing capacities of people with bipolar disorder, it appears to have taken on the status of common sense – who would not want to be better informed about the condition they have? But it is its taken-for-granted status that makes it of interest to discourse analysis, which offers a means to stand back from the ideas and the language of psycho-education and treat it as just one truth among many, held in a place of dominance by language and power (Parker, 1992). In this way, it is possible to reflect on what it is we do as mental health clinicians when we think and speak; from the assessment of problems understood to effect the mind through to the treatment of emotional distress, language acts as the primary technology by which mental health clinicians act upon others. The productive nature of language in combination with clinicians' role as discursive practitioners also draws attention to the therapeutic potential in prompting people experiencing mental distress to explore the assumptions they hold about themselves and make space for new ways of constructing experience that are more enabling (Crowe, 2004; Kaye, 1999).

By focusing on a psycho-education text for bipolar disorder, we have identified how the language and practices of psychiatry tightly regulates the object known as bipolar disorder and the person with the condition. Using The Manual as our point of reference, to live successfully with bipolar disorder explicitly requires people to take on a way of thinking and acting that conforms to psychiatric assumptions of normality and engage in practices of self-governance mandated only by psychiatry. This means that any talk of a possible social or relational location for a person's difficulties are effectively silenced, as are emotions such as trust, shame, and guilt.

This discourse analysis also draws attention to how the text acts as a form of disciplinary power that Foucault called pastoral power (Foucault, 2003b). It brings together notions of salvation, self-sacrifice, attention to the individual, and the importance of knowing the individual's inner world and a style of power relations that is common in health and welfare practices of care (Foucault, 2003a; Toll & Crumpler, 2004). Instead of saving the soul, it is a person's physical and psychological health that is in need of saving, while it is the knowledge of the psy-sciences that acts as the authority and means by which to know a person's inner world. It is all 'those tender and beneficial forms of attention and regulation operating on the basis of the mechanism of love, or some heart-felt "calling", which nonetheless serve state power-interests even whilst facilitating greater well-being' (Hook, 2003, p. 617). As such, it highlights the asymmetrical nature of power relations in a practice that is more usually constructed as empowering and promoting agency in the individual with bipolar disorder (Smith, Jones, & Simpson, 2010; Stafford & Colom, 2013).

Through the way The Manual uses language to sanction its view on the truth, it takes on the appearance of a rule book, a list of do's and don'ts, and, as such, brings with it a sense of it as a moral code – this is the only way to understand and live with bipolar disorder. As ideas of pastoral power suggest, healthcare practices including psycho-education are provided from a desire to heal suffering and not exacerbate it. What this analysis suggests is that while that may be the stated intention, psycho-education practices may also be acting upon subjectivity in ways that are undesirable. For a simple summary of the practical implications, please see Table 7.1.

Summary

Using a Foucauldian inspired discourse analysis we have shown how in a psychiatric discourse everything about the person with bipolar disorder is

Table 7.1 Clinical practice highlights

1. Psychiatric discourse dominates how bipolar disorder can be understood and, in the process, provides a limited vision of how a person can live with it successfully.
2. Engaging in practices of self-management enters people into relations of power that are not necessarily empowering in nature.
3. Discourse analysis provides one way for mental health clinicians to step back from the way they use language, consider the effect it has upon subjectivity, and change how they use words as a result.
4. Mental health clinicians are ideally positioned to develop ways of working with people that allows space to explore assumptions about self and others and find ways of constructing experience that are enabling.

interpreted in terms of the condition they are understood to have and how the psy-sciences have a tightly regulated way of constructing what bipolar disorder is and an equally all-encompassing approach to understanding the person who is understood to have the condition. This discourse analysis also demonstrates the productive capacity of discourse and the way it makes it possible to think in certain ways and exclude others. Psychiatric and scientific discourse makes particular things thinkable and understandable (Parker, 2004; Rose, 1999) and, in doing so, creates a particular space to play out one's life on the basis of knowledge that stakes out the boundaries of those things that are permissible and those that break the rules. Using techniques of a secular pastorate, psychoeducation calls people to take on a way of understanding and caring for the self that relies only upon the authority of medical science because of its truthfulness and trustworthiness. Any attempt by people with bipolar disorder to think and speak outside of these positions them as lacking self-awareness which for psychiatry makes them potentially suffering a relapse.

But what does it mean for a person's sense of self if they are ambivalent about psychiatry's views on bipolar disorder? What about those who recognise themselves in the tale of the three little bipolar pigs but are not able to live to its standards? Those deemed successful at self-management get to construct themselves as responsible, thoughtful, and self-aware, while those who don't or can't would seem to be left with few ways to make sense of themselves beyond unruly, oppositional, or resistant.

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8

Discourses of Autism on Film: An Analysis of Memorable Images that Create Definition

Andrea Garner, Valerie Harwood, and Sandra C. Jones

Introduction

The characteristics that provide a platform for a categorical distinction between being 'disabled' and 'abled' is arguably dependent on the shared understanding and socially agreed upon ideas of a group of individuals. Collectively, groups derive meaning through communications and interactions with each other and their environment using particular language and common assumptions (Prawat & Floden, 1994; Rogoff, 1990). The intersubjectivity of the community aids in shaping personal meaning of their position in relation to another person's position. Some argue that the intersubjectivity, or shared understanding, creates social meaning and knowledge of ability and disability which are socially constructed dichotomies, and that through the polarised construction people are positioned on one side or another of an apparent factually based line of difference (Kang, 2009; Scully, 2009; Titchkosky, 2003; Williams et al., Chapter 4, this volume). The construction and definition of disability arise through a variety of mediums including social, cultural, historical, and political discourses (Scully, 2009). As disability is constructed so to is the 'line of difference' that distinguishes the abled from the disabled. This line of difference is continuously constructed and reconstructed to coincide with changing cultural, political, and personal landscapes. These landscapes are constantly changing as a result of multiple influences including, although not limited to, gaining new information or exposure about a topic.

While members of a community communicate and engage with one another, they transmit ideas and derive knowledge from interactions with their environment. It is argued by social constructionists that learning takes place in a social context and constructing knowledge about new information happens through

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Some of the content of this chapter are excerpts from the doctoral thesis by Garner (2014).

exposures to more knowledgeable members of the community (Schunk, 2000; Vygotsky, 1986). Of particular interest in the construction of ability and disability are the seemingly knowledgeable members of specific communities who utilise specific language and promote apparently agreed-upon ideas to the new, less knowledgeable members of the community. For example, educators and support workers apply personal meanings of disability shaped through experiences and interactions with their environments and communities to those they encounter, specifically students or clients. Therefore, it is useful to understand the language and socially agreed-upon ideas about the line of difference between 'abled' and 'disabled' that these members of the community promote through the intersubjectivity of the group as a 'reality'. In other words, it is important to investigate not only the ideas that position an individual with an impairment as 'disabled' but also, the social, environmental, and intersubjective communications that contribute to the continuing dichotomy. Indeed, diagnosing a mental disorder is in itself an interactional achievement (Roca-Cuberes, Chapter 10, this volume).

Historically, certain abilities and disabilities have garnered public intrigue, and these generally correspond with the interests or agendas of both the scientific or political communities. The various landscapes interact producing and reflecting the interests of one domain through the text of another. This intersect between the social and the scientific arenas results in what Singh, Hallmayer, and Illes (2007) referred to as 'flocking'. Flocking is particularly evident in recent times in relation to autism spectrum conditions, commonly referred to as autism, where both science and society have experienced an increased focus on cause, cure, interventions, and support strategies. The increased social interest in autism may have begun with the film *Rain Man* (1988) (Murray, 2008, 2012) and has continued to captivate the social conscience through media stories revolving around vaccinations as a cause (Singh et al., 2007), stories of despair and heroism, funding, and new research campaigns (Jones & Harwood, 2009). As the scientific world continues to seek information about the nature of autism, the social representations of autism continue to increase through media and film narratives that speculate on the unknown cause and effect of this condition.

The definition of autism has been a topic of debate, most recently with the changing medical model definition found in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (*DSM-5*) (American Psychiatric Association, 2013). Autism spectrum conditions (referred to as autism spectrum disorder (ASD) in the *DSM-5*; American Psychiatric Association, 2013) have no known cause and have a lifelong impact on the individual. Typically, autism spectrum conditions are defined as affecting the social communication, the social interaction, and the social imagination (Wing, 1981). However, the unidentified nature of autism, coupled with the many talents and abilities that members of the autistic community have demonstrated, blurs the defining 'line of difference'. The blurring of seemingly factual distinctions between the abled and the disabled has arguably led to a public fascination with autism (Murray, 2006, 2012; Wing & Potter, 2009).

The public fascination is reflected in the increased presentation of autism spectrum conditions in visual and print media (Conn & Bhugra, 2012; Wing & Potter, 2009). In addition, Wing and Potter (2009) contend featuring autism 'virtually guarantees the economic success of the production', a prospect to which they attribute the increase in media featuring 'autism'. Notably, the media plays a central role in the production of and attention to mental disorders (e.g., see Fowlis, O'Reilly, and Farrelly, Chapter 9, this volume; Giles, Chapter 16, this volume), and in particular the increase in autism-related texts are an indicator of the burgeoning presence of autism in the social consciousness. As the profile of 'autism' rises through social artefacts such as media, the lay public is presented with notions of what it means to have an autism label. In addition, the potential for construction of knowledge regarding defining the parameters of 'being on the spectrum' increases. This is to say that the influence of media on viewers is worthy of exploring because 'what representations of autism do is to systematically form particular notions of "autism"' (Jones & Harwood, 2009, p. 6). As such, this chapter will focus on entertainment media, specifically film, as films have the power to influence viewers through persuasive narratives and parasocial relationships with characters (Moyer-Guse & Nabi, 2010). In this chapter, we are concerned with the cohort of viewers who are regarded as knowledgeable meaning makers, for example teachers and carers, as these viewers both construct and impart ideas about ability and disability.

The social, medical, and political flocking towards the autistic spectrum has typically focused on children, with funds being directed at early intervention and searches for cause and cure. There has, until very recently, been little focus on the ageing individual on the spectrum. The lack of interest in late adolescence and early adulthood is evident through examination of the limited options and opportunities experienced by this cohort across the globe (Dempsey & Ford, 2008; Taylor & Seltzer, 2011). A similar lack of interest in the adult with autism can be seen in the social artefact of film. The production of films featuring characters on the spectrum has increased each year since the millennium and continues to grow (Conn & Bhugra, 2012). However, until the millennium the featured characters were usually children (or savant adults with childlike characteristics).

The manner in which the media frames topics can contribute to the development of an inexperienced individual's understanding of that topic. Santos (2004) argues that the media is often the main reference for new information for the inexperienced viewer. The inexperienced person's knowledge about a disability could range from a broad awareness to a simple definition of a term (for instance, having heard of the term 'autism' while having no specific knowledge of what it means). The media, especially entertainment media, often portrays evocative framing of disabilities (see, for instance, Russell Crowe's depiction of schizophrenia in *A Beautiful Mind*, 2001). Significantly, the viewer's reliance on the media's semantic descriptions, visual presentations, modelling of interactions between characters, and emotive nature of the film likely influence the cultivation and synthesis of 'new knowledge'. The intersubjective dialogue between the inexperienced and experienced viewers the 'new knowledge' is confirmed and aides in the construction of new ideas about 'autism'. Essentially, the characteristics of the filmic character portrayal and the details the viewer recalls about a character can contribute to the collective defining and redefining of 'autism'.

Films possess a definition producing quality which results from depicting stereotypes and archetypes in an entertaining and consumable way (Draaisma, 2009; Moyer-Gusé, 2008). The exploration of the entertainment film portrayals of autism and how scenes are recalled provide some insight into how teachers and carers perceive autism. This is important because teachers construct disability through their everyday experiences and ideologies as they exercise their beliefs about the students they teach (Collins, 2003). Demonizing or glorifying the presence of savant skills, for instance, risks propagating a negative ideology. For instance the notion that to be of value an individual on the spectrum requires compensatory qualities (Draaisma, 2009; Murray, 2008). Such notions have been found to increase the stigma experienced by people with disorders as a consequence of the public being exposed to inaccurate portrayals (Gabbard & Gabbard, 1999).

As such, this chapter will explore two contributors to the definition of the difference labelled ASD. First, the defining parameters of autism as they are constructed through the social artefact of entertainment film will be explored. Here it is argued that the presentation of spectrum characteristics provides a deficit perspective of autism through the presentation of limited and similar abilities, or disabilities, providing the viewer with the misperception that those individuals on the spectrum range solely from 'severe' to 'severe with savant skill'. Second, the significant scenes from three films featuring a character with autism as pre-service teachers recall them will be presented. As previously mentioned, the teacher/carer cohort are influential people since their personal construction of disability may influence the social construction of disability for those they educate and impact the collective social positioning of the person on the spectrum.

Project overview

The data and analysis discussed in this chapter are a combination of two larger studies conducted by Garner (2014) as part of a doctorate degree. The first study was a detailed character and dialogue analysis of films portraying characters on the spectrum and the second was a study of pre-service teachers' attitudes and knowledge and the influence of exposure to films featuring characters on the spectrum.

To conduct an analysis of the film characters in the first study, a two part search was undertaken to identify films featuring characters with autism. The first part of which was a search of academic databases for journal articles, books, and conference proceedings that referenced films about disability and/or autism, Asperger syndrome (AS), high-functioning autism (HFA), or ASD. The second aspect of the search was of grey literature using search engines such as Google, Bing, and Yahoo, as well as the search tools on websites for autism and Asperger organisations.

The resulting list was subjected to an independent search to verify the presence of characters portraying the spectrum using the Internet Movie Database (IMDB; www.imdb.com), as was done by Hartman (2006) and Conn and Bhugra (2012). This list was then subjected to the inclusion of criteria that the film was released prior to 31 December 2010 and that it identified a character with an autism spectrum condition in the synopsis on the Internet Movie Database (IMDB, www.imdb.com), DVD synopsis, or film trailer. The films identified in the IMDB synopses were verified to feature a character on the spectrum by checking the DVD boxes or trailers. Where there were discrepancies between the IMDB synopsis and the DVD description or trailer, the printed descriptor on the DVD box or oral descriptor in the trailer was taken.

The second part of the analysis aimed to understand how viewers recalled specific films or scenes in these films. The original study was a pre/post/follow-up survey design. This chapter reports the responses to the open-ended questions about scene recall, which were items on the post–film viewing and follow-up (four weeks after film viewing) surveys. The films selected for viewing were *The Black Balloon*, *Molly*, *Snowcake*, and *Mad Love*.[1] The findings pay particular attention to the quoting of dialogue by viewers and emergent themes from the recalled scenes since the choice and delivery of dialogue has been shown to sway the construction of learning and ideas (Kozloff, 2000) and the scenes with negative valence have been found to be more memorable (Anderson & Shimamura, 2005; Fischoff, Cardenas, Hernandez, Wyatt, Young, & Gordon, 2000).

The post-activity survey was completed on paper by 104 participants after attending the two-hour film viewing session, and 78 participants completed the follow-up survey online via Survey Monkey (Survey Monkey, 2015) four weeks after viewing the film. Survey Monkey is online software for conducting surveys and was used because participants can access it at their leisure and submit their responses anonymously.

Findings

Characters and their defining features

The film list from the original search of academic and grey literature prior to verification (n = 108) is available from the author. This list comprises every film referenced in academic and gray literature as featuring a character with an autism spectrum condition (as at 31 December 2010). Through the application of the inclusion criteria, a number of films were excluded from the final list, reducing the number of films to 49.

The character(s) portraying ASD (n = 52)[2] in the 49 films were analysed by gender, ethnicity, and age. The films primarily featured male (n = 35) children and adolescents (0–17 years, n = 33) that were Caucasian (n = 47) in appearance.

Defining scenes

The results from the post-activity survey and follow-up survey, open-ended questions are unmatched and presented as a single group (n = 144): *The Black Balloon* (n = 24 post, n = 23 follow-up); *Snowcake* (n = 16 post, n = 12 follow-up); *Molly* (n = 19 post, n = 15 follow-up); *Mad Love* (n = 19 post, n = 16 follow-up) (Garner, 2014).

The responses are discussed in three emergent themes: most memorable scene, references to autism-related behaviour, and references to the relationships between characters in the film. Finally, post- and follow-up matched responses (n = 78) are examined for differences in recall of detail, emotive valence, and descriptive language to explore defining qualities from the films which may be used in the construction of viewer definitions of autism-related ability and *dis*ability.

The Black Balloon

The Black Balloon had the largest viewing group (n = 33) and largest number of completed open-ended responses, a total of 47 comments (n = 24 post, n = 23 follow-up) that are summarised below (Garner, 2014).

Most memorable scene. There were a select number of scenes that elicited multiple comments from viewers. A majority of the comments (n = 25) identified ‘the fight scene’ as memorable. This scene was the dramatic climax of the film and illustrated the line of difference through a literal battle between the ‘able’, neurotypical brother, Thomas, and the ‘disabled’, autism affected brother, Charlie. The brothers engage in a fistfight and results in Charlie having to visit the hospital for stitches. This scene was the result of Thomas’ anger at his brother’s difference. It clearly portrays Charlie as a victim of misunderstanding and Thomas as a teen frustrated with the burden of having a brother on the other side of the line of difference. The scene is highly emotive and elicited compassionate descriptors such as ‘distressing’, ‘shocking’, ‘sad’, and ‘very emotional’ (Garner, 2014).

The interaction between viewers and characters demonstrates a compassion for Thomas and pity for Charlie. This perception is demonstrated in the following statements made by participants: ‘Thomas was ashamed and embarrassed of his brother’ (Participant 45); ‘when they had a fight and Thomas smashed Charlies [*sic*] play station’ (Participant 56); ‘When Thomas hits Charlie’ (Participant 54); and ‘when the main character, the brother of the boy with autism started fighting his brother, saying how much he hated him’ (Participant 42).

The other scenes that viewers frequently referenced were those regarding behaviours associated with autism spectrum conditions in the film and those grounded in the relationships between the characters. These scenes are discussed below since they may contribute to forming definitions of autism.

Behaviour related to ASD. Many of the comments referring to behaviours that were associated with the spectrum (n = 23). A majority of the references were to the smearing of faeces on the bedroom carpet or entering a stranger’s house to urinate. The comments describing these events generally indicate an allegiance to the belief that persons with autism are passive in their existence and that Charlie had no choice in his behaviour. For example, one participant stated, ‘he had no idea what he was doing was not normal and didn’t comprehend what he was doing’ (Participant 48).

A majority of the comments referenced unacceptable or odd behaviours. These scenes at times provided comic relief, for example Charlie putting an unused tampon in his mouth, while other scenes clearly articulated Charlie’s inability to cope within a typical social context.

Relationships. Overwhelmingly, comments made by participants described a relationship or an action that resulted from shifting dynamics within a relationship. For instance, in describing a relationship, ‘they helped Charlie cope with the rainstorm and he was able to have a meaningful day’ (Participant 40), versus actions resulting from the shifting dynamics as illustrated by these participants, ‘Charlie said sorry to Thomas… he understood he had done something wrong’ (Participant 53), or ‘when the brothers fought near the end, and then when they acted in the play together. It was great contrast, and I think it portrayed the true nature of the relationship between them’ (Participant 73).

Participants noted disapproval of characters who blatantly voiced the line of difference. For example, one participant commented, ‘when Charlie was teased and publicly humiliated. The constant disapproving looks and judgement from those who were ignorant stood out for me’ (Participant 39).

The social and familial impact of being in proximity of a person on the spectrum was also noted in responses to the open-ended question about whether the participants discussed the film with anyone. Most viewers (n = 21) had discussed it and noted: ‘it was interesting and gave a very personal account of the families [*sic*] struggle and society's view' and 'I told them (my friends) what the movie was like and how living with someone with these needs affects people'.

Snowcake

Snowcake was viewed by 24 participants. Over half of the participants responded to the open-ended questions at post-activity (n = 16) and half completed open-ended questions at follow-up (n = 12) (Garner, 2014).

Most memorable scene. The participants did not recall any overwhelmingly climactic scene. This film featured a woman on the spectrum who lived semi-independently and had a daughter. Interestingly, this film was not reported to have any major climactic scene. The most noted scenes (n = 8) from this film occurred at opposite ends of the film. The first scene took place within the first 15 minutes of the film and featured the death of Linda's daughter, Vivienne. The second scene being the funeral/wake scene that occurs in the last 15 minutes. The comments regarding these two scenes referenced the explanation of the daughter's death and the wake, and referred to the main character's atypical response to events (the death of a child) that would carry a social expectation of grief and sadness. One respondent commented, '…the simplicity of her joy contrasted with the black and white way in which she dealt with the loss of her daughter. Complex, yet beautiful' (Participant 31).

Behaviour related to ASD. The participants recalled many moments from the film which they utilised in the construction of what it means to be 'high-functioning' and autistic. All 24 comments referred to her autistic characteristics (rigid, routined, and literal with unexpected emotional expression) or autism-related behaviours (self-stimulatory behaviours such as jumping on a trampoline or interest in sparkly things). These autism-defining observations were noted in comments such as, '(the character's) obsessive for cleanliness tidiness [*sic*] and contamination showing a symptom [*sic*] of a disorder' (Participant 32), and 'the protagonist's obsession with snow' (Participant 24).

The largest number of comments pertaining to behaviours emphasised the unexpected and abnormal emotional responses by Linda (the character with high-functioning autism). Participants seemed unable to relate to Linda, placing themselves on one side of the line of difference and she on the other. They referred to Linda's atypical responses with confusion, for example, 'she isn't upset in a conventional [*sic*] way. She almost seems wise (Participant 22) or, when Linda is told of her daughter's death, '…she brushes it off like she is lacking the emotional side to understand what has happened' (Participant 23).

Participants also referenced the disparity between acceptable and odd responses. For example, the lack of socially anticipated emotional expression for dramatic events, such as the death of a child, and the extreme emotional display over socially considered inconsequential events, such as spilling liquid on the carpet. One participant said, Linda has 'no emotion for significant event, extreme for insignificant' (Participant 25), and then recalls at follow-up, 'her misplaced emotions (not crying that the daughter has died, but devastated by a stain on the carpet)' (Participant 25) (Garner, 2014).

Relationships. The few (n = 7) comments regarding relationships were about the unfamiliar way in which Linda connected with people around her: 'music and dance was how she connected to her daughter' (Participant 26), and, 'In order to cope with the intrusion of guests to her home she plays her daughter's favourite music loudly and danced in memory of her daughter. Linda accepted the death of Vivienne as an inevitable event that happens in life. The scene of the guests in Linda's home after Vivienne's funeral. People in her home was challenging and in order to regain her private life again Linda puts on one of Vivienne's favourite music and danced in the way Vivienne did. This was the closest connection Linda displayed in her grief but it was a joyous memory of her daughter' (Participant 32).

Additionally, participants noted that they felt protective of Linda, a sentiment that was modelled by the main male character (Alex) and Linda's daughter (Vivienne), because of her childlike innocence. One participant commented, 'you start off not quite knowing how to react to her character, but by the end you are moved and really feel the protectiveness that the main male character and her parents feel for her' (Participant 31).

A majority of the comments, however, indicate that the viewers perceive Linda to be unequivocally on the opposite side of the line of difference to themselves. For example, one viewer notes 'the scene where the main character is dancing with her daughter (who is deceased), and also her misplaced emotions (not crying that he daughter has died, but devastated by a stain on the carpet)' (Participant 25).

Molly

Finally, the film *Molly* which had the smallest viewing group (n = 19) and received 44 comments from participants (n = 19 post, n = 15 follow-up) provided many visual and auditory displays, which at many points were framed as facts, for viewers to incorporate into their definition of 'autism'.

Most memorable scene. The majority of comments elicited by this film related to the relationships between characters which can be classified into two categories. The first category comprised scenes of a surgery that 'cured' the main character, Molly, of autism and her reversion 'back to an autistic state'. The second category of scenes comprised humorous scenes that resulted from Molly being in a state of limbo between being neurotypical (cognitively typical) and being 'autistic' (Garner, 2014). Although some viewers were savvy enough to realise no such "cure" exists, illustrated by one participant said, 'I didn't like that she had surgery to make her 'normal' and that her being 'normal' was celebrated. Everyone is beautiful and unique in their own special way. There should be no need to change that' (Participant 73) the underlying message delivered through the film is pervasive: autism needs to be cured, and declining into an autistic state of being is a loss of quality person. The latter category referenced scenes of 'tying every piece of string in the house, interrupting a theatre production and becoming upset at a fancy restaurant' (Participant 82).

Behaviours related to ASD. Only 11 of the comments referred to autism-related behaviours. The 11 scenes the viewers recalled were intended to be humorous, and the humour resulted from the character's difficulties in understanding social conventions. For example: 'repetition of scripts from books/films by Molly; beach; lobster at dinner' (Participant 76); 'in the lift when Molly punches all of the buttons' (Participant 75); 'she interrupts a play that she was watching, thinking it to be true' (Participant 80); 'Molly ties the shoes laces of every shoe in the house once she learnt how to tie shoe laces' (Participant 66); and 'the scene where Molly wets herself' (Participant 64).

Relationships. The film emphasised Molly's relationship with her brother, Buck, or her love interest, Sam. Most comments about Buck highlighted that the viewers placed Buck on the able side of the divide with themselves and Molly on the other side, definitively different from themselves. For example, 'the brother's obsession with his sister being "normal"' (Participant 70); 'when told Buck that she always knew who he was and she would wait every year to see him at Christmas. She explained that although she had difficulties expressing herself, she still loved him and cared about him when her condition was bad' (Participant 71); or his eventual acceptance of Molly, as noted by this participant, 'Buck realised that even though she will be as she was, she will still be a "person" on the inside' (Participant 77).

The film featured Molly's relationship with a carer named Sam. Sam seemed to have an untold connection with Molly which may be attributed, it is implied, to Sam's own disability. In placing Sam and Molly on the same side of the divide between 'normal' and 'abnormal', the viewers seem to expect that these two individuals with differing challenges will undoubtedly understand each other. For example, 'when Molly and Sam are sitting by the fountain and she's afraid to 'go back' to her old self and he says he'll never leave because he'll always know it's her' (Participant 70).

Some comments alluded to Molly's relationship with autism. Through references of her fear of losing skills she had gained since the surgery. For instance, 'go back to her "original" self' (Participant 69), or the impact of portraying a first person account of the experience of autism through explanations Molly provides; 'when she said that everyone talks about her as if she's not even there and that she can understand what they are saying' (Participant 63). Additionally, viewers commented that Molly is a person 'in spite' of her autism, demonstrating there may be a lesser value attributed to the disabled than that afforded to the able.

Perpetuating Images

The intersubjectivity derived from viewing any of these films is increased through discourse and discussion with others who hold membership to able side of the line of difference. The imagery and vocabulary used in these films may be incorporated into dialogue in the broader community as viewers relay their understanding of the content and put forth their recommendations for further viewing. There were 91 participants that responded to the questions pertaining to discourse and discussion, and each of the three films elicited responses from approximately 20 participants (*The Black Balloon*, n = 24; *Molly*, n = 22, *Snowcake*, n = 21; and other n = 4). The category 'other' indicates that the participant could not correctly identify which film they viewed.

A majority of the participants claimed to have discussed the film with peers, colleagues, or family (75.8% n = 71, *The Black Balloon*, n = 21/24; *Molly*, n = 15/22, *Snowcake*, n = 18/21; and 'other' n = 3/4). Additionally, 70.4% said they would recommend the film to learn about the specific disorder/disability. A mean comparison showed that *The Black Balloon* (M = 1.5, n = 24) was the most recommended, followed by *Snowcake* (M = 1.88, n = 17), and then *Molly* (M = 2.28, n = 18) (Garner, 2014). The recommendation of these films, which have been perceived as accurate accounts of *the* 'autistic life' by some viewers, further defines the parameters of being autistic and broadens the line of difference. For example, one viewer of *The Black Balloon* stated, 'I told them (my friends) what the movie was like and how living with someone with these needs affects people'.

Educational relevance summary

The representations of autism in the films explored in these studies has classified the spectrum in specific and limited terms by adhering to restrictive representation qualities. For example, a majority of the characters portraying autism are male Caucasian youth. Having a larger number of male characters may not misrepresent the reality of the prevalence of autism in the population as there is a four to one ratio of males to females among those with an autism label (Williams et al., 2008); however, autism is lifelong and does not have a higher prevalence rate in certain ethnic or cultural communities nor at specific ages, a possibly implied 'reality' from film representations. These misrepresentations are particularly important when considering the impact on adults on the spectrum. In general, because films tend to portray autism as a plot device (Mallett & Runswick-Cole, 2012; Murray, 2006, 2012) in the drama genre, the characters, even the adult characters, possess an innocence or incompetence. The adult character is frequently used in the plot to construct an 'able' character as a more conscientious person, for humour, or to use their super skill to assist the 'able' character in some manner. This representation is acknowledged and adopted by the viewers, which is demonstrated as they recall emotive scenes of inability, burden, comic relief, or resolution of the portrayed 'able' character into being a more tolerant and compassionate being. The intersubjectivity, or shared understanding among the pre-service teacher viewers in these studies, that being on the spectrum is distinctly and categorically opposite to themselves and littered with negative experiences, limited capabilities, and poor inclusion skill. Notions that not only create inaccurate and damning knowledge, but also perpetuate the existing constructed 'reality' of limitations imposed through misunderstanding and discursive practices.

Furthering the inaccurate socially constructed idea that people on the spectrum have limited capabilities, the films rarely describe, illustrate, or imply an evolving character on the spectrum. Typically, this medium represents people on the spectrum as stagnant entities, who have not learned what they know, nor will they ever evolve beyond what they are; the films explored in this chapter imply that a person with the label autism will forever be *us*able but not able (Garner, 2014). The adult with autism, as shown in these films, even when living on their own, is essentially stuck in the present, shown as having no future to work towards and no past to evolve from. This representation clearly distinguishes those who are useful and contributing adult members of society from those who accomplish solely as a result of the presence of a generous person from the 'able' side of the line of difference. As Collins (2003) states, disability is constructed through everyday experiences as people exercise their beliefs about those they are interacting with. While the adult viewer is witnessing the *dis*abled character in relation to the abled character, it is possible that they forge an alliance with the 'abled' seeing themselves as more similar to this group (Moyer-Gusé, 2008). This has the impact of further constructing broad 'lines of difference' between viewers in caregiver roles and those on the spectrum. Furthermore, in the context of the education and carer communities, interaction with seemingly knowledgeable members of their allied group, albeit portrayed members, who participate in a dialogue that is presenting people on the autism spectrum as vastly different, limited in development, and at times pathetic, may have a direct impact on the treatment of adults on the spectrum. For example, maintaining the perception or assumption that people on the spectrum cannot gain independence, learn new skills, or contribute to relationships in a meaningful way could contribute to idleness on behalf of professionals who adopt this socially constructed idea of autism. In approaching persons on the autism spectrum from a constructed reality of limitation, the individual on the spectrum is inherently limited in their ability to achieve.

In addition to the potential perpetuation of negative stereotypes, the viewers recalled scenes that were highly emotive and negatively valenced most often. It should be noted, however, that while *The Black Balloon* had specifically memorable scenes, *Molly* elicited recall around relationships and *Snowcake* around autism spectrum-related behaviours. Irrespectively, it is evident that exposure to emotional content in film can be recalled over time as demonstrated by the recall of emotionally valenced scenes on the post-activity survey and the follow-up survey four weeks later (Garner, 2014). There is also evidence to support the memory of the title event rather than the details of the circumstances surrounding the events. These moments are recalled, at times inaccurately, but these are the instances that are emotionally charged. In films featuring characters portraying disability, these moments are the fragments of time in which the individual is not coping or has not responded to a situation 'appropriately', which when recalled later as title events and paired with the label of autism can have enormous negative impacts on individuals affected by this disorder. For instance, Greenburgh (1988) contends particularly memorable or strong portrayals of characters may have more influence on the viewer than less memorable but more frequent exposures; thus, a single portrayal could shape a viewer's parameters of definition towards a minority group. The negative impact arises from recall of these scenes that afford the viewer the opportunity to reduce the complexity of living with an autism spectrum condition down to a snapshot (Valentine, 2001).

The recall of climactic scenes may contribute to forming the features of a concept, for example when thinking of autism. The information the viewer retrieves from these scenes could lend insight into how complex experiences are recalled as discrete events. Furthermore, the transfer of negative notions of autism from experienced carers to inexperienced seems probable since 75.8% of viewers said they had discussed the film they viewed with someone. These 'social mentions' further the potential impact on individuals with a disability that is featured in film, particularly because the recall is poor, generalised, and negatively valenced as is evidenced in the results discussed above. Take for example *Molly*. While nine participants said they would not recommend this film to someone who wanted to learn about the disorder, 13 said that they would. Given some of the film's content, encouraging friends and family to view this film is a potentially problematic as it increases the potential to 'flock' towards the obscured and unrealistic perception of living with autism displayed by the character (Garner, 2014). This film depicts a brain operation that 'cures' a woman of autism and shows her 'sad decline back into autism', and yet it was deemed entertaining, involving, and discussion worthy and was being recommended. For a simple summary of the educational implications, see Table 8.1.

Table 8.1 Educational practice highlights

1. Characters in entertainment films that are portraying autism spectrum conditions are typically extreme displays of autism characteristics shown by male Caucasian children.
2. Many of the characters portraying autism in films do so in the drama genre and act as plot devices rather than developed characters.
3. Pre-service teachers remember highly emotive and negatively valenced scenes from specific films featuring characters portraying autism.
4. Pre-service teachers likely incorporate the negative and emotive images from memorable scenes into their definition of autism and act upon those beliefs.
5. Filmic characters portraying ASD contribute to discourses of definite difference and undeniable inability that can lead to stereotyping and discursive practice.

Summary

The social artefact of entertainment film provides easily consumable and memorable concepts that can be used as defining qualities of autism. Portrayed as a primarily Caucasian male disorder, autism has been framed as burdensome, overly severe, and intriguing due to mysterious super skills (Baker, 2008; Draaisma, 2009; Murray, 2008; Sarrett, 2011). In comparison to the reported incidence of autism spectrum conditions in the population, the filmic representations of persons on the autism spectrum are few relative to the total number of films produced each year. Furthermore, the scope of character portrayals remains limited compared to the vast array of possible characteristics associated with persons in the autism community. The proliferation of one-dimensional media images contributes to a limited understanding of human differences and a shallow perception of autism.

Considering the observable power of film to draw viewers into the story, as well as the viewer's limited accurate recall, further research into the real-world impact of exposure to portrayals of human difference is required. This chapter has discussed the scenes from films featuring characters on the autism spectrum and found that the viewers recall scenes that provide support for the distinct line of difference and allow for a comfortable distancing between themselves and the 'other'. Further, building awareness and promoting discussion of portrayals of human difference could increase the production of a positive discourse of autism spectrum representations and thereby avoid reducing the lived experience of autism to a few emotive snapshots.

Notes

1. *Mad Love* acted as the control film as it featured a character with clinical depression rather than autism. The details of film selection are specified in a paper which is under review and available from the first author, Andrea Garner.
2. Some of the films featured more than one character on the spectrum.

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Recommended reading

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9

Abuse Victims and High-Profile Offenders: A Discourse Analysis of Victim Construction and Adult Mental Health

Naima Fowlis, Michelle O'Reilly, and Mary Farrelly

Introduction

> *Unfortunately, evidence worldwide indicates that children and adolescents are at risk from sexual predators, exploiters, and opportunists.*
>
> (Lalor & McElvaney, 2010, p. 159)

When individuals are sexually abused in their childhood, it can have a long-lasting effect on their well-being and mental health. Child sexual abuse has been at the root of many scandals globally, many of which have been exposed by the media. This form of abuse of children is a widespread issue that affects children of all ages, and their socioeconomic and cultural backgrounds (Modelli, Galvão, & Pratesi, 2012), and is carried well into and throughout their adult years. Consequently, the impact of being a child victim of sexual abuse has attracted a great deal of media attention and there is now a broad research literature examining these issues. In this chapter, we focus on how traumatic incidents in childhood can have a significant impact on adults who were childhood victims of sexual abuse. Specifically, we examine this phenomenon in the context of celebrity abusers, to examine how media spotlight on such high-profile cases creates an additional layer of complexity in relation to the discourse of blaming victims and mental health construction of the now adult individuals.

The mental health effects of being sexually abused

Recognition of the impact of trauma on the mental health of individuals has formed the basis of numerous investigations into the occurrence of mental health problems among individuals who have experienced adverse events in childhood. There is now a long-established evidence base that sexual abuse is associated with an increased risk of developing a mental health problem, attempting suicide, and abusing drugs or alcohol (Leserman, 2005). Spataro, Mullen, Burgess, Wells, and Moss (2004) argued that the most compelling research into discovering a link between child sexual abuse and adult mental health comes from community samples, birth cohorts, and twin studies (e.g., Burnam et al., 1988; Kendler, Thornton, Gilman, & Kessler, 2000; Mullen, Martin, Anderson, Romans, & Herbison, 1994); historically, the majority of the research studies investigating the impact have focused on female victims (Easton, 2013).

The research on female victims who have been subjected to sexual abuse in childhood has repeatedly illustrated that these women suffer more psychopathology in adulthood (Browne & Finkelhor, 1986; Tong & Oates, 1990), with the mental health effects including affective and eating disorders (Palmer, Oppenheimer, Dignon, Chaloner, & Howells, 1990; Root & Fallon, 1988), somatisation disorders (Morrison, 1989), a range of personality disorders (Coons & Milstein, 1986), and suicidal behaviour (Briere & Runtz, 1986). Research has also identified a clear link between child sexual abuse and post-traumatic stress disorder (PTSD) (Epstein, Saunders, & Kilpatrick, 1997). While psychotic disorders have until recently been solely attributed by psychiatry to biochemical factors, recent research indicates strong associations between childhood adversity, including sexual abuse, and the experience of psychosis and schizophrenia in later life (Bebbington, 2009; Morrison, Frame, & Larkin, 2003; Read, 2013; Shevlin, Dorahy, & Adamson, 2007).

Notably, not all victims are treated the same by society, and the dominant social understanding of females being victims of male offenders has been challenged (Owen, 1995). For example, in domestic violence situations, there are occasions where men have been abused by their partners (Stam, Zverina, Radtke, & Babins-Wagner, Chapter 33, this volume). Child sexual abuse can involve both male and female victims, and the issues faced can differ to some extent. While historically given less attention in the literature, there is now a growing understanding of male victims (Easton, 2013). This contemporary research has illustrated that both male and female victims of abuse have significantly higher rates for treatment of mental health problems, with rates being especially higher for childhood mental health problems, personality disorders, anxiety disorders, major affective disorders (Spataro et al., 2004), and substance abuse disorders (Molner, Buka, & Kessler, 2001). Similarly, Paolucci, Genius, and Violato's (2001) meta-analysis found that abuse during childhood had an impact on adult mental health functioning among men and women. However, while there is a clear association between the experience of sexual abuse in childhood and mental health problems in adulthood, this is influenced by a number of factors, such as the severity of the abuse (Dube et al., 2005), individual psychology, and the quality of parental, peer, and subsequent adult relationships (Collishaw et al., 2007). An important factor in child sexual abuse is disclosure, in relation to both gaining support for the victims and for wider societal reasons in terms of prevention. Mc Elvaney, Greene, and Hogan (2014) suggested that early disclosure can lessen the psychological impact of abuse; however, willingness to disclose has been shown to be linked to anticipated reactions, including fear of rejection, blame, and disbelief (Heshkowitz, Lanes, & Lamb, 2007; Mc Elvaney et al., 2014).

The social construction of victimhood and the rhetoric of blame

Clearly, the ways in which victims are perceived by society have implications for their willingness to come forward and subsequent coping, as well as coming to terms with what happened. Although disclosing abuse can have some positive effects (Arata, 1998), as the impact on their mental health can be attended to by professionals through medication and therapy, the mere act of disclosure can in itself have a negative impact on mental health (Lamb & Edgar-Smith, 1994). Problematically, a core concern for the child/adult is that they can be left dealing with the additional effects of a blaming rhetoric from society.

Victim status is frequently associated with negative traits, and societal views on these characteristics have led to similar negative connotations being afforded to people assigned the position of 'victim' (Leisenring, 2006). For example, in the past the legal discourse related to female victims has found that young girls were seen as malicious and responsible for their abuse (Smart, 1999), thus denying recognition of their vulnerability as victims. This wider blaming discourse is in addition to the problem that the victims are often blamed for the abuse by their perpetrators (Davidson, 2006). Thus the accountability and the responsibility discourse of offenders are rhetorically offered as external to the offender. Many individuals blame themselves for the abuse for a variety of complex reasons (Mc Elvaney et al., 2014), and while some victims reject this assignation of blame, it adds a level of difficulty to their circumstances, and many victims do indeed blame themselves (Davidson, 2006). This overt rejection of blame is complicated by complex psychological intrapersonal processes that result from the experience of abuse, where the 'vicitim's' individual notions about personal responsibility and the humiliation and powerlessness experienced as a result of the abuse frequently converge to cause them to internalise blame (Paivio & Pascual-Leone, 2010), impacting significantly on their mental health. Resistance to the victim discourse is evident in movements which have sought to re-position 'victims' as 'survivors', emphasising the political consequences of social processes and institutional practices (Naples, 2003).

Notably, a considerable influence on the social construction of the victim and societal views of blame and culpability is shaped by the mass media. Increased media coverage of sexual abuse over the past 30 years has provided a cultural reference for survivors of abuse in articulating their narrative and making sense of their experiences and in raising general public awareness about sexual abuse (Kitzenger, 2001). Consequently, the popular press has contributed to the views and understandings the public holds about child abuse (Daro, 2002).

Indeed, there have been a number of research studies that have specifically explored the role of the media in reporting child sexual abuse (e.g., Beckett, 1996; Breen, 2007; Goddard & Saunders, 2000). However, much of the literature that has explored the media and child sexual abuse has focused mostly on judicial discourses, and thus the social construction of the victim (particularly in relation to discourses of adult mental health) remains under-researched.

The focus of our study

There has been a lack of research into media discourse of child sexual abuse victims in relation to celebrity offenders, and thus this is an innovative and unique topic in the contemporary celebrity-obsessed culture we reside in today. Globally, and over recent years, there have been several celebrities arrested and convicted of rape and/or child sexual abuse, with others being accused but not arrested or convicted. In the United Kingdom (UK), much of the media scandal around celebrity abusers was particularly highlighted recently with the emergence of over 450 alleged victims of Sir Jimmy Savile, who died in 2011. This became one of the most high-profile cases the UK has ever seen and sparked a series of arrests of several celebrities in connection with child sexual abuse. Given the significantly high number of alleged victims, the high celebrity profile of Jimmy Savile, and the extensive media coverage given, our chapter focuses specifically on the adult mental health of Savile's victims.

For context, Sir[1] Jimmy Savile was a UK television presenter, DJ, and charity fundraiser, who hosted his own television shows and was very popular in the UK. He spent considerable time presenting shows for children (such as 'Jim'll fix it') and raising money for children's charities. It has been estimated that he raised approximately £40 million for charities, including the hospital in Stoke-on-Trent where he volunteered (*The Daily Telegraph*, 2011). Savile died on 29 October 2011, and after his death over 450 allegations of child sexual abuse were made by adults claiming to have been victims in their childhood. While some victims had made allegations while he was alive, these allegations were typically dismissed, disbelieved, or simply ignored.

In this chapter, we focus on high-profile offenders and the impact of child abuse on adult mental health. This is partly because of the high-profile nature of these cases and the additional layers of complexity for the victims this creates, but also partly because of the 'victim blaming' rhetoric that has become prominent in the press. Because of the celebrity status and high profile of these offenders, there is the additional issue of compensation, which contributes to a blaming discourse. In non-celebrity cases, research has indicated that the media reports concerns of fiscal accountability, which contributes to a prevailing disbelief of victims' stories (Gavey & Gow, 2001), while much of the debate centres around the issue of monetary compensation for victims (Frewin, Pond, & Tuffin, 2009). Indeed, Frewen and colleagues found evidence of a 'big scam' discourse in reports of victims claiming compensation. These kinds of reports have contributed to the distrust of sexual abuse victims and this is deeply rooted not only in society but also in the justice system (Gavey & Gow, 2001). Therefore, potentially problematic for the victims of celebrity abusers is the issue of financial compensation.

Research overview

For our research, we utilised a discourse analytic (DA) approach underpinned by a social constructionist theoretical orientation (Potter & Wetherell, 1987). We adopted a macro-social constructionist position, as we were concerned with the role that linguistic and social structures have in shaping the social world (Gubrium & Holstein, 2008). Furthermore, macro-social constructionists take the view that knowledge is produced through daily interactions and our constructions are tied to power relations (Burr, 2003). By using a form of DA underpinned by social constructionism, we were able to study how accounts were constructed (Potter & Wetherell, 1987), as well as how rhetorical devices were used as a persuasive feature to lead people to a certain understanding (Billig, 1991). This focus is particularly helpful when exploring media discourses, as media texts are open to multiple readings (White, 2004).

Using the form of DA presented by Potter and Wetherell (1987), we utilised three tools for identifying the victims' construction of mental health and orientations to a blaming rhetoric:

1. Interpretative repertoires. This concept was developed by Gilbert and Mulkay (1984) and refers to the regular descriptive features and common-sense ways that people construct the world through language. Potter and Wetherell (1987) described these as the common knowledge used by interlocutors to build arguments, accounts, and explanations.
2. Subject positions. These are commonly found in discourse and are the culturally available categories used to define the person (Davies & Harrè, 1990).
3. Ideological dilemmas. This refers to the dilemmatic nature of conversation whereby the speaker locally manages competing discourses and contradictions in language and the fragmented and contradictory nature of everyday common sense (Billig et al., 1988).

To acquire an appropriate data corpus, a purposive sampling framework was adopted and Internet data acquired. Articles and video interviews were sourced through Google by using key search terms, including ‘Jimmy Savile victims’, ‘Jimmy Savile victim interview’, and ‘Jimmy Savile victim video’. A random sample of the pages returned was selected, with every fifth item (regardless of its content or nature) from the first 23 Google pages being included for analysis (as this was the saturation point – see O’Reilly & Parker, 2013, for an overview of this concept). We included only websites that definitely fell within the public domain and excluded personal blogs. The search also returned five videos for inclusion. The videos were transcribed using the traditional conventions of Jefferson (Jefferson, 2004). Additionally, we included the transcript from the police interview with Jimmy Savile in 2009, to ensure that Savile’s own voice was represented in the analysis. All aspects of the research process adhered to the ethical parameters laid out by the British Psychological Society (BPS). Approval was granted through the ethics committee of University of Leicester.

Analysis

Analysis was undertaken through a series of data sessions with the research team to identify the salient issues of interest and using the general strategy of unmotivated looking (see Hutchby & Wooffitt, 2008). Close attention to the data revealed that there were three core interpretative repertoires: (1) mental well-being and mental health impact; (2) accountability, blame, and control; and (3) questioning the authenticity of victim accounts.

Repertoire one: Mental well-being and mental health impact

A common issue was the impact of Savile’s abuse on his victim’s mental health and well-being. The impact on mental health in some cases was significant and research has illustrated that there is an increased rate of suicidal behaviour among those who reported abuse during childhood (Briere & Runtz, 1986; Mullen, Martin, Anderson, Romans, & Herbison, 1993). Banyard, Williams, and Siegel (2004) suggested the negative mental health consequences caused by sexual abuse during childhood were the result of coping mechanisms or responses to the abuse. This was evident within the data where victims showed Savile’s abuse had a negative impact. For example, a newspaper article claimed suicidal behaviour to be among the effects of Savile’s abuse, as illustrated in Extract 1.

Extract 1: *The Guardian News* article ‘Jimmy Savile victims laughed at, says NSPCC report’

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The report found that Savile’s victims suffered wide-
ranging repercussions from the abuse throughout their lives,
including mental health problems, substance abuse and
thoughts of suicide. Some said that seeing images of Savile
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in media reports triggered flashbacks and made them feel physically sick.

Here the writer of the article employs the authority of a written report to illustrate the *'wide-ranging repercussions'* which orient to the mental health effects of the abuse. As the journalist has possible stake and interest (see Potter, 1996) in evoking empathy and shock within the reader, they use the three-part list (Jefferson, 1990) 'mental health problems, substance abuse, and thoughts of suicide' to highlight and incrementally build the damaging consequences of being subjected to abuse, which firmly positions Savile as being to blame. The journalist goes further to demonstrate the destructive effect of Savile's abuse by employing the current effects of *'seeing images of Savile in media reports triggered flashbacks and made them feel physically sick'*. By bringing the effects into the current state of mind of the adult victims, the journalist displays the longevity of the consequences of the abuse. It is fairly common for sexual abuse victims to report feelings of nausea (Hulme, 2000), and here the power of the imagery is brought into play by showing that feeling *'physically sick'* is a direct consequence of the association between the imagery of the perpetrator and the reaction of the victim. Notably, this embodied distress adds weight to the effects, showing that the consequences go beyond psychological distress to having a real effect on the physical beings of the victims. The embodiment of negative feelings is also evidenced in Karen's description of how she feels:

Extract 2: Karen's interview for the BBC (British Broadcasting Company)

I'm so full of self-disgust I can't believe that I did such things

In this extract Karen employed the phrase '*self-disgust*' to conceptualise her mental well-being at the time of the interview, illustrating the impact that Savile's actions had on her self-image. She is 'full of self-disgust', giving 'self-disgust' a physical quality that equates to the parameters of her body. This in turn reflects some level of psychological impact on how she felt about herself as a consequence of the abuse.

These effects can also affect the interpersonal relationships of the victims, extending beyond the individual to the social, as is outlined in the following extract.

Extract 3: Stephen George's interview with Eamon Holmes for Sky News

EH: Stephen you know I I know you an' I have talked befo:re
and I know the effect a:ll of this has (.) had on you
an' whatever but t' people maybe watchin' this morning

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     and say <look he was you> he wuz an old man >he's dead
     and gone< (.) er move on
     what would you (.) what would you say t' those people?
SG:  W ell I'm nearly sixty-two I've never had (0.5) any
     relationship of an intimate nature (.) since 1994 apart
     from two absolute disastrous ones prior to that when
     I first left secure hospital
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The interviewer here sets up the possibility that Savile's death provided a mechanism for moving on, stating that *'he was an old man he's dead and gone (.) er move on'*. Notably, however, the use of footing shift (Goffman, 1981) from his personal identity to one of an interviewer positions this proposition as being from the voice of the public *'what would you say to those people'*. This expectation to move on echoes previous research, which found that child sexual abuse victims are often forced to forget or dissociate due to others' responses conveying shock, disbelief, and denial (Ullman, 2002). The rejection of this proposition from Stephen is evidenced through illuminating the long-term psychological effects that the abuse has had on him throughout his lifetime, that is, his inability to develop and maintain *'any relationship of an intimate nature'*. Research has indicated that there is an association between a history of childhood sexual abuse, psychopathology, and relationship problems (Alexander & Lupfer, 1987; Finkelhor, 1984), and this psychological repertoire is utilised by Stephen to account for his inability to *'move on'*.

Repertoire two: Blame, responsibility, and control

Blame, accountability, and responsibility had numerous formulations within the data, shifting between blaming the victims, blaming the offender, and blaming other agencies. This fluid interplay between accounting practices was constructed through various discursive formats, with Extract 4 (a continuation of Extract 2) providing a useful example of this.

Extract 4: Karen's interview for the BBC (British Broadcasting Company)

```
I'm so full of self-disgust I can't believe that I did such
things (1.5) I can't believe that I allowed such things to
happen (1.5) that I didn't immediately (.) rush and (.)
scream it from the rooftops (1.5) make this stop just make
it stop (1.5)
```

Here Karen positions herself as accountable for some of the blame for the sexual abuse she claims to have experienced at the hands of Savile as she draws upon repertoires of responsibility. By resisting the subject position of 'victim', Karen presents a version of herself as one who ought to have had some control over the situation, and in failing to take control she attributes some responsibility for her current feelings to herself. It is interesting that Karen positions herself as having the power to stop the abuse, stating *‘I can’t believe I allowed such things to happen’*. Research into defence arguments about consent found sexual consent was not legally relevant in child abuse cases (Sas, Wolfe, & Gowdy, 1996). Due to this, MacMartin and Wood (2005) claimed that victim responsibility only had relevance in adult sexual assault cases. However, Karen’s positioning as having the power to stop the abuse is perhaps not surprising as judicial discourse defines children as being authors of their own downfall (Smart, 1999), thus placing all the power upon the child. Importantly, Karen is now an adult reflecting back and therefore it may not be surprising that she employs a ‘power’ narrative as she reflects from an adult perspective. In Extract 5 the interviewer introduces the notion of victim responsibility:

Extract 5: Stephen George interviewed by Eamon Holmes on ‘This Morning’[2]

EH: Why didn’t you scream why didn’t you slap him why didn’t you say you dirty old git leave me alone
SG: I would have been punished
EH: Okay

Here the questioning strategy of Eamon Holmes (the presenter) is one that subtly suggests some level of responsibility on the victim and the implicit accountability that he could have physically lashed out at his perpetrator *‘why didn’t you slap him’*. This victim blaming arguably stems from original rape myths where women have been constructed as agents for their own rape (Anderson & Accomando, 1999). The idea of fighting back is potentially a public perception that the television interviewer has a responsibility to present ideas that reflect different points of view in a balanced way. For male victims, however, there are arguably greater issues faced when disclosing their abuse, as there is potentially a greater stigma for some, as many fear being labelled ‘homosexual’ (i.e., ‘gay’) (Alaggia, 2005). Indeed, research has shown that adult males abusing male victims are often perceived by the victims to be worse and have a greater impact than heterosexual abuse (Dollar, Perry, Fromuth, & Holt, 2004), which is linked to the culturally embedded ways in which sexuality may be constructed and a broader negative cultural construction of homosexuality. Importantly, Eamon is a male interviewer talking to a male victim, and it is somewhat interesting that the solution is depicted as being a physical and overt display of resistance. By questioning Stephen’s response, Eamon called to account the abuse and positioned Stephen to some degree as blameworthy for accepting what was happening to him at that time. While Stephen provided an account for his passive response 'I would have been punished' indicating a fear of reprisal, a typical fear from the position of a child, the account simply afforded an acknowledgement token *'okay'* from his interviewer.

Double (2005) proposed that the reason why society tends to blame the victim is because it is comforting and because of a deep-seated belief that this is how blame works. Thus, positioning the blame with the victim, even if partially constructed, lessens the level of transgression of the abuser and provides us with an arguably distorted underestimation of risk and an overestimation of our own omnipotence. However, this was only partially supported by the data, as we illustrated that the media occasionally blamed the victims but also paradoxically those who failed to believe them. This ideological dilemma of who was to be blamed for the abuse was played out through the media.

> **Extract 6**: *Telegraph* article 'Jimmy Savile sex abuse victims told they were lucky he paid them attention'
>
> Detailed interviews with victims show how several attempted to speak out but were laughed at, accused of lying or even told they were 'lucky'. The research, published by the NSPCC, gives a glimpse into the pattern of disbelief and fear which enabled Savile to get away with his crimes for so long.

The author of the newspaper article (John Bingham) took up a subject position of not only a reporter but a voice through which the public views could be heard. His reporting strategy indicated that Savile was able to evade justice and noticed that the victims who attempted to *'speak out'* were not believed by those in authority. Using a three-part list (Jefferson, 1990), he illustrated how the victims were treated negatively if they were able to speak up about their abuse, being accused of *'lying'*, *'laughed at'*, and positioned as unreasonable, as well as being told they were *'lucky'*. This notion of being 'lucky' is an interesting and important formulation. This has been noted in accounts of abuse in families where the abused child is viewed as receiving special attention from the parent or in an institutional context where the child is 'singled' out for special treatment by the 'powerful' adult (Commission to Inquire into Child Abuse, 2009) and is part of a process of 'grooming' which McAlinden (2013, n.p.) defined as 'the preparatory stages of abuse where abusers gain the trust of the child or significant others to both facilitate abuse and subsequently avoid discovery'. Furthermore, this reflects an ideological tension for victims who suffered the negative impact of being abused and of speaking out. Savile's national public profile as a charity worker and celebrity can be seen to equate with the centrality and perceived powerfulness of the position of a 'parent', 'teacher', 'priest' in families and communities that influences victims' perceptions of the likely impact of disclosure and indeed the sequelae of actual disclosure. Indeed, Bingham cited scientific research as reported by a credible agency the National Society for the Prevention of Cruelty to Children (NSPCC) to authenticate his account of the way in which victims were treated. Through this narrative, while not ameliorating blame from the victims, he shifted the greater blame to those who failed to believe at the time of initial disclosure.

Importantly, the celebrity status of the offender was invoked as an account for the evasion of culpability; a common repertoire throughout the data was that of celebrity status protecting the actions of the offender. This issue of 'celebrity status' is not typically faced by victims of sexual abuse, but for those in our data it was one that added additional concerns related to power and control. McAlinden (2012) used the term 'institutional grooming' to refer to the grooming of children in an institutional context (which was a feature of the abuse in the Jimmy Savile case) and suggests that key features include delays in disclosure, initial disbelief of victims, a conspiracy of silence and denial, and minimisation of allegations. Indeed, a fear of not being believed and a sense of shame were important influences on non-disclosure in young people (Mc Elvaney et al., 2014).

Extract 7: Debbie's interview with the *Telegraph*

> I think a lot of the issues with erm (1.0) Jimmy Savile is the fact that he is a celebrity that people thought oooh you know he he's God we'll we won't bother you know he he knows best it c- you know keeping in with him basically erm whereas I'm hoping now that that will change because basically when it comes down to abuse it doesn't matter who the person is whether they are family or not or whether they are a celebrity they're just as responsible

Research has indicated that celebrities are often not prosecuted for illegal activities that are unlikely to be tolerated by those who do not occupy a celebrity status (Kurzman et al., 2007). This positioning of celebrities as untouchable is evidenced in Debbie's narrative as she compared Savile's identity to that of '*God*'. By presenting this subject position, she constructed the powerful status that he held, while positioning society as his worshippers and crediting him as incapable of doing any wrong. Drawing upon a general repertoire of blame and responsibility, Debbie suggested that many of Savile's abuses could have been prevented if people had been able to see beyond the carefully constructed identity. She mainly adopts a societal voice in the interview, with a more balanced view of how abuse should be viewed, regardless of the power of the perpetrator. Nevertheless, interestingly, Debbie appears to adopt a personal view when she mentions that *'hoping that things will change'*, as Paivio and Pascual-Leone (2010) found that therapy clients who judged themselves as being responsible for negative feelings after abuse aspired for change.

Repertoire three: Questioning the authenticity of victims' accounts

Juxtaposed with issues of accountability and blame is the repertoire of authenticity and credibility. The public rhetoric of authenticity and credibility of the victims' accounts was a pervasive discourse throughout the various data sources. Notably, some of the questions regarding credibility of accounts were reported to be raised during Savile's reign of abuse, and Savile used various discursive practices to protest his innocence while simultaneously attempting to damage the victims' authenticity.

In the following extract, Philip Schofield questioned Kevin's authenticity as a victim by referring to Kevin's age at the time of the assault. This reflects a challenge faced by many child victims that being believed is reflected as both an interpersonal and intrapersonal factor (Mc Elvaney et al., 2014). At an interpersonal level a child fears not being believed to the point where they are blamed and judged for the abuse or the disclosure of abuse (Mc Elvaney et al., 2014). This reflects a common repertoire that children are unable to differentiate fantasy from fiction. There is a range of forensic evidence that suggests that children are seen as being susceptible to suggestion and confuse imagination and perception when recounting memories (DeVoe, 2002). Phillip touched upon this when referencing Kevin's ordeal.

Extract 8 Kevin Cook's interview with Phillip Schofield and Holly Willoughby for *This Morning*.

```
PS:  Now you say that at one stage you were aware of
     someone coming in
KC:  Yeah (.) erm t- there was a knock on the door (.) erm
     a- a- and the door opened and s- s- soon as the knock
     (.) it there was a man walked in instantly (.) erm
     (.) he walked in the door took one look (.) turned
     round and walked [straight back out]
PS:                   [did he say [any]thing?]
HW:                               [was]
PS:  Can you remember anything I [mean] you're nine years
     old
KC:                              [it]
PS:  So your memory I do say your memory is completely
     sharp at that time
KC:  that uh- in th- in that room yeah
```

As the lead presenter, Phillip took up the position of interviewer as he solicited information from Kevin about the abuse. Although Phillip oriented to the specific young age that Kevin was at the time and implicitly questioned Kevin's competence to recall events accurately, it is clear that Kevin worked to counter this with an informative and detailed account of the event. Indeed, the use of such detail in accounting is a discursive mechanism for facilitating the authenticity of a claim (Potter, 1996). This charge from Phillip, which questions Kevin's ability to remember as a child, is perhaps not surprising, as Mc Elvaney and colleagues (2014) found incredulity as a common reaction to disclosure of abuse and suggested that this disbelief is used as a protective function for both the child and the person listening to the disclosure. Additionally, this questioning of victims' authenticity is not new as there is an established history of negativity and scepticism towards victims' accounts with deep roots in wider society and the criminal justice system (Gavey & Gow, 2001). Therefore, it is perhaps expected that Phillip took up the position of the public voice and charged Kevin with the authenticity of his claims of abuse by asking questions, such as '*did he say anything*' and '*can you remember anything*', and then emphasising scepticism with statements such as '*your memory is completely sharp at that time*'.

> **Extract 9:** A news article in *Closer* stated that Jimmy Savile sex attack doctors told by hospital staff they were 'lucky he had paid them attention'
>
> According to the report, titled 'Would they Actually Have Believed me?', some of Jimmy Savile's victims - aged between eight and 26 when Savile assaulted them - told hospital staff, who dismissed their claims. The NSPCC said the research, which was commissioned by Her Majesty's Inspectorate of Constabulary, highlighted the 'devastating scar' that victims had suffered from Jimmy Savile's abuse. Some turned to drink and drugs to cope, others contemplated suicide and some suffered mental illness.

While in some ways this extract resonates with Extract 5, in the sense that this article re-invokes the notion of 'lucky' victims and orients to the coping mechanisms with mental health effects, what is interesting here is the discourse of blame. The focus for this aspect of the article related to the reactions of the hospital when allegations of abuse were disclosed (*'told hospital staff, who dismissed their claims'*). The validity of this claim was authenticated with the evidence in the form of an official report that noted '*commissioned by Her Majesty's Inspectorate of Constabulary*'. By including the report's title, '*Would they Actually Have Believed Me*', the journalist illustrated the doubt that Savile's victims had to endure during that period.

Importantly, although the authenticity of the victims' accounts was called into question at the time of their reporting, the police did take them seriously enough to interrogate Savile. Notably, Savile had his own freedom and reputation at stake, and thus the account provided in the interrogation was filled with markers of stake and interest (Potter, 1996). As such, it is perhaps unsurprising that he denied all allegations and he provided a detailed account regarding the potential reasons why the alleged victims were fabricating such stories. The following extract is taken from Savile's interview with the Surrey Police over allegations of his abuse of young girls at Stoke Mandeville hospital and Duncroft.

Extract 10: Jimmy Savile's interview with Police in 2009

```
Police:  And finally did you sexually assault ((blanked
         out)) by placing your tongue in her mouth at Stoke
         Madeville hospital?
JS:                Not at all, not at all, complete fantasy
Police:  and my last question which I know you want to sort
         of touch on, why would those girls say about you?
JS:      Well in fifty years in showbiz, we showbiz people
         get accused of just about everything. One of the
         reasons is people are looking for money, and they
         will try blackmail, and they will write letters,
         saying if you don't send us money, I will say
         you've done this and you've done that. So that's
         why, there is a group of people who just like
         causing trouble, because we get plenty of that
         anyway, they just like causing trouble.
```

As perhaps expected the charge of sexual assault of a patient at the hospital was completely and unequivocally rejected by Savile. He used several discursive devices to achieve this conclusion, including repetition, aligning with the category of *'showbiz'* people, and discrediting the alleged victims' motives. Savile adopted the subject position of an innocent agent as he disregarded the accusation as '*complete fantasy*'. Thus, by using the rhetoric of fiction, and the extreme case formulation 'complete' (Pomerantz, 1984), he presented the alleged victim's claims as lacking authenticity and credibility. While the police officer did not accept or reject the version offered by Savile, s/he did give him the opportunity to comment on the motives for such allegations. By aligning with other *'showbiz'* individuals and orienting to the regularity of false claims for financial compensation, Savile positioned such allegations as commonplace for the world in which he resided. He positioned the victims as merely seeking financial gain from his celebrity status and even accused the alleged victims of *'blackmail'*. By using the collective pronoun 'us' he positioned himself as part of a group of 'victims' – a position he reinforced through his construction of the victims as *'trouble-makers'*.

Discussion

Our data have illustrated that the subject positioning of the victims of the celebrity offender Jimmy Savile was fluid and socially constructed through various channels, including the mass media. Through a series of high-profile interviews, newspaper reports, and even discussions with Savile himself, the impact on the victims, the rationale for blame, and the public perception of sexual abuse were negotiated. Throughout the data, Savile's abusive behaviour was constructed as having significant negative effects on his victims' mental health and well-being, which is consistent with the current research evidence. Throughout the data, issues of suicidal thoughts, mental health difficulties, relationship problems, and substance misuse were utilised to illustrate the severity of the impact on victims as adults. In particular, there seemed to be a link between disclosure and a negative effect on victim's mental well-being and mental health. Notably, the rhetoric of blame was negotiated and reconceptualised through various formats, with the victim at times being blamed for not having done more and permitting the abuse to happen. Savile himself constructed his victims as '*blackmailers*' and simply seeking monetary gain. Perhaps unsurprisingly, given the high celebrity profile of the offender, the authenticity of victims' account was called publicly into question, with their competence being questioned, and more importantly accusations of having stake and interest in potential compensation claims being positioned as the motivation for the accusations. The 'victim' identity clearly has multiple components, and these shift according to the rhetoric and public discourses at any given time. Ultimately, the offender's status as a celebrity complicates the positioning of the 'victim', because of the powerful positions the celebrity holds and the projection of the allegations into the public eye and media spotlight.

Although the effects of Savile's abuse need to be considered within the relatively unusual context of his offending, the findings were consistent with other research on child sexual abuse and mental health. The evidence of Savile's abuse leading to a negative effect on victims' mental health and well-being, in particular suicidal inclination, substance misuse, and mental illness, supports previous research on mental health effects of sexual abuse experienced in childhood. Furthermore, the issue of financial compensation has shown to be a problematic factor within these cases, and although the sums of money are likely to be significantly smaller, it still raises questions regarding the authenticity of a claim and the motivation of the accuser (e.g., Frewin et al., 2009; Gavey &

Gow, 2001). Of course in the case of celebrity abuse, considerable financial compensation is at stake.

This failure to report abuse has been continuously noted in the research, showing that professionals who are obligated to report child sexual abuse have often failed to do so (Paine & Hansen, 2002). In particular, results of a prevalent study investigating child sexual abuse showed a surprisingly high failure to report abuse in hospitals (National Center on Child Abuse & Neglect, 1998). Disclosure is important for victims, given that as adults they are increasingly questioned as to why they did not speak out (see Extracts 4, 5, and 7). In addition, evidence has suggested the importance of disclosure as it is a critical component in decreasing the likelihood of negative long-term effects (Paine & Hansen, 2002), and yet this decrease relies heavily on being taken seriously and being given the appropriate support. It is clear from the data that this was not the case for Savile's victims and thus the long-term mental health consequences reported were, at least in part, potentially related to this.

We do of course acknowledge that there are certain limitations to this study as we have focused only on a single celebrity offender. It would be beneficial to expand this research to explore how and if the pertinent repertories are indeed prevalent within a discourse of celebrity abusing more generally and what the implications may be for this. It could also be valuable to explore the media constructions of celebrity offenders in other parts of the world, to see if the same issues are raised in the American or Australian press when their once loved celebrities are revealed to be sexual predators.

Practical relevance summary

Employing DA underpinned by macro-social constructionism we have been able to contribute an innovative way of studying victims of childhood sexual abuse and explore the perceived impact on mental health. By using DA, we have provided a more in-depth investigation into the fluid victim identity and the associated discourses that are perpetuated in society. It is important that those working with victims of sexual offenders be aware of the impact that these crimes have and do not allow myths about rape, judgements about capacity, or messages from the media to cloud their judgement.

This is particularly important in light of the strong rhetoric of blame and responsibility that was pertinent in the data. Our findings and previous research on victim blaming (Anderson & Accomando, 1999; Schönbucher, Maier, Mohler-Kuo, Schnyder, & Landolt, 2012) suggest that the way in which victims were constructed has a profound effect on how the public judge victims as a whole, consequently affecting whether or not victims disclose their abuse. Based on previous evidence stating perceived support is an important factor influencing a child's willingness to disclose sexual abuse (Bussey & Grimbeek,

Table 9.1 Highlights of clinical practice

1. Those working with victims of sexual offenders and adults with mental health problems should be aware of the potential long-term psychological impact that sexual abuse in childhood has.
2. Gender biases or myths about rape and assault should not cloud the judgement of those working with victims of sexual offenders.
3. Those in positions where disclosure of sexual abuse to them is likely should ensure that victims should feel supported enough to disclose abuse and be believed when they do so in order to decrease the likely onset of negative long-term effects.
4. Professionals with knowledge in the field of child sexual abuse and its associated complexities should target media with accessible information to de-bunk myths regarding responsibility, blame, and effects.

2006; Paine & Hansen, 2002), it is of great importance that victims feel supported enough to disclose abuse in order to decrease the likely onset of negative long-term effects which were shown within our findings.

Our focus on the celebrity Jimmy Savile has illustrated the high levels of power that celebrity abusers occupy. We perhaps should not be surprised that victims of high-profile abuse find it so difficult to speak out, particularly as children, given the popular discourses that penetrate society at so many levels. This study therefore has important implications for the role of journalists in their practice of interviewing victims and reporting on cases of high-profile celebrity abuse, demonstrating that the way victims are presented has a great influence on public discourse, potentially impacting on how victims are judged and subsequently victims' disclosure. For a simple summary of the clinical highlights, please refer to Table 9.1.

Summary

This research has investigated how the media and Savile's victims construct their victim status. Three core repertoires arose: mental health impact and mental well-being; accountability, blame, and control; and questioning the authenticity of victims' accounts. It appears that, similar to previous literature investigating the impact of child sexual abuse, Savile's abuse was reported to have had a profound negative effect on his victims' mental health and mental well-being, leading to mental illness, relationship difficulties, suicidal thoughts, and substance abuse. The victims in their various accounts drew upon a range of repertories, took up different subject positions, and navigated through various ideological dilemmas to propose their version of events. Furthermore, due to Savile's celebrity power, through the popular press victims were on some occasions constructed as inferior, resulting in their authenticity being questioned with the blame and responsibility shifting between the victims and Savile. All findings highlight the importance of victims having support to speak out about abuse in order to avoid subsequent negative long-term effects.

Notes

1. Jimmy Savile was given a knighthood by the Queen in 1972. There was some controversy following the scandal and calls for the knighthood to be stripped, but it is reported that knighthoods cease to exist after the person is deceased. http://www.theguardian.com/media/2012/oct/09/jimmy-savile-knighthood.
2. Daytime television programme in the UK.

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Part II

Naming, Labelling, and Diagnosing

10

Diagnosing as an Interactional Achievement in Psychiatric Interviews

Carles Roca-Cuberes

Introduction

What is involved in exploring a patient's mental state? How is a diagnosis or a decision about a patient's psychopathological status accomplished? How do psychiatrists make patients talk about their *problems*? The first encounter, in a psychiatric hospital, between a psychiatrist and the prospective patient is quite significant for the fate of the latter. In a psychiatric intake interview (PII) the psychiatrist's official task is to determine whether a person should be hospitalised – voluntarily or involuntarily – as a patient on the basis of the person's observable behaviour during the interview. Customarily, this implies that the psychiatrist needs to solicit the patient to talk about the problems that brought him/her to hospital and make a decision regarding the candidate patient's mental state. In the other type of psychiatric interview, the subsequent psychiatric interview, the psychiatrist's assignment is to monitor the behavioural progress of a psychiatric in-patient, with the view to a possible future discharge. For example, in the adult psychiatric treatment interview, psychiatrists are charged with asking questions of the patients with appropriate depth and pace (Thompson & McCabe, Chapter 20, this volume).

This investigation focuses specifically on PIIs with the purpose of showing: (1) the various discursive strategies that psychiatrists may employ to make patients talk about their problems; tentatively, depending on the degree of control that psychiatrists wish to exercise over the course of the interaction, they may use two different discursive strategies: an 'invited story' or the canonical question–answer sequence typical of many institutional encounters. (2) The resources on which psychiatrists may draw to accomplish a diagnosis or decision regarding their patients' psychopathological status. The ultimate goal of this chapter is to show how the ethnomethodological approaches of conversation analysis (CA) and membership categorisation analysis (MCA) could contribute to a better understanding of psychiatric practice and, in turn, mental health and illness.

Project overview

The current investigation forms part of a wider research project initiated with my doctoral research, for which I gathered a data corpus of eight psychiatric interviews – with two psychiatrists and eight patients – and applied CA and MCA to the study of mental health practice. The psychiatric interviews were video-recorded in a large Spanish hospital and permission for video recording was obtained from all the participants in the psychiatric interviews. The patients represented different mental illnesses and a range of stages of involvement with the hospital psychiatric services.

The data extracts presented in the current investigation involve two PIIs with two different patients and one psychiatrist (T1). P1 is a local candidate patient who voluntarily presented herself to the hospital services after an attempted suicide. P3, on the other hand, is a French national originally from Martinique who was brought involuntarily to the hospital after having been found at a train station, experiencing an alleged episode of confusion. The method of analysis is that developed by the ethnomethodological approaches of CA and MCA. The analysis is carried out on the original language data and the extracts have been translated into English.

There has been widespread interest in CA for the study of mental health practice. Most of the work in this field has focused on psychotherapy (e.g. Antaki, Barnes, & Leudar, 2005; Davis, 1986; Ekberg, Barnes, Kessler, Malpass, & Shaw, 2014; Muntigl, Chapter 29, this volume; Peräkylä, 1995; Schwartz, 1976; Tay, Chapter 28, this volume; Voutilainen & Peräkylä, Chapter 27, this volume), and only a few studies have investigated psychiatric interviews (e.g. Antaki & O'Reilly, 2014; Bergmann, 1992; Jefferson & Lee, 1992; O'Reilly et al., 2014; Roca-Cuberes, 2011). Formulations have constituted a prominent area of interest. The pioneering study was that by Schwartz (1976), which showed that formulations may be used by therapists to display the psychotherapeutic value of their own interpretations. Several recent studies are consistent with this finding (Antaki, 2008; Antaki & Jahoda, 2010; Antaki et al., 2005; Beckwith & Crichton, 2010; Kurri & Wahlström, 2007; Roca-Cuberes, 2011; Weiste & Peräkylä, 2013). Other interactional practices in mental health practice have also been examined; for instance, the use of repair (Healey, Colman, & Thirlwell, 2005; Rae, 2008; Roca-Cuberes, 2011; Themistocleous et al., 2009), assessments, or word searches (Roca-Cuberes, 2011).

MCA, on the other hand, has not been profusely employed to investigate mental health practice. The precursor work was that by Holstein (1993) on commitment hearings in which candidate patients' involuntary mental hospitalisation is decided. He described how psychiatric testimonies frequently use categories such as gender, age, or group membership to interpret and evaluate patients and their potential involuntary commitment. More recent studies are those by Roca-Cuberes (2008) or O'Neill & LeCouteur (2013).

Initiating the exploration of patients' mental state

Around two minutes after the beginning of this PII, we find the following exchange between T1 and P1.

Extract 1 [T1: psychiatrist; P1 = patient]

T1: Well I have introduced myself before Maria
Antonia=
P1: =Yes=
T1: =Right? I'm the doctor who is going to supervise
you during your admission together with doctor
Barjuan though you don't know him yet (0.8) right?
and she's Sofia [and is a nurse so any problem
P1: [Yes I know her
T1: Well so can you explain (to us) a bit wha::t what
happened why were you admitted yesterday
(2.5)
P1: So what really happened
T1: Yes
(1.3)
P1: So what happened is one of the many cases that
used to happen (1.0) er: I've: been suffering for
a long time er: in a very unusual way because the
truth is that (   ) the thing is that
you don't carry around your story written down nor
do you explain it every day (0.7) the reason o:f
of what happens (0.9) I: um have been a happy:
person er:: dynamic: hard working (1.1) a very
good mother better than a daughter (1.1) as a wife
mh: I wasn't very good becau:se well (1.7) er:
(1.8) I found a man that was from a good family
um:: er: the youngest of a family a spoilt child
[and
T1: [So you are married?
P1: Yes=
T1: =And you've got how many children
P1: I've got a twenty-three-year-old son and a
nineteen-year-old daughter
T1: Nineteen
P1: Yes
T1: So: you live with them now?

```
36  P1:  Um well er my story is a bit strange (0.8) it
37       turns out that I married that guy being very much
38       in love
39  T1:  How old were you when you got married
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We may appreciate how the reason for this conversation, after some 'preliminaries', is properly placed on the table by T1 in lines 9–10 with 'Well so can you explain (to us) a bit wha::t what happened why were you admitted yesterday'. Further, T1's utterance seems to demand a biographical account of P1's life circumstances prior to their encounter in the form of a 'story'. The concept of a story, as a particular kind of collaboratively produced narrative in conversation, was first studied by Labov and Walletsky (1967) and developed within the field of CA by Sacks (Jefferson, 1978, p. 219). Sacks suggested that since the telling of a story involves the production of a multi-unit turn, by generating sentences like 'I saw something terrible today' (which constitute the preface of the story) one may be seen as asking permission for the telling of a story (Sacks, 1992, p. 18). Additionally, the preface signals and prepares the hearer for a forthcoming story – aligning, therefore, both teller and recipient – and also announces what kind of story this will be.

The stories so far described could be characterised as 'volunteered stories' (Watson, 1990) – that is, teller-initiated narratives. However, stories can also be invited by the recipient. In effect, unlike volunteered stories, 'invited stories' are recipient-initiated. In other words, the recipient of the story provides the preface (or first utterance) of the story to be told (ibid., p. 275). The putative teller, then, after s/he has been invited, might accept or decline to narrate the story s/he has been requested to produce. Further differences between these two types of narratives can also be identified. An obvious one is that the materials of an invited story are proposed by the recipient. This element affords the recipient of the invited story a wide margin of control over what may be said in the story (ibid., p. 276). Another difference is that the intercalations that the recipient is allowed to introduce into the narrated story are typically not restricted to 'response tokens' – the recipient also seems to be entitled to request story expansions by introducing (for example) questions. Overall, then, in invited stories it is the teller who has to provide the story the recipient wants to hear, and it is the recipient who decides at what point how much of the story has been told. In other words, it seems that the inviter has the right to resolve when the story is complete or estimate when the teller has said enough.

Let us return now to data Extract 1. We may observe in lines 15–27 that P1 has accepted to produce a story since she is furnishing one to T1. However, before that happens, P1 asks in line 12 'So what really happened'. Since the recipient (i.e. inviter) of invited stories has an increased margin of control over the story to be told, the teller of the story might find it problematic to ascertain the kind of story that recipient might be requiring. In this respect, P1's utterance in line 12 (after a long pause of 2.5 seconds, which emphasises her hesitation) might be heard as involving a check (or 'repair') on what an 'appropriate' story to T1's preface might constitute. T1 then confirms that what she wants to hear is 'what really happened' (with her 'Yes' in line 13).

P1 commences in lines 15–27 the telling of her story in the form of a biographical account. However, it is not just any biographical account, in the sense that it could be developed as 'I was born in such and such place, in that year and in the context of such and such family'. It is a biographical account that formulates a problem and, specifically, a marital problem. As Sacks (1992, p. 19) suggested, the main activity in the narration of stories is that of describing which, in turn, involves the production of multiple categorisations. An interesting question about descriptions is this: from among the infinite *correct* ways in which we can describe something – an object, person, activity, and so on – how can we ensure that this description is intelligible, self-explanatory and referentially adequate? According to Sacks, descriptions are selected according to category collections or membership categorisation devices (MCDs). These collections consist of membership categories, which constitute a type of reference form used to describe persons. Examples of membership categories are for instance 'politician', 'daughter', or following Sacks's (1974) example, 'baby', or 'mommy'. Meanwhile, each membership category is to be seen as a part of an MCD such as (in the case of 'baby' and 'mommy') 'family'. What confers special intelligibility to descriptions is the relationship that we understand exists between membership categories and the activities or predicates commonsensically associated with them. Thus, conventionally we understand that certain activities, rights, obligations, knowledge, attributes, entitlements, and so forth are category-bound. The notion of category-boundedness thus permits us to reflexively relate identities to their associated activities or predicates.

Returning to the above data extract, we may observe that what P1 does at the beginning of her story in lines 15–27 is self-categorising herself as having been a happy, dynamic or hard-working 'person' (lines 21–22); as a very good 'mother', better than a 'daughter', or a not very good 'wife' (lines 22–24). A 'man', presumably her husband, is also categorised as a 'spoilt child' (lines 25–26). We may also infer that the 'suffering' (line 16) endured by P1 is predicated upon their relationship. I take it that all these categorisations provide T1 with relevant information about who P1 *is* and make sense of her presence 'in this place, now'. In other words, by discovering with which categories P1 might be associated (e.g. within the MCD 'family') T1 may have all kinds of inferences available about P1's identity, activities, problems, and the like. For example, by learning that P1 is married – which she confirms in line 29 – T1 may be able to detect some of the patient's problems. As it turns out P1 had for a long time been suffering abuse from her 'husband', which might project incumbency upon the category ‘abused wife’.[1] Thus, in the process of discovering ‘who is this person’, T1 might find some answers to the question ‘why is she here’.

P1’s answers about her children (lines 31–32, 34, 36–38) may provide T1 with some clues as to who and how P1 is. The number of her children, ages, gender, and the like might furnish relevant details about P1’s lifestyle. For instance, since one of them is still an adolescent, P1 could be affronting the problem of having to deal with a child at a difficult age. We may see that T1 also asks ‘So you live with them now’ (line 35). Since being a wife is predicated upon living with a husband (and not just with children), T1 seems to be projecting that P1 might be separated. Thus, although T1 has been able to ascertain that P1 is married, by invoking the category ‘separated wife’ T1 might be able to make sense of a patient’s problem.

In line 39, T1 asks ‘How old were you when you got married’. Again, answers to this question may help T1 to further categorise P1. For instance, P1’s age when she got married may offer particulars (however imprecise they might be) about her personal history, interests, independence, and so on. It might also be informative about the length of her marriage and, in turn, of emotional balance or (alternatively) conjugal problems and conflicts, and the like.

Thirty seconds after the commencement of this PII, T1 enquires about the length of P3’s stay in Spain. This psychiatric interview was conducted in French, of which T1 has a limited command.

Extract 2 [T1: psychiatrist; P3 = patient]

```
 1  T1:  ((clears throat)) How long have you: been here in
 2       Spain
 3                             (1.3)
 4  P3:  In Spain fifteen days
 5  T1:  How:: long?
 6  P3:  Fifteen days
 7  T1:  Fifteen days (1.1) [fifteen ten plus five uh huh
 8  P3:                     [Mh:
 9  T1:  So why did you come here
10  P3:  Mistake the bus
11                             (1.5)
12  T1:  Mistake the bus
13  P3:  Mh hm
14  T1:  Where were you: going to
15                             (0.8)
16  P3:  To take the train to go to France
17  T1:  To France
18  P3:  I’ve mistaken the way
19  T1:  Mh hm so: because you’re going to France to work?
```

P3: No I was going to France to take the train when I fell over I (   ) I had to take the train
T1: Mh hm hm
P3: I fell over on my way (   ) because I was walking a lot (   )
T1: But um do you live at France or do you live at Morocco=
P3: =I live in France
T1: In France usually
P3: In France yes
T1: In France in France [mh hm so:=
P3:   [Yes
T1: =you live with his family (0.6) in France
P3: On my own
T1: On your own
P3: Mh hm
T1: Mh so you work in France
P3: Yes for many years
T1: So where do you work
P3: For many years
T1: For many years bu::t (1.0) what is your job
P3: Bricklayer
(0.9)
T1: Bricklayer?
P3: Mh hm=
T1: =What is that?
P3: Yes bricklayer bricklayer=
T1: =I don't know what that is
P3: Construction
(1.0)
T1: Construction you is doin::g
P3: Constructing yes
T1: Uh huh so to:: like this=
P3: =Constructing [constructing
T1:   [Like a
T1: Constructing constructing
P3: Construction=
T1: =Mh hm (0.8) you is: is well in France?
P3: Mh?
T1: Are you happy?
(0.9)
T1: To France

In this PII T1's utterance in lines 1–2 initiates the topic for this conversation. We may observe that this question constrains P3 to produce an answer with a limited topical scope: one which requires a temporal estimate of the time he has been in Spain so far. Thus, unlike the previous PII, T1's question is not designed to elicit the production of a story. From this point on, we may notice in this data extract (and for most of this PII) the presence of a relatively recurrent sequential structure:

- T1: Question
- P3: Answer
- T1: Initiation of repair (of sense)
- P3: Confirmation
- T1: Another question

As suggested above, stories are collaboratively produced sequential structures. The teller has the right to produce a multi-unit turn – by virtue of his/her story having been prefaced – and the recipient has to monitor the course of the story to display attentiveness (e.g. through the insertion of acknowledgement tokens) and estimate when the story might be complete. Given these observations, it is not surprising that T1 is not inviting P3 to produce a story. Since her command of French is limited, by providing restrictive questions (as opposed to inviting a multi-unit turn story) she can ensure that the floor is promptly returned to her to ascertain that she understood P3's answers.

In conclusion, the assessment of the patient's problems might take, at least for the two PIIs examined, two distinct formats. Since one of the tasks of a psychiatrist in PIIs seems to be to elicit talk from patients, to ensure that this is going to happen, the psychiatrist has to design his/her actions according to his/her particular recipients. As we have seen, one way to do that is by inviting the patient to narrate her story. The other was to take 'a step at a time'.

One of the first things we may notice about P3 is that he is hearably and visibly a 'foreigner' – at least, that is what should be perceived by any Spanish onlooker. Generally speaking, it could be said that one is an incumbent of the category 'foreigner' when s/he is in another country. However, having said that, by being in another country one does not *automatically* become a 'foreigner'. The activity of being a 'foreigner' requires that its incumbents are constituted as such in one way or another. For instance, in this PII, the fact that T1 and P3 use P3's language (French) to communicate may serve 'in this place, on this occasion' the purpose of collaboratively constituting P3 as a member of the category 'foreigner'.

We may notice that T1 indirectly refers to the foreignness of P3 when she asks him 'How long have you: been here in Spain' (lines 1–2). This question is designed to generate inferentially rich answers. In particular, it may be designed to find out what kind of a 'foreigner' P3 is. P3 might be a member of the category 'tourist' or a member of the category 'immigrant', which might have quite contrastive predicates attached. Whereas the category 'tourist' might be predicated on 'enjoying oneself', the category 'immigrant' might be linked to (for example) 'having a difficult life' and/or 'having legal problems'. P3's answer in 'Fifteen days' (line 4) seems to be equivocal as to his status, since one may have been a tourist or an immigrant for that period of time. This answer, in turn, prompts T1 to directly invoke P3's foreignness in 'So why did you come here' (line 9). This question is precisely intended to find out what kind of a 'foreigner' ('tourist' or 'immigrant') P3 is. The answer P3 provides in '(Mistake) the bus' (line 10) is, again, equivocal as to his incumbency upon the categories 'tourist' or 'immigrant'. Mistaking the bus could make him appear to be a member of a category like 'accidental tourist' (or 'visitor'). Since being a tourist may be considered to be a purposive activity (i.e. it requires to be seen as intentionally performed), P3's answer may be interpreted by T1 as denoting a mental state of confusion. In fact, T1's question 'Where were you: going to' (line 14) may be said to address P3's awareness about where he was going.

It seems that a recurrent theme in T1's line of questioning is that of finding out whether P3 has a job. T1 precisely tries to discover that in 'Mh hm so: because you're going to France to work?' (line 19). After having determined that P3 is not an immigrant in Spain, T1 seems to be trying to find out what kind of an immigrant P3 might be in France. For instance, P3 could be a member of the excluding categories 'immigrant worker', 'unemployed immigrant', 'asylum seeker', and so forth, which have, again, different predicates attached. The category 'immigrant worker' could, for instance, be indicative (given a regular source of income) of 'stability', whereas the category 'unemployed immigrant' might be tied up to 'leading a stressful life'. Another important feature of T1's questioning is that of attempting to establish P3's occupation (lines 39, 41). That, again, might be informative about P3's education, skills, intellectual aptitude, problems associated with certain jobs, and so on. This sort of information is what T1 might use to assess P3's *problems*.

We may also observe how T1 enquires about P3's family (line 33), which is responded to with 'On my own' (line 34) to denote that, at least, he is not currently 'married'. Therefore, T1 might be able to infer that the origin of P3's problems cannot have been caused by (for example) marital problems.

Exploring the circumstances that triggered admission

A recurrent feature of PIIs is that of psychiatrists enquiring about the occurrences that prompted patients' hospitalisations, as the following extract may exemplify.

Extract 3 [T1: psychiatrist; P1 = patient]

1 T1: So how did you think of doing it
2 P1: Then I thought of cutting my wrist (1.2) bu:t it
3 seems that I have a guardian angel (0.8) because ((P1
4 laughs)) I: heard my mother go upstairs and I thought
5 that's my opportunity (0.6) but I didn't realise that
6 my aunt (0.6) was in the stairwell (0.9) so then when
7 she saw me getting up she thought that I was feeling
8 worse and she started calling my mother Teresa Teresa
9 the girl is feeling bad! so then um I had a kind o:f
10 (1.2) of spasm
11 T1: Did you get to cut yourself?
12 P1: I I couldn't becau:se
13 T1: Mh hm

We may see in this extract how T1 asks in line 1 'So how did you think of doing it'. The answer to this question may help T1, among other things, to establish whether P1 fits in the category 'suicidal person'. Members can, for practical purposes, conventionally and contextually make assumptions about suicidal intentions. For instance, the *method* chosen to execute the suicide, the contextual particulars of its occurrence, and so forth, may be informative as to the *real* desire to commit suicide. The method itself may provide some clues as to the degree of suicidalness, since some methods are deadlier than others. The contextual particulars of the attempted suicide (when at least two relatives were about in the house) and the non-execution of the method to commit suicide might be constituted as a resource to interpret P1's suicidalness. Indeed, P1's account of her actions might be taken by T1 to violate the predicates conventionally ascribable to a category like '(real) suicidal person'. Instead, P1 could be seen as a member of a category such as 'attention seeker'.

In conclusion, I would suggest that by discovering of which categories a candidate patient might be a member (daughter, mother, abused wife, foreigner, tourist, immigrant worker, married person, parent, etc.) through the invocation of their expected predicates, the psychiatrist may obtain relevant information to establish the reasons for the candidate patient's presence 'in this place, on this occasion'. Consequently, the psychiatrist might be in a position to decide on the candidate patient's mental state and accomplish a diagnosis.

Is he an 'ex-patient'?

Extract 4 [T1: psychiatrist; P3= patient]

1 T1: .hhh have you sometimes been in a hospital?
2 (2.8)
3 P3: Yeah

```
 4  T1:  Why ill
 5                        (1.2)
 6  P3:  I was in hospitals yes
 7  T1:  Why
 8  P3:  Ill
 9  T1:  Ill from what
10  P3:  From what ill I was there for my feet
11       [to get them cured
12  T1:  [For your feet
13  T1:  Mh hm=
14  P3:  =I am going to get my feet cured if that's
15       possible
16  T1:  Mh hm so: no but before
17  P3:  Before?
18  T1:  Before have you sometimes been in a hospital
19  P3:  Yes
20  T1:  How long for?
21                        (1.1)
22  P3:  Several days indeed
                   ((2 minutes later))
23  T1:  Uh huh (2.4) so: are you taking some
24       medication no now?
25  P3:  (            )?
26  T1:  Some medication
27  P3:  No I'm not taking anything
28  T1:  You are not taking anything
29  P3:  No=
30  T1:  =Nothing
31  P3:  No=
32  T1:  =Nothing at all
33  P3:  Why?
34  T1:  In order to know er: whether you have any um
35       illness
36  P3:  Mh
37  T1:  Right?
38  P3:  No I [am not ill now
39  T1:       [(                )
40  T1:  You are not ill .hhh
```

The first thing we may notice in this extract is that when T1 asks '.hhh have you sometimes been in a hospital?' (line 1), what she is trying to find out is whether P3 is an incumbent of the category 'ex-patient'. Such a question, in the context of a PII, is quite consequential for the business undertaken: given the fact that the *symptoms* that once led someone to hospitalisation could still persist, determining whether this person was once a patient may be essential to ratify his candidacy as a patient now. Note as well that the formulation of the question might be, if isolated from this context, somehow ambiguous. One may reply by making himself/herself an incumbent of a category like 'visitor to a hospital'. However, P3 exhibits a contextual orientation to this question by responding with 'Ill' (line 8).

It may seem plausible too that T1 is not only trying to discover whether P3 was once a patient, but whether he was once a psychiatric patient. Taking into account the organisation of hospitals, where physical and mental illnesses are treated in the same compound, this very same organisation may be perceived (at this point in time) as an undesired element: T1 repeatedly asks what kinds of illnesses P3 was treated for, to which P3 provides an account of several physical illnesses (his feet, a skin disease, and a stomach disease).[2] However, there is something that might offer a direct link to the establishment of a past (and perhaps current) mental disorder: medication. In effect, by asking 'Uh huh (2.4) so: are you taking some medication no now?' (lines 23–24), T1 might be able to obtain significant information to associate the activity of taking a certain type of medication with a variant of mental illness. Furthermore, by asking whether P3 is taking any medication now, she might be able to ascertain whether that medication (of whatever sort – e.g. antibiotics, pain-killers) could be the cause of P3's current mental state of (for example) confusion.

Announcing the verdict

Extract 5 [T1: psychiatrist; P1 = patient]

```
 1  P1:  and she said mum come to live with me (0.6) I'll
 2       work (for you) (0.9) so I said my daughter I can't
 3       do it now (0.5) I have to get cured (0.9) because
 4       I've tried to do something very ugly
 5                            (3.0)
 6  T1:  Well we're going to do something (0.5) right?
 7  P1:                  ((nods her head))
 8  T1:  For the moment it seems all right to me that
 9       you're in hospital for a few days (0.6) so that
10       you can relax (0.5) basically (0.6) right? er::
11       so:: in the future (0.8) we'll (0.6) er::
12       discharge you in: a way that you have a
13       psychologist that someone that can help you (0.7)
14       obviously no sudden changes should take place I
15       mean that this is something these are your mid-
```

```
16       term goals (0.6) a different thing is that when
17       you leave well you'll obviously have to go back
18       with your mother and try
19  P1:  ((P shakes her head to say no to going back with
20       her mother))
21  T1:  Or well or at least try to solve it while you are
22       here so that when you are discharged (0.8) then
23       you are able to live [independently=
24  P1:                       [(          )
25  T1:  =I mean one thing is that you don't want to live
26       [with your:=
27  P1:  [Yes
28  T1:  =with your mother and something else is that you
29       have any possibilities
```

A recurrent feature of my data corpus is that in PIIs – in contrast to doctor–patient interaction (cf. Heath, 1992) – psychiatrists, after having explored patients' presumed illnesses, do not disclose a diagnosis. Thus, for instance, something like 'you have schizophrenia' is never said. Instead, psychiatrists announce a set of arrangements that the patient will have to endorse. Even in psychiatric interviews with in-patients, in which the latter know their diagnosis, the explicit name of their illness is typically not mentioned by psychiatrists.[3] What we might tend to find is something like an announcement, as is properly initiated by T1 in line 6. There, after T1 decides that P1 has told enough of her story, she announces what P1 will have to do while admitted in hospital and after being discharged. This announcement entails, among other things: (1) P1 will be an incumbent of the category 'patient' (which is predicated upon 'being in hospital', line 9) for 'a few days' (line 9). (2) P1 will become subsequently a member of the category 'out-patient', which has as relevant activities 'being discharged' (line 22), 'having a psychologist that can help her' (lines 12–13), 'having no sudden changes' (lines 13–14), and 'going back to live with her mother' (lines 25–29). All these activities are identified by T1 as being P1's 'mid-term goals' (line 15).

What resources does T1 have available to formulate a diagnosis of P1's conduct? Precisely those that both T1 and P1 have interactionally, collaboratively produced in this PII. T1's invocation of P1's putative categories and P1's (invited and self-) categorisations have inferentially facilitated the assembly of a patient's profile. P1's profile, in lay psychological terms, is of someone that according to T1 would belong to a category such as 'stressed person' because she is in need of 'relaxing' (line 10). The attributable grounds of this *state of mind* lie in the considerable volume of categorisations produced throughout P1's invited story, such as that of 'abused wife' and her subsequent conversion into a ‘separated wife’ (Extract 1), or the fact that P1 will have to live with the mother (Extract 5), which is predicated upon ‘loneliness’.

Altogether, these and other categorisations produced in the interview provide the grounds for P1’s attempted suicide (Extract 3). But is P1 *really* suicidal? Is she mentally ill? What about her diagnosis? The fact that P1 will be a ‘patient’ for only some days (instead of, say, being monitored and administered medication for a longer period of time) to ‘relax’ contravenes the predicates of a suicidal person. Rather, she seems to be considered an ‘attention seeker’ crying for help. In sum, then, for institutional purposes P1 is not categorisable as ‘mentally ill’, although she can be a ‘patient’ for a few days and ‘relax’ while in hospital.

Extract 6 [T1: psychiatrist; P3 = patient]

```
T1:  You’ll go but not er three or four days you’ll
     have to stay here
P3:  (            ) stay here [for four days
T1:                           [(                 )
     four days
T1:  Yes
P3:  Not three?
T1:  Um but it’s Satur Saturday not er: Saturday not
     in French Saturday? Saturday
P3:  Saturday
T1:  Friday Saturday Sunday
P3:  No I don’t know that
T1:  Yes the next days
P3:  Yeah
T1:  We’re not here
P3:  You’re not here?
T1:  Because i::t’s
P3:  Bank holiday
T1:  Yes yes
P3:  [Christmas Christmas
T1:  [Right?
T1:  Yes that’s why that’s why the social worker
     won’t be able to do (0.7) [er=
P3:                            [Mh
T1:  =thi[ngs (0.8) do you understand?=
P3:      [(                         )
P3:  Yeah
T1:  We’ll hav: have to wai: wait
P3:  Yeah(               )
```

After discussing some issues about P3's need to see a social worker (which has been omitted), we may see that T1 says 'You'll go but not er three or four days you'll have to stay here' (lines 1–2). By saying that, T1 may be heard to be announcing her verdict to P3: he will be a member of the category 'patient' for four days. Being a patient is, again, predicated upon being 'here' (line 2) – a hospital. We may notice how P3, a few turns afterwards, tries to negotiate with T1 the length of his admission in 'Not three?' (line 7). Such negotiation does not achieve the desired outcome for P3, since various organisational matters (the Christmas holidays were approaching, meaning that T1 would not be working) would prevent T1 from implementing the discharge procedure on P3's desired day. In any case, after that period of time P3 will cease to be an incumbent of the category 'patient', because he will be able to 'go' (line 1).

As with P1, what is entailed in assessing P3's problems or his mental state? On what basis has T1 decided that P3 will be in hospital for just four days instead of, say, an indefinite period of time? Again, her diagnosis might be accomplished after T1's own MCA of P3, which encompasses invoking the candidate patient's putative categories or interpreting his self-categorisations. In other words, such assessment or diagnosis seems to be achieved within the relational context of P3's membership categorisations and their expected ascribed predicates. Hence, for instance, P3's apparent state of confusion, inferred from his possible potential membership upon the category 'accidental tourist' (Extract 2); or the difficulties he might be experiencing as a result of his belonging to a category like 'immigrant worker' (Extract 2). These and other categorisations have enabled T1, perhaps, to consider P3 as a prospective patient. However, by learning that P3 is not a member of the category 'ex-patient' (Extract 4), T1 might contemplate P3's potential mental state of confusion as only transitory and not constitutive of mental illness. For P3, four days as a 'patient' will suffice.

Clinical relevance summary

Exploring a patient's mental state in order to produce a diagnosis, one of the most important aspects of clinical practice in psychiatry, seems to be based on common-sense knowledge or moral reasoning rather than on some type of specialised knowledge.[4] As such, psychiatric diagnoses are basically constituted out of normative evaluations of conduct converted into medical, scientific, taxonomy. Diagnosing is much simpler than matching context-independent rules from a manual of disorders to a set of behavioural occurrences, as it does not require much technical knowledge. In fact, diagnosing is incompatible with the application of a psychopathology model to someone's behaviour. Psychiatric interviews are interactional, worded phenomena, and as such the

Table 10.1 Clinical practice highlights

1. Psychiatric diagnoses are based on common-sense knowledge or moral reasoning rather than on some type of specialised knowledge.
2. Psychiatric diagnoses are basically constituted out of normative evaluations of conduct converted into scientific taxonomy.
3. Diagnosing is incompatible with the application of a psychopathology model to someone's behaviour.
4. Psychiatric interviews should be conceived as situated events whose practical purpose is to establish the patients' suitability for hospitalisation and treatment.

indexical properties of language preclude psychiatrists establishing a clear-cut and ultimate appraisal of patients' avowals. As a result, any attempt to correlate irrational behaviour and aetiological theorising will just reveal the futility of such an enterprise and the irremediable, inescapable, contextuality of human conduct. Diagnosing is, after all, a prominent psychiatrist's task in PIIs, which should be conceived as situated events whose practical purpose is to establish the patients' suitability for hospitalisation and treatment. In actual practice, PIIs do not certainly constitute the occasion to ratify orthodox psychopathology theories. For a simple summary of the practical implications, see Table 10.1.

Summary

From the two discursive strategies that psychiatrists might employ at the beginning of PIIs to elicit talk from patients, the question–answer sequence appears to be better suited to gain substantial control over the course – in terms of timing or topics – of the interaction than an 'invited story'. The analysis of these two discursive strategies has been illustrated through fragments from two different PIIs: one with a native and the other with a foreign prospective patient.

As we have seen, exploring or assessing a candidate patient's mental state in order to produce a diagnosis involves the application of common-sense or lay psychological reasoning. The resources that T1 had available for this are those interactionally generated during the PIIs with her prospective patients. By invoking candidate patients' putative membership categories and interpreting their self-categorisations, the psychiatrist is able to (for practical, institutional purposes) assemble a patient's profile and accomplish a diagnosis. The assessment of a candidate patient's psychopathological status is thus performed on the basis of what is normatively expectable from particular membership categories. In other words, assessing a patient's mental state is tantamount to realising a *lay* MCA of that patient's talk/actions.

Notes

1. For reasons of space, P1's disclosing of this matter has been omitted.
2. For reasons of space, P3's description of some of these illnesses has been omitted.
3. A plausible explanation for this phenomenon is provided in Roca-Cuberes (2008).
4. For a further development of this argument, see Coulter (1979) or Roca-Cuberes (2008).

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11

Psychogenic Non-epileptic Seizures: How Doctors Use Medical Labels when They Communicate and Explain the Diagnosis

Chiara M. Monzoni and Markus Reuber

Introduction

Psychogenic non-epileptic seizures (PNES) superficially resemble epileptic seizures, but are not associated with ictal electrical discharges in the brain. PNES are episodes of paroxysmal impairment of self-control, which represent an experiential or behavioural response to distress. The most effective treatment of PNES involves psychotherapy (LaFrance, Reuber, & Goldstein, 2013).

Consultations in which doctors deliver the diagnosis of PNES and recommend psychotherapy are challenging (Kanaan, Armstong, & Wessely, 2009; Monzoni, Duncan, Grűnewald, & Reuber, 2011a) because of the contrast between the psychosocial nature of the disorder and the fact that most patients perceive their symptoms as 'physical' instead (Reuber, 2009; Whitehead, Kandler, & Reuber, 2013). This contrast has interactional consequences in these consultations. Patients display interactional resistance to doctors' explanations about the psychosocial aetiology of PNES (Monzoni et al., 2011a), which is one of the reasons why doctors use great caution even before patients have displayed any resistance, or when talking to patients who readily accept doctors' psychosocial explanations (Monzoni, Duncan, Grűnewald, & Reuber, 2011b). Doctors' interactional delicacy is most evident when the diagnosis is formulated and explained and when psychological treatment is recommended (Monzoni et al., 2011b).

A second challenge which doctors face is to select a name or label to refer to their patients' condition. Ideally, the label would be clear and unambiguous for patients (cf. Schegloff, 1996a), as well as informative about the nature of the illness, and have no negative connotations. Unfortunately, there is no consensus among neurologists for an 'ideal' label for PNES. Here we use the term 'PNES' because this has been the most commonly used label in the recent literature on the subject. More overtly 'psychiatric' terms such as 'dissociative seizures' (*ICD-10*) or 'conversion seizures' have not been widely accepted by neurologists, and their validity has been questioned by researchers (Kanaan et al., 2009; Mayor, Smith, & Reuber, 2011). Other names have been in clinical usage (including 'pseudoseizures', 'psychogenic non-epileptic attacks', 'hysterical seizures') (Benbadis, 2010; LaFrance, 2010; Stone et al., 2003). However, these labels carry connotations that doctors may be trying to avoid, or patients may find offensive (Stone et al., 2003). For instance, the label 'attack' (Benbadis, 2010) might be traumatic for patients who may well have been the victim of violent attacks (Gates, 2000). Also, the alternative term 'seizure' may be problematic since it can be misunderstood as 'epileptic seizure' (Benbadis, 2010).

Moreover, our analysis of consultations demonstrated that doctors and patients use the terms 'attack' and 'seizure' quite differently (Plug, Sharrack, & Reuber, 2009). Patients rarely chose the term 'attack' which was commonly used by doctors preferring 'seizure' instead. Despite demonstrating a relative preference for the word, patients with PNES showed resistance to the term 'seizure'. This label had to be endorsed by doctors before patients felt entitled to use it – otherwise, they seemed to prefer lay-terms such as 'fit' or 'blackout' (Plug et al., 2009). Apart from our previous work, the few studies investigating diagnostic labels for PNES have used questionnaires/interviews to sample doctors' preferences and patients' perceptions (Kanaan, Armstong, & Wessely, 2012; Mayor et al., 2011; Stone et al., 2003). However, the choice and meaning of a label is related not just to its lexical properties but also to the actual linguistic and interactional context in which it occurs, and to the social activities carried out during its production (Hakulinen & Selting, 2005; Kitzinger & Mandelbaum, 2013; Lisboa & Spink, Chapter 12, this volume; Nore'n & Linell, 2007). For instance, labels might be used in namings, descriptions, or evaluations (Heath, 1992; Peräkylä, 2006). In the specific context of communicating and explaining a diagnosis, doctors can choose from a range of different labels and linguistic formulations. Furthermore, they have different options at an interactional level: they may 'report' the diagnosis and treat patients as passive recipients of an informing; or they may use more bilateral ways of negotiating the diagnosis (Maynard, 1992). The selection of a particular linguistic or interactional device may inform the choice for a specific label (cf. Schegloff, 1996a; Kitzinger & Mandelbaum, 2013).

For these reasons, this study examines how doctors employ diagnostic labels when they present and explain the diagnosis of PNES in clinical encounters by using Conversation Analysis (CA), which has proven useful in the investigation of how doctors communicate their diagnosis (Heath, 1992; Peräkylä, 2006; Roca-Cuberes, Chapter 10, this volume), how treatment is advised and decision-making is achieved (Collins, Drew, Watt, & Entwistle, 2005; Kiyimba &

O'Reilly, Chapter 26, this volume; Mangione-Smith, Stivers, Elliot, McDonald, & Heritage, 2003), and how neurologists discuss the diagnosis of functional symptoms and recommend psychotherapy (Monzoni et al., 2011a, 2011b).

Project overview

This study is based on 17 consultations previously analysed with a different focus (Monzoni, et al., 2011a, 2011b). We video-recorded encounters between three neurologists with extensive experience in diagnosing and treating patients with PNES, and 17 patients in two clinical neuroscience centres (Sheffield Teaching Hospitals NHS Foundation Trust and Southern General Hospital, NHS Greater Glasgow and Clyde Health Board). Patients were recruited when neurologists knew they were likely to communicate the diagnosis of PNES and recommend psychological treatment. All patients had PNES. One patient had PNES and epilepsy. In most cases (14/17), the diagnosis of PNES was certain.[1] The data were transcribed following CA conventions and analysed through CA (Heritage & Maynard, 2006).

The corpus used for this study was collected to investigate how doctors present the diagnosis of PNES and functional disorders and how they recommend psychotherapy (Monzoni et al., 2011a, 2011b). Our initial analysis revealed that the selection and use of labels for the diagnosis represented particular difficulties for doctors, despite the wide range of possible labels at their disposal. As we will see, doctors display a high degree of avoidance of specific labels, especially of those explicitly hinting at the psychosocial nature of this condition, even when patients overtly invite clarification and/or use more 'psychiatric' labels themselves.

Findings

We will start our analysis by considering the first labels or diagnostic formulations used by doctors. In the second part of our analysis, we will discuss subsequent mentions of diagnostic labels.

First mentions of labels and diagnostic formulations in the delivery of the diagnosis

When doctors first communicate the diagnosis, they rarely employ explicit labels such as 'psychogenic non-epileptic seizures'. Instead, in the majority of cases (13/17, 76%), we found non-specific labels or circumlocutions: PNES are not initially defined as a condition in their own right, but usually presented through the exclusion of the linguistic opposite, epilepsy. Doctors use negative syntactic formulations (such as 'it certainly isn't epilepsy') through which the patients' condition is presented as the absence of epilepsy. Let us consider the following case from the phase in which the doctor presents test results. The extract begins when he has just reported that the patient was unconscious during the examination.

Extract 1 (Kevin, 272–284)

```
 1 D:   If,if this sort of unconsciousness was caused by epilepsy,=
 2 P:   =mm::↓:.=
 3 D:   =then one would expect to see abnormal epil[eptic activity
 4 P:                                              [yeah!
 5 D:   [in the EEG.=
 6 P:   [mm.
 7 P?:  =((cou[ghs))
 8 D:          [and if that's not there and you're unconscious and
 9      not moving .hh then we, we can be pretty certain that
10      this is not epilepsy.=
11 P:   =right.=
12 D:   =So er therefore it's non-epileptic.=
13 P:   =right.
```

The doctor uses a set of negative formulations, before providing a first (vague) description of the diagnosis (line 10 'this is not epilepsy'). First, he explains what result one would have expected in patients with epilepsy (lines 1–5).[2] This is contrasted with the absence of this result (i.e., there was no abnormal electrical activity in the brain, lines 8–10). Hence, during this early phase, the problem is presented through a negative formulation, focusing more on the 'physically equivalent' condition (epilepsy) which the patient does not have. Such negative formulations are also used subsequently to define the seizure the patient had during the test ('this is not epilepsy', line 10). This formulation is a litotes, a figure of speech employed to provide a description through the negation of its opposite (i.e., 'it's not good', for 'it's bad'; Bergmann, 1992). Through the litotes the patient's condition is not described in its own right, but by its linguistic and physical 'opposite', that is, epilepsy. Through it, the doctor engages in different activities. First, he orients to the fact that a diagnosis is due at this point. Second, through the litotes he avoids, at this point at least, a more specific label for the condition, for example PNES, while concurrently orienting to the type of diagnosis which might have been expected by the patient and which is instead *relevantly missing* (cf. on the use of 'negative observations', cf. Schegloff, 1988, 1996b). At the end, the doctor presents the upshot of his previous explanation: 'so er therefore it's non-epileptic' (line 12). Even though 'non-epileptic' is used as an attribute, thus specifying the nature of the seizures, the label itself is still no more specific and no more informative than the previous description, since it merely refers to the absence of epilepsy. The whole explanation therefore amounts to no more than a circular syllogism.

Doctors used similarly general labels in the initial phases of those consultations in which the diagnosis had *not* been proven by video-EEG prior to the consultation, that is, when doctors were not entirely certain and discussed a range of different diagnostic options before ultimately presenting PNES as the most likely hypothesis. For instance, in Extract 2, the doctor discusses different treatment options in case the patient has epilepsy or PNES (data not shown) before presenting his (still uncertain[3]) diagnosis:

Extract 2 (Rose, 409–412)

1 D: and=um::: from your descriptio:ns um >I'm still not sure<,
2 although if I had to put my (.4) money on it um I would
3 still think that *non-epileptic seizures are* more likely
4 than *epileptic seizures.*
5 (.6) ((P's NODDING))

The attribute 'non-epileptic' has a contrastive role: it occurs in direct juxtaposition to 'epileptic' seizures (lines 3–4). Such a contrastive role between epilepsy and PNES and the use of similarly unspecific labels can also emerge interactionally: doctors employ the label 'non-epileptic seizures' when formulating a diagnostic hypothesis in contrast with previous (wrong) diagnoses, as in Extract 3 – here, the patient has just hinted that his attacks might be related to some past events:

Extract 3 (Simon, 60–82)

1 D: =So you accept that they're emotional attacks?=
2 P: =Yeah.
3 (3.3)
4 D: Yeah.
5 P: Well I do and I don't, because in past I've been for tests
6 with different hospitals. One says yes it's epilepsy and
7 another one says no, and then another one says yes and then
8 another one says no and, huh. it's, it's driving me mad.
9 (1.0)
10 D: mm.
11 (2.6)
12 D: Well I think the reason we: think that *they're non-*
13 *epileptic is cos we recorded one.*
14 P: ↓Yeah.

During the history-taking, the doctor probes whether Simon is aware of the psychosocial causes of the attacks. In a question designed to elicit confirmation (line 1, 'so you accept that they're emotional attacks?') (Stivers & Rossano, 2010),[4] the doctor uses a label which refers to the psychogenic nature of the seizures. However, here he does not deliver his own diagnosis. Simon first responds just through a confirmation (line 2), before reporting contrasting diagnoses he has received from other doctors (lines 5–8). While Simon uses a specific label for epilepsy (line 6), he does not use any specific term for whichever other condition he might have (lines 6–8, 'one says yes it's epilepsy and another one says no . . . '). Then, the neurologist delivers his own diagnosis for the *first* time (lines 12–13) using the general attribute 'non-epileptic'. Through this label he (1) aligns to the patient's report, (2) shows alignment with the previous (correct) diagnoses of PNES formulated by others (implicitly confirming them), (3) rejects the diagnosis of epilepsy made by others, and (4) avoids, at least temporarily, the delivery of a diagnosis related to 'emotional' problems, even though the patient has already displayed that he *knows*[5] about the psychosocial nature of his condition (lines 1–2). Thus, here the label 'non-epileptic' is not just an 'arbitrary selection' from a range of labels, but this choice is interactionally generated: it is explicitly employed in contrast to some of the previous (incorrect) diagnoses. In this way, as in other cases, the doctor displays alignment to the patient's previous talk and maintains coherence when presenting his own diagnosis.

The use of such negative and nonspecific formulations is one important aspect of doctors' delicate interactional work during the diagnosis delivery of PNES. Litotes are employed to avoid more specific formulations (Bergmann, 1992). Similarly, in these consultations, neurologists use negative formulations and litotes to sidestep the formulation of an explicit psychosocial diagnosis when this is due, even though the labels used do not constitute a 'complete' diagnosis. Through this delicate interactional work, doctors concurrently orient to the fact that patients might have expected a diagnosis of epilepsy. This allows doctors, at this stage at least, quickly to move to the discussion of the psychosocial aetiology and to avoid delivering a psychosocial diagnosis as a direct attribute to patients (Teas-Gill & Maynard, 1995).

Reformulations and alternative labels once a first diagnostic hypothesis has been delivered

Doctors may eventually reformulate the diagnosis and provide labels that are somewhat more explicit. There are ten instances of this in seven consultations (7/17; 41%). As discussed, the most commonly used label, 'non-epileptic seizure', is not more descriptive than the initial litotes. Of the other labels subsequently used ('non-epileptic attack disorder', 'pseudoseizures', 'psychogenic (non-epileptic) seizures'), only the last one contains any additional information about the presumed aetiology of the seizures. In two consultations, more explicit labels relating to the psychological causes of the condition are used ('dissociative attack', 'dissociation'), at later stages, only once the aetiology of symptoms has been discussed.

Let us consider again the case of Simon and see which labels the doctor uses in his subsequent (long) explanation of the diagnosis.

Extract 4 (Simon, 80–115)

D: Well I think the reason we: think that *they're non-*
epileptic is cos we recorded one.
P: ↓Yeah.
D: And that really is the best (.) level of evidence.
((...9 lines omitted...))
D: ...it's quite common for people with um *non-epileptic attacks*
to have er::, be told that they've had epilepsy.
Sometimes they've been treated for, with anti-epileptic
drugs for many years.
P: Same as me.
D: (   ) I- I'm afraid it's all too common. Um the reason we
suspected that *they weren't antiepileptic drugs*[6] er wa:s
um:: (3.6) the, there were some features which pointed
towards them *not being anti-, not being epileptic*, um in
particular sometimes they're very prolonged and *epileptic*
attacks are usually only maybe ninety seconds long, (.) not
very much longer. Um and then afterwards you're being
upset, it, it's, would be um:: rather unusual for an
epileptic attack, usually you don't feel particularly
upset after. (.) You'd just feel dazed or out of it
or you may have injured yourself. Um and then of course
there's all the background of your trauma and
the nightmares you've been having.
(1.5)
D: But er we recorded one of course and, and that gives us a
diagnosis, so we know that *they're not (.) <epileptic in*
nature>. Now the issue here is um (2.8) what the response
to that is, how you treat people with *non-epileptic*
attacks, cos they're actually quite common. We see:::,
about a quarter of our patients have *non-epileptic attacks,*
so it's not at all uncommon to have these, and they are
characteristic in people who've had significant emotional

33 trauma in their lives.
34 (1.3)
35 D: Um:: (.) and sometimes they respond to psychotherapy,
36 that is talking therapies, (1.5) (but in my experience)
37 they don't really respond to anti-ep-=epileptic medication
38 at all, and the anti-epileptic medication is largely
39 worthless. There's a small group of people who have *both*
40 *epilepsy and (.)these, these um psychogenic seizures* and um
41 they may need anti-epileptic drugs. But I don't think we've
42 got any reason to believe that that's the case with you,
43 because we recorded one of your attacks, which was quite
44 typical,...

The doctor still uses negative formulations highlighting the absence of epilepsy (line 6, 'non-epileptic attacks'; line 14, 'not being anti- not being epileptic'; line 26/27, 'they're not (.) epileptic in nature>.'; line 28–30, 'non-epileptic attacks'). As noted, such labels do not provide any information about the nature of PNES, constituting a circular syllogism ('it is not epilepsy, therefore the seizures are not epileptic, so that they are non-epileptic attacks').[7] Through these labels, the doctor avoids, at least temporarily, terms which would more explicitly attribute the attacks to psychological causes, despite Simon's apparent confirmation of having accepted the emotional nature of his seizures (Extract 3, line 2). Notably, a negative formulation ('non-epileptic attacks') is still used when a link between PNES and trauma is made (lines 30–33). The doctor uses the explicit label 'psychogenic seizures' (lines 39–40, 'there's a small group of people who have both epilepsy and these, these um psychogenic seizures') only after he has explained the emotional nature of the symptoms and after mentioning the possibility of psychotherapy. However, this formulation is deeply embedded in its context. First, it occurs in the middle of the explanation, so that it cannot easily be topicalized by the patient. Second, the formulation 'psychogenic seizures' is juxtaposed to 'epilepsy' so that the label 'psychogenic' highlights the distinction between these two conditions. Third, by talking about a class of patients, the doctor uses detached footing (as in lines 28–29), thus predicating the diagnosis at a distance from the patient (Monzoni & Reuber, 2015a, 2015b; Teas-Gill & Maynard, 1995).

More explicit labels about the psychosocial nature of PNES are rare, especially when compared to the very extensive use of negative formulations and circular syllogisms. However, such labels always occur *only once* the psychosocial aetiology of symptoms has been discussed and, more importantly, when patients have already displayed some kind of awareness of the nature of their symptoms. Moreover, as in Extracts 4 and 5, such labels are never predicated as an attribute to the patient, but presented through detached footing, indicating the delicate nature of this interactional work.

The following case is from a consultation in which the patient has been receptive to the diagnosis and aware of likely psychosocial causes from the outset. At this point, the doctor discusses that, from the video-recording of the seizures, there is evidence of amnesia for seizure-related activities (line 4), which the patient had reported earlier:

Extract 5 (Kelsey, 12/39–13/15)

```
 1 D: =But er when when e especially when you see the video[8]
 2    i: it's it's apparent how you ↑TALK. You know you you
 3    you .hhh you: handle the sick bowl, you're talking.
 4    .hhh And all this you can't remEmber.
 5    (0.2)
 6 P: ↑N[o
 7 D:   [Uhm (0.5) and and sometimes (0.6) uhm e: e: one
 8    one psychiatric name for for for this sort of problem
 9    (          ) would be dissociation. .hh Uhm wh- where
10    people do things and then they they they sort split
11    it off as if it didn't hAppen. As a you know e e uhm
12    e:: e:: it's like as if they can talk. They can er speak
13    but they can't remember. .hh Or sometimes there er:: are
14    other problems with dissociation ↑too.
```

The doctor first focuses on a specific seizure symptom (amnesia) and relates it directly to Kelsey (lines 1–4). Then, he offers a label for the condition associated with this symptom (lines 7–9 'one one psychiatric name for for for this sort of problem (   ) would be *dissociation*.'), thereby establishing a connection between a psychiatric condition (which is explicitly referred to as such) and Kelsey's symptoms. However, the term 'dissociation' is embedded, and it is *not* presented as a diagnosis in its own right, only as a label for a specific seizure symptom. Also, this condition is *not explicitly* predicated as an attribute of the patient (cf. Maynard, 2004). Moreover, when the doctor reports once again Kelsey's seizure symptoms, he uses detached footing ('.hh Uhm wh- where people do things and then they they they sort split it off as if it didn't hAppen. As a you know e e uhm e:: e:: it's like as if they can talk. They can er speak but they can't remember.', lines 9–13) (Teas-Gill & Maynard, 1995), further distancing her from these symptoms.

In general, then, doctors avoid using overtly psychiatric labels as much as they can, especially at the beginning of the consultation. The use of more specific labels is very rare and strictly dependent on the interactional context and on sequential aspects of the consultation. More specific labels are employed overtly to establish an explicit contrast with previous diagnoses (Extracts 2 and 3). More importantly, these are employed at later stages when the aetiology of symptoms has been thoroughly discussed and when patients have indicated that they accept that their seizures have emotional causes. Thus, doctors have considerable difficulties with the use of aetiologically more explicit labels. These difficulties are highlighted when patients explicitly invite clarification, even when they offer more specific labels, as below:

Extract 6 (Joyce, 68–75)

1 D: ok. .hhh they're more likely to be due, or they, they are
2 due to the:: (.4) you know, things that are, the way I put
3 it is things that are in your life or have been in your
4 life, and the way these things are affecting you.
5 (.7)
6 P: like *pseudoseizures* you're saying?=
7 D: =we(h.)ll kind of, yes, er I mean it's, that's not a term
8 I, you know, there's lots of terms for these things. But
9 they, yeah, they are, the, the, the, the, the movements
10 and, by extension, *the turns,* and we often capture just a
11 bit of *the turn*=
12 P: =Uh huh.=
13 D: =(Um/an'), that's quite usual actually.=
14 P: =yeah.
15 D: Um, er (.) as I say they're not due to a medical illness
16 they're due to that <(kind) of thing>.

While the doctor is introducing the psychosocial aetiology of symptoms, Joyce offers a medical label through a positive interrogative (line 6, 'like pseudoseizures you're saying?'), thereby seeking confirmation. The doctor's response misaligns with the question by partially confirming the statement without any true topicalisation and elaboration (lines 7–8, '=we(h.)ll kind of, yes, er I mean it's, that's not a term I, you know, there's lots of terms for these things'). Through the turn initial 'well', he resists the question-project and shows that the answer will not be as straightforward as indicated by the assumption in the question (cf. Schegloff & Lerner, 2009). Before expressing a confirmation, he qualifies the label employed by the patient (through 'kind of'). Then, he begins an explanation which excludes the use of that label from his own perspective ('er I mean it's, that's not a term I, you know,'). Next, he introduces a general discussion of the seizures in which he deliberately avoids any medical term for PNES, first by using the unspecified term ‘things’, then by employing the lay-term ‘turns’ (line 10). He then goes back to describing the test and the causes of the seizures (‘they’re not due to a medical illness’, lines 15), allowing him to avoid again providing a specific label. Through the use of unspecified terms, lay-terms, and negative formulations he rejects the label the patient offered.

Here, we have seen that the wide range of different labels available for PNES does not make it particularly easy for doctors to use them. Instead, their linguistic choices are a manifestation of the difficulties which doctors exhibit when delivering a diagnosis.

Clinical relevance summary

The analysis of how doctors use diagnostic labels in consultations is of interest because diagnostic labels influence patients’ illness representations (Manber, et al., 2003), which, in turn, impact on their acceptance of the diagnosis and treatment outcomes (Goldstein et al., 2004). This study demonstrates that the uncertainty about what to call PNES extends beyond academic considerations into real-life consultations. The avoidance of specific labels for PNES may be strictly connected to recipient design (Kitzinger & Mandelbaum 2013; Schegloff, 1996a); some of the labels doctors choose from (such as ‘psychogenic non-epileptic seizures’) can be rather opaque to patients. Even though this is a problem doctors face, here we have demonstrated how the interactional issues at stake in these consultations are much more complex than just providing labels patients can readily understand. Despite doctors’ extensive clinical experience, they avoid – especially at the beginning of the encounter – specific labels, particularly those referring to the psychosocial nature of this condition. The negative formulations they use instead constitute little more than ‘non-diagnoses’. Even though these ‘non-diagnoses’ can be unclear to patients and may even cause confusion (Mayor et al., 2011), they are the result of rather complex interactional work and, more importantly, serve significant interactional functions, in the later stages of the consultation, once the diagnosis has been explained. Through ‘non-diagnoses’, doctors orient to the fact that a diagnosis is due at that stage in the interaction and that it is relevantly missing. ‘Non-diagnoses’ can also act as placeholders for more explicit diagnostic labels, allowing doctors to move forward from the explanation of the condition to treatment recommendations.

The application of specific diagnostic labels is not a socially neutral activity. Diagnoses can become personal attributes (e.g., ‘you’re diabetic’) (Kanaan et al., 2009; Maynard, 2004). This is particularly problematic if the diagnosis is associated with social stigma (like mental disorders) and if the labelling has medical and social implications (Goffman, 1963; Teas-Gill & Maynard, 1995). For example, the labelling can create a 'spoiled identity' (see Horton-Salway & Davies, Chapter 6, this volume). In fact, the apparently simple act of naming a medical problem is merely an artefact of the creation of social and institutional order (Mehan, 1991). These issues are likely to be pertinent when doctors attribute a 'psychogenic' (i.e., 'mental') illness to the patient. This label could cause patients to feel offended and to reject treatment (even if 'psycho'-therapy for 'psycho'-genic seizures should make perfect sense; Stone et al., 2003). In our data, doctors are extremely cautious in their diagnosis delivery and also avoid, through a series of different linguistic and interactional devices, to predicate their diagnoses as an explicit attribute of the patient. For instance, doctors do not use syntactic formulations such as 'you have non-epileptic seizures' or 'you are non-epileptic' (although patients may refer to themselves in this way). Instead, they employ attributes specifically relating to the symptoms (seizures) rather than the patient ('I would call them non-epileptic attacks'). This awkward attribution of the problem is also evident in one instance (Extract 4), in which the label 'psychogenic seizures' is employed. This formulation is only used after psychosocial causes and psychological treatment have been discussed. The label is embedded and predicated at a distance from the patient through detached footing. In this way, the doctor labels the illness instead of the patient. Thus, doctors only talk allusively or indirectly of the psychogenic problem as an attribute of patients (Kanaan et al., 2009; Maynard, 2004), presumably in order to allow patients to accept doctors' aetiological theory first, thereby increasing the chances of accepting psychological treatment recommendations.

Having said this, the persistent use of non-explicit diagnoses may be problematic. Previous studies in patients with PNES and patients with other functional symptoms show that patients are keen to have a name for their condition (Thompson, Isaac, Rowse, Tooth, & Reuber, 2009). This is also evident from those cases in our data in which patients specifically ask for the name of their problem or suggest a more specific label than the one the doctor used. Patients may think that doctors are not taking them seriously if they are not given a diagnostic label for their complaint. Moreover, previous studies have suggested that one of the commonest outcomes of the communication of the diagnosis of PNES is that patients are left confused and that confusion is associated with poorer outcomes (Carton, Thompson, & Duncan, 2003). It is likely that merely telling patients what disorder they do not have and not providing them with a clear alternative diagnosis enhances rather than reduces the risk of leaving patients confused. Furthermore, there is no convincing evidence that giving patients specific labels is associated with poorer

Table 11.1 Clinical practice highlights

1. The diagnosis delivery of PNES constitutes a communicative challenge for neurologists.
2. Doctors consistently *avoid* at different stages of the consultation the following:
   (a) Specific and clear labels, but use non-explicit diagnoses instead
   (b) Explicitly predicating a psychological diagnosis as an attribute to the patient
   (c) Doctors orient to the diagnosis of PNES as 'bad news'.
3. Consequences during and outside the consultation:
   (a) Patients may explicitly require more specific and informative labels (which are subsequently still avoided by doctors).
   (b) Doctors' avoidance to use specific labels may trigger patients' resistance to the diagnosis and the advised psycho-therapeutic treatment, and leave them confused.
4. Suggested changes for clinical practice:
   Doctors' elaborated explanations of test results and psychosocial aetiology of symptoms should be followed by the use of specific, clear, and unambiguous labels.

therapeutic outcomes. For a simple summary of the practical implications, please see Table 11.1.

Summary

In our corpus, doctors used a wide range of terms and constructions when labelling their patients' condition. Like patients themselves (Plug et al., 2009), they do not apply different labels randomly. Terms of different grades of specificity are employed for particular purposes. Litotes function as non-explicit diagnoses. These linguistic constructions act as grammatical placeholders for diagnostic labels. While conferring little meaning, they serve a number of interactional functions. In line with a communication guide for this particular encounter (Shen, Bowman, & Markland, 1990), the exclusion of epilepsy may provide genuine reassurance to the patient. At first sight, it might seem that doctors enhance this reassurance by referring to normal test results in the same context (such as the lack of abnormal electrical activity during the video-EEG recording of the seizures) (Monzoni et al., 2011b). However, these conversational moves only provide a formal justification to present the diagnosis of PNES as 'good news': at the same time, the initiation of the discussion of the patient's actual diagnosis with the exclusion of another displays a strong orientation to the eventual disclosure that the patients' condition is 'bad news' (Maynard, 1992, 2003). Rather than as reassurance, doctors' references to the 'normal' video-EEG recording interactionally function as implicit hints at the much more problematic conclusion that there is likely to be a psychosocial rather than a medical explanation for the attacks. The reference to a specialist test is a safe conversational tool for doctors, because patients are not in a position to challenge doctors' expertise; and it functions in the same way as normalising online commentary during physical examinations (e.g., 'your thyroid feels quite normal') (Mangione-Smith et al., 2003) to prepare patients for the finding that symptoms are medically unexplained. 'Bad news' is also made expectable by the fact that the exclusion of epilepsy is not immediately contrasted with an alternative diagnosis (as in 'these are not epileptic seizures, they are psychogenic non-epileptic seizures').

Instead of providing a name for the problem at this point, doctors leave patients in a state of uncertainty in which they are expected to infer the nature of their disease indirectly through the doctor's subsequent aetiological explanations and treatment recommendations, thereby leaving it to patients to guess what the unvoiced news is. This strategy is also used in ordinary interaction for the guessing of bad news (Schegloff, 1986); in medical interaction, a similar phenomenon has been described as a perspective-display sequence: instead of parents being told straightaway that their child has intellectual disability, doctors present parents with facts and observations which guide them to come to this conclusion themselves (Maynard, 1992; Teas-Gill & Maynard, 1995). Neurologists use this technique to encourage patients to make the link between functional symptoms and their psychosocial causes themselves (Monzoni & Reuber, 2015a).

This chapter has a number of limitations. Our analysis can only draw on audio-recordings. It would be best if future work in this area combined the observation of actual encounters with doctors' and patients' ratings of the encounters and also with measures of desirable outcomes (such as PNES stopping or patients engaging in effective treatment). Our data set was also limited to a small number of neurologists with high levels of clinical expertise and perhaps conversational competence in this area. This limits the generalisability of our findings. Lastly, given the scope of our study, we focused more on the doctors' lexical choices, linguistic formulations, and the activities made by doctors, rather than on the patients' activities, which were only partially taken into account.

In conclusion, our study demonstrates that doctors' selection of a specific label is one part of a series of complex activities. Doctors tend to use a range of different labels as the consultation progresses. Their choice of labels is influenced by the linguistic formulations through which labels are delivered in interaction, and by patients' interactional contributions. In practical terms, our data provide support for the idea that, when presenting the diagnosis of PNES, a specific and clear label for the seizures should be provided at the beginning of the encounter (Hall-Patch et al., 2010).

Notes

1. Ethical approval was granted by Sheffield Ethics Review Committee and the Research Departments at the Sheffield Teaching Hospitals NHS Trust and NHS Greater Glasgow and Clyde Health Board.
2. The 'if..., then...' construction might be heading towards a diagnosis different from epilepsy.
3. Despite presenting his diagnosis as a candidate one, thus still uncertain, the doctor strengthens his epistemic ground through 'still' (line 1, 'I'm still not sure'), which refers back to his original hypothesis discussed in previous consultations.
4. This question is part of a longer perspective display sequence (cf. Maynard, 1992).
5. The fact that the patient displays of knowing the emotional nature of his attacks, however, does not mean that he has thoroughly accepted it, in fact he does not immediately elaborate his turn, but a 3.3-second gap ensues indicating trouble (cf. Jefferson, 1988).
6. We checked the audio several times, and the doctor indeed says 'antiepileptic drugs'; this is part of the great formulation effort characterizing these consultations (Monzoni et al., 2011b).
7. Such circular syllogisms are common (see Extract 1): doctors use them also when explicitly asked about the nature of the condition.
8. The doctor refers to the video-EEG.

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12

The Process of Social Labelling of Mental Illness: An Analysis of Family Conversations

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Introduction

The aim of this chapter is to illustrate the use of Conversation Analysis for understanding the relational nature of what is conventionally called 'madness/mental illness'. It begins with a brief presentation of Labelling Theory, a sociological approach based on the analysis of social reactions to normative deviations. The section introduces the psycho-sociological concepts that are relevant to the process of identification of a particular deviance as 'mental illness' and its normalisation, stabilisation, and/or amplification with focus on the interactions within the family and psychiatry services.

The results of the analysis of the interactions between members of a family that had one of its members recently diagnosed as 'mentally ill' by the health services are discussed in the second part of the chapter. The analysis is focused on the interactional strategies used by the family when negotiating different moments of the process of social labelling as a contribution towards a discursive and psychosocial-oriented understanding of 'mental illness' that takes into account the process of negotiation of what counts as normal for people in their immediate social contexts.

Project overview

This discussion is based on an analysis of everyday family interactions concerning the process of labelling someone as 'mentally ill' (Lisboa, 2008). The research was carried out with a family chosen because one of its members had recently been treated in the psychiatric emergency of a general hospital, thus initiating his 'career as a mentally ill person' (Goffman, 1963). Two interviews were carried out in order to explore aspects considered by Labelling Theory as important in the initial stages of the labelling process. The analysis of the interaction patterns in the conversations was carried out based on the methodological procedures of Ethnomethodology and Conversation Analysis. The audio registers were transcribed and categorised. This chapter presents some of the results of this research.

The process of labelling deviance and its effects: The theory of social labelling of 'mental illness'

The study of the manners in which deviances are captured by labels and their effects in the lives of people thus labelled has been an important focus of research for sociologists associated with the Symbolic Interactionism movement that emerged in the United States in the 1940s. Social Labelling Theory, based on theorisations by Goffman, Becker, Scheff, and Lemert, among others, is one of its offshoots. According to this theory, 'mental illness' is a label attributed to people who present behaviours that do not conform to the normative expectations derived from existing patterns of sociability, specially those that are accompanied by community responses of indignation and outrage (Becker, 1973).

According to Scheff (1984), one must distinguish between deviation and other forms of rule breaking. Deviations must provoke at least one of three responses in the community: moral outrage (*stigma*), segregation, and labelling. *Stigma* is the most important social reaction regarding deviance, and it involves a depreciation of the person following the understanding by members of the community that this is a discredited person (Goffman, 1963), and the consequence can be the creation of a 'spoiled identity' (see Horton-Salway & Davies, Chapter 6, this volume). *Segregation* calls for special procedures and institutions for dealing with the deviant: prisons, lunatic asylums, criminal courts, and so on. All societies reserve a special status for those considered deviant, devising formal procedures for rule breakers, as well as for their return to the status of normal members of society. *Labelling* is a specific aspect of the social reaction to the deviant that ascribes them to a special status through nominations available in every culture and society.

Scheff (1984) proposes that our society has an explicit label for each act considered as a norm violation (as in the case of the labels drunk, tramp, assassin, drug addict, etc.). However, there are also many implicit norms or unnamed norms, called residual norms, that are not elaborated as labels. For these, societies create generic labels, such as witchery, spiritual possession, and, in the case of western societies, 'mental illness'.

It is pertinent to ask under what conditions breaking residual norms becomes stabilised as 'mental illness'. Labelling Theory's bet is that social reaction is the most important factor, and labelling is at the core of the process of positioning someone as deviant based on the assumption that breaking norms is an evidence of 'mental illness'. According to Lemert (1951), the moment when a person uses his or her deviant behaviour, or their role as 'mentally ill', as a means of defence, attack, or adjustment so as to expose or hide problems derived from social reactions is central to the process of crystallisation of the 'mental illness'.

But, how do people learn to position themselves actively with regards to expectations about what counts as 'mental illness'? For Scheff (1984), this happens through stereotypes of insanity learned in childhood and continuously reaffirmed, unintentionally, in everyday social encounters. Mass media is especially important in the maintenance of such stereotypes, especially with regards to the qualitative difference established between 'insane' and 'normal' people through the use of terms such as 'dangerousness', 'incurability', 'unpredictability', and its 'negative evaluation'. Scheff also points to the relevance of the reaffirmation of such stereotypes in ordinary conversations through the use of pejorative terms. These are manifestations regarding an *outgroup* that have the function of reaffirming the value of the *ingroup*, and serving as a way of ratifying current social norms, enabling social cohesion and working, by contrast, as a way of preserving current mores.

This type of social reaction, based on images about the 'mad/mentally ill', is important for the determination of the duration and outcome of the residual rupture, which, at first might be vague and unstructured. Innate or learned causes of the infringement have a secondary role, given that it is the learnt social reaction regarding the rupture that determines its permanence under the label 'mentally ill'. Although society's usual reaction to residual ruptures is within the scope of normalisation, configuring it as a transitory process, in some cases the rupture is accentuated and immediately labelled. In these cases, the degradation and discrediting process is part of the labelling process: society's reaction ends by effacing the signs of normality in the person's previous life, who then becomes essentially positioned as a deviant.

In this context, given that there are multiple causes and sources of deviance, it is important to understand how the uniformity of behaviours associated with insanity comes to be. For Scheff (1984) and Goffman (1964), in a public crisis, the traditional stereotype of 'insanity' guides the actions of both the deviant person and those who react to deviance. The uniform reactions of professionals and family members when dealing with deviance as 'insanity' end up by creating expectations, with the result that normative rupture, which at first might be vague and unstructured, end up by being oriented by these expectations, becoming crystallised into conformity and stabilised as such along the years.

Public crisis are especially important moments in this process of labelling, given the need for immediate action and the confusion that characterises it. For Scheff (1984), these occasions create opportunities for bartering between professional of deviance, the family, and the deviant person, a situation in which the deviant person ends up by fittings into one of the categories proposed by the professionals.

But, how does a person fit into a psychiatric interpretation? These are not generally present at the beginning of the labelling process; they are preceded by the family's suspicion of a psychiatric diagnostic, especially because psychiatric discourse is not restricted to psychiatry. Society is familiar with the manner in which doctors make their diagnostic as shown in research about the way in which psychiatric discourse is learnt and reproduced in communities (e.g., in Brazil, research on the 'nervous' carried out by Rabelo, Alves, & Souza, 1999). Furthermore, in the initial phase of the labelling process, denominations other than those of psychiatry are used. Various institutions offer different meanings for deviance. This shows that there are many possible meanings for behaviours that are considered deviant by the social network that are not yet labelled as 'mental illness' (Rabelo et al., 1999).

In this context, the family is the locus of interactions that are of fundamental relevance for the initial moments of the labelling process. The family is the main context for socialisation and for learning the communicational skills that are necessary for presentation of selves to the world. Within-family conversational exchanges are intense, and the positioning games are decisive for the life of its members. But, more than the role of the family in this positioning game, each person is exposed to cues about their deviance that also resonate with their own experience with the 'insanity stereotype'.

Labelling theory and conversational analysis: Ethical and methodological considerations

In order to understand the role of family interactions in the process of labelling a person as 'mentally ill', a research was carried out based on the analytic categories of Labelling Theory and the methodological procedures of Conversation Analysis (Lester & O'Reilly, Chapter 1, this volume; Lisboa, 2008). Conversation Analysis is a derivate of the ethnomethodology approach developed by Sacks (1992) and is focused on everyday conversations in search of the normative and interactional rules of conversation. Ethnomethodology considers that, in their interactions, people utilise situational 'tips' (verbal and non-verbal) in order to understand and categorise the meaning of their interlocutor's speech and gestures and thus adjust their conduct accordingly. Garfinkel calls this form of tacit understanding ethnomethod: forms of situational understanding used in quotidian interactions that enables definitions of situational meanings and continuous adjustments of their actions (Garfinkel, 1967; Heritage, 1984a).

According to this theory, a person defines an interactional situation based on an enunciation directed to an interlocutor, thus creating a context that orients all further talk. Heritage (1984b) proposes that this occurs when a certain speech projects an activity or a series of activities for the next speaker, a phenomenon referred to as sequential implicativeness of a turn of talk. The projection of a relevant next action is done through pairs of actions recognised through conventions such as greeting/greeting, question/answer, invitation/acceptance–rejection. For Silverman (1998), the organisation of these consecutive forms of talk constitutes what he calls 'adjacency-pair', sequence of talks that are discriminatively related as the first part defines or discriminates which second parts are adequate.

At each enunciation, people re-actualise the context, and, as new topics are created, the social situation is redefined. Various aspects of the sequences of talk can be analysed: for example, pauses, 'preferred and dispreferred answers' (term used in ethnomethodology to refer to unexpected responses that reveal norm breaking), turn talk exchanges, interruptions, and control of topics. These various aspects of conversational rules have been analysed by a diversity of Conversation Analysis authors: for example, Drew, Chatwin, and Colins, (2001); Mishler (1984); Boyle (2000); Schenkein (1978); and Boden and Zimmerman (1991).

Studies of conversations of people considered 'mentally ill' carried out in the ethnomethodology tradition tend to focus on situations that are quite different from quotidian turn of talk and involve very specific conversational rules, such as in the psychiatry–patient relationship that was analysed by Ribeiro (1994). It is important, therefore, to examine the way conversation is carried out in non-medicalised settings, such as the family, in order to understand how these labels are used and what are the implications for the re-elaboration of selves of people thus labelled. For this purpose, collective interviews with a family in which one of its members was a person who had recently been referred for the first time to a mental health service, thus starting his 'mentally ill career', were recorded.

Ethical considerations

The ethical posture adopted in this research was based on respect and autonomy. Considering that people labelled as 'mentally ill' are capable of participating in a research project, that they are able to recognise their rights (such as the guarantee of anonymity and the right to withdraw from the research), are able to understand the research aims and procedures and the manner in which data will be used, the ethical posture adopted is a declaration that people who are considered to be 'mentally ill' can position themselves as citizens of rights. Officially, a person is not able to answer for his or her acts only if he or she is either in the midst of a 'mental health crisis' (or psychotic break) or under judicial interdiction. None of the people who participated in this research were in these circumstances and were able to understand the explanation regarding aims, procedures, and the ethical position of the researcher.

Before making contact with the participants, the research project was submitted to the Research Ethical Committee of the Pontifical Catholic University of São Paulo and of the Department of Health of the Municipality, abiding by the ethical regulation approved by the Ministry of Health (Resolution 196, 10th October 1996). The term of consent was presented to participants in the first encounter. As in any contract based in a relation of trust, it asserted the right of no-response and of withdrawing from the research at any stage. Explicit permission was obtained for recording, transcribing, and reproduction of dialogical situations for research purposes with the guarantee of not revealing identities.

Procedures for the analysis of transcripts

As stated in the project overview, the research was carried out with a family chosen because one of its members had recently been treated in the psychiatric emergency of a general hospital, thus initiating his 'career as a mentally ill person' (Goffman, 1961). Two interviews were carried out to explore those aspects considered by Labelling Theory as important in the initial stages of the labelling process.

The interviews were recorded and later transcribed in minute detail following the conventions established in Conversation Analysis (see Table 12.1 and Lester & O'Reilly, Chapter 1, this volume). The analytic categories were based on moments and characteristics considered in Labelling Theory as important to the process of labelling a person as 'mentally ill': (1) degree, quantity, and visibility of residual rule breaking; (2) power of the rule breaker; (3) social distance between rule breaker and control agents; (4) community tolerance level; (5) availability of alternative non-deviant roles; (6) severity of social reaction;

Table 12.1 Transcription symbols

Sign	Meaning
:::	Preceding sound or letter stretched
-	Sharp cut-off of the prior word or sound
= =	Latching between utterances
↓	Falling intonational shift
↑	Rising intonational shift
(0.5)	Time gap in tenths of a second
. . . . .	Each dot indicates a pause in the talk of two-tenths of a second
*	Misunderstood word
**	Misunderstood passage
‖ ‖	Onset and end of an overlapping talk
(( ))	Non-verbal activity
[ ]	Unclear fragment on the record – the best guess

Source: Adapted from Hutchby & Wooffitt (1998) and Sacks (1992).

(7) public crisis; (8) deviant stereotypes learned in childhood; (9) response cues of significant others that emphasise deviant role definition; (10) suggestibility of deviant; (11) compatibility of ego's vocabulary of expectations with others cues; (12) deviant acts in accordance with the expectations of the 'mentally ill' role; (13) incorporation of the 'mentally ill' role; (14) impairment of self-control capability; and (15) stigmatisation and segregation of further deviations.

Two levels of analysis regarding dialogical negotiations of the process of labelling were taken into account: one related to the speech content and the other focused on the interactive games and conversational strategies used by the participants when addressing these topics. The characteristics of the conversational exchanges were analysed through conversation analysis conventions (Hutchby & Wooffitt, 1998; Sacks, 1992). This procedure was coherent with the research objective of broadening our understanding of how interactional and discursive negotiations take place within the family, with special attention to the transformations that lead to positioning a person who committed deviance as 'mentally ill'. As the conversations were carried out in Portuguese, and given the limits for this text, only the analysis of one category (public crisis) will be discussed in this chapter in order to illustrate the transformations in the interactional positions of our subject in the process of labelling.

Distrust and negotiations in the initial phases of the construction of the mental illness label: The public crisis of Iago

In his medical records, Iago received code F20.0 of the *ICD-10* indicating 'schizophrenia' (see Thompson & McCabe, Chapter 20, this volume, for a discussion of schizophrenia). He was first seen at the Mental Health Centre by a psychologist, who registered the family's complaints in May 2007, including persecutory delirium (Iago believes that neighbours 'put a spell on him'); religious-type hallucinations (he feels the presence of demons and 'macumba' (witchcraft) – a kind of spell performed by practitioners of Candomblé religion, linked to African tradition in Brazil); and 'twisted body' (he has no notion of his pathological state). In his second visit to the unit, he was seen by a psychiatrist, who, after a very brief contact with him, confirmed the diagnostic of 'schizophrenia'. However, one month later, when an application was made for an expensive psychiatric medication, the diagnostic was changed to F29 (unspecified nonorganic psychosis). Iago was thus directed to the Outpatient Centre (CAPS) by the psychiatric emergency of the hospital.

Iago was 24 years old when we met him; he was the son of immigrants from Northeast Brazil and had lived in the São Paulo district of Brasilândia since his childhood. He lived with his parents (Isolda and Pedro), three sisters (Guilhermina, Neide, and Berenice), a brother-in-law (Victor), and three nephews (Clara, Josenildo, and Fernanda). He had his first 'crisis' just before accepting to participate in this research. In one of these crises, he said a neighbour had put a 'macumba on him' that made him see spirits, urinate himself, and wriggle to such an extent that he would have fallen on the floor if someone had not held him. He said he had felt as if someone had been 'tearing out his heart' and could not talk properly. In our visits to the family, his speech was slurred and his body was very stiff, suggesting a state of overuse of psychotropic medications.

Main findings of Iago's family conversations about his public crisis

According to the Social Labelling Theory, moments of public crisis are fundamental for retroactive labelling of residual ruptures that are considered, from then onwards, as signs of 'mental illness'. In Iago's case, his understanding of his problem/suffering is different from his family's explanation. He considers that his problem started with his first public crisis. But his mother and sisters say that signs of the problem appeared four years before as a result of losing his job. The small 'signs' perceived by the family are in agreement with Social Labelling Theory regarding breaking residual norms. Two extracts of the interviews concerning Residual Rule Breaking illustrate aspects that help to understand Iago's suffering and his later crisis.[1] In Extract 1, which starts with a clarification of Iago's first crisis, the disagreement between Iago and his mother Isolda is clear:

(**Extract 1**– First Interview)[2]

E: Yeah, I am not understanding Yeah:::, but::: and before this
happened, did anything happen? Before you became ↓ bent?
I: No, nothing.
E: You were here/ how did you become bent? Tell me.how ↓it was.
I: I was here, then ‖(suddenly-the-woman-shouted-from-there)‖
M: ‖ (He really started to *) ‖ at the time he started
to leave his employment.
I: No-it was-before-the-employment, no.
M: Wait a moment, my son.
I: [I left-the-employment four-years-ago].
M: You were already meant to be doing your treatment since that
time. But you didn't accept. You were in such a bad state that
you did not accept. [She could see] that he had a problem.
Isn't that so, [my daughter?] I would say to you, when you were
talking to yourself, you lost that employment and started to
stay like this.
I: It-is-not-my fault also.
M: Hum. He used to work at a firm…

It is interesting to note that Isolda interrupts Iago's explanation about what had happened in his crisis and, overlapping utterances, presents her explanation about what had happened to him (lines 195–196). According to Sacks, Schegloff, and Jefferson (1974), overlapping utterances are frequent in interactions, indicate a high level of interlocutor involvement with the topic, and are not restricted to disagreement about themes. Turn taking in overlapping utterances is a discursive strategy used so as to impose a point of view when the other interlocutor does not provide an interactional space. In the example above, the interviewer had selected Iago to be next in turn (lines 190, 191, 193), but Isolda replies to the question that had been addressed to Iago in an overlapping mode, taking the turn to herself, silencing Iago and changing the topic of conversation.

As the opinions dissent, Iago clearly tries to resume his turn, negating Isolda's remark (197 – 'I: It-was-not-before-the-employment, no.'), and thus attempting to disqualify her. The dispute for turn taking continues with Isolda's request that he keep silent (198 – 'M: wait a moment, my son.'). This repair mechanism of turn taking is a metalinguistic marker in which one speaker asks the other to shut up so as try to reorganise the conversation.

Still trying to defend his version, Iago contests Isolda's explanation (199 – 'I: [I-left-the-job four years ago'). For conversation analysts, this kind of utterances is understood with reference to the concept of 'account' which, according to Buttny (1993), are sentences through which people justify their actions attributing or removing responsibility. In everyday language, accounts are identified as excuses, justifications, defences, narratives, and accusations among other strategies. The sentence 'I left the job four years ago' is an account, given that it is aimed at disqualifying the statement made by Isolda that his problem started with the loss of his job.

Isolda then uses this justification to clarify further: in her view, Iago was already unwell at the time, but was not able to acknowledge it and refused to be treated. As proof, she calls forth a third interlocutor (her daughter was present at this interview) so as to confirm her version and give legitimacy and strength to her argument. This is when she introduces the first residual rupture, 'talking alone', in lines 202–204: '[She could see] that he had a problem. Isn't that so, [my daughter?] I would say to you, when you were talking to yourself, you lost that employment and started to stay like this'. In this sentence, Isolda, addressing the interviewer, first refers to Iago using the pronoun 'he'. But immediately afterwards treats Iago as an interlocutor (using the pronoun 'you'), stating that he might not have perceived he was unwell, but others could corroborate this because he was talking alone. In this manner, Isolda was able to legitimate her point of view.

For her, the present crisis was a consequence of Iago losing his job. Now, Iago agrees with Isolda's version and justifies losing his job, affirming it was not his fault, a sentence that is corroborated by Isolda in the next turn of talk. From then on, it became possible to talk about the moment before Iago's first crisis, a topic for which Isolda establishes herself as a privileged interlocutor. This topic is explored in Extract 2, bringing to the fore elements for the identification of residual ruptures.

(**Extract 2** – First Interview)

E: But at that time was anything strange happening? Do you think there was something like the present problem? (1.2s). When he left work.
I mean, behaviour wise.
M: Like this, he became like this, a person like this, he wanted to be alone (E: =Ham.=), to himself, he wanted to be alone, he didn't want to be with anyone (E: =Hum hum.=), he just wanted.. for him he wanted to be alone. And then he started.. to become distant, didn't want to speak to us, but wanted to be alone (E: =Hum hum.=)... he:: went out, took to the street, he'd stay out in the street, sometime a colleague of mine would say "Iago is [just talking], is *, there seated". So that how it started.
E: Do you agree, Iago?
I: I already told her, this has nothing to do with it.
M: There, talking to himself.
E: Talking to himself? Do you remember that, Iago? (1.6s) No?
I: It was.. [I-was-talking-of-witchcraft, I-was] *, she-thought-that-I-was talking to myself (E: =Hum.=), but [it was-her-anguish].
E: Hum, I understood. You were talking about witchcraft, was she present/
I: Was present, she thought-that-I-was-talking-alone.
E: I understand.
I: It was that.
E: But it was only once that he talked alone?
M: No, he talks:: many times, even today he says that people are putting a spell on him, that live here inside this house, and is putting a spell on him.
I: [It-is-not like this, it-is-not like this].
E: You think it is witchcraft that a neighbour did, is it?
I: No, it was not that.
E: Hum.
I: I shouted at her from here, right? (E: =Hum.=) And she shouted at me from there. (E: =Hum.=). We know each other.

The interviewer opened up the topic with a request for clarification, and Isolda lists some of the residual ruptures: isolating oneself, not talking to anyone, staying out in the street, talking alone. At this point, Isolda was able to talk freely about her perception of Iago's suffering. Only in line 259, when the interviewer offers the turn to Iago, he expresses his disagreement with his mother's interpretation of the beginning of his 'mental suffering' ('I: I have already told her, this has nothing to do with it.'). The accusation of talking alone, for example, is a serious deviation of the public order (Goffman, 1964), and in his defence, Iago says he was talking to a neighbour (although each was at their own house), even though people could not see or hear the neighbour.

At various moments in our encounters, Iago reaffirmed his explanation that his mental suffering was due to witchcraft (macumba), an aspect that will be discussed further on. But this explanation does not appear in this excerpt and is in fact negated (278 – 'E: You think that it is witchcraft put on you by a neighbour, yes?' 279 – 'I: No, it was not that'). As Iago was attempting to defend his view that nothing was happening when he left his job four years before, his account had to deny that there was any suffering at that time. Therefore, it was necessary to deny that witchcraft had been placed on him and explain that the conversation with the neighbour was just normal (lines 281–282): 'I shouted at her from here, right? (E: =Hum.=). And she shouted at me from there (E: =Hum.=). We know each other'.

The residual rule-breaking behaviour mentioned by Iago's family, such as talking alone, isolating himself, staying overnight in the street, talking loudly and shouting, seeing and hearing spirits, and having his mouth glued to the floor, is denied by Iago. It is possible that these different ways of interpretations by family members is part of a joint construction of a new understanding about his suffering. In other words, the meaning of the residual ruptures was still under negotiation, especially when we analyse it in relation with the moments of public crisis.

In Extract 3, Iago, Isolda, and Neide present two different versions regarding the first public crisis:

(**Extract 3** – First interview)

281 I: I shouted at her from here, right? (E: =Hum.=) And she shouted at
282 me from there.. (E: =Hum.=). We know each other.
283 E: You know each other. And why do you think she did a spell?
284 I: Because-it-was-wickedness.
285 E: Why, what?
286 I: It-was-her-wickedness.
287 M: Wickedness.
288 E: Wickedness ((Laughter)) of hers. Ah, I get it. And how was it for

you having gone there.. to the hospital emergency?
I: Well, for me it was a-bit-annoying.
E: It was you who wanted to go?
I: No.
E: Whose idea was to go to the emergency?
I: It was::: her-and-my-godfather. She and my godfather.
M: You asked for help, didn't you?
I: Anh?
M: Did you ask for help?
I: I asked-for help [at the time of the problem].
M: And then what. And then what?
I: You took me, you [not-knowing-what-was-the-matter-with].
M: ↑Didn't you ask for help? You were in such a bad state, all twisted, peed in your clothes?
I: ↑I-did-not-pee-on my clothes, no.
M: ↑Yes, you peed on your clothes. ‖You didn't see that you peed ‖ in your clothes.
I: ‖ I did not *‖
M: ‖Then you were ↑ twisting like this‖, in your neck.
I: ‖****‖.
E: Hum hum.
M: So you asked for help.
I: [She-invents-too-much].
E: Ah, what did you say just now?
I: She-invents-too much.
E: She invents too much?
I: Yes.
M: Your godfather should be here, like I told him to ph/ to phone him. ‖And Felipe was the one who took you‖, because it was Felipe who bathed you.
N: ‖ * * * * because he can't remember ‖.
M: To take you to emergency.
I: ****.
E: But I will be coming often, another day we arrange with the godfather, he comes. There is no problem.
M: So, it was Felipe who ‖ took my son in that very bad day ‖
I: ‖[I was already-under witchcraft]‖....... Was already putting a spell on me.
M: ((Laughter)) Was putting a spell, that he says it was already another witchcraft.

329 E: Another witchcraft? Why? Or another day, you say?
330 I: It was.
331 E: How was this second time? What was it?
332 I: [This-time-I-felt-the heart-was-being-pulled-out].
333 E: What was it? Pulling out the heart?
334 I: Yes::, a-spell-of-pulling-out-the-heart.
335 E: How? Explain to me.
336 I: They told me that:: they-sent-Exu, right? (E: =Ham.=) And they
337 pulled out my heart.
338 E: They told Exu to pull out your heart?
339 I: Yes.
340 E: Ah:::
341 I: And then I [felt bad], right? [They-sent-Exu] and I felt
342 something pulling. (E: =Hum hum.=) I ended up feeling the need to
343 pee, right? Then I peed in my pants.
344 E: On another day or on this same day?
345 I: On another day.

On previous occasions, Isolda had mentioned that Iago talked to himself, thus configuring a residual rupture that was also noticed by her daughters and neighbours. But Iago denies this. So Isolda brings to fore Iago's own explanation about what happened, postulating that witchcraft explained the reason for talking to himself. Once again Iago disagrees, affirming that, in this case, talking was a normal dialogue with this neighbour, and therefore attempting to defend the normality of a behaviour that was being presented as a residual rupture.

As, in this same interview, Iago had mentioned that his problem had been caused by witchcraft placed by the neighbour, the interviewer points to the contradiction, implicitly adopting Isolda's comprehension. Faced with this confrontation, Iago abandons his defence (that he was not talking alone) and resumes his narrative about the spell.

At this point, the interviewer changes the topic of conversation and initiates the sequence regarding the hospital consultation. From then on, the dialogue becomes more tense, as Iago says that he did not want to go and was forced to do so by his mother and godfather instituting a pair of adjacent accusations with two possible outcomes: apology/justification or accusation (Hutchby & Wooffitt, 1998). His mother immediately offers an account: a justification in the format of a question, implicating him on the decision to be taken to hospital emergency (295 – 'M: You asked for help, didn't you?'). Iago's reply (296 – 'I: Anh?') can be taken as a request for clarification, due to not having understood, or as a hesitation, a moment of reorganisation of dialogue.

Isolda repeats the question, but Iago continues his course of accusation in line 300 ('I: You took me, you [not-knowing-what-was-the-matter-with-me].'). Isolda once again justifies, but now with a tone of accusation (lines 301–302 – 'M: ↑Didn't you ask for help? You were in such a bad state, all twisted, peed in your clothes?').

It is interesting to note that, when confronted, both maintain their position, repeating the same utterances in a more vehement manner. These strategies, of repetition, increase in the volume of voice and changes in intonation and are typical of situations of confrontation and explicit disagreement, when interlocutors do not want to show insecurity (Hutchby & Wooffiitt, 1998).

In lines 295–296, Isolda brings forth new information by way of an account in the form of justification/accusation, creating another moment of discredit. She tells that Iago was not well, referring to the deviation of 'peeing in his clothes', considered serious in interactions among adults. Iago denies this, generating a very tense moment in the dialogue, with adjacent pairs of affirmation and negation, followed by overlapping talk. His mother carries on with narratives about the crisis, in line 307: 'M: ||Then you were↑ twisting like this||, in your neck'. This was followed by overlapping talk by Iago, very fast and slurred, difficult to understand (marked with asterisks in the excerpt). It is followed by a strong accusation made by him, in line 311 ('I: She-invents-too-much.'). At first, the interviewer does not understand so Iago repeats. The interviewer surprise can be seen in the intonation of doubt regarding the dispreferred character of the action.

In her defence, Isolda invokes the authority of the godfather and a neighbour, who were present at the moment of crisis, so as to confirm her version and prove she was not inventing: 'M: Your godfather should be here, like I told him to ph/ to phone him. ||And Felipe was the one who took you||, because it was Felipe who bathed you'. The sister, also in an overlap manner, takes side with the mother and says Iago could not remember this day, thus suggesting that he should not make such accusations. To ease tension, the interviewer initiates a switch in topic, proposing talking to the godfather some other day as a way of easing the interactional conflict.

Mother and daughter corroborate the need to call Iago's godfather so as to confirm the imperative of having taken him to the hospital. The joint talk by Neide interrupts the turn initiated by Isolda who resumes her turn proposing a return to the topic, in lines 316–318 ('M: So, it was Felipe who || took my son in that very bad day ||'). The pre-positioned marker 'So' indicates that the interrupted communication was being resumed in an attempt to take hold of the turn a topic. But Iago does not collaborate and, in overlapped talk, starts another topic related to witchcraft. Isolda's premature stop indicates that the turn was ceded to Iago (Sacks, Schegloff, & Jefferson, 1974). The dispute over the control of topic shows that this subject is treated differently by the various family who that compete for its control.

Once Iago installs the new topic, the change of turn between him and his mother, in lines 335 and 326 is intriguing: 'I: ‖[I was already-under-witchcraft]‖ .... Was already putting a spell on me. M: ([Laughter]) Was putting a spell, that he says it was already another witchcraft'.

In this extract, it is possible to perceive how Iago's understanding of his problem as an effect of witchcraft is discredited by Isolda. Besides its function as a non-verbal marker, her laughter can be understood as a form of discordant positioning, as a sign of discredit referral. By repeating exactly the same phrase as Iago, Isolda is ironical and positions herself as someone who does not share this interpretation.

The interviewer then offers the possibility for both to talk about the spell. Isolda doesn't seem to accept this suggestion and replies succinctly to the question with no further comments. The interviewer then gives Iago the turn, allowing him to elaborate, and he collaborates with the topic, which in fact was initiated by him, and begins to narrate his experience (line 332 – 'I: [This-time-I-felt-the heart-was-being-pulled-out.]').

In this topic, Iago takes control of the interaction, reporting on his bodily sensations and his comprehension that his problem/suffering was associated with witchcraft. An account sequence was initiated by him, justifying his unusual behaviours and offering an alternative explanation for the crisis reported by his mother and sister. Using strong images about his experience, he keeps control of the topic not giving any possibility of discredit or invalidation by the other participants (336 – 'I: They told me that:: they-sent-Exu, right? (E: =Ham.=) And they pulled out my heart.'). Thus, he was able to justify having 'peed in his pants' without having to make use of a psychiatric explanation, and sustaining the position that his mother and sister did not know about the witchcraft and took him to hospital because, for them, he had 'symptoms' of 'mental illness'. Once having defended his perspective about what had happened, Iago and the interviewer changed the topic, initiating a sequence of clarifications about the three crises and the hospital referrals made by the family.

The moments in which Iago's three public crises were discussed were accompanied by divergences and tensions derived from constant negotiations of meaning. Controversies regarding what had actually happened concerned mainly the causes of deviance ('macumba' for Iago; 'mental illness' for his family). Here, conversational interactions presented many instances of turn taking, interruptions, overlapping talk, and use of metalinguistic markers, indicating that the actors were engaged in the defence of different arguments. Iago's conversational resistance to 'psychiatrisation' of his crisis can be taken as an indication of how, even at such late date, negotiations concerning these moments still exerted influence in the manner in which meanings about Iago's suffering were being constructed.

Final considerations and clinical relevance summary

Given that Iago was in the process of being labelled as 'mentally ill', this case study provided some insight into the initial stages of labelling, with rich narratives and conversational exchanges about normative ruptures and social reactions to these deviances. Being a recent case, different understandings regarding these deviances competed among themselves, offering a variety of meanings for the family's comprehension about Iago's self that was being now re-signified with reference to the label 'mentally ill'.

Social labelling was still under course; each day new meanings were being interactionally elaborated by the family. The analysis of the dialogical negotiations allowed a glimpse of the many ethnomethods used by the actors to negotiate and construct versions of reality. It became clear that day-to-day conversations about past events still exert an important role in the labelling process.

However, one must take into account the effects of the researcher's intervention in creating an interaction space where the reflexive elaboration concerning the process of labelling became possible. The interactions under study involved all participants in the conversations, including the researcher and her intentionality that functioned as guides for the development of topics that were related to the aims of the research. The family's quotidian thus included the presence of the researcher as an outsider that searched for certain types of information concerning the interaction characteristics of the social labelling of Iago. Therefore, there is no pretence of having accessed the manner in which member of the family construct meanings and negotiate dialogically in a 'pure' way.

Nevertheless, despite the researchers' implication and the interaction space generated by the research procedures, the results indicate the relevance of language use and, more specifically, of daily conversation within the family context for the process of social labelling. The study of people in their social contexts was enriched by the coupling of Labelling Theory and Conversation Analysis, given that it thus became possible to get a better glimpse at the manner in which interactions happen in the micro-contexts of family life. The analysis of the ethnomethods associated with labelling provided a new vantage point for looking at the way meanings about mental suffering are negotiated and constructed.

Although conversation analysis is not an easy task, it can bring important contributions to Labelling Theory indicating, for example, how social actors talk retroactively about the various stages of social labelling proposed by the theory. It is thus possible to demonstrate the importance of these moments of later elaboration for the construction of a self based on the label 'mentally ill'. The mental health services also may profit from the analysis of the effects (of stigmatisation and/or protection) of labelling as an unintended consequence of the therapeutic protocols and, above all, of the negotiation of meanings with clients and their families as they enter in community and family contexts. Care, in mental health services, must not fall into the trap of instituting a 'career of mental illness' through their procedures. Attention must also be paid to its role in providing opportunities for emancipation or, alternatively, creating forms of imprisonment of their clients through careful consideration of the effects of the use of labels. It is also important so as to enhance their involvement in the elaboration of individual therapeutic projects, organisation of care, and of institutional structures.

However, despite the potential contributions of the procedures adopted in this research, some limits and difficulties must be highlighted. The microanalysis proposed by Conversation Analysis, even if associated with attention to the social reactions of the labelling process, is not an easy task within the context of mental health services, often becoming restricted to the theoretical-scientific gaze of academic research. The detailed analysis required restricts research to few cases and, as such, could lead to the conclusion that it only applies to the specific context under analysis. In order to understand the process of social labelling, other situations and contexts must be included and the effects of the CAPS, as an institution, must also be considered in this process. The study of clients at other mental healthcare centres would also be necessary for furthering understanding of the labelling process.

The challenge we set ourselves was to develop a way of looking at the phenomenon named as 'madness/mental illness' that could go beyond the mere identification of the stigmatising and capturing effect of labels, so as to advance towards the acceptance of difference and the understanding of the suffering endured by each person in their singularity. As a result, the elaboration of therapeutic practices could be made more poignant by being sensitive to the family and the immediate social context so that care does not become yet another tool for the pathologisation of social life. Opting for an approach that takes everyday conversations as a focus might be a way for the construction

Table 12.2 Clinical practice highlights

1. Contributions of a methodological dialogue between Labelling Theory and Conversation Analysis: the role of the ethnomethods in the process of social labelling.
2. Interactional care of mental health professionals in their negotiations of the meaning of 'mental illness'.
3. Difficulties and limits of doing Conversation Analysis in the context of mental health services.
4. The family as a privileged locus for the negotiation of meanings of labelling 'mental illness'.
5. Social labelling of 'mental illness' as a continuous and open-ended process: the importance of the analysis of negotiations of meaning after diagnosis.

of shared meanings and as such advance towards a type of care for mental health suffering that might further emancipation, rapport, human rights, and health promotion. For a simple summary of the practical implications, please see Table 12.2.

Summary

This brief presentation of a case study of the process of social labelling in the context of mental health had two aims. On one hand, it attempted to show the viability and potential contributions of the association between two theoretical traditions: Labelling Theory and Conversation Analysis. On the other hand, it attempts to show the difficult task of conciliating singularity and the generalisation needed for developing more sensitive protocols in mental health services.

Readers are thus encouraged to explore the literature regarding the processes of making sense of the world in our daily life (Spink, 1999), with special regards to the use of interpretative repertoires that mingle the long time of history, our socialisation processes and the interactional encounters were these repertoires are activated.

Notes

1. Each interlocutor received a letter: I for Iago; M for his mother Isolda; B for his younger sister, Berenice; N for his middle sister, Neide, G for Guilhermina, the younger sister, and P for Pedro, the father.
2. Transcriptions followed the conventions of Conversation Analysis in an attempt to translate the way participants talk: their specific intonations and vocalizations. For example, 'sesesese' to indicate the noise made by the tongue in the midst of a sentence.

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13

Making Mental Disorders Visible: Proto-Morality as Diagnostic Resource in Psychiatric Exploration

Jörg R. Bergmann

Introduction

In the same manner in which problems of physical health are identified in medical practice as problems residing within an individual's body, problems of mental health are typically located as problems within an actor's mind, personality, or physical condition. This coupling of physical and mental reality has crucial epistemological and practical implications.

If mental disorders are treated categorically like physical diseases, they adopt the status of observer-independent facts 'out there' in the world like fractures or infections. Some of these bodily disorders are directly evident as in cases of bleeding or mayhem, some others – such as high cholesterol level or a valvular heart defect – are not directly visible despite of their factual nature. Similarly, mental disorders cannot be observed directly; as 'mental' disorders they are internal phenomena and as such unobservable by others. Whereas invisible physical disorders can be found and observed by way of specialised medical technology (blood tests, ultrasound, X-ray, etc.), a similar technology does not exist for mental disorders. Thus, a guiding question for the ensuing chapter is how mental disorders are identified, made visible, and objectified in psychiatric settings.

The parallelisation of physical and mental health/illness has a second important implication. A physical condition can only be 'diagnosed' as medically conspicuous or abnormal by applying a normative scheme (e.g. the normal range of body temperature, the normal rate of blood sedimentation). With regard to mental disorders similar institutionalised schemes of normalcy – nosological systems of classification, diagnostic manuals, and so on – are developed and propagated, but the definitions of what counts as normal/abnormal change over time and remain contingent, as Ian Hacking (1997) has shown with regard to the concept of multiple personality. This chapter sets out to uncover and identify the normative measure based on which a mental disorder is identified in psychiatric examination.

Project overview

This chapter deals with the question how mental disorders are identified and made visible in psychiatric examinations and on which normative substructure these professional psychiatric assessments are based. It starts from the assumption that social interaction is the medium in and through which mental disorders manifest themselves, and it pursues the thesis that social interaction with its inbuilt proto-morality serves as the main normative resource by which irregular or unacceptable behaviour is made observable as sign of mental disorder. 'Proto-morality' is meant to refer to the tacit expectations through which interlocutors mutually hold each other accountable for their actions and for the successful accomplishment of their encounter. This concept is theoretically informed by ethnomethodology's basic presumption that the unfolding of interaction and the possibility of common understanding consists 'in the enforceable character of actions in compliance with the expectancies of everyday life as a morality' (Garfinkel, 1967, p. 53).

The following study is based on observations and a large number of tape recordings of psychiatric intake interviews in various mental hospitals in Germany. In these interviews, the psychiatrists' official work assignment was to decide whether a person who came to the hospital by himself or attended by a relative, a social worker, or the police should be – voluntarily or involuntarily – hospitalised as a mental patient. The psychiatrists' decisions were entirely based on that person's – the candidate patient's – observable behaviour during the interview. The examination did not include any physical check-up of the candidate patient; in most cases, no differential diagnosis was given in the psychiatrists' subsequent file reports. After a discussion of the pitfalls of formal psychiatric testing, two phenomena will be singled out and studied from a conversation analytic perspective: (1) practices of interacting with a silent candidate patient and (2) practices of asking without questioning. The common thread in the study of these two phenomena will be the question how the interactional practices of establishing the exploratory interview as a social encounter with its inbuilt moral nature are used by psychiatrists as resource for inference and decision-making.

The pitfalls of formal diagnostic testing

According to their professional self-conception and claimed entitlement psychiatrists' assessments are based on standardised and verified procedures for the identification and diagnosis of pathological deviations from the spectrum of 'normal' behaviour. The reputation and ascribed expertise of psychiatrists is in major parts based on the assumption that they do not just engage in trivial talk with patients, but that they have artful and sophisticated ways of communicating for diagnostic and therapeutic purposes. All handbooks and manuals for psychiatrists include at least one chapter on exploratory techniques often with elaborate instructions how to set up an interview, how to ask questions, how to engage in the conversation, and so forth (e.g. Semple & Smyth, 2013, Chapter 2). There are, however, three problematic issues related with the diagnostic interview, which are sometimes mentioned and dealt with in the literature.

Humiliating effect of questioning

Similar to a police interrogation in which questions can be threatening because they place the respondent under suspicion of wrongdoing ('Where have you been on Tuesday between 5 and 6 p.m.?'), questions in a diagnostic interview can be perceived as degrading because the sheer questions ('Do you know where we are?', 'Do you hear voices?') suppose the possibility that the respondent may not be normal. In addition, the diagnostic interview covers topics such as sexual behaviour or drinking habits, which are regarded as sensitive. This can be particularly challenging in the child psychiatry setting, where children are questioned about such sensitive matters and presumed competence is negotiated (Stafford, Hutchby, Karim, & O'Reilly, 2014). And, furthermore, the 'simple admission of psychiatric symptoms is humiliating for many people, as is the admission of behaviours considered by society to be either undesirable or abnormal' (Carlat, 2005, p. 22).

Dissimulation and resistance

In response to the potentially embarrassing effects of exploratory questions respondents may prefer to conceal or deny unfavourable thoughts, feelings or acts. Since psychiatrists know about the possibility of dissimulation they show professional scepticism with regard to respondents who present in their answers a picture of psychiatric health. However, the psychiatrist's scepticism and persistence in assuming non-normalcy is in turn an obvious reason for respondents to be even more annoyed or to show resistance up to the point, where they outright refuse to comply with the question–answer format initiated by the doctor. Sometimes, as in the following extract, taken from Michael Lynch's (1984, p. 74f.) study on diagnostic interviews in a neurobehavioural clinic –

Extract 1: Eva Stark's exam

Dr: I'm going to say a number, and then I want you to
repeat it to me backwards.
If I say, 'One, two, three,' you say, 'Three, two,
one.'

```
5  Pt:  Why::?
6  Dr:  Four, two, three, say it backwards.
7  Pt:  Say it backwards.
8       Why do you do this to me, it's embarrassing to me
9       when you ask these little children questions.
```

– a respondent may altogether refuse to be turned into a subject of the exam and may demand instead an account for the psychiatrist's questions.

Negligence of the patient's first words

In order to sidestep or compensate the emotional and interactional impediments caused by a formal exploratory regimen, psychiatric manuals advice professionals to establish a friendly relationship with the respondent and to move slowly into the psychiatric exploration. 'You do not compromise an imbecile by administering an intelligence test out of the blue' (Spoerri, 1970, p. 160; my translation) is one of several suggestions.

Another reason for the common practice of psychiatrists to acquire knowledge of a candidate patient's mental state prior to and independent of the formal exploration is the professional tenet that 'the first few words and sentences of the patient are often of particular significance; it pays to ponder over them' (Redlich & Freedman, 2008, p. 204). This advice typically refers to the 'first' utterance of a patient in his answer to the psychiatrist's topic-initiating question 'What can I do for you?'. This is, however, in most cases not the patient's 'first' utterance. Psychiatric interviews usually start in the same way as any other social encounter with the exchange of greetings. It is here, during the interactional opening with greetings and mutual identification, where patients utter their first words. Textbooks tend to disregard these first exchanges at the very beginning of the interview as irrelevant, but actually, as will be shown, they serve as an important, albeit informal diagnostic source which allows psychiatrists to instantaneously gain a rough impression of the respondent's mood and willingness to cooperate and, thus, to overcome the pitfalls of formal diagnostic testing.

Talking with/about a silent respondent: Recurrent dis- and re-engagement

Although psychiatrists rely on talk as the medium through which they can find out whether a candidate patient needs to be admitted to the mental hospital, they frequently have to deal with cases in which the respondents do not talk at all. How can a psychiatrist explore a candidate patient in order to decide whether he is in need of hospitalisation when he remains silent? An instance of this can be found in the following extract:

Extract 2: INTAKE: A-8:1

Dr. N, the psychiatrist on duty, briefly skims the letter of referral and then sets out, accompanied by the sociologist JB, to the ambulance where he slides the side door of the car. He faces Mrs B who is sitting inside and looking at him with eyes wide open.

Dr.N: **Hello Mrs Benz,**
Gu:'n Tach Frau Benz,
(1.8)
Dr.N: **Mrs Be:::nz?**
Frau Be:::nz?
(.)
Dr.N: **Hello,**
Gu'n Tach,
(1.0)
Dr.N: ((to JB)) **°Well she is very tired she has to go**
((zu JB)) °Ja die is' ganz mü:de die muss
to bed [right away. Right?°
gleich [in' Bett. Ni:ch?°
JB: [mm
Dr.N: ((to Mrs Benz))**You'll be brought to bed right away;**
((zu Frau B.)) Sie komm' gleich ins Bett;
(.)
Dr.N: **Okay:?**
Ja:?

Dr. N addresses Mrs. B, who is sitting in the ambulance and gazing at him, with the conventional opening format [greeting] + [personal name]. When Mrs. B does not offer a return greeting, Dr. N summons her after about two seconds by using her personal name as address term with a strong rising-falling-rising intonation.

Failing to respond, remedying a silence, ascribing responsibility

If a speaker expects a response to a prior initiating action and instead the recipient remains silent, the speaker may want to find out the reason for the blank space and to remedy it. Anita Pomerantz (1984) has identified three types of 'remedy-pursuits' with which a speaker may deal with absent (or incoherent) responses and she has shown that these remedy-pursuit actions differ in locating the cause of the problem – and hence the responsibility for the problem – either with the speaker or the recipient. The summons with which

Dr.N. terminates the emerging silence (line 4) pursues a response by Mrs. B, but additionally it allocates the cause for the problem on her side. The summons is an 'attention-getting device' (Schegloff, 1968) which identifies the recipient's lack of attention or engagement as reason for the silence, thus making the subsequent summons reflexively accountable as solution for the momentary hitch.

After his pursuit-response action and after a micropause Dr. N quickly continues with a repetition of his initial greeting (line 7). This is noticeable in two respects: The summoning action has just cast doubt on Mrs. B's availability or competence, and Mrs. B has not given any sign that she complies with the summons and will now pay attention to the doctor. Although Dr. N. has just addressed Mrs. B. as inattentive if not disoriented, he continues as if the trouble has disappeared and as if Mrs. B. was a normal responsive recipient.

The very same pattern can be observed in the immediate following passage. After Dr. N's second greeting (line 7) his recipient does not show any recognisable response and fails to cooperate again. A pause evolves, which is interrupted by Dr. N. after one second: He shifts his attention, turns to the field researcher at his side, who until then is not involved in the interaction, and tells him what he thinks is the condition of Mrs. B. and what he intends to do with her. He then redirects his orientation again, turns back to Mrs. B. and informs her that she will be brought to bed immediately (line 15).

It is not unusual that speakers shift their attention from one addressee to another – even within the construction of a single turn (Goodwin, 1981; Szymanski, 1999). It is, however, very unusual to make comments to another recipient about a co-interactant in the co-interactant's presence. Talk about a shared known third person normally presupposes, like in gossip, that this person is physical absent or out of earshot. Talk about co-interactants while they are present and able to hear what was said about them is usually restricted to ritualised encounters (e.g. laudations, awards shows) or to situations in which the talked-about third party is deemed unable or incompetent to understand (e.g. small children, pets). Dr. N's comments about Mrs. B spoken in low voice but hearable to her, treat her as a non-attentive if not incompetent party who does not listen or understand and who will therefore not feel offended by his comment about her. But despite of this implicit ascription of incompetence Dr. N immediately moves on to address her as a normal, attentive and understanding recipient when he turns back to her and conveys to her the information about the further proceeding.

Shifting participation framework: Finding a way out of silence

This shift forth and back between actions which treat candidate patients as competent co-participants and actions which ascribe to them a lack of competence (inattention, disorientation, inability to understand, etc.) is a frequent pattern in the collected data corpus of psychiatric intake interviews. It is connected with a shift in the 'participation framework' (Goffman, 1981, p. 137) – a change from talk addressed to the candidate patient to talk addressed to some other co-participant and back again – and does not only occur at the very beginning of an interview as in Extract 2 but also later in the interaction, as in the following extract:

Extract 3: INTAKE: A-10:6

After several unsuccessful attempts to get a response from Mr. D Dr. M is now talking with the two companions, B1 and B2, who brought Mr. D to the mental hospital. Mr. D is lying on a stretcher with eyes wide open.

1 B.2: ((To Dr.M.)) **This morning he ate a slice of**
2 *((Zu Dr.M.)) Er hat heute morg'n 'ne Schnitte*
3 **bread or two 'nd tea and (.) since then**
4 *oder zwei gegess'n und 'n Tee und (.) seitdem*
5 **(nothing again until) this evening. ( ) not**
6 *wieder (nichts bis) heut' abend. ( ) nicht*
7 **much. And given that (.) he has a disease**
8 *viel. Wenn er dann (.) noch leberkrank ist,*
9 **of the liver, this- (.) can be quite harmful**
10 *dann- (.) kann das ganz schön schädlich sein.*
11 (2 sec)
12 Dr.M: ((Turning to Mr.D.)) **Well: Mr. Darschkow.**
13 *((Zu Herrn D.)) Ja: Herr Darschkow.*
14 **You don't say anything to that.**
15 *Sie äußern sich nich' dazu.*
16 (.)
17 Dr.M: **Not at all.**
18 *Gar nich'.*
19 (0.3)
20 Dr.M: **Hm:?**
21 (8 sec)
22 Dr.M: ((Turning to nurse)) **You think we should fixate**
23 *((Zu Pfleger)) Sie mein'n wir mach'n die*
24 **his arms,**
25 Arme fest.
26 N.1: **Well I- definitely- right,**
27 *Ja also ik- auf jed'n Fall- nich' wahr,*
28 (4 sec)
29 N.2: **He could well run away. Couldn't he?**
30 *Er kann ja durchbrenn'. Nich?*
31 Dr.M: **m'm:,**
32 N.1: **After all it's for his own safety nothing**

33 *Es is ’ja seine eigenen Sicherheit sonst ja*
34 **else. Isn’t it?**
35 *nischt. Nicht?*
36 (1.3)
37 Dr.M: ((Turning to Mr. D.)) **Wouldn’t you like to**
38 *((Zu Herrn D.)) Woll’n Sie sich nicht dazu*
39 **comment on that mister Darschkow, hm?**
40 *äußern Herr Darschkow, hm?*
41 (2.5)

Extract 3 sets in at a point where Dr. M has already made several attempts to get a response from Mr. D. All these attempts were unsuccessful and aborted after a few turns. In line 12 Dr. M once again turns to Mr. D with the invitation to express himself, but Mr. D remains silent. Upon the noticeable failure of Mr. D to respond, Dr. M (line 22) turns to one of the co-participants (a male nurse) for a short exchange only to switch back to the candidate patient again (line 37) after few turns. This episode is significant insofar as the interaction between the psychiatrist and a silent candidate patient is characterised by a frequent dis- and re-engagement, where the psychiatrist moves from the non-responsive recipient to other co-present parties and back again. How is this interactive pattern brought about and what is its meaning?

When a recipient does not respond to an initiating action and remains unresponsive to all ensuing attempts to overcome the evolving silence the continuation of this asymmetric ‘interaction’ becomes difficult and eventually impossible. By itself the silence leaves the reason of recipient’s non-responsiveness in the dark, but what is more important is the fact that the range of possible measures to terminate the silence and make the recipient talk via other routes is very limited. When all attempts to invite, persuade, entice, seduce or urge the recipient to show even a minimal response come to nothing a speaker may quickly be at the end of his tether. The continuing silence makes the continuation of the apparently ineffective attempts to solicit a response meaningless. The shift of attention to other co-interactants or objects (e.g. reading in the letter of referral) becomes a perfect way out of the stalled interaction.

Rebooting the interaction: Turning up signs of disorder

The re-orientation has additional advantages for the psychiatrist. By shifting attention to other sources the psychiatrist may get information from the medical file or the accompanying persons to better understand the reason for the candidate patient’s stubborn non-responsiveness. But the most crucial benefit materialises when the psychiatrist turns back to the candidate patient after his side involvement with other objects or co-present parties. In that moment a new interactional episode is started and the interaction is so to speak 'rebooted' insofar as the recipient is addressed with the underlying assumption that he is 'normal', that is, oriented, attentive, able, and willing to respond. A similar observation was already made by Goffman (1961):

> The psychiatrist begins the exchange by proffering the patient the civil regard that is owed a client, receives a response that cannot be integrated into a continuation of the conventional service interaction, and then, even while attempting to sustain some of the outward forms of server-client relations, must twist and squirm his way out of the predicament. All day long the psychiatric staff seems to be engaged in withdrawing from its own implicit overtures. (p. 368)

Within the psychiatric intake interview this 'withdrawing from implicit overtures' occurs in a condensed mode, but here it is more than just a nuisance. Of course, for the psychiatrist the oscillation between two recipients is an elegant way out of a stalled interaction, but due to the rebooting-effect it is also an ideally suited method for the psychiatric intake interview. The recurrent shift between dis- and re-engagement is an operation through which mental disorder is instantaneously 'turned up' (Lynch, 1984). Every time when the psychiatrist's attention shifts back to the candidate patient the interaction starts 'another first time' (Garfinkel, 1967, p. 9). The encounter between psychiatrist and candidate patient is reset to zero, the history of failure is momentarily erased. Returning the attention to the candidate patient provides for a 'fresh' start, the recipient is approached with the underlying optimistic assumption of membership and if he fails to cooperate under these favourable conditions he becomes – again – visible as someone who is unwilling or unable to act as any normal and reasonable person would do.

The technique of turning up mental disorder by dis- and re-engagement in cases of silent or baulking candidate patients is not a method which is suggested in psychiatric textbooks or which is part of the psychiatrists' professional repertoire. Instead its operating principle derives from the proto-morality of social interaction. 'Proto-morality' gained some prominence during the last years as a concept which is used in studies of human social interaction to refer to a deep layer of mutual obligations upon which concrete and culturally specific moral orders rest (Bergmann,1998, p. 283ff; Luckmann, 1995, p. 76ff). Whereas the empirical notion of morality refers to a limited set of rather specific communicative forms in which moral actions are realised (blaming, reproaching, excusing, justifying, praising, gossiping etc.) proto-morality is meant to capture an obligatory substructure of any social interaction, a basic feature of the social constitution of man that, although it has an obligatory quality, has not yet crystallised in identifiable norms or values. An essential feature of proto-morality derives from the fact that we act on the assumption that we are capable of choosing among alternative courses of action. Recognising others as competent members implies that we ascribe to them the same capability of choice and, as a consequence, to ascribe to them responsibility for the action they choose – hence the close affinity between 'response'/'responsibility'. Proto-morality can thus be seen as an intersubjective structure of reciprocal obligations emerging in social interaction.

Silence by itself is not conspicuous, a silent candidate patient becomes visible as 'silent' only within a certain sequential environment as when the psychiatrist solicits a response and does not get an answer. But even such a noticeable silence is neither a violation of a moral norm nor a manifestation of a psychopathological condition. It is, however, a disregard of the basic proto-moral commitment, which obliges interlocutors in a focused interaction to be mutually responsive to each other or to give at least an account for a missing response or a refusal of participation. The interactional stagnation caused by a participant's continuous silence can therefore be identified as a social breakdown by mundane common-sense reasoning, no psychiatric expertise is needed (Roca-Cuberes, 2008). In intake interview A-10, a few minutes after the exchange which is documented in Extract 3, Dr. M, the psychiatrist, terminates her unilateral 'interaction' with Mr. D with the comment 'Obviously something is out of order/Also irgndwas is' ja nich' in Ordnung' (INTAKE: A-10:9). This assessment can be seen as a simple result of Dr. M's common-sense reasoning and exemplifies Jeff Coulter's (1973) argument, that the operations of mental health personnel 'are tied to common-sense rationalities of judgement and inference' (p. 140). However, it is Dr. M's achievement as psychiatrist to objectify and corroborate this 'out-of-order' perception through a series of dis- and re-engagements during which the candidate patient is transformed again and again from a recipient-addressed-as-normal into a recipient-showing-signs-of-non-normalcy.

Asking without questioning: Testing complicity

As is the case for other interrogative contexts, psychiatric intake interviews are characterised by a traditional division of labour whereby one party asks questions and the other party gives answers. Many studies have shown that asking a question does not necessarily imply the use of a sentence in questioning format, and, vice versa, an utterance in the syntactical form of a question may be used for many interactional tasks other than asking. In the study of intake interviews a peculiar questioning format could frequently be observed in which a psychiatrist does not ask for information from the patient but instead tells the candidate patient something about himself (Bergmann, 1992). An example of this 'asking without questioning'-format can be found in the following extract:

Extract 4: INTAKE: A-13:II:2

After a short side conversation with Mr.B who is accompanying his wife to the mental hospital, Dr.F. turns to the candidate patient

1 Dr.F: ((to Mrs.B.)) **.hh okay u::h I mean I can**
2 *((zu Frau B.)) .hh ja ä::h ich mein Ich*
3 **see (from) your face that the:- (1.0) mood-**
4 *seh Ihrm Gesicht aus dass die:- (1.0) Stimmung -*
5 (.)
6 **apparently is not ba:[d.**
7 *anscheinend nicht sch[lecht is::.*
8 Mrs.B: **[.hhh yea:h**
9 *[.hhh jaa*
10 **now let me tell you this.**
11 *jetzt will ich Ihnen mal was sa:ng.*
12 (.)
13 Mrs.B: **If you:- (1.0) know- (1.0) God(h)- (0.7)**
14 *Wenn Sie:- (1.0) wissen- (1.0) Gott(h)- (0.7)*
15 **is my fa:ther;**
16 *ist mein Va:ter;*
17 (.)
18 Dr.F: **Hm[m,**
19 Mrs.B: **[I am his child; .....**
20 *[ich bin sein Kind; .....*

Instead of asking Mrs. B about her mood the psychiatrist is telling her that her mood is 'apparently not bad' (lines 3–6) after which Mrs. B voluntarily and without being asked directly unfolds the reason for her good mood. The questioning format singled out in this extract is not an exploratory format exclusively used by psychiatrists. It can regularly be found in everyday interaction and has been described and analysed by Anita Pomerantz (1980) as 'fishing'-device: A speaker tells his outside view of an event in which the recipient is a primary actor thereby inviting (or inducing) recipient to tell his inside view. Pomerantz' (1980, p. 189) paradigmatic example is the line at the beginning of a telephone conversation: 'I called you but your lines been busy' by which a recipient can be brought to disclose with whom he was talking. But what is the 'fishing'-format doing in psychiatric intake interviews?

Compared with a direct question an information-eliciting telling uses a modulated route to an answer. Questioning and in particular questioning in interrogative contexts has an intrusive if not oppressing component. It not only selects the topic, it also stipulates the terms and presuppositions for the answer. An information-eliciting telling is a much softer way of enquiring, it reduces the coercive power of a question by inviting instead of obliging a recipient to an answer and it leaves space to the recipient to formulate an answer in his own terms. Against this background it is not surprising that the format 'asking without questioning' is considered as an empathic and affiliative way of enquiry which is typically used in various types of psychotherapy, especially nondirective psychotherapy.

There are three relevant features of this questioning format, which makes it eminently suitable as an exploratory device for the psychiatric intake interview.

Testing the willingness to cooperate

When a speaker tells his side in order to bring his recipient to tell her side, the activity of asking does not deploy the asymmetric relation between requesting information and complying with a request but the more symmetrical relation of giving and return giving. A 'my side'-telling actuates the proto-moral obligation of reciprocity, generating the expectation that the recipient will deliver information in return. The recipient's answer becomes a quasi-voluntary quid pro quo, which is why the information-eliciting format can be used as a device to test the candidate patient's willingness to cooperate in a potentially difficult and tensed situation. Non-cooperation may then be interpreted by the psychiatrist as indicating a 'difficult' patient, as can be seen in the following extract:

Extract 5: INTAKE: A-6:10

Dr.B. is reading the letter of referral.

1 Dr.B: ((To Ms.K)) **Obviously you withdrew very much.**
2 *((Zu Ms.K)) Sie habn sich offensichtlich sehr zurückgezogen.*
3 (.)
4 **recently.**
5 *in der letzten Zeit.*
6 (.)
7 **in your flat.**
8 *in Ihrer Wohnung.*
9 (0.7)
10 Ms.K: **Hu! That's private business. There is nothing**
11 *Ha! das ist doch Prifa:tsache da gibt's nix*
12 **to talk about!.=**
13 *darüber zu re:den!=*
14 =**Withdrawn.=I can do what I want.**
15 *=Zurückgezogen.=Ich kann machen was ich will.*

Ms. K is invited by Dr. B to comment on the unverified (line 1: 'obviously') observation, taken from the letter of referral that she retreated conspicuously in her apartment. But Ms. K rejects to give any account, reclaims her activity as private business and thus misses an opportunity to show cooperation by presenting her point of view. The affiliative character of Dr. B's information-eliciting telling (lines 1–7) becomes evident a few seconds later when he confronts Mrs. K with the same issue but now reformulated as 'Here it says you had yourself barricaded'. Again Ms. K rejects to talk about the issue and thereby appears as uncooperative. (The intake interview ends with the involuntary admission of Ms. K to the mental hospital.)

Detecting lies

Another feature of this indirect questioning format which is of relevance for the psychiatric exploration is closely linked to the fact that the candidate patient is addressed as primary actor in an event of which the psychiatrist has only an 'outsider' knowledge. Casting the recipient into the position of someone who is invited to present, then and there, an authoritative correct version of an event may lead the recipient to tell more than he was asked for (as in Extract 4) or even to tell – under the cloak of assigned authority – a lie, as in the following extract:

Extract 6: INTAKE: B-15:5

Dr.D. is reading through the candidate patient's file and letter of admission.

1 Dr.D: **Uh you've already been with us.**
2 *Ah Sie waren scho:n mal bei uns.*
3 **I[s that right.**
4 *S[timmt das.*
5 Ms.P: **[On:ce:.**
6 *[Ei:nmo:l.*
7 (.)
8 Dr.D: **Fou:r ti:mes!**
9 *V:ie:rmal!*
10 Ms.P: **°Or four ti[:mes.°**
11 *°Oder vier[mal.°*
12 Dr.D: **[Four times.**
13 *[Viermal.*

In response to the telling 'Uh you've already been with us' Ms. P. does not simply produce a confirmation or disconfirmation, which may be seen and treated as an accountable withholding. Instead, she 'voluntarily' announces the precise number of her past admissions ('On:ce:'). But with the exclamation 'Fou:r ti:mes!' the psychiatrist immediately confronts her with a quite different number of her past admissions. By confirming this statement (line 10) the candidate patient implicitly confesses that she was caught lying, further evidence for which may be found in the transition from her determined ‘On:ce:’ to a subdued ‘Or four ti:mes’.

Given their operational structure, information-eliciting tellings can successfully be used as a lie-detecting device and are therefore highly suitable for exploratory interviews, examinations, and interrogations. The recipient is addressed as someone who has authoritative access, and the proto-moral obligation to reciprocate a telling may induce him to tell a more favourable version, in other words: a profitable lie. But the psychiatrist who presents himself as someone who has limited access may have derived further knowledge from other sources, knowledge which enables him to doubt the recipient’s supposedly authoritative version, or even to expose it as a lie.

Establishing as well as refusing to establish doctor–patient complicity

When an information-eliciting telling is used in lieu of a straightforward question the activity of asking is done in a cautious mode. Cautiousness can additionally be observed in the intake interviews on the semantic level: Very often when psychiatrists ask their questions in the format of an information-eliciting telling they also describe the event to which they refer in a cautious and discreet way; for example, they use certain rhetorical figures (litotes formulations such as ‘not bad’), euphemisms (‘withdrawn’ instead of ‘barricaded’) or mitigators (‘a little bit’) (Bergmann, 1992, p. 148ff). What is the reason for being so cautious in asking?

Instead of speculating about the speaker’s motives for the cautiousness, the reflexivity of this activity can be taken as guide to its meaning, that is, the cautiousness reflexively provides for an implicit account of its use. By describing something with caution, this ‘something’ is turned into a matter which is in need of being formulated cautiously and discreetly, matters such as private business, touchy subjects or improprieties. When the reflexivity of social activities is approached in this way, the familiar everyday perspective is turned upside down: In the everyday world we first see an embarrassing, delicate, morally dubious event or improper behaviour about which people then speak with caution and discretion. In an ethnomethodological perspective, the delicate and precarious character of an event is constituted by the very act of talking about it cautiously and discreetly. In order to discern the meaning of caution and discretion in the intake interviews, it is necessary to ask how candidate patients reply to the abundance of cautious and discreet elements in psychiatrists’ questions.

It can be observed that cautiously and indirectly exploring utterances in psychiatric interviews are treated by the candidate patients as one of two very different types of activity. Recipients can treat these overcautious formulations as considerate, sympathetic, and supportive invitations to give authentic descriptions, to put feelings into words, to disclose motives or – as in the following extract – to explain an emotional condition:

Extract 7: INTAKE: D-19:2

1 Dr.F: °**You're kind of edgy a little bit?**°
2 *°S' sind so:'n bißchen gereizt?°*
3 Ms.W: **Pardon?**
4 *Was?*
5 Dr.F: **You're kind of edgy a li[ttle bit,**
6 *S' sind so:'n bißchen ge[reizt?*
7 Ms.W: [**Yes because I'm**
8 *[Ja weil ich da eben*
9 **living there in a house with lunatics....**
10 *in e'm Haus bei Verrückten läbe....*

As is the case in this extract many candidate patients respond without any reservation to the psychiatrists' prompting utterances, they cooperate and willingly deliver more information than they were asked. They apparently take the cautious and soft way of exploration as indication of the psychiatrists' empathy and affiliation and respond accordingly.

This trustful response blocks out, however, that the psychiatrists' information-eliciting tellings can be interpreted entirely different and can trigger strongly hostile and adverse reactions. Some candidate patients read the psychiatrist's questions as carrying a moral meaning beneath the surface of expressed helpfulness, as can be seen in the following extract:

Extract 8: INTAKE: D-20:5 (shortened transcript)

((Intake interview with Ms.K. who was admitted to the mental hospital by her family doctor))

1 Dr.F: **Well Miss Kant.**
2 *Ja Fräulein Kant*
3 Ms.K: **Yes.**
4 *Ja.*
5 Dr.F: **We know each other somehow by sight, don't we?**
6 *Wir kenn' uns ja irgndwie vom Seh'n. Nich?*
7 Ms.K: **Hm**

8 (0.6)
9 Dr.F: **[(already-)**
10 *[(schon-)*
11 Ms.K: **[.hhh hhh why do you point this out to me in**
12 *[.hhh hhh warum weisn Se mich jetzt so*
13 **such a way?**
14 *drauf hin?*
15 ((40 seconds omitted))
16 Dr.F: **.h thh. You feel angry about being admitted**
17 *.h thh. Sie ärgern sich drüber dass Dokter Kluge*
18 **by Doctor [Kluge. ( )**
19 *Sie einge[wiesen hat. ( )*
20 Ms.K: **[.hhh No:: I don't feel angry about**
21 *[.hhh Nei:n ich ärgere mich nicht*
22 **h- being admitted by Doctor Kluge**
23 *dass i- dass mich Doktor Kluge eingeliefert hat*
24 **.hh but that you somehow-**
25 *.hh sondern dass Sie irgendwie-*
26 (1.0)
27 Dr.F: **What?**
28 *Wa:s?*
29 (0.6)
30 Ms.K: **hhh**
31 (3.0)
32 Ms.K: **Mhh(a)hh(a)h please.**
33 *Mhh(a)hh(a)h bitte.*
34 ((With a wave of the hand Ms.K. wipes the
35 doctor's papers off the table))
36 Ms.K: **I:- (.) can't stand you Doctor Fischer.**
37 *Ich:- (.) mag Sie nicht leide' Herr Doktor Fischer.*

Dr. F's attempt to affiliate with the candidate patient by pointing out a common ground (line 5) is blatantly rejected by her and countered with the complaining question why he is spelling out for her their mutual acquaintance (line 11). A few turns later the psychiatrist starts another attempt to empathise with Mr. K (lines 16–18) but again she rejects his proposition and turns against him with a vigorous gesture and the announcement that she dislikes him.

By virtue of its reflexive accountability the cautiousness with which the psychiatrist asks his question can be interpreted by candidate patients as referring to a sensitive, possibly embarrassing and morally dubious topic which demands discreet treatment. A candidate patient may prefer to disregard this moral side of the psychiatrist's question, because chances are that neutral and friendly responses may be considered by the psychiatrist as sign of normalcy and mental health. Other patients, as Ms. K in Extract 8, prefer not to enter this type of moral game. They don't go along with the implicit insinuation of a moral misconduct and refuse to establish a doctor–patient complicity (Lynch, 1984, p. 75). For them the psychiatrist's effort to act cautiously and discreetly is a display of pseudo-empathy and much friendly ado about an unfriendly proceeding.

Information-eliciting tellings in psychiatric intake interviews are characterised by an ambiguity, they can be heard as helpful and supportive invitations, but they can also be apprehended as implicit moral challenges. Due to their ambiguity cautiously exploring questions are vulnerable to being heard by candidate patients in moral terms and may trigger uncontrollable, interactionally disastrous social situations. Thus, an utterance that was intended as supportive invitation and looks innocuous may lead to a kind of explosive reaction. A reaction of this kind in the context of a psychiatric exploration will unavoidably be seen as bizarre and lead the exploring doctor to the judgement that the candidate patient is showing strange if not aggressive behaviour, and in any case is in need of treatment.

Conclusion

When psychiatrists interact in intake interviews with silent candidate patients they continuously shift between dis- and re-engagement with their co-interactants. It is this interactive practice which makes mental disorder visible by documenting repeatedly the candidate patient's disregard of the basic proto-moral commitment of responsivity. When interviewing candidate patients psychiatrists frequently make use of an indirect exploratory format. This practice of asking without questioning can only be successful when the recipient accepts the proto-moral obligation of reciprocity and voluntarily delivers unsolicited information about himself. In some cases this practice, based on which psychiatrists can reach and substantiate their decisions, is brusquely rejected by candidate patients albeit with the result that they are all the more regarded as mentally disturbed. Both studies have shown that proto-morality and common-sense reasoning is an elementary component of psychiatric diagnostic work. Treating these common-sense and moral portions in the psychiatric work as contamination which needs to be eliminated as quickly as possible is a futile endeavour, as Coulter (1979) has cogently argued:

> Unless we are arbitrarily to restrict the vocabulary of morality and ethics, the psychiatric diagnostician is to be found employing it all the time in order to accomplish his practical task; how else are we to characterize the vocabulary

> of judgments such as 'inappropriate affect', 'unreasonable behavior', 'failure to react normally'. (p. 145)

As long as psychiatric work is based mainly on interviews and other forms of social interaction common sense and proto-morality will remain to be an essential part of it.

Clinical relevance summary

The assertion that psychiatric practices are unavoidably bound up with the proto-moral substructure of the pragmatics of everyday life may be seen as standing in contrast to the psychiatrists' medical self-image. It is, however, not meant to criticise mental health professionals but to deepen the awareness of the specific nature of their professional practice and of some implications of their morally tinged activities. A particularly apt environment for practitioners to realise their dependence on the proto-morality of social interaction is the pre-clinical opening part of the psychiatric interview during which greetings are exchanged, seating arrangements are organised and other preliminaries are dealt with. The interlocutors start to relate to each other with mutual identification, co-orientation, eye contact, topic co-selection etc. This chapter shows that it is worthwhile to pay attention to this otherwise neglected part of the interview.

Interactional openings can only be accomplished jointly and can in the case of a psychiatric interview only be successful when the (candidate) patient is willing and able to cooperate and, thus, to meet the proto-moral obligations of interaction. This means, in practical terms, that the psychiatrist's very first utterances – and not just his later official question 'What brings you here?' – generate an important exploratory moment. In this sequential environment the (candidate) patient's responsiveness and willingness to follow the rules of sociality become visible. Of course, the perception of a conspicuous or non-normal behaviour in this context does by itself not lay ground for a psychiatric diagnosis, but it may provide a first hint at the patient's problem. It is part and parcel of the psychiatrist's competence to decide in this situation whether to disregard and normalise the incident (as is usually done in everyday interaction) or to bookmark the episode as a first significant manifestation of a mental health problem that needs to be identified and treated.

A telling case in point is the situation in which the psychiatrist has to deal with a (candidate) patient who, despite of all signs of wakefulness, remains silent. In order to figure out the meaning of the patient's non-responsiveness, the psychiatrist may use everyday practices to make his co-interactant talk, such as addressing, appealing, requesting, summoning, urging etc., all of which make use of the principles of proto-morality. If the patient nevertheless remains silent it becomes more and more difficult to continue the interaction and to treat him as normal, but by dis- end re-engaging with the patient the mental health professional can reboot the interaction and start it 'anew'. The patient is thereby addressed as competent and normal and the problematic episode which has just happened is momentarily obliterated.

Psychiatrists usually make sure that through the way they are asking questions it becomes apparent for the (candidate) patient that the interview is not an interrogation. Their soft and indirect way of collecting information and their display of empathy, which is meant to help and assist the patient in formulating his experience and view, may however turn out to be counterproductive. Asking questions in a cautious manner may be understood by patients as referring to an infringement or morally dubious act which is in need of being formulated cautiously. As a consequence, discreetly formulated questions may be heard by patients as a hidden moral allegation and my lead to evasions, justifications, resistance or even counter accusation. Mental health professionals are therefore well-advised not just to trust their – certainly well-intended – soft and sympathetic way of interviewing but to take the moral connotations of their considerate style of asking into account.

Taken together the lesson that can be drawn from this study is that mental health professions must find ways to accept and take into account the moral features of their doing. In practical terms this means that mental health professionals

- pay attention to the opening of a psychiatric encounter during which it can be observed whether or to what degree patients comply with the proto-moral obligations of social interaction,
- address a non-responsive patient not persistently but dis- and re-engage with him repeatedly so that he is not fixated in his muteness but locally normalised and approached as a person, who knows how to act according to proto-moral principles,
- develop an ear for the moral ambiguities of their cautious and indirect style of interviewing, and
- realise how the proto-moral implications of their activities afford if not engender behaviour which is then regarded as inappropriate or abnormal.

For sure this will not lead to an immediate turnaround of the day to day work of mental health workers but in the medium and long run it may contribute to a significant enhancement of their self-reflexivity and professionalism. This is particularly pertinent given that psychiatric treatments are often delivered through the use of multidisciplinary mental health teams with different training backgrounds, and together these professionals must make decisions and

Table 13.1 Clinical practice highlights

1. Psychiatric interviews are a type of social interaction and as such they include a proto-moral substructure which needs to be reflected upon since it can be consequential for the exploratory and diagnostic work.
2. Exploratory practices are aimed at making mental disorder visible, and it is advisable that practitioners know how their activities contribute and bring about signs of behavioural disorder.
3. Because of their implicit moral meaning, exploratory utterances may carry an ambiguity of which the practitioner is not aware. Since this ambiguity may lead to responses which appear as erratic, it needs to be carefully controlled.

communicate with patients (Angell & Bolden, Chapter 19, this volume). For a simple summary of the practical implications please see Table 13.1.

Summary

Activities in everyday life which do not make sense, violate expectations or infringe rules of conduct are usually quickly repaired or normalised. In psychiatric settings, however, the normalcy of a participant who already has a prehistory of disorderly behaviour becomes questionable, and seemingly strange or unreasonable behaviour becomes significant. This chapter presents a study of intake interviews in which the psychiatrists' work assignment is to find out and decide whether a candidate patient needs to be admitted to a mental hospital. Two phenomena are studied in empirical detail from a conversation analytic perspective. On the one hand, the chapter focuses on episodes in which a candidate patient remains silent during the interview ('refuses to speak'), on the other hand the chapter deals with certain indirect exploratory practices ('asking without questioning') through which psychiatrists can test the candidate patients' willingness to cooperate. It will be argued that the psychiatrists' exploratory practices as well as their decision-making is in major parts based on common-sense reasoning and the observation of proto-moral aspects of interaction. Proto-moral features of social interaction serve as a resource for the mental health professionals to make mental disorder visible and to document and warrant their professional judgements. The reliance on mundane resources may be regarded by psychiatrists as a contradiction to, if not an assault on, their professional self-concept. However, it is unavoidable that psychiatric judgements involve mundane practices and recourse to proto-morality. Instead of denying the proto-moral implications of psychiatric work it is suggested that mental health practitioners reflect upon and take into account the moral constituents of their work whereby their professionalism can be significantly be enhanced.

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14

The Role of Self-Disclosure in the Social Construction of Understandings of Alcoholism and Mental Health within Talk between Members of Alcoholics Anonymous

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Introduction

An estimated 17 million Americans suffer from alcohol use disorder, rendering alcohol abuse as the third leading cause of preventable death in the United States. Over 700,000 US citizens receive treatment for alcoholism daily. Beyond the physical and personal costs, alcohol-related problems cost the US economy an estimated $224 billion each year. Accordingly, alcoholism is one of today's most significant personal and social problems. Participation in mutual help groups (MHGs), with or without professional treatment services, remains an effective and ubiquitous method for addressing this social problem (Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kelly, Stout, Zywiak, & Schneider, 2006; Moos & Moos, 2006; Timko, Moos, Finney, & Lesar, 2006). MHGs are groups of individuals coming together to provide and receive support regarding specific problems. These groups run without professional assistance, and members may attend as long and often as they choose. The availability of MHGs' support during times when relapse is likely and their low cost make them very attractive options for maintaining recovery (Brown, O'Grady, Battjes, & Farrell, 2004; Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009; Kelly & Yeterian, 2011). Twelve-step MHGs are the predominant source of mutual support for alcoholism in the United States, and with the fellowship of more than 1.8 million members Alcoholics Anonymous (A.A.) remains the overwhelmingly largest 12-step MHG.

Social constructionist approaches in Alcoholics Anonymous research

The face-to-face, layperson discourse model of addressing alcoholism, in which current and potential A.A. members engage in interpersonal, small-group and public communication, has encouraged communication researchers to adopt social constructionist approaches for A.A. research. Ford (1989) posited that A.A. members are bound together by Bormann's (1977) fantasy theme of 'fetching good out of evil'. This fantasy theme serves as a powerful rhetoric to construct the recovering identity of the individual member and the A.A. group. Wright (1997) revealed how features of A.A. tenets and the organisation of group meetings help facilitate indoctrination to a socially constructed shared ideology by which A.A. members interpret their assumptive worlds. Witmer (1997) employed structuration theory demonstrating how a founder of a particular A.A. group dissembeds the structures of the larger A.A. fellowship, transforming them in the local group, and how members within the group adhere to this embedded construction and participate in its maintenance. Humphreys (2000) revealed how articulating one's life history within the form of the A.A. narrative of 'what it was like, what happened, and what it is like now' helps the individual reframe his or her personal history into the A.A. worldview and becomes part of a continual construction of a group narrative. Ratliff's (2003) analysis of an A.A. group for 'professionals' identified a tension between two competing social constructions, traditional A.A. and treatment-centred psychotherapeutic models. Hall (1994) discussed how some participants in a lesbian A.A. group worry that A.A. precepts might lead to a socially constructed false consciousness that obscures political realities through a focus on individual responsibility. Thatcher (2011) illustrated how meaning is constituted in the discourse of A.A. members as they negotiate spiritual tensions in A.A. talk.

Self-disclosure

Self-disclosure involves providing information about the self that another most likely would not discover without such disclosure (Wood, 2007). This concept serves as a primary point of convergence for social psychology and communication, particularly in the areas of relational development and maintenance. One of the most prevalent social psychological theories employed in communication research, Berger's uncertainty reduction theory (Berger & Bradac, 1982), posited that people experience discomfort when they encounter strangers and seek to ease this discomfort through seeking information. One form of such information seeking involves the interactive strategy of self-disclosure. Focusing on relational development, social penetration theory (Altman & Taylor, 1973) understands relational intimacy as involving breadth and depth of disclosure. Petronio's (2004) communication privacy management theory considers self-disclosure in the process of negotiating the boundaries and ownership of personal information. Relational dialectics theory (Baxter & Montgomery, 1996) considers how partners negotiate tensions in relationships, such as what and to whom to disclose or not disclose.

Self-disclosure is the primary form of discourse in A.A. There are two primary types of A.A. meetings – speaker and discussion. Speaker meetings routinely involve an individual A.A. member conveying a narrative account of what it was like when the member was a practicing alcoholic, what happened to allow the member to recover and what that member's life is like today. Discussion meetings routinely involve a chosen topic about which different A.A. members speak for a limited amount of time. A discursive norm for each of these different forms of talk is to maintain the focus on personal experience rather than theorising or providing advice. Nonetheless, these accounts often serve a rhetorical function of advocating certain understandings of the A.A. programme or norms of behaviour.

Project overview

While scholars have employed social constructionist approaches to studying A.A. discourse, there remains a significant gap in the current research as no current studies focus on the social construction of meaning with respect to mental health in A.A. This issue is of current importance in the A.A. programme due to a dramatic increase in the diagnosis of mental health issues and prescription of medication in substance abuse treatment and the general population (National Centre for Health Statistics, 2014). Identifying this as a key concern, the A.A. General Service Board is currently considering a proposal to create a pamphlet for alcoholics with mental health issues. An existing A.A. pamphlet, 'The A.A. Member-Medications & Other Drugs' (A.A., 1984, 2011), includes narratives of individuals taking medication for psychiatric conditions and discusses how some fellow A.A. members condemn the use of mood-altering medication. The pamphlet also includes the narrative of an A.A. member who became addicted to medication and one who had overcome the need for psychiatric medication while working the 12 steps. The pamphlet offers some key suggestions, including, No A.A. member should 'play doctor; all medical advice and treatment should come from a qualified physician'. Striking a somewhat dialogic tone, the pamphlet presents different experiences of A.A. members with respect to treatment of mental health issues and medications decisions without additional editorial comments regarding any particular account. Nonetheless, strong arguments that some members need psychiatric medication, warnings against A.A.'s making negative assessments of mood-altering drugs, the inclusion of narratives of six people who discuss their positive experience taking prescribed mood-altering drugs compared to only two that discuss negative experiences, and the absence of warnings against discussing mental health diagnoses or the positive results of mood-altering medication in A.A. meetings infer a positive bias towards psychiatric medication. The new pamphlet would address these same issues, but the title would focus solely on mental health issues instead a general pamphlet on drug issues.

Influenced by Pearce and Cronin's Coordinated Management of Meaning Theory, this study focuses on how A.A. members come to understand the stories told (Pearce, 2007, p. 210) by other A.A. members related to issues of mental health and alcoholism and how they come to make meaning of these stories. Accordingly, this study emphasises the constitutive process of developing meaning, rather than the veracity of any specific claims of meaning. Employing what Pearce calls, 'the communication perspective,' (29), this study seeks to answer the following types of questions. (1) How was understanding made? (2) Who participated in making it? (3) How does it affect the ongoing process of social construction? (p. 54).

Additionally, this study adds to the research on self-disclosure and communication by considering the role of self-disclosure in the social construction of meaning. Grounded in the dialogic paradigm, which concentrates on emergent meaning at the local level (Deetz, 2001), and informed by dialogism theory associated with the work of Russian literary critic and philosopher Mikhail Bakhtin (1981, 1984, 1986, 1990) (Holquist, 1990), this social constructionist approach understands meaning as fleeting, emerging in the interplay of multiple voices. Voices include the proximal voices of immediate interlocutors and others and distal voices such as past speakers and future audiences.

As a means of understanding the role of self-disclosure in the social construction of meaning, this study focuses on self-disclosure as reported speech. 'Reported speech is regarded by the speaker as an utterance belonging to *someone else,* an utterance that was originally totally independent, complete in its construction, and lying outside the given context' (Voloshinov, 1973, p. 116). Nevertheless, these accounts of what others said are often employed rhetorically to further the aims of the person providing the account. There are four forms of rhetorical reported speech, which may be distinguished along a dialogic continuum. Referent-analytic reported speech involves quoting another to support one's own independent claim. This form is the least dialogic, as the persuasive agency lies entirely with the current speaker. Texture-analysing reported speech involves quoting another to take advantage of the way the original statement was made, for instance intonation. This form of reported speech is more dialogic than referent-analytic because the significance of the utterance is associated with the actual performance of the original disclosure. Nevertheless, the specific contextual meaning still lies with the objective of the current speaker. A more dialogic form, particularised direct-discourse reported speech, involves speaking as if the original speaker is speaking the words with the reported speech aligning with the intended claim of the current speaker.

While ultimate agency lies with the current speaker the current speaker's intention is to convey the original speaker's ideas as accurately as possible. A final form of rhetorical reported speech is preset direct-discourse. This form involves representing each voice significantly as if the reported speech represents an open discussion between the current and prior speaker. The rhetorical effect derives from the audience understanding the current speaker's overall theme.

The dialogic quality of reported speech renders it particularly fitting to illustrate the social construction of meaning through self-disclosure. Every act of reported speech includes at least three voices, a past speaker, a present speaker, and an audience. Meaning emerges in the interpenetration of these voices in which an individual interprets the words of another and uses those words to persuade an audience. Nonetheless, while each of the aforementioned forms of reported speech is rhetorical, the specific form infers a particular disposition among current speaker, former speaker and audience. For instance, referent-analytic reported speech infers an authoritative attitude of the current speaker in which the words of others function solely as tools to persuade an audience. Conversely, preset-direct discourse infers a more egalitarian attitude in which the voices of former and current speakers are afforded equal status and the meaning of the reported speech is left for the audience to decide.

To consider the function of self-disclosure in the social construction of mental health in A.A., this study aims to answer the following research question: How do A.A. members socially construct understandings of mental health through the process of self-disclosure with other A.A. members?

Methods

Sample

The population for this study includes a purposive sample of 96 A.A. members across the Western United States. The sample includes A.A. members with whom the researcher was associated from participation in previous research on A.A. and others that volunteered to participate in a comprehensive study on self-disclosure in A.A. Participants were also recruited via a snowball sample of A.A. members suggested by existing participants.

Data

The data derive from transcripts of loosely structured narrative interviews (Baxter & Babbie, 2004). The interviews addressed several topics centring on the role of self-disclosure in A.A. discourse, including, for the purposes of this study, the following question. 'I am interested in any instances you can recall in which an A.A. member shared something with you that related to mental health, insanity or any related issue regarding alcoholism that you have found helpful in your sobriety. This could be a discussion with a sponsor or other member or something you heard at a meeting.' Participants were asked to provide as much detail as possible. Minimal prompting was employed to encourage elaboration. Eighty-nine of the interviews occurred face-to-face and seven were conducted over the telephone. The interviews were digitally recorded and then transcribed. Once the digital recordings were transcribed, they were erased to protect the anonymity of the participants. The researcher's university institutional review board approved this study.

Data analysis

I employed constant comparative method (Glaser & Strauss, 1967) for initial data analysis. First, I reviewed all the data. Secondly, I conducted analytic coding to identify instances in which participants could be understood to be addressing concerns regarding mental health. This process of axial coding resulted in three distinct category groupings, which are discussed in the following section. I then employed Voloshinov's (1973) categories of reported speech as a sensitising concept for dialogic discourse analysis in order to illustrate how A.A. members construct meaning through reported speech.

Discussion

Three distinct themes related to self-disclosure and various understandings of mental health (1) understanding alcoholism as a disease manifested in the mind, (2) understanding the alcoholic to some extent as insane and (3) the relationship between alcoholism and other mental diseases emerged within the study.

Alcoholism as a disease of the mind

Participants discussed alcoholism as a disease that is mostly situated in the mind in a manner related to the first half of the first step of A.A., which reads, 'We admitted we were powerless over alcohol' (A.A., 2002). Participants discussed how they came to this understanding through the self-disclosure of others in face-to-face communication and within A.A. discussion and speaker meetings. The following utterance by Julie evidences how members addressed their relation to alcohol through examples of disclosure from their A.A. sponsor:

> My sponsor, Vicky, told me that, 'alcoholism was a disease that manifested itself mostly in the mind.' Like the Big Book says, alcoholics have a 'mental twist' when it comes to alcoholism. She told me a bunch of different examples of what she meant, like when she would have every reason not to drink, but still somehow think it was a good idea? And just how that happened over and over?

Julie proceeded to discuss how her identification with the examples Vicky shared helped her to come to understand she shared the same mental twist. The manner by which Julie recounted Vicky's self-disclosure is most indicative of particularised direct-discourse as she allows Vicky's voice its own agency, albeit Julie summarises Vicky's utterance in such a way as to support her argument of alcoholism being situated in her mind.

In contrast to Julie's example of dyadic communication, Harley conveyed an example of indirect reported speech in which an A.A. member told his story at an A.A. meeting and how it helped Harley understand his powerless over alcohol:

> I got a nudge from the judge (judge's orders) to go to my first meeting. I snuck in late and some guy got up to tell his story. I wasn't sober. I didn't hear much, but something got through. He didn't go to his daughter's wedding. She only wanted him there if he didn't drink. He couldn't do it. I got that.

This is an indirect example of reported speech, because Harley did not cite the speaker directly, but rather provided a limited summary of what he had said. Nevertheless, Harley attributes this act of self-disclosure as profoundly significant in his ability to accept a primary element of the first step. Rhetorically, such examples function similar to Julie's previous example in that the authority of the account remains with the original speaker.

However, unlike Julie's narrative, Harley did not convey his story as particularly instructional. Instead, Harley's story focused more on the manner by which he was able to identify with the speaker. The difference may be understood as the distinction between the perceived perceptions of more phatic or rhetorical communication. This being said, in most instances, the data indicates A.A. self-disclosure as performing a dual phatic/rhetorical function. This dual function may be associated with Burke's (1950) understanding of the rhetorical power of identification. The persuasive power of such appeals is based on the sense that interlocutor and audience are consubstantial. Hence, often the experience handed down from one A.A. member to another is not perceived as personal criticism or control, but connection via a shared character trait.

The persuasive force of such identification is evidenced through many of the narratives as convergence between the current speaker's intent and the reported speech. As the data indicate most of the examples of particularised direct-discourse lead to instances of convergence between the reported speech and the aims of the current speaker. Accordingly, even though the prior speaker is afforded some agency in such accounts of reported speech, the convergence between the current and prior speaker's intentions results in a more or less monologic or authoritative understanding. As these converging accounts get told and retold, they become powerful tools of persuasion in the social construction of meaning in A.A.

Several participants expressed that they could not relate to certain aspects of A.A. doctrine until they experienced other members putting these concepts into context by sharing personal experience, which was particularly true with respect to the notion of being powerless over alcohol. The following statement by Art is an example of how members expressed this understanding:

> I was at a book study meeting and we were reading the part that talks about the car salesmen who thinks it would be okay to drink whiskey in his milk. It seemed kind of phony to me, but then this lady talked about how she had done all these different things to control her drinking, um, 'not drinking certain things, trying to only drink in certain places, and/uh not buying booze to take home' - I had done it all.

For Art, the textual experience of reading the A.A. Big Book did not have the same effect as the self-disclosure of another A.A. member. This distinction is evident through the different forms of reported speech he employs to discuss the reading and self-disclosure. His discussion of the reading reflects a referent-analytic approach as the passage from the text is employed merely as support for his independent argument about the importance of identification with other members. Conversely, his reported speech of the disclosure of the woman who spoke at the meeting follows a particularised direct-discourse form in which her comments align with his argument.

The alcoholic as not sane

The second step, 'Came to believe that a Power greater than ourselves could restore us to sanity' (A.A., 2002), informs another way participants addressed the social construction of mental health among A.A. members. The distinction between this and the previous category is evidenced by the ways A.A. members talked about the impetus for drinking and the internal experience of the alcoholic. People drink because they have a disease that manifests itself in the mind. They react to the world in certain ways, because they are insane.

> I just always felt like I was crazy. But, the guy who twelve-stepped me told me about how, you know when we was still drinking, how he seemed to be able to know what other people were thinking and how the only way he could, um, shut that off, was to drink...That was the self-centered part of

> the alcoholic and he felt like that his whole life until he got sober. I just thought I was crazy, I guess I was, but at least now I knew it had to do with alcoholism and there might be some way to stop it.

A similar sense of relief when the self-disclosure of others helped in attributing psychological discomfort to alcoholism was expressed by a number of participants. Or, as Chandra stated, 'It was a relief to know that I was not just insane, but I was just an insane alcoholic.'

In contrast to the previous discussion in which participants contrasted their reaction to the A.A. text and member self-disclosure, many participants discussed both the text and other members' disclosures in ways that aligned with the current speaker's intention. Ernesto's following discussion of having come to accept that he was not sane is a common way such alignment was reported in the interviews.

> My sponsor read me the part in the book where it says something like, 'The delusion that we are like other people has to be smashed.' This is how I understand the whole insanity thing...So, he asked, 'how are you different from other people?' He then went on to give me examples of how he was different, like 'None of *his* neighbors had mistakenly walked into his house and fell asleep in *his* bed.' (Laughter).

Ernesto then proceeded to report some very funny stories about things he did that distinguished his behaviour from the norm. The alignment between the A.A. text, reported speech and the current speaker's persuasive intent involves recounting both engagement with the text and reported speech through the particularised direct-discourse form.

Alcoholism and other mental health concerns

The previous two categories reflect a convergence of the reported speech and the aims of the current speaker through the particularised direct-discourse form. Conversely, far more divergence of opinion and forms of reported speech occurred in instances when participants discussed self-disclosure of mental health diagnoses and medication in A.A. Accordingly, this final category provides a richer understanding of the function of self-disclosure in the social construction of understandings of mental health in A.A.

Participants expressing displeasure regarding the disclosure of an individual member's mental health condition most frequently appeared in the data.

Laurie's following account is indicative of how members expressed such displeasure.

> I really hate it when people start to talk about their psyche meds. You never hear people talk about their blood pressure medication, or their cholesterol medication, or anything. But put someone on Zoloft and they have to shout it from the rooftops. I just wish they would keep these outside issues to themselves.

Laurie's utterance is indicative of the form of reported speech most members used when addressing disclosures regarding mental health medications or diagnoses in A.A. meetings. The vast majority of such accounts adopted a referent-analytic approach in which the words of others were either paraphrased or uttered as single short declarative statements to which the current speaker made a strong counter-argument.

The following example illustrates how some participant disclosures disparaged the use of mood-altering medication:

> My sponsor told me about how she had come into the program and had been on anti-depressants. She talked about how it was hard to work the program because she was so doped up. She eventually decided to try to get off all the meds and changed her sobriety date to the date where she became clean and sober.

That she changed her sobriety date is extremely significant, because a sobriety date marks an A.A. member's first day of sobriety. By changing her sobriety date, Juanita's reported speech implies that taking psychiatric medication means an individual is not sober while on such medication. This rhetorical argument is additionally supported by her claim that 'it was hard to work the program' while on medication, which corresponds with the one narrative in the A.A. medication pamphlet in which Sally says she relied on tranquilisers to 'give [her] the bulwark against anxiety that most of my fellow A.A.s were finding through the Twelve Steps.'

Robert expressed a contrasting experience deriving from an A.A. speaker he heard talk about the use of anti-depressants:

> I was at this meeting and this speaker talked about how he had been to a bunch of psychiatrists and he tried a bunch of different treatments, including different medications and then he came to A.A. and found the twelve steps were the right treatment, because he didn't have depression, he had

> alcoholism. This was really attractive to me so I decided to quit cold turkey. I hung on for a couple of days and then the bottom just dropped out. My doctor was pissed at the program and I started to think if it was the right thing for me. I told my sponsor I thought I needed to quit A.A., because I didn't think I could do it without my medication. He said, 'Why would you stop taking your medication?'

While stories such as Robert's were not particularly frequent in the data, there were a few other similar instances and more members shared about hearing about others who had similar experiences to Robert. Each of these examples involved situations in which members came to question their medical diagnoses based on the disclosure of another A.A. member. In some of these instances, the participant did not seek medical advice regarding the decision to stop taking medication or the process by which these individuals should go through to quit. Rather, the disclosure of other members appears to have created a significant shift in the understanding of their medical diagnosis. Nonetheless, the impact of such sudden change resulted in each of these individuals realising the need for appropriate clinical care.

A number of participants discussed successfully being able to gradually cease taking psychiatric medication after hearing how other A.A. members were able to transition off medication. Similar to the first two categories, these examples employed the particularised direct-discourse model of reported speech.

> It was kind of weird. I guess I was thinking about not wanting to be on pills anymore, but then in like in just a couple of weeks or so I heard three speakers talk about getting off of medication. I was like, it must be a message or something.

These instances of reported speech converged with Michelle's previous consideration of transitioning off of her psychiatric medication. Participants conveyed a number of similar experiences. Some of these involved hearing people share their experience at the group level, some involved interpersonal communication. In each example, there was a strong convergence between the reported speech and aim of the current speaker.

Conversely, some participants shared a strong lack of identification with members including narratives of transitioning off of psychiatric medication when they talked at AA meetings.

> I know they are just sharing their experience, but it always comes off as a bit judgmental when people talk about quitting

> medication in meetings. Its like they are claiming they are more sober or something.

Marilyn had not experienced direct criticism of her use of anti-depressants, as she did not routinely disclose her diagnosis or treatment with others. Nonetheless, she occasionally experienced member disclosures about transitioning off of medication in meetings. Marilyn felt these disclosures were presented as signs of the speaker's recovery and thus infer a less than optimal recovery for individuals who are still taking such medication.

Richard shared an experience in which his medical treatment resulted in having to change AA sponsors.

> I had to get a new sponsor because my sponsor said he couldn't work with me after he found out I was taking medication. He said he just didn't have experience with anti-depressants and so he just didn't work with people who took them.

While Richard expressed he did have some difficulty finding a new A.A. sponsor, he did not express animosity towards his former sponsor and stated he did not perceive any judgment or negativity in their ongoing interactions. Interestingly, Richard's account of reported speech is one of the only instances that appear to follow the present direct-discourse form. Richard's former sponsor did not argue against people taking anti-depressants. Similarly Richard did not criticise his sponsor's decision to not work with people taking anti-depressants. Accordingly, it could be perceived that audiences could react to the reported speech in different ways depending on their individual perspectives on the matter.

In contrast to these instances in which A.A. members experienced criticism regarding their decision to take medication, Sally shared an experience of hearing disclosure from a friend in A.A. who experienced negative consequences because she chose not to go on medication:

> So, her sponsor said, 'You are depressed and you need to do something about it.' She said it was a chemical imbalance and shared her experience of how anti-depressants helped. Then the real kicker, she said she wouldn't work with her anymore if she didn't take her direction and go see a doctor about it. She didn't want to seem unwilling, so now she's on anti-depressants, even though she doesn't really think she needs them.

When pressed to explain why she thought the sponsor had been so adamant about her friend seeking help, Sally said, 'She probably just didn't want to hear her complain about her life anymore.' This example of referent-analytic reported speech clearly indicates Sally's strong feelings against medication for mental health issues in A.A., and how some A.A. members advocate the use of anti-depressants among the fellowship.

While Sally's example stands alone as one in which a sponsor directed a member to get mental health treatment, several participants discussed how friends in A.A. had personally advocated the use of psychiatric medication in interpersonal interactions. Joshua shared the following example of an interaction with a fellow A.A. member who had recently began taking medication for attention deficit disorder:

> I couldn't tell if he just trying to justify what he was doing, or what? But, it seriously felt like he was trying to push drugs on me by telling me about how much clearer he felt and everything. I just couldn't really hear it without thinking about how coke (cocaine) let me drink more.

Joshua experienced discomfort at what he felt amounted to advocacy for prescription drug usage. Similar to Sally's example, the referent-analytic approach to the reported speech clearly indicates Joshua's negative assessment of mental health medication among the A.A. fellowship. In Joshua's case, his negative assessment stems from his personal experience of abusing drugs that share similar effects with the prescription medication a fellow A.A. member is taking.

Although a number of participants shared similar accounts to Joshua's in which they had experienced a negative response to other members talking positively about mental health medication, members also discussed their experience of hearing disclosures from other members regarding psychiatric medication in neutral or somewhat favourable ways. For example, Ann shared the following comment, 'Some people just come in with significant trauma.' The key distinction of these accounts is that they did follow a specific rhetorical form.

A final colourful example comes from a long-term member in A.A. As a long-term member it might be that Ray has a more balanced perspective regarding controversial topics within the A.A. fellowship, or that he might not be as easily influenced by the disclosure of others.

> You know it's like how the book talks about us not wanting to be the arbiter of others' sex lives. The same kinda needs to go for medication. Whether someone wants no flavor or a strait pepper diet needs to be between them and their doctor.

> `And just like sex, its best not to air that stuff at the group level. Cause that's kind of how it feels when I hear people talking about their medication in the meeting. It seems a bit too personal to be really unifying. Like if we all started arguing about what kind of sex members should or shouldn't be having.`

Ray refers to a section of the A.A. Big Book (A.A., 2002, pp. 68–91) that refers to sex relations for A.A. members. This section uses the terms 'no flavor for his fare' and 'straight pepper diet' as idioms for puritanical ('no flavor') or hedonistic ('straight pepper') perspectives on sex, to argue against concrete guidelines for sexual behaviour for A.A. members. In comparing medication to sex, Ray implies that A.A. members should refrain from holding rigid opinions regarding medication and, in essence, for doctors to be the ultimate authority for medication decisions. Nonetheless, his comments also indicate that he feels medication is not an appropriate topic in A.A. meetings. So, while he advocates flexibility with respect to individual choice with respect to medication, the same cannot be said regarding his opinions on disclosing information regarding mental health diagnoses or medication in A.A. meetings.

Conclusion

The A.A. pamphlet on medication states, 'No A.A. member should play doctor,' and suggests that negative comments regarding mental health treatment or medication should be avoided. Nonetheless, as the data indicate, A.A. members discuss mental health treatment and medication, often resulting in significant tensions. Additionally, such disclosure may encourage some A.A. members to seek access to medication when it may not be necessary or seek to stop necessary treatment.

Clinical relevance summary

Those involved in the treatment of individuals diagnosed with alcohol use disorder, particularly practitioners who employ a 12-step model of recovery or recommend A.A. participation as aftercare, will benefit from understanding how A.A. members socially construct meaning regarding the relationship of alcoholism and other mental health conditions in their interaction with fellow A.A. members. Practitioners would be well served by talking with patients about the messages they receive from other members in their A.A. meetings with respect to mental health services, particularly the use of psychiatric medication. While advantages could be perceived with respect to A.A. members sharing about the benefits of mental health treatment, the data informing this study indicate it is just as likely that patients will encounter negative messages regarding mental health treatment from other A.A. members. Understanding the implication of different types of disclosures might help medical practitioners inform their patients in making decisions about when, where, and how to disclose mental health concerns in A.A.

Additionally, clinicians may benefit from participating in A.A. public information opportunities to more fully understand the possible implications of mental health diagnoses or prescribing mood-altering drugs for A.A. members. While clinicians should advocate for their patients and help inform the A.A. fellowship regarding medical care, a clear understanding of how many members misused prescription and illicit drugs may help clinicians understand the possibility that patients may become addicted to certain drugs and also to help develop a more balanced discourse to help negotiate existing tensions within the A.A. fellowship.

The chapter may also help inform the ongoing discussion regarding the development of A.A. literature addressing mental health issues. For instance, the current pamphlet on medication indicates a problem with A.A.'s suggesting that others not take mood-altering prescription medication. Nonetheless, the pamphlet does not address the possible over-prescription of psychiatric medication in the treatment industry or the general culture. Additionally, it does not address how members might perceive others' positive accounts of taking mood-altering prescription medication as threatening. Accordingly, from a social constructionism perspective, the current pamphlet, comprising the A.A. fellowship's position on mental health treatment and medication, may unintentionally create discomfort for some members while advocating for others.

Consideration should also be given to the function of discourse in constructing meaning with respect to alcoholism and mental health in A.A (for a similar discussion on substance abuse, mental health and discourse see Herzog, Chapter 5, this volume). This study reveals how the social construction of the meaning of mental health in A.A. occurs through the interplay of divergent and convergent dialogic voices. The current A.A. pamphlet implies restrictions on discouraging members from taking prescribed medication, however, it does not offer prescriptions for effective discourse. As the data indicate this approach has not been effective in reducing tensions among the fellowship with respect to prescription drugs and mental health treatment. Additionally, adding another pamphlet that advocates the same restrictions of discourse without providing suggestions for effective communication to ease tensions in the fellowship will not improve the situation. What is needed is a thoughtful dialogue in which different individuals may come together to discuss suggestions for discourse that may more effectively negotiate existing tensions. For a simple summary of the clinical implications, see Table 14.1.

Table 14.1 Clinical practice highlights

1. It could be useful for practitioners to talk to their patients about the messages that they are taking away from their A.A. meetings and to better understand how this influences treatment adherence.
2. The A.A. information carries an implication of discouraging its members from taking medications, and this may influence engagement with prescribed treatments.

Suggestions for further research

This focus of this study on self-disclosure limits its scope with respect to understanding issues related to mental health in A.A. For instance, the study did not ask members to discuss their personal experience with respect to mental health issues apart of concerns of disclosure. As the data and interest in creating a pamphlet for the A.A. member with mental health issues indicate, this is a significant issue within the fellowship. Accordingly, a comprehensive study considering a wide range of perspectives regarding this concern would be useful.

The current study also offers some insight into how forms of reported speech influence the social construction of meaning. Instances of reported speech are not neutral endeavours in which one individual objectively communicates the words of another. They are rhetorical acts in which a speaker uses the words of another to support the current speaker's aims. Accordingly, further study regarding the function of reported speech in the social construction of meaning is warranted.

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15

‘But How Often Does This Happen?’: Problem Reducing Responses by Coaches in Email Counselling

Joyce Lamerichs and Wyke Stommel

Introduction

This chapter explores the interactional dynamics of email counselling from a conversation analytic (CA) perspective. The conceptual apparatus of CA has been successfully applied to study turn-taking and the sequential placement of email messages (cf., Stommel, 2012; Stommel & Van der Houwen, forthcoming; Vayreda & Antaki, 2009), as well as the ways in which accountability is managed in online talk to do with health (cf., Guise, Widdicombe, & McKinlay, 2007; Lamerichs & Te Molder, 2003). Participants’ interactional concerns in email counselling are therefore treated as an empirical matter and not a priori different from speakers’ orientations in spoken interaction.

In this chapter, we demonstrate how coaches orient to the dilemma of promoting self-directedness in their clients while also giving ear to clients’ concerns. Managing this interactional dilemma appears to include more than focusing on ‘a problem to be solved’, as GPs attend to in consultations (Heritage & Robinson, 2006, p. 75) or ‘aligning with a person and their troubles’ (Jefferson & Lee, 1981), particularly as staff in therapeutic contexts might resist helping the client to achieve particular goals (See Pino, Chapter 34, this volume). Rather, we find that coaches recurrently employ a set of five interactional strategies or ‘problem reducing responses’: (1) demonstrating reading; (2) optimistic formulations and questions; (3) agency ascribing compliments; (4) ‘depersonalising’ problem descriptions; and (5) contrastive questions. Our analysis explicates the patterned ways in which clients react to these responses followed by a discussion of the implications for professional practice.

Online counselling

Online counselling can be defined as ‘any type of professional therapeutic interaction that makes use of the Internet to connect qualified mental health professionals and their clients' (Rochlen, Zack, & Speyer, 2004, p. 270). It is believed to increase the quality of healthcare and its cost-effectiveness and provides convenient and anonymous access for people with mental health problems, who are known to be reluctant to seek treatment (Barak & Grohol, 2011). Online mental health interventions in the Netherlands are considered promising because of high Internet penetration rates, a positive outlook on self-management in dealing with matters of health and illness, and a willingness to consider online help (Sorbi & Riper, 2009).

Online mental health interventions, which are mostly based on cognitive-behavioural self-help programmes, have increasingly proven to be effective (see Sorbi & Riper, 2009). Little is known, however, about the communicative practices that accompany these online sessions. And while treatment adherence benefits from frequent contact with a therapist, it remains unclear how therapists' involvement specifically matters (Andersson, 2009). Professionals themselves also indicate to struggle with their role and the effectiveness of their communicative practices in an online setting (Chester & Glass, 2006; Schalken, 2013). Before examining the latter in greater detail, we first turn to discuss relevant CA studies on online counselling.

Conversational studies of online counselling

CA studies of online counselling have highlighted the challenges counsellors are faced with when demonstrating 'active listening' through continuers and formulations. Chat counsellors on the Australian-based Kids Helpline were shown not to use continuers whereas formulations were frequently offered 'in overlap' with clients' ongoing and extensive problem presentations. As a result, it remained unclear whether formulations in chat were used to summarise or to prompt a continuation of the client's problem presentation (Danby, Butler, & Emmison, 2009).

Although they may work differently online, the aforementioned practices of 'active listening' are constitutive of the counselling relationship. CA research has offered a contribution to this field of study by showing how several other features of the counselling relationship are interactionally accomplished. Stommel (2012), for example, has explored the use of address terms in email counselling showing how clients frequently proposed to use more informal address terms than counsellors were using. And although counsellors usually accepted, they sometimes reverted back to the formal register, not demonstrating sensitivity to the nature of the relationship they co-constructed with their clients. A similar insensitivity was discovered in the analysis of counsellors' responses to clients' complaints in email counselling (Stommel & Van der Houwen, 2014). While the professional–client relationship was preserved by aligning with the clients' negative assessments of the online counselling programme, counsellors treated the assessments as questions rather than complainables, thereby failing to fortify the relationship with their clients.

Another aspect of counselling relevant to the analysis we present here is how counsellors harbour clients' agency by using particular question formats. Chat counsellors on the Australian Kids Helpline employed indirect requests to propose a change from chat to telephone counselling. The question format reflected counsellors' understanding of contingent issues such as privacy or anxiety that made a transition to telephone contact difficult (Harris, Danby, Butler, & Emmison, 2012). Stommel and Van der Houwen (2013) have also shown how the clients' ability to realise improvements was emphasised by formulating positive aspects of the clients' account.

In her work on face-to-face therapy, MacMartin (2008) showed that fostering clients' agency is not always unproblematic. She found that 'optimistic questions', which were designed to invite answers from clients that affirmed their competence and resilience, were often resisted by sarcastic responses, downgraded optimism, or jocular remarks. MacMartin also showed how counsellors dealt with patients' disaffiliative turns, by incorporating material from previous turns and 'recycling' questions. We will point to similar practices in our data.

Troubles-tellings

Online counselling is essentially about responding to clients' troubles. There is a tradition in CA that has looked at troubles-tellings and their receipt. In their classic study on a troubles-telling sequence in everyday talk, Jefferson and Lee (1981) showed how 'interactional asynchrony' (1981, p. 402) occurs when a recipient to a troubles-telling does not align with the telling and engages in advice giving. The friction seems related to the closing implicativeness of advice: once advice is offered, continuation of the troubles-telling appears interactionally difficult. This was also the case in online support groups, where it was shown that providing advice or asking further questions resulted in a different receipt from the troubles teller and author of the opening post (Stommel & Lamerichs, 2014).

The interactional risks of non-aligning responses to a troubles-telling have also been addressed in telephone counselling, where call takers seek ways to prevent bringing a client's problem presentation to a premature close (Potter & Hepburn, 2003). This chapter explores the interactional dilemmas that occur when coaches employ 'problem reducing responses' when replying to clients' problem tellings in email counselling.

Project overview

Our online counselling data come from a counselling programme that was offered to people with moderate symptoms of depression and anxiety disorder. The programme was set up to investigate the possible benefits of online counselling via chat and email when clients received different levels of support from a coach (Donker et al., 2009). Coaches were trained to give ear to clients in the way a neighbour or a good friend would do and to refrain from using particular psychotherapy techniques (Donker et al., 2009).

For our study we collected over 200 emails from 21 clients who took part in email counselling with four different coaches for a period of five weeks. The email threads usually consisted of 11 messages per client (five by the client, six by the coach, a welcoming message included).

We draw on CA for analysis of the data. CA's central focus on turn-taking, sequential placement, and turn design lends itself particularly well to study different types of computer-mediated communication, such as online discussion groups (Stommel & Lamerichs, 2014) and online counselling (Stommel & Van der Houwen, 2014).

Our analysis started by close reading the email threads which led us to identify patterns in how coaches replied to clients' problems. We then examined the ways in which clients and coaches responded to each other throughout the five consecutive weeks. On the basis of this sequential analysis, we identified five main types of replies coaches employ, which we referred to as 'problem reducing responses', as well as some 'counter-moves' clients recurrently engaged in.

Participants structure their emails in paragraphs, often separated by a blank line suggesting a topical orientation. This structure is maintained throughout the email thread, as one paragraph sets up an interactional space for the next (see Vayreda & Antaki, 2009, for a discussion), thus demonstrating members' methods for managing the ongoing interaction (see Extracts 5 and 6; cf., Reed, 2001).

We found that the actions in these paragraphs occur in a particular order, with optimistic or critical questions by the coach typically placed at the end of a paragraph. The interactional significance of the order in which actions occur will be further examined in our analysis.

A final remark is needed about the presentation of our data. As each email in our data set consists of one to two pages and email threads vary between 10 and 34 pages (respectively, 4,550 and 11,950 words), we are not able to present the interactions in full. We present two rich sequences that illustrate the response types we have identified, based on a full analysis of our data. We have included an idiomatic English gloss that captures the local interactional meaning (Hepburn & Bolden, 2013) and in which typing errors are preserved to remain as close to the actual interaction as possible. For the Dutch extracts, see Appendix 1.

Analysis

We focus on five patterned ways in which the coaches respond to clients' problem presentations in email counselling: (1) demonstrating reading (S1), (2) optimistic formulations and questions (S2), (3) agency ascribing compliments (S3), (4) 'depersonalising' problem descriptions (S4), and (5) contrastive questions (S5). We also show how clients engage in practices that involve countering the specific claims made by the coach (e.g., presenting the problem as legitimate) and how they are taken up by the coach. In Extracts 1, 1CL is the first email by the client and 2CO is the second email by the coach and so on.

'Bad mothering'

In Extract 1, the client introduces herself first of all as a single mother who keeps busy taking care of her four-and-a-half-year-old son. By describing the other activities she engages in, besides raising her son, in less detail and as less significant ('studying for a while', 'a small job', line 5), she downplays their significance in favour of constructing a primary identity as a mother.

Extract 1: CL1-1031

```
   ((2 lines omitted))
1  I am a 42 year old woman and this is where I am at
   this time in my life:
2  My most important occupation is caring for and being
   busy with my 4,5 year old son.
3  Since 4 years I have been raising him on my own.
   ((12 lines omitted))
4  My son is doing well, although I find it difficult
   to do everything alone with him with little time to
   myself and little good sleep.
5  Am studying for a while now and have a small job.
6  Feel like I am surviving rather than living.
7  Often afraid to die and who will have to care for my
   son (deeply Christian family I don't want him to end
   up with.
8  Think negatively about myself, often feel like a bad
   mother, why do bad things happen to me, burden of
   a stringent dad in the past, missing out on genuine
   interest in me as a person by my parents.
   ((5 lines omitted))
```

Her problem presentation starts in line 6 with a clichéd pre-announcement: 'Feel like I am surviving rather than living', emphasising the contrast between the two categories ('surviving' vs. 'living') highlighting the seriousness of her situation. What follows is a summing up of different concerns that are constructed as persistent, recurrent fears ('Often afraid to die') and negative thoughts and feelings ('often feel like a bad mother'), stressing their felt intensity (lines 7–8). She concludes by drawing on two externalising explanations (line 8) that account for the 'weight' on her shoulders.

In the first paragraph of their reply, coaches routinely start by complimenting the clients for their courage to write about their personal life to a relative stranger (data not shown here). Lines 1–10 in Extract 2 display the second paragraph of the email by the coach.

Extract 2: 2CO-1031

1 In your email you wrote that you're a single mum of a 4,5 year old son.
2 And that you are solely responsible for caring for and raising your son.
3 You point out that you have the feeling that rather than to live yourself, you are being lived.
4 And even more so, you have the feeling to have to survive.
5 Understandable you feel this, it's really something to raise a child on your own!
6 To be mum and dad at the same time and not to be able to share the care and the responsibilities with someone.
7 It takes a whole lot of energy and a lot of strength and commitment are needed for that.
8 And you have all that, as you've cared for your son for four years already.
9 And you're doing a good job, since you wrote that he is doing well.
10 Still you point out you feel like a bad mother. How does that show? And what do you think at those times?

In lines 1–3, the coach starts with a 'neutral' summary of what the client has written, which demonstrates reading (S1). She continues by drawing on the client's feelings of 'living' versus 'surviving' (lines 3–4). Reiterating the contrast and building from that ('And even more so', line 4) stresses the seriousness of the client's emotional state. In lines 5–7, the coach further demonstrates her understanding of the client's feelings and uses a clichéd expression ('it's really something') as an agency ascribing compliment (S3). By pointing to two tough implications when raising children on your own, the coach elaborates on what is laudable: 'being mother and father at the same time' and not being able to 'share the care and the responsibilities with someone' (S3). In doing so, the coach at the same time depersonalises the client's problem as a generic situation all single parents may find themselves in (S4; cf., Weiste, 2015, p. 26). In line 7, the coach stresses how much effort is needed to raise a child on your own ('a whole lot of energy', 'a lot of strength and commitment'). Cast as big demands, these efforts get worked up as character traits to compliment the client on (S3). The coach then takes the compliment one step further: in offering up the client's own words as proof of how good things are 'in real life' ('And you're doing a good job, since you wrote that he is doing well', line 9), she offers an optimistic formulation and an agency ascribing compliment (S2 and S3).

In what comes next, the coach sets up a contrast with the client's description of feeling like a bad mother. The 'still' prefaced gloss in line 10 ('Still you point out you feel like a bad mother') suggests that these feelings are unwarranted for. The contrast is elaborated on with two questions (S5). Asking the client to specify concrete instances of behaviour and accompanying thoughts suggests that this information is needed to more accurately establish what the client's problem is. Extract 3 is the client's reply. In the preceding paragraph of this reply, the client has asked to be addressed less formally by the coach (data not shown here, but see Stommel, 2012).

Extract 3: 3CL-1031

1 When I feel like a bad mother that usually is when I am tired and can't stay calm if my son does not want to listen.
2 I shout sometimes and feel I am getting very angry inside.
3 I wish I could always say the 'right' things to him.
4 Now I have the idea that by my being exhausted,
I convey things I don't want: 'it's normal to shout, mummy can't cope, mummy doesn't love you etc.
5 Afterwards I then always try to talk with him but that is also difficult.
6 He often asks 'mummy do you still love me' when he is just playing, and that is why I think he does get damaged because mummy can't cope sometimes.

In lines 1–2, the client describes the routine instances in which feeling like a bad mother comes up. Glossing her son's concurrent behaviour as uncooperative renders her own inability to stay calm (line 1) legitimate and understandable. The client presents one noticeable feature of her behaviour as incidental ('I shout sometimes', line 2) and describes the anger that wells up insider her as an autonomous force (line 2). It constructs her behaviour as atypical and as something she cannot be held accountable for. In line 3, the client points to her wish to always say the 'right' things. Drawing upon this aspiration in an ideal world sets up a contrast with what comes next, where the less-than-perfect reality is rejected but also presented as something she is unable to prevent (cf., Wetherell, Stiven, & Potter, 1987). Describing her condition in a nominal style ('my being exhausted', line 4) speaks to its causal force as something that exists outside herself and for which she can only be held partly accountable (see also lines 1–2).

The 'things' she does not want to convey are then listed further as normatively sanctionable ideas and as representing her son's thoughts when confronted with his mother's behaviour. In pointing to her routine attempts to talk about what happened afterwards (lines 5), the client emphasises her ability to act in the normatively preferred way of dealing with such situations in a rational manner. In line 6, the client uses reported speech to show that even while engaging in the spontaneous act of playing, her son frequently asks, 'do you still love me'. It prepares for the conclusion that this counts as proof that some damage is done and further legitimises her concerns. Drawing on her son's reported thoughts and words, the client demonstrates how her behaviour impacts her child and establishes her problem and its consequences as real. In line 6, the problem of having 'feelings of being a bad mother' gets rephrased as 'mummy can't cope sometimes', which highlights the client's inability to behave differently rather than it stemming from any other motives. It shows another instance of accountability talk by the client, in response to the email by the coach. Extract 4 is the second paragraph of the coach's reply, which started with the coach agreeing to using informal address terms (data not shown here).

Extract 4: 4CO-1031

1 You point out that you, most often when you're tired, can't react like you would want to react when your son doesn't want to listen.

2 Instead of staying composed and calmly say the things you want to tell him, you feel angry and you shout sometimes.

3 Because of this you are afraid that you give him the wrong messages, like you would not love your son and would fail in raising him on certain occasions.

4 You're afraid that because of this you damage him.

5 When there is a lot on your mind and you are tired, you want peace of mind and at those times you may react differently from how you would want to when your son doesn't want to listen.

6 I can well imagine that you're afraid to give him the 'wrong messages'.

7 All you want is being a good (perfect!) mom and to give your son the best and most loving upbringing.
8 When you, because of stress, uneasiness (his too), fatigue, can't give this to him, it feels like you are failing.
9 But how often does this happen?
10 Is this always the case or are there also moments when you can be the mother you want to be for your son?

The coach starts with an elaborate paraphrase of the client's words (S1), mirroring the client's previous distinction between *not being able to* react the way she would *want* to react. Hence, the coach not only ratifies the client's inability account and acknowledges the client's fears but also highlights (as the client did) the role of the son in these circumstances (line 1). In doing so, the coach aligns with the account provided by the client. Note how the coach casts the client's concerns as fears (lines 3, 4, and 6) and furthermore as hypothetical ('like you would not love your son', line 3; see also line 6, where 'wrong messages' is put in between quotation marks), suggesting they lack a grounding in reality. In line 5, the coach provides a general gloss of what one would (ideally) want if one is tired and has a lot on one's mind. The 'you' in line 5 is ambiguous and may both refer to the client and provide a general gloss of how these things work for everybody. It constructs the client's worries as plausible and remains ambiguous about whether her situation represents a common experience, thereby offering a 'softened' depersonalising strategy (S4).

The coach continues by showing her understanding of the client's fears and ties them to the client's desire to be 'a good (perfect!) mom' (lines 6–7), complimenting the client on her ambitions as a single mother (S3). The client's (high) standards are linked to her feelings of failing (line 8) which are cast as inevitable when faced with particular (external) circumstances (e.g., the son's behaviour, see lines 1 and 5). This works to reduce the client's responsibility when failing. This externalising account provided by the coach prepares for a further question, which is designed as a contrastive 'but-prefaced question' ('But how often does this happen?', line 9). It suggests that failure does not frequently occur (S5). The subsequent questions in lines 9 invite a similar response: formatted as an alternative-offering question, the extremised 'always the case' is unevenly balanced in comparison to the more positively framed option and invites an answer affirming the latter (S2; cf., Antaki & O'Reilly, 2014).

In sum, in her first reply to the client's troubles-telling the coach started by demonstrating reading (S1) and complimenting the client on her achievements (S3). The client's problem was then cast as one that might not be tied to the client as a person but germane to all single parents (S4), after which further compliments followed (S3). A contrastive question (S5) followed early in the email thread (Extract 2), in response to which we saw the client carefully underlining the legitimacy of her problem and engaging in accountability talk on multiple occasions. The coach's subsequent response in Extract 4 oriented to this uptake by offering an explicit acknowledgement of the client's inability account, compliments (S3), and understanding. The depersonalisation strategy was presented in a softened manner and the contrastive question (S5) designed to invite an 'optimistic' answer (S2). Extracts 5 to 7 will demonstrate how a coach engages in more alignment work, after the client resists some of the coach's strategies.

'Being too self-reliant'

In Extract 5, a male client writes in his opening email that his self-reliance, which he values as one of his biggest assets in his professional life, is 'troublesome' in his social life.

Extract 5: 1CL-1371

```
1 I am a self-employed entrepreneur who helps private
  individuals and small businesses with computers and the
  like, am doing that for 3,5 years now and I do well, my
  week is mostly fully booked.
2 Self-employed means planning everything on your own
  and such, means also bringing in all the discipline,
  motivation and solutions yourself.
3 That fits me like a glove.
4 Have previously owned a shop and worked a couple of
  years as a deejay.
5 This fits in with the difficulties I experience socially
  if there is no business situation at hand; I am TOO
  independent and always present myself as a loner.
6 That pattern is so deeply-rooted that I can't manage to
  bring about any change there.
  ((27 lines omitted in which the client talks about his
  family))
```

The client presents himself in a positive light and emphasises how the qualities his current job requires seamlessly fit his personality and suggests how previous jobs have been similar in this respect (lines 3–4). In line 5, the client then contrasts the traits that have been so 'rewarding' in his professional life to be 'troublesome' in his social life, explicating a paradox many more clients draw on. By presenting his self-reliance in an extremised fashion ('TOO', line 5), he redefines his strong point now as a problem. Note how 'loner' (line 5) could even be heard to be more negative than ‘self-reliance’. It also suggests a persistent and conscious way of presenting himself in the world. In line 6, the client works up the suggestion that change is the preferred option. Suggesting that his character traits are too entrenched accounts for why he has not been able to do so. In this setting, this may also position him as someone looking for advice to accomplish change after all and invite counselling talk from the coach.

Extract 6: 2CO-1371

1 You write to me that you have been a self-employed entrepreneur in IT for 3,5 years.
2 You are doing well and that is worth a whole lot in times of economic downfall!
3 The work activities that go with this job fit you like a glove.
4 Especially the independent aspect agrees really well with you.
5 It’s nice to know about yourself where your strong points lie.
6 Are there more strong points you could name that apply to you?
7 The drawback to being independent is that you maybe become a bit distant if you are too self-reliant.
8 Is that also something you mean to say when you write that you present yourself like a loner?
9 You talk about a pattern that sits so deep that it’s difficult to change.
10 But why would you want to change this? Isn’t a person allowed to be who he is?
11 If you would want to change it then what would the ideal situation look like?

The coach starts with a ‘neutral’ summary (‘you write to me’) that demonstrates reading (S1). Compliments about the client’s achievements and his ability to identify his strong points (S3) follow in lines 2–6. Inviting the client to name more strong points is similar to asking ‘optimistic questions’ (MacMartin, 2008) and asks the client to stress his competences and successes (S2).[1] The coach then draws on the client’s concern about being too self-reliant in a cautious manner, employing a ‘double conditional’ to formulate an upshot: there *might* be a down side to being independent *if* you are too self-reliant. She casts the potential downside in comparable cautious terms (‘maybe’, ‘a bit’, in line 7). It is formulated as a generalised upshot (S4) and followed by a checking question about the meaning of the word 'loner' (line 8).

In line 10, a contrastive but prefaced question is posed that attends to the implied need for change in the client's email: 'But why would you want to change this?' (S5). The (candidate) idiomatic answer category in line 10 ('Isn't a person allowed to be who he is?') invites the client to respond to the question in a way that emphasises his qualities rather than a need for change (S2). The candidate answer is also a clichéd expression that may pose a solution for people in general and not only for this client (S4). The hypothetical question in line 11 enquires after an ideal situation and invites an 'optimistic' response (S2). The client has placed his response immediately underneath the preceding paragraph of the email by the coach, creating topical coherence (Reed, 2001).

Extract 7: 3CL-1371

1 Practically speaking it is not a problem at all, but it is when I am with people.

2 It seems like there is also a fear of people there, being afraid to get hurt (from a rational point of view there isn't much reason for that).

3 Also being who I am is not an ordinary thing for me.

4 I am over-conscious and that prevents spontaneous actions and apparently I think it's important how I might be looked at or whether I would do something that provokes response.

The client offers a qualified agreement, which stresses that there is a real problem in his social life and resists the optimistic gloss by the coach. The legitimacy of his problem is increased by pointing to underlying deeper fears in line 2 that are presented as autonomous emotions that can be 'located' but not necessarily explained for in rational terms, thus rendering them beyond 'conscious' control. In lines 3–4, the self-evident, idiomatic expression by the coach is dismissed as being far from an ordinary matter nor a general truth. The client then engages in accountability talk that present causes that determine his behaviour and which are cast as partly lying beyond his comprehension ('apparently I think it's important …', line 4). Extract 8 is the reply from the coach after this 'resistant' response from the client.

Extract 8: 4CO-1371

1 You have told me something about how difficult you sometimes find it in social situations.

2 When it comes to work, you manage well, the contact with customers goes well.
3 But as soon as the contact gets to a relational level, then some fear pops up.
4 Would you say that insecurity could play a role in that?
5 I can tell you from experience that many people experience a certain tension at moments when they engage in social interaction.
6 You suspect that your biggest fear lies in the possibility of getting hurt or being judged by others.
7 I can imagine this fear because of the sensitive side within you.
8 It's unpleasant if people take advantage of that.
9 Something like that does not contribute to opening up again.
10 Have you had bad experiences at times when you showed feelings to someone?

The coach employs various strategies here to realign with the client. She starts by stressing the conversational nature of the exchange ('you have told me') with which she demonstrates reading (S1) albeit in a more colloquial manner. She acknowledges the client's claim that there are problems in his social life and aligns with the client's suggestion that fear may play a role (line 4). The coach then cautiously proposes insecurity as an additional causal factor for the client to consider, the plausibility of which is further enhanced by quantifying that causal claim as a 'general cause' for many people (S4). Lines 6–9 offer an elaborate formulation of what the client's fear is about, starting by literally conveying the client's words, with which she demonstrates reading of what the client presented as an underlying problem (S1, 'you suspect', line 6). This is followed by demonstrating understanding and by proposing another causal argument for the client which states that his current fears and behaviour are rooted in a previous experience of being taken advantage of (lines 8–9). The coach then checks with a follow-up question whether the client has actually had any such negative experiences when opening up to other people. In doing so, the coach not only aligns with the client's externalising' causal reasoning but also extends it (see also lines 3–4).

Professional relevance

Clients were shown to strongly orient to contrastive questions (S5) asked by coaches. Hence, coaches could benefit from a more detailed understanding of

Table 15.1 Professional practice highlights

1. Coaches should be aware of the response requirement invoked by contrastive (confrontational) questions, and how countering the claims embedded in these questions may invoke resistance in clients' receipt as an interactionally relevant next matter.
2. Coaches should be aware of the importance of question format and question design and attempt to use a variety of question formats, including (checking) questions that ask the client to elaborate on aspects of the troubles-telling.
3. Coaches may benefit from employing interactional strategies that not only 'neutrally' demonstrate reading but also convey a more active acknowledgement of the client's problem.

the response requirement induced by these questions. The sequential implicativeness of questions in emails is enhanced by their position at the end of a paragraph. Furthermore, the design of the questions, contrastive and critical of the client's problem, was shown to render a response from the client as a relevant matter to deal with in their next email. When these questions are taken up as a critique by clients, as we have shown by examining their receipt, we can begin to see how they become central to the interactional dynamic of email counselling.

It is important to critically consider the effect this has on the practice of counselling and that is why we want to pose the question whether it is desirable if online counselling talk seems to predominantly invite (legitimising) accounts from clients. It seems that this type of receipt is not in line with the organisation's goals of showing understanding and giving ear to client's concerns, nor with eliciting self-directedness in clients. A 'defensive' or 'resistant' reply might even be considered counterproductive, because it works to reify the client's problem. The counselling relationship might be hampered as a result, as it blocks other types of talk.

We have also shown how coaches subsequently engage in realigning work, such as reinforcing or contributing to the clients' causal arguments. Although client resistance and counsellors' ways of dealing with it are considered part and parcel of doing therapy (see Sidnell & Stivers, 2013 for a discussion), it might be worthwhile for coaches to facilitate modes of interaction in email counselling whereby clients engage in less 'defensive' reasoning practices. For a simple summary of the practical implications, please see Table 15.1.

Summary

This chapter has demonstrated how coaches employ five interactional strategies when responding to clients' emails: they demonstrate reading as opposed to a more explicit acknowledgement of the client's problem (S1); they promote and highlight positive aspects rather than problems (S2 and S3); they cast the problem as a concern many or all people encounter (S4) and they pose questions that are critical of the client's problem and ask the client to elaborate or explain (S5).

We have shown how these strategies, and in particular the contrastive questions (see Extract 2, line 10; Extract 4, lines 9–10; Extract 6, line 10) have a strong sequential impact. They invoke countermoves in clients' emails with which they cast their problems as legitimate (e.g., by offering 'proof' of its existence and by addressing an underlying, deeper problems), and they elicit accountability talk (e.g., identifying external causes, stressing how the desire to do better is hampered by practical constraints, presenting the problem as incomprehensible). These countermoves illustrate how the 'problem reducing responses' by the coach are received as disaligning with the troubles the client has put forward. We found that in their subsequent responses in Extracts 4 and 8) coaches 'retract' and realign with the client, incorporating the 'resistance work' by the client where they previously failed to fully acknowledge their problem.

Appendix: Extracts in Dutch

Extract 1: 1CL-1031

((2 lines omitted))
1 Ben een vrouw van 42 en hier sta ik op dit moment in het leven:
2 Mijn voornaamste bezigheid is zorgen en bezig zijn met mijn zoon van 4,5 jaar.
3 Sinds 4 doe ik de opvoeding alleen.
((12 regels weggelaten))
4 Met mijn zoon gaat het goed, alhoewel ik t moeilijk vind alles alleen te doen met hem met weinig tijd voor mezelf en weinig goede nachtrust.
5 Doe sinds kort n opleiding van 1 dag per week en heb n klein baantje.
6 Heb t gevoel dat ik aan t overleven ben ipv leven.
7 Vaak bang om dood te gaan en wie er dan voor miijn zoon moet zorgen (zwaar christelijke familie waar ik niet wil dat ie terechtkomt).
8 Denk negatief over mezelf, voel me vaak slechte moeder, waaorm overkomen mij rotdingen, ballast van strenge vader vroeger, gemis van echte interesse in mij als persoon door mn ouders.

Extract 2: 2CO-1031

1 In uw e-mail schreef u dat u een alleenstaande moeder van een 4,5 jarig zoontje bent.
2 En dat u de zorg en de opvoeding van uw zoon in uw eentje draagt.
3 U geeft aan het gevoel te hebben dat u in plaats van zelf te leven, geleefd wordt.
4 En zelfs nog meer, u heeft het gevoel te moeten overleven.
5 Begrijpelijk dat u dit voelt, het is ook niet niets om een kind in uw eentje op te voeden!
6 Om vader en moeder tegelijk te zijn en de zorg en verantwoordelijkheid niet te kunnen delen met een ander.
7 Het kost ontzettend veel energie en er is veel kracht en toewijding voor nodig.
8 En dat heeft u ook, u zorgt namelijk al vier jaar voor uw zoon!
9 En dat doet u goed ook, aangezien u schreef dat het met hem goed gaat.
10 Toch geeft u aan dat u zich een slechte moeder voelt. Waar uit zich dat in? En wat denkt u dan?

Extract 3: 3CL-1031

1 Als ik me een slechte moeder voel is dat meestal als ik moe ben en niet rustig kan blijven als mijn zoon niet wil luisteren.
2 Ik schreeuw weleens en voel me dan erg kwaad worden van binnen.
3 Het liefst zou ik altijd de ‘juiste’ dingen tegen hem zeggen.
4 Nu heb ik het idee dat ik door mijn uitgeput voelen hem dingen meegeef die ik niet wil:‘het is normaal om te schreeuwen, mama kan het niet aan, mama vind je niet lief etc.
5 Later probeer ik dan altijd met hem te praten maar dat is ook lastig.
6 Hij vraagt vaak ‘mama vind je me nog lief’ als hij gewoon aan het spelen is, en daaruit maak ik op dat hij er toch schade van oploopt dat mama het soms niet aankan.

Extract 4: 4CO-1031

1 Je geeft aan dat je, voornamelijk wanneer je moe bent, je niet kan reageren zoals je zou willen reageren wanneer je zoon niet wil luisteren.
2 In plaats van kalm blijven en rustig die dingen zeggen die je wil vertellen, voel je je kwaad en schreeuw je wel eens. Hierdoor ben je bang dat je de verkeerde boodschappen aan hem meegeeft, zoals dat je niet van je zoon zou houden en zou falen in de opvoeding op bepaalde momenten.
3 Je bent bang dat je hem hierdoor beschadigd.
4 Wanneer je veel aan je hoofd hebt en moe bent, wil je rust en dan reageer je Wel eens anders dan dat je zou willen wanneer je zoon niet wil luisteren.
5 Ik kan me goed voorstellen dat je bang bent om hem de ‘verkeerde boodschappen’ meegeeft.
6 Je wilt tenslotte een goede (perfecte!) moeder zijn en je zoontje de beste en meest liefdevolle opvoeding geven.
7 Wanneer je, door stress, onrust (van hem ook), moeheid, dit niet kan geven aan hem, voelt dat alsof je zelf faalt.
8 Maar hoe vaak komt dit voor?
9 Is dit altijd zo of zijn er ook momenten waarop je wel de moeder kan zijn die je wil zijn voor je zoon?

Extract 5: 1CL-1371

1 Ik ben een zzp ‘er die particulieren en kleine ondernemingen helpt met pc’s en aanverwante zaken,
2 doe dat nu 3,5 jaar en het gaat goed, m’n week is meestal helemaal vol.
3 Zelfstandig betekent alles zelf indelen enzo, betekent ook alle discipline, motivatie en oplossingen zelf inbrengen.
4 Dat is me op zich op het lijf geschreven.
5 Heb eerder al een winkel gehad en heb ook een aantal jaar als als deejay gewerkt.
6 Dit sluit ook aan bij de moeilijkheden die ik heb in het sociale verkeer als er geen sprake is van een zakelijke situatie; ik ben TE zelfstandig en stel me altijd als een einzelganger op.

7 Dat patroon zit zo diep dat het me niet lukt daar verandering in te brengen.
((27 lines omitted))

Extract 6: 2CO-1371

1 U schrijft me dat u sinds 3,5 jaar bezig bent als zelfstandig ondernemer in de computerbranche.
2 Het gaat u goed en dat is heel wat waard in deze economisch mindere tijd!
3 De bijbehorende werkzaamheden zijn u op het lijf geschreven.
4 Vooral het zelfstandige aspect ligt u erg goed.
5 Het is fijn om van jezelf te weten waar je sterke punten liggen.
6 Zijn er nog meer sterke eigenschappen die u van uzelf kunt noemen?
7 De schaduwzijde van zelfstandig zijn is dat je misschien wat afstandelijk wordt als je té zelfredzaam bent.
8 Is dat ook iets wat u bedoelt wanneer u schrijft dat u zich opstelt als een 'einzelganger'?
9 U heeft het over een patroon dat zo diep zit dat het moeilijk is om er verandering in te brengen.
10 Maar waarom zou u dit willen veranderen?
11 Een mens mag toch zijn wie hij is? Als u het toch zou willen veranderen hoe zou de ideale situatie er dan uitzien?

Extract 7: 3CL-1371

1 Het is in praktische zin zeker geen probleem, echter wel in omgang met mensen.
2 Het lijkt of er ook een angst voor mensen zit, bang gekwetst te worden (rationeel gezien lijkt daar niet veel reden toe).
3 Ook zijn wie ik ben is niet gewoon voor me.
4 Ik ben overbewust van mezelf en dat voorkomt spontane akties en ik vind het belangrijk blijkbaar hoe er eventueel tegen me aangekeken wordt of dat ik iets zou doen wat reaktie oproept.

Extract 8: 3CO-1371

1 `Je hebt me iets verteld over hoe moeilijk je het soms vindt in sociale situaties.`

2 `Op zakelijk gebied red je jezelf prima, daar loopt het contact met de klanten wel.`

3 `Maar zodra het contact op ‘menselijk’ niveau komt, dan komt er wat angst om de hoek kijken.`

4 `Zou je kunnen zeggen dat onzekerheid daar een rol bij speelt?`

5 `Ik kan je uit ervaring vertellen dat er bij veel mensen een bepaalde spanning opkomt op momenten dat zich in het sociale verkeer bevinden.`

6 `Je vermoedt dat jouw grootste angst zit in het mogelijk gekwetst of beoordeeld worden door anderen.`

7 `Ik kan me die angst wel voorstellen gezien de gevoelige kant die je in je hebt.`

8 `Het is niet leuk als mensen daar misbruik van maken.`

9 `Zoiets draagt er niet aan bij om jezelf weer snel bloot te geven.`

10 `Heb jij slechte ervaringen gehad op het moment dat je gevoelens aan iemand liet blijken?`

Note

1. It is beyond the scope of this chapter, but our data also show how clients may resist or demonstrate hesitancy when answering optimistic questions. This client does so for example when asked to identify more strong points.

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Recommended reading

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16

Does ana = Anorexia? Online Interaction and the Construction of New Discursive Objects

David C. Giles

Introduction

In 2001, glossy lifestyle magazine *Cosmopolitan* unveiled 'the world's most dangerous secret society'.[1] This wasn't the paramilitary wing of a terrorist organisation, or a Nazi paedophile network, but a motley band of interlinked websites promoting something described by the magazine as 'pro-ana': a romanticised, fetishised take on eating disorders that bestowed a mythic status on anorexia as a state of purity achievable only through the ascetic discipline of the dedicated faster. So what, you might wonder, if a bunch of weirdoes want to starve themselves in the name of some bizarre quasi-religious cult? But then came the media scare: this could be *your* daughter, teenage and troubled, innocently surfing the web, stumbling across horror sites filled with skeletal pictures of starving women ('thinspiration'), seductive imagery, and 'tips and tricks' for cheating your family and friends by concealing the extent of your eating disorder, and before you can set the parental controls on the computer, she'll be brainwashed by this evil sect....

By 2002, pro-ana had become demonised throughout the media, medical experts were warning of the dangers of the sites, and academic researchers were starting to trawl through the forums wondering what it was all about, and, maybe, what it revealed about anorexia itself. One decade later, pro-ana has become an established phenomenon, widely researched and discussed in the media and academia alike, feared and reviled by anxious parents and health professionals, cautiously tolerated by the more progressive clinicians and some liberal feminists, and joyfully celebrated by those who see it as a V-sign to the stuffy medical/psychiatric establishment.

My own professional interest in pro-ana was sparked by those early press reports, and the fact that I was supervising clinical research on eating disorders at the time. In the early 2000s, the clinicians' fears about media influence were restricted to the allure of the fashion catwalk and the 'thin ideal' of the celebrity world. Numerous experimental studies claimed to show how a brief 'exposure' to pictorial 'stimuli' of thin models was enough to trigger a cognitive distortion in young women's appraisal of their own bodies, with participants selecting an inappropriately chubby body-shape silhouette from a selection of alternatives (see Harrison, 1997). One psychiatrist I spoke to disputed the claim that anorexia could be triggered by such images: he argued that the anorexic patients on his ward were more likely to idolise Winnie the Pooh than Kate Moss. But the power of online communities had barely been appreciated at this point, with most studies of 'bulletin boards' and 'newsgroups' focusing on geeky groups of role playing gamers and students larking around with their first email accounts. The idea that the Internet might have a significant part to play in the future of mental health was a long way off.

What also interested me about pro-ana was that it reflected some of the discourse that, anecdotally at least, was produced in autobiographical accounts of anorexia: the slavish devotion to the weighing scales, the painstaking rituals around eating, and the self-loathing that exists simultaneously with pride in extreme calorie control. This was nothing new in terms of content, but never before had so many people been able to congregate in a dedicated place to share their experiences: for lonely, distressed individuals trapped in their own eating- and weight-obsessed bubbles, the Internet was a godsend, and if some of the dialogue seemed a bit extreme, the opportunity to engage with hundreds of like-minded individuals from around the English-speaking world, in the privacy of their own bedrooms, in complete anonymity, was too great to be passed up. Whether or not members truly believed in the 'ten commandments of Ana', the websites flourished, spawning imitations galore, and the media backlash only reinforced the belief that this community was essential to counter the hostility of the 'haters' all around them (for further discussion of the role of media and representation, see Garner, Harwood, & Jones, Chapter 8, this volume).

Research on pro-ana still abounds across and between academic disciplines: it is still a *social problem* that health, medical, and other professionals are struggling to resolve. A report published in late 2012, funded by the Nominet Trust (a social technology charity), in partnership with eating disorders and children's charities (Bond, 2012), conducted an overview of 126 'pro-eating disorder websites' and concluded that the 'risks' posed by such sites continued to be a concern for 'health professionals, educators and parents' (p. 2).

But in the 15 years or so of online presence, the community has undergone so much transformation that we cannot ignore the question of what pro-ana really *is*, or has become, and its ontological relationship with anorexia nervosa, the medical category first identified by Sir William Gull in 1874. My argument in this chapter is that the 'ana' fetishised by the online community and the psychiatric diagnosis of 'anorexia' are two distinct discursive objects. They perform different actions, frame different practices, and have different implications not only for mental health but for society itself, not to mention those individuals affected by psychological distress that manifests itself in aberrant eating behaviours.

After considering the tools available to the discourse analyst for performing this type of genealogical research, I will attempt to define 'pro-ana' as represented in the academic literature, arguing that the uncertainty over what actually constitutes a website, let alone the nature of the individuals involved, makes it difficult to answer the research questions typically posed by social scientific researchers.

Discursive objects

For me, nobody has produced a better definition of discourse, and how to use discourse analysis to identify discursive objects, than Ian Parker. For Parker (1992), a discourse is 'a system of statements which constructs an object', and 'once an object has been elaborated in a discourse, it is difficult not to refer to it as if it were real' (p. 4). From this basis, the ontological status of the discursive object is established through its recurrence in cultural material, and the shared reference points within a given society. We may be sure that UFOs don't exist in a strictly material sense, but everyone with exposure to Western media and cultural tradition can describe one, draw one, and discuss their meaning. Daleks are very real for a UK audience but less so for an American one, with more limited exposure to the long-running BBC series *Doctor Who*. Despite the efforts of paranormal experts to prove otherwise, ghosts are a near-universal example of a shared object whose ontological status is realised only through discourse.

Parker (1992) goes on to specify a number of criteria by which we can identify discourses, whose relevance will vary according to the cultural material under investigation, but several will be useful to the present analysis. Firstly, a discourse is realised in texts: these comprise the analytic material, namely forum discussion posts (on various eating disorder–related websites), as well as journal articles and news media reports about pro-ana. Secondly, a discourse is about objects: pro-ana, clearly, as the primary object of the study, but also the websites, forums, and other places inhabited by pro-ana, as well as the various identities and categories that perform discursive work – anorexics, parents, boys, teachers, anas, and mias (see Giles, 2006, for a fuller discussion of the social identities drawn on in the community). A discourse also contains subjects: the audiences addressed by the online material – medical and parental (outsiders, looking on), academic (researchers), as well as the various factions within the pro-ana community. An important criterion in this study is

Parker's contention that 'a discourse is a coherent system of meanings'. What is coherent about pro-ana, and what is incoherent?

Two additional criteria will also be addressed in this analysis. 'A discourse refers to other discourses' (Parker, 1992, p. 9) in that various figures in the pro-ana texts draw on, from time to time, medical and psychiatric discourses around anorexia, eating disorders, and the relationship between biology and psychology, while others – including some of the researchers – draw on radical or revolutionary discourses citing feminism, counter-culture, hegemony, resistance, or subversion. The uneasy juxtaposition of sharply contrasting discourses is one of the most distinctive features of the phenomenon. Finally, 'discourses support institutions', and while it is clear which institutions are supported by medical and psychiatric discourses, it is not always clear whose interests are served by radical and revolutionary discourses in this work, other than the emancipatory goals of self-advocacy. However, as numerous researchers have discovered, the power of self-advocacy may be counterproductive when invested in a project with such conservative and subservient aims as those of pro-ana.

What is meant by 'pro-ana'?

For over a decade now, researchers in the social and health sciences have been conducting studies of the 'pro-ana' phenomenon (typically referred to as 'the pro-ana community' or 'pro-ana websites'; see Casilli, Tubaro, & Araya, 2012, for an extensive overview). The term 'pro-ana', at its simplest, refers to the belief that anorexia, far from being an illness to be treated or cured, is a condition to aspire to, if not to celebrate. The nature of the community, or even the websites themselves, is much more ambiguous, and has not really been the subject of any serious investigation. As I will go on to argue later in the chapter, this constitutes a problematic gap in the pro-ana literature. After all, a 'website' can mean anything from a single home page or blog with a handful of viewers to *Twitter* or *Facebook*, effectively mass media in their own right. The prototypical 'pro-ana website', arguably, would be a stand-alone site with its own URL, a home page, a discussion forum (sometimes still referred to as a 'bulletin board'), blogs/diaries, poetry, artwork, pictures of emaciated women intended to act as 'thinspiration' for members, and a page – much derided in the media coverage – detailing the 'tips and tricks' that can be used in order to conceal your eating disorder from family and friends.

The pro-ana phenomenon has been discussed as a challenge for health professionals working with eating disorder services (Harshbarger, Ahlers-Schmidt, Mayans, Mayans, & Hawkins, 2009), as a feminist issue (Day & Keys, 2008; Ferreday, 2003; Pollack, 2003), and as an interesting topic for psychologists and other social scientists (Giles, 2006; Hammersley & Treseder, 2007;

Maloney, 2013). A huge range of both quantitative and qualitative methods have been used to study the phenomenon including covert participant observation (Brotsky & Giles, 2007), content analysis (Harshbarger et al., 2009), online focus groups (Williams & Reid, 2010), grounded theory (Haas, Irr, Jennings, & Wagner, 2010), and even experiments (Bardone-Cone & Kass, 2007).

The methodological diversity of pro-ana research is matched by the wide variation in ways that authors have labelled the object of their studies. Not all authors use the term 'pro-ana'. Some use the term interchangeably with 'pro-anorexia' (Boero & Pascoe, 2012; Haas et al., 2010; Tierney, 2008). The distinction may appear trivial, but discursive objects are constructed by the labels in use: to call a website 'pro-anorexia' is not the same thing as calling it 'pro-ana' (or even, by reference to the 2001 Cosmo article, 'pro-anna'). The term 'ana' is specifically indexed to the online community and not to the clinical or medical discourse around 'anorexia'.

Other, typically older, studies have sometimes used the term 'pro-eating disorder' or 'pro-ED' (Wilson, Peebles, Hardy, & Litt, 2006), which might seem more appropriate since many members of the pro-ana community identify more with bulimia (or even ED-NOS – an eating disorder 'not otherwise specified'). However, one of the distinctive features of the community is that anorexia, or ana, is aspired to as a state of purity, with bulimia and other eating disorders even seen as failure, or at best intermediate stages on the path to the target condition (Giles, 2006). The point I am making here is that researchers select, consciously or otherwise, their own labels for defining the community, thereby placing a medical frame (pro-anorexia) around something that may actually be *not* medical (pro-ana).

One of the most common characteristics that defines pro-ana as both a statement and a community is the reluctance of its members to seek treatment, or to 'recover' from their eating disorders. This is inevitably the most worrying manifestation of the phenomenon for clinicians (not to mention parents and other people who care about the individuals that join the community). It is this anti-recovery stance as much as anything that sets pro-ana apart from anorexia itself, since there are undoubtedly many individuals with eating disorders who see anorexia as a thoroughly unwelcome condition and who are fully committed to carrying through a course of treatment. Not all people with eating disorders endorse the pro-ana philosophy, although one of the issues I will discuss later is whether indeed the community has developed a consistent and coherent stance on the topic that could be called a philosophy (or even a 'movement', as frequently claimed).

One way that researchers have sought to distinguish pro-ana sympathisers from those wishing to recover from their eating disorder is to identify specific websites as either pro-ana or 'pro-recovery'. Although the latter term is in frequent use by the creators and managers of the sites themselves, I argue here that it is overly simplistic to divide the eating disorder community into these two opposing camps, since there have long been pro-ana sites that host forums for those wishing to recover, and even welcome such individuals on their home pages. Indeed, one of the pro-ana sites reviewed by Lipczynska (2007) claimed, 'Pro-Ana is not about encouraging people to "stay sick" or "get sick". We are pro-recovery' (p. 547). Meanwhile, one study directly comparing pro-ana and pro-recovery sites found a good deal of overlap in content, observing that almost half of their sample had learned weight loss methods from visiting pro-recovery sites, and that the latter 'may not be benign' (Wilson et al., 2006, p. 1641). Another study found that 75% of visitors to pro-ana sites gained 'recovery' tips and advice (Ransom, La Guardia, Woody, & Boyd, 2010).

While the prevalence of pro-ana might not, at first glance, seem a concern for discourse analysts, figures relating to the size and spread of the community have significant rhetorical power, particularly when cited by the authors of scare stories. However, the actual scale of pro-ana has eluded most researchers on the subject. An early figure (400 websites) cited by Atkins (2002) was repeated in several published articles, including my own (Giles, 2006), although it was little more than a rough estimate provided in a newspaper article. Bond (2012) is a rare example of a study that provides a clear breakdown of the material analysed, identifying 98 'multi-page complex websites' that could be detected by entering relevant terms into search engines. Of these, only 18 made the final cut in the author's analysis of 126 (of a total of 444 'online spaces'), along with many more 'individual image-based sites', stand-alone blogs, and other 'multi-page websites' with broader coverage. Frustratingly, no timeline is provided for the data collection, a common oversight in the literature but an important one, as I go on to discuss in the next section.

Three phases in the history of pro-ana

Drawing from both published academic research and my own extensive study of the phenomenon for over a decade, I argue that we can identify three distinct phases in the history of pro-ana.

Naive phase

The *naive phase* covers the period up to around 2003, which covers the emergence of pro-ana through discussion about eating disorders on electronic mailing lists (listservs) and other early Internet technologies, and the establishment of the first dedicated stand-alone websites, such as *Anorexic Nation*, a prototypical site that was established in 1999. I have called this phase 'naive' because the ethos behind the sites themselves was at this point uncontaminated by large-scale media attention and, until 2001, had not been censored or removed by their web hosts. Subsequent pro-ana materials have to be interpreted in this light, and many of the developments in the phenomenon can be regarded as reactive, or self-censoring.

Anorexic Nation attracted much of the early negative media attention. As Ferreday (2003) has argued, the site 'set the standard for many imitators': its thinspiration gallery, page of tips and tricks, 'defiantly punky aesthetic', and 'aggressively pro-anorexic and anti-medical stance' were copied by many of the early sites (p. 283). One of the most striking features of the naive pro-ana phase was the high level of creative output by the community. Song lyrics, poetry, artwork, and fiction were abundant on these early sites and undoubtedly proved attractive features of pro-ana for many of its members.

Very little of the pro-ana literature has discussed the counter-cultural iconography of the phenomenon: one exception is Burke (2012), who aligned pro-ana with grunge fashion, embodied in the figure of 'superwaif' Kate Moss. Whether in the form of grunge, punk, or Goth, pro-ana has always embraced alternative youth culture. This is exemplified by the character Ruby Gloom, who emerged as a kind of pro-ana icon around 2002–2003 in *Ruby's Gloomy Place*, a sisterly spin-off from the site *Ana by Choice*. Ruby, a mournful doe-eyed Goth teen, eventually pulled up her pro-ana roots in order to be recast as a Canadian TV star. Her Gloomy Place, meanwhile, became absorbed into mainstream mental health site *Mind Support*.

The trigger for the end of the naive pro-ana phase came in the shape of a scare article in *Cosmopolitan*. Warning its readers of the new 'pro-anna [*sic*] movement' ('the world's most dangerous secret society'), it generated alarm among parents and health professionals, and when US eating disorder association ANAD asked Yahoo! to remove pro-ana sites from its server, the web host duly complied: within four days, 115 sites had already closed. Shortly afterwards, Alta Vista and other hosts followed suit.

Reformation phase

The *reformation phase* describes the period from around 2002 to 2007, during which fierce censorship and hostility from outside the community forced pro-ana sites either to tone down or disguise their identity. Sites became less likely to include obvious indicators like 'ana' and 'thin' in their titles and began to issue disclaimers on their home pages in order to avoid litigation should they be cited as responsible in court cases brought by relatives of fatally anorexic community members.[2] However, despite these concessions to the accusations of health professionals and parents, web hosts continued to close down sites, leading to a game of cat and mouse as the site owners simply reassembled their old communities on new sites.

Pro-ana communities in this period became more inclusive, even welcoming members who are 'pro-recovery'. This reflects partly the growth of eating disorder sites calling themselves '(pro-)recovery' in order to not only distance themselves from pro-ana but also to defend against culpability for triggering eating disorders in unsuspecting victims. Nevertheless, the claims made on site home pages were not always supported by their members, and the range of positions within each community became increasingly diverse. In a covert participation study, Brotsky and Giles (2007) entered a series of chat rooms on identifiably pro-ana sites and found that the same 'persona' (adopted by the first author) using the same vocabulary and interactional style, received a remarkably different reception from one site to the next. In some chat rooms, requests for information on how to improve one's 'ana' credentials were met with warmth and welcoming responses. In others, the persona was rounded on and harshly abused, members claiming that talk of 'ana' was taboo among the community.

Perhaps because of this diversity, some members of the pro-ana community have referred to this second generation of sites as 'ana-lite', fearing that the fear of censorship had led to the original pro-ana sentiments being diluted for acceptability. An alternative interpretation is that sectors of the community were, partly through necessity, gradually moving away from some of the more obviously juvenile characteristics of the early sites towards a more reflective and mature stance (it is also possible that this simply reflects the actual maturation of the individuals involved).

There is relatively little academic research that has identified this shift over time in the nature of the pro-ana phenomenon. One of the few exceptions is Boero and Pascoe (2012), although their study is unusual in being the first to collect pro-ana material from groups on social media sites – 'discussion groups' on MySpace during 2005–2006. They identify a critical position adopted against some of the earlier pro-ana themes, notably the quasi-religious imagery that is characteristic of many first generation sites, such as 'prayers to the Ana goddess' and 'ten commandments of ana'. Such material is associated in the MySpace groups with 'wannarexics' – inauthentic 'newbies' who fail to treat anorexia with the seriousness it deserves.

Another feature of this period is the globalisation of ana, with the appearance of several non-English sites, notably in German, Spanish, and French. Members of both the French and Spanish governments launched ultimately unsuccessful attempts to prosecute the owners of pro-ana sites, although web host control over their production became looser as the community gradually migrated from stand-alone sites to social networks like *Facebook* with explicit anti-censorship philosophies. Another shift during this period saw the 'homepage' era of early pro-ana representation on sites like *LiveJournal* return in the form of blogs, connected through blogrings, and eventually vlogs on *YouTube*.

Social media phase

The *social media phase*. The third generation of pro-ana has seen the phenomenon move fully into the web 2.0 era, with representation on social networking sites of all kinds. In addition to the discussion groups on sites like

Facebook and *Twitter*, there has been much pro-ana activity on photo-sharing sites like *Flickr* and *Instagram*, with their inevitable potential for hosting 'thinspirational' images of very thin models, as well as photographs of pro-ana community members. With these sites being less vulnerable to censorship, there has inevitably been a resurgence of the more fundamentalist pro-ana standpoint. This could suggest that either former community members have abandoned the websites to pursue their activity in the less-regulated domain of social media or a new generation of younger community members has emerged, voicing more extreme sentiments for the first time.

Scholarly research on the social media presence of pro-ana has been slow to appear: one notable exception is the content analysis by Juarascio, Shoaib, and Timko (2010) of groups on Facebook and MySpace in late 2008. As the researchers admit, the nature of such groups is extremely volatile (and many are 'closed', requiring member access), and although high in number, the actual membership of groups in the analysis ranged from 796 (a reasonable size for a stand-alone website) to a mere 8. Though no precise figures are included, one would expect most social media 'groups' to be on the smaller side, since they lack the structural appeal and sense of community of stand-alone sites and are likely to be short-lived as a consequence. The content analysis revealed less in the way of eating disorder material and more 'support' than is typical of the stand-alone sites, but this may simply reflect the general usage of social media in its earlier phase. As more visually orientated media appeared around 2010, the circulation of 'thinspiration' re-emerged, and in 2012 a ban on such material was announced by two of the most popular image-based services, *Pinterest* and *Tumblr*.

Meanwhile, the stand-alone sites have diversified further, almost to the point where it would be hard, if not impossible, for a researcher to carry out anything more than a handful of case studies without obtaining membership and tackling the ethical issues of covert participation. There are few remaining explicitly pro-ana sites, and most have either carefully controlled membership access or user interfaces that are so unfriendly that they could surely only appeal to long-standing members from the listserv generation. The majority of sites have abandoned a pure pro-ana stance, and either embrace a wide range of positions or have cultivated their own unique perspective on the phenomenon. An example of the former site is *MiAna Land*, whose title would lead one to expect a first-generation community, but whose home page disabuses such suspicions. 'If you came here thinking MiAna Land was a proana group, it isn't', it states. 'It is an eating disorder support group'. Nevertheless it maintains a pluralistic outlook: 'Some members are pro-ana or pro-mia so we are tolorent [sic] towards those who are'.

More commonly, contemporary sites proclaim that they have progressed beyond pro-ana. *House of Thin*, originally established in 2006, claims on its home page that it represents 'the birth of the evolution of proana, and the start of the second wave pro-anorexia movement'. While it still caters for those stuck at an early evolutionary phase by remaining 'true to the proanorexic roots', it has abandoned the provision of 'tips, tricks and thinspiration' and claims to have carefully segregated the topics on the password-protected discussion forum so that unsuspecting newbies are not seduced by 'triggering' content.

The evolution theme is repeated in several other sites, most notably *PS: Evolution*,[3] which describes itself as a pro-ana 'collective' for over-18s only and also promotes a pluralistic outlook incorporating 'recovery' while still appealing to the more traditional devotees of the phenomenon. Likewise, *We Bite Back*, whose front page describes it as a 'pro-recovery eating disorder community', previously defined itself as a 'post-proana' site (its history is described on the site). Other sites describe themselves as 'pro-active proana' (*Project Shapeshift*) or 'neo-ana' (*NeoProAna*, which raises the age threshold for membership to 25).

Misconceptions about pro-ana

Many working in the field of eating disorders might wonder about the relevance of this historic detail about the pro-ana community. Surely pro-ana is a coherent, if toxic, world view that some anorexic individuals adopt, have always adopted, and will always adopt, and the websites exist merely in order to promote it. This is an assumption that emerges from time to time in the literature. Harshbarger et al (2009, p. 367) begin their introduction to a content analysis of pro-ana sites by stating that 'anorexia nervosa is a psychiatric disorder characterised by secret keeping and deception', which allows them to proceed to the claim that an underground pro-ana subculture is precisely the kind of activity in which one might expect someone with anorexia to participate.

As I have mentioned, my own interest in pro-ana was sparked by its resonance with clinical accounts of (some) individuals with eating disorders, and there is some evidence of in-patient eating disorder cultures emerging around competitive weight loss (Vandereycken, 2011). But neither of these anecdotal observations can really be equated with the prolific phenomenon that pro-ana has become, and fails to capture its diverse and eclectic, chaotic nature. Many scholars nevertheless describe pro-ana as something separate from its online context. Just to give one example, Bond (2012) sets the context for her wide-ranging content analysis of 'pro-anorexia websites' by examining how the sites 'are contributing to either the anorexic condition or the pro-ana phenomenon' (p. 5), as if the latter were established long before the advent of the Internet. As I have attempted to show by detailing the shifting nature of pro-ana, it is not only an exclusively online phenomenon but also one in constant flux.

Misconception 1: Pro-ana as (health) misinformation

The aspect of pro-ana that has drawn the heaviest criticism from medical and health professionals is the 'Tips and Tricks' section typically featured on the archetypal stand-alone websites of the early 2000s. So toxic is such material held to be, one study (Harshbarger et al., 2009) conducted a content analysis solely on such pages, or at least those found on all but one of the first ten sites identified by a Web search on the term 'pro-ana'. While calling for clinicians to better inform themselves about the content of these pages, they also concluded that most 'tips' were largely 'benign', and some were even 'beneficial to readers' health' (p. 369). As medical researchers, they were most concerned about advice that encouraged community members to conceal their weight loss from professionals (such as weighing down clothes with coins, or pretending that a sore throat is viral rather than the result of purging).

Seen from this perspective, pro-ana sites fall into the category of 'online health misinformation' that has incurred the displeasure of medical professionals since the mass uptake of the Internet in the 1990s. However, it seems to me wholly inappropriate to label most pro-ana content as 'information' of any kind. Any support that the communities offer (and most academic studies seem to agree that this is the case) is largely social in nature, even if most advice is concerned with maintaining extremely low weight rather than 'recovering' weight (the kind of advice clinicians would prefer to see online).

However, most medical concerns rest on the assumption that at-risk individuals are innocently visiting pro-ana sites for information on how to recover from an eating disorder and are falling prey to messages about thinspiration and the glory of a skeletal figure. Despite this, studies of pro-ana forum users have found that the majority of users joined forums for social support, particularly around their choice to maintain restricted eating practices (Ransom et al., 2010). Moreover, by using the very term 'Tips and Tricks', this advice is clearly not to be read by users as *health* information but as resistance to medical constructions of anorexia.

Misconception 2: Pro-ana as (underground, radical) movement

While the first misconception of pro-ana is something that is largely circulated in non-academic contexts like charitable and medical websites, and media coverage, the second misconception is one that social scientists sometimes fall prey to, largely in their enthusiasm for a phenomenon that has a countercultural allure. This is the notion that pro-ana constitutes a cohesive 'movement', bringing together marginalised individuals who share a consistent world view that constitutes a challenge to the medical/psychiatric establishment. While some elements of pro-ana (like the 'Tips and Tricks') undoubtedly fall into the last category, the majority of researchers seem to be in agreement that much forum content is benign if not banal: teenage girls discussing everyday struggles with school, boys, and families. Belonging to the community bounded by a single website seems more important than belonging to any broader 'movement' following a unified philosophy: mobility between sites is driven more by structural demands (e.g., site closure) or social demands (a group of users defecting en masse to a more attractive site) than by ideological differences.

Much of the enthusiasm for pro-ana arises from feminist scholars who identify with pro-ana as a gendered site of resistance, in the long tradition of feminist appraisals of anorexia more generally (e.g., Malson, 1998; Orbach, 1993). However, close inspection of the community reveals some disappointing truths. Day and Keys (2008), for example, having talked up the radical 'counter-hegemonic' work that pro-ana members might undertake as part of 'their politics' (p. 5), end up concluding that their performance of 'resistance' is largely a foil for their 'pursuit of normative cultural ideals' (p. 12) – that is, the 'thin ideal' constructed by the media (itself a hegemony?). Agency is an illusion, since by conforming to the weight regulation self-discipline of anorexia they are simply following the surveillance practices of the patriarchal society. Pollack (2003), in questioning what 'the feminist response' to pro-ana 'should' be, speculates about the empowering potential of the community while herself engaging in an othering process whereby pro-ana members are positioned as 'these women' (on two occasions) who ultimately need to be engaged in 'dialogue' by feminists in order 'to negotiate meanings' (p. 249).

Elsewhere, social scientists who have chosen to construct pro-ana as a movement fall into the trap of assuming homogeneity, talking of a (unifying?) slogan (Haas et al., 2010), or of a community 'unified in its belief' (Burke, 2012, p. 43). The latter author unusually focuses on the cultural distinctiveness of pro-ana as a descendant of 1990s grunge culture, although this description already seemed dated by the time the paper was published, with the third wave of pro-ana already well under way. Likewise, Boero and Pascoe (2012) made many assumptions about the pro-ana community on the basis of their study of second-wave sites (data collected in 2005–2006), where criticism of the first-wave sites was common. As Sarah Brotsky and I found in our contemporaneous study (Brotsky & Giles, 2007), a sharp divide had emerged by this point whereby authenticity had become paramount, and 'wannarexics' were harshly dealt with. Pandering to the first-wave iconography (e.g., ana as a goddess) was frequently met with derision or abuse. From their data, the authors conclude that 'a true pro-ana anorexic does not see the disorder as a deity to whom she prays' (Boero & Pascoe, 2012, p. 42) and that the media coverage of such iconography fails to appreciate its 'irony'. In the first wave of sites, however, irony had not yet set in. Like so many pro-ana researchers, the authors nailed down the community at a specific point in time and generalised accordingly.

Alternative conception: Pro-ana as media product

I want to end this section of the chapter by presenting an alternative reading of pro-ana, one that acknowledges its history and its cultural context: that of pro-ana as a media product, not unlike a genre of television programming or glossy magazine publishing. Internet content is unquestionably a mass media phenomenon, and when it is analogous to traditional media (online news channels and newspapers, for example), it is uncritically treated as such by researchers. Pro-ana has been treated as the online equivalent of offline talk between eating disordered individuals largely, I suspect, because those interested tend to hail from the health and social science disciplines, and their primary focus is *eating disorders* rather than media content per se. Unsurprisingly, they have viewed the phenomenon through a medical/health lens and drawn conclusions either about 'anorexia' or about society more generally.

Anyone who opens up an online space without membership screening is, consciously or otherwise, inviting over a billion people to observe the social dynamics of the community (a point continually missed by people who post abusive material on *Twitter* and are subsequently indignant about their activities being treated as criminal). By posting their accounts and recommendations online, they are not engaged in private dialogues, and researchers who base conclusions about anorexia itself from analysing pro-ana forum discussion are effectively claiming that, by visiting the forums, they are in a privileged 'fly on the wall' position, eavesdropping on intimate exchanges.

For this reason, it is important that pro-ana researchers give us more context about the data they are using to make claims about online eating disorder communities, and any claims thereafter that are extrapolated to eating disorder populations in general. It is not simply a matter of documenting time periods but also, like Bond (2012), providing a clear breakdown of the materials analysed: whether stand-alone sites with dedicated forums (and their own histories), blogs, personal pages or social media groups.

Pro-ana as functionally distinct object from recovery

Thus far, I have dwelled solely on pro-ana as one of several online phenomena concerned with eating disorders. I have argued whether, from a social constructionist/discursive psychology perspective, we can claim a functional distinction between (pro-)ana and anorexia (nervosa) as discrete discursive objects. Further, 'ana' can be broken down into two discrete discursive objects: one constructed by the media, the medical establishment, and other professional groups (ana as toxic online manifestation of offline mental illness); and one constructed by liberal social scientists (ana as underground resistance movement challenging hegemonic norms).

Who owns a discourse? Who decides whether an object is valid or not? From the Foucauldian perspective, we need to take power relations into account in order to answer this question. In this case, the former object (ana as manifestation of offline mental illness) is surely the more pertinent. However, as I have argued throughout this chapter, problems arise when trying to identify ana as the psychiatric diagnosis of anorexia, because it is largely irrelevant whether community members are diagnosed with anorexia, or are mental health service users of any kind.[4] For this reason, it is simply not appropriate to construct ana as a medical/psychiatric discursive object. To do so is to ignore culture, history, communication, and context.

The second potential discursive object – ana as underground resistance movement – only makes sense if we can identify a coherent ideological stance across the community (and, perhaps more importantly, that it shares an emancipatory goal that targets actual political activism offline as well as online). However, not one study has ever provided convincing evidence of a clear ideological stance. Indeed, most research points to two quite contrasting positions adopted by the community, summed up in a study by Roberts Strife and Rickard (2012), who examined pro-ana site 'mission statements' and classified them into two camps: those endorsing anorexia within a medical model (warning against those visiting the site in order to learn to be anorexic) and those embracing a lifestyle model, in which choice and control are salient constructs. Many pro-ana researchers, however, are familiar with the situation whereby both positions jostle for priority within the same community, and sometimes in the accounts of the same members. It is generally agreed that *ambivalence* is the defining characteristic of the community (Burke, 2012; Day & Keys, 2008, Haas et al., 2010).

The status of ana as a discursive object makes more sense when we set it against another object: the *recovery* website. Some studies have set out from this perspective by directly comparing the two kinds of site (Riley, Rodham, & Gavin, 2009; Wilson et al., 2006), while others have only examined recovery, or 'pro-recovery' sites (Williams & Reid, 2012). Naturally, given the curiosity around pro-ana as a phenomenon, the latter are fewer in number than studies that have focused solely on pro-ana sites, though, as the researchers argue, recovery sites are of potentially greater interest from a clinical perspective.

Both sets of studies are predicated on the assumption that pro-ana and recovery constitute meaningful and oppositional discursive objects. If there is a consistent philosophy underpinning each, this might seem sensible. However, as we have seen, pro-ana embraces at least two quite contradictory views of anorexia, and several studies have found that users of both pro-ana sites and recovery sites have encountered material that one would expect to belong exclusively to the other. Wilson et al. (2006) found that almost half of 'pro-recovery' site users learned new weight loss or purging methods from those sites, while Riley et al. (2009) concluded that recovery sites can still teach eating disorder–related techniques and promote the 'thin ideal'. Meanwhile, some avowedly pro-ana sites actively welcome members 'in recovery' (Lipczynska, 2007).

Although the term 'recovery' has been in use since the late 1990s, there are two important points to make about the phenomenon. The first is that recovery sites were initially defined as such because they were managed by clinical or medical professionals, having been set up with a clear treatment agenda. The second is that the term 'recovery site' or 'pro-recovery' only appeared widely in the literature in the early 2000s, by which time media coverage of pro-ana sites had demonised the eating disorders online community, and many original pro-ana members had set up sites that deliberately distanced themselves from the term. The adoption of a 'recovery' stance was part of this distancing process, resulting in the emergence of 'recovery sites' managed by individuals who were themselves 'in recovery', taking with them a substantial chunk of the former (and possibly disillusioned) pro-ana community.

It seems reasonable to consider 'recovery' sites (or at least those not affiliated to any clinical services) as part of the third phase of the pro-ana landscape. There is clearly some concern about pro-ana sentiments being smuggled in through the back door: some sites have attempted to ban all mention of pro-ana, and moderators on one German site, *Hungrig Online*, even edited forum posts using the term by replacing mention of 'pro-ana' with substitutes like 'glamourising illness' (Stommel & Koole, 2010). The leakage of pro-ana material into recovery sites (and vice versa) means that constructing a dichotomy between the two may not always be appropriate. Nevertheless, the terms are understood by those in the online eating disorder community more generally as meaningful and oppositional. While it is not a simple task to define a website as necessarily one or the other, the phenomena remain salient as *media products*. Each tradition has an identifiable history within the context of the Internet, even if they do not map precisely on to offline social phenomena.

Clinical relevance summary

Professionals working within the medical model of anorexia might find little of comfort in the pro-ana community. Psychologists, psychiatrists, and GPs constitute a broad 'outgroup' that is not to be trusted: like unsympathetic parents, they are interested only in force-feeding, treating the symptom of mental distress rather than its cause. Recovery sites are to be encouraged, even when their management is not grounded in the health professions (here, they function as peer support). Anything not calling itself a *recovery* site is likely to contain 'triggering' material, even if the term 'pro-ana' is not immediately evident.

Table 16.1 Clinical practice highlights

1. 'Ana' is not necessarily to be equated with 'anorexia'.
2. It is likely that most pro-ana community members have no diagnosis of eating disorder.
3. In 2015, there are very few stand-alone pro-ana websites, and these are largely password protected.
4. The differences between 'recovery' and 'pro-ana' websites may have been overstated.

Other clinicians are advised to dig a little deeper, however. Recovery is not always what it seems, while pro-ana sites, despite some alarming content, are not the devil-worshipping cults depicted in the popular press. Don't expect to find any illuminating dialogue in the forums, however, unless you are prepared to 'fake it' and sign up as a bogus member: they are practically all closed to interlopers these days. It's probably best to enter some appropriate search terms on Facebook, Twitter, or one of the more visually orientated social media sites if you want to get an idea of the kind of environment where pro-ana sentiments are openly voiced. If you can find them, the most useful material is likely to be the discussions about health professionals: what to say to them, what not to say to them, and why they're not helping. For a simple summary of the clinical implications, please see Table 16.1.

Discussion

My objective in this chapter has been to examine the extent to which the pro-ana phenomenon, as a discursive object, can be said to have a separate ontological status from the medical category of anorexia (nervosa). I have done this through the genealogical method of discourse analysis outlined by Parker (1992), inspired by Foucault, which involves addressing several criteria by which objects are constructed by discourse, which become effectively 'real' within a given culture. I have provided evidence from the research literature of the diversity of meanings that pro-ana holds for online audiences, and how certain popular constructions of pro-ana fail to hold up when the phenomenon is examined as a historically and culturally situated phenomenon that embodies numerous contradictions and inconstancies. My argument is that pro-ana is best understood as a media product with a clear online history, and, despite some echoes with offline and pre-Internet eating disorder research, it is not simply the online manifestation of a deep-rooted and universal characteristic of eating disorders per se. This has important implications for those in clinical, medical, and social professions who wish to better understand this controversial and troubling phenomenon, and, in particular, who wish to understand the meanings it holds for those who participate within the community.

Summary

Pro-ana websites have been demonised in the health professions and in the traditional media for offering vulnerable young people ill-founded health 'information' and membership of a cult-like secret society. Taking a genealogical discursive approach, I have argued that the cultural dynamics of pro-ana's history need to be considered against two broad misconceptions in academic research on the topic: (1) that 'ana' can be automatically equated with the psychiatric diagnosis 'anorexia'; and (2) that pro-ana constitutes a coherent 'movement' grounded in a consistent ideology. As an alternative, I offer the construction of pro-ana as fundamentally a media product, historically unique to Internet culture, fragmented across different online contexts, in permanent flux, overlapping more than supposed with its opposing discursive object, 'recovery sites'.

Notes

1. http://obsessed.koolhost.com/34.html
2. Examples include: 'this site features triggering content' or 'if you do not already have an eating disorder, please do not enter'.
3. PS = personal strength.
4. Indeed, we know from the literature that many, if not most, pro-ana members are not actually diagnosed with anorexia (in Ransom et al.'s 2010 study, for instance, only 40 per cent of the pro-ana respondents had been diagnosed with any kind of eating disorder).

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Recommended reading

- Brotsky, S. R., & Giles, D. C. (2007). Inside the 'pro-ana' community: A covert online participant observation. *Eating Disorders: The Journal of Treatment and Prevention, 15*(2), 93–109.
- Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa*. London: Routledge.
- Tierney, S. (2008). Creating communities in cyberspace: Pro-anorexia web sites and social capital. *Journal of Psychiatric and Mental Health Nursing, 15*(4), 340–343.

Part III

The Discursive Practice of Psychiatry

17

Exploring the Heterogeneity of ‘Schizophrenic Speech’

Lisa Mikesell and Elizabeth Bromley

Introduction

Despite claims that pragmatic impairment is a defining feature of schizophrenia (Covington et al., 2005), few studies explore the communication practices of individuals diagnosed with schizophrenia (IwS) in spontaneous interactions where pragmatic impairment may come to the fore. A number of linguistic deficits have been identified (Fraser, King, & Thomas, 1986; Hoffman & Sledge, 1988), but many studies examine language features de-contextualised from their interactional environment. Such an approach allows quantification of isolated, well-defined features but may mask how language use impacts functional outcomes and defines interactional moments, a gap which has led to somewhat mechanistic descriptions of ‘schizophrenic speech’. Although not all IwS exhibit problematic speech patterns, it is often clinically presumed that language is disordered, reflecting a disturbance in cognition or thought processes (Bleuler, 1911/1950). Clinicians thus often pay attention to related categories of pathology rather than to whether the language or discourse practices are communicative. As a result, the situational complexities of language behaviour may be overlooked.

More recently, studies have begun to examine pragmatics, often resulting in characterisations at a ‘molar’ level (Bellack, 1983; see Meilijson, Kasher, & Elizur, 2004). Cretchley, Gallois, Chenery, and Smith (2010), for instance, recorded elicited conversations between IwS and family and professional carers and found that participants’ communication profiles differed ‘according to the level of conversational activity’. The authors claim that *low-activity* communicators ‘underaccommodated by contributing minimally, largely through back channels’ and ‘contributed fewer concepts’ (p. 5), whereas *high-activity* communicators ‘produced more of the conceptual content’ and ‘dominated the discourse by introducing and changing topics rapidly’ (p. 10). Cretchely et al. (2010) pointed to pragmatic variation at the level of topic control – a molar characterisation of discourse. As Bellack (1983) noted, both molar and molecular descriptions of 'schizophrenic speech' are needed.

This chapter brings together a range of data to explore the heterogeneity of 'schizophrenic speech', which is often treated homogeneously. Such a uniform treatment may reflect research approaches that allow for quantification and generalisation, and for those reasons they are quite useful. This chapter, however, aims to highlight variation or observed heterogeneity not only at a molar level but also at a molecular level by using conversation analysis (CA) to examine communication practices that emerge in naturalistic interactions (Mikesell, 2011, 2013). CA allows an examination of how some individuals are able to consistently maintain the floor so as to be characterised as 'high activity', and in what interactional contexts 'low-activity' speakers seem to be 'non-responsive'. An examination of interactional practices may be relevant to understanding how one builds and maintains relationships, relates to others and potentially participates in community, areas that have been noted to be impoverished in schizophrenia (Kingston Stevens, McNichol, & Magalhaes, 2009) but crucial to recovery (Pilgrim, Rogers, & Bentall, 2009; Tew et al., 2011).

There is growing recognition in psychiatry that schizophrenia may not be a single disorder and that clinical variation and phenotypic heterogeneity exist (Arnedo et al., 2015). Given that participants were diagnosed with 'schizophrenia' on the Structured Clinical Interview for DSM Disorder (SCID), we use this diagnostic label; however, we recognise that classification of either having schizophrenia or not may be problematic. Nevertheless, our attention to molecular features of language behaviour reflects a broader research trend of examining phenotypes, behavioural and neurobiological features to develop alternative methods for classification. Examining molecular features may augment strategies for clarifying 'the schizophrenias' (Arnedo et al., 2015) to include naturalistic, context-sensitive and socially embedded behaviours.

Heterogeneity, 'language styles', and the 'duality' of a communication practice

Cretchley et al.'s (2010) study characterising communication styles of IwS also reported on 'patterns of accommodation' adopted by family and professional carers. To examine these patterns, they used Leximancer, a text analytic software that logs the content of a transcript to produce a conceptual map of the interaction. The authors highlighted how their study takes into account the 'interactional dynamics of real-life conversations' (p. 5) by including 'agreements, fillers, questions, and intention words' in the mapping.

The authors found that the subset of IwS characterised as high activity produced more of the conceptual content than family and professional carers. The authors described that high-activity communicators 'dominated the discourse by introducing and changing topics rapidly' while 'carers behaved more reactively' (Cretchley, 2010, p. 10). With family carers, the authors described both 'struggle for conversational control' and 'mutual topic development', with family members asking questions about topics introduced by the IwS. Conflict talk and shared topic development, however, were described as absent from the conversations with professional carers: as the authors summarised, 'although politeness was maintained, the participants tended to talk "at" rather than "with" one another', with professional carers 'appear[ing] to struggle to contribute to the conversations' (p. 12).

The reverse pattern was found for low-activity communicators. Conceptual maps showed that family carers produced more conversational content while IwS most commonly contributed with agreement tokens (*yeah*) and 'fillers' (*oh*, *um*). In conversations between low-activity communicators and professional carers, carers were again found to contribute most of the content, although when compared to conversations with family members 'the imbalance in contribution between participants was reduced' (p. 8). Conversations are co-managed: dyadic interactions are not simply two parties contributing linearly to conversational content. Interactionally, Cretchley et al. (2010) framed carers' contributions as adaptive to the practices of the IwS, although this seems difficult to discern from the content mapping alone.[1]

Identifying patterned heterogeneity in the discourse of IwS in no way demonstrates that such differences are due to pathological processes. Heterogeneity in 'conversational styles' among (presumably) undiagnosed individuals has also been documented. Tannen (1984/2005) analyses 'talk among friends' and reports on contrasting conversational styles or 'way[s] of talking' (p. 14) among interactants. She contrasts a 'high-considerateness style' with a 'high-involvement style'. The latter, she argues, is marked by 'linguistic devices', some of which loosely reflect Cretchley et al.'s molar-level characterisations of high-activity communication: abrupt topic shifts, introducing topics without hesitation, faster turn taking, marked pitch and amplitude shifts, and strategic within-turn pauses, among others (pp. 40–41).

Whereas Cretchley et al. (2010) described high-activity contributions as 'dominating', Tannen described features of high involvement as ways to build rapport. At the same time, Tannen pointed to interactional conflict, noting that the participants with the contrasting 'high-considerateness style' misinterpreted the intentions of the high-involvement speakers, perceiving the high-involved speakers to have 'dominated' the conversation (p. 6). Cretchley et al.'s characterisation of high-activity communication with family carers as resulting in 'domination' *and* 'mutual topic development' similarly points to a dual function of high-activity/high-involvement practices. This suggests that a language practice may reflect both problematic and skilful elements, a feature which may contribute to the complementary ways communication practices are framed in Cretchley et al.'s characterisation of high-activity communicators and in Tannen's characterisation of high-involvement speakers.

From the data presented in these studies, it is difficult to know how authors' characterisations may be influenced by knowledge of a participant's (non)diagnosis. Relatedly, we do not intend to align with a deficit model (Chen & Noosbond, 1997), and the pilot study (Bromley, Mikesell, Mates, Smith, & Brekke, 2011) that provided the data on which this chapter is based was designed to capture skills. Yet, we also do not uniformly align with a competency model and acknowledge the neurobiological underpinnings of disorders that cannot be socially 'deconstructed' or whose severity requires clinical intervention. Given the possibility raised about the 'duality' of a communicative behaviour or practice – that it may reveal both deficit and skill – an alternative approach is to consider what is skilful about a practice that may be adapted to address an individual's needs.

Project overview

Nine IwS participated in a pilot study (Bromley et al., 2011) exploring the relationships between neurocognitive measures and everyday functioning of IwS. Participants were selected from a pool of subjects ($n = 155$) if their composite T-scores on the MATRICS Consensus Cognitive Battery (MCCB) (Green et al., 2008), a neurocognitive assessment, fell within the top or bottom one-third of the pool. Scores on the Brief Psychiatric Rating Scale (BPRS), a clinical interview measuring the severity of 24 symptoms[2] on a scale of 1 (not present) to 7 (extremely severe), were also collected.

Ethnographers[3] continuously video recorded participants as they engaged in everyday routines over the course of several weeks, including outings on buses and subways, doctors' visits, classes, grocery stores, and church service. The research team held regular meetings, during which the ethnographers discussed what it was like to interact with participants. Ethnographers' molar characterisations (see below) of two-thirds of the participants could be seen to parallel those of Cretchley et al. (2010) with one-third characterised as high-activity and one-third as low-activity communicators. Cretchley et al. note that in their study the conversational contributions of 8 of the 17 participants were not easily grounded as low- or high-activity styles. Similarly, ethnographers described interacting with the remaining one-third of the pilot participants as 'easy', 'natural', and 'effortless'. These participants were visited for longer periods of time and were also the top one-third scorers on the MCCB (ranging from 26 to 37). For space reasons, these 'easy' interactions are not highlighted but certainly demand exploration in consideration of heterogeneity.

We also use CA to analyse the video data, allowing 'interactional traction' on what Bellack (1983) described as 'molecular' features: contextualised communication practices such as gaze or prosody. CA is a rigorous, empirical method that allows identification of a recurring interactional practice by examining its form and function across naturally occurring contexts. It therefore provides a way to empirically ground the ethnographic and clinical characterisations of an interactional experience as 'problematic' or 'atypical': CA 'does more than characterise interactions as [inappropriate] but helps show how they may have come to be perceived that way' (Mikesell, 2014, pp. 155–156). In what follows, we overview the clinical, neurocognitive and ethnographic characterisations of two study participants and then turn to the video data to examine two recurring communication practices.

Participants

We highlight two individuals, with the pseudonyms Kevin and Laura, who participated in the original pilot study. Ethnographers' characterisations of Kevin and Laura reflect contrasting communication styles. Kevin was characterised similarly to Cretchley et al.'s (2010) descriptions of 'high-activity' communicators while descriptions of Laura reflect characterisations of 'low-activity' communicators.

Three ethnographers, who visited Kevin for approximately 15 hours, described him as 'very engaged', 'knowledgeable about a range of topics' with 'a lot to say'; one ethnographer noted that Kevin spoke in 'monologues'. Another remarked that she came to feel irrelevant because her contributions were usually superficially acknowledged. With community members, Kevin was observed to engage in brief social interactions – greetings with neighbours or in service encounters (ordering food). These community interactions averaged 26 seconds, ranging between 2 seconds to say 'hello' to an unknown passerby and 76 seconds with a bank teller. Lengthier interactions took place between Kevin and the ethnographers.

Two ethnographers visited Laura for approximately 12 hours and described interacting with her as 'effortful', noting that they often carried the conversation and she was sometimes unresponsive. Ethnographers occasionally discussed moments when Laura showed interest in them, describing them as 'breakthroughs'. Ethnographers also commented that Laura's community interactions were 'instrumental' or task oriented and 'efficient'. Laura regularly interacted with store clerks, residents in her building, and with her sisters on the phone. These interactions ranged between 2 seconds and 18.4 minutes, averaging about 90 seconds. In 12 hours, Laura participated in three interactions lasting over 3 minutes, two with her sister and one with another resident.

The data shown highlight the lengthier interactions with ethnographers because the interactional import of high- and low-activity 'styles' is more easily observed in these interactions; brief encounters such as greetings often did

Table 17.1 Participant summary data: Age, clinical, and ethnographic characterisations

	Age	**BPRS (sum)**	**MCCB (composite T-score)**	**Clinical description**	**Ethnographic description**
Kevin	49	57	16	Pressured, Tangential, Flight of ideas	Engaged, knowledgeable, monologic, challenging, superficial, interlocutor feelings of irrelevancy
Laura	46	61	13	Poverty of speech, Restricted/blunted affect, Lacking inflection/ monotone prosody	Direct, instrumental/ task-focused, minimal, efficient, interlocutor feelings of burden and perceptions of disinterest

not lead to or require a balanced exchange. Interactions with ethnographers are atypical, perhaps even a poor representation of casual conversation given participant roles and the institutional reason these interlocutors have come together. They do, however, allow consideration of how different participants engaged in a similar context: the first moments upon meeting for the first time.

Ethnographers were blind to participants' neurocognitive and clinical assessments. Kevin and Laura scored in the bottom one-third on the MCCB; composite scores were 16 and 13, respectively (Table 17.1). Kevin's BPRS sum score was 57. Two symptom domains scored 5 ('moderately severe'): *somatic concern* and *suspiciousness*, followed by *unusual thought content*, *depression,* and *anxiety*, which scored as 4 ('moderate'). All other BPRS symptoms scored between 1 ('not present') and 3 ('mild'), and no domains scored 6 ('severe') or 7 ('extremely severe)'. Clinical characterisations of Kevin's speech (i.e., based on symptom categories of the Mental State Exam (MSE)) included *pressured* or 'talking quickly and in such a way that interruption is difficult' and *flight of ideas*: 'skipping from one topic to another in a fragmented, often rapid fashion' (Lakeman, 1995).

Laura's BPRS sum score was 61, with two symptom categories – *suspiciousness* and *hallucinations* – receiving a score of 6 ('severe'). *Blunted affect* and *unusual thought content* scored 5 ('moderately severe') and *depression* scored 4 ('moderate'). All remaining symptoms scored between 1 ('not present') and 3 ('mild'). No symptom categories were rated as 7 ('extremely severe'). Clinical characterisations of Laura's speech included *poverty of speech* (a lack of or reduced speech output), and her 'mood and affect' were described as *blunted* and *restricted* (lacking inflection and expressivity).

Kevin: Some prosodic features of turn design

The ethnographic descriptions of Kevin's discourse point to features that impact how turns are distributed among participants. While several turn-design features are worth investigating (Mikesell, 2011; Mikesell & Bromley, unpublished manuscript), this chapter highlights the use of holding silences (Local & Kelly, 1986) following points of syntactic incompletion. In Kevin's discourse these units of talk are composed as 'incohesive' intonation units (Selting, 2000). Several such units can be built in succession, with each incomplete syntactic segment designed with its own independent global contour and hearable as contributing to a larger extended turn.

Silence or pauses can occur both at points of syntactic completion and where the syntax can be heard as incomplete, which has implications for speaker transition. Jefferson (1983), for example, showed that pauses following conjunctionals (*well, but, so*) can be treated as *intra-utterance* pauses or as *trailoffs*. The former curtails speaker transition whereas the latter makes transition available. These two pauses have been found to be phonetically distinguishable (Local & Kelly, 1986). With trailoffs, the conjunctional 'is typically followed by audible out-breathing' and the transition is marked by a 'noticeable loudness diminuendo, and by slowing down of tempo' (Local & Kelly, 1986, p. 195).

For instance, in our video data, an ethnographer asks a participant, Steve, if he got his piercings in Los Angeles (pronounced LA, 'el ay') – *did you get them all done in 'el <u>a</u>y' or::* – where 'or' is turn final, produced as a trailoff. The trailoff is stretched and slowed, produced across 0.45 seconds, whereas the second-most prominent syllable (containing the highest pitch peak at 270.8Hz) is produced across 0.14 seconds. The start of the trailoff also drops in pitch that remains at that pitch level throughout its production. A rudimentary representation of the timing might look as follows where the first seven syllables are compacted across 1.30 seconds:

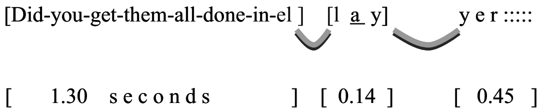

Figure 17.1 shows the trailoff, from the tailend of the dipthong /ay/ as it glides through /y/ into 'or' (sounds like 'yer') with the last syllable held across 0.45 seconds (the vertical dotted line marks the point of transition between

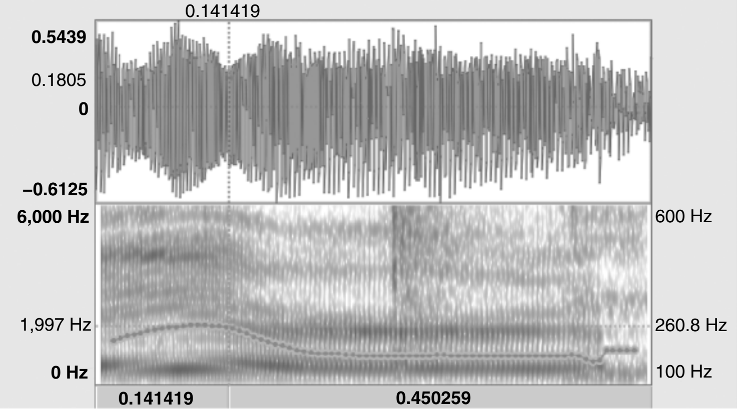

Figure 17.1 Trailoff: 'ay-yer'

/y/ and the trailoff). The horizontal dotted line marks the pitch contour that remains level across the production of 'or' and falls slightly before Steve latches 'yea' (marked by the sudden rise in pitch at the end).

Contrastively, Local and Kelly (1986) characterised 'holding silences' as containing a glottal closure held throughout the silence and released at the start of the next word. As they describe, holding silences do not only co-occur with conjunctionals but 'constitute a locally-available resource for "breaking" talk' and projecting more talk to come (p. 200). As Lerner (1996) discussed, 'the intonation contour of an utterance can certify various syntactic constituents as complete . . . ' (p. 243). In contrast, holding silences may be one prosodic feature that works to certify a unit as incomplete.

To illustrate, the following exchange takes place just after Kevin and the ethnographer (ET1) meet for the first time at Kevin's apartment. ET1 asks Kevin how he finds living there (not shown). Kevin describes his apartment as a 'small little place' (not shown), then as *an SRO:* (line 1), which he clarifies (line 4), produced nearly simultaneously with an enquiry from ET1. Kevin then explains that he found the apartment through a programme that helps secure subsidised housing (lines 8–9, 11). He thus transitions in somewhat stepwise fashion (Sacks, 1972, as cited in Jefferson, 1984) from describing his apartment to naming the kind of housing to identifying the programme that helps find housing. Holding silences were timed and examined in Praat; they are transcribed in tenths of a second within parentheses (Jefferson, 1984) and include glottal stop symbols around the timed silence: (ʔ0.5ʔ). Two examples occur turn-medially in Extract 1 (line 8), the first at a point of syntactic completion.

Extract (1) [KAGA_050309:T1]

```
 1  KEV:  It's- it's considered an SRO:
 2        (0.3)
 3  ET1:  W[hats-
 4  KEV:   [A single room occupancy.
 5  ET1:  mkay.
 6  KEV:  Okay, I'm on you know like subsidized housing,
 7  ET1:  Uh huh.
 8  KEV:  This is a programme(ʔ0.5ʔ)ca:ll(ʔ0.7ʔ)[name].
 9        And w[e're associated with
10  ET1:       [yea. Okay.
11  KEV:  Uh ay- 'aycawf' [acronym: ACAF] [spells out
12        acronym],
```

In line 8, Kevin introduces a noun phrase with a demonstrative reference (Oh, 2001), followed by a holding silence: *this is a program* (ʔ0.5ʔ). While this sentential unit is syntactically possibly complete, impressionistically it does not appear prosodically complete or turn transfer relevant. The articulation of the final bilabial /m/ of 'programme' is unreleased before the silence – the lips remain closed releasing no audible outbreath. The final /m/ of 'program' (Figure 17.2; onset marked by the arrow) thus appears 'short', produced across ~0.08 seconds of the 0.66-second production of 'programme'. The utterance at this point is also questionably complete as an action (Ford & Thompson, 1996): the left dislocation highlights 'a programme' as the most relevant piece of information (Oh, 2001), which is yet to be identified. Although the demonstrative

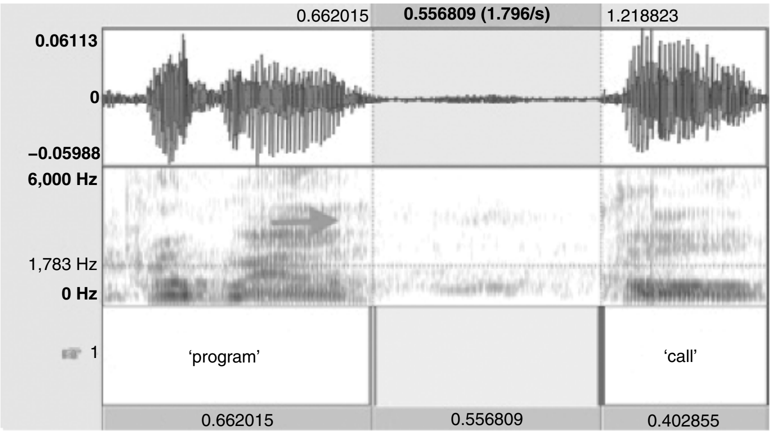

Figure 17.2 Spectrogram of *programme (ʔ0.5ʔ) ca:ll*

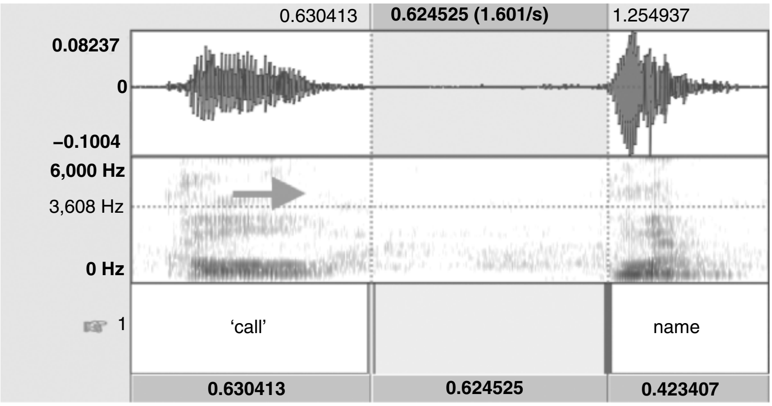

Figure 17.3 Spectrogram of *ca:ll (ʔ0.7ʔ) [name of programme]*

This signals that what follows *a programme* may be linked to the previous discourse, the demonstrative is not clearly indexed, an ambiguity that may be common in oral discourse generally and not unique here (Fromkin, 1975). Indeed, Kevin goes on to identify the programme by name (end of line 8). The unreleased /m/ of 'programme' remains unreleased across the following ~0.56-second silence.[4]

While the first holding silence (line 8) follows a syntactic completion point, the second does not. The second is produced following the verb *call*, which here requires a noun argument. The utterance at this point is unlikely to be heard as syntactically complete. Nevertheless, the 0.62-second silence following 'call' (Figure 17.3) has a similar phonetic character to the previous silence. The final sound of *call* (onset marked by the arrow) is 'swallowed' so that the silence onset[4] (marked by the first vertical dotted line) is heard to begin quickly, allowing the turn in mid-production to be momentarily suspended.

Selting (2000), in discussing challenges identifying unit boundaries and determining possible completion, mentions types of German 'holding devices' occurring before pauses including *ahm*, sound stretches and level pitch, which allow speakers to build a 'larger' bit of talk that is 'split' into several hearably incomplete intonation units. She notes this composition 'may be heard as being produced hesitatingly' (p. 502). However, she also notes that packaging talk into smaller intonational units (i.e., splitting) can be used 'to display emphasis' (p. 503), allowing a speaker to build successive units, each containing a global prosodic contour. She calls these 'incohesive' units because there may be many units in succession that are realised as one continuous 'whole'. Such emphatic cases, in contrast to hesitant ones, are produced 'without signals of hesitation or self-repair' (p. 503). Hesitations or perturbations might be intra-turn gaps, 'filled silences' such as *uh, uhm*, and *er* and sound stretching (e.g., Freese & Maynard, 1998; Selting, 2000), and may be hearable as indexing possible trouble (Selting, 2000) in recall, access, or formulation. Kevin's intonationally 'split' turns are, by and large, of the emphatic type, and hesitation markers and self-repair are virtually absent before pauses across the 14 hours of data.

We examine the prosodic contours of such 'incohesive' units often followed by holding silences in Extract 2. This extract takes place 2.2 minutes after initial introductions. Before Extract 2, Kevin described his involvement in a recovery programme. Again in stepwise fashion, he moves to discuss the subject matter covered at programme meetings. In doing so, he links substance abuse to risky sexual behaviour, which he describes as leading to HIV. In the course of making these connections, he produces 14 holding silences, three at possible points of syntactic completion (marked in the transcript with #), ten at points of hearable syntactic incompletion, and one which occurs at a boundary of a non-canonical grammatical unit (following *the sex* in line 6). There is one hesitation marker (*uh:::*) in line 13 that is not bounded by a holding silence.

Extract 2 [KAGA_050309:T1]

```
 1  KEV:  [You know we would study the bible and stuff.=
 2  ET1:  [mmm
 3  KEV:  [=a:s well we had social issues you know because
 4        of (ʔ0.3ʔ) ya know dealing with dru:gs, and alcoho:l,
 5        #(ʔ0.6ʔ) ya know guys go out there, #(ʔ0.5ʔ) mess
 6        w'th women #(ʔ0.5ʔ) (the) sex (ʔ.ʔ) ordeal=
 7        =then you have the HIV (ʔ.ʔ) situat[ion.
 8  ET1:                                     [Yea.
 9  KEV:  (An') I have friends who died behind that you
10        kno[w.
11  ET1:     [Yea. °E[h-
12  KEV:              [And so on and so forth.<So (ʔ0.5ʔ) in this
13        environment here, (ʔ0.2ʔ) we have a lot of uh::: say
14        AA meetings or NA meetings or (ʔ0.3ʔ) you know (ʔ0.3ʔ)
15        meetings dealing with (ʔ0.6ʔ) social issues Because
16        they realize how dru:gs and (ʔ0.2ʔ) say sexual (ʔ0.4ʔ)
17        behaviour (ʔ0.3ʔ) go together.
```

Looking closely at lines 4–7, we consider Selting's finding that incohesive intonational units can be produced in succession to build a 'larger' continuous unit with an emphatic effect along with Local and Kelly's findings that speakers can use holding silences to project more talk and maintain the floor.

Line 4 is in mid-turn: In line 1, Kevin has produced *you know we would study the bible and stuff*. This unit comes to hearable completion (syntactically and prosodically) and Kevin latches the start of a hearably new unit that is raised a step in pitch in line 3 (*As well as we*...). At the end of line 4, Kevin's turn has reached a point of possible syntactic completion and the last syllable of *alcohol* is stretched perhaps hearable as preparing for unit completion; however, *alcohol* is produced with level pitch and is followed by a holding silence of 0.6 seconds, features which may work to project more talk.

Kevin continues, producing the discourse marker *you know*, which may invite hearer inference (Jucker & Smith, 1998). Here it frames *guys go out there* where *there* is hearably produced with an initial flap (∼'dare') and a slight pitch increase (Figure 17.4). The pitch over *there* falls slightly but remains at the height of the previous talk and is followed by a 0.5-second holding silence. This first grammatical unit is produced as a prosodically incohesive unit with a unique global contour. The fall-to-level pitch height on the final syllable followed by the holding silence may additionally project more talk.

Mess is then produced with a half step up in pitch, seemingly designed as a new prosodic unit, *with* falls slightly in pitch and the first syllable of *women*, hearably stressed, steps up. The second syllable of *women* is produced quickly with no sound lengthening and a slight drop in pitch (i.e., a single global contour) and is followed by a holding silence; (*the*) *sex* continues on the same pitch level hearably stressed but short in duration. The slight pitch rise on *sex* remains level throughout the production of the word followed again by a short holding silence. This prosodic contour is hearably incomplete or not produced

Figure 17.4 Intonational detail of Extract 2, lines 5–7

with a global contour as Selting describes. The pitch remains at the same height on the first syllable of *ordeal*, which raises slightly on the second syllable, hearable as word stress. Although a holding silence intervenes, (*the*) *sex ordeal* is produced with a single global prosodic contour as described by Selting.

Ordeal 'runs into' *then* with a very slight rise in pitch on *then*. Although latched to *ordeal*, the step up in pitch renders this hearable as a new unit. The pitch height is carried over the next four syllables. The final syllable – 'vee' – rises in pitch with a slight fall across the dipthong. The prosodic contour of *then you have the HIV* is produced with a single global contour and followed by a holding silence. The final intonation unit comprised of one word – *situation* – starts at a raised pitch level relative to the final syllable of the previous unit with word stress on the penultimate syllable to come to a fall and hearable completion on the last syllable.

Impressionistically, these five successive incohesive units bounded by holding silences result in compressed intonation units. By compressed, we mean to convey that the intonation units sound 'short' (sometimes comprised of only two syllables). They maintain a global prosodic contour, are frequently syntactically incomplete, and are followed by holding silences, and so appear to be in mid-production. Additionally, although each prosodic unit often falls in pitch, they rarely come to a full fall within Kevin's typical pitch range. The result is that most of these units are not hearably complete and rarely does an interlocutor attempt to initiate a turn during a holding silence.

Contrastively, in lines 9–10, Kevin produces *you know* turn-finally with a hearable fall in pitch and without a holding silence, possibly rendering it vulnerable to speaker transition. Just prior Kevin discusses social problems of the community including HIV. His production of *And I have friends who've died behind that* may be heard as a summary statement of these problems conveying their personal relevance and thus as inviting a response from his interlocutor, a move that may be enhanced by the addition of turn-final *you know* possibly inviting hearer inference. Indeed, ET1 comes in in terminal overlap in line 11. In this case, the turn is at risk of being lost, and Kevin employs other means to maintain the floor.

In sum, the regular use of these prosodic contours and holding silences may momentarily stall a turn in ways that allow a speaker to produce incohesive units, maintain fluency and the conversational floor. These features resulted in an interactional engagement that was experienced by ethnographers as dominating, and they perceived their contributions to not matter. At the same time, these practices demonstrate a level of skill and dexterity in exploiting or 'playing with' (Lerner, 1996) prosodic design features to accomplish turn holding and maintain a high level of involvement. Additionally, the emphatic effect of these unit compositions, noted by Selting, may also reflect a level of skilfulness, and ethnographers positively characterised Kevin's willingness to share.

Laura: Responses to first assessment topic proffers

Whereas the recurring use of holding silences at the boundaries of incohesive intonation units contributes to Kevin's ability to hold the floor, the practice examined in interactions with Laura – responses to first assessment topic proffers – seems to work towards sequence closure and relinquishing the floor.

Although assessments serve several functions, they are one practice for sharing a common orientation towards an object or experience (Goodwin & Goodwin, 1987). Assessments have been described as 'social activities', 'produced as products of participation' (Pomerantz, 1984, p. 57). Much work has focused on assessments of past events and how they achieve sequence closings, but the examples below show first assessments that open a sequence and function as topic proffers.

In Extract 3, Laura and an ethnographer (ET2) are meeting for the first time. They spoke on the phone to arrange the meeting time and this is their first contact face-to-face. Just after Laura comes to the door, ET2 greets her with 'Hi::.' (line 1). Laura bypasses the greeting to produce what might be hearable as a possible complaint about the ethnographer's 9 a.m. arrival. In line 3, ET2 provides an account, noting that they agreed on 9 a.m. At the end of line 5, they head inside with Laura leading the way. As they are walking, ET2 produces a first assessment of the neighbourhood, describing it as 'nice' (line 9). As this first assessment locates an object, it proffers a topic by creating an interactional space for Laura to align or not with the initial assessment. Laura acknowledges the assessment with an agreement token (line 10) but refrains from providing an assessment of her own.

Extract (3): [LAHE_011409:T1]

```
 1  ET2:  Hi::.=
 2  LAR:  =You came pretty early (though).
 3  ET2:  Yea we said ni:(h)n(h)e he[h heh heh heh
 4  LAR:                              [Its nine o'clock already.
 5  ET2:  It is nine.=Already.
 6  ET2:  How are ya doin' toda[y.
 7  LAH:                       [Lemme get a chair for you.
 8        (7.0)
 9  ET2:  This is a nice neighborhoo:d.
10  LAR:  Yea.
11        (2.0) ((gets chair))
12  ET2:  I can carry it if ya (0.4)
13        ((walking up stairs))
```

Simple agreement responses to topic proffers may be heard by the profferer as an attempt to close possible discussion on that topic. In Tannen's (1984/2005) discussion of high-involvement devices that may facilitate bonding, she presented an instance where one dinner guest 'introduce[es] a new topic unexpectedly' asking another *Do you read?* She remarks that the recipient 'not only answers the question but supplies information about the book he is currently reading', thus 'provid[ing] matter for further talk' (p. 106). She notes how this kind of response contrasts with a response from a speaker with a less involved style who responded to a similar question with an agreement token (*yeah*) only (p. 106). Her discussion suggests that responding to such a yes–no interrogative with an agreement token only may work to close the sequence by not contributing to the 'overarching' activity (Mikesell, 2014) of getting to know one's interlocutor.

Although yes–no interrogatives produce different interactional demands on the recipient than first assessments, there may be a parallel force of simple agreement token responses, especially in contexts where small talk is initiated by the first speaker. Indeed, these first assessments were commonly produced by ethnographers just after initial greetings upon entering a residence and seemed to be a practice for initiating small talk with an unfamiliar interlocutor (Mikesell & Smith, 2014). We see the same practice employed by a different ethnographer (ET1) in Extract 4. Here, as Laura and ET1 enter her building after meeting for the first time, he positively assesses the building as 'neat' (line 1) to which Laura agrees (line 2) with no elaboration.

Extract (4): [LAHE_010609:T1]

```
 1  ET1:  This is a neat (.) building.
 2  LAR:  Yea.
 3        (16.0) ((walking to room))
 4  ET1:  So this is your place, huh?
 5  LAR:  Yea.
 6  ET1:  It's a cute little room.
 7        (15.6)((getting items from fridge))
 8  ET1:  What are you gettin'?
 9  LAR:  Some grease.
10        (0.3)
```

Similar to Extract 3, the first assessment (line 1) proffers a topic and Laura acknowledges the assessment with an agreement token only (line 2), thereby bringing the sequence to a possible close. Once Laura and ET1 make their way to Laura's room, ET1 produces a question (line 4), composed as a question for confirmation, that seems to ask the obvious but actionally may be probing for some elaborated stance. Laura's responsive agreement token (line 5) aligns with the question by confirming only. The ethnographer then follows up by producing another positive first assessment (perhaps hearable as a compliment), remarking that the room is 'a cute little room'. Laura produces no response and begins to retrieve items from the refrigerator.

A few moments later, Laura and ET1 are on their way downstairs to the kitchen, and ET1 provides another positive first assessment, this time of the artwork in the building (Extract 5, line 3). After a fairly lengthy silence following his first assessment, he follows up with an enquiry about the artwork (line 5), perhaps treating the lack of uptake as an accountable matter by more directly proffering the artwork as a topic to discuss.

Extract 5: [LAHE_010609:T1]

```
 1  LAR:  Alright.((shift implicative))
 2        (15.5)  ((walking to kitchen))
 3  ET1:  I like the artwork down here.
 4        (5.2)  ((passerby on stairs says 'excuse me'))
 5  ET1:  Who did all this artwork, do you know?
 6  LAR:  huh
 7  ET1:  Who did this artwork. Around [here.
 8  LAR:                               [hh ah I don' (even)
 9        know. (  )
10  ET1:  uh- no- not not somebody that lives here is it?
11        (1.3)
12  LAR:  No.
13        (12.3) ((walks into kitchen))
```

These sequences initiated by first assessments seem to be a practice for arranging an interactional space in which to proffer topics, engage in small talk, and possibly establish shared orientations, while the simple agreement tokens and non-responses work towards sequence closure.

While in these contexts ethnographers seemed to interpret Laura's minimal uptake as disinterest, in contexts where specific tasks were accomplished, Laura's engagement was noted to be exceptionally efficient (Mikesell, 2013). For instance, at a grocery store she solicited help from different staff to find three items. Her practices for soliciting help might be characterised as 'direct' or 'streamlined', perhaps demonstrating a singular orientation to the instrumental nature of the task. Upon entering the store, she immediately approached a checkout clerk to ask what aisle the macaroni was in. Once she retrieved it, she approached a second store employee to ask where the relish was (Extract 6).

Extract 6 [LAHE_011409:T1]

```
LAH:  ((walks down aisle; facing staff))
LAH:  Hi what aisle your relish (down).
      (0.5)
EMP:  Uh (0.3) it's thirteen. ((points
      in the direction of aisle))
```

We present this example to show that while Laura's 'streamlined' practices of engagement may be perceived as problematic (as dismissive or disengaged) in social contexts where interlocutors might expect relatively balanced levels of participation (as in contexts of getting to know someone), such practices also reveal a skilfulness in accomplishing everyday tasks efficiently and realising instrumental objectives.

Discussion

Heterogeneity and the 'duality' of a discourse practice

We described recurring practices observed in interactions with Kevin and Laura that reflected distinctly different engagement 'styles'. Kevin, characterised as high-activity, engaged, talkative, and dominating, employed prosodic features that successfully enabled consistent holding of the conversational floor in the context of meeting the ethnographers. Contrastively, Laura was characterised as low-activity, disengaged, and efficient. In the same context, she often responded with simple agreement tokens to first assessment topic proffers, a move bringing interactional sequences to possible close.

These practices seemed to contribute to how Kevin and Laura's discourse was characterised at a molar level, characterisations that pointed to potential problems as perceived by clinicians and ethnographers but also to levels of skilfulness. Ethnographers described Kevin as both insensitive to their contributions and engaged, and Laura as non-responsive/disinterested and efficient. Kevin's turn-design features revealed a level of mastery in his ability to manipulate prosodic resources to maintain the floor, while Laura's 'streamlined' practices demonstrated an efficiency in accomplishing well-defined tasks in the community.

Limitations

Notably, the interactions examined are peculiar and may have contributed to the heterogeneity described. Kevin's engagement may have demonstrated an orientation to the recognised norms of institutional expectations to disclose, while Laura's engagement may have resisted those institutional norms, treating ethnographers as institutional agents in whom she had little interest personally or professionally. While the unique context may certainly have surfaced these differing orientations, Kevin's prosodic features of turn design were consistent across the 24 interactions observed with 20 different interlocutors, and as noted, although Kevin was noticeably social, these interactions tended to be brief where interlocutors' contributions might be expected to be minimal: a return greeting, a fulfilment of a service request. For this reason and because there was a parallel context that could be examined with Laura, we highlighted practices observable upon meeting ethnographers for the first time. As well, it should be noted that Laura did not always show disinterest in the ethnographers. For instance, she asked one ethnographer if she wanted to get married. These personal questions, however, were infrequent and highly marked by ethnographers in their research discussions. In terms of responsiveness, Laura sometimes gave very detailed responses, but they often targeted information that could be verifiably true or false rather than personal opinion (Mikesell, 2013).

A salient limitation is that participants were not systematically asked to share their own perceptions of their interactions. So while this chapter portrays the heterogeneity that might exist across IwS, it does so by utilising characterisations of 'outsiders' – clinical and ethnographic descriptions. A more nuanced characterisation would likely emerge with the inclusion of the participants' perspectives that these data do not capture. Nevertheless, a discussion of the 'duality' of a single practice – how a discourse feature may reveal interactional management practices that are both problematic and skilful – provides a lens with which to consider clinical implications, highlighted in the next section.

Clinical relevance: Everyday functioning in practice and research

Since one might expect individuals across demographics to exhibit variation in engagement styles, the heterogeneity we highlight may not be qualitatively different than variation among the larger population. A question, however, emerges about whether there is a quantitative difference: whether IwS are more consistent in the practices employed across contexts where one might be expected to adapt practices to new settings and interlocutors. While we cannot address this here, the possibility points to how a practice may be both problematic and skilful: in some interactional contexts (greeting strangers) a practice may appear skilful but in others (small talk) perhaps less so.

While we often perceive a practice to be neatly situated along a deficit-competence dichotomy – to be competent *or* impaired – this fails to capture the flexibility or 'semi-permeable character' (Lerner, 1996) of language in interaction. A discourse practice does not itself demonstrate 'goodness' or 'badness', what matters is the speaker's linguistic dexterity; how the practice gets deployed; and in what contexts. Clinically, in social skills trainings, for instance, it may be beneficial to adopt an approach that embraces linguistic dexterity; hence, training leaders may work with individuals to identify 'impaired' practices but also to identify why such practices are perceived as impaired in a particular context. This approach demands a shift in how perceived impairments are addressed – by considering the *actions* they afford (or not) in real-world contexts. Features reflecting *poverty of speech* may be perceived as problematic in small talk because they do not permit the actions small-talk interactions typically aim to accomplish, such as showing affiliation. In contrast, these features in customer service transactions support actions such encounters intend to accomplish, often truncating niceties to complete institutional tasks quickly.

While clinical research often uses simplistic categories to describe speech patterns, CA provides a rigorous method to analyse the phenomenology of 'schizophrenic speech', contributing to the increasingly common belief that phenomenological differences in symptomology may be relevant to understanding the underlying nature of schizophrenia as an illness. Interdisciplinary collaboration between clinical researchers and conversation analysts is thus especially valuable for uncovering the impact of communication practices on everyday functioning. One might, for instance, consider how these interactional practices are relevant to considering a grounded symptomology. First, language features of 'schizophrenic speech' that have been characterised uniformly may not present uniformly, reflecting some recent claims that schizophrenia may be more aptly characterised as 'schizophrenias' (Arnedo et al., 2015). This work highlights variation relevant to everyday functioning that has been mostly unexplored. Prosody, for instance, has been frequently characterised as blunted, which is perceived to impede social functioning. In Laura's case, blunted prosody alone did not predict the quality of her social interactions. Additionally, the prosodic features of Kevin's discourse equally impacted social interactions, although these prosodic features have received considerably less attention in research.

Other clinical features, like *poverty of speech*, may be poorly contextualised. With regard to such 'low-activity' features, some have been described at such a molar level that application may not always be apparent. Poverty of speech, for instance, essentially means minimal contributions in the context of a clinical interview. However, across Laura's interactions, she 'talked less' in social contexts, not instrumental or task-focused ones. Grounding these clinical characterisations in real-world interactions allows us to better understand when individuals are talking less and why, an exploration that may contribute to closing the gap between formal assessments of functioning and real-world

Table 17.2 Clinical practice highlights

1.	Understanding communication practices are context sensitive and embedded in interactional contexts
2.	Recognising that the same language feature can demonstrate deficit and skill and may contribute to 'symptom' variation across individuals
3.	Identifying 'grounded' or contextualised behavioural symptoms highlighting language use and communication practices
4.	Identifying skilfulness of a practice to extend to or adapt for other contexts

functioning. For a simple summary of the practical implications, please see Table 17.2.

Summary

This chapter has brought together neurocognitive, clinical, and ethnographic data to explore the heterogeneity of 'schizophrenic speech', which has historically been treated homogeneously. This is despite the importance of 'good' communication with patients diagnosed with schizophrenia (Thompson & McCabe, Chapter 20, this volume). Recent studies, however, providing 'molar' characterisations of pragmatic engagement, highlight variation across speakers, which may reflect the growing recognition that schizophrenia is not a singular disorder. To complement these molar characterisations, we also used conversation analysis to highlight two situated recurring communication practices of two individuals diagnosed with schizophrenia: the first was a prosodic feature of turn design and the second a response to first assessment topic proffers. We discussed how these practices contribute to the clinical and ethnographic molar characterisations, how each practice may be framed as both problematic and skilful, and what this 'duality' suggests for situating communication practices within deficit or competency models.

Notes

1. Although the authors present detailed transcripts of the interaction where turn-taking practices might surface, the findings focus on topic control as represented in the concept maps.
2. The 24 BPRS symptoms include somatic concern, anxiety, depression, suicidality, guilt, hostility, elated mood, grandiosity, suspiciousness, hallucinations, unusual thought content, bizarre behaviour, self-neglect, disorientation, conceptual disorganisation, blunted affect, emotional withdrawal, motor retardation, tension uncooperativeness, excitement, distractibility, motor hyperactivity, mannerisms/posturing.
3. Ethnographers were not clinicians known to study participants.
4. The noise visible in the spectrogram during the 0.56 second holding silence is from a television playing in the background.

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18

Mental Health Treatment Planning: A Dis/Empowering Process

Michael A. Mancini

Introduction

The model of mental health recovery has become a guiding vision for mental health services around the world (Hopper, Harrison, Janca, & Sartorius, 2007; Saxena & Setoya, 2014; Slade, Adams, & O'Hagan, 2012). Professionally derived definitions of recovery have focused more on clinical outcomes such as enhanced psychosocial functioning, reduced symptomology, decreased hospitalisation days, and increased stable housing (Moran, et al., 2014; Slade et al., 2012). Another definition of recovery is grounded in the narratives of psychiatric service users (Mead & Copeland, 2000). In this definition, recovery is defined as a personal journey of transformation from an illness-dominated identity marked by helplessness and hopelessness to a positive identity marked by meaning, self-determination, independence, and holistic well-being (Andresen, Oades, & Caputi, 2003; Anthony, 1993; Mancini, Hardiman, & Lawson, 2005).

In recent years, mental health systems around the world have moved to adopt practices that support both views of recovery. Psychiatric rehabilitation practices have emerged that assist persons with mental illness to develop the skills and resources needed to improve functioning across multiple domains that include independent living, employment, social relationships, wellness, and recreation (Corrigan, Mueser, Bond, Drake, & Solomon, 2009). Motivational interviewing has also emerged as a preferred style of therapeutic interaction in recovery-oriented organisations and systems (Miller & Rollnick, 2012). Practitioners of motivational interviewing eschew confrontational and interrogational styles of clinical interviewing in favour of a more open and evocative style that uses open-ended questions, reflections, and affirmations as a means to help people work through their ambivalence surrounding a particular behaviour in order to come to a shared conclusion about what to do (or not do) about an identified problem or concern (Miller & Rollnick, 2012).

In addition, the emergence of recovery-oriented practices have sought to reduce the traditional power differential that exists between service users and providers by encouraging these actors to be collaborative partners and engage in a process of shared decision-making (Davidson, Rowe, Tondora, O'Connell, & Staeheli-Lawless, 2009; Deegan & Drake, 2006). Two areas where this is evident are in the practices of assessment and treatment planning which has become more strength-based and person-centred (Adams & Grieder, 2005; Rapp & Goscha, 2006). Traditional forms of assessment and treatment planning have involved professionals defining the problem (diagnosing), recording the problem in the official historical record (documentation), and then identifying (prescribing) relevant goals and outcomes and the treatments needed to achieve them. Professionals often determine goals with little active input from service users. These goals often involve reducing behaviours that professionals have deemed problematic or deviant (i.e., drug use, aggression). They also involve increasing behaviours seen as desirable, such as participation in therapy and compliance with medication regimens. These common goal-setting practices are contrary to the specific components of self-determination and choice inherent in the recovery model. Treatment planning that is recovery-oriented and person-centred requires that professionals engage in a negotiation of a shared understanding of 'problems', 'goals', and 'solutions' (Adams & Grieder, 2005). Shared decision-making requires that professionals listen and respect the desires and needs of service users. It also requires that service users take a more active role in their own treatment (Deegan & Drake, 2006).

Treatment planning as a social practice exists along a continuum of practices that include outreach and engagement, psychosocial assessment, and active treatment. In an idealised form, it is a means by which service user and provider identify relevant goals and map out their plan to achieve those goals in a specific time period. Treatment planning is both a product (i.e., a written official, signed document) and a process that consists of discursive interactions influenced by power, structure, and positioning of actors (Mancini, 2011).

While treatment planning has the potential to lead to positive transformation of the individual, it is an activity that is often dominated by professional treatment or therapy discourse. These discourses can position a service user's emotions, thoughts, and behaviours as problems to be evaluated, managed, and monitored as they move from a sub-optimal state to a more optimised condition as defined by professionals (Illouz, 2008). Furthermore, treatment planning is an activity that is monitored closely by third-party payers of psychiatric services such as state or federal governments or managed care insurance companies. These entities often decide what treatment goals are 'appropriate' and eligible for funding. This monitoring has led to a medicalisation of common physical and social states such as sadness, grief, rudeness, and apathy among others (Conrad, 2005).

Treatment planning, like any social practice, can be both transformative in some ways and oppressive in others. While much has been written about practices and concepts that comprise recovery, little has been written about how the recovery process may also be socially constructed through discursive practices. The question remains, what are the discursive practices that comprise recovery-oriented treatment planning?

I use critical discourse analysis (CDA) to explore this question. CDA is grounded in the assumption that social identities and power relations between persons, groups, and systems are created, reproduced, and transformed through discursive practices (Fairclough, 1995). Fairclough (1995) refers to 'orders of discourse' as a means for examining power dynamics within social practices. The orders of discourse represent the ways people interact, represent, and position themselves through discourse. From a CDA perspective, treatment planning is a social practice where the identities of service users and providers are established, reproduced, disrupted, and possibly transformed.

Project overview

This chapter draws on data from a three-year ethnographic action research project within a community mental health centre in a mid-sized metropolitan city in the United States. One of the goals of the broader action research study was to assist social work practitioners in adopting recovery-oriented assessment and treatment planning practices in their day-to-day activities through the establishment of a community of practice called the Co-Occurring Treatment Team (COTT) (Mancini, 2011; Mancini & Miner, 2013).

The COTT consisted of community mental health practitioners who were interested in being early adopters of assessment, treatment planning, and treatment practices that were designed to be more collaborative and to practice in such way as to position clients as experts in their own recovery rather than as problems or cases to be managed. As a co-member of COTT, the author and the COTT team leader worked closely with a cross-section of service providers from each of the community support teams at the agency in weekly two-hour sessions for a three-year period. Two separate COTTs were established. The first COTT ($n = 10$) met for two years. The second COTT ($n = 14$) met for one year. Each session was recorded. Following the principles of participatory action research (PAR) (Kemmis & McTaggart, 1988; Stringer, 2007) and the Communities of Practice model (Wenger, 1998), the COTT was designed to be a safe place of problem-based learning, critical reflection, and action.

Over the course of the study the author collected data in the form of field observations, interviews, and organisational documents (e.g., meeting minutes, policy statements, forms). During weekly COTT meetings, members were placed in the role of 'co-enquirer' through reflective and educational case presentations from their caseload. Rather than focus on a service user's deficits and what they 'should' be doing, COTT members would first describe a service user's strengths and then they would describe a current challenge they have related to their practice with the client. They and the team would then brainstorm recovery-oriented solutions and next steps. As part of the discussion, members would challenge each other's use of language, intervention strategy, and how they positioned the service user in order to provide support and reinforce each other's use of recovery-oriented language and social practices.

The focus of this chapter will be on a single, one-time meeting between the COTT and Arthur (a pseudonym), a long-time service user of the agency where the study took place. Arthur's caseworker, Jessica (also a pseudonym), requests consultation from the COTT on how best to help Arthur engage in healthier and less disruptive behaviours. Jessica is a former COTT member from a previous cohort that concluded the previous year. She is familiar with the methods of COTT and the format of the meetings. She has been Arthur's caseworker for one to two years and has a strong therapeutic relationship with him. She encouraged Arthur to attend the COTT and also provided incentives in the form of lunch and release of some of his funds. Anecdotally, she has expressed frustration in regard to Arthur's behaviours and fears that he may be evicted from the programme. Given her knowledge of the COTT, she hopes that the COTT might provide a means by which Arthur can identify activities that would help him avoid eviction.

This meeting was chosen for analysis because it represents the only time an actual service user met with the COTT for consultation. COTT practices were usually practiced using vignettes, case records, or second-hand descriptions of actual service users provided by COTT members or other case workers from the agency. Arthur provided an opportunity to see the methods utilised by the COTT in action.

Collaborators

The COTT consisted of 12 community mental health caseworkers and two clinical supervisors. About half had bachelor's degrees while the other half had master's degrees in a helping profession (i.e., social work, counselling). Four members of the team were African American, while the rest were Caucasian. Four of the members were men, while the rest were women. The team leader was a white male with a master's in counselling, while the author was a white male with a master's and PhD in social work. The age of the COTT members ranged from mid-twenties to early fifties. Approximately a third were under 30. The experience of the COTT members also varied, with about half of the COTT members having approximately five years of experience in the mental health field. Some members had ten or more years of experience.

Arthur, the focus of the COTT's interview, is a single, gay, white man in his mid- to late forties. He has been receiving services from the agency for many years and is well known to many on the COTT. He lives in an apartment programme that provides independent housing and on-site support services to approximately 18 residents diagnosed with mental illnesses and addictions. Arthur is HIV positive and has been diagnosed with a serious mental illness, cerebral palsy, and an addiction to crack cocaine. He enjoys cooking, doing arts and crafts (i.e., making jewellery, pottery), and helping out at the agency (i.e., running errands, cleaning). COTT members have described him as a 'sweet guy' when he is not engaged in disruptive behaviours that they attribute to his addiction and mental illness diagnoses.

The reason for the consultation is that Arthur has been engaged in behaviours seen as dangerous and problematic by his caseworkers and the apartment programme staff. The behaviours in question include alleged sex work in exchange for drugs or money to buy drugs, frequent crack cocaine use, panhandling, drug buying in dangerous neighbourhoods, and verbal and physical altercations with other residents at the apartment complex and programme staff. Many of the altercations involve profanity and the use of racist and misogynistic language towards staff and residents. He is on the verge of being evicted due to his lack of participation in treatment, medication noncompliance, his deteriorating health, and disruptive behaviour. If released from this programme, it has been discussed that he will either be homeless or placed in a secure nursing facility. The goal of the consultation according to his primary caseworker is to find healthier ways for Arthur to spend his time (e.g., treatment participation, attending arts and crafts workshops, helping out at the club, exercising) so that he may reduce his problematic behaviours and stay in the programme. Boredom and lack of structure have been identified by his caseworker as a reason for his behaviour. Arthur himself identifies grief and depression due to loss of family members and loved ones as a reason for his drug use. He acknowledges some of his disruptive behaviours and identifies areas in which he has improved, particularly in relation to his reduced involvement in drug-using behaviours (i.e., being a 'runner' or someone who takes money and gets drugs for others) within the apartment complex and a reduction in verbal outbursts towards staff. He identifies cooking, helping out with odd jobs at the agency, and doing arts and craft projects such as making jewellery as preferred activities.

Arthur's caseworker Jessica explains to the COTT that she and Arthur agreed to come at her request to brainstorm ideas to lead a healthier life. However, it is not entirely clear that Arthur has freely chosen to come before the COTT. Arthur's caseworker, who has power over his money and living arrangement, directed him to attend and allowed him to have $15 of his own disability stipend to meet with the COTT. This was revealed during a meeting between the caseworker and the COTT prior to Arthur's entrance. He may also be simply appeasing his caseworker, whom he obviously respects and admires, or he may recognise that this is something that he must do in order to satisfy the 'powers that be' at the apartment complex. In any case, the inherent hierarchical nature of a client meeting with a large group of professional caseworkers should be noted.

CDA methodology

CDA is used to explore the discursive practices that occur within a single treatment-planning meeting between the COTT and Arthur. Critical social theory provides the theoretical foundation for CDA. Critical social theory focuses on how oppression and domination is constructed, reproduced, and transformed through social practices and structures (Agger, 2006; Horkheimer, 1972). This set of theories focuses on the empowerment of oppressed individuals and groups through critical reflection and action (Agger, 2006). Through this foundation, CDA researchers critically analyse power relations and explicitly resist the domination of oppressed groups by seeking to transform relationships and practices that contribute to their domination (Blommaert, 2005; Rogers, 2011; van Dijk, 1993).

A central component of CDA is how discourses create, reproduce, and disrupt power relations and social identities between individuals and social systems (Fairclough, 1995). It is proposed that social practices such as treatment planning are made up of discourses that are dialectically linked to broader ideologies and social structures (Fairclough, 2003). Discourses can influence, and are influenced by, the beliefs, actions, and values of the social actors involved in a particular social practice (i.e., service users and providers). The impact of these discourses may also be veiled (Fairclough, 1995).

Norman Fairclough (1995) proposes using the 'orders of discourse' to deconstruct these veiled power dynamics. The orders of discourse include (1) ways of interacting or genres; (2) ways of being or styles; and (3) ways of representing or discourses. Ways of interacting, or genres, are the texts and discourses that give structure to social practices (e.g., diagnostic meeting, treatment planning interview, and case consultation). Ways of being, or styles, refers to the positions, roles, and identities people take on during participation in a social practice (e.g., service user, client, professional, provider, team leader, and patient). Ways of representing, or discourses, are the underlying socio-political ideologies that give rise to identities and positionalities within a particular social practice (e.g., psychiatry, recovery, academia, medicine, social work, patienthood, and resistance). Analysis of the relationship within and between the orders of discourse can unlock a deeper understanding of the relationships between discourses and social practices (Fairclough, 1995).

Interpretations

The meeting that is the subject of this chapter consisted of a 45-minute exchange between Arthur, the COTT, and Jessica, his caseworker. This meeting aimed to put into practice the tenets of a recovery model of treatment planning. Using a CDA framework, I analysed the genre (e.g., turn taking, repetition, cohesive devices, and argument structure), discourses (e.g., lexical choices used to express ideas, themes, and counter-narratives), and styles or stances (e.g., modality, affect, and amplification) in each section of the meeting and provided illustrative excerpts from each section. In doing so, I describe, interpret, and explain how service providers and service users negotiate and renegotiate social understanding of 'the problems' and their 'solutions'.

For instance, the COTT intended to use motivational interviewing (Miller & Rollnick, 2012), an open, evocative style of interacting that positions the service user as the guide for the meeting. During the meeting I show that this genre shifted at times to a more disempowering interrogational genre of interaction with detrimental effects to the tone of the meeting. I also show how the team reacted to the tension and how the interaction shifted back to a more motivational interviewing genre. Lastly, I show how Arthur's position (style) in the meeting fluctuated. At some points in the meeting, Arthur was positioned as a traditional, passive 'patient' or 'client', whereas at other times he was positioned as an expert and, ultimately, the decision-maker when it came to his behaviours. I later discuss implications for the institutional structures, procedures, and policies that impact how recovery-oriented practices are implemented and its effects on service users and providers.

Recovery, motivational interviewing, and Arthur

At the opening of the meeting Arthur comes in and sits at the head of the table. The tone is light and conversational. Following introductions, Arthur's case worker, Jessica, explains that she and Arthur agreed to come to the COTT on her suggestion in order to explore ways that Arthur can engage in behaviours that his caseworkers and apartment staff would see as healthier and less dangerous. Following this explanation the team proceeds to ask Arthur a series of questions that are geared to get him to talk about how he can be healthier and safer. In many ways, this portion of the meeting aligned with the genre and discourse of institutional psychiatry. For instance, the directionality of the questioning is one way as only the team is allowed to ask Arthur any questions. Arthur does not ask the team any questions, nor is he invited to. Arthur and his problematic behaviours are the sole subject of the meeting. The team does not share any personal information about themselves with Arthur. This one-way flow of information is representative of an institutional discourse of psychiatry due to the heavy emphasis on social control of deviant behaviours (i.e., outbursts, drug use, panhandling) and the need to develop healthier behaviours and activities that are more acceptable (see, e.g., O'Reilly & Lester, Introduction, this volume)

It is only when a motivational interviewing genre is intentionally practiced by the team leader that a recovery discourse begins to emerge. Motivational interviewing (Miller & Rollnick, 2012) is a non-confrontational style of clinical interaction that relies on evocative, open-ended questions, reflections, and affirmations that seek to explore areas of common ground. This choice of genre results in the emergence of a recovery discourse. I define a recovery discourse as social practices that position Arthur as a collaborative partner in the treatment planning process and focus on the factors that would contribute to his holistic well-being as a person, rather than solely symptoms or problematic behaviours. Rather than focus on what Arthur is doing 'wrong', the discourse of the question attempts to define what Arthur sees as relevant to his own happiness. At no point in the meeting when this genre is practiced is Arthur told what he 'should' do with his time. Rather, the team tries to engage in a conversation with Arthur about his interests and pleasures as well as about what aspects of his life have been difficult and what he would like to do differently. Extract 1 provides an example of this mixing of motivational interview genre and recovery discourse.

Extract 1

Team Leader: I was kind of curious...when things are going good for you what's going on in your life?
Arthur: [10 second pause] I'd probably have a boyfriend.
Team Leader: I'm sorry?
Arthur: I said I'd probably have a boyfriend that's what I said.
Team Leader: OK...so having a boyfriend...So Arthur...being in a relationship with somebody is important and so what are some other things that help you find yourself at the happiest or doing better besides...
Arthur: (interrupting)...I really can't feel no happiness. Everybody's gone. I mean my grandma's 90 years old, my grandfather died on my mom's side. My aunts, my uncles on my mom's side [died] and it's hard to get over it. I mean I tried to get over them sometimes I cry myself to sleep. But it don't do no good it just comes back. The guilt is right there. So...
Caseworker 2: So what do you do to deal with all that sadness and guilt?
Arthur: I try to talk to somebody or and it works sometimes but I can't deal with it. Something about death I cannot...it's just there and I'm afraid to let it show

In Extract 1, the team asks Arthur specifically what would make him happy (lines 1 and 2), and he responds candidly that he would like a 'boyfriend' (line 3). While his interest in a romantic relationship is recognised in lines 6 and 7, it is never brought up again and neither the COTT, nor Arthur further explores it. In fact, his first response is not even recognised (line 4) and so he repeats it again, rather forcefully with an added clarifier 'That's what I said' in line 5. While Arthur states what he thinks would relate to happiness does not directly answer the specific question asked by the team leader, it is an opportunity for exploration that is lost. So, while the use of a motivational interviewing/conversational genre opens up opportunities for exploration of something that Arthur finds important (e.g., having a boyfriend), some of those opportunities may have been shut down by the representational discourse of institutional psychiatry since they didn't align with what the COTT professionals deemed as relevant to treatment. Arthur then states in lines 10–15 the reasons he can't feel happiness is due to his despair, grief, and guilt. After being asked how he deals with this (lines 16–17), he states that he talks to someone (lines 18–20). Later in Extract 2 he states that this despair is the reason he uses drugs. In this extract, discourses of recovery and institutional psychiatry are both represented. For instance, while the questioning attempts to ascertain what Arthur sees as important in his own recovery (recovery discourse) the entire meeting is mainly dedicated to three areas: (1) to structure Arthur's day around what the team sees as healthier behaviours, such as attending arts and craft workshops, social groups, working, and exercising at the gym; (2) changing his interactional style with other residents and staff to be more compliant; and (3) engaging in less risky behaviours. The team's questions and probes are all geared towards changing Arthur's behaviours. In this way, recovery and institutional discourses exist in a hybrid fashion due to the intentional use of a motivational interviewing, a genre associated with the recovery model of mental health.

Arthur's interactional pattern throughout the meeting might be characterised as humorous and conversational. He relies on long, winding narratives about his life and his past experiences to any questions that are non-directive. In at least half a dozen sequences Arthur tells long narratives regarding a particular aspect of the question he is asked. For example, one of Arthur's behaviours that were identified as problematic is his selling of his food for money, presumably to buy crack cocaine. When asked a leading question of whether he is eating enough, Arthur states that he does and then goes into a story about how he almost set his kitchen on fire, eliciting laughter from the group.

Through his use of narratives, Arthur is able to use the soft, open, and non-confrontational motivational interviewing genre of the COTT against itself, jujitsu-style, resulting in much of the meeting being dedicated to listening to stories by Arthur. As the meeting progresses in this fashion, the frustration of COTT members, who cannot make any progress towards the goals they set for the meeting, begins to grow. Arthur, in a sense, takes over the meeting and his positioning becomes more empowered. Interestingly, as Arthur's position within the meeting becomes more empowered, the tension within the COTT also grows as evidenced by long pauses, rigid body language, shifting, downward eyes, and head shaking. Arthur's position in the meeting is one of decision-maker. The choice of genre (motivational interviewing) has not only led to the emergence of a recovery discourse as noted above but also effectively altered the position of Arthur to be more empowered. Consequently, we see that Arthur resists 'collaborating' with COTT members to develop a plan to change the lifestyle patterns that the COTT has identified as problematic, presumably because he does not see his behaviours as they do.

The re-emergence of institutional discourses and genres

Despite the intended focus on recovery, in many ways, the underlying discourse throughout the meeting was aligned with traditional psychiatry whereby mental health professionals exercise power over identified 'patients' by diagnosing problems, identifying 'appropriate' or socially acceptable and institutionally defined goals, and prescribing treatment plans in order to correct inappropriate or deviant behaviour. When a motivational interviewing genre is intentionally implemented, does the discourse become more recovery-oriented? When this genre is abandoned, there is a re-emergence of a more institutional psychiatric discourse.

For example, approximately two-thirds of the way through the interview with Arthur there is a shift in genre and a resulting tension point in the meeting. Extract 2 shows a shift from a conversational/motivational genre to an interrogatory/confrontational genre (lines 1–5). It begins with an enquiry by a caseworker into Arthur's use of money obtained from his work at a fast-food restaurant (line 3). His work, which is explained in another segment, consists of panhandling, searching for lost change at the drive through window and opening doors for people in exchange for a quarter.

Extract 2

1 **Case Worker 3**: are you still working at white castle?

2 **Arthur**: Off and On. Off and on.

3 **Case Worker 3**: What do you do with the money you earn from there?

4 **Arthur**: (5 second pause)

5 **Case Worker 3**: Come on Arthur!

6 **Arthur**: (7 second pause)

7 **Case Worker 3**: Arthur, I appreciate you coming in here and I am not trying to put you on the

8 spot you know and I'm here and I'm here to help you and we're buddies
9 **Arthur**: . . . I'll be honest.
10 **Caseworker 6:** [overlapping with case worker 1 and 3] I know.
11 **Caseworker 1 (Jessica)**: You're doing a good job Arthur (several people supportive).
12 **Caseworker 3**: No that's cool. Thank you. I didn't want to put you on the spot.
13 **Case Worker 6**: It's ok, We're being generous here. Yeah I know.
14 **Arthur**. I mean get so tired hearing about it you know but I told Jessica [Arthur's caseworker] I
15 only smoke [crack cocaine] 1 o'clock at night. And then I calm down. Stay in my room for a
16 little bit. Real quiet and nice air conditioner and sometimes I come down to eat. Fix my own food
17 and . . . and . . . I love to cook.

In Extract 2, a case worker confronts Arthur forcibly on what he does with his money (line 5), insinuating that he spends the money he earns panhandling at White Castle on crack cocaine. The tone in line 3 is interrogatory and then confrontational in line 5 to the point that it borders on aggressive and is out of step with the rest of the interview. The caseworker is clearly frustrated about the way the interview is proceeding and tries to disrupt the status quo with a shift in interactional style towards brief confrontation. It is a disempowering statement that is rife with domination and hierarchy. For example, it would never occur to anyone in the room to openly ask a COTT member what they do with their earned money.

The result is 12 seconds of silence by Arthur (lines 4 and 6). At this point, the caseworker attempts to self-correct in lines 7–8 by thanking Arthur for coming to the meeting and implying that they are 'buddies'. The caseworker also defines his relationship with Arthur as a mutual friendship (i.e., buddies), ignoring the inherent power differential between the roles of provider and user of services. They are 'buddies' because the caseworker says so. Arthur is told that he knows this relationship exists, despite never being consulted on the matter. It may also be that the caseworker was perhaps demonstrating to the rest of the COTT that the caseworker's style of questioning is appropriate since they have some kind of deeper relationship that allows such questioning.

But perhaps most profoundly, the caseworker also states that he was not intentionally trying to pressure Arthur or put him 'on the spot' despite this being the end result (lines 7, 8, and 12). The caseworker also states that 'I'm here to help you' in line 8. This seemingly innocuous statement is perhaps the central component of the discourse of institutional psychiatry/social control, both currently and historically. It is a statement that implies that mental health professionals are sanctioned to engage in hegemonic practices that are coercive, humiliating, intrusive, rude, and sometimes violent against service users because it is what is necessary to 'help' the person with a diagnosed mental illness who, presumably, doesn't know any better. In short, it is 'for their own good'. It is the essence of the good intentioned paternalism that proponents of the recovery model claim actually does more harm than good.

Arthur finally makes a defensive stand ('I get so tired of hearing it'). Several COTT members then rush to support him in lines 10–13 ('You're doing a good job Arthur'). There is a hybridity in that the two opposing genres are being expressed almost simultaneously. The result is tension within the room marked by silence from most COTT members and uncomfortable shifting and eye contact. Caseworkers strive to restore the original genre of motivational interviewing. Interestingly, after all this, Arthur seems to offer a confession about his use in lines 14–17. He provides a frank explanation as to the reason he uses crack (i.e., to relieve pressure and heartache) in a candid and open dialogue. The statements of reassuring from COTT members also contain a seed of paternalism since they offer evaluative judgement on Arthur's performance in the meeting. The COTT's performance, of course, is not open to scrutiny. The motivational interviewing genre is then restored for the remainder of the meeting.

One observation here is that the discourse of the meeting and the position of Arthur shifted as the genre of the meeting changed. When the team members used motivational interviewing, the discourse was more recovery-oriented, Arthur's position was more powerful and the ability of the COTT to influence him was diminished. As the genre shifted to a more disempowering, interrogation style of interviewing, the discourse of the institution prevailed and Arthur's position was less powerful.

The restoration of recovery-oriented discursive practices

Arthur's position within the COTT meeting is hybridised between a traditional 'client' or 'patient' and being a decision-maker. This hybridisation is not surprising given the clash between institutionalised psychiatric versus recovery discourses, as well as a motivational interviewing versus interactional patterns that are more interrogatory. However, because of the motivational nature of the interview genre and the COTT's attempted integration of the recovery model, Arthur is ultimately free to make his own decisions regarding the suggestions of the COTT and his schedule. He is free to deny the COTT any treatment goals or plans. He is free to choose whether he will engage in activities that are more healthy and 'appropriate' or continue with the status quo. In this sense, Arthur is positioned as having final decision-making power within the treatment planning meeting. For instance, when asked directly towards the end of the meeting to engage more regularly in arts and crafts, Arthur passively denies this request by stating, 'I have too much to do on Tuesdays.' When pressured again to potentially rearrange his grocery shopping day to attend arts and crafts, Arthur more forcefully states, 'I'd rather have 2 days off instead of doin'' [arts and] crafts. I do enough. (Jessica: OK). I do enough at home.' Arthur is positioned as in control of his own behaviours. The team, by design, does not confront Arthur and tell him what to do. They, as a sign of respect, try simply to problem-solve issues with him. Extract 3 occurs at the end of the interview after the team has re-established a motivational interviewing genre and Arthur regains his positioning as a decision-maker.

Extract 3

1 **Team Leader**: So Arthur, given all this, is there anything in your life
2 right now you want to be different?
3 **Arthur**: No. Everything's fine.
4 **Team Leader**: Arthur, I don't know if this question is confusing but
5 when as I asked if you want anything to be different (D: No) and you
6 said 'no everything is cool' but it sounds like some of the people in
7 your life are saying 'we're concerned about your health, your safety,'
8 and I am curious, things are cool, when you look at them you're saying
9 I'm cool but I'm wondering how you could help them help b/c it sounds
10 like they're saying 'we want Arthur to be a little more healthy, a
11 little safer,' is there anything you could partner with them on to do
12 some of that stuff.
13 **Arthur**: No.
14 **Team Leader**: No?
15 **Arthur**: No. I'll do it on my own.

Extract 3 represents the last interaction between Arthur and the team. He is asked a final time in lines 1 and 2 about what he would like in his life to be different. He responds quite convincingly that he would like nothing to be different in line 3. The team leader tries a second and third time to appeal to Arthur in lines 4 through 12, stating that perhaps Arthur did not understand the question in line 4. Because the team has determined that something is wrong, it is unthinkable that Arthur could possibly not want anything to be different. Arthur responds 'no' again in line 5. In line 6 through 12, the team leader, in a remarkably open statement reflecting the motivational interviewing genre, states plainly the team's concerns about Arthur's behaviour and, positioning Arthur again as the decision-maker, asks him to identify areas where he could collaborate with the team to help ease their concerns over his behaviour in lines 9–12. This statement positions Arthur as a partner and equal member of the team. The open question allows Arthur to refuse or choose to collaborate and also asks Arthur to choose how he would collaborate. This statement embodies the shared decision-making approach that is embedded in recovery-oriented practice. In lines 3, 5, 13, and 15 Arthur denies the team leader and states at the end that he will do 'it' on his own. 'It' is never defined.

Clinical relevance summary

Putting into practice a recovery model of treatment planning is complex. This complexity is, in part, due to the long-standing genres, discourses, and styles that permeate institutional psychiatry. This chapter has focused on what happens when a recovery-oriented group of practitioners attempt to put into practice discursive strategies designed to empower a single service user. The COTT's efforts, led by their team leader, to adopt a more open and evocative interviewing genre as their mode of interaction and to intentionally position service users as collaborative partners disrupted the traditional power relations that impact treatment planning and other mental health practices. In this instance, the more recovery-oriented positionality produced a situation where goals were not developed, leading not only to frustration by some workers but also a recognition that they perhaps need to work harder to engage Arthur in a working alliance.

It has been suggested that mental health casework is inherently hegemonic with a goal of social control of the minds and bodies of the psychiatrically disabled through surveillance and the management of increasingly medicalised physical or emotional states (Conrad, 2005; Foucault, 1977). For instance, in Arthur's case, his caloric consumption, leisure time, and social behaviour have all been transformed into treatment targets to be monitored and managed by professionals. This management will undoubtedly involve codification within the treatment plan and ongoing surveillance by the team.

The mental health literature is rife with accounts of domination of service users at the hands of institutional psychiatry. Disempowerment is woven into the fabric of the institutional discourses (Whitaker, 2010). Recent research suggests that social control is often expressed by healthcare workers and is inherent in their positions and training, which can lead to client disempowerment. This is particularly the case when clients are seen to be resisting, contesting or evading treatment (Hazelton & Rossiter, Chapter 21, this volume). Intentionally focusing on social communication between client and workers can disrupt these dynamics (Lawn, Delany, Sweet, Battersby, & Skinner, 2014).

Other research has indicated that a strong relationship between service user and provider is the basis for enhancing personal recovery (Horvath, 2005; Moran et al., 2014; Priebe & McCabe, 2008). Providers' ability to engage in recovery-oriented strategies such as enhancing hope and self-acceptance as well as an ability to be empathic and respectful has been shown to impact a person's recovery (Russinova, Rogers, Ellison, & Lyass, 2011).

Interrupting the ways service uses and providers interact and position themselves may be an opportunity to establish a more helpful and respectful working alliance.

The data from this project support three approaches that may assist in the implementation of more recovery-oriented practices. The first is the development of design teams of agency leaders and staff that wish to engage in an extended process of critical enquiry into their practices. Agencies can set up policies and procedures to assist spreading the work of these teams across the agency (Mancini & Miner, 2013). A second is for agencies to develop collaborative partnerships with engaged scholars that can assist case workers and team leaders in engaging in a process of critical and reflexive enquiry into their own practices. The author's prolonged engagement with the organisation assisted COTT members to utilise CDA in order to develop a process by which they could critically reflect upon their practices from a recovery standpoint. This form of engaged scholarship (Boyer, 1990; Van de Ven, 2007) also shaped the researcher's own knowledge and practice and enabled him to share those experiences in the classroom through guest lectures from practitioners and clients involved in the COTT. This created a relationship whereby the practices of caseworkers, researchers and pre-service social workers were all transformed through the critical enquiry process.

Lastly, and perhaps most importantly, mental health organisations can challenge disempowering discursive practices that are inherent in mental health casework by routinely integrating certified peer specialists into treatment teams with clear and enhanced roles. Certified peer specialists are persons who have a history of psychiatric disability and recovery (i.e., service users) and work to help others in their recovery process (Solomon, 2004). Peer specialists, also called 'consumer-providers', have been identified as a key need in the community mental health arena along with the provision of consumer-operated programming in North America (Drake & Latimer, 2012). They bring a unique perspective of a lived experience of mental illness and recovery. They also have experienced first-hand the disempowering and often veiled social practices of mental health professionals that can lead to despair and hopelessness that the COTT was designed to disrupt. They can unveil and transform the taken-for-granted assumptions of treatment teams that reproduce oppressive practices, thereby making them less hegemonic and more sensitive to the practices that can lead to enhanced working alliances. Service users, individually and through organised social action groups, have long disrupted the dominant psychiatric discourse. Having them integrated within treatment teams may help to dismantle the psychiatric discourses that are inherent in the discursive practices of treatment planning leading to a transformation of ideology and practice at the interaction level and beyond. For a simple summary of the practical implications, please see Table 18.1

Table 18.1 Clinical practice highlights

1. Recovery-oriented practice requires practitioners to disrupt disempowering practices that have been institutionalised.
2. Implementing more open and evocative forms of interactional genre's can lead to the disruption of disempowering discourses and practices, while repositioning service users as empowered participants in their own recoveries.
3. Establishing design teams that engage in a process of critical reflection and action can lead to more recovery-oriented practices within community mental health agencies.
4. Collaboration with engaged scholars and the integration of certified peer specialists into mental health casework teams can lead to a transformation of mental health practices at multiple levels.

Summary

The emergence of the recovery model as a guiding vision for mental health treatment systems around the world is a welcome development given the brutality faced by those diagnosed with psychiatric disabilities both historically and currently. However, acknowledgement of the importance of this vision at the policy level is not enough. A warm, respectful, egalitarian working alliance between service user and provider represents one of the main sources of recovery for people diagnosed with psychiatric disabilities (Moran et al., 2014, Russinova et al., 2011). The development of this type of relationship requires the critical analysis and disruption of the traditional power relationships between service user and provider at the interactional level. The effective implementation of recovery-oriented theories and practices in the day-to-day routines of community mental health caseworkers requires practitioners to engage in an extended process of critical enquiry into the social and discursive practices of assessment, planning and treatment.

Accomplishing this requires systems, organisations, and professional education programmes to provide the tools, resources, and encouragement necessary to assist caseworkers engaging in this process. The emergence of recovery as the guiding practice of community mental health requires the involvement of all those impacted across the practice landscape. Therefore, projects designed to transform structures and policies to be more recovery-oriented must be forged by collaborations between community mental health practitioners, administrators, academic scholars, and service users. Methodologies of critical enquiry such as CDA offer important tools that can be utilised to uncover and disrupt disempowering practices and, ultimately, provide the very strategies needed to transform them.

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19

Team Work in Action: Building Grounds for Psychiatric Medication Decisions in Assertive Community Treatment

Beth Angell and Galina B. Bolden

Introduction

Interdisciplinary teams are a common organisational form in community mental health treatment (see also Pino, Chapter 34, this volume), particularly for adults with serious and persistent mental illness. Assertive community treatment (ACT) is the most widely known team model (Simmonds, Coid, Joseph, Marriott, & Tyrer, 2001). The ACT model was originally designed to mimic the multidisciplinary functions of an inpatient unit in a community-based setting, with the aim of preventing long-term institutionalisation (Stein & Test, 1980). ACT teams offer round-the-clock comprehensive case management and psychiatric medication support and tend to be reserved for individuals with extensive histories of hospitalisation and treatment non-adherence. Other, less intensive models of case management using a multidisciplinary team approach have also been developed and are widely used in the United States and the United Kingdom.

Team-based models hold a variety of advantages over models that use individual case managers. ACT teams, for example, offer wrap-around support that is thought to provide vulnerable clients with a sense of belonging and ensures that their multiple needs are addressed (Chinman, Allende, Bailey, Maust, & Davidson, 1999; Pescosolido, Wright, & Sullivan, 1995). Because staff turnover is common, organising a client's care via a team also ensures continuity of care following staff departure. The interdisciplinary nature of teams permits each profession to contribute specialised expertise while also ensuring that generalist functions can be covered flexibly by team members. Finally, team organisation is preferred for supporting staff and avoiding professional burnout in working in unpredictable and challenging conditions (Bond, Drake, Mueser, & Latimer, 2001).

A team model may also have a number of limitations, however. Pescosolido et al. (1995) caution that while a team-based 'community of care' offers protective benefits to clients, there may exist a tipping point whereby a dense network of support may become over-controlling, contributing to feelings of coercion. Indeed, recent studies suggest that some ACT clients report that the team-based support is at times intrusive (Redko, Durbin, Wasylenki, & Krupa, 2004; Salyers & Tsemberis, 2007), and other research hints at possible processes by which such experiences occur. For example, Angell, Mahoney, and Martinez (2006), in a qualitative study of ACT practitioners, found that individual clinicians reported invoking collective team opinion to strengthen persuasive appeals to clients to promote adherence to medication.

In this chapter, we analyse this team work in action – that is, how, and to what interactional ends, the team approach to psychiatric treatment is carried out in interactions between clients with serious mental illness and their treatment providers in an ACT team. Using the methodology of Conversation Analysis (Sidnell & Stivers, 2013), we examine audio-recordings of 'medication check' appointments – consultations between psychiatrists and clients that are dedicated to evaluating the client's current psychiatric status and managing the client's medication regimen (e.g., adjusting, if necessary, medication dose and type). Because psychiatric treatment is embedded within the package of ACT services, psychiatrists and non-psychiatrist team members collaborate in the coordination of the client's treatment plan. Our analytic focus is on how team members' diagnostic assessments of the client are brought into the interaction in the course of rationalising and justifying a treatment proposal to a client.

Prior conversation analytic research on medical treatment decisions

Conversation analytic research has described how patients and medical providers negotiate treatment recommendations (Collins, Drew, Watt, & Entwistle, 2005; Mancini, Chapter 18, this volume), demonstrating that treatment decision-making is a bilateral process involving both parties (Collins et al., 2005). Even though it is medical providers who ordinarily make treatment recommendations, patients are in a position to accept (or reject) the doctor's proposals (Koenig, 2011; Stivers, 2005b, 2006) and may even pressure physicians for particular treatments (Gill, 2005; Stivers, 2007). Indeed, for secure forensic hospitals, the patients can be particularly hard-to-treat (Dobbinson, Chapter 22, this volume). If the patient does not accept a medical recommendation explicitly (e.g., if the patient remains silent following the proposal formulation or questions the proposal), medical providers pursue acceptance of their recommendation via a variety of conversational practices (Costello & Roberts, 2001; Koenig, 2011; Roberts, 1999; Stivers, 2005a, 2005b). One of such documented practice is to account – that is, to provide rationales, justifications, or explanations – for a treatment recommendation (e.g., Angell & Bolden, 2015; Chapter 19, this volume; Parry, 2009).

Diagnostic assessments and treatment proposals are closely tied activities, with a diagnostic formulation preparing grounds for a treatment recommendation (Heritage & Stivers, 1999; Robinson, 2003). When doctors provide accounts or explanations for their diagnosis and treatment recommendation, they balance their medical authority with accountability, suggesting that patients are capable of understanding medical matters (Peräkylä, 1998). Physicians' accounts may be used prospectively – to build agreement and reduce incipient patient resistance to a sensitive diagnosis (Maynard, 2004) and to pre-justify a particular treatment recommendation (Costello & Roberts, 2001; Hudak, Clark, & Raymond, 2011). They may also be offered retrospectively – to justify a proposed treatment in the face of patients' (active or passive) resistance (Costello & Roberts, 2001; Koenig, 2011; Roberts, 1999; Stivers, 2005a, 2005b). Medical providers sometimes account for their diagnostic conclusion by explicating how a diagnosis has been reached (Peräkylä, 1998). This explication of the diagnostic evidence takes place in contexts where an inferential distance between the evidence and the diagnostic conclusion is great or when the diagnosis is uncertain, unexpected, or controversial (Peräkylä, 1998). In this chapter, we explore a particular type of evidence formulating accounts – those that invite, cite, or invoke the evaluations of other treatment team members – so as to ground and bolster a potentially controversial evaluation of the client's current psychiatric status and to build consensus about a medication proposal. In this way, the chapter contributes to a small but growing literature on decision-making in psychiatry (Angell & Bolden, 2015; Bergmann, 1992; McCabe, Heath, Burns, & Priebe, 2002; McCabe et al., 2013; Quirk, Chaplin, Lelliott, & Seale, 2012) and sheds light on team-based medical care.

Project overview: ACT as a team-based treatment modality

ACT teams typically encompass 8–12 staff members and include a psychiatrist (who may be part time), psychiatric nurses, social workers, psychologists, and paraprofessionals. While all team members develop a working relationship with clients, many programmes create 'mini-teams' for clients in which a subset of professionals see the client most frequently and are assigned specific roles in the client's treatment plan (Allness & Knoedler, 2003). The treatment plan is designed for each client individually and may include medication management, supportive psychotherapy, assistance with activities of daily living, coordination of financial benefits, support to clients' families, and vocational rehabilitation.

Although psychiatrists are the professionals on the team who are authorised to prescribe psychotropic medications, medication management activities – dispensing and delivering medications, supervising clients to ensure they take the medications, and monitoring medication effects – involve a coordinated effort between professionals with differing professional expertise (Brodwin, 2010). As Lamberti (2001) described, the coordination of professional roles in medication management is vital when working with clients with serious mental illness because the non-psychiatrist team members who visit clients, take them shopping, or help them clean their apartments are in an ideal position to observe how the client's symptoms and functioning change in response to medication adjustments. Team observations of client mental status are shared in writing and orally at a daily team meeting at which the status of all clients is reviewed. From these daily updates, psychiatrists (who may see clients only every few weeks or months) receive frequent feedback about medication effects.

Medication management decisions (i.e., whether or not medication regimen should be adjusted and how) are ordinarily made by psychiatrists during 'medication check' appointments. Early in a typical 'medication check' visit, the psychiatrist asks a series of probing questions into 'how things are' – how the client is feeling, thinking, sleeping, and so on. These questions serve to evaluate (among other things) how well the medications are working, both therapeutically to control the client's psychiatric symptoms and in terms of the harmful side effects. Following this diagnostic evaluation stage, possible changes in the treatment plan – that is, whether (and how) to modify doses or types of medication the client takes – may be discussed (Bolden & Angell, 2015). A number of different trajectories are possible, depending on who (the psychiatrist or the client) initiates the discussion of a possible medication change. First, following the diagnostic questioning phase of the visit, the psychiatrist may begin to build a case for a medication change. The psychiatrist may formulate her evaluation of how well the client is doing in a way that prepares the ground for a particular recommendation and subsequently propose a medication change and solicit (more or less directly) the client's in-principle agreement to the change. The psychiatrist may then consult the client's medical records (e.g., test results, medication history) and propose a specific implementation plan (such as, the exact dosages and timeline for implementing the change). The client's acceptance of the plan is then sought and may be explicitly solicited (and re-solicited) at multiple points. Alternatively, the client may be the one who initiates the discussion of a medication change by, for example, directly requesting a change in the regimen or, less directly, by reporting a medication side-effect problem. These requests may occur at the beginning of the visit or later, during the treatment discussion. The client's request may instigate diagnostic questioning, and the psychiatrist will eventually respond by either rejecting the request or proposing some alternative plan (e.g., re-evaluating the situation at a subsequent visit or reducing the dosage rather than eliminating the drug altogether). An acceptance of the alternative plan is then sought from the client.

Thus, a 'medication check' appointment provides the psychiatrist with opportunities to conduct her own observations of and draw conclusions about the client's current status. However, the frequency with which other team members see the client leads the psychiatrist to rely, to some degree, on the 'eyes and ears' of her fellow team members. In making her medication decisions, the psychiatrist thus draws upon varied epistemic grounds (e.g., Heritage, 2013): test results, client behaviours directly observable during the appointments, and reports by the client and by other team members. In this way, medication treatment decisions are grounded in a collective judgement of team members and are seen as such by the team members and by the clients.

This orientation to the collective character of medication change decisions may be displayed during medication management appointments. For instance, in Extract 1, the psychiatrist (PSY) formulates her medication proposal as contingent on the case manager's (Mary; CM) agreement to it (lines 13–15).

Extract 1: 238P (25:30)

```
 1  PSY:  .h That sounds more like the restless .hh
 2        edginess that Prolixin #causes for people#.
 3        .h A:n' we could give y[ou more]
 4  CLT:                         [Yeah:  ] That's:
 5  PSY:  If you don't need th- p- this do:se ↓right now,
 6        (0.8)
 7  PSY:  ↑>I think it'd be worth<↓ trying a lower dose
 8        an' jus' see if over the next few sho:ts
 9        it gets better.
10        (0.2)
11  CLT:  [Let's see:,
12  PSY:  [°Y'know°
13  PSY:  .h Let me talk to Mary, see if she's still out there.
14        because I don't wanna do this
15        [without (0.2) without her (0.2) opinion.]
16  CLT:  [Ask her what she's noticing            ]in my
          behaviour.
```

In lines 1–3, the psychiatrist formulates a diagnostic assessment of the client's stated problem (tremor) and then proposes to lower the dose of the medication she is on (lines 5–9). The client begins to respond to this proposal with 'Let's see:' (line 11), which appears to project, at best, a tentative acceptance of the proposal. Before the client completes her turn, the psychiatrist states that she will solicit the case manager's opinion on the issue, asserting that she (the psychiatrist) does not want to make the decision without the case manager's agreement (lines 13–15). In an extended overlap with the psychiatrist's turn (line 15), the client endorses this course of action with 'Ask her what she's noticing in my beh<u>a</u>viour' (line 16). In articulating her support, the client also displays an orientation to the decision as grounded in the case manager's first-hand observations of the client and, thus, the decision-making process as a collective one. This extract is indicative of how both the psychiatrist and the clients in the ACT programme see prescribing decisions as products of collaboration between the team members who have differential epistemic access to the client's state.

Data and method

The data were collected in 2009–2010 in an established ACT programme in a mid-sized US city. The data corpus used for this analysis consists of 36 audio-recorded naturally occurring interactions between clients and a team psychiatrist, each between 15 and 45 minutes long. Non-psychiatrist team members were present in 11 of the 36 consultations. Treatment relationships are well established in this programme, with clients having been in the programme for 12 years, on average. Data were gathered via audio-recording, for each client participant, one medication management appointment with the team psychiatrist who provided primary psychiatric services to all clients in the programme. Informed consent was obtained from both client and provider participants, which included permission for the relevant provider to tape the session as it occurred.

The audio-recorded consultations were transcribed (Hepburn & Bolden, 2013) and analysed using the methodology of Conversation Analysis (Sidnell & Stivers, 2013). All names and other identifiers on the transcripts are pseudonyms. In accordance with conversation analytic methods, we identified and analysed sequences of interactions in which non-psychiatrist team members were consulted or their opinions invoked as part of a medication decision discussion. Two activities that comprise the treatment discussion were included: the formulation of a diagnostic assessment of the client's current status and the treatment proposal sequence. The data excerpts included in the article are representative of the corpus and were selected for their clarity; multiple instances of all analytic categories were found in the data.

Analysis

In our analysis we examine a range of practices through which the psychiatrist builds grounds for a particular medication decision by presenting the decision as a result of collaboration between team members. First, we show how team members who are present during the consultation are used as a resource for evaluating the current status of the client so as to bolster a medication proposal. Second, we show how team members' assessments, obtained outside the consultation, are cited to ground arguments in support of a diagnostic assessment. Finally, we show how collective person reference forms (invocation of 'we' to denote either the team or the institution of psychiatry) are used to lend collective authority to an evaluation of a client status and for grounding a medication change decision. All of these practices rely on and invoke a distribution of knowledge about the client among members of a treatment team, with the psychiatrist bringing in other team members' first-hand observations of the client in the service of presenting the team's 'united front'.

Co-opting present team members into diagnostic evaluation

When other team members (typically, the case manager) are present during the psychiatric appointment with a client, the psychiatrist may solicit the team member's independent diagnostic assessment of the client so as to justify or build a persuasive case for a treatment recommendation, especially when the recommendation is seen as controversial or in contexts of client resistance.

In the consultation from which Extract 2 is taken, the psychiatrist has been probing into the client's persistent problems with focusing – a topic that was raised earlier in this consultation as an ongoing concern. The client, on the other hand, has been describing his efforts to apply for a job in the navy he found advertised online. As the discussion of the job unfolds, the psychiatrist attempts to assess the client's current mental status so as to evaluate the necessity of changing his medication regimen. The case manager (Mary; CM on the transcript) has been present throughout this consultation but for the most part remains silent.

In lines 1–2, the psychiatrist returns to the issue of focus she brought up earlier (data not shown). As she re-raises the topic, the psychiatrist first formulates it as something she is concerned about ('what I-'; line 1) but then replaces the personal reference 'I' with the collective one 'we' ('what I- what we were thinki:ng'; lines 1–2), thereby presenting herself as speaking on behalf of the treatment team (see below) (Lerner & Kitzinger, 2007). The psychiatrist then goes on to invite the case manager to contribute her assessment of the client (lines 3–5), especially with regard to his ability to focus. In designing her enquiry, the psychiatrist explicates the experiential grounds on which the case manager's assessment should be based: 'seeing Ja:mes' (line 4) and 'what you see from: interactions with him' (line 5). In this way, the psychiatrist invokes the differences in epistemic access between herself and the case manager. In making the basis of the invited assessment explicit to the case manager and to the (overhearing) client, the psychiatrist raises the authoritativeness of the forthcoming assessment as grounded in the case manager's first-hand and sustained observations and reached independently prior to this appointment.

Extract 2: 212P (19:00)

```
 1  PSY:  .hh So:: (0.2) what I- what we were
 2        thinki:ng in terms of the focus issue, ya know,
 3        like- I think Ma:ry, y'- wha'ch your sense in-
 4        seeing Ja:mes about- (.) about his fo:cus, an:' (.) .h
 5        y'know kinda what you see from: interactions with him.
 6        (0.2)
 7  PSY:  an' st[uff.
 8  CM:         [Just on his focus?
 9  PSY:  Y^eah. Or any other things. too that [you know.
10  CM:                                        [W'll I think well
11        just from what he's repo:rted, .hh I know sometimes
12        it's ha:rd- .h w'll I- I told James that (.)
13        sometimes when I ca- I'm more concerned about him,
14        (.) I was just saying before that .hh it's usually when
15        he becomes too focused on so[mething,
16  PSY:                              [okay
17  CM:   .h more than:=
18  CLT:  =m'yeah. An' I think- I-I-I think that-
19        that [this navy jo:b,]
20  PSY:       [(Okay kinda   )] obsessive [focus.
21  CLT:                                   [Yeah,<this na[vy job
```

```
22  CM:                                                   [Right.
23  CLT:  might yeah- i- if- if- if I wasn’t moving
24        in the directions towards .hh spending the majority of
25        my day on the Wall Street Journa:ls,
26        an’ j[ust catching up on ne:ws,
27  PSY:        [mm hm,
28  CLT:  .h I think yah that might be a little bit of a problem.
29        =being a little too focus[ed on that.
30  PSY:                           [Yeah.
31  CLT:  .h [(but- I ba- I been) focused enough over the la:st-
32  PSY:     [(that you have.)
33  CLT:  two or three weeks .h to feel comfortable with
34        what I’ve presented (0.5) for that.
35  PSY:  Yeah.
36  CLT:  =and to just wait it out.
37  PS?   [(ah)
38  CM:   [So that’s kinda what more of my con- was my concern
39        or what I was seeing. is him becoming more foc-
40        <coz I know you before it was like on #the:# feeds an’
41        stuff, that he [wa[s like really (correlated)
42  PSY:                 [Ri[ght. The feeds. Yeah. Really=
43  CLT:                    [Yeah, uh huh,
44  PSY:  =focused [on that.
45  CM:            [isolated more.=kinda in [his pla:ce,=
46  CLT:                                    [yeah, mm hm,
47  CM:   =an’ not around a lot of peo:ple:, .hh[h ehm
48  PSY:                                        [Right,
49  CM:   an’ then that kind of ca:lmed down a little bit,
50  CLT:  Mm h[m
51  PSY:      [Right.
52  CM:       [So now it’s the navy jo:b, an’ a lot of: (.)
53        that stuff no[w an’ I’m just kind of=
54  PSY:               [°Mm hm°
55  CM:   =see:[ing (   )
56  CLT:       [(I don’t feel like [it) I mean
57  PSY:                           [Yeah
58  CLT:  it’s I- I didn’t expect to find a jo:b th[at would
59  PSY:                                           [°Yeah°
60  CLT:  .hh so closely ma:tch (0.5) what I wonned do.
```

After clarifying the psychiatrist's question (lines 8–9), the case manager responds by, first, formulating the grounds for her assessment and then suggesting that the client is now 'too focused' (line 15). This assessment does not fully align with the one the psychiatrist has been pursuing (the client *not* being able to focus), and the case manager does quite a bit of interactional work to frame the epistemic grounds on which it has been produced. She first downgrades its status as based on the client's reports ('just from what he's repo:rted'; line 11) and then cites her own words to the client on a prior occasion ('I told James'; line 12). This implies that she has held this opinion for some time, thereby upgrading the certainty of the assessment. Following a confirmation from the client ('m'yeah.'; line 18), the psychiatrist reformulates the case manager's concern as 'obsessive focus' (line 20) – a diagnostic formulation that is potentially medically actionable and could be used as grounds for a medication change. The client appears to first agree with this characterisation of his focusing ('Yeah'; line 21), but then downgrades his agreement to this characterisation: 'that might be a little bit of a problem. being a little too focused on that' (lines 28–29). He then continues to justify his focusing on the job by the demands of the application process (lines 31–36). In this way, the client resists seeing 'focus' as a psychiatric (and medically actionable) problem. In line 38, the case manager resumes her account of the client's focusing issue, thereby resuming the psychiatric agenda of the visit. Here, she again formulates the epistemic grounds for her 'concern' ('what I was seeing'; line 39) and then recites the client's recent experiences in support of her assessment (throughout lines 40–55). So this extract shows that a co-present team member may be asked to provide her assessment of the client's current psychiatric status on the basis of her independent and continual access to the client's life.

Later in the same visit (Extract 3), the psychiatrist formulates her diagnostic assessment of the client's current status, attributing the client's problems with job applications to his psychiatric condition ('due to the illness'; line 4). In lines 7–8, the psychiatrist suggests that his medication regimen is 'not quite (.) ri:ght' (line 8), which implies that a medication change is needed. When the client fails to respond (see the gap in line 9), the psychiatrist accounts for her evaluation of the client's status by contrasting the client's potential with how his 'mind' is 'every once in a whi:le' (lines 10–13). The client responds in ways that suggest his agreement with the psychiatrist's assessment ('yeah' in lines 14 and 17). However, as the psychiatrist extends her diagnostic formulation to articulate the epistemic grounds on which it is based ('what I'm hearing.' and 'from: the description that you told me.'; lines 18 and 20), the client downgrades his agreement to a much more resistant 'M^aybe' (line 21). Immediately upon the completion of the client's response (in line 21), the psychiatrist turns to the case manager to confirm the evaluation of the client (lines 22 and 24).

Extract 3: 212P (25:30)

```
 1  PSY:  An- in a- they're ga:ps (0.2) that I wouldn't expect
 2        for a gu:y as smart as you:, an' with your (.) educational
 3        level.=An' what that tells me i:s .hh I think
 4        they're due to the illness.
 5        (.)
 6  CLT:  Mm [hm,
 7  PSY:     [I think they're du:e to the meds being almo:st
 8        adjusted right but- (.) but not quite (.) ri:ght¿
 9        (0.5)
10  PSY:  A:nd (.) so there's this Ja::mes (0.2) with all your skills,
11        an' talents, and stuff working an' doing (.) really cool
12        stuff,=an' then every once in a whi:le your mi:nd
13        kinda isn't where
14  CLT:  Ye[ah
15  PSY:    [it would be normally, .h to do it (.)
16        in a fu:ll way.
17  CLT:  Ye[ah
18  PSY:    [It's what I'm hearing.=
19  CLT:  =Mm hm¿
20  PSY:  from: the description that you t[old me.
21  C:                                    [M^aybe,
22  PSY:  <I-Would you say that ↑that would [be kind of accurate
23  CM:                                     [°Mm mm°
24        Mary?(a[n-)
25  CM:          [Mm hm:,=
26  PSY:  =.hh So (0.2) so what I would- propo:se (.) because you've
27        been on: (.) this amount of med for awhile.
28        We w'd- an' we >↑checked↓ your blood level.(d-)<
```

Unlike Extract 2, in which the case manager is invited to provide a broad perspective on the client's behaviour ('what's your sense'), here the psychiatrist's question is a yes/no interrogative that narrowly delimits a range of relevant responses. The question is designed to receive a confirmation of the psychiatrist's assessment of the client (Schegloff, 2007) and thus help her build a case for a medication change. The case manager does confirm early and minimally (lines 23 and 25), and the psychiatrist moves on to formulate her medical recommendation (line 26). In this way, the case manager's presence is used as an interactional resource to neutralise the client's resistance. Here, both the timing of the psychiatrist's question to the case manager and its design contribute to building a 'united front' of medical professionals vis-à-vis the client.

Thus, the extracts discussed in this section show a psychiatrist seeking input from another team member present during the visit (the case manager). By soliciting the case manager's independent assessment of the client, the psychiatrist relies on the case manager's first-hand access of the client's daily activities so as to build a case for a particular medication decision. These solicitations may occur during the diagnostic stage of the visit, as the psychiatrist begins to build a case for a medication change (as in Extract 2), and subsequently when a medication change is proposed (as in Extract 3). Since the case manager's assessments are typically grounded in direct and frequent observations of the client's lives (and these epistemic bases may be directly articulated, as in Extract 2), they carry an epistemic authority and are difficult for the client to refute. When the case manager sides with the psychiatrist, the 'united front' the medical professionals present may function as a tool in getting the client to assent to their professional evaluation.

Citing team members' independent evaluations of the client's status

Psychiatrists may cite independent assessments of other team members when they build grounds for their treatment proposal even when other team members are not present during the medication check appointment (as is typically the case). This practice is made feasible by the fact that the team communicates about clients frequently, which is commonly known by clients.

Extract 4 (A–B) shows how the team psychiatrist uses this practice as a resource for building a case against decreasing the dosage of antipsychotic medication, Zyprexa. Early in the visit (Extract 4A), the psychiatrist asks for an update on the client's current status in light of a previous worsening ('things' being 'a little=bit o:ff'; line 1) that had prompted an increase in the dose of Zyprexa. In his response (lines 3–8), the client mentions the extra five milligrams of Zyprexa that had been prescribed, attributing this medication decision to the treatment team ('You guys' in line 6 and 'That's you guys' ca:ll' in line 11). In this way, the client clearly displays his understanding of the (previous) medication change decision as a collective one. The client then goes on to imply that, perhaps, the recent dosage increase can be reversed (lines 14–19), which leads the psychiatrist to launch a series of enquiries about the effects of the change (from lines 23 to 24).

Extract 4A: 204P (3:00)

1 PSY: You were feeling like things were a little=bit o:ff,
2 (0.2)
3 CLT: Well I- (1.0) about the only: issue I- I'm content

```
 4        with where we're a:t. now.
 5  PSY:  Mm hm,
 6  CLT:  You guys know more about thuh:: (.) the five- (b-) (.)
 7        uh::m (1.0) milligram of Zy:prexa. extra.
 8        where [the- (.) y'know:
 9  PSY:        [right
10        (0.5)/{.hhhh}
11  CLT:  That's you guys' ca:ll.
12        (.)
13  CLT:  I=I: .hh right now I'm fi:ne. (n) if it's H
14        y-y'know if it's not good for me to have off,
15        we:ll hh .h °well-° y'know that'[s
16  PSY:                                  [you mean to=
17  CLT:  =put't- put it back down to twonny.
18  PSY:  Ah hah.=
19  CLT:  ='ts at twenty-five #right [now#(°  °)
20  PSY:                             [Right. Right.
21        (.)
22  CLT:  So. .HH So that would [be:
23  PSY:                        [Didju notice any cha:nge when
24        it went up¿
```

Approximately five minutes later in the consultation (Extract 4B), the psychiatrist begins to build a case for *not* reversing the previous Zyprexa increase. In lines 1–4, the client reports an increase in sexual urges (described in line 3 as 'lookin' at women::') prior to his medication dose increase. In lines 8–9 and 11, the psychiatrist formulates an interpretation of the sexual urges as indicating an incipient increase in manic symptoms. (Sexually inappropriate behaviour is a common sign of mania, and sexual thoughts and urges may characterise the pre-manic phase that precedes such behaviour.) The psychiatrist attributes this interpretation of the symptoms to the team (as evidenced by the use of 'we' in 'we thought' in line 8; see the section below).

Extract 4B: 204P (8:50)

```
1  CLT:  Yeah, I did ha:ve (0.2) well there was uh .hh
2        y'kno:w I- (0.5) in the fall weather, an'
3        the change of seasons, I was: (.) lookin' at women::
4        an:: (.) eh- [(hard)- (.) [(hard times)
5  PSY:               [that-       [(they started)
6        Yeah.
```

```
 7  CLT:  .h An' uh y'know
 8  PSY:  Just kinda maybe (.) we thought those were
 9        a little=like (0.2) kinda hypo manick[y type
10  CLT:                                       [Yeah:
11        symptoms. peeking there [a little bit [through,
12  CLT:                          [R:ight,      [Right.
13  CLT:  [and uh:
14  PSY:  [before the Zyprexa #increase.#
15  CLT:  Yeah=
16  PSY:  =An-an-an:' [from what John said
17  CLT:              [Right
18  PSY:  he has noticed (0.5) that things have cha:nged
19        since we started [the Zyprexa (an')
20  CLT:                   [Yeah: uh::=I-
21        (.)
22  CLT:  [I- I-
23  PSY:  [thos:e things from the outsi:de .hh
24        seems to settle down. [somewhat,
25  CLT:                        [Yeah.
26  PSY:  How do you feel from the in:side(d) about it.
```

The client acknowledges and agrees with the psychiatrist's explanation of his past symptoms (lines 10 and 12). The psychiatrist then extends her turn with a time formulation ('before the Zyprexa #increase.#'; line 14) that suggests that the increase in the dosage is responsible for averting the progress of the manic episode. In line 15, the client begins to produce an apparently agreeing response. However, the psychiatrist immediately extends her turn further to add the reported 'noticing' of an absent team member, John, of 'things' changing subsequent to the increase in Zyprexa (lines 18–19). This corroborates the position that the Zyprexa increase had effectively reversed the manic episode that was in progress ('those things from the outside.hh seem to settle down', lines 21–22).

Thus, the case manager's first-hand observations of the client's behaviour (with which the client agrees; lines 20 and 25), presumably reported to the psychiatrist in an earlier conversation ('John said'; line 16), are deployed here as a resource for justifying the non-reversal of the dose increase. Since the psychiatrist has not seen the client since the dosage was increased, citing John's opinion builds a stronger case for this medication decision. This practice relies on the client's and the psychiatrist's shared understanding that case managers see clients on a frequent basis and thus have greater opportunity to observe symptom changes. Furthermore, its deployment here supports the client's own early characterisation of the decision-making as a collective one ('That's you guys' ca:ll'; line 11 in Extract 4A).

Using collective person reference forms in justifying medication decisions

Practitioners may formulate their treatment proposal as based on a collective assessment made by the entire team, thereby presenting their medical decision as in line with and supported by other members of the client's care staff. This is commonly accomplished via the use of the collective self-reference *we* in place of the individual self-reference *I* (Lerner & Kitzinger, 2007). The collective form *we* can be deployed in two – sometimes conflated – senses. First, practitioners may use the 'institutional *we*' to invoke their institutional rather than personal identity and to communicate to the client that they speak on behalf (or as representatives) of the institution (Drew & Heritage, 1992; Sacks, 1992). Second, psychiatrists may use the collective form *we* to more narrowly refer to the people involved in the client care – that is, the client's case manager, other psychiatrists, and so on. These two senses of *we* are not always clearly distinguishable. However, both the institutional and the team *we* may be deployed to attribute a (controversial or contested) medical recommendation or assessment to a collectivity rather than to the individual speaker. This may serve to diffuse the psychiatrist's individual epistemic authority and responsibility.

Extract 5 is taken from the treatment discussion phase of a consultation. The psychiatrist recommended leaving the medications at the current level. Just prior to this extract, the client asked about lowering Prolixin, an antipsychotic medication, which the psychiatrist rejected. In lines 1–2, the client brings up Ritalin, an ADHD medication. While the client does not explicitly request the psychiatrist to prescribe Ritalin, by mentioning the medication and its possible benefits (to 'think more clear – (0.2) correctly'; line 2), the client can be heard as making a request (or building a case for a subsequent request) (cf. Stivers, 2002; Toerien, Shaw, & Reuber, 2013).

Extract 5: 202P (23:35)

```
1  CLT:  [My-        [my   bro]ther said
2        Ritalin? or: something (.) for your brain,
3        for you think more clear- (0.2) correctly?
4        (0.8)
5  CLT:  What is that (.) Ritalin? or
6        (0.5)
7  PSY:  Well that's a stimulant if you have A D H D.
8        It's a (.) med for A D H D [( )
9  CLT:                             [For your brain?
```

```
10        (0.2)
11  PSY:  .h Yeah if you have that diagnosis.
12        (.)
13  PSY:  We don't think you do:.
14        (.)
15  PSY:  Y'know:, an' it's [a (.) kindof a dangerou[s medicine.
16  CLT:                    [My- brother says       [My brother
17        wants me on: °(eh this      )°
18        (1.0)
19  CLT:  I don't know why he wants me on it=he says my-
20        y'know as I'll be watching the ne:ws right¿
```

When the psychiatrist does not immediately respond to the client (see the gap in line 4), the client reformulates his turn as an enquiry about the medication (line 5). In lines 7–8, the psychiatrist explains what the medication is (e.g., 'a stimulant') and what it may be prescribed for (e.g., 'if you have A D H D.'). By naming the condition for which the medication is prescribed, the psychiatrist begins to build a case for why the medication may be inappropriate for the client. The client further pursues the line of enquiry by proffering a candidate understanding of the psychiatrist's turn ('For your brain?'; line 9), which may be understood as the client persisting in his (implied) request for the medication.

In line 11, the psychiatrist first confirms the client's candidate understanding ('Yeah') but then immediately goes on to qualify her confirmation with 'if you have that diagnosis.', again orienting to the action implications of the enquiry as a request for a prescription of Ritalin. The client does not immediately respond (the micro-pause in line 12), and the psychiatrist continues her turn by adding 'We don't think you do:.' (line 13). This formulation disqualifies the client as a possible recipient of the medication. In other words, it serves to formulate the grounds for rejecting the client's implied request. One noticeable feature of this formulation is the psychiatrist's use of 'we' (versus 'I'). 'We' can be heard as referencing the team of professionals who have been involved in treating the client over the years and/or the medical establishment as a whole (the 'institutional *we*'). In either case, by using 'we' (as opposed to 'I'), the psychiatrist upgrades the certainty of the diagnosis and diffuses her personal responsibility for it. It is not just her personal opinion that the client doesn't have ADHD; it is an opinion of the medical team or the profession. When the client does not respond (line 13), the psychiatrist further justifies her rejection by describing the medication as 'dangerous' (line 15), thereby enacting her concern for the client's well-being (Angell & Bolden, 2015).

The use of both the team *we* and the institutional *we* in the service of rejecting a medication change request by the client is evident in Extract 6. The client was recently hospitalised and his medications raised. In lines 1–3, the client complains about recent increases in his antipsychotic medication dosage, and then in lines 6–8, he requests a sharp decrease in the meds, asserting that the increases have been unfounded (e.g., in line 18). In line 9, the psychiatrist outright rejects the request with a chiding ‘Oh Ro::::n¿’, thereby treating the request as unreasonable. From line 12 on, the psychiatrist attempts to justify keeping the medications at the current level in the face of the client’s active (and sometimes hostile) resistance. Note that both the client and the psychiatrist orient to the decision to raise the meds as a collective one. In line 18, the client attributes it to a collectivity (with ‘ya’ll raised it’), and the psychiatrist also refers to it as ‘our decision’ (line 24). In lines 27–33, the psychiatrist justifies the decision by claiming that it was based on the observations of the people involved in the client care (including the ACT team, the hospital staff, etc.), referring to the people involved with the collective reference ‘we’.

Extract 6: 211P (5:30)

```
 1  CLT:  An’ then uh: all’f a sudden, (0.5)
 2        three months ago ya’ll raised my meds again.
 3        It’s bull shit.
 4        (1.0)
 5  PSY:  Hm mm::,=
 6  CLT:  =I want my meds lowered.
 7        (0.2)
 8  CLT:  Back to ten milligra:ms.
 9  PSY:  Oh Ro::[::n¿
10  CLT:         [(        )
11        Yap.
12  PSY:  Ten milligrams wasn’t really helping you much
13        at a::ll. #back th[en.#
14  CLT:                    [Yes it wa:s.
15  PSY:  (Ah) it wasn’t <my: recollection,>=
16  CLT:  =It’s my reco[llection=
17  PSY:               [so.
18  CLT:  =th’t ya’ll raised it for no rea:son.=
19  PSY:  =°Ye:ah.°
20        (.)
21  CLT:  Three times.
22  PSY:  °M’kay,°
23        (1.0)
```

```
24  PSY:  So you: thou:ght our decision to raise it
25        didn't really have any basis.
26        (.)
((14 lines omitted))
27  PSY:  We did see th:ings going o:n
28        tha:t:hh (0.8) uh we were concerned about
29        that- we thought were really hard on you:.
30        (.)
31  PSY:  y'know, (0.2) when- (.) when we raised >the meds.It<
32        wasn't just because'f the gu::y,(0.5)
33        it was because we were seeing other stuff too,
34        <like a- a lo:t a lo:t'av l- uhm kinda irritabl:e,
35        (0.8) uh:: (0.8) th' irritabl:e, >y'know< angry,
36        .hhh kinda feelings¿ coming out¿ more so
37        than you even seemed to want¿
38        (0.2)
39  PSY:  Uh::m (1.0) problem sleeping,=at ti::mes:¿
40        (0.5)
41  PSY:  uh:m (1.0) getting really wo:rried¿
42        (0.2)
43  CLT:  That don't mean-=
44  PSY:  =about stuff that=
45  CLT:  =All that stuff you j[ust sain'
46  PSY:                       [the demo:ns, an'
47        th[e (.) [ghosts,
48  CLT:    [All that st[uff you just sa:id. (.) don't mean
49        I have to stay on 'at dos:e.
50        (1.0)
51  PSY:  We:ll, (2.0) what- what we fi:nd is usually:
52        if- (0.8) if a person needs a higher dose
53        to get rid of some of ↑that stuff? (0.8)
54        ↓that (.) if we lo:wer the dose back down
55        that stuff will come back.
56  CLT:  No it [won't.
57  PSY:        [It doesn't like cu:re it.
58        (.)
59  PSY:  It only: (0.2) So that's how we find out how much
60        a person nee:ds. is gradually increasing it little
61        by little over time,
```

The client, however, persists in rejecting the psychiatrist's account as a valid reason for keeping the medications at the current dosage (lines 43, 45, 48–49). After a gap (line 50), the psychiatrist further justifies her decision by formulating a likely possible outcome of lowering the dose (lines 51–55). While this prognostic formulation is directly applicable to the client's current situation, the account is produced in generic terms (in reference to 'a person' and 'usual' course of treatment; lines 51–52) and invokes the psychiatrist's medical authority. Here she uses the 'institutional *we*' (lines 51, 54, 59) to speak on behalf and as a representative of the institution (Drew & Heritage, 1992; Sacks, 1992). So in this case, first the team and then the institutional *we* are used to attribute a contested medical decision to a collectivity rather than to the individual speaker.

Clinical relevance

Much of the existing literature on assertive community treatment describes its team structure as a critical component, but the ostensible benefits of teams are often presumed to accrue from the inclusion of multiple professional specialisations and prevention of care gaps and discontinuities (Bond et al., 2001). The analysis presented here suggests that more attention should be paid to the ways in which team coordination plays a role in the interpersonal aspects of treatment and to the identification of best practices in teamwork in adult mental health. The therapeutic relationship is widely recognised as a cornerstone of psychiatric treatment, but it is typically conceptualised as a dyadic phenomenon, while the role of team members in relating to a single client is relatively unexamined (see also Pino, Chapter 34, this volume). Deploying team member assessments in arguments for treatment decisions may render such arguments more effective and may lend clients reassurance that their treaters are unified; yet, as projected by the theoretical insights of Pescosolido et al. (1995), coordination of efforts by team members around a client may also amplify the social control functions of mental health treatment, perhaps contributing to perceptions of coercion among clients. Given the historic legacy of coercion in the field in psychiatry, as well as the broader issue of social and political disempowerment of people with mental illness (Kelly, 2006), further study of these everyday interactions and the responses of clients to them is warranted. So too, the movement towards incorporating shared decision-making and recovery-oriented practice in ACT would benefit from considering the ways in which mental health providers might be trained to more effectively use team interactions as a resource for advocating for clients in their efforts to negotiate treatment decisions with their providers. For a simple summary of the practical implications, please see Table 19.1.

Table 19.1 Clinical practice highlights

1. Multi-disciplinary teams, featured in assertive community treatment and other similar models of care, are a common yet understudied form of mental health treatment.
2. In long-term psychiatric treatment, negotiation of medication decisions is an ongoing function that is accomplished through sequences of interaction (diagnostic evaluations, proposals, acceptances, etc.).
3. When building grounds for a medication decision, psychiatrists working in assertive community treatment draw on non-psychiatric team members (both present and absent) to amplify support for their positions.
4. Team dynamics are therefore important to the work that therapeutic relationships accomplish in psychiatric treatment and warrant further examination.

Summary

Despite their ubiquity in community mental health settings, relatively little research has examined the coordinated efforts of these teams in accomplishing the work of psychiatric treatment. In this analysis, we have demonstrated how one particular type of practitioner (psychiatrist) uses team members – whether co-present in an interaction or in absentia – as a resource to formulate arguments in support of medication decisions. As we have shown, psychiatrists may call upon co-present team members to contribute observations or to confirm the psychiatrist's own impression during a medication check consultation. Even when team members are not present, moreover, the psychiatrist may contribute team member opinions derived from interactions outside the client's purview to support diagnostic grounds for a particular decision. Finally, the psychiatrist may upgrade an argument for or against a particular medication change by using the collective reference 'we' to denote either team opinion or the general views of the institution of medicine.

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20

‘Good’ Communication in Schizophrenia: A Conversation Analytic Definition

Laura Thompson and Rose McCabe

Introduction

Schizophrenia is one of the most serious conditions psychiatrists are likely to encounter. Its complex psychopathology includes changes in thought and perception – delusions and hallucinations. Along with personal distress, this detachment from ‘reality’ (psychosis) brings complexity to psychiatrists’ interviews with patients. Not least, at times, an ontological ‘incompatibility’. The clinician must walk a ‘tightrope’: asking questions of appropriate depth and pace, while maintaining an attitude of non-confrontation and non-collusion around psychotic symptoms (Turkington & Siddle, 1998). Meanwhile, the heterogeneous course and clinical presentation of schizophrenia (Van Os & Kapur, 2009) creates a second delicate balance to achieve. The psychiatrist must understand the individual in their unique psychosocial context: diagnostically disentangling ‘pathological’ behaviour from what may be valid attempts to deal with distress or disturbances caused by particular social circumstances (see BPS, 2014). Achieving this means putting patient *experience* at the heart of psychiatric communication – a ‘partnership’ paradigm of care (NICE, 2009), removed from psychiatry’s historic reputation of social repression.

The stakes involved are high. Psychotic symptoms are associated with increased risk of suicide (Palmer, Pankratz, & Bostwick, 2005) and rehospitalisation, incurring substantial clinical burden. Given the ultimate goals of consultations are the amelioration of symptoms and prevention of relapse, empirical models of ‘good’ communication are of economic value. Paradoxically, they are underdeveloped. Recent work attends seriously to the role of communication in improving the therapeutic value of clinician–patient relationships (Priebe et al., 2011) and, in turn, even multifactorial outcomes such as treatment adherence (Thompson & McCabe, 2012). Nonetheless, ‘partnership’ constructs deemed essential for service delivery – 'shared decision making' and 'patient-centredness' – remain elusive (Epstein, et al. 2005; Tay, Chapter 28, this volume). These are, in the main, *abstract* ideals, not specific techniques conducive to clinician training.

How should we define 'good' psychiatric communication?

Conceptualising 'good' communication begins with identification of *specific* practices and how they advance the values of patients and the therapeutic relationship, or 'alliance' (Thompson & McCabe, 2012). Alliance (a subjectively rated psychological construct) and communication (components of the behavioural exchange, with the capacity for objective analysis) are interrelated, but analytically distinct concepts (Priebe & McCabe, 2006). Starting with the latter 'micro-level' would allow identification of tangible practices from which to explore their relationship with 'higher-level' subjective constructs or behavioural outcomes: treatment adherence. By identifying the systematic practices through which people perform and recognise social *action* in talk, the method of conversation analysis (CA) shows promise in understanding psychiatric communication at this level (Angell & Bolden, Chapter 19, this volume; Bergmann, 1992; Chapter 13, this volume; McCabe, Heath, Burns, & Priebe, 2002; McCabe, Leuder, & Antaki, 2009; Mikesell, & Bromley, Chapter 17, this volume). CA researchers use video and audio recordings of naturally occurring psychiatric interaction, and a detailed method of transcription to capture the minutiae of speech and elements of non-verbal behaviour. These provide analytical tools for exposing the underlying structures, or 'rules', that govern how activities are composed and organised. The results are highly descriptive, allowing exploration of topics as dynamic as the tacit skills by which delusional talk is recognised by psychiatrists (Palmer, 2000).

Health research, however, is driven by a motivation to link social phenomena to specific outcome metrics, enabling quality 'standards' of care (NICE, 2014). This brings a poignant challenge. Is it possible to establish findings with applied value: to reconcile the *nuances* of psychiatric communication, like those elicited through detailed CA analyses, with more global outcome measures? To explore this question, we take the most fundamental practice in psychiatry as a case study: psychiatrists' questions.

Psychiatrist questions and the therapeutic alliance

Questions are the primary method for developing therapeutic goals, assessing symptoms and deducing diagnostic hypotheses. Their implications for the social relationship between doctors and patients should not be underestimated. As Heritage (2010) explained, if clinicians use neutral 'social survey' questions, they convey a stance of objectivised indifference towards the patients' response, cumulatively instantiating a bureaucratic or 'anonymous' relationship. Effective clinicians tailor their questions to a particular individual (recipient design) instantiating 'a caring relationship with patients' (Heritage, 2010, p. 43).

CA is congruent with work on the constitutive view of relationships. Rather than treating facets of social relationships as 'independent variables with discursive consequences' (Hopper & Chen, 1996, p. 310), the constitutive view construes them as constituted and reconstituted, on a turn by turn basis, by practices of social action that are co-constructed by speakers (Mandelbaum, 2003). Communicative practices, like questions, are therefore, not 'inherently neutral in terms of their implications for social and personal relationships' (Robinson, 2006, p. 154). CA findings increasingly reveal important ways in which talk may propose or construct particular relational alignments between participants (e.g. Heritage & Sefi, 1992; Robinson, 2006). Unexplored however, is how, or if, questioning relates to the subjective psychological construct of 'relationship' – how one participant *feels* about another. The capacity to link communication practices to *psychological* measures of the psychiatrist–patient alliance in schizophrenia is not only of theoretical interest, but clinical value. S*ubjective* ratings of the alliance are associated with improved treatment adherence in psychiatry (Thompson & McCabe, 2012). Moreover, it would facilitate *evidence-based* interviewing techniques, enhancing the advice currently available for clinicians.

Clinical texts offer variable definitions of 'good' psychiatric questioning, bar one frequently overarching message: 'In general try to use open questions rather than leading questions or closed questions' (Burton, 2010), particularly at the start of the interview. This (quite crudely) categorises questions in binary terms on the assumption that 'open' questions align with ideals of patient-centredness, allowing patients to present themselves more freely in their psychosocial context:

> Conducting an interview hastily and indifferently with closed-ended queries often prevents patients from revealing relevant information. Tracing the history of the presenting illness with open-ended questions, so that patients can tell their story in their own words, takes a similar amount of time and enables patients to describe associated social circumstances and reveal emotional reactions.
>
> (Routine psychiatric assessment, The Merck Manual, 2012, n.p.)

However, crucially, 'open' and 'closed' categories encompass numerous different subtypes, each of which may have different interactional consequences (Heritage, 2010) and index alternative social between the doctor and patient (Raymond, 2010).

Moving beyond 'open' versus 'closed': A more sensitive question classification

Question taxonomies that move beyond an 'open' versus 'closed' conceptualisation vary according to the accepted meaning of a question itself, that is, whether constituting a type of sentence (interrogative), the speech act of requesting information (interrogative act) or 'the "thing" which is being asked, and which, as a consequence, may be (partially) answered' (Groenendijk & Stokhof, 1997). These definitions result in contrasting approaches to question classification, broadly (but not exhaustively) speaking; syntactically (by form), semantically (by meaning), pragmatically (by function). Independently, each of these classification types can only hope to identify a subset of the turns used for 'doing questioning' in clinical dialogue. Using a combination of these methods of classification – concepts derived from linguistics and CA – to sensitively code naturalistic interaction, Thompson, Howes, and McCabe (2015) developed a hand-coding protocol to identify and classify psychiatrists' questions in 134 outpatient consultation transcripts. Ten possible question subtypes were distinguishable, but they found psychiatrists used a subset (4/10) of question types regularly:

1) Yes/no auxiliary verb questions: a subtype of 'closed' question, syntactically identifiable with an auxiliary verb in the first position of the sentence, followed by the subject: for example, *do you go to a day centre?*
2) Wh-questions: 'open' questions that elicit information on a state of affairs or the property of an event, containing a question word in the first position: for example, *who, what, when, why* or *how – how have you been feeling?*
3) Declarative questions: a subtype of 'closed' question with the syntax of a declarative sentence: for example, *so you feel a bit anxious?* Recognition of declaratives as 'questions' (i.e. requiring confirmation/disconfirmation) depends on sequential, prosodic, and epistemic features, not syntax alone (Buen, 1990; Gunlogson, 2002; Heritage, 2012; Stivers & Rossano, 2010). Declarative sentences with final rising 'questioning' intonation, denoted by '?' in transcripts were included, or coders looked to the next turn (the patient response) to see if it had indeed been *understood* as a question.
4) Tag questions: a subtype of 'closed' question that transforms a declarative statement or imperative into a question by adding an interrogative fragment (the 'tag'), that is, an auxiliary verb followed by a pronoun: for example, '*isn't it?*'

Associations with measures of patient adherence and the therapeutic alliance (Priebe & Gruyters 1993) were examined, adjusting for patient symptoms, psychiatrist ID, and amount of speech. Counter-intuitively, only declarative (closed) questions predicted better adherence and perceptions of the therapeutic relationship. Conversely, wh- (open) questions predicted poorer perceptions of the therapeutic relationship and were also associated with increased positive symptoms, such as delusions and paranoia. It is unclear why this should be the case. Furthermore, from a conversation analytic perspective:

> Even where an utterance is in the linguistic form of a question, and seems to be doing questioning, the latter will not be adequately accounted for by the former. For if the question form can be used for actions other than questioning, and questioning can be accomplished by linguistic forms other than questions, then a relevant problem can be posed not only about how a question does something other than questioning, but about how it does questioning; not only about how questioning is done by non-question.
>
> (Schegloff, 1984, pp. 34–35)

As Schegloff (1984) explained, identifying questions in dialogue is not a trivial matter. What unites questions is their placement in conversation sequences – their form is not always synonymous with their social *action* (see also Stivers & Rossano, 2010). Declarative questions may be accomplishing more/other actions than questioning itself. Identifying these actions may provide explanatory and pragmatic insights into this outcome-based research, aiding application in practice.

Project overview

Building on Thompson et al. (2015), this study explores how language 'as action' can illuminate discursive practices embedded within psychiatry and help define 'good' communication in schizophrenia by an alternative – bottom up – approach. Using psychiatrists' questions as a case study, the chapter contextualises statistical associations with the therapeutic alliance and treatment adherence and subverts more abstract, but widely held, views about how psychiatrists 'should' communicate.

Data analysis

A random subset of 30 consultations from Thompson et al. (2015) was selected for analysis. Transcripts with mean frequencies below 3 declarative questions per 1,000 words (31 consultations) were excluded to ensure a sufficient density of questions. Approximately 7 declarative questions from each consultation were extracted, providing a total of 210 for initial, exploratory analysis. The study was informed by the methodology of CA. The questions and surrounding talk were transcribed using Jeffersonian orthography (Jefferson, 1983), capturing micro-level features of interaction. Question extracts were analysed inductively for recurrent systematic, linguistic, and sequential features – and on the understanding that to talk is always to 'do' something (Schegloff, 1996). On the basis of analytic descriptions from a turn-by-turn consideration of a single case, more general observations were gradually formulated as additional cases were examined – continually revising the summary of an apparent pattern to accommodate these instances (Ten Have, 1999).

The corpus

Data was drawn from an MRC study examining clinical interaction in psychosis (McCabe et al., 2013). Psychiatrists (36) from outpatient and assertive outreach clinics across 3 centres (one urban, one semi-urban, and one rural) were randomly selected. Written informed consent was obtained from 134 patients who met Diagnostic and Statistical Manual of Mental Disorders – IV (APA, 2000) criteria for schizophrenia or schizoaffective disorder, following which their consultations were audio-visually recorded. Verbal dialogue was transcribed verbatim.

Findings

The functions of declaratives are more nuanced than their, often negatively connotated, label of 'closed questions' implies. Several features will be observed throughout the ensuing analysis. These show psychiatrists' declarative questions have the capacity to

- support attentiveness to client stances: showing the psychiatrist working closely with the patients talk;
- display and confirm understandings of patient experience (hearably retaining an empathic function);
- distil summaries within a psychiatric frame of relevance; and
- effectuate topical closure and change, offering a narrative sequencing function.

A crucial distinction: Declaratives compared to other 'closed' questions

A declarative question not only projects the relevance of a yes/no type action, but can be differentiated from other 'closed' questions in important respects. In the psychiatric domain, epistemic stance is particularly relevant. Epistemic stance refers to the degree to which the psychiatrist conveys access to (i.e. is 'knowing' of) the information the question aims to solicit. Taking a simplified example from the present corpus, we can see there are various ways the same question could have been designed as a yes/no (Y/N)-type initiating action –

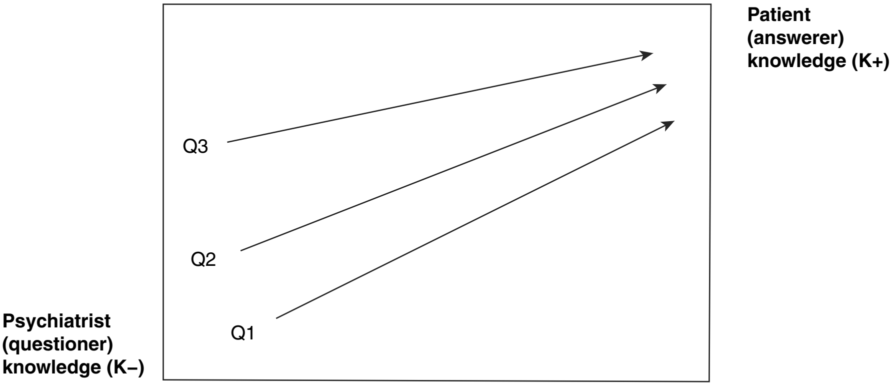

Figure 20.1 Psychiatrist question designs and epistemic gradients (see Heritage 2010)

each to elicit the same information, yet a establishing a different 'epistemic gradient' (Heritage, 2010) between the psychiatrist and the patient:

Q 1. Do you feel a bit anxious? (Y/N interrogative)
Q 2. You feel a bit anxious, don't you? (tag question)
Q 3. You feel a bit anxious? (declarative question)

All of these questions refers to whether the recipient 'feels a bit anxious' – 'B-event information' (Labov & Fanshel, 1977), only properly known by the patient who has epistemic primacy. However, each question represents distinct stances towards the information, as displayed in Figure 20.1, adapted from Heritage (2010, p. 49, figure 3.1).

Q1 indicates that the psychiatrist has no certain knowledge of the patient feeling anxious, indexing a steep epistemic gradient (see Figure 20.1) between the knowledgable (K+) patient and a relatively 'unknowing' (K–) psychiatrist. Contrastingly, Q2 indicates a shallower gradient by displaying an inclination towards the likelihood that the patient does feel a bit anxious. While the psychiatrist formulates the utterances initially as a declarative statement 'you feel a bit anxious', his epistemic entitlement is 'downgraded with a tag question' (Heritage, 2012, p. 12): 'don't you?', seeking confirmation of the assertion made in the declarative component.

Finally Q3, a declarative question, without an interrogative fragment (Q2) or auxiliary-subject preface (Q1), proposes a strong allegiance to the idea that the patient does indeed feel anxious. As Heritage (2010) posited, the latter declarative form 'merely seeks to reconfirm or alternatively convey inferences, assumptions or other kinds of "best guesses"' (p. 49). Accordingly, Raymond (2010) argued that 'speakers assert the matters formulated in their initiating action and thereby claim to know about them (or assume them or treat them as established) as a basis for making confirmation of them relevant' (p. 92). While Q1, Q2, and Q3 are all versions of 'closed' questions that aim to solicit the same information from the patient, the selection of one form over another can invoke contrastive social relations between speakers and have significant consequences for the ensuing interaction (for an example in health interaction, see Raymond, 2010). Taking the 'unknowing' stance of a Y/N interrogative 'can invite elaboration and sequence expansion, while the 'knowing' y/n declarative form merely invites confirmation of known information by the recipient, who is projected as an authoritative source' (Heritage, 2010, p. 49). Having identified interactional distinctions relative to other 'closed' questions, some core observations of declaratives in this data set are next reported.

'So-prefaced' declarative questions: Psychiatrists working closely with patients' talk

A fundamental assumption in CA is that, in constructing a turn at talk, speakers usually address themselves to preceding talk and, most commonly, the immediately preceding talk (Sacks, 1987, 1992; Schegloff & Sacks, 1973). On initial examination of the 210 declarative questions, two distinctions were observable in this respect (as initially summarised in Thompson et al., 2015). A minority appeared in a 'checklist' (Heritage, 2010) form – truncated questions that represent rapid topic shifts following a patient answer to a prior question (16): for example, *'sleeping okay?'*, *'good appetite?'*. A slightly larger proportion (23) incorporated patients' immediately prior talk, repeating lexical elements verbatim (see Robinson, 2013, Robinson & Kevoe-Feldman, 2010).

```
e.g., PAT I've had some side effects
      DOC You've had some side effects?
```

The majority of questions displayed a further level of abstraction – as per Heritage's (2010) assertion – conveying 'inferences or assumptions' about the patients' prior talk (171). Further examination showed that nearly half of these cases were 'so-prefaced' inferences (90). Similar practices have been shown to have analytical salience in contexts outside of psychiatry (Beach & Dixon, 2001; Johnson & Cotterill, 2002), and 'so' particles have been found to affects a question's function (Bolden, 2006). Table 20.1 displays a collection of examples (pre-Jeffersonian transcription) from the data set (Thompson et al., 2015). Two basic observations will be drawn from these examples and their sequential environments, features analysed in more depth as the analysis proceeds. The cases shown here were selected as particularly clear examples of the systematic properties observed.

Table 20.1 A collection of psychiatrists' 'so-prefaced' declarative questions

So you are feeling not so well?
So you feel a bit anxious?
So you're quite happy being on your own?
So you're lethargic, you just couldn't be bothered to do these things?
So you feel okay about it?
So that's something you want to switch off from?
So you are quite happy to continue with the Risperidone?
So you're under a lot of pressure at the moment?
So you got a little bit depressed?
So you feel anxious about the amount you're eating?
So you think you're better off?

1) The declarative questions presented in Table 20.1 are all prefaced by 'so'. This discourse marker constitutes one way of indexing 'inferential or causal connections' (Bolden, 2009, p. 974) with prior talk (For alternative pragmatic functions of 'so', see Bolden, 2009). As such, in each case, the psychiatrist frames the ensuing declarative question as closely resulting from, thereby contingent upon, the patients' prior talk (see Bolden, 2009; Schiffrin, 1987). Bolden (2006) found that 'so' is overwhelmingly involved in 'doing other-attentiveness' in interaction. Indeed, what invariably followed was not only a declarative, but a display of understanding of that talk: each of the declaratives in Table 20.1 constitutes a 'formulation' (Heritage & Watson, 1979). The psychiatrist appeared to present a summary of these utterances, replacing the patients' wording with their own formulation that captures the 'gist' (Heritage & Watson, 1979) of the patients' turns. This was frequently within a psychiatric frame of relevance (cf. Beach & Dixon, 2001, Depperman & Fogasy, 2011). As evident from Table 20.1, four of the questions refer to the how the patients' 'feels' and all contain reference to some kind of emotional state. The psychiatrist was observed producing a psychological upshot of events that the patient describes (an account or troubles-telling), but while presented as something implicit within the patients' prior talk, this process involved editing, deleting, and, to some extent, transforming (Heritage & Watson, 1979) the patient's contribution, consistent with current research on formulations in psychotherapy.

2) Psychiatrists' use of declarative questions had significant interactional consequences. Each of the examples in Table 20.1 contain 'B-event information' (the patient's psychological state) characterised by the 'known in common' (Heritage, 2012) epistemic authority of the patient (which can preside over rising 'questioning' intonation in terms of the interpretation of a declarative as 'doing questioning'). The psychiatrist therefore creates a slot for the patient

to (dis)confirm. The (dis)confirming action made relevant is minimal relative to other yes/no type imitating actions with less shallow epistemic gradients. By providing a resource to ostensibly display a summary of understanding, declaratives may be one tool psychiatrists can use in sensitively closing down particular trajectories of talk and managing topic transition. Indeed, Johnson and Cotterill (2002) documents the use of 'so' for prefacing questions that function as 'topic sequencers.' The constraining effect on sequence expansion here was evident in four ways: (1) Patient responses were confirming/disconfirming tokens rather than narratives. (2) Psychiatrists' did not expand beyond the base declarative – answer sequence: third position talk was absent or merely a 'sequence-closing third' (Schegloff, 2007); for example, an assessment like 'good'. (3) This was followed by a topic or activity shift. (4) Greater use of declarative questions was associated with less patient talk overall in consultations. As such, psychiatrists' so-prefaced declaratives appeared one resource for closing down patients' narratives/troubles-tellings – in a manner that simultaneously displayed intersubjectivity – and managing the interactional progress of the interaction.

These two features are evident in Extract 1:

Extract 1

```
 1  PAT:  >I ↑mean< ↑it's (.) it's ↑↑eight months on and I can
 2        still remember it.
 3  DOC:  °Mm::°
 4  PAT:  The ↑last thing I wa:nt is for somebody to keep
 5        re↑minding me.
 6  DOC:  °Oka::y° so ↑you you think you're better off
 7  PAT:  Yes.
 8  DOC:  Just looking forward.
 9  PAT:  Yes.
10  DOC:  °°Okay.°°
11        (5.6)((Doctor writes in notes)
12  DOC:  .hhh did you get the ↑job you've ↑been (.) applying
13        ↑for?
14  PAT:  Yes I got the job.
```

(DOC = psychiatrist, PAT = patient)

In line 6, the psychiatrist formulates what the patient has said regarding his reluctance to receive counselling for distressing (past) psychotic experiences. He replaces the patient's description with his own psychological summary 'so you you think you're better off?', bringing the discussion to a close. The question appears to merely recapitulate and display understanding of the patient's words: the 'so' preface indicates the patient should understand the upcoming action as a natural upshot. As Fraser (1999) suggested, discourse markers (such as 'so' in question prefaces) can 'signal a relationship between the segment they introduce ... and the prior segment' (p. 50). However, the brevity of this turn relative to the patient's (spanning lines 1–5) indicates that, in the process of formulating, the psychiatrist has deleted parts of his account (i.e. eight months on/his disinclination to be reminded, etc.). Moreover, given the patient's prior action was hearable as a complaint – recalling the enduring and undesirable nature of his memories – through editing of its design and terminology an element of transformation has occurred (Heritage & Watson, 1979). The psychiatrist recasts the patient's answer to accord with a more positively framed outlook, that is, that he thinks he is 'better off' (without counselling).

Turning to the sequential aspects of the question - the patient's thoughts constitute 'B-event information' (Labov & Fanshel, 1977), mutually conceivable as the patient's epistemic domain. A relevant slot is therefore created for the patient to confirm/disconfirm. While he provides this in line 7, the psychiatrist increments his question: 'just looking forward' in line 8. By recompleting his question, he sequentially deletes the patient's answer: renewing its relevance in line 9. Notice that the declarative question was originally produced with a turn-initial 'okay'. These actions can be used as 'pre-closing' devices (Beach, 1993, 1995) deployed to acknowledge, yet enforce closure on immediately prior elaborations (Beach & Dixon, 2001). Indeed, following this confirmation in line 9, produced with terminal intonation, the psychiatrist hearably orients to topical closure. He does not expand the sequence in the third position (Schegloff, 2007) by projecting further related talk, rather deploys the receipt token 'okay' – which can be used to mark an upcoming change of activity (Gardner, 2001). Accordingly, a change is forthcoming: following a pause in which the psychiatrist writes in his notes, we see a marked shift in topic in line 12 – the psychiatrist enquires about the patient's prospective job application.

Making empathic inferences: So-prefaced declaratives as formulations of patients' talk

In Extract 1, the psychiatrist produced a formulation of the patient's prior turns at talk. Garfinkel and Sacks (1970) first defined this interactional phenomena:

> ... a member may treat some part of the conversation as an occasion to describe that conversation, to explain it, or characterise it or explicate, or translate, or summarise or furnish the gist of it ... that is to say, a member may use some part of the conversation as an occasion to formulate the conversation. (p. 350)

Formulations have been a prominent theme in conversation analytic research on psychotherapy. Through this resource, speakers can offer their interpretations (Drew, 2003), candidate understandings (Schegloff, 1996) or candidate representations (Hutchby, 2005) of previous talk by their interlocutor. This line of enquiry was initially developed in two seminal papers by Heritage and Watson (1979, 1980), in which they characterised some systematic properties of formulations. Here, the focus is on a central aspect, readily detectable in the present data set:

> Displays of understanding can be achieved by producing a transformation or paraphrase of some prior utterance. Such paraphrases preserve relevant features of a prior utterance while also recasting them. They thus manifest three central properties: preservation, deletion and transformation.
>
> (Heritage & Watson, 1979, p. 129)

Extracts 2, 3, and 4 demonstrate how such a pattern was manifest in this corpus of so-prefaced declarative questions. In each extract, the psychiatrist formulates the patients' account, replacing it with their own version of the patients' words. Specifically, a summary that displays sensitivity to the psychological implications of the events described (cf. Beach & Dixon, 2001; Johnson & Cotterill, 2002). In doing so, the psychiatrist edits and deletes parts of the patients' prior utterances, transforming the report within a 'psychiatric' frame of relevance. These declaratives thereby repeatedly display the 'fitting of differently focused, but related talk to some last utterance in the topic's development' (Schegloff & Sacks, 1973, p. 305). Extract 2 (Thompson et al., 2015) below displays this in relation to how the patient feels about spending time by himself.

Extract 2

```
 1  PAT:  ↑Yeah I like to chill out in the ‘ou::se doctor
 2        [you ] know=
 3  DOC:  [°Mm° ]
 4  PAT:  =I watch telly::: and (.) cook something and (0.4)
 5        then m- washing and (0.4) tidy the ‘ouse up you
 6        know.
 7  DOC:  ↑Yeah.
 8        (3.4) ((Doctor writes in notes))
 9  DOC:  So: you’re quite happy being on your o:::wn?
10  PAT:  I’m quite happy doctor yea:h yea:h.
```

In line 9 the psychiatrist deploys a so-prefaced declarative to condense a larger stretch of the topical talk in which the patient describes his daily home life –

activities engaged in when not spending time with his friends. The psychiatrist offers a formulation of the patient's experience 'so you're quite happy being on your own'. This provides the opportunity to intersubjectively ground (Clark & Schaefer, 1989) the doctor's conclusion by establishing the conditional relevance (Schegloff, 1972) for a confirmation from the patient – which he provides in line 10. The psychiatrist's formulation is presented as a mere summary – 'you're quite happy being on your own' being 'something implicitly meant by the client' (Bercelli, Roassano, & Viaro, 2008). However, in the process of its production, the psychiatrist has the opportunity to discard irrelevant material, here the information of mundane activities (watching television, cooking and tidying, etc.) and shape that which remains in a more 'overall' emotional framework that the patient is 'happy being on his own'.

Antaki (2008) asserted that such displays of understanding in psychotherapy show 'ostensible cooperation': they appear to be replaying a summarised version of the patient's prior utterances, but in doing so have 'deleted some material, selected what suits the interests at hand, and edited is design and terminology' (p. 30). This is also observable in Extract 3.

Extract 3

```
 1  PAT:  Yeah quite bad yeah.
 2        (.)
 3  PAT:  I don't like going anywhere on my own really and
 4        that now .hhh my mum's been taking me a lot of
 5        pla:ces and that.
 6        (0.6)
 7  PAT:  In the car.
 8        (0.4)
 9  PAT:  cos I get paranoid when I'm on the bus and
10        everything and I think other people are after me
11        an' that.
12        (0.6)
13  DOC:  .hhh so you are feeling (0.4) not so well?
14  PAT:  No:::
```

Unlike Extract 2, the patients' narrative that precedes the psychiatrist's question (line 9) is hearable as a troubles-telling. The patient claims his paranoid thoughts of late (the topic of a prior line of questioning) have been 'quite bad', proceeding to provide evidential grounds for this assessment in lines 1–9 – a reliance on his mum to take him places and feeling paranoid when on the bus. The psychiatrist passes up the opportunity to receipt or respond in lines 2, 6, and 8 – the latter silence follows an increment 'in the car' that Schegloff (2000) noted, when initiated post-gap, can be seen to address 'the absence so far of ensuing talk' in pursuit of a response. This occasions the patient's continuation in line 9 'cos I get paranoid ....' that serves to account for his disinclination to go out and his dependence on his mother by reference to a delusion.

Like the prior examples, in line 13 the psychiatrist formulates what the patient has said. While he displays a candidate understanding and evaluation 'so you are feeling not so well', he simultaneously distils, and thereby deletes, the relatively extensive material provided by the patient into an overall general sense or 'gist' (Heritage & Watson, 1979) of the patient's well-being. By summarising the patient's description in a general framework, this enables the psychiatrist to 'label' (Johnson & Cotterill, 2002, p. 105) the patient's narrative – in so far as how the patient is 'feeling' overall – and reduces the individual significance (thereby need to address) of specific elements of the patient's account. This may be particularly pertinent when discussing delusions, like those the patient concedes to in lines 9 and 10. By displaying, and inviting confirmation of, how the patient may 'feel' on account of his description, it may allow the psychiatrist to be sensitive to the implications of the experience, while maintaining a clinically desirable attitude of non-collusion with aspects of its content, for example, here that 'people are after' the patient. Moreover, this arguably makes transition onto the next activity (including possible resolution of the problem), an easier subsequent interactional move. A similar orientation is evident in Extract 4 (Thompson et al., 2015).

Extract 4

```
 1  PAT:  E::::r, ↑i:t's just that (0.4) someti:me in the
 2        afternoon I get (0.6) like, (.) you know I get the
 3        feeling that (.) i:t's (0.6) going to happen to me:::
 4        (.)
 5  PAT:  I will end up in the hospital.
 6        (0.2)
 7  DOC:  Okay.
 8  PAT:  A:::nd er
 9  DOC:  So you feel a bit anxious?
10  PAT:  Um yea:::h
```

Here, the patient's narrative, also hearable as a troubles-telling, asserts concern regarding his recent mood, concern of relapse, and associated return to hospital. The psychiatrist receipts the account in line 7 'okay' and, while the patient produces an incomplete turn constructional unit (TCU) in line 8 'and er', the psychiatrist takes the next turn as an opportunity to formulate the talk so far. Indexing the inferential connection between the prior talk and his upcoming action with a recognisable 'so' preface, he invites confirmation of his understanding of the emotional upshot of the patient's account 'you feel a bit anxious'. In doing so, he preserves the 'feeling' the patient describes in line 3, while simultaneously deleting the finer details of the account surrounding its circumstance, for example, that the patient will end up in hospital, the feeling occurs in the afternoon.

At the same time, an element of transformation occurs: the psychiatrist specifies the 'feeling that it is going to happen to me (.) I will end up in hospital' as feeling a 'bit anxious' (line 9), thereby recasting the information in more recognisably 'psychiatric' terminology. In this way the psychiatrist, as in Extract 3, is able to evaluate, summarise, and label the patient's more extensive talk. This provides the opportunity to intersubjectively ground the psychiatrist's understanding of patient's topical talk, but may also assist in transforming the account according to 'institutional relevancies' (Depperman & Fogasy, 2011, p. 117). The psychiatrist's (institutional) tasks may be supported by a device that allows for selective formulation of the relevant outcomes of patient's answers. We can see evidence of this in Extracts 5 and 6.

Extract 5

1 DOC: So on the whole from a psychiatric point of view (.) you're
2 very stable,
3 PAT: Yes for the mome::nt.

Extract 6

1 DOC: So I think in terms of ↑what we're doing at the moment you are
2 quite satisfied?
3 PAT: ↑Yes ↑yes.

The psychiatrist produces, and attempts to solicit agreement of, an upshot by first qualifying that the formulations, in which the patient is the central figure (you're/you), are not verbatim, but a consequence of the sense the psychiatrist has made of the patients' prior talk. Specifically, 'in terms of what we're doing at the moment' (Extract 6, line 1), that is, 'from a psychiatric point of view' (Extract 5, line 1). As such, the psychiatrist narrows the frame of relevance for the formulation that follows: Extract 5, 'you're very stable', and Extract 6, 'you're quite satisfied', are presented as contingent on these terms of reference, the emphasis being psychiatric interpretation – a summary of well-being using the medical terminology ('stable') and overall patient satisfaction with treatment. In doing so, the psychiatrist asserts justification for the editing and deleting of the patients' prior talk by explicitly formulating that the communication and its frame of relevance is being shaped by the activities and setting (see Drew, 2003) in which they are engaged.

While, as Heritage and Watson (1979) explained, 'the uses of formulations are multiplex... they may be used to address an immense variety of matters, these matters being, in their most specific terms, heavily embedded in the specific stretches of talk in which they occur' (p. 128), there may be particulars to formulations that make them a conducive resource for institutional encounters (Drew, 2003) such as those in psychiatry. For Antaki (2008), the 'common thread' of formulations is that the institutional agent 'plucks' out something in the other's words and, while presenting it as a mere neutral summary or implication, uses the opportunity to edit it in ways that will help the speaker's own institutional interests. As one resource psychiatrists can use to produce 'psychiatric summaries' of preceding talk, declarative questions may further be suited to the closing down and managing of topical trajectories.

Psychiatrists' declarative questions, patient responses, and sequence constraint

A consistent theme in CA research on declarative questions and formulations is that of sequence constraint: both in terms of expanse of the second pair part (dis)confirmation or third position post-expansion by clinicians (i.e. talk by a first speaker that deals with a second position response; Schegloff, 2007). Bercelli (2008) noted clients' confirming responses generally consist of a minimal token (such as 'yes' or 'hm', with falling intonation) and are not post-expanded, or only minimally post-expanded by therapists. Beach and Dixon (2001) examined how formulations were used to organise patients' talk by closing down narratives/troubles-tellings – the formulations (declaratives) initiated a three-part cycle (1) interviewers' formulated understandings, (2) patients' confirmations, and (3) topic shift by the interviewer – accordant with Extract 2.

Raymond (2010), compared the sequence constraining effect of declaratives, compared to that of yes/no interrogatives: 'The different actions made relevant by yes/no declaratives and yes/no interrogatives are reflected in the forms that responses to them typically take and in the ways that sequences initiated by them come to be expanded or not' (p. 95). Yes/no declaratives effectively constrain sequence expansion: the constraints set in motion by this question type (that assert the matter as 'known') can be satisfied by mere confirmation, typically involving no third position expansions, or minimal sequence-closing thirds (e.g. assessments) (Schegloff, 2007).

Table 20.2 displays the distribution of patient responses and third position talk (beyond that of a sequence-closing third) from the psychiatrist. We can see that declarative formulations were designed largely with positive polarity, preferring 'confirming responses', consistent with Heritage and Watson's (1979) observation of the 'sequential power' of formulations – their projection of agreement – that patients have to actively provide, as in Extract 6, or combat in the next turn as in Extract 7.

Table 20.2 Responses to so-prefaced declaratives and third position psychiatrist expansion

	(Dis)confirming response	**Narrative**	**Third position expansion by psychiatrist**
All questions	49	19	11
Positive questions	41	14	9
Negative questions	8	5	2

Extract 7

1 DOC: SO YOU'RE FEELING better in any case.
2 PAT: Well I feel a lot better than I did two weeks ago two
3 or three weeks ago ↑e::r

The patient resists the terms of the question, specifying that he feels better than he did 'two weeks ago', thus narrowing the scope of what he is confirming with additional elaboration. 'Non-conforming', that is, narrative responses, like we see here, are the most frequent sequence-specific method for managing misalignment between speakers regarding the particular choice posed by a y/n question (Raymond, 2006).

As can be seen in Table 20.2, only 19 patients within the corpus resisted the constraints of the question by producing a non-conforming narrative response (Raymond, 2006). The majority produced confirming responses (e.g. yeah, mm) consistent with the identified preference for type-conformity (Raymond, 2003). In terms psychiatrist expansion past the minimal base declarative–confirmation sequence, in only 11 instances did psychiatrists produce a turn in the third position that projected additional talk. As we see in Extract 8:

Extract 8

1 DOC: So yo- you're feeling a bit low at the moment?
2 PAT: Yeah.
3 DOC: Can you explain ho::w,

In line 3 the psychiatrist projects further elaboration (an account to 'how' the patient feels low) as relevant by shifting to display a less 'knowing' (K−) stance. In the remaining cases, psychiatrists followed patient answers with a shift in activity, sometimes prefaced by the token 'okay' signalling this as upcoming, or brief assessments, that is, sequence – closing thirds (Schegloff, 2007).

Is sequence constraint associated with amount of patient talk?

Psychiatrists' declarative questions in this corpus were responsive to patients' prior utterances. They displayed sensitivity to, and understanding of, the psychological aspects of their accounts, drawing sequences to a close by

Table 20.3 Correlation with amount of patient talk

	Psychiatrists' declarative questions	
	R	P
Patient words	−.219*	.013

*Correlation is significant at the $p < .05$ level

regularly attracting (dis)confirming, rather than more lengthy 'misaligned', responses. This prompted the hypothesis that, using more 'sequence closing' devices in consultations to manage the interactional progress of the session – perhaps indexing greater mutual 'understanding' – may have a bearing on patients' contributions overall. Using Pearson's correlation to preliminarily explore this conjecture, the bivariate association between psychiatrists' declarative questions and amount of patient talk (words per consultation from verbatim transcripts) within each encounter was examined.

As can be seen in Table 20.3, there is a statistically significant negative correlation – the more declarative questions psychiatrists asked, the fewer words patients said in consultations.

Summary of findings

Psychiatrists' use of declarative questions is associated with better perceptions of the therapeutic alliance and adherence in schizophrenia (Thompson et al., 2015). Indeed, examined qualitatively, these questions are more complex interactional objects than the conventional binary definition (open questions vs. closed questions) implies. Declaratives were recurrently so-prefaced formulations of patients' prior talk. Through the shallow epistemic gradient they created between clinician and patient, and features of turn design, declaratives could be used to convey a distinct relationship to patients' prior utterances. Not least, so-prefacing framed the question as contingent on (and inferentially connected to) patients' prior talk (narratives or troubles-tellings) and psychiatrists' lexical choices displayed sensitivity to its emotional implications by making implicit psychological meanings explicit: often specifying how the patient must 'feel' on account of the events they described.

While displaying a degree of understanding and the opportunity for the patient to confirm the psychiatrists' summaries, the production of declaratives involved simultaneously deleting and editing the patients' contribution so as to recast it in a more psychiatric frame of relevance: for example, 'thematising' the patient's answers within a general framework – an 'overall' emotional state, condition or sense of well-being. A resource to ostensibly display a summary of understanding, declaratives also constitute one tool psychiatrists can use in sensitively closing down particular trajectories of talk and managing topic transition. The constraining effect on sequence expansion in relation to patients' prior talk was evident in four ways: the minimal responses made relevant by declaratives; absence of third position post-expansion from psychiatrists; subsequent topic/activity shift; and correlation between more declaratives and less patient talk overall.

Discussion and clinical relevance summary

Questions are fundamental in managing the alliance between psychiatrists and patients with schizophrenia. Yet, formal guidelines for questioning practices remain unspecified, beyond general advice discouraging overuse of 'closed questions' (Burton, 2010). Conversely, declarative formulations, one subtype of 'closed' question, offer a sensitive device for intersubjectively grounding and displaying understanding of patient's contributions while capturing psychiatrically relevant upshots – crucial for appropriate treatment decisions, conducive to adherence. Moreover, what would clinical interaction look like without these displays of understanding? By displaying a more 'knowing' stance than other question types, declaratives create an opportunity for patients to confirm psychiatrists' grasp of their state of affairs – such that they can function, and be hearable by as – displays of understanding (Depperman & Fogasy, 2011), active listening (Hutchby, 2005) and empathy (Ruusuvuori, 2005, 2007), perhaps explaining their link with better therapeutic alliances. Indeed, as the definition by Suchman, Markakis, Beckman and Frankel (1997, p. 678) states:

> Empathic communication entails the accurate understanding of the patient's feelings and the communication of that understanding back to the patient in such a way that he/she feels understood.

Training clinicians to ask more declarative questions at appropriate points may be one method of *improving* the therapeutic alliance and subsequent adherence. Alternatively, declarative formulations may *reflect* psychiatrists' increased propensity to display empathic responses with engaged, adherent patients. Through this lens, declarative questions represent one possible communicative index for how positive alliances and/or adherence are manifest in interaction, that is, 'a rich region of interaction in which to study the constitution of relationships and intersubjectivity' (Robinson, 2006, p. 156). It may be easier for psychiatrists to achieve, display and invite confirmation of their 'understandings' with patients who are more adherent and engaged with treatment in the first place. Meanwhile patients who are 'understood' may need to misalign from the constraints of psychiatrists' questions, for example, through narrative responses, much less – one possible explanation for why declaratives were associated with less patient talk overall. Relatedly, one would expect that achieving mutual understanding might be more difficult in symptomatic patients, for example, those experiencing delusions. This could explain why wh-questions – 'open' questions that presuppose less understanding thereby inviting more extensive responses – were associated with symptoms and poorer psychiatrist alliance ratings in the earlier study (Thompson et al., 2015).

Declaratives may also be a useful tool for clinicians on another practical level: aiding in distilling and recording psychiatric summaries and managing the interactional progress of the session. These questions are 'epistemically designed' to add little 'new to the sequence and thereby to effectuate a move toward closing the topic' (Heritage, 2012, p. 48). In doing so, they created relevant junctures at which psychiatrists could shift to the next topic of the next pending agenda item. As they can do this in 'responsive' and psychologically sensitive way, perhaps such actions 'detoxify topic shift, therefore minimising the likelihood that movement forward in the interview can be framed as a doctor's heavy-handed pursuit of a medical "agenda" removed from the patient's concerns' (Beach & Dixon, 2001, p. 29). Formulations are a means to transform patients', often detailed and multifaceted, accounts according to psychiatric relevancies. In particular, sensitivity to the main emotional theme underpinning their descriptions was observed, thus conceptualising the situation talked about in a 'certain way' (cf. Antaki, 2008; Drew, 2003; Heritage & Watson, 1979). The capacity of formulations to achieve this may offer pragmatic applications in the treatment of schizophrenia. Psychotic symptoms are often the source of interactional tension in psychiatric outpatient consultations (McCabe et al., 2002): it can be problematic to establish a shared understanding of two differing versions of 'reality'. Declarative formulations, when used to display candidate understandings of how the patient may 'feel' on account of these experiences, could be one resource to display sensitivity to, and establish a shared understanding of, the emotional implications while avoiding collusion or direct confrontation with the content of particulars of that account. See Table 20.4 for a summary of these clinical implications.

While the issue of quantification has been somewhat controversial in CA (e.g. Schegloff, 1993), these findings show promise in establishing which communication practices may be meaningful to outcomes like the therapeutic alliance and adherence. Combining qualitative and quantitative methods 'allows for the synergistic interaction between the two' (Epstein et al., 2005, p. 1522). After inductive quantitative/coding analyses (ideally based on CA sensibilities (see Stivers, 2015) yields a phenomenon of interest, CA provides a contextualised case-by-case analysis to generate explanatory hypotheses, in a detailed and transparent manner that is not possibly with quantitative analyses alone. These hypotheses are theoretically strengthened as they are grounded in empirical observations. Specifically, conversation analytic results that 'are descriptions

Table 20.4 Clinical practice highlights

1. Binary definitions of 'good' questioning ('open' vs. 'closed') in psychiatric texts books may be too crude for utility in practice.
2. The function of declaratives, a subtype of 'closed' question, are more nuanced than this definition suggests; they offer clinicians a device to enhance their interactions, in ways aligned with 'patient-centred' ideals.
3. Using 'so-prefaced' declarative questions may help clinicians display attentiveness to patient stances and accounts – explicitly showing that they are working closely and responsively with the patient's talk. This may be preferable to more 'checklist' approaches to psychiatric interviewing, associated with rapid topic change and minimal responses to each patient answer.
4. Using declaratives appropriately may help clinicians conduct topic transition sensitively and maintain the relevance of psychiatric goals: for example, allowing clinicians to distil an *overall* impression of patients' mental state and well-being from patients' previous (lengthier) accounts.
5. Clinicians can use declarative questions to display empathy by seeking confirmation of their understandings of patient experience and its emotional salience.
6. Declarative formulations may enable clinicians to engage with the emotional implications of psychotic experiences, for example, delusions, while avoiding confrontation or collusion with particulars of patients' accounts.
7. Making clinicians aware of declarative formulations and how they can be used in psychiatric interaction may be one way of improving the therapeutic alliance and subsequent adherence to treatment.

of the organisation of conduct that investigators validate qualitatively by reference to the participants' own actions in situ' (Heritage & Maynard., 2006, p. 365). Such findings would pave the way for training interventions to optimise therapeutic effects by explicitly orienting communication to accomplish intermediate outcomes (e.g. empathic understanding) in service of improving the psychiatrist–patient alliance.

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21

‘Talk about Trouble’: Practitioner Discourses on Service Users Who Are Judged to Be Resisting, Contesting, or Evading Treatment

Mike Hazelton and Rachel Rossiter

Introduction

> *Where the environment is stupid or prejudiced or cruel, it is a sign of merit to be out of harmony with it.*
>
> (Russell, 1930, p. 105)

In this chapter, we report research investigating interactions of practitioners and adults with mental health conditions where the latter are judged to be resisting, contesting, or evading treatment. During the last 15 years, we have conducted various studies examining the discursive practices through which practitioners make sense of and respond to those with whom they work, focusing especially on situations in which individuals are considered difficult to manage. Our main purpose has been to better understand the practices by which the mental health disciplines seek to regulate service user expectations and behaviours in light of the discourses that inform them, especially those arising from the social justice and human rights concerns evident in recent mental health policy both in Australia (Australian Parliament Senate Select Committee on Mental Health, 2006) and internationally (UN, 2006). Much of our work in this area has involved practitioner interactions with people living with borderline personality disorder (BPD). In what follows, we begin by outlining the current policy and practice context in Australia. The remainder of the chapter discusses a number of studies in which we have investigated interactions between health practitioners and people living with BPD or other forms of severe prolonged mental illness.

Mental health policy and practice in Australia

Despite having a modern comprehensive mental health system, there is a high unmet need for psychiatric treatment in Australia (Hazelton, 2005). Since the early 1990s, a range of mental health-related issues and service shortcomings have been addressed through a national mental health strategy, implemented through successive five-year plans (Commonwealth of Australia, 2009). A number of policy expectations have evolved including: services ought to be responsive to the needs of users and located close to where people live; care ought to be delivered continuously across both inpatient and ambulatory services; and the citizenship entitlements and human rights of persons living with mental illness must be safeguarded. By the fourth plan (2009–2014), social inclusion and recovery, prevention and early intervention, quality improvement and innovation, and accountability were being emphasised (Commonwealth of Australia, 2009).

While the reforms have brought increased resources and some service improvements (Whiteford, Buckingham, & Manderscheid, 2002), there has been little evidence of beneficial impacts on citizenship participation and human rights protections for those living with mental illness and their families (Hazelton, 2005). Indeed, the findings of recent studies such as the Survey of High Impact Psychosis (SHIP) in Australia indicate that people living with severe prolonged mental illness experience educational and employment disadvantage and are heavy users of alcohol and illicit drugs (Morgan et al., 2012). When asked to identify immediate challenges, participants in the SHIP study indicated those listed in descending rank order in Table 21.1. It is not clear that the policy aspirations can be realised, especially if responsibility for claiming rights falls on the vulnerable individuals concerned and their families (Johnstone, 2001; Watchirs, 2000). While people living with severe mental illness identify financial concerns, loneliness, and insecure accommodation as pressing challenges, progress has been slow in developing the rehabilitation, housing, and support services necessary for life in the community (Carr, Whiteford, Groves, McGorry, & Shepherd, 2012).

Table 21.1 Challenges over the next year as identified by people living with psychotic disorders

Challenges
Financial matters
Loneliness/Social isolation
Lack of employment
Poor physical health/physical health issues
Uncontrolled symptoms of mental illness
Lack of stable/suitable housing
Other
Stigma/discrimination
No family or carer
Inability to access specialised mental health services
Difficulty getting a medical appointment

Source: Carr et al. (2012).

In recent decades, underdeveloped services and human rights violations have been recurrent themes in numerous reports addressing deficiencies in mental health services in Australia (Australian Parliament Senate Select Committee on Mental Health, 2006; Human Rights and Equal Opportunity Commission, 1993; National Mental Health Commission, 2014). It is ironic that in an era in which the policy aim is to humanise mental health services, the experience of 'being in care' may have become more restrictive than in the past. Mental health facilities have become more risk averse (Clancy, Happell, & Moxham, 2014; Hazelton, Rossiter, Sinclair, & Morrall, 2011). Risk management regularly supplants therapeutic concerns, often on the basis of 'health and safety requirements'. Despite a policy focus on reducing restraint and seclusion (National Mental Health Working Group, 2005) and evidence that such reductions are possible (Gaskin, Elsom, & Happell, 2007), a range of security and surveillance techniques and devices (e.g. duress alarms, closed circuit television monitoring) are in routine use in Australian mental health facilities. There has also been heavy reliance on 'zero tolerance' polices in dealing with patient aggression and violence.

Mental health consumers or citizens recovering from mental illness?

A key aspect of current mental health reform globally has been attempts to transform the mental health patient into the mental health consumer. While the aim has been to elevate the status of those living with mental illness to citizens and shift therapeutic discourse towards a focus on recovery, such reforms have not gone unchallenged. For instance, it has been suggested that if (mental health) 'consumerism' implies choice, there are many circumstances in which the choices available to users of mental health services are severely curtailed (Hazelton, 2005). The experience of living with mental illness is difficult to reconcile with 'consumer choice'; we need only to think of involuntary admission to a mental health facility; being placed on a community treatment order requiring treatment with powerful psychiatric drugs; or being denied access to a mental health treatment when in a distressed state.

Similarly, it has been suggested that while the recovery movement was instigated by the actions of service users and their advocates, it has long since been co-opted by policymakers, managers, and practitioners and that the progressive potential in recovery has largely been neutralised through processes of professionalisation and bureaucratisation (Hamer, Finlayson, & Warren, 2014). Undoubtedly, notions of recovery and consumerism have come to feature heavily in the professional discourse of policymakers, managers, and practitioners. However, in countries such as Australia, many people treated for psychosis meet criteria for metabolic syndrome, which in part reflects the iatrogenic effects of psychiatric pharmacotherapy (Morgan et al., 2012); improvements in Indigenous mental health remain elusive (Parker, 2010); the physical health of people living with mental illness is poor (Carr et al., 2012); and controversy surrounds the influence of the pharmaceutical industry on medical science and health professional practice (Boyce & Malhi, 2012). It seems important to ask how such concerns might be reconciled with a notion of recovery (e.g. Mancini, Chapter 18, this volume).

People diagnosed with BPD have consistently been marginalised and discriminated against, often by the very services and practitioners who should be providing help:

> A diagnosis of BPD closes the door to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as 'attention seekers' and 'trouble makers'. BPD is the diagnosis every patient wants to avoid.
>
> (Senate Community Affairs Committee Secretariat, 2008, p. 168)

Concerns such as these align with our own experiences of working in and conducting research with mental health services. While our clinical practice and research interests have involved working with a range of service user groups and healthcare practitioners, a central focus has been on practitioner discourses surrounding the management (or non-management) of people living with BPD and other forms of severe prolonged mental illness (see also Bone & Marchant, Chapter 23, this volume for discourse work on personality disorders).

Project overview

While there are various forms of discourse analysis, all share a concern with exploring the political dimensions of language and the ways in which organised sets of discourses are connected to particular social interests. The approach to discourse analysis used in most of our research operates at two levels – text and context. Textually, we are concerned with the structural aspects of a discourse – how grammar and syntax are used, rhetorical devices are employed, and preferred meanings are constructed. Contextually, the focus is on the social-political function supported by a discourse (Chapman & Lupton, 1994; Hall, 1996; Lupton, 1992).

We have also been influenced by Foucault's (2007, 2008) notion of 'governmentality'. Foucault sought to downplay the importance of the state in processes of political subjectification, pointing instead to the role of practices operating both within and beyond the state – a kind of 'government at a distance'. He construed political subjectification in various practices located both within and beyond the state. For mental health, this might involve practitioners working in hospitals and other organisations, self-help groups, and the families of services users (Dean, 2010; Miller & Rose, 1988;

Rose & Miller, 1992). Foucault (2007, 2008) considered political action and personal conduct to be interlinked and suggested that the successful government of others depends heavily on the capacity to govern oneself (Dean, 2010).

An important but often overlooked consideration in studying interactions between practitioners and service users is power. Psychiatric power has typically been linked to social control, implying restrictive understandings of the activities of practitioners. We would argue that such an approach risks missing a range of mental healthcare activities that might be understood in more positive, productive power-analytic terms (e.g. talking therapies, counselling, group work, and emotional work). Here again Foucault's work is instructive, drawing attention to the 'productive' aspects of power implicit in much of mental health work. Following Foucault, power can be approached in relational terms as seeking to affect the actions of individuals by working on the ways in which behaviour is largely self-regulatory; and the extent to which the exercise of power is always accompanied by possibilities for resistance, contestation, and evasion (Hindess, 1996). Such an approach suggests the need to reconsider the nature of interactions between practitioners and service users, understanding the therapeutic enterprise more in terms of the promotion of subjectivity and the forging of alignments between the personal projects of citizens and the prevailing social order (Dean, 2010).

Following the approach outlined above, much of our work has involved analysing the mindsets, techniques, and practices routinely employed by mental health practitioners in monitoring, directing, and shaping the conduct of those under psychiatric 'care'. Procedurally, we follow an approach suggested by Dean's (2010) elaboration of Foucault's (2007, 2008) work on governmentality: we question practitioners about what they are *seeking to achieve through the interventions* being used; the *nature of the interventions* being used to target mental health problems and disorders; the various *identities* (or subject positions) assigned to people living with mental illness; and finally, what are considered to be the *ideal outcomes* for those receiving such help.

The initial use of this approach was in a study of the discourse employed by mental health personnel in making sense of concerns surrounding safety and risk management in everyday psychiatric work (Hazelton, 1999). That study set the scene for subsequent work by exploring how discourses deployed around the themes of safety and risk management were displacing therapeutic themes in the everyday work of practitioners, undermining the social justice aspirations of mental health policy and shifting the ethos of mental health work away from the provision of *care* and towards *control*.

The studies reported in what follows received ethics approval from the respective university and health service human research ethics committees. More detailed methodological discussions can be found in Hazelton (1999), Hazelton, Rossiter, and Milner (2006) and Hazelton et al. (2011).

Talk about trouble

'Managing' to manage

Among people who present regularly to emergency departments and mental health services are a deeply stigmatised group of individuals who have been given a diagnosis of BPD (Cleary, Siegfried, & Walter, 2002; Deans & Meocevic, 2006; Fraser & Gallop, 1993; Hazelton et al., 2006; Nehls, 1998). This disorder involves significant emotional distress and impaired interpersonal and emotional functioning, has an early onset (18 to 25 years of age), and is more likely to be diagnosed in females (about 75%) (Hazelton et al., 2006). Gunderson (2001) has suggested that the severity of disability associated with BPD 'involves a terrible way to experience life' (p. 13).

In 2004–2005, we conducted a series of practice-based workshops in a semi-rural health service in Australia, to support clinicians to develop compassion and skills in dialectical behaviour therapy (DBT) that would enable a more positive response to people living with BPD. Survey results and transcripts from focus groups conducted prior to the DBT workshops found overarching themes of 'difficult consumers' and 'ineffective treatments' (Hazelton et al., 2006). Each workshop commenced with a small group activity in which participants were asked to identify 'messages and myths' regarding BPD. Butcher's paper notes collected from such activities provided a rich tapestry of phrases that further illuminated the pre-workshop findings. Regardless of the profession (nurses, allied health professionals, and psychiatry registrars), workplace (emergency departments, mental health services, or generalist services) or experience of the participants, the messages were consistent. Derisive phrases such as 'manipulative', 'impossible', and 'undeserving of services' arose in each workshop. A belief that difficult behaviours were deliberately designed to cause trouble was apparent in comments such as 'they're there to make your life a misery', 'they don't want to change', and 'no matter what you give them they want more'. That self-harm and suicide attempts were considered attention-seeking gestures was apparent in comments such as 'they don't really want to kill themselves'. Questions such as 'why do we have to see them, they're bad not mad' and comments such as 'they belong in jail' suggested that some practitioners found it difficult to contemplate that people living with BPD were deserving of help.

When asked to identify issues and challenges experienced while working with people living with BPD, the frustration and difficulties were obvious. Some practitioners identified the BPD behaviours as the cause of the challenges. These were often phrased in generalities such as 'never keep appointments', 'they sabotage attempts to help', 'loud and can be obnoxious', and 'they consume more attention and believe they are more special than others'. Others identified practitioner-related factors that contributed to the challenges experienced. These included, 'staff attitudes', 'a need to distance oneself from one's own reactive responses', 'countertransference', and 'limited training in working effectively with this client group'. Service-related problems were also identified including 'siloed services', time and resource limitations and service-related stigmatisation of the people with BPD.

Practitioners were then asked to consider the impact of these messages and challenges on the care provided for people with BPD. Repeatedly, participants identified a sense of 'hopelessness', 'a lack of consistency within and between services', 'disorganised responses', people 'miss out on services', and efforts are made to 'avoid' contact with people put in the 'too-hard basket'. Frequently, responses were described as 'crisis-driven' and reactive. The extent of the impact could be viewed as indicative of a misuse of practitioner power where people with BPD are marginalised, labelled, and stigmatised as being 'untreatable', unworthy of treatment, and likely to cause trouble. These beliefs were then used to rationalise behaviours that are rejecting and invalidating of the person living with BPD (Hazelton et al., 2006).

While it is perhaps tempting to vilify practitioners who struggle to respond therapeutically to people living with BPD, it is important to acknowledge the impact of attempting to work with behaviours that at times can be confronting, challenging, and frightening. Wright, Haigh, and McKeown (2007) have made the point that '(however) we care to define or make sense of it, the particular behaviour that typically leads to a personality disorder diagnosis is likely to challenge and frustrate care staff engaged in attempts at therapy' (p. 244). Participants in our study spoke of treatment interactions with people living with BPD as 'making us feel like we don't care', while others admitted that these interactions 'bring out our own worst features' (Hazelton, Milner, & Rossiter, 2003). Added to these challenges, practitioners' comments suggested a service culture in which people living with BPD were discursively constructed as 'trouble', and that 'more worthy' people were missing out on care. Some participants disclosed that they had not previously had training they felt equipped them with the skills required to work effectively with 'these people'.

A substantial literature describes the effect on therapist psychological well-being of working with people such as those living with BPD who have experienced a range of traumatic events in their lives (Kottler, 2008; Sprang, Clark, & Whitt-Woosley, 2007; Todd, 2007). Participants in our study identified issues associated with working in settings where people living with BPD are regularly encountered as contributors to 'higher stress and burn-out', reductions in empathy, a sense of hopelessness, avoidance and disputes between staff members. Also identified were increases in sick leave and acknowledgement that some staff members were left carrying a heavy clinical load as others avoided contact. Wright, Lavoie-Tremblay, Drevniok, Racine, and Savignac (2011) argue that it is important not to minimise the challenges of providing help for this group of people. However, the 'unhelpful polarization of viewpoints' reflected in practitioner comments about BPD may result in 'the diagnosed' becoming 'divorced from the rest of humanity' (p. 241).

Given the negative and stigmatising attitudes expressed by many participants, attempts to teach skills and therapeutic interventions needed to be preceded by strategies designed to challenge such attitudes and elicit capacity for empathy and compassion for people living with BPD. Without the ability to recognise a shared humanness or 'a re-engagement with common humanity', training is likely to be unsuccessful (Wright et al., 2007, p. 236). The training provided initially focused on this issue and analysis of focus group transcripts conducted post-training in DBT found a positive change in practitioners' views of people living with BPD. Therapeutic pessimism had been replaced by optimism, compassion and humane understanding, and a more hopeful outlook regarding the outcomes of treatment (Hazelton et al., 2006).

The impact of the DBT training was such that the health service supported the development of a DBT treatment team. An unexpected finding was accounts of personal benefits experienced by practitioners as a result of undertaking the DBT training. In particular, a comment by a clinician that 'this therapy has changed my life' prompted further reflection. It would be reasonable to anticipate that the person receiving therapy might describe positive changes occurring as a result of treatment. However, it was unforeseen that practitioners/therapists might attribute positive personal benefits from learning and delivering a particular therapy. Comments such as this led to follow-up research to explore, interpret, and understand the experience of clinicians training and practising as DBT therapists (Rossiter, 2008, 2009).

Practising and preaching

The follow-up study referred to above employed phenomenological methods, utilising three distinct, yet interrelated steps or 'rules', that is the rules of epoché, of description and of horizontalisation (or equalisation) (Spinelli, 1989). Data collection involved both in-depth and semi-structured interviews. A purposeful sample sought medical, allied health, and nursing practitioners who were trained and actively involved in practising as DBT therapists within a public mental health service. Participants were aged between 27 and 55, with five male and eight female clinicians representing a range of mental health professionals. One psychiatrist, four psychologists, three occupational therapists, three social workers, and two nurses were interviewed. Six participants were employed in a multi-disciplinary, tertiary-level team providing specialist services for people with BPD. Six worked in a semi-rural mental health service comprising an acute inpatient psychiatric ward and a community team with a small therapy team. This service provided generalist services with treatment for people with BPD comprising a component of the work only. The final participant worked across an acute inpatient service and the tertiary-level team. Experience working in mental health services varied widely as did experience practising as a DBT therapist. The least experienced participant had six months active involvement with over three years familiarity with DBT while the most experienced had six years of practice as a DBT therapist.

Each person reflected on 'pre-DBT' experiences, with some presenting their personal experiences while others highlighted their observations of the challenges and difficulties associated with people living with BPD. Views consistent with a discourse situating the problem within 'this group' were expressed:

> `But oftentimes it's just too hard and you can think I don't want to work with this group (Extract` *R6*`).`

> `I was working very much on the frontline...seeing the culture of a hospital setting, and seeing how people treated this group...It was really very tough...This is a very hard, awful group. We don't want to work with them...very stigmatizing (Extract` *R3*`).`

This suggestion that association with people with BPD tainted anyone associated with them was expressed much more strongly by another participant:

> `This is a population that is still effectively being told to go away and get lost...People with borderline personality disorder are the stigmatized of the stigmatized, and I mean there's secondary stigmatization that occurs for the staff that have worked with them (Extract` *R7*`).`

Another participant flagged the emotional intensity of the interactions between staff and people with BPD:

> `Looking at the angst in the staff...and the conflict that arose between the clients and staff,...staff seemed to be so sensitized to anything that they did, and very reactive in nature (Extract` *R2*`).`

Observations such as this suggest a limited capacity among some practitioners to respond therapeutically to people who have been admitted under the diagnostic label of BPD. This is consistent with strongly held beliefs that such people are not deserving of care, are irritating, and do not have a 'legitimate' mental illness.

The interview data provided insights into how engagement with DBT as a therapist impacted both personally and professionally on each person's sense of self and other. Participants spoke of the ways in which the process of learning

DBT, the philosophical principles underpinning the therapy, the assumptions that guide therapist–client interactions, and the skills taught had shifted their view of people living with the disorder:

> By actually doing the training...you're almost forced to become more mindful and go through some of the process itself, so I think it really helps in...understanding what's actually happening, right here right now with...the client (Extract *R8*).

> Taking a much more non-judgmental stance towards the client...rather than just kind of getting angry and pissed off at the client for doing that...It helps you to understand how they've come to be that they were behaving in such a way (Extract *R6*).

This contrasts starkly with pre-DBT discourse with participants acknowledging the shift that has occurred in their responses. They were able to discriminate between previously non-empathic stances to a newly adopted non-judgmental stance and mindfulness. To what did these participants attribute this shift towards more compassionate and effective care? Just as mindfulness is described in DBT as a 'core skill', for many participants their practice of mindfulness was described as central to personal changes and an enhanced capacity as a therapist. The impact was often seen as pervasive:

> I think the biggest one for me is...the whole idea of mindfulness and how useful it can be in everyday life (Extract *R8*).

> ...mindfulness and that's something that I'm just continually aware of in my life...it helped me to actually have more of a sense of being alive by using mindfulness...to actually notice kind of each moment (Extract *R6*).

For some, an enhanced capacity for emotion regulation was noted:

> I don't take things so personally anymore...it just gives me...the capacity to engage my wise mind regularly...it's just with me all the time (Extract *R1*)

For others, the mindfulness-related concept of radical acceptance was paramount:

> The radical acceptance idea has been really big. That this just is how it is. It's a big thing...and once you can stop focussing energy on battling that because many of us do, it's amazing how much energy you've got to do other things (Extract *R3*).

> I think that practice of mindfulness and... acceptance, has just made it easier to work what at times is a really difficult job...but not let that have an impact in other parts of my life. But most probably easier on myself and others outside of work (Extract *R7*).

The discourse related to participants' practice of mindfulness was linked to an enhanced level of self-awareness:

> A greater awareness of myself...also those around me and my interactions with them,...a greater awareness around notions of self...When things are okay, when things are not quite so okay. Do I need to work on them, or do I need to just...let it go (Extract *R3*).

Specific DBT skills, in particular, interpersonal effectiveness skills, were attributed with an enriched capacity to more effectively negotiate encounters in relationships outside of work:

> I was not always cognisant of the whole describing what I want and expressing my emotions and asserting myself and reinforcement...it's helped me at times to think about...how to communicate what I want...and thinking about other people and the way I word things ...I'm a bit more aware of how I do that (Extract *R10*).

Participants provided insights into the ways in which training and practice in DBT had challenged their attitudes, beliefs, and behaviours both in their professional and personal lives. With increasing self-awareness came an awareness of potential hypocrisy or 'incongruence' between what they espoused and how they lived:

> I'm asking my patients to do this, well bugger it, I've got to do it too...but I think it's important for me to practice what I preach, and to have an actual experience of what I'm teaching people (Extract *R10*).

> ...we make it very, very clear you know that to clients we're in no way perfect and that when we're teaching skills, my God there's lots of stuff that we should be doing. You know that practising and preaching thing (Extract *R3*).

In contrast to attitudes indicative of a level of arrogance or of being the 'one who knows' and judges harshly, participants demonstrated awareness of their own humanity and recognition that they too have much to learn. Some participants discussed ways in which aspects of DBT now informed and guided their lives, leading to enhanced capacity to 'live life to the full':

> I think some of the fundamentals that this practice has really given me, like a model to work with that's very manageable and I've embraced in all areas of my life...I find it comforting to know that I've got a way of understanding things (Extract *R1*).

> ...we've had discussions ourselves around the way in which DBT becomes part and parcel of your life...we talk at length about the way in which we've grown from it...I think it's really important...that we recognize and we reflect on the way in which it impacts on us, because...as a service, DBT has become a whole service approach...to acknowledge that it's done more than just affect the service (Extract *R3*).

These examples can be understood as expressions of a theory and therapy embodied within the lives of the participants; of fundamental changes that have occurred at both a personal and professional level from immersion in a therapy that provides both a set of assumptions that challenge the prevailing discourse and a tightly held structure and supportive framework that enables therapists to stay in relationship throughout the most demanding encounters (Spinelli & Marshall, 2001).

When addressing attempts at engaging therapeutically with people living with BPD, the discourse shifted markedly from one replete with expressions of frustration, blame, futility, and hopelessness to one suggesting a heightened capacity for collaborative relationships:

> ...people are doing the best they can...remembering that is one of the key things (Extract *R10*).

> ...a really big focus on...acceptance...in the validation of that relationship (Extract *R5*).

An even greater shift was evident as participants described with enthusiasm and admiration their responses to the progress made by people with whom they had worked closely:

> It takes a lot of courage and commitment to do that,
> ...you're very humbled often by their stories and what
> they've done and...you share in their joy when they ...get
> it you know...you kind of get excited about how they go
> off into life with a whole bag of skills that means
> they'll enjoy their life, and have control and be in
> charge of their life (Extract *R1*).

> We were seeing people's lives change radically...seeing
> them challenged within their lives but their skills
> allowing them to keep moving forward (Extract *R7*).

These changes indicate that participants' professional development and their sense of self had matured in such a way that they could now develop therapeutic relationships with people for whom intimate relationships had previously been damaging. This maturity included an enhanced moral sensibility – behaving in a 'just and moral' manner towards people who had previously been seen as 'unworthy of care' and 'untreatable' (Rossiter, 2008, p. 139).

People with BPD are at high risk of suicide and may present frequently with self-harm such that many health professionals struggle with strong emotional reactions and are reluctant to become involved in working with this group (Commons Treloar & Lewis, 2007). Participants demonstrated an ability to override this antipathy and engage in accepting and caring therapeutic relationships. This shift involved a more humanistic attunement to the other with a capacity to care for and rejoice with the person at signs of progress even in the midst of the distress related to living with BPD. 'The capacity... to deconstruct the damaging attitudes and beliefs about people with BPD and replace these with an empathic stance and enhanced self-awareness is integral to enabling therapeutic engagement and effective treatment outcomes' (Rossiter, 2008, p. 141).

The trouble with new graduates

> It is the ultimate hypocrisy of our profession that we do not or cannot do the same things we ask of our students and clients.
>
> (Kottler, 2003, p. 57)

As part of a wider study addressing the experiences of new graduate nurses commencing employment as registered nurses in a public mental health service, our attention was drawn to the ways in which mental health services may impede rather than facilitate recovery from mental illness. That study was conducted in 2005 and 2006 and involved the evaluation of a group mentorship programme for new graduate nurses working in an Australian public mental health service. The mentorship programme was one year in duration, comprised three, four-month rotations through different clinical services, involved shift work, and commenced with a one-week orientation. Participants were new graduate registered nurses (n = 18) commencing full-time employment in mental health and clinical nurse consultants (n = 5) – advanced practitioners, with postgraduate qualifications and extensive experience in mental health. The mentorship groups met fortnightly, and comprised six new graduates and two clinical nurse consultant mentors. Data collection involved audiotaping mentorship group discussions, participatory observation by research team members, and brief participant-completed summaries of the key points of discussions. Data were analysed using the approach described in the methodological description provided above.

While the main focus of the study was on the needs of the new graduates for structured support and guidance as they commenced employment as registered nurses, the discussions frequently addressed problems such as the arduous nature of mental health work; the uncaring attitudes of and practices of many of the veteran nursing staff; and the maltreatment and neglect of service users. In general, the new graduate nurse participants characterised the public mental health facilities as tough security-minded places, where staff act more as risk-managers rather than therapists, and all service users are treated as if they might be dangerous. The following extracts are examples of the issues frequently raised by the new graduates within the mentorship discussions.

New graduates being put in their place by veteran staff:

> You go on the ward and a simple thing like transferring a [phone] call...'You don't know how to transfer a call'? And [I] said, 'no, but if show me [I will] know'...in the end you don't want to ask questions (Extract *female new graduate*).

The maltreatment and neglect of people living with mental illness:

> There was an incident last week...the client actually said: 'well we can do this the easy way or we can do this the hard way'. [A staff member] said 'f...it, let's do it the hard way'; they weren't prepared to wait around...I would have explored the other option first (Extract *male new graduate).*

> We had a girl [admitted]...She was absolutely paranoid... but I made a connection with her...and she told me all

> this stuff and I am new. I went back to the staff... and they said, 'off you go [home]'. [I said] 'I have just spoken to this girl...I want to tell you...what she told me [because] that is going to affect her treatment'...That is how they related to her...nobody is interested (Extract *female new graduate*).

While the participants' discussions ranged over many issues in mental healthcare, a particular area of concern was how to help a person who had been vilified by staff. In one discussion, a participant discussed her recent experience of working with a person who has been admitted with a diagnosis of BPD:

> We had a [person with] borderline [personality disorder] on the ward and I spent some time [with her]...So I am writing up her notes and three people said: 'waste of space, you are wasting your time writing it up' (Extract *female new graduate*).

A number of the new graduates also perceived a connection between the dismissive ways in which they were often treated by veteran colleagues and the widespread mistreatment of service users:

> I still find at handover there will be three people...and they will talk as if I am not in the room; am I not working on the shift? Do I not need to know about the client...I don't know if it is a conscious thing, or maybe it is because people have worked here for so long (Extract *female new graduate*).

> The people who intimidate me,...intimidate...patients on a worse level (Extract *female new graduate*).

Clinical relevance

Effective mental health work requires self-regulation in balancing the degree of liberty one extends to service users with the need for providing help and managing risk. Getting the balance right is especially demanding when working with people at risk of harming themselves or others. The risk-bound nature of mental health work is evident to practitioners regardless of health professional background and experience; is raised in undergraduate health professional education in Australia (and comparable countries); and is reinforced from the moment a new graduate enters the mental health work force. At the same time, university studies also emphasise the human rights and citizenship entitlements of persons living with mental illness. Concepts such as 'mental health consumer', 'least restrictive environment', and 'recovery-oriented practice' imply the need to exercise a kind of 'soft' power to regulate the behaviours of vulnerable and distressed individuals. However, coming to terms with the power-relations inherent in mental health work poses a challenge for new graduates, and it should be said, many 'old hands'. While new graduates and more experienced health practitioners may be confronted by the uncaring and coercive ways in which some professional colleagues deal with service users, lack of experience and/or prevailing (formal and informal) workplace authority structures may contribute to a (perceived) lack of professional power to change things. Such lessons are not readily covered in formal university studies, and the informal lessons of the workplace often seem more concerned with maintaining 'how things are done around here'.

In the studies referred to above, participants indicated a desire to become more effective practitioners/therapists; many also acknowledged the need for confidence to deal ethically with what were considered to be poor standards of practice encountered on an almost daily basis. What ought to be done if ethical issues were encountered was a frequently discussed topic and might range from how to manage in situations in which service users had been demonised by staff (e.g. working with a person with a history of child abuse, or working with a person diagnosed with BPD) to instances in which an individual's rights are being violated. The following extract from the new graduate mentorship project illustrates the type of narrative likely to leave participants ill at ease and unsure of how to respond:

> [This service user] thought she was going to get out [of hospital], we weren't allowed to say that we were going in for a two-month order to keep her here. [The nurse unit manager said] we weren't allowed to say you are going to be here for two months. I wished her luck and hoped she got what she wanted all the time knowing that she was going to have a two-month stay. That's really hard, but I wasn't in a position to [tell her the truth] (Extract *female new graduate)*.

The participants in the studies referred to in this chapter were involved in mental health work a decade or more following the implementation of the National Mental Health Strategy in Australia. Given the reform directions set down in policy, the principles learned at university, and the standards of practice advocated by the health professions, the participants might have expected to find a service culture in which genuine care and concern were shown for service users;

where staff and service users collaborated in treatment decision-making; where policies and procedures were non-discriminatory and sensitive to human rights; and staff expected service users to recover even in cases of severe mental disorder. However, the findings of the studies reported in this chapter suggest that the work environment in mental health services may fall short of the stated ideals of policymakers, consumer spokespersons, and health professionals. Similar findings in other parts of the country would imply a wide gap between ideals and practices in many mental health services throughout Australia.

Clearly, mental health work is demanding. While participants could identify strong role models and supportive colleagues, they also disclosed numerous instances of having to work alongside staff they considered to be indifferent or even hostile towards services users and also in some instances towards themselves and other staff; this was certainly the case for new graduates, but was not restricted to this group alone. Participants discussed many instances of a lack of concern and defensiveness shown by colleagues towards people living with mental illness, and frequently such staff reactions involved diagnostic groups assumed to be 'troubling' and 'troublesome'. The maxim that relationships 'are the heart and soul of mental health care' (Wright et al., 2011) seems to have had little sway over such uncaring staff.

Todres, Galvin, and Holloway (2009) have argued that when health professionals offer care that supports the autonomy, dignity, and complexity of individuals, they bolster opportunities for humanisation. Such caring values were little evident in participants' descriptions of how many staff interacted with those for whom they provided 'care'. Historically, attempts at humanistic care have often been shadowed by punitive and constraining treatments to achieve broader social aims for the control of madness and 'crazy' individuals. In this sense, we might say there has always been a 'dark side' to mental health work which is sustained by the social role of the mental health professions in maintaining social order and intermittent moral panics surrounding mental illness and dangerousness (Beresford, Nettle, & Perring, 2010; Morris, 2006).

The findings of the studies reported in this chapter indicate the ways in which policy and practice improvement initiatives may be modified, undermined, or simply ignored by staff. Unfortunately, such policy-resistive practices align with the increasingly risk-averse and defensive nature of mental healthcare in Australia and internationally (Hazelton, 2005; Hazelton et al., 2011); high security design and defensive practice have become standard in many services. One especially worrying recent development is the increasing use of electronic stun (Taser) devices by police in the course of intervening in mental health emergencies in the community (O'Brien & Thom, 2014); might this be extended to clinical settings in the future? 'Zero tolerance' polices have also been introduced to deal with patient aggression and violence with 'mentally ill being seen as especially threatening in busy acute care services such as emergency departments and psychiatric assessment units' (Pich, Hazelton, Sundin, & Kable, 2010). Zero tolerance has also been criticised for taking the therapeutic initiative away from healthcare practitioners, thus removing opportunities for building service user engagement with care (Stone & Hazelton, 2008; Wand & Coulson, 2006).

Bringing about change in any area of public policy requires that consideration be given to stake-holder engagement. If the process of professional identity formation influences workforce development and retention (Morrissette, 2010), new graduates' workforce transition experiences are likely to shape their developing understanding of mental health work. Regular exposure to senior colleagues displaying cynical, uncaring, and hostile attitudes and behaviours to service users and professional peers could influence whether new graduates build a professional ethos primarily in terms of duty of care or duty of control (Bertram & Stickley, 2005). For participants in the new graduate project, the mentors provided a model of how to build a therapeutic skill set within an ethics of caring. The participants in the DBT studies also faced demanding work circumstances in which the practices of some colleagues might be damaging to service users and staff. For these more experienced staff, training in and then working with a focused psychological intervention seemed to play much the same role as the mentors in the new graduate project – providing structure and support.

Other studies have used different approaches to analyse situations in which the understandings and expectations of practitioners and patients and different groups of practitioners do not align. Crepeau's (2000) narrative analysis of clinical team meetings considered similar issues to those addressed in this chapter, but in the context of an inpatient geropsychiatric service in the United States. That study explored how patient refusal to comply with sick role expectations might undermine the professional composure and therapeutic confidence of some treating staff and the ways in which persistent negative staff images of a patient might be changed .

There are important implications here for the prospect that key mental health policy reforms might be realised in practice. In each of these studies reported in this chapter, participants were offered and usually took up opportunities of accessing structured in-service education and ongoing support. Such involvement included techniques for recognising and subverting damaging discourses; shifting work-related conduct in more positive directions; building the capacity for moral behaviour; and becoming more effective in dealing with people and situations. To put it another way, participants were asked and supported to practice what they preach; to do many of the same things they ask of the

Table 21.2 Clinical practice highlights

1. Evidence-based therapeutic practices implemented with careful attention to challenging prevailing stigma-laden discourse can positively influence both service user outcomes and practitioner well-being.
2. The risk averse nature of the current environment in which mental health services are delivered requires practitioners who have the opportunity to regularly engage in debate focused on the moral and ethical implications of practice.
3. Practitioners who actively engage in practices focusing on enhancing self-awareness and mindfulness will be better equipped to resist urges to misuse the power inherent in their role.
4. Adopting DBT or similar therapeutic assumptions such as 'the person is doing the best that they can' supports a focus on working with people living with mental illness in a person-centred manner.
5. Abiding by the golden rule to 'treat others as you would wish to be treated' and 'practicing what you preach' are essential if practitioners are to see the person living with mental illness as a 'fellow human'.

service users with whom they work. For a simple summary of the practical implications, please see Table 21.2.

Summary

This chapter has reported research investigating interactions between practitioners and people living with mental illness who are considered to be resisting treatment. The main purpose has been to better understand the discursive practices by which 'troubling' and 'troublesome' service users are constructed and managed, within the context of policy and practice tensions in which practitioners often seem caught between providing care and managing risk. In the various ways in which they sought to resolve these tensions, participants in the studies reported took up opportunities for structured in-service education and ongoing support. Through involvement in techniques designed to enhance self-awareness, increase mindfulness, build compassion, and challenge stigmatising attitudes, participants came to realise that they were practising what they preach.

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22

Conversation with an Adult with Features of Autism Spectrum Disorder in Secure Forensic Care

Sushie Dobbinson

Introduction

This chapter focuses on an interaction which takes place in a medium secure psychiatric hospital between a forensic speech and language therapist (FSLT), M, and a male, H, in his early 20s, whom she works with. H is a patient detained under the Mental Health Act (Department of Health, 2007) who, at the time of recording, had been resident in the secure hospital for almost three years. H has a diagnosis of moderate learning disability and also presents with features of Autism Spectrum Disorder (ASD). Prior to the recording of the conversation, the interactants had worked together for two years, always in the same setting and always on themes surrounding H's offending behaviours and the beliefs underlying these, hence the two had a well-established relationship and were both familiar with the context in which the interaction takes place.

The conversation was recorded as part of an ongoing project in which patients in the hospital were assessed for previously undiagnosed ASD. Some of these patients were found to be part of the hospital's hard-to-treat cohort, having not responded to standard psychiatric interventions. The central aim of the project was to establish whether or not there is a need for a treatment pathway for such patients using different strategies other than the ones currently employed by the hospital. The second, related aim is to establish what such treatment strategies may involve in the forensic context, in which the main focus is on risk reduction and rehabilitation to less secure settings.

The chapter first considers how some forensic hospitals in the United Kingdom have come to miss diagnoses of ASD and what this means for patients in their care. Secondly, the conversation between M and H is analysed. The analysis illustrates how FSLTs can add to the understanding of treatment of patients such as H who have features of ASD by dealing with difficulties as they arise in the talk. The FSLT approach shown here is very much bottom-up and patient led and, importantly, illustrates how interaction can be used as the basis of interventions in which behaviour and belief modification are the key aims (Burns, Bird, Leach, & Higgins, 2003). Throughout, the terms *forensic* and *secure psychiatric care* are used interchangeably.

The forensic ASD project: Project overview

Prior to the start of the project, it had been noted that a core of patients throughout the hospital consistently presented with features suggestive of ASD. Some of these patients were hard-to-treat. Nevertheless, some clinicians not only achieved good rapport with them but were also able to make inroads on their problematic behaviours and poor understanding of self, both important adjustments for forensic patients to make if they are to reduce their risk factors. These clinicians neither clustered in any profession nor was it clear how their good working relationships translated to successfully achieving treatment goals. Very little is known about how interaction takes place between forensic clinicians and their patients, despite the importance of establishing effective ways of working with this complex patient group (Gildberg, Elverdam, & Hounsgaard, 2010).

Research questions of the project are:

1. Do some of the hard-to-treat patients in the medium secure hospital have undiagnosed ASD?
2. What methods may be effective in improving present treatment strategies so that these patients can reduce risk and become successfully rehabilitated to lower levels of security?

The importance of accurate diagnosis in the forensic context

Psychiatric hospitals have a long and complex history (Bone & Marchant, Chapter 23, this volume). Currently, secure psychiatric care in the United Kingdom consists of high, medium, and low facilities and is compulsory for adults detained under the Mental Health Act (Department of Health, 2007). The Act defines the categories of persons detainable as anyone posing a significant risk of harm to self or others and who has a mental disorder. Psychiatric assessment and most forms of treatment are compulsory, although status of patients varies according to which section of the Act is used. For example, while Section 2 only lasts for 28 days at which point it must be renewed, release from Section 37, often used to detain patients in the medium secure hospital, is only made at the discretion of the Ministry of Justice. Persistent lack of change in presentation means that for some patients a section can be kept in place for a lifetime. For anyone to whom the Act applies their mental disorder as defined by a diagnosis can become a critical cornerstone of their detention.

Diagnostic categories, however, are not set in stone. Both to take account of our developing knowledge about mental well-being and mental illness, as well as to keep pace with changing attitudes and continually evolving socio-political context, the manuals of psychopathology, *ICD 10* (World Health Organisation, 2010) and *DSM* 5 (American Psychiatric Association, 2013), are periodically revised and updated; *DSM IV*, published in 1994 was replaced by *DSM 5* in 2013. Such revisions can create uncertainty, undermine confidence, and even foster distrust towards the medical professions, but in forensics, meaningful diagnosis based on the most recent research and up to date thinking is vital to keep patients progressing rather than stagnating in long-term care.

Once a person enters the world of forensic psychiatry, a diagnostic label takes on a portentous aspect. While individuals in the community are able to dispute diagnoses, seek a second opinion, request further assessment, or may simply refuse treatment, forensic patients may have little say in the question of their illness and none in their acceptance of most forms of treatment, since consideration of risk to the community rather than recovery of the individual is prioritised. The only way forward within the forensic establishment is to evidence reduction of risk. The best way to reduce risk is to respond to treatment; treatment which depends to no small extent on an accurate diagnosis. In an ideal world, all aspects of a detained patient's functioning would be known, understood and treatment fitted around them (patient-centred care). On busy wards with financial constraints set within complex, ever-changing bureaucratic hierarchies of management, the reality is that there are treatments available, they may work; if they don't then an individual's detention continues. Patients can easily become locked into the system. Perhaps, for certain patients, their dysfunction really is intractable. Perhaps rehabilitation is not, nor ever was a realistic option for them. But if the first premise, that is, the diagnostic label, is flawed, then the chances of successful rehabilitation must necessarily reduce as a consequence.

Diagnosis of ASD in secure care

There are many reasons why investigating a differential diagnosis of ASD has been low on the list of priorities in forensic psychiatry. The forensic system is not particularly well designed for differential diagnosis of conditions less frequently encountered in the setting. ASD is not considered a risky condition in the same way as schizophrenia or personality disorder are, so clinicians are less likely to be looking for signs of it. Before admitting new patients to their service, clinicians are reliant on a sometimes overwhelming amount of existing information previously gathered by disparate services and establishments which may be paper-based and densely packed with extraneous information. Admissions are often made quickly without opportunity to comprehensively review histories until later, by which time drug-based treatment-regimes may already have become established. Once underway, a psychiatric treatment regime may confuse a presentation and may not be easily amenable to termination.

ASD remains poorly understood by non-specialists; media portrayals which focus on its more exotic aspects confuse the picture of this heterogeneous condition further. ASD has been contentious practically from its inception, with the view that 'refrigerator mothers' were, quite literally, the progenitors of their children's autism due to their cold, parenting-style holding sway throughout the 1950s and 1960s (Bettelheim, 1967). The debate continues to cast a shadow even today. Despite Asperger's not-quite-simultaneous description of the same condition just a year later, Kanner's 1943 definition of autism was the one that made it into the diagnostic manuals in 1952. Asperger's did not appear in *DSM IV* until 1994. Despite the similarity between Asperger's and autism when first described, *DSM IV* made the two distinct, the difference resting on an absence of cognitive and language impairment and a less marked social impairment in Asperger's (Ghaziuddin, 2010). In practice, clinicians and researchers seem to have found the autism–Asperger's distinction difficult but compelling. Following its appearance in *DSM IV*, the number of publications with Asperger's in the title rose sixfold between 1994 and 2010 suggesting increasingly active research interest (Ghaziuddin, 2010). Nevertheless, the distinction between the two conditions remained unclear to the extent that Asperger's syndrome was excised from *DSM 5*, conflated into the more general term of Autism Spectrum Disorder (Hazen, McDougle, & Volkmar, 2013).

From the point of view of differential diagnosis in forensic psychiatry, the *DSM IV* inclusion of Asperger's syndrome was helpful. People who come into forensic services tend to function at an intellectual level sufficient to engage in criminal activity, and hence were more likely to fit the more highly functioning Asperger's profile. Up until 1994, however, psychiatrists were not equipped to make the diagnosis of Asperger's since according to the manuals it simply did not exist. This meant that clinicians with powers to detain lacked the necessary tools to identify the condition. Even diagnosing clinicians, post 1994 are unlikely to have received adequate training to identify the often subtle signs of Asperger's (Haskins & Silva, 2006).

The *DSM IV* requirement that ASD should become apparent during early childhood made adult diagnosis difficult, since even if childhood caregivers were still available and willing to help with the diagnostic process, their recall of milestones and early behaviours will have naturally deteriorated with age. Additionally, anyone with ASD not clinically identified during early childhood is likely to have a more subtle variant of the disorder making detection still more difficult. In *DSM 5*, the criterion of appearance before three years of age has been replaced by one which states that the disorder may not become apparent until 'social demand exceeds capacity', partly circumventing this difficulty of late diagnosis and also the reliance on the testimony of willing informants with both knowledge and robust recall of early milestones.

Differential diagnosis and co-morbid conditions further complicate the picture of forensic ASD diagnosis. Schizophrenia can be difficult to distinguish from autism, while a relatively high rate of co-morbidity between schizophrenia and ASD adds another element of confusion (Hare, Gould, Mills, & Wing, 1999). Personality disorders, particularly schizoid and schizotypal, may be similarly difficult to distinguish from Asperger's (Haskins & Silva, 2006). All this adds up to the possibility that there may be a small but significant number of people with ASD in secure care carrying missed or incorrect diagnoses (Stahlberg, Anckarsater, Rastam, & Gillberg, 2004).

ASD's variability and heterogeneity can be deceptive for clinicians used to looking for patterns that fit the usual forensic profiles. ASD is essentially a disorder of social communication, meaning that it may not become apparent unless observed across a variety of social contexts, a necessarily limited possibility for detainees confined by the very controlled environment of the secure hospital. Routines form the basis of life in secure hospitals, meaning that the ASD insistence on sameness may easily pass unnoticed. The precursors to difficult behaviours may not be immediately apparent from observation, unless clinicians actively seek evidence from an informed basis. Without careful hypothesis-driven clinical reasoning, ASD avoidance of sensory stimuli may easily be misconstrued as willful lack of engagement, lack of social and emotional reciprocity interpreted as solipsistic coldness, over-literal understanding as social naivety, or worse, a rejection of the accepted norms of society. Diagnosing forensic ASD ideally requires the correct diagnostic tools to be accessible, training, experience, a multidisciplinary approach, an open but informed attitude towards differential diagnosis, a variety of reliable informants, and different contexts in which to make observations.

Confusion in diagnosis is likely to have a significant effect on the care a forensic patient receives in order to address and remediate the difficulties underlying their offending behaviours. A mistaken diagnosis of schizophrenia given to an ASD patient, whose problems in fact devolve from neurologically deep-seated developmental causes, may result in detention for extensive periods of time without recourse to strategies that could improve the chance of effective rehabilitation. Where the mainstream ASD population may be considered poorly served by UK society, with social policy adjustments either sporadically applied or simply absent, the consequences of misdiagnosis of ASD within the forensic population are both societally and personally more serious. Anti-psychotic drug-regimes may be a literal life-saver to sufferers of schizophrenia, but could compound the difficulties of people with ASD. Environmental treatment strategies, which properly applied may make significant inroads on an ASD offender's behaviours, tend to be used more sparingly in the treatment of schizophrenia. People with schizoid and schizotypal personality disorders may superficially resemble people with ASD since both tend to have poor interactional and social skills and low empathy, but while personality disorder has been shown to respond to Cognitive Analytic Therapy, ASD thinking derives from a neurodevelopmental aetiology which makes this kind of treatment far less accessible. People with ASD offered this kind of treatment may go along with it only to find clinicians interpret their inability to change mind-set as proof that they are not invested in their treatment, hence not fully engaged in addressing their offending, hence still a risk, hence still detainable.

Long-term detention of people in secure care is expensive and exposes the clinical workforce to undue risk; the greater the numbers of persons detained, the less money is available for training or safe staffing establishments. People with ASDs can be intolerant of their peers or changes in routines, or have sensory sensitivity which varies unpredictably. Their means of communicating the consequent anxiety or distress are sometimes unconventional, often behavioural, and can appear out of proportion to the stimulus, which may after all not be readily apparent in the context of a busy forensic hospital with a population for whom complexity is the norm.

Precise data concerning the number of people with ASDs in forensic care are not routinely collected, but studies have been conducted using various methodologies. Using a screening questionnaire, Hare et al. (1999) found prevalence rates of ASDs in the United Kingdom's high secure estate of Broadmoor, Ashworth, and Rampton Hospitals as 2.4%. The prevalence of ASDs in the general UK population is reckoned to be around 0.7% (Ehlers & Gillberg, 1993). Scragg and Shah using a different methodology found a prevalence rate of 1.5% in Broadmoor which rose to 2.3% when equivocal cases were also included (as opposed to a prevalence of 0.36% in the general population using the same criteria) (Murrie, Warren, Kristiannsson, & Dietz, 2002). Workers in the United States found a prevalence of 4.4% by using the Autism Quotient tool (Baron-Cohen, Wheelwright, Robinson, & Woodbury-Smith, 2005); that is, four times the rate of ASDs found in the US general population (the difference between UK and USA general population estimates may be accounted for by the use of different diagnostic criteria: *ICD* and *DSM*, respectively) (Fazio, Pietz, & Denney, 2012).

The gold standard for diagnosing ASD in adults continues to be the clinical judgement of the MDT (multi-disciplinary-team) panel (National Institute for Health and Care Excellence, 2012). In these times of radical cuts to services, many NHS trusts are unable to provide such a service, however. Identifying ASD in adults may not be considered a priority, the assumption being that those who have managed to reach adulthood without being picked up by services are functioning adequately enough for them to be without need of clinical support. The prevalence figures mentioned above, however, indicate that people with ASD are certainly present in forensic communities, prisons and secure hospitals, where far from being without need of clinical support, they may form an expensive, hard-to-treat, long-staying cohort.

Forensic SLT

As an SLT, M has received specific training in communicating with people who have ASD. Unfortunately, such expertise is limited in the forensic context. A 2011 survey indicated that out of around 1000 SLTs working in Scotland, just 24 were working in the Criminal Justice System. Their work accounted for an average of 27 hours per client (Clark, Barrow, & Hartley, 2012). In the same year, there were 11, 500 practising SLTs in the United Kingdom but, at the time of writing, no published figures about how many were working in the criminal justice system, although almost certainly the numbers are similarly low. The high client–contact ratio in the Clark et al. survey reflects the difficult nature of work in this area, where complex conditions are routinely under diagnosed, meaning that therapists have to undertake a significant amount of pre-intervention work to establish client needs before work on risk reduction can take place. While accurate diagnoses on which the potential for a person's risk reduction is contingent are not made, the extent of complexity in the criminal justice system can be ignored. However, the concomitant likelihood of reducing recidivism is also necessarily reduced. Though not made with specific reference to ASD but to the wider group of people who have unmet communication needs, Bryan's comments on how this impacts community as well as individuals, are pertinent, as it was noted that

> around 40% of young offenders might have difficulty in benefiting from verbally mediated interventions such as anger management and drug rehabilitation courses. This would imply they might be more likely to leave prison with unresolved problems known to contribute to re-offending. A young offender leaving prison who finds it hard to talk to others and who has difficulty in understanding others is likely to experience added difficulties in reintegrating into society.
>
> (2004, p. 399)

Method

Within a medium secure psychiatric hospital for adult males in the United Kingdom, MDT meetings were convened to identify those patients who presented with behaviours and neurological features consistent with ASD. This process was informed by reference to the AQ10 (Smith, Robinson, Wheelwright, & Baron-Cohen, 2005) and the *DSM 5* diagnostic criteria for ASD (American Psychiatric Association, 2013). Those patients who presented with sufficient criteria to warrant further screening were then administered the AQ10. Where cut-off was reached, further assessment was carried out using the Adult Asperger Assessment (AAA) battery (Baron-Cohen, Wheelwright, Robinson, & Woodbury-Smith, 2005) and Autism Diagnostic Interview-Revised (ADI-R) (Rutter, Le Couteur, & Lord, 2007).

Using this method, a cohort of patients with ASD was identified. Informed consent was obtained from the patients and audio recordings made of interactions between them and their clinicians, who were provided with a Philips Pocket Memo LFH9380 dictaphone for this purpose. Participating clinicians included nursing assistants, mental health and learning disability nurses, and FSLTs. All were asked to record their usual 1:1 treatment sessions with patients, noting the purpose of the session and conversation topics. Conversations in which trouble-in-talk was evident, whether resolved through negotiation or not, were then analysed. Topics include understanding how unchecked negative emotions can lead to risky behaviour, recognising personal risk factors, such as drinking alcohol, and unpicking dangerous entitlement beliefs, such as the right to act aggressively as a response to unmet needs. The analyses are used by staff teams to inform their everyday interactions with patients on their wards, with the aim of achieving more consistently effective approaches to addressing problematic areas and instilling a more patient-centred approach to treatment management.

Topic and turn structures in therapist–patient talk: Accommodating to ASD features in the forensic context

This conversation is taken from one of a series of FSLT sessions with the purpose of enabling the forensic learning disability patient H to make a smooth transition to his next placement. The ostensive business of this session between M (therapist) and H (patient) is to compose a list of questions (the ‘stated topic’), which H can ask when he next visits the new setting. However, the movement of topics and turn structures suggest that the underlying theme of understanding emotions (the ‘superordinate topic’) as a way of improving behaviour is in fact more focal to both participants.

Throughout, H’s ASD features can be seen as an influence on the structure of the talk. Since around 70% of people with ASDs also have a learning disability (Schwartz & Neri, 2012), H is not dissimilar to the majority of the, admittedly highly heterogeneous, ASD population (Kats, Payne, Parlier, & Piven, 2013). H has social, communicative, and imaginative deficits, manifesting as slow processing of speech, difficulties taking part in conversations and other forms of social communication, difficulties with understanding emotions and poor awareness of others’ perspectives. Nevertheless, to move on to his next placement, he must show progress in that his risk of committing another crime is deemed to have been significantly reduced as a result of the therapeutic interventions undertaken by the forensic team of which the FSLT, M, is a key member.

A large part of the conversation is structured in question and answer format. Conversation extracts are transcribed according to the conventions outlined in Psathas (1995). An open (‘wh’) question phase starts the talk:

Extract 1

M what have you been doing this we̖ek then (.) what you been up
to

This leads to a sequence of questions and answers with M providing first-parts and H second parts.

Sometimes M evaluates H’s responses as in Extract 2 below, in a typically didactic initiation-response-feedback structure, such as is found in classroom talk (Cullen, 1998).

Extract 2

H I been going on my::: (3.5) garden ˈlea::ve (2.0) café
Frŏdo:::
M **how’s cafe Frodo go̖ne**
H **good**
M **↑go̖od**

H’s learning disability and ASD impact on his processing speed, so that for H a turn is usually composed of a single turn construction unit (TCU). To facilitate H’s somewhat slow processing of speech, M also makes regular use of continuers, sometimes marked with tone contours (Extract 3 occurs between Extracts 1 and 2 above).

Extract 3

M ^{0}hm$^{\vee}$hm^{0}

H’s interpretation of being asked a question appears to be quite literal in this initial phase as he tends to respond by providing only the information specifically requested, thereby handing back the role of first pair part provider to M. In place of a natural topic movement, this adds to the generally didactic tone. Even when M allows a significant pause to remain unfilled, H adds little in the way of topic progress, as in Extract 4, which shows H continuing with the previous topic of things he has been doing this week.

Extract 4

M they come on Su̖nday
H yea̖:h **(1.5)** an:::d (.) I been rapping aga̗in
(1.0)

M sometimes attempts to take up the topics raised by H, but even when she picks up a topic from H's second pair part (Extract 4, line 1), H's turn is still minimally brief (Extract 4, line 2).

The pattern changes briefly when the topic of behaviour emerges. The topic of H's behaviour appears to first emerge from M's mention of *the ward*, H immediately interpreting M's mention of it as alluding to his behaviour.

Extract 5

```
1 M yĕa::h (2.5) an ˈhow has it been on the wa'::rd this ˈweek
2   ⁰whatəv you been up to⁰
3 H                           um I been go[od I a-]
4 M                                       [⁰have you-⁰]=
5 H                                                    = ə(.)yeah I
6   ant been kicking off
7 M                           go`od (0.5)
8   [əv yer-]
9 H [dʒ-    ]
```

The importance of *the ward* is evident from the emphasis which M gives it on first mention. Once *the ward* topic is raised, both participants orient to the theme of behaviour, and the didactic tone dissipates briefly as H now latches and overlaps, moving away from the tidy, formal Q and A structure.

At line 3, Extract 6, H even steps out of his role as second pair part provider, asking his own question and initiating an other-repair, although this doesn't last long as M takes the role of first pair part provider back at the earliest opportunity; that is, Extract 6, lines 5–6.

Extract 6

1 M ⁰m̂hmm⁰ (1.5) cos were yer nôt so nice to somebody a while-

2 (0.5) la`st week (1.0) or the week before

3 **H** **(2.5) umm (1.0) oh dyer mean onn (7.0)**

4 **ə which dăy was it** **OTHER REPAIR**

5 M I don't know di- (1.0) did you say something that might have

6 made somebody upse̖t

The overlap at Extract 7, lines 3–4, suggests H may have been about to initiate a sequence of his own. However, the turn cedes to M and continues with a series of behaviour-specific, M-led questions. This is the first time that behaviour arises as a topic in the 20-minute session. M addresses the topic of H's behaviour through framing her questions in such a way as to prompt H to take the other-perspective. Her questions become very specific to the details of H's behaviour:

Extract 7

M an- (.) wh̖y might it- that- what you said made Pete a bit
upset (1.5)
H **um[m]**
M **[or]** *why would that make ↑yôu upset*
(1.0) if somebody *fast*
said something (.) like that (.) to you
H (1.0) um- co::s (.) I might (.) get
embarrassed

In the immediately subsequent sequence, Extract 8, M uses first pair parts to steer H to talk about his own experience of emotions, linking this to the likely experienced feelings of others as a result of H's actions.

Extract 8

M ↑ye̖ah (1.5) n if somebody says things to yo̖u:: that you do-
what so̖metimes can ˈhappen (.) what do you ˈget sometimes
H upset
M an the̖n what happens when you get
a bit upset
H I get angry
M ↑yêa:h (.) an other pe̖ople might get
like that mi̖ght they

In this section, many of M's turns are constructed as cloze-type structures, or frames with 'blank' slots, thereby preferentially projecting H's next turns as minimal, since all H is required to do in response is fill the 'blank' slot indicated by the wh-word in M's prior turn. Thus, when cognitive demand is relatively high, the processing load on H's communicative competence is kept low. Extract 8 has a rehearsed quality, a return to talk as instructive after the interludes around Extracts 5 and 6.

The theme of feelings-and-behaviour-as-linked is returned to throughout the interaction, with both participants frequently redirecting the topic back to it. Figure 22.1 shows how both M and H move between it and the stated topic of compiling a list of questions for the new placement. The feelings-and-behaviour-as-linked superordinate topic appears to have a compelling salience for both participants, but with somewhat different perspectives depending on who initiates.

Extract 8 with M's cloze-type structures is typical of an M-initiated topic shift as M endeavours to improve on H's insight into how what he does can cause problems on the ward. But when H initiates a topic shift away from the question-list topic back to the feelings-and-behaviour superordinate, the theme

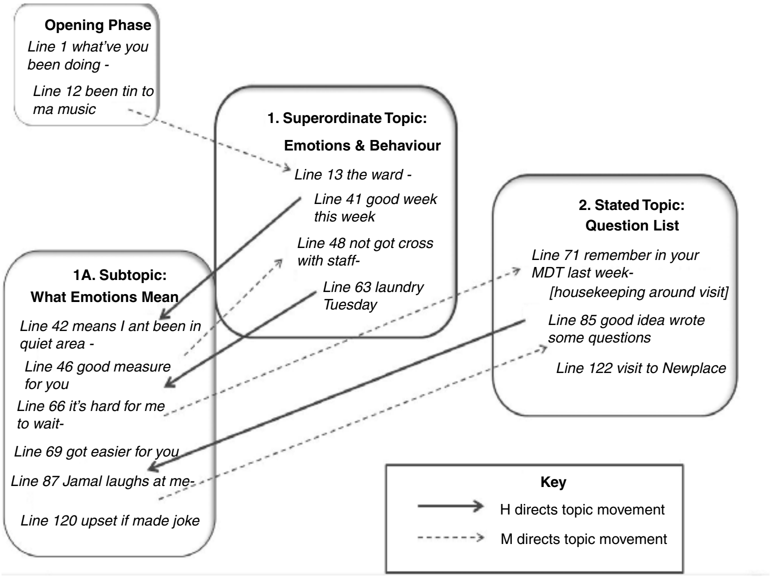

Figure 22.1 Topic movement in lines 1–133 of M and H talk: making a question list for move-on

he infers psychologically precedes that of how emotions and behaviour are linked, to that of understanding what others' and his own emotional displays might mean:

Extract 9

M (1.0) .hh yeă::h
H (1.0) um i- (.) er um it's hard for meˏ: to w hhh. ait
M I know it is (.)but yer- (.)yer praˎctising âren't yer

Extract 10

M ↓mwăh (1.0) ˈwhat we thouˏ:ght (.) might be a good idea (0.5)
see: (.) what you think (.) is (.) if (2.0) we- (.) wrote-
we ˈwrote some queˎstions down if you wanted to ask at
ˈNewplace
H yeah (.) ↑bu- aw yeah-we er well no mm no mm know what I said
to Jâmal (.) erm he-he always laughs at me fer me -when I-(.)
when I say stuff
M yea`h=
H = he finds it funny
M (1.0) but is that âll right (2.0) cos you ˈsay fu- you li ‘ke
to be funny sometimes doˎ:n't yer

Both participants orient to this theme, as can be seen above as M interprets H's mention of Jamal finding him funny as something requiring exploration.

An M-negotiated move between topics is often marked by M with a *yeah* token followed by a pause, then a TCU that either summarises the gist of the immediately preceding turn sequence or projects the subsequent sequence. Extract 11 comes at the end of a feelings-and-behaviour superordinate topic sequence. M's summary may be an attempt to end this topic and move on to the question-list, but H instead provides an interpretation of what M might mean by *a good week.*

Extract 11

```
H                            yea::h
M  yěah (1.5) an .hhh (1.0) but you've had a go̖od week this week
                                                            fast
H  um (.) ye̖a::h (.) I yeah- tha- yeah (3.0) um (.) that means I
   a::nt (.)been in the qui ˇet area =
```

A few lines later, the M *yeah* token, pause + summarising or projecting TCU appears again. This time M projects more H turns exploring what *a good week* means for H.

Extract 12

```
H                              yeah
M  ↑yěa:h (2.0) and av you- (.) you've ˈnot got ˈcross with
   sta̖ff this week
```

There follows a sequence of Q and A cloze-type TCUs in which M builds on the work of H's understanding of *a good week* to offer guidance about how H should behave on the ward today. This sequence includes the H-negotiated topic of understanding of his own emotions (Extract 9). Finally, four lines later, M introduces the stated session topic, the 'main' topic, of the question list (Extract 13). The one-second pause gives H enough space to negotiate a move back to feelings-and-behaviour topic which on this occasion H doesn't take up. Once again, M's topic move is indicated by a *yeah* token + pause and a new topic-projecting-TCU.

Extract 13

```
H                            yeah
M  yea̗h (1.0) sô :: (.) dyou remember in your MDT̖ last week
   (0.5) Karen- (.) what did-(.) what was Ka̖ren gonna do with
   yer
```

M explicitly introduces the question-list topic at lines 1–4 of Extract 10 (shown below as Extract 14), again with the *yeah* token, here realised as `mwăh`, pause, and topic-change-projecting-TCU.

Extract 14 (Extract 10, lines 1–4)

M ↓mwăh (1.0) ˈwhat we thouˏ:ght (.) might be a good idea (0.5)
   see: (.) what you think (.) is (.) if (2.0) we- (.) wrote-
   we ˈwrote some queˎstions down if you wanted to ask
   at ˈNewplace

Extract 10 shows H returning to feelings-and-behaviour as he (apparently) puzzles over Jamal finding him funny. The topic takes up the subsequent 40 lines of talk. M finally successfully negotiates a return to the question-list topic in Extract 15. As previously, she marks this with a *yeah*-token, pause and topic-projecting-TCU.

Extract 15

H yea::h
M yeaˏ::h (1.0).hhhh sô:: (.) yer visit to Nèwplace (.)
   on Thùrsday

Clinical relevance summary

Interaction as intervention

The examination of conversation in the hospital setting can have important implications for clinical practice and can inform us about patients' own understandings of emotion. M's *yeah*-tokens + pause and summing or projecting TCUs which punctuate the talk at regular intervals make it regular and orderly and allow H space to negotiate delaying take up of the next topic until he has satisfied his understanding. A rejection of the move forward leads to a circular topic movement as the talk returns to the superordinate topic. Circular topic movement in ASD talk has been associated elsewhere with a kind of cognitive processing limitation (Dobbinson, Perkins, & Boucher, 1998); here it seems to be a product of the therapeutic interaction, a means by which misunderstandings about emotions and behaviour can be aired and explored as they arise in the conversation. Importantly, M does not resist the recycling of topics but accommodates to H's interaction style, using the opportunity to work on the superordinate feelings-and-behaviour topic. In a similar way, M also uses rote learning and routines, both strengths in ASD cognition, to enable H to work through his lack of insight.

M's *yeah* tokens generally immediately follow an H *yeah* token, indicating M's alignment with the previous H turn. M's *yeah* tokens are produced with rising tone or fall rise, which can be considered here as a sub-type of rising tone (Local, 1992), while, in keeping with the rest of his speech, H's *yeahs* are somewhat flat. A common feature of ASD speech, H's tone movement is significantly restricted; if present, ASD tone movement tends to adhere to a sentence – length unit rather than to a single word. M's choice of *yeah as* alignment token, the most frequently used word in H's talk, places minimal demand on H's processing capacity. *Yeah*-tokens are therefore particularly well suited to enabling H manage the topic shifts which are necessary if he is to take on new information. In this talk-as-work, using the ASD patient's most high-frequency vocabulary item with marked but predictable tone-contour signposts where H needs to pay most careful attention. H takes advantage of these points to indicate where he needs to review issues of importance to him (the superordinate topic of emotions-and-behaviour) which may not have been evident to M. The *yeah*-tokens therefore seemingly act as negotiation checkpoints in the talk, where M signals that she is about to change topic, and H can either confirm his alignment with this move, or negotiate a recycling of the superordinate emotions-and-behaviour topic. As a kind of off-the-shelf negotiation point, that is easy to recognise and regularly occurs without H needing to orchestrate them, the *yeah*-tokens work to compensate for H's limited conversation skills. From the M perspective, the orderliness they bestow ensures misjudgements of H's understanding can be kept in check and dealt with there and then, as they occur to H and have relevance to his situation. For a simple summary of the practical implications, please see Table 22.1.

Table 22.1 Clinical practice highlights

1. ASD is difficult to distinguish in the secure psychiatric setting due to similarities in presentation to common forensic conditions such as schizophrenia, and personality disorder. Forensic clinicians are not always fully equipped to recognise ASD in their patient group.
2. Interactional features of ASD include a tendency to move through topics in a circular fashion, slow processing of speech, restricted tone movement, and difficulty in recognising cues in others' talk.
3. The forensic work of adapting behaviour and recognising their own and others emotions and how these two are related are difficult to accomplish for people with ASD. Due to their socio-emotional deficit and reliance on routines and sameness, people with ASD may not signal clearly where they have difficulties. It is up to the clinician to interpret these signals.
4. Forensic clinicians would benefit from viewing interaction as an important locus of difficulty in making adjustments to beliefs and behaviour. By paying attention to interaction, clinicians can spot where there are problems in the ASD patients' understanding.
5. By adapting to their patients' interaction style, forensic clinicians can proceed with the work of intervention to change beliefs and behaviours in a cooperative rather than combative framework.

Summary

ASD is a complicated disorder and one that is represented in various ways in society (see Garner et al., Chapter 8, this volume). In the analysis, I have illustrated that H's ASD is a fundamental component of his risk, preventing him from understanding how his behaviour is contingent on his feelings and causal on his environment. Working on understanding these links is important in all disorders which include a socio-emotional deficit, but critical where the difficulty has become enmeshed in criminal behaviour. M addresses these issues interactively with H, responding to cues and dealing with misunderstandings as they arise. She is not only tuned in to the signs that H is in difficulty but works to make the talk orderly and predictable giving H the best chance of participating and expressing his thoughts and feelings, even when these are not necessarily related to the present topic.

The specific idiosyncrasies associated with an ASD presentation demand a particular style of interaction if the work of risk reduction is to be accomplished successfully. The therapist, M, can be seen to orient towards these features in an online manner, adapting her turn structure and topic initiations to accommodate to the communication needs of her ASD interlocutor whenever trouble-in-talk arises. Here, trouble-in-talk can be taken to be indicated by H's recycling of the psychologically prior sub-topic of what emotions mean. Figure 22.1 showed that all of H's topic moves were towards this sub-topic. M's role as director of the talk and more competent interactionist is evident from the wider range of topic movement destinations as well as the greater number of topic shifts which she initiates.

The FSLT M both aligns interactively to H's turns and also directs in order to instruct. The rehabilitation message is delivered through the cloze structures and question/answer sequences, but tempered by M's accommodation to H's movements through topics and the use of *yeah* as negotiation check points. While the content of what is discussed may be driven externally by the forensic context, the talk itself is fitted to H's needs as an ASD language user. The interaction in fact is the intervention, arising as the spontaneous creation of therapist and patient as they jointly address the issue of how best to enable H to present less of a risk to his community. Since changing beliefs and behaviour are difficult areas in which to accept direction, a cooperative rather than an adversarial interaction suggests more likelihood of success, notwithstanding the dearth of forensic interaction studies. How effective these types of intervention are in the long term remains to be seen. Studies that shed more light on forensic interaction as well as those that investigate rehabilitation rates in hospitals where FSLTs are in post may be useful follow ups to such work as is presented here.

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Recommended reading

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23

A Critical Discursive Perspective on Psychiatric Hospitals

Claire Bone and Nichola Marchant

Introduction

Psychiatric hospitals have always been a topic of contentious debate (see O'Reilly & Lester, Introduction, this volume). Shorter (1997) pointed out that the urban world has always had to confront the problem of homeless 'psychotic' or 'demented' individuals, and so cities have organised institutions to accommodate them. There are issues of power involved when incarcerating any individual, and the history of the management of mental illness is loaded with questionable practices from the time of witch-hunts, to the use of asylums, to poorhouses and state-run mental health institutions (LaFrance & McKenzie-Mohr, 2013). Media representations of psychiatric institutions are often sensationalist, horror films set in psychiatric institutions remain popular, and the 'insane' are frequently associated with disturbing emotions. Anti-psychiatry movements have levied many criticisms at psychiatry, particularly in relation to artificial diagnoses, over-medication, misuse of power, and questionable therapeutic outcomes (Foucault, 1965; Laing, 1967; Szasz, 2007). Indeed, current services continue to be perceived in negative ways, understandably due to ongoing scandals such as Winterbourne (Department of Health, 2012).

There have been competing ideologies relating to the debate on psychiatric institutionalisation. For example, there are those who take an *optimistic perspective* and interpret history in terms of continuous progress towards an ideal social order, and where failure is transitory. They advocate the need for institutional care where necessary, citing psychiatric hospitals as evidence of human progress, humanitarianism, and liberal sentiment. While they concede that there are some serious imperfections in these institutions, they operate on the assumption that with more funding and efforts most social deficits could be eliminated. Others however take an *anti-psychiatry interpretation* and argue that hospitalisation is the worst possible option, where the dominant elite restrain deviant groups or lower classes to ensure their own hegemony (Grob, 1977).

This has its origins in the social and behavioural sciences and sees the failures as an inevitable consequence of institutional solutions. They reject ideas that mental illness is comparable to disease and insist that it is a creation of social groups, where cultural behavioural norms determine what is abnormal or 'ill' (Grob, 1977). While ostensibly these two views seem dichotomous, such a conceptualisation of the debate is not so simple.

In this chapter we seek to explore the issues surrounding psychiatric hospitals, from the perspective of psychologists working with women with a diagnosis of personality disorder within a low-secure psychiatric hospital. We are not therefore claiming to approach the issues from a neutral standpoint, but we intend to draw on our personal experiences of working within an inpatient setting. Our position is that without such services many of our patients would not have survived, or they may have remained with their abusers and unable to cope in the community. Rather than taking one side, we believe that psychiatric hospitals are complex systems that can be both flawed and useful environments for people experiencing distress, and we believe that it is important that all parties involved can engage in open debate. Given our belief that it is not currently possible or pragmatic to get rid of psychiatric hospitals, we seek to understand how current practices and problems have been formed and how mental health professionals might attempt to better help those in the present. We also aim to discuss how professionals might engage in longer term socio-political matters.

Critical discursive psychology

Within the context of examining psychiatric hospitals, we will also consider how useful a critical social perspective can be. Fozooni (2012) discussed what 'critical social research' actually means and stated that the most radical form 'aims to synthesise academic and everyday knowledge in a praxis aimed at emancipation', where emancipation refers to 'going beyond global capitalism and its numerous anti-working class, sexist, racist, disablist, superstitious, alienating and homophobic tendencies' (cover sleeve).

In particular, we consider it useful to apply the principles of critical discursive psychology (CDP) to these issues. CDP looks at the ways in which cultural discourse resources are situated and constitute whole institutions such as 'psychiatry' and how they create power differentials when employed. These discourses can be used to define people in certain ways that create subject positions somewhere within a hierarchy of power, with implications for the types of identities and opportunities available to people (Horton-Salway & Davies, Chapter 6, this volume; Wetherell, Taylor, & Yates, 2001; Wilson & Crowe, Chapter 7, this volume). Edley and Wetherell (2001) also pointed out that while discourse resources (or everyday communications) are culturally constrained, we are also able to exercise agency via our flexible deployment of them as positioning devices. Power relations flow in many ways through such competing discourses and are therefore central to understanding social processes and change (Foucault, 1970; Rose, 1990).

We also believe it useful to approach an examination of psychiatric institutions from the ontological standpoint of critical realism (Bhaskar, 1989). Critical realism takes a realist ontology, in that it acknowledges the reality of the material world which is claimed to provide the raw material from which we begin to construct our understandings, while simultaneously arguing that our understandings are necessarily constructive and interpretive and mediated through discourse. This is appropriate within this chapter because 'From a critical realist approach, individual misery and challenge are understood within the context of hegemonic systems, such as patriarchy and capitalism. Within this more holistic framing, we may be able to name and legitimize individuals' pain without reverting to understandings that invoke individual pathology' (LaFrance & McKenzie-Mohr, 2013, p. 135).

We start the chapter by considering the ideologies and discourses that are prevalent in historical accounts of psychiatric hospitals in order to gain a better understanding of the potential influences on current practices in modern psychiatric institutions. We go on to consider the debates on disorder, anti-psychiatry, deinstitutionalism, and capitalism, drawing on our personal experiences of working on the ward. Finally, we discuss future directions in terms of increasing the profession's engagement both with service users and in wider socio-political issues.

History of psychiatric hospitals

All knowledge is culturally and historically situated and influenced by personal value systems (Haraway, 1991). The history of psychiatry is no different and has been a source of some tension, particularly in relation to the rise and fall of the asylum, the politics of compulsory confinement, the justification of questionable treatments, and the beneficence of psychiatry (Porter, 2002).

Popular thinking tends to be shaped by dominant discourses, which are constrained by overarching themes that reflect historical eras, such as the enlightenment or romantic eras, or currently for us the era of global capitalism. Thus, the discourses that prevail about how cultural members should behave will influence thinking about those who do not fit in to this way of behaving. These discourses are often taken as natural truths. However, as history has shown, what is considered natural and true in one era can shift and be considered mistaken in the next (although this does not indicate a linear improvement). It is useful therefore to consider how some of the prevailing ideologies within historical eras have influenced thinking about mental illness and asylums, and how these have changed and influenced current systems now, in order to better understand the debates surrounding psychiatric hospitals and how they have come to function as they do within the present.

Demons and witch-hunts

Religious or spiritual ideology governed thinking about appropriate behaviour as early as 5000 BC, where evidence from the archaeology of skulls indicates that they have been trephined (small holes bored in them with flint tools), to allow evil spirits to escape. Discourses of superstition continued and were rife during the Middle Ages in Europe. In early Christian thinking, the Holy Ghost and the Devil battled for possession of the soul. Normal and abnormal behaviour were considered to be at the mercy of external, supernatural forces, and Sprenger and Kramer (1486) (in Johnstone, 1998) demonstrated that during the middle ages mental disorders were seen as spiritual rather than medical. Hence the dominant explanations for unusual behaviour during this period were that the person was possessed by the Devil or that they were practitioners of witchcraft.

These ideological viewpoints served to position those who failed to conform as dangerous threats (hell or witchcraft) and sinful (anti-religious). Those with odd behaviour were therefore to be feared and tamed, and lunatics were locked in dungeons or towers under public auspices (Porter, 2002), or treated in religious institutions (Porter, 1987). The religious house of St Mary of Bethlehem was founded in 1247 (to be known as Bedlam) and was designed for catering for lunatics by the later 14th century (Johnstone, 1998; Porter, 2002; Shorter, 1997). Bedlam's insane are documented to have been used as a form of social control, as lessons in the dangers of vice or sin, which served to feed back into and uphold those dominant discourses of lunacy.

Enlightenment and reform

The 17th and 18th centuries were governed by the Age of Enlightenment, where original sin was seen as a myth, and the ideologies of reason, science, and individualism were dominant (Porter, 2002), and the notion of curability was part of the larger agenda for improvement during social, political, and medical engineering (Shorter, 1997). In particular, asylums were reconstructed as curative environments as opposed to places for the incarceration of lunatics (Porter, 1997; Shorter, 1997). The philosopher Locke was one of the most important influences, where the mind was considered a blank slate that was shaped by experience and developed through habit (Porter, 1997, 2002). Locke's ideas did incorporate social experiences as shaping the psyche, and these discourses contributed to the re-positioning of lunatics as human (rather than demonic) and as victims of mistreatment. However the emphasis on the psyche, coupled with a desire for scientific discovery and reason, maintained a focus on the individual mind and irrationality or disorder of thought, and hence causal attributions were located with the individual.

These discourses of experience shaping the psyche continued to develop however, with 18th century physician William Battie arguing that although some people may suffer from 'original insanity', most suffered consequential insanity, or insanity resulting from events, which was curable (Johnstone, 1998; Shorter, 1997). William Tuke established a model of moral treatment in 1796 based on the ideal of bourgeois family life where restraint was minimised and recovery was encouraged through praise and blame, reward, and punishment; the ultimate goal was self-control, and as Johnstone (1998) pointed out, this produced some excellent results. While the focus remained on the individual, there was evidence now of the conceptualisation of mental distress in terms of events that were not entirely located within the individual mind.

By 1800 there was surging faith in the efficacy of the asylum, and in England doctors followed Battie's ideas that moral management was more effective than medicine, although moral management techniques could include psychological bullying (Porter, 2002). Nonetheless, the 19th century saw the 'new' reformed asylum becoming an object of praise as a progressive and effective site for the treatment of insanity (Porter, 2002; Shorter, 1997). By the mid-19th century the rise of professional bodies, and journals concerning the insane, marked a high point of asylum psychiatry in the United Kingdom and the United States. During this period, asylums were prized as humane, scientific, cost-effective, and curative institutions (Porter, 1997).

Failure of reform

The new faith in asylums was not to last however and by 1900 psychiatry had reached a dead end. Asylums had become warehouses and the hope of therapy was illusory; psychiatrists had a poor reputation. Shorter (1997) pointed out that asylums were indeed capable of helping those in distress; however, there was the assumption that physicians would have the time and resources available to treat them. The reformers did not have a faulty concept but were defeated by numbers. For example, in 1800 only a few individuals were confined to asylums, even in places such as Bedlam. However, by 1895 London had 16 asylums just within its region. By 1904 the numbers exploded, with 150,000 patients in US hospitals, for example (Shorter, 1997).

Several reasons are proposed for this increase in hospital numbers: some argue that this was an artefact of labelling; some argue that neurosyphilis contributed to actual increases in psychiatric illness; and some argue that it was a redistribution effect, where families, workhouses, and prisons transferred their mentally ill to the asylum (Shorter, 1997). This marked a significant crisis for asylums, and by the last third of the 19th century cure rates dipped as public asylums silted up with 'long-stay zombie-like' individuals. This in turn led to the circulation of discourses proclaiming that moral therapy did not work, and new truths were formed related to insanity being chronic and hereditary, with outcomes limited to confinement and prevention of breeding (Porter, 2002).

Modern psychiatric hospitals

During the second half of the 19th century there was renewed interest in how exposure towards traumatic events may cause nervous symptoms, in relation to compensation claims following railway accidents. This focus became more prominent following the First World War, where the number affected by 'shell shock' meant that a clear distinction between neuropathological and emotionally based disorders was not tenable (Johnstone, 1998; Mayou, 1989). By the early 20th century many psychiatrists began to accept that neurotic problems were best treated by psychological methods in general medical settings; however, asylum doctors are documented to have generally rejected these ideas, being guided by the dominant biomedical discourses of the era (Mayou, 1989).

Interest therefore turned towards medication, and the mid-20th century saw a rise in expectations for psychopharmacology with the first psychotropic drug, Lithium, being used to manage manic depression in 1949. Psychopharmacology brought a new therapeutic optimism to psychiatry and supported its aim to be a 'hard' science. Chlorpromazine was synthesised in France in 1950 and used initially as a sedative in psychiatric practice (Johnstone, 1998; Mayes & Horwitz, 2005). In 1948, Britain introduced the National Health Service, which allowed milder cases of psychiatric disorders to be managed alongside the development of effective drug treatments. Additionally, less restrictive regimes for patients with serious mental disorders were introduced and there was a stronger emphasis on social rehabilitation. The preferred model of therapy during this time was psychoanalysis; however, due to pressures that psychoanalysis was not in keeping with objective scientific ideology, psychiatry had to be seen to abandon this treatment (although it continued to flourish in non-medical circles – Jacoby, 1997; Shorter, 1997).

Disorder and anti-psychiatry

In the 20th century, psychiatry therefore faced a challenge of legitimacy due to the powerful pull of scientific discourse, and attempts to define what constituted normality (and disorder) came to the fore (Horwitz, 2002), with consequences for who was to be institutionalised and who was not. In 1980, the third edition of *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) radically transformed the nature of mental illness as a new system of classification was adopted, importing its diagnostic model from medicine and viewing diagnosis as a central aspect of both clinical research and medical practice (Goodwin & Guze, 1996).

The *DSM-III* was initially welcomed by many as a standardised system of diagnosis, allowing for appropriate placements of patients and the targeting of treatments. It placed an emphasis on categories of illness rather than blurred boundaries between normal and abnormal behaviour. It emphasised overt symptoms as opposed to underlying aetiological mechanisms and dichotomies as opposed to dimensions (Horwitz, 2002). Thus, psychiatry moved from a discipline whereby diagnosis played a marginal role to one whereby diagnosis became the basis of the speciality.

The 1960s–1970s however had also seen the birth of a critical era which sought to challenge the dominant positivist and medical ideologies of the time, with scholars such as Szasz, Foucault, and Laing arguing that psychiatric hospitals were sites of social control and served illegitimate penal functions rather than therapeutic roles (Mayes & Horwitz, 2005). This is where challenges to the very notion of mental illness and disorder arose in full force, and the *DSM* came under extreme criticism from anti-psychiatry movements, notably for including homosexuality as a disorder in *DSM-II* (Bayer, 1981). Szasz (1961, 2007) contended that mental illness was actually a 'myth', providing labels that stigmatise mere eccentricity, and Scheff (1966) argued that mental disorders were labels behind which psychiatrists and the public hid their ignorance of the real causes of deviant behaviour.

Within diagnostic language, distress is argued to be understood as an expression of personal dysfunction and medicalised (LaFrance & McKenzie-Mohr, 2013). From a social constructionist perspective, however, this can be understood as a narrative, as a social construction of impairment. For social constructionists, language is performative and not merely descriptive, and hence medical language serves to legitimise and justify medical science as the authority of truth. On the one hand, diagnoses can be validating and can direct appropriate services; yet on the other, it is argued that it is through diagnostic manuals that power is exercised through the determination of what is socially acceptable, what is normal (see O'Reilly, Karim, & Lester, 2015). Thus, psychiatric regulation continues in some circles to be viewed as a strong form of social control, positioning those who do not conform as deviant while acting in the interests of those in power, both in terms of finance and status (Marecek & Hare-Mustin, 2009).

Clinical challenges

The debates outlined so far in the chapter present important challenges for us as psychologists working within a low-secure hospital. There are power dynamics at work in terms of the beneficence of institutionalisation, the impact of diagnostic labelling, and debates on how we can ever create empowering environments where people have been sectioned against their will. There is also a strong element of risk management within services, which can potentially overshadow that of treatment. We cannot begin to cover everything here, but we would like to discuss these particular issues now, drawing on our own experiences of working on such a ward.

Institutionalisation and capitalism

As a result of the criticisms of the *DSM* and the increased availability of drugs to manage symptoms, during the 20th century a process of deinstitutionalisation began which continues to present day. This seeks to control more serious symptoms, usually with medication, to allow people to live in community settings. A current prevailing ideology therefore is that living in the community successfully is the ideal, and that being 'locked up' is the worst case scenario. While being able to live meaningfully in the community is an idealistic goal, there are potentially unintended consequences of this type of discourse. For those people who would find it extremely difficult to survive in the community, this poses a problem, as they may be positioned as failures for being in an institution, leading to suspicion of the system and reluctance to accept help or engage in potentially beneficial therapies. Furthermore, while it has become evident that the deinstitutionalisation of psychiatric patients has produced examples of innovative service models, the process remains unfinished due to political and structural obstacles, where a comprehensive primary care-led community mental health service has failed to be implemented universally (Russo & Carelli, 2009).

Geller (1992) argues that while there are a multitude of terms for patients who are frequently hospitalised, including recidivists, revolving-door patients, and heavy users, the resources for meeting their needs are enormous. Typically, these are patients who have persistent and serious mental health problems who have been back and forth between community and inpatient settings. Geller draws on the competing ideologies of paternalism and autonomy to reflect this struggle between hospitalisation and community. Indeed, autonomy of patients and a return to the community is something that could be seen as ideal, yet in our experience this may place unrealistic expectations on patients that are a high risk to themselves or others. It would be fair to say that this represents a reluctant paternalistic ideological stance; however, it is difficult to envision a solution without substantial changes in the socio-political landscape.

Capitalist ideology should also be considered here: the strong work ethic and emphasis on productivity and material worth, which permeates our culture, may further alienate people who do not fit in. It could be argued that some finance is at least available for mental healthcare, and historically it does not appear that those in mental distress were necessarily better off pre-capitalism. However, current capitalist models propose that making cuts will offer long-term economic prosperity; yet these cuts to services will potentially lead to another redistribution of the 'insane' into the community. In the early days of deinstitutionalisation, many patients ended up on the streets or criminalised (Pilgram, 2007). Currently, people may face being pushed out into a community that often lacks the resources or specialist, coordinated services to support them.

Personality disorder

In terms of diagnoses, personality disorder seems to carry particularly pejorative associations, and the literature claims that 4%–11% of the UK population are affected by personality disorder, with this being 60%–70% of the prison population (Bienefeld, 2013). It is fair to say that the women who end up in our service have often got a substantial history of abuse and present with self-harm and/or other behaviours that transgress what our culture considers acceptable. In 1980, the term 'borderline personality disorder' was introduced in *DSM-III*, ostensibly to make sense of their suffering, however there are potential consequences of such diagnostic labels. Broadly speaking, there are two sides to the debate: a key objection is that it places the problem within the individual, which is reductionist and potentially damaging; however, the other side of the debate is that the diagnosis can unlock services and validate suffering.

Hence, there are difficult problems to navigate when considering diagnoses, particularly when directed towards people who have already experienced much trauma and abuse (Coles, 2013). Notably, the person may have already suffered significant life events, which have shaped their ideas of self and self-esteem in ways that cause them much distress. If they then present at services for help only to be given a diagnosis which positions them as individuals who are disordered of personality, this can be potentially quite damaging. The problem is once again located within the individual and they are often sectioned within secure services, while the abuse is hard to prove (and hence abusers continue with their lives in the community), and the socio-political and economic conditions in which abusive patterns of relating are fostered appear to be completely neglected (Coles, 2013).

Goicoechea (2013) pointed out that feminist critiques of the *DSM* have explored how the application of diagnostic vocabulary re-traumatises women (or indeed men) with labels that fail to fully attain the complexities of their experiences and attributes problems to them as individuals. This leads to stigmatising situations whereby 'spoiled identities' are created for people, which involves the projection of judgements as to what is undesirable onto the individual or group (Goffman, 1963).

Our experience is that patient histories often reveal complex cases of abuse, and we adopt a formulation approach to make sense of their problems, which takes into account the background context in which their problems developed and attempts to understand the person's resultant core beliefs and how these contribute to distress (see Johnstone & Dallos, 2014). The difficulty of course lies in the issue that we may only be able to work with the individual and not the family or cultural systems from which they originate. By only working with an individual, and attempting to empower them and support them to develop new skills, we can be seen to be inadvertently reinforcing the view that the 'problems' are located within the individual rather than occurring as a result of complex dynamics within a family and cultural system. As a service, we have reflected on this and have made efforts to engage families where at all possible. This process is itself fraught with challenges as patients are often residing a long way from families, and we have found that the families of our patients are often themselves traumatised, sometimes even as a result of their contact with the mental health system.

Another side of the debate is that the discursive power of the *DSM* to extend validation can be compelling, and psychiatric diagnoses can, in some instances, be helpful in offering validation and hope, directing interventions, and directing research which has enabled the development of new clinical interventions (LaFrance & McKenzie-Mohr, 2013). Consumers and their families tend to seek explanations for mental distress or the behavioural manifestation of it. Social constructionism has taken the effort to resist biological reductionism; however, a radical social constructionist position risks denying the material reality of misery (Ussher, 2011). Hence, there is the issue that if a person is told that their experiences are just a reasonable response to life circumstances, this may not sufficiently validate the problems that they are experiencing: 'a biomedical approach can work to underscore the severity of people's difficulties and deflect condemning formulations of people's distress that impose judgments of weakness, laziness, belligerence, or a simple failure to cope' (LaFrance & McKenzie-Mohr, 2013, p. 121). In some ways, the formulation and sharing of a psychiatric diagnosis can be itself therapeutic, in the sense that psychological symptoms can be given meaning and discussed effectively with patients. Making a diagnosis is not necessarily an essential component of treatment decisions. It is one of the reasons, but clinical professionals also use a range of other information to make judgements regarding treatments (Wykes & Callard, 2010).

One of the problems may be that arguments tend to be polarised and ignore differences between people and variation in diagnostic usage dependent on context. The idea that diagnoses handed down from authority figures are passively taken, or that they automatically cause damage, sounds like social determinism, where only the structural side of an agency-structure dualism is considered (where the structure is those in power) and human agency is denied (see Hollway, 2012). Discourses of mental illness or disorder are also now circulated through a variety of sources such as social media, with celebrities becoming more willing to engage in mental health debates and share stories, and websites or social media offering platforms for the construction of new knowledge. On the one hand, these can be a resource for challenging stigma; on the other, there are 'pro' sites, where self-harm, suicide, or anorexia are promoted, for example. This illustrates the potential vast array of competing discourses of mental illness or disorder, and within a service such as ours we have a responsibility to promote ideologies that we believe are in the best interests of our service users, while also acknowledging that our patients have rights to freedom of thought and that our beliefs as a service are historically situated and contingent.

This raises the point that services need to be set up in a way that allows service users to exercise their agency while also collaborating on treatment goals. For example, we are endeavouring to encourage collaboration on formulation, risk, treatment, and recovery goals. However, while current ideology understandably promotes the empowerment of service users, this is a very difficult thing to achieve where people have been sectioned against their will. A key part of recovery may be in creating a validating, empowering environment, yet this is continually overshadowed by the necessary imposition of ward rules and locked doors.

There is also the issue that not everyone wants to be so involved in their recovery plans; this can create pressure for the individual who may find the responsibility overwhelming, and so it is important to be flexible and sensitive to the individual's needs. We also see patients who do not wish to move on, which is possibly one of the hardest tasks to manage. Where the community has been a source of pain and fear, patients can find validation and support and a social identity within the hospital, meaning that sometimes they will do anything to remain within secure services. So, again the ideology that the community is automatically the best place and hospital the worst is not straightforward. We find it rewarding when people can move forwards with their lives; however, it is extremely difficult where someone is understandably afraid of moving on or when there are gaps in the provision of mental health services in the community. We are left with the task of supporting them as best we can to move forward, while being concerned that the resources are not sufficiently there to maintain their recovery, and where the wider socio-political landscape remains uncertain.

There are also issues relating to locally competing discourses of personality disorder to navigate while working on wards such as ours. As stated, the notion of the personality disorder does carry many pejorative discourses with it, and what are actually understandable reactions to traumatic events (Linehan, 1993) can become a further source of criticism for that person, leading to yet more rejection. Linehan (1993) argued that emotion dysregulation is a reasonable response for people who have grown up within invalidating environments, where their needs have not been met and where they have not learned that they will be okay in the face of strong emotions. However, terminology often associated with personality disorder, such as 'inappropriate', 'angry', 'manipulative', 'attention seeking', 'impulsive', or 'paranoid', does not describe reasonable responses.

This is a key point for staff to manage, and there is the added pressure of working with people who often resort to hurting themselves to cope with overpowering emotions. There can be competing discourses between different staff working within these types of services (Tantam & Huband, 2009), and it is important for all staff to keep in mind the origins and functions of such outward behaviours, which may be done for different reasons at different times. Psychological models such as those associated with Dialectical Behaviour Therapy, Schema Therapy, and Compassion-Focused Therapy can aid this understanding. Our patients have often come from invalidating environments, so there is a need to provide the right kind of environment where we act as role models, validating their experiences yet being boundaried and not contributing to the reproduction of emotionally distressing attachment styles. Workers need space, good quality supervision, and time to reflect on and cope with their own feelings in order to consider the most effective ways to work. Staff are in many cases open to working with reflection and self-critical awareness if the opportunities are there, and in our experience these services can be potential sites of considerable personal development.

Risk management

A further key issue we have to consider in a low secure service is that of risk management, as the majority of the women we work with engage in serious self-harm and display suicidal behaviours at times; some also pose a risk to others. It is important to have an understanding of risk when working with people who are suicidal (Bowl & Reeves, Chapter 30, this volume). Yet, in the hospital environment we have the tension of encouraging patients to engage in therapeutic daily activities while restricting access to items that may be used to cause harm, and the least restrictive approach is preferred to avoid encroaching on human rights and to best promote independence and recovery. Understandably, however, services come under criticism when patients have harmed themselves or worse when they have managed to commit suicide while under the care of professionals (see a recent *Guardian* article on the Equality and Human Rights Commission – Ramesh, 2015). This has led to media discourses that psychiatric services are neglectful and an increased focus on risk management within services.

However, an unintended consequence of this increased emphasis on risk management is a potential reduction in time available for therapeutic treatment. As in the Age of Enlightenment, overstretched resources risk leading services back towards being warehouses of containment rather than as sites of therapeutic recovery, which would be akin to containing the physically ill in specialist centres and spending no money on treatment (not to mention ignoring the social causes of disease). Hence, there is a need to realistically manage the tensions between taking responsibility for patients' safety, fostering therapeutic environments, and managing discourses that staff are to blame for self-harm. Clear, consistent, and evidence-based procedures need to be in place to ensure that staff are doing everything they can to prevent harm and manage risk in positive ways, and again good quality supervision is key in managing personal and professional development (with supervision being aimed at honest critical reflection on work practice). Discourses of personality disorder and psychiatric hospitals are therefore not straightforward. Being given a diagnosis can be both a source of comfort and distress, and this will vary depending on the individual and context. It is interesting to note that we perhaps have a lot in common with the Age of Enlightenment and moral therapy, in combination with a biomedical ideology. As a society, we still have tendencies to locate problems within the individual, but many of us are striving to incorporate the social context and are aware of the need to engage at wider socio-political levels. To tell an individual in crisis that mental disorder is socially constructed would be unhelpful, but understanding that conceptions of mental health or illness are not pre-given or static makes important contributions to debates aimed at different levels, looking at longer term societal change. This of course begs a discussion of the types of things that we might do to improve services moving forwards.

Future directions

It is important to not only engage in current debates but also participate in the future development of mental health services. It would seem reasonable to argue that we need to take responsibility for participating in work at many levels going forward. There is the level of the individual within one-to-one sessions, the level of collections of individuals at a service user engagement level, engagement in the local practices within our institutions as well as more broadly within health services nationally, and the necessity to participate in wider socio-political ideological debates to be proactive in social change. This may sound overwhelming on top of our usual work demands; however, we have identified two key areas in which it might be possible to achieve development in realistic ways.

Service user engagement

Current discourses within mental health professions look towards new solutions in terms of an emphasis on hearing service users' opinions. Understanding service user perspectives is imperative because patient narratives offer new perspectives on their socio-historical contexts: 'Patients' narratives have been used to illuminate the "inner world" of mental illness, rather than the outer world of the changing experience of being mentally ill' (Davies, 2001, p.268). Service users have views and experiences that may differ in important ways from that of professionals and can potentially contribute to more engaging environments and hence better outcomes (Bone, O'Reilly, Karim, & Vostanis, 2014).

There are a lot of buzzwords around service user perspectives in recent times, however, and care needs to be taken not to place full responsibility in the hands of service users to come up with solutions for their distress. There is a requirement to make genuine rather than tokenistic partnerships, and actually put collaborative changes into practice, rather than going through the motions due to popular discourse (Boyle, 2014). This might involve creating time for staff to run focus groups and actually putting together realistic action plans for improvement. There are always issues of funding, which can be barriers; however, services that are interested in making long-term improvements do need to engage in such collaborative activities.

Socio-political engagement

There is also the problem of the wider socio-political climate. We are now in the era of global capitalism, and being social animals our identities are shaped by the norms and values of culture around us, which is changing dramatically (Verhaeghe, 2014). Every culture defines normality and abnormality, so it is necessary to watch how this increasingly global culture will influence definitions of mental distress. A potential risk is that disorders may become ever more universal rather than being understood in context, with pharmaceutical companies standing to gain. On the other hand, there is the potential for learning from globalisation, not just about different types of therapies that help, but how differing socio-political climates influence mental distress. Human thinking reflects the outer workings of society (e.g. voice hearing is shaped by culture – Luhrmann, Padmavati, Tharoor, & Osei, 2014), so we have a chance to understand how political ideological standpoints within the United Kingdom and other countries influence mental well-being.

However, we do need to be able to engage in these debates (which is difficult given the current cost-cutting climate within mental health services). For example, we need to examine the consequences of austerity cuts and the impact on mental health, not just locally within services, but more broadly in society (such as cuts to legal aid and domestic violence). In order to do this, professionals need to be engaged in open debates on prevention strategies and to be involved in the promotion and dissemination of social research (Boyle, 2014). Danzinger (1994) pointed out that to participate in challenging the status quo it is necessary to engage in increased sociological research (biological research far outweighs social). Accounts that fully incorporate the social context have the potential to offer new ways of thinking and understanding mental distress and can direct solutions towards socio-economic policies rather than blaming those individuals from lower status groups.

Clinical relevance summary

Our discussion indicated that there are issues surrounding diagnosis that are not straightforward to manage. On the one hand, a diagnosis of personality disorder can re-traumatise someone who has already experienced extremely distressing events. On the other hand, it can validate their suffering, and diagnosis does not tend to be used in isolation to determine treatment plans. We have sought to work closely as a multi-disciplinary team within our service and believe that debating perspectives from a range of professionals is healthy (see Thomas, 1997, in relation to schizophrenia). In order to attempt to address issues of power imbalance, we need to ensure that service users have the opportunity to challenge diagnoses and collaborate on treatment goals. Related to this, we also need to build in time to fully take on board service user voices and actually integrate ideas into practice, rather than this being a tokenistic exercise.

There are competing debates about psychiatric hospitals relating to paternalistic and autonomous ideologies. While living in the community is an ideal goal, this is not as simple in practice. There are questions over resources and also problems relating to the socio-political environment. Where the community is seen as a hostile environment, rife with abuse and with limited opportunities for meaningful social identities, patients are not motivated to return.

Negative discourses of personality disorder require careful management with staff. Understanding the underlying reasons for various behaviours is important and crucially staff require good quality supervision for personal and professional development. Related to this is the issue that services are becoming increasingly focused on risk management, potentially at the detriment of therapy. There are discourses of blame for staff when patients self-harm, and so there is the need to manage the tensions of responsibility for patient welfare versus staff support. Again, good quality supervision is a key factor in managing this, as well as the need for resources to be in place to manage both the risk and therapeutic aspects of hospitalisation, to avoid a return to therapeutically barren warehousing. Finally, if we really want to help people then we need to engage at the wider socio-political level. This involves taking part in open debates and engaging in sociological research and taking a critical approach to understanding the impact of globalisation on mental distress. For a simple summary of the practical implications, please see Table 23.1.

Table 23.1 Clinical practice highlights

1. Diagnoses – Clinicians should endeavour to be sensitive to the individual patient's needs, where ideological standpoints may come from a variety of sources and experiences. Collaboration is important to allow patients to challenge diagnoses, but a diagnosis may sometimes be helpful.
2. Empowerment – Building-in practical time to listen to service users' voices can offer new perspectives on mental distress and promote engaging environments.
3. Supervision – There can be pejorative discourses of personality disorder, and good quality supervision is necessary for all staff that work within these environments, to understand the underlying developmental contexts and functions of these behaviours.
4. Risk – There are tensions between taking responsibility for patients' welfare, promoting their independence, and discourses that staff are to blame for self-harm. Providing staff with good-quality supervision is important, as well as developing supportive environments that foster transparency.
5. Autonomy – There are debates relating to hospitalisation versus community care, with tensions between the ideological viewpoints of paternalism and autonomy. Understanding barriers to patients moving on is important, which also relates to the wider socio-political environment and continuity of care within the community.
6. Capitalism – Being aware of the impact of capitalist ideology on stigma and availability of resources is important. The influence of increased globalisation on discourses of mental health is also of interest, where this may offer the potential for learning as well as the risk of increasingly global and individualised definitions of disorder.
7. Social research – Discourses of mental distress are not static and it is important that psychologists engage in wider societal issues, such as understanding the impact of austerity cuts on mental health/illness. Engaging in open debate, promoting and disseminating social research, and targeting socio-economic policies are necessary to avoid working at a reductionist level.

Summary

A critical discursive perspective has been useful for examining psychiatric hospitals as it has provided a framework for considering how cultural ideologies shape prevailing ideas and has allowed us to look more closely at power dynamics and the varied consequences that competing discourses might have. Considering how historical ideologies shaped current services helped to throw current tensions into light. It seems apparent that as a profession we need to assume a responsibility to engage in issues of mental distress at various levels, from the individual to the wider socio-political.

Psychiatric hospitals can be both empowering and disempowering, therapeutic and potentially harmful. They are shaped by overarching ideology and competing local discourses. We do not take the anti-psychiatry position that they are automatically bad regardless of circumstance, or the optimistic position that we are on a linear progression towards perfection. Perceptions and treatments of mental distress will continue to shift, and where actions are taken with ostensibly good intentions, there will always be unintended consequences. Something as apparently simple as wanting to help others in distress becomes extremely complex when taken into the professional domain of the state, where competing ideological standpoints are enmeshed with systems of power, rights, human agency, economy, and politics. Nonetheless, we have a responsibility to engage in the debates and to reflect on our input and decision-making as part of these systems, as part of our desire to help people and not to cause harm.

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Part IV

Therapy and Interventions

24

Discursive Awareness and Resourcefulness: Bringing Discursive Researchers into Closer Dialogue with Discursive Therapists?

Tom Strong

Introduction

> *It is not possible to tease out and separate where culture ends and nature begins, where the moral starts and the psychological no longer exists, where the political takes center stage and the economic fades from sight.*
>
> (Cushman, 1995, p. 333)

Discourse analysis, such as analyses of mental health discourse, has enabled researchers, practitioners, and policymakers to step back from communications in order to see what is constructed in and from them. The great phenomenologist Edmund Husserl (1913) had suggested that such stepping back would help us to break with our natural attitude towards understanding experience. Thus, most discourse analysts do their analyses from afar – viewing videotapes or other media representations, or peering at transcripts, integrating findings from prior discourse analyses, and offering their accounts of what transpired and resulted from different kinds of communications in which they had *not* participated. Such critical and analytic distance clearly offers useful knowledge, yet what if one could deploy the analytic sensitivities of discourse analysts to participate in the immediacies of helping dialogue?

I am a self-described discursive therapist who took up the insights of the linguistic or discursive turn (Lock & Strong, 2012; Strong & Paré, 2004), as these insights became evident through my reading and practice of narrative therapy (White, 1994; White & Epston, 1990). One aim of this chapter is to review what I believe discourse analysts and discursive therapists have to offer each other. There are families of discourse analysts (taking up varied ideas and practices) and families of discursive therapists (ditto), and in my view they regrettably talk past each other, despite some shared views on language use.

I will zig-zag between macro- and micro-views of discourse in both research and therapy, linking big picture cultural and institutional influences to the face-to-face immediacies of therapeutic dialogue. My general aim in this chapter is to promote a synthesis of discursive awareness (derived from discourse analytic research) with discursive resourcefulness to enhance therapeutic dialogue.

Background to the discursive therapies/discursive research

It is one thing to micro-analyse a sequence of therapeutic interaction for what is or is not accomplished, or to identify the dominance of particular cultural and institutional discourses, but quite another to be intentionally, discursively aware and resourceful in the face-to-face dialogic encounters and rapid fire exchanges of therapy. To be social constructionist (see Gergen & Ness, Chapter 25, this volume), or poststructuralist, these days is to recognise that there are upsides and downsides of language use – relationally, institutionally, and culturally. Language is seldom benign; what matters to discourse analysts is what results in and from its use. Because language use is among the taken-for-granted of human activities, discourse analysts have much to offer therapists through their research. Identifying linkages between language and power, or what comes from routine and other performances of communication, discourse analysis enables better understandings of the uses and consequences of varied kinds of language use. Discursive awareness – gained from varied forms of discourse analysis research – can orient therapists to ways they can be discursively resourceful with clients.

The kind of discursive resourcefulness to which I refer was pithily described by Billig (1996) as 'witcraft', which some might dismiss as 'smarts', but that I associate with resourceful uses of language. A related notion was referred to by the great philologist Vico (2000/1744) as poetic wisdom used to overcome what he referred to as 'linguistic poverty'. The key enabling insight associated with this resourceful use of language comes with recognising the rhetorical reflexivity of language use – through what such use produces in physical reality, and what it brings forth in the immediacies of dialogic exchanges via questions and ways of responding (Tomm, 1988). Scholars of rhetoric (Aristotle onwards) have long recognised a poetics and politics to discourse, but most scientist-practitioners are uncomfortable with seeing applications of scientific knowledge regarded as rhetorical. Rhetoric seems a word best left to truth-distorting politicians and salespeople. For Maranhão (1986), therapeutic communication was rhetorical all the way down, as therapists use language to both represent experience and negotiate changes in how experience is 'languaged'. Any queasiness therapists might have with these last sentences might have something to do with their metaphors of communication, to which I will return later. Discursive resourcefulness follows from a discursive awareness that people are not always well served by how experience is understood and communicated in humanly constructed language.

While my becoming an academic was partly prompted by critical concerns about psychiatric discourse (Strong, 1993), my developing focus as a practitioner-researcher (Strong, 2005) was on what was talked into awareness, significance, and action in face-to-face therapeutic conversation. This brought me to the micro-focus associated with conversation analysis (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008; Voutilainen & Peräkylä, Chapter 27, this volume) because, as a therapist, I wanted a better sense of how clients and I talked some processes and outcomes 'into being' (Heritage, 1984) over others. This kind of micro-focus, however, invited macro-critiques, as colleagues weighed in on how my focus on collaboration and resourcefulness obscured issues of power. Worse, my reading of critical psychologists, like Nikolas Rose (1997) or sociologists like Eva Illouz (2008), made the very idea of therapy suspect – since therapists, by their view, were institutional colonisers and reproducers of neoliberal subjectivities. While we are not 'cultural dopes', to use Harold Garfinkel's (1967) well-known words, neither are we free from powerful institutional and cultural influences associated with language use. Discourse analysis can be a powerful critical resource for unmasking how cultural and institutional power is reproduced, including therapist complicity in such power relations. Discursive awareness and resourcefulness are features variably taken up in the discursive approaches to therapy, to which I will next turn.

Discursive therapy?

Many conversations have a quality that Wittgenstein (1953) described as being part of the 'hurly-burly' of life – socially accountable conversations where we often have to justify ourselves to each other (Shotter, 1984). Therapy conversations potentially offer an antidote to such ways of conversing and interacting (cf. Rogers, 1957) since people can find it hard to step outside of everyday discourse for reflection and other kinds of dialogue. Talk therapy itself is a relatively recent idea and practice (cf. Cushman, 1995), though some of the concerns it was developed to address are not (e.g. Foucault, 1988). For psychotherapy to develop as we mostly know it today, however, psychology was necessary. Specifically, the notion that psychological knowledge could be acquired and applied in ways similar to how natural science knowledge serves engineering has been an animating premise of psychology up until recently (Gergen, 1999). Close scrutiny of this premise reveals many different applications of psychological (and other kinds of) knowledge while the consensus emerging is that the quality of the conversational relationship between therapists and clients – and not specific applications of psychological knowledge within it – is what matters most in effective therapy (Miller, Duncan, Wampold, & Hubble, 2010).

Discursive therapies are conversational approaches aiming to address the limiting and taken-for-granted effects of language use in clients' lives. Deliberately reflexive, discursive therapists see *their* uses of language as inviting clients into critically reflective and generative dialogues to construct client-preferred meanings. For them, a collaborative relationship is needed in which the ultimate judgement on what is helpful rests with clients (cf. Anderson & Goolishian, 1992; deShazer, 1984). Thus, discursive therapists welcome clients' initial constructions of problems but see therapeutic dialogue as a means to join in a search for language clients deem fitting for addressing their concerns and aims. The discursive therapist's primary 'tools' in this sense are reflexively asked questions (Tomm, 1988) to clients that may prompt critical reflection on language use, on taken-for-granted resources and forms of resourcefulness, and on preferences. Whereas an information transmission/reception metaphor of communication (Lakoff & Johnson, 1980) goes generally unquestioned by many therapists, discursive therapists view their participation in therapeutic conversation as inescapably reflexive, and from that reflexivity they are critically reflective and generative with respect to clients' and their own uses of language.

The most familiar discursive therapies are narrative (White & Epston, 1990), solution-focused (deShazer, 1985), and collaborative therapies (Anderson, 1997). While each makes language use and the therapist's reflexive involvement in therapeutic dialogue central, the differences between these therapies tend to relate to their particular discursive foci of intervention and the conversational practices used to intervene. Respectively then, one finds in narrative therapy a focus on co-authoring preferred (over problem-saturated) client stories; in solution-focused therapy, a focus on solution over problem-focused conversation; and in collaborative therapy problem-dissolving conversations. Each approach draws on aspects of discourse theory that would feel at home for most discourse analysts.

Discourse analysis and therapy discourse?

Discourse analysts comprise a similarly heterogeneous group, but their primary research focus is on analysing the variability and consequences of language use. That use occurs in differently interpreted interactions, from a cultural and institutional level on down to how speakers, like therapists and clients, respond to each other. What matters to discourse analysts and discursive therapists alike are what language or discursive resources are used in communicative interactions and what comes from such use. The variability relates to the politics that can be associated with such interactions, in differences over meaning that can have human consequences for extending or modifying cultural and relational life.

Zooming out, macro-socio-cultural influences can be traced in these communications, highlighting the symbolic resources turned to, to make sense of and represent particular phenomena. For example, I have had a critical discourse analyst's interest in medicalisation discourse as it has become increasingly used to represent concerns or vulnerabilities formerly considered normal aspects of the human condition. As our media portray these aspects in medical terms, I share the concerns of Furedi (2004) and Illouz (2008) that we are moving towards a 'therapy culture' where people increasingly self-identify on the bases of psychiatric discourse. Zooming in, as a therapist, others and I have been interested in strategic micro-sequences of talk in the discursive therapies, for the discursive resources and conversational practices used, and for what gets constructed in and from such sequences (DeJong, Bavelas, & Korman, 2013; Strong, 2005). Of course, cultural and institutional discourses are at play in specific sequences of therapist–client talk, as colleagues have shown (Kogan & Gale, 1997), or as they also play out in family interactions presented in therapy (O'Reilly, 2014). These kinds of analyses of therapeutic discourse, I believe, can equip therapists with discursive awareness to facilitate their being intentionally and resourcefully reflexive when talking with clients.

While analysis of therapeutic discourse has been on the rise (cf. Tseliou, 2013), Gregory Bateson's team was researching therapeutic discourse to inform therapeutic practice over 50 years ago (Reusch & Bateson, 1951; Watzlawick, Bavelas, & Jackson, 1967). They recognised therapy is primarily discursive, yet somehow therapists had largely ignored their discourse, focusing instead on discrete, conversational interventions, that later researchers purportedly measured for their effects on clients as if they were drugs (cf. Stiles & Shapiro, 1989). Discursive therapists would not see themselves as administering a therapeutic intervention and would instead conversationally orient to such an intervention as a possibility, a possibility to be proposed and hopefully taken up by clients – in the immediacies of therapeutic interaction and hopefully beyond (Strong, 2005). While macro-cultural and institutional discourses clearly shape the conditions of possibility for therapeutic dialogue and intervention, they do not determine therapy's meanings and processes. Thus, it is a personalising of meaning and process – in respectful and responsive dialogue – that conversationally and relationally brings words to life in the moment of their use (Bakhtin, 1981; Lowe, 2005), and hopefully beyond. Though I agree with Derrida (1976), that too much can be expected of words, change potentials in dialogue owe something to new uses of language that enable previously unconsidered and acceptable ways to move forward where such movement seemed impossible.

To most critical (macro-focused) discourse analysts, meanings are like proxies for doing the work of larger discourses. Such discourses, when dominant, circumscribe possibilities for meaning and interaction, and while such dominance can obscure other potentially accessible discourses and their accompanying resources, it seldom prohibits such extra-discursive awareness and resourceful access. That would be like suggesting that people couldn't change their understandings or politics. Discourse analysts focused on micro-interactions (Edwards & Potter, 1992; Peräkylä et al., 2008) suggest that what is said and done in conversational turn-taking matters in terms of perpetuating or departing from an existing or dominant discourse. Straddling these macro- and micro-approaches to discourse, as a discursive therapist, my conversations with clients constantly remind me to zoom in or out depending on what gets said.

Recognisable tensions between these macro- and micro-approaches to therapeutic interaction can be helpful in informing one's practice as a therapist (Gale, Lawless, & Roulston, 2004). Tensions can seem like an ambiguous word for dilemmas of scale and scope as therapists discursively locate their conversational work with clients. For example, whose agendas are being pursued as therapists engage clients on the bases of diagnoses and evidence-based conversational protocols (Strong & Busch, 2013)? What kinds of subjectivities and identities are privileged and produced in and from 'therapeutic' conversation (Illouz, 2008; Lazzarato, 2014)? What conversational evidence tells therapists that dialogues with clients are 'on track' (Strong, Busch, & Couture, 2008)? In this era of cultural diversity, does it matter that applying psychology's normatively derived knowledge in therapy might further marginalise people (Rose, 1997)? And what are we to make of the growing phenomenon of prospective clients self-diagnosing and managing their lives as managers of their personal mental health (Furedi, 2004; Strong, Ross, & Sesma-Vazquez, 2015)? Discourse analyses of therapeutic conversation can help answer both big picture and small picture questions regarding what occurs in and from therapy. Until recently, however, very little discourse analysis research has examined the discursive therapies.

Discursive research and discursive therapy?

I want to begin this section with two quotes that amplify what I described above as the micro- and macro-foci of discursive approaches to research and therapeutic practice, which now strike to me as ways of 'zooming in' and 'zooming out' of therapeutic discourse.

> Any action of the therapist – be it a question, a statement, or something else – expresses an understanding of the patient's experience, and an understanding of how that experience can and possibly should be related

> to.... Likewise, the patients' actions – be they stories, answers, responses to interpretative statements, or comparable understandings of their own experiences..... Because the participants' actions are tied together by sequential implicativeness, the participants inevitably have to orient to and work with the understandings that they each bring about through their actions.
>
> (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008, p. 16)

> To the extent... that therapy and counselling assume that the effects of social ills can be remedied on the basis of the hidden potentials of individuals, they can be regarded as ideological practices, which may be in competition with practices of political mobilization based upon the contrary assumption that social ills can be remedied only through social change.
>
> (Fairclough, 1990, p. 225)

While psychologically informed therapists have largely turned to individualised understandings of struggle and suffering (or conversely, resilience and well-being), discursive therapists tend to see such understandings and experiences as socially constructed and therefore contestable and negotiable (Gergen, 1999). Social construction typically is regarded as a broader institutional or cultural phenomenon, but it can also be observed in the immediacies of people interacting. Zoom in and one can find consequential micro-interactions in the face-to-face immediacies of therapeutic dialogue-in-its-development. Zoom out and one finds people shaped by more pervasive social (macro-)constructions such as our cultural institutions, discourses, and technological innovations (such as the 24-hour world clock, Galison, 2004). The quotes above about zooming in and out relate to differences in how the discursive therapies are practiced, and in how they could be researched. Discursive awareness facilitates both zooming in and out.

Zoom in and one finds solution-focused therapists (e.g. de Shazer, 1985) avoiding problem-focused dialogues, while trying to co-construct with clients processes and outcomes: 'miracles', actionable exceptions, and resourcefulness. Solution-focused therapists see therapy as a different 'language game' than the problem-focused one that preoccupies the dialogues of most clients and therapists (deShazer, 1991). Therapy's process and solutions are negotiated and customised by therapists (Strong & Turner, 2008) guided by what clients deem as do-able in their circumstances. The focus is reflexively micro-interactional as therapist and clients take their turns at talk. What therapists next need to say is based on the last thing a client says to them – with that solution-focus mentioned. It is in this sense that solution-focused therapists take up a sequential view of what is produced over turns in talking – *as* they talk with clients.

Solution-focused therapists have turned to forms of discourse analysis to examine their conversational practices and what results from their use in actual therapeutic dialogues (DeJong, Bavelas, & Korman, 2013; Gale & Newfeld, 1992; Miller, 1997; Smock & Bavelas, 2013). From a training and supervision standpoint, such discursive studies help to orient therapists to micro-details of therapeutic dialogue that arguably occur under the therapist's conversational radar. Specifically, such studies highlight responsive features of talk that typically escape notice, enabling what Shari Couture (2006) referred to as a kind of 'slow motion' analysis common to televised sports activities. This makes the focus and methods of discourse analysts very helpful as a training or self-supervision tool: therapists can review what their actual turns at conversation produce in terms of what clients say in response (Gale, Dotson, Lindsey, & Negireddy, 1993). Relatedly, I have been interested in how solution-oriented therapists conversationally engage client resourcefulness through their questions (Strong & Turner, 2008) and through negotiating exceptions (i.e. to when problems dominate) discourse (Strong & Pyle, 2012). Bottom line, micro-interactional methods like conversation analysis (Peräkylä et al., 2008) enable close evaluation of what is sequentially constructed in client–therapist dialogue.

Narrative therapists (White & Epston, 1990), by contrast, tend to invite clients to zoom out, to critically reflect on and deconstruct the workings of larger cultural stories and discourses, as a step towards resourcefully living by more preferred discourses and stories. One assessment and intervention focus of narrative therapists is unpreferred identity stories. Identity construction has also been a very important feature of discourse analysis for some time (Antaki & Widdicombe, 1998), particularly given how some aspects of identity work in therapy can be used to pathologise (Avdi, 2005) people. For narrative therapists, 'problems, not people, are problems'; thus, an aim of narrative therapy is to externalise identity descriptions people may have internalised. Once externalised, the story used to characterise or describe a person can be critically (i.e. discursively) reflected upon. Such identity stories are often laden with terms and evaluations from psychiatric discourse (Illouz, 2008) or discourses of moral culpability (cf. Lindemann Nelson, 2001). Where discourse analysts may try to expose the operations of dominant discourses, narrative therapists ask questions that invite clients to critically reflect upon such discursive operations as they feature in identity stories or problem stories – as linguistic descriptions separate from their personhood (White, 1988, 1994). The therapeutic aim is emancipatory, developing discursive awareness of 'requirements' of problem-saturated identity stories, to resourcefully discuss preferred, plausible, and enact-able alternative stories.

Narrative therapists use and write about their conversational practices but have generally avoided discourse analysis when examining conversational practices in therapy (exception: Strong, 2008). While clients' limiting stories and discourses focus therapeutic intervention, the 'co-authoring' conversations have received scant attention from discourse analysts. Instead, readers are typically offered transcripts of passages of therapeutic dialogue that lack the performative details normally of interest to conversation and discourse analysts (Wooffitt, 2005). This focus away from the performative features of therapeutic dialogue may relate to the earlier-mentioned communication metaphors. Some practitioner-authors have raised ethical concerns regarding how the avowed collaborative stance in narrative and other forms of social constructionist therapy are transacted at the level I have been describing as micro-interactional (Weingarten, 1991). Therapists can forfeit what one narrative therapist, Paré (2013), has referred to as their discursive wisdom, by in effect colonising clients with their preferred ideas and practices – a concern some narrative therapists have directed at solution-focused therapists (Nylund & Corsiglia, 1994). To many critical discourse analysts, narrative therapy's focus on helping people expose unwanted and dominating discourses in their lives, so that they can live according to more preferred discourses, will be like discovering a previously unknown relative.

Whether considering stories or cultural discourses, or solution-focused versus problem-focused discourses, therapists face conversational and ethical challenges in decentring from their own discourse positions so that they do not become 'instruments of culture' (Hoshamand, 2001) dominating clients with society's status quo expectations, or obliging clients to respond to them in the therapist's discourse. To paraphrase, Richard Rosen, author of *Psychobabble* (1977), therapists should not be evaluating clients' progress based on how well they come to use the therapist's language. Beyond the overreach indicated by the popular phrase, the 'talking *cure*', for therapy to make a difference something changes or initiates changes in the conversational interaction of client and therapist. Therapists' approach-based explanations for such changes are abundant and they typically focus on what therapists say to or ask clients.

From my discursive standpoint, therapists of all these approaches engage clients in meaning-making activities of varied kinds. Somewhat unique to narrative and solution-focused therapists' conversational work is their focus on changing discourse, whether that be through negotiating a different focus and performance of discourse (solution-focused) or exposing and liberating oneself from a dominating and problematic discourse (narrative). At a pragmatic level, these kinds of therapists conversationally engage clients with a preference-animated focus (i.e. on the client's preferences; Sutherland, Sametband, Gaete Silva, Couture, & Strong, 2013). How such dialogues translate beyond the consulting room are still in the process of being evaluated. Recently, Dreier (2008) conducted a sobering and instructive study of families outside of therapy (not specifically narrative or solution-focused therapy), indicating how little the outcomes of therapeutic dialogue featured in family members' non-therapy experiences and interactions.

Differing notions of expert communications in therapy?

My entry point into the discursive therapies partly came through learning Milton Erickson's hypnotherapy (Zeig, 1980) which was popular at the time I was a graduate student. My initial interest in Ericksonian hypnotherapy was based on a view, still largely taken up by therapists, that I could expertly communicate in ways that would *cause* client change. Erickson could apparently do his hypnotic work without clients being in deep trances – he knew *what* to therapeutically say and *how* to say what was needed. The purportedly curative factor of such a therapy was that I, too, could direct, impart, or compel therapeutic change with my expert hypnotic communications. This view relates in part to a speech act metaphor of communication associated with Austin (1962) or Searle (1969) whereby – given knowable conditions and what conventionally addresses those conditions by what is communicated – one should be able to enact therapeutic change FOR another. Evidence-based therapeutic interventions build on this speech-act view, requiring precise, somewhat scripted, communications for their standardised protocols to get the work of therapy done (Chwalisz, 2003). An extreme and sometimes idealised version of what I am describing sees all of therapy occurring according to adherence to particular conversational and decisional algorithm for inquiring into and diagnosing clients' presenting concerns, for translating those concerns into therapists' explanatory models, and according to which further evidence-based intervention protocols are applied.

A concern that accompanies the expert (pre-decided) metaphor of therapeutic dialogue described above came from Foucault (1976), who saw disciplinary expertise as requiring 'docile bodies'. The clients I was seeing in practice after learning my Ericksonian communications were not so docile, and that recognition came at about the same time the discursive therapies were gaining initial prominence. The discursive therapies are based on a collaborative view practice where *resistance* to professionally directed therapy can be key to the resourceful participation of clients in therapy (Andersen, 1997; deShazer, 1984; Wade, 1997; White & Epston, 1990). Discursive therapists collaboratively engage clients' preferences, resources, and understandings, while seeing themselves as needing to be the flexible or resourceful ones in therapy, not clients.

Some might ask how such a collaborative metaphor of dialogue is possible when therapists hold greater institutional and cultural power, not to mention potentially superior rhetorical skills and privileged expert knowledge. Critical psychology (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984; Rose, 1997) developed, in part, out of such concerns. While views vary on this concern within the different discursive therapies, a few key points stand out.

Translating postmodern and poststructuralist insights to the discursive therapies has meant having to tackle modern notions like expertise head on (see Anderson & Goolishian, 1992). Though discursive therapists still have pet notions of what to focus on in therapy (e.g. solutions or preferred stories), they do not assume fore-knowledge of what clients' concerns are 'really about', or what needs to be done regarding such real problems. Their skill rests with hosting discursively aware and resourceful dialogue with clients, as opposed to expecting clients to fit their understandings and preferences into the therapist's accustomed monologue (Strong, 2002). In this regard, discursive therapists listen and respond like ethnographers encountering unfamiliar people on foreign territory (Hoffman, 2001). They are guided by what their 'not knowing' questions bring forth and then customise understandings and solutions with clients. For example, in narrative therapy clients' names for problems are privileged. Arguably, discursive therapists use their cultural and institutional privilege, to privilege clients' meanings and solutions, seeing the conversational work as a form of consultancy aimed at producing client-preferred processes and outcomes. Finally, preferences as I have been describing them should not be idealised. Preferences associated with making the best of a bad circumstance, or as 'resistance' to therapist suggestions, can be seen to animate the forward movement of such conversations (Sutherland et al., 2013). The challenge is for therapists to respond with discursive resourcefulness and flexibility to enable collaborative movement forward. Some discursive therapists, with the help of discourse analysts, have been working to deconstruct the power and privilege associated with their roles, in effect making their roles and participation contestable by clients (Parker, 1999).

Discursive awareness and resourcefulness

> The tension between knowledge and rhetoric resides in the difficulty of deciding what knowledge is and what persuasion by argument is. Every system of knowledge exudes its rhetoric, and every rhetoric supposes a system of knowledge, however unaware of it the rhetor is.
>
> (Maranhão, 1986, pp. 221–222)

A recognition brought to therapeutic discourse by both discourse analysts and discursive therapists is that the metaphors and words that make up the discourses people live by are human constructions and not 'mirrors of nature' (Rorty, 1979). As human sense-making and action-informing constructions, there is something inevitably partial about discourse. In other words, there is always something more to be said and understood, and not just as part of extending an already existing discourse. Thus, discursive awareness involves mindfulness as one encounters discourse differences, or gets too steeped in a particular discourse, as the one true way of understanding and interacting. Discursive awareness can be irksome for those who prize unity and harmony, as it points to relations based on foundational premises typically different from our own. Discursive awareness, in therapy, can mean growing comfortable with engaging the discourse differences of clients or that clients have with each other. At the end of therapy, what isn't needed are people on the same discursive page, putting things metaphorically, but people able to coordinate their relations in spite of discourse differences. This is why the ethnographer metaphor mentioned can be so important. In Canada, we are in the process of undoing the 'helpfulness' brought to our First Nations people by European colonisers. How do we help people on *their* terms – that is another aspect of what I have been calling 'discursive awareness'.

Discursive resourcefulness reflects what practitioners can do when faced with limiting or conflicting discourses. It can mean looking beyond the discourses that dominate understanding and interacting, for the symbolic and other resources that alternate discourses might provide. However, such resourcefulness could not occur without discursive awareness. Discursive therapists, to me, bring together discursive awareness in the service of discursive resourcefulness when helping clients. In other words, recognising the partiality of any discourse, they look beyond that partiality for other discursive resources. The interesting pragmatic parts come with how such awareness and resourcefulness are invited and negotiated into therapeutic dialogue.

Discursively aware/resourceful therapists recognise that part of their challenge is in hosting conversations with clients that invite unfamiliar and unpredictable ways of talking and listening. These are the kinds of conversations, to paraphrase Bateson (1972), that elicit or catalyse discourse differences that make a difference. Bateson, an anthropologist and cybernetician, was interested in performances of patterns of communication, for the meanings and ways of being and relating that can become stabilised in such patterns. For therapists and researchers who focus on the semantic or cognitive content of such patterned communications, this performed and patterned dimension of discourse can escape attention. Practice theorists, like Schatzki (2002), see social orders as being stabilised through how people *do* social life, with patterned discursive interaction being part of that doing. Thus, discursive reality – our sayings and doings – is reproduced through patterns of familiar communicative interaction, and not by some semantic thought cloud that has overtaken people's consciousness. The discursively aware therapist can resourcefully capitalise on these insights. Specifically, for the discursively resourceful therapist, there is Harlene Anderson's (1997) challenge of hosting a collaborative conversation that is different from those clients have been having with themselves and others. This can be a particular challenge given that therapists typically initiate their conversations with clients by welcoming what they are initially presented. Therefore, at some point discursively resourceful therapists need to become aware of their involvement in such patterns with clients and negotiate a conversational direction beyond where clients may already be stuck, to avoid joining them in that stuckness. There is, of course, an ethical dimension to these resourceful negotiations; therapists (even those with evidence-based science purportedly on their side) cannot impose such a conversational direction on clients.

Therapeutic discourse can also be sometimes understood in problematically singular terms. For example, psychiatric discourse can further a nasty habit of 'totalising' diagnostic understandings of self and others in ways that can seem to preclude conversations in other languages of suffering and agency (Brinkmann, 2014). This can be particularly difficult when psychiatric discourse offers a legitimacy to suffering and struggle that could not be found in other discourse (Jutel, 2011). Eva Illouz (2008) has been concerned that therapists' discourse has taken on a more insidious cultural manifestation – as – the 'lay public' increasingly understand, fashion lives, and present themselves and others in such expert discourse. Therapeutic discourse is also a genre of communication that has been studied for its predictable conversational practices, developments, and semantics for some time (Labov & Fanshel, 1977). In that sense, it occurs through systems of discourse that Maranhão described above. Clients can become well schooled in such predictable conversation, while the familiarity therapeutic dialogue has bred at a cultural level has become a target of parody, as is evident in some of Woody Allen's films.

It may seem odd that discursive therapists might need to help clients disengage from a therapeutic discourse through which they have come to understand, conduct, and limit their lives. Whether encountering psychiatric or any other singular discourse of therapy clients present, discursively resourceful therapists can turn to a discursive practice Ken Gergen (1999) has referred to as 'supplementation'. This brings us back to the partiality of any discourse and what might be left out of a singular therapeutic discourse given the client's preferred ways of being. Supplementation involves asking what a singular discourse or understanding leaves out given a person's experiences, preferences, and circumstances.

Clinically applying and researching discursive awareness and discursive reflexivity

> *. . . constructionist social science would benefit from taking seriously the issue of construction. Rather than treating construction as a taken-for-granted start point, it should consider construction and deconstruction as a central and researchable feature of human affairs.*
>
> (Potter, 1996, p. 206)

Potter's quote above could apply as much to therapists as it could to researchers, if one approached the change potentials of therapy discursively. What are therapists producing in the back-and-forth turn-taking of their conversations with clients: reproductions or extensions of the therapist's or some other dominating discourse? Even if something novel and preferred for clients is discussed in therapy, should we put any stock in what transpires in such dialogues, given the larger cultural or institutional influences at play? Given that the one most enduring research finding is that the quality of the therapeutic relationship is paramount, does it even matter how therapists and clients talk and listen?

My experience in talking with most discourse analysts has been that they view therapy as a suspect and over-rated activity. My experience in talking with most therapists is that they see discourses affecting conversations with clients, but not in ways that actually feature in those conversations – discourses are somehow outside the conversation, influencing it like ghosts from beyond. Many also seem confused about how their contributions to the immediacies of responsive dialogue play a role in therapy's outcomes. Interventions, in other words, are often seen as occurring apart from the other aspects of therapeutic dialogue. This is why I think Potter's quote above is so important, and why I think discourse analysis has much to offer therapists wanting to better understand what therapeutic dialogue constructs – for good and otherwise. But, I also think, from my conversations with discourse analysts who are not therapists, that they too often have constructed a Foucaultian straw man, as professionals who are complicit in reproducing dominant cultural and institutional practices at clients' expense.

Clinical relevance summary

So, what does a discursively aware and resourceful therapist offer that counters such stereotyping? Further, what might discourse analysts have to offer discursive therapists? (An overview of Discourse Analysis and Conversation Analysis in therapy is offered by Kiyimba & O'Reilly in Chapter 26, this volume.) Since this is a book targeted to discourse analysts, let me start with the latter question. I think the macro- and micro-analyses made possible by discourse analysis can help discursive therapists examine theoretical claims that undergird their practice. Discursive therapists claim to help clients co-construct preferred realities (McNamee & Gergen, 1992). Theirs are empirically testable claims if one examines what new ideas and discourses are produced from within therapeutic dialogue (i.e. via the micro-focus of CA; Strong et al., 2008) for clients. How such newness is expanded upon beyond the consulting room and into everyday life (Dreier, 2008) can be studied as a new form of dominant discourse (the macro-focus) in clients' everyday lives. My personal hope is that clients learn also to become discursively aware and resourceful as they experience their therapist doing so, and gain confidence in making such shifts. The cue that therapists and clients alike might use their discursive awareness when stuck or stale to become resourceful by turning to the resources of alternate resources could be a by-product of therapy.

Therapists, to practice with the kind of discursive awareness and resourcefulness I have been describing, need to question their metaphors of communication (Lakoff & Johnson, 1980; Turnbull, 2003). How do they answer the question of why their talking with clients can make a difference in the clients' lives, and if clients are resisting their ways of listening and talking, what can they learn from those clients? Discourse analysts present a view of reality and communication that can challenge those therapists who idealise the world as understandable and communicable by a single discourse: theirs. So, the view that reality can be related to in multiple ways can feel both liberating and scarily vertigo-inducing. Discursively responsive practice invites therapists to learn from clients, and the means for doing so is via clients' discourse. Learning to resourcefully work within clients' discourse does not mean sharing the same subjective experiences; it means that the words, metaphors, and stories used are like cultural emissaries speaking of foreign experiences, despite these being shared in a common language. Finding ways together (therapist and client), to get beyond the limitations of a discourse, is a resourceful and ethical aspect of the conversational work that discursive therapists undertake. For therapists, here are some concrete suggestions for practicing with discursive awareness:

- Consider what your dialogues with clients produce 'in micro' – over turns at talk.
- Consider the discourses clients are 'coming from' in how they present their understandings and intended actions. Reflect on your own unquestioned discourses and metaphors, particularly when these are coming up short for you in your work.
- Review the everyday cultural discourses used to describe concerns clients present. Consider each of these different discourses in terms of what they enable and what they constrain in terms of clients' and your own resourcefulness.
- Personally, I find the greatest boost to developing discursive awareness is to participate in reflecting teams (Andersen, 1991) where different discourses for clients' concerns, and therapists' understandings and interventions can be discussed.

Regarding discursive resourcefulness:

- If this approach is new to you, consider how you *negotiate* the meanings and processes of therapeutic dialogue. For example, what do your questions invite from clients, and how do clients respond to your questions to them? Practice how all of this can be done through your immediate and performed uses of language.
- Once clients feel heard and respected, discursively negotiate a reflective or supplementation orientation to their existing discourse in the area of their

presenting concern. Help clients reflect on what is left out of their experience by re-presenting their understandings and asking them to join you in finding ways to supplement those understandings.
- See these discursive negotiations as preference-animated, meaning that client resistance to what you are attempting to negotiate should prompt you to turn to other discursive resources.

For discourse analysts wanting to work with discursive therapists:

- Consult narrative, solution-focused, or collaborative therapists to better understand the kinds of discourse-oriented questions they have about their conversational practices. For example, they may want to better understand junctures in their talk with clients where they get stuck. Here a critical discourse lens could be very helpful. Similarly, they may want to join conversation analysts to look at micro-interactions related to particular conversational practices.
- There is a major need to connect discourse analytic research to therapy process/outcome research and longer term therapeutic results. How can discursive therapists work together with discourse analysts and other researchers to relate conversational developments in therapy, for their possible successful application in everyday life?

For a simple summary of the clinical practice highlights, please see Table 24.1.

Summary

In closing, I have used this chapter to make the case that discursive therapists and discourse analysts have much to offer each other. For the most part, in my view, they talk past each other. Beginning with some background on their conceptual points of overlap, I presented a case for a discursive view of therapy – that is, an approach to therapy where the insights of different

Table 24.1 Clinical practice highlights

1. It is helpful if therapists reflect upon their engagement with their clients by paying attention to the turns at talk.
2. Therapists should consider the client perspective (i.e., their discourse) in how they present their understanding and their intended actions. It is useful to reflect on one's own discourses.
3. Critically reflect upon the common cultural discourses used in the media to represent the concerns clients commonly present. Consider what these discursive representations enable and constrain in terms of clients' resourceful ways of addressing their concerns.

approaches to discourse analysis can inform therapeutic practice. I highlighted two of the prominent discursive therapies – solution-focused and narrative therapy – showing how each draws on a different orientation to discourse analysis. The prior sections were offered as my build-up to how discursive awareness and discursive resourcefulness could be understood and practiced in ways generic to the discursive therapies. Finally, I concluded with specific practice recommendations associated with discursive awareness and resourcefulness and with an appeal to discourse analysts to join discursive therapists on shared, practice-focused forms of inquiry.

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25

Therapeutic Practice as Social Construction

Kenneth J. Gergen and Ottar Ness

Introduction

> *If I were to wish for anything, I should not wish for wealth and power, but for the passionate sense of the potential... what wine is so sparkling, so fragrant, so intoxicating, as possibility!*
>
> (Soren Kierkegaard, *The Sickness Unto Death*)

Across a significant spectrum of the therapeutic profession, we find a gradual but ever intensifying convergence in conceptions of the therapeutic process. At the heart of this convergence lies the human activity of generating meaning. First and foremost, we find the therapeutic relationship one in which human meaning is not only focal, but also pivotal to the process of therapeutic change. The significant preparation for the contemporary movement has come from many sources. Humanistic/phenomenological/hermeneutic psychologists have long argued for the centrality of individual meaning to the therapeutic process; the pioneering work of George Kelly (1955) and the ensuing dialogues on constructivism also placed individual construal at the centre of the therapeutic relationship. The emergence of object relations theory in psychoanalytic circles further stressed the interdependence of meanings within family relations and between the therapist and client (Mitchell, 1988); similarly, Gestalt therapists shifted their focus towards the creation of meaning within the relational process. The work of the Palo Alto group – eventuating in Watzlawick, Jackson, and Beavin's 1967 classic, *Pragmatics of human communication* – extended this emphasis on interdependent meanings within families; Milan systemic therapists (Boscolo, Ceccin, Hoffman, & Penn, 1987; Campbell, 2003) carried this orientation forward into a range of new and challenging practices. More pointedly, however, a concern with the social as opposed to the individual origins of meaning making became increasingly focal. This concern, often referred to as *social constructionist*, is realised in a wide range of therapeutic practices, including narrative therapy, solution-focused therapy, Gestalt therapy, and dialogic therapy. This work is extended, as well, into such arenas of social work (Witkin, 2011), pastoral counselling (Liegeois, Ramsleigh, Corveleyn, & Burggraeve, 2012), bereavement (Hedtke, 2012), youth ministry (McCoy, 2013), and mindfulness practices (McCown, 2013).

As these early dialogues on social meaning have unfolded and interacted, the therapeutic profession has become increasingly cognizant of social constructionist interchange within the broader intellectual community – in anthropology, communication, history of science, sociology, philosophy, women's studies, cultural studies, literary theory, and more. Within this broader community, constructionist ideas have functioned at two levels (Gergen, 2015). First, they have functioned as *a general theory of knowledge*. At this level, it is proposed that all accounts of the real, the rational, and the good find their origins in social communities. Thus, all candidates for truth – whether in science, religion, or everyday life are the outcomes of culturally and historically situated social interchange. At this meta-level, constructionism functions as a non-foundational foundation. Its value lies not in its truth (which claims are themselves constructed) but in its pragmatic value for humankind. Second, constructionist ideas also function as a *vocabulary of practice*, that is, a set of ideas that can be put into use – professionally, personally, and otherwise. At this level, they have often been contrasted with constructivist conceptions (Maturana, 2008; Von Glasersfeld, 1995) which trace the origins of meaning (and thus to presumptions about reality) to individual minds. While constructionists have found constructivism conceptually and ideologically flawed, there is no attempt to destroy such a position. The question here is not whether constructivism is true, but how useful are its suppositions for various purposes. Here, practitioners from various fields have relied on constructionist ideas not only for social critique (with liberatory goals) but also to furnish insights and inspiration in developing new forms of research, along with dialogic and collaborative practices in organisational change, education, conflict resolution, and more.

To be sure, social constructionist ideas have provoked a great deal of controversy both within the therapeutic profession (Efran, McNamee, Warren, & Raskin, 2014; Held, 1996), and without (Hacking, 2000; Parker, 1998). For cognitively oriented constructivists, it has also meant a shift towards a *social constructivism* (Neimeyer & Raskin, 2001). More productively, however, a new range of significant questions have emerged: what new therapeutic orientations may be invited by a shift towards a social constructionist account of meaning; in what important ways does a constructionist shift disrupt existing therapeutic traditions; what forms of therapeutic practice are invited; what are the implications for diagnostic practices and mental health policies; what may be lost in this transformation and what is gained? Thus, in what follows, we shall first attempt to extricate a number of pivotal assumptions playing through the emerging dialogues on social construction, to sharpen them through comparison with existing traditions, and to treat some of the central problems that they raise. This treatment will set the stage for an enquiry into the kinds of practices that are invited by a social constructionist orientation to therapy. The attempt in these accounts is not to generate a new foundation for therapy; such a goal would be antithetical to social constructionist dialogues. Rather, the hope is that the present discussion can contribute to generative conversation, a maturing of sensibilities, and the emergence of new practices.

Social construction and therapeutic orientation

We wish first to focus on four transitions in understanding that follow from a conception of therapy as the relational construction of meaning. While these transitions have a variety of practical implications, our focus here is not centred so much on specific techniques as the kind of therapist sensitivities that are invited. What do these shifts in assumptions invite in terms of our thinking about therapeutic options? Consider the following:

From foundations to flexibility

Traditional orientations towards therapy are derived from what are commonly viewed as rational foundations of knowledge. These foundations are typically lodged within what is narrowly defined as an empiricist conception of knowledge. As this tradition has played out in the social sciences, most professionals have come to hold that theories of human behaviour should be grounded in observation. With continued and rigorous observation, we should approach a true and objective understanding of both normal and abnormal behaviour. Further, from this standpoint, continued research should reveal which of a variety of therapeutic practices is most effective for treating various forms of abnormality. There may be many candidates for truth about persons, dysfunctions, and cure, but empirical research should, on the traditional account, ultimately enable us to winnow the many to a few – and ultimately to perhaps one.

For the social constructionist, theories of human action are not built up or derived from observation, but rather grow from our collective attempts to interpret the world. In this sense, it is the conventions of intelligibility shared within one's professional enclave that will determine how we interpret the observational world. Thus, a psychodynamic therapist will find evidence for repressed desires, while a cognitive behavioural therapist will locate problems in the individual's mode of information processing, and a family systems therapist will be drawn to the realities of family communication patterns. Because theories serve to construct the world in their terms, there is no means of empirically testing between them. Each 'test' would inevitably construct the field of relevant facts in its terms and thus serve to privilege some theoretical standpoint as opposed to another. Outcome research is subject to the same problem; a positive outcome from one therapeutic standpoint (e.g. symptom reduction, expressed feelings of well-being) may signify a regression or problem exacerbation for others. From certain standpoints even suicide may be counted as a positive outcome.

Based on this line of reasoning, constructionism invites an abandonment of the search for foundations – a single view of knowledge or human functioning that prevails over all others. The constructionist dialogues encourage us to relinquish the long-standing competition among schools of therapy, along with the related conceptions of fixed diagnostics, 'best practices' of therapy, and outcome comparison (Lock & Strong, 2012; McNamee, 2004; McNamee & Gergen, 1992). Rather, if we view the various therapeutic schools as communities of meaning, then each school possesses transformational potential. Each offers an opening to a form of life.

The major implication of this line of reasoning for therapeutic practice is clear: the therapist is invited to move across the domain of therapeutic intelligibilities and practices and to employ whatever may be serviceable in the immediate therapeutic context. In this sense, there is no 'social constructionist method' of therapy. To formalise any method – to canonise its principles – is to freeze cultural meaning. It is to presume that effective processes of forging meaning in the present will remain so across time, circumstance, and context of interpretation. This is also to say that the common critique within the therapeutic community – that the multiple and ever-shifting field of theory and practice reveals a state of confusion and a lack of real knowledge – is ill founded. This very richness of intelligibility and the capacity of the therapeutic profession continuously to refashion understanding represent perhaps its most significant strengths.

Yet, the implications of this position are more radical than that of favouring theoretical and practical eclecticism. Within the empiricist tradition the professional account of the person and the therapeutic process was privileged over that of the common culture. Whereas the quotidian understandings of the culture were said to be fraught with bias, misunderstanding, and superstition, the discourse of the profession furnished more comprehensive and accurate understanding. For the constructionist, the criterion of 'more accurate or objective understanding' is removed; all forms of understanding are culturally embedded constructions (Gergen, 2009). Effective therapy may – and typically will – require the use of many speech genres, including those of the culture at large. This is to say that for purposes of therapeutic practice, the door is opened to the full range of cultural meanings. To be sure, this may include all existing forms of therapy – from psychoanalytic, behaviour modification, cognitive, Rogerian, and more.

At the same time, we must be prepared to radically expand the arena of usable meanings. For example, there is strong support here for those wishing to include spiritual discourse within the therapeutic process (Lines, 2006). For much of the population, such discourse speaks in a powerful way; to neglect its significance is therapeutically myopic. The skilled therapist in a constructionist mode might be as much at home speaking the languages of romance, the street, the locker room, or the nightclub as mastering the nuances of Lacanian analytics. Each new intelligibility enriches the range and flexibility of the relational moment. This does not mean that professional theories are without special merit. Professionally developed theories are especially significant in their capacity to offer alternatives not easily located within the common culture. Professional languages also enable therapists to engage in communal deliberations – to speak meaningfully with each other and thus to coordinate their efforts more effectively. And, such discourse further enables the therapeutic profession to reflect critically on the common intelligibilities of the culture – which reflection cannot be done from within these intelligibilities themselves.

From essentialism to consciousness of construction

As suggested, the modernist therapeutic tradition is invested in truth. Thus, therapy is typically oriented towards locating 'the real problem', the 'causes of the difficulty', 'the forces at work', 'the determining structures', and the like, and assessing the effects of contrasting therapeutic practices on outcomes. For the constructionist, there are no problems, causes, forces, structures, and so on that do not derive their status as such from communally based interpretations. This is not to propose that 'nothing exists', or that 'we can never know reality' – common misunderstandings of constructionism – but rather that when we attempt to articulate what exists, to place it into language, we enter the world of socially generated meanings. It may be more helpful, then, to say that constructionism operates against the tendency to essentialise the discourse, that is, to treat the words as if they were pictures, maps, or replicas of essences that exist independent of we who interpret our existence in this way.

Traditional therapy has more or less presumed a picture theory of language. Thus, useful language should provide an accurate picture of an independent world. It is only under these assumptions that such terms as 'delusion', 'distortion', 'misperception', and 'misattribution' are intelligible. Constructionism, in contrast, invites us to see such terms in a horizontal rather than a vertical plane, that is, as indicators of an alternative way of constructing the world (one among many) as opposed to the necessary or superior way. To accuse a person of being deluded is primarily to say that he or she does not share your interpretive conventions. As Berg and De Shazer (1993) thus proposed, 'Meanings arrived at in a therapeutic conversation are developed through a process more like negotiation than the development of understanding or an uncovering of what is "really" going on' (p. 7). Understanding of therapy as a venture in constructing worlds is now broadly shared.

This emphasis on constructed realities must be accompanied by an important caveat. Constructionism does recognise the significance of truth in context. Within any community there will be tendencies towards essentialising the commonly shared modes of discourse – treating the language as a 'map of the real' – and this essentialisation is of inestimable importance in sustaining the community's traditions. It is thus important for the constructionist-oriented therapist to participate in the reality creating conventions (i.e. 'He is my husband', 'I am depressed'), while simultaneously realising the contingent character of the conventions.

From expertise to collaboration

As proposed, there is no singular set of practices that follow or can be derived from a constructionist view. For example, there is nothing about constructionism that would necessarily be against the therapist's 'taking an authoritative stand' in a therapeutic relationship; strong and directive opinions may sometimes be useful. However, if we play out the implications of constructionism as a theory of human action, new doors are opened to practice. In particular, constructionist theory invites the therapist to consider alternatives to the traditional position of authority, and particularly to explore a collaborative orientation to the client. The shift in style is no small undertaking. As Hoffman (1993) wrote:

> The change from a hierarchical to a collaborative style . . . is a radical step. It calls into question the top-down structuring of this quasi-medical field called mental health and flies in the face of centuries of traditional western practice . . . To challenge these elements is to challenge the whole citadel.
>
> (p. 4)

The shift to a collaborative orientation has early roots in the work of Goolishian and Anderson (1987) on 'collaborative language systems' approach, which proposed a collaborative partnership with the client in which the therapist enters with a stance of 'not knowing'. Not knowing refers to

> an attitude and belief that a therapist does not have access to privileged information, can never fully understand another person, always needs to be in a state of being informed by the other, and always needs to learn more about what has been said or may not have been said . . . Interpretation is always a dialogue between therapist and client and not the result of predetermined theoretical narratives essential to a therapist's meaning, expertise, experience or therapy model.
>
> (Anderson, 1997, p. 134)

This is not to say that the therapist does not bring uniquely valuable skills to the relationship. It is to say, however, that such skills are not derived from a mastery of descriptive and explanatory accounts of therapy. They are primarily skills in *knowing how* as opposed to *knowing that*, of moving fluidly in relationship, of collaborating in the mutual generation of new futures. A collaborative dialogue in therapy involves more than expert exchanges of information from therapist to client. Collaboration in therapy is a dialogic process requiring a delicate and ongoing negotiation of client and counsellor preferences, meanings, and conversational process (Strong, Sutherland, & Ness, 2011). A specific emphasis on therapy as collaboration is now shared by wide-ranging therapists (Anderson & Gerhart, 2006; Håkansson, 2009; Ness, Borg, Semb, & Karlsson, 2014; Paré, 2013; Strong et al., 2011). Exemplary, for example, is the work of Asen and Scholz (2010), which brings multiple families together to share their resources.

From value neutrality to value relevance

From the empiricist standpoint, therapy is not a forum for political, ideological, or ethical advocacy. The good therapist, like the good medical doctor, should engage in sensitive observation and careful thought, unbiased by his or her particular value biases. Critiques of the assumption of value neutrality have long been extant. The works of Szasz (1961), Laing (1967), and participants in the critical psychiatry movement have made us acutely conscious of the ways in which well-intentioned therapists can contribute to forces of oppression. Spurred by Foucault's (1979) critique of the 'disciplining' effects of therapeutic practices, many recent analysts have focused on ways in which various therapies and diagnostic categories contribute to sexism, racism, heterosexism, individualism, class oppression, and other divisive biases. From a constructionist standpoint, even a posture of non-engagement or 'neutrality' is viewed as ethical and political in its consequences. Whether mindful or not, whether for good or ill, therapeutic work is necessarily a form of social/political activism. Any action within a society is simultaneously creating its future.

Many therapists, cognizant of the relationship between therapeutic constructions and societal values, have begun to explore the implications of ethically and politically committed therapy. Rather than avoiding value considerations, socio-political aims become central. We have, then, the development of therapies that are specifically committed, for example, to challenging the dominant order (see e.g. White & Epston, 1990) and pursuing feminist, gay, socialist, and other political ends. Feminist therapists, for example, frequently focus on female oppression as a fundamental therapeutic theme, or deconstruct gender categories to provide clients an expanded set of options. Social therapy carries with it a vision of equalitarian society (Holzman & Mendez, 2003). With the expanding power of identity politics there is every reason to anticipate an expansion in such investments.

Social construction and therapeutic practice

As we have seen, social constructionist dialogues favour four major movements in therapeutic orientation – movements towards flexibility, consciousness of construction, collaboration, and value-relevant practice. However, such dialogues also invite a new range of practices. Many of these practices are now well entrenched in certain circles; others are under development. In each case, it is important to see their relationship with constructionist thinking. We will focus here on five major shifts in practice.

From mind to discourse

Most traditional therapy is focally concerned with individual mental states. From the psychoanalytic emphasis on psychodynamics, Rogerian concerns with self-regard, to contemporary cognitive behavioural therapy, it is the central task of the therapist to explore, understand, and ultimately bring about transformation in individual minds. Even group psychotherapy has retained a strong investment in psychodynamic principles. As outlined in the preceding chapter, interest in therapeutic communication did begin to occupy increasing attention over the years, and within recent decades converging interests in family systems, communication pragmatics, and second-order cybernetics – among the more visible – have brought issues of language into major focus. Yet, as also proposed in the preceding section, the constructionist dialogues extend these discussions in significant ways. It is largely through the discursive relationship that realities, rationalities, values, and desires come into being, flourish, or expire.

This shift to discourse is perhaps the most widely apparent aspect of therapy in a constructionist frame and has given rise to a broad range of therapeutic innovations. As Sluzki (1992) put it, therapy may be understood as a process of 'discourse transformation'. If meaning is generated within linguistic processes, then it is to these processes that attention is drawn (Lock & Strong, 2012). The vast share of innovative work has been congenial with the groundswell of social science interest in narrative, or essentially the storied construction of self and world (Bamberg, 2007; Randall, 2014; Sarbin, 1986). For many therapists, Donald Spence's (1982) 'Narrative Truth and Historical Truth' represented a critical turning point. Here was a practising therapist of long experience who no longer believed that historical truth could be captured in the patient's accounts of his or her early life, and explored the positive uses of the narrative truths developed in therapy.

Yet, perhaps the most prominent expression is found in what McLeod (1997) called the 'postmodern narrative movement'. As developed by therapists such as White and Epston (1990), and enriched and expanded in numerous ways over the years (Epston & Lobovits, 1997; Freedman & Combs, 1996;

Madigan, 2011), the prevailing concern is with the ways in which language constructs self and world and the implications of these constructions for client well-being. The radical implication of such work is that life events do not determine one's forms of understandings, but, rather, the linguistic conventions at our disposal determine what counts as a life event and how it is to be evaluated. It is much the same concern with the force of language in constructing client realities that has sparked the therapeutic use of metaphor (Combs & Freedman, 1990) and the development of client writing practices as therapeutic tools. As this emphasis on language has expanded, many have come to see constructionist-oriented therapies specifically as *discursive therapies* (Lock & Strong, 2012; Strong, Chapter 24, this volume; Strong & Paré, 2004).

It should be pointed out that there is a tendency among the emerging therapies to adopt a narrow definition of discourse – principally as spoken or written language. Given our traditions, this is a comfortable starting point, enriched as well by an expansive literature on semiotics, literary theory, rhetoric, and linguistics. At the same time, such a preoccupation is reductionistic. First, it reduces discourse to the utterances (or writing) of the single individual. Yet, if meaning is the by-product of relationship, then such a focus is blind to the relational process from which any particular utterance derives its meaning. In effect, words mean nothing in themselves, and it is only by attending to the flow of interchange that we can appreciate the origins, sustenance, and decay of meaning. Further, the emphasis on words strips discourse of all else about the person (and situation) that is essential to generate intelligibility. One speaks not only with words but also with facial expressions, gestures, posture, dress, and so on. Ultimately, it is important to add bodily and material dimensions to the concern with therapeutic communication.

From self to relationship

The traditional therapeutic emphasis on mental states is in close harmony with the Western belief in the individual actor as the atom of the social world. For at least 300 years, we have moved progressively towards what is now simply a taken-for-granted fact: the individual's public actions are by-products of internal states of mind (e.g. thoughts, emotions, motives, choice, desire, and memory). Shouldn't therapy, then, be primarily focused on the internal world of the individual? And yet, within recent years we have also become increasingly conscious of the biases built into this view. For example, on the traditional view, relationships are secondary or artificial contrivances, constructed from the raw materials of independent selves. In an attempt to correct for this individualist bias, movements in group and family therapy have offered a range of alternative practices built around such concepts as group dynamics, family structure, and psychological interdependence.

With the constructionist shift from mind to discourse, the terrain shifts significantly towards the primacy of relationship. As Wittgenstein (1953) argued, there can be no private language; if you created your own private language, you could not communicate. In effect, language is fundamentally a relational phenomenon – much like a handshake or a tango, it cannot be performed alone. Or in Shotter's (2008) terms, meaning is not created by individuals acting alone, but in *joint action*. In effect, meaning is not located within the mind of individual actors, but is a continuously emerging achievement of relational process. It is in this context that we appreciate more fully the earlier emphasis on co-construction. It is within the relational matrix of therapist and client that meaning evolves.

Yet, while many of the practices included in this analysis shares this premise, the emphasis on relationship (as opposed to individual mind) expands in many directions. It is useful here to think of concentric circles of relationship, starting first with the therapist–client, and expanding then to the client's relationship with immediate family, intimates, friends, and the like. At a first level of expansion, some therapies press backward in time to consider relationships in the distant past. As Mary Gergen (1999) proposed, we carry with us a cadre of 'social ghosts'. As one means of tapping into significant relationships, Penn (2009) and others have had clients to write letters to a lost loved one. Tomm, George, Wulff, and Strong (2014) propose a means of investigating and treating a variety of patterns common in families and other groups. Further expanding the circle, still other therapies take into account the broader community – the workplace, church, and the like. In Sweden, Håkansson (2009) and her colleagues enable diagnosed schizophrenics to live with farm families, with remarkable results. And finally, other therapies are vitally concerned with the relationship of the individual to the broad social context – to institutions of power, cultural traditions of suppression, and the like. The 'social therapy' of Holzman and Mendez (2003), for example, attempts to link individual problems with the broad social conditions of society – race relations, employment opportunities, and community action. In the same vein, Freedman, Epston, and Lobovits (1997) have proposed: 'Since problem-saturated stories are nested in social, cultural, economic and gender assumptions about roles and behaviour, we inquire about these factors and strive to be aware of how they are affecting different family members' (p. 51).

From singularity to polyvocality

Traditional therapies have been enchanted by metaphors of the singular and unified. By this we mean, first of all, that the therapeutic profession has gathered round the dream of the single best therapy. We continuously carry out evaluation studies in the hopes of finding which form of therapy is the most effective. Further, we have convinced ourselves that the ideal person is coherent in mind and action. We have not been content with internal tensions, splits, and multiplicities of self (consider for example 'diseases' of multiple personality disorder and schizophrenia).

With the emergence of constructionist consciousness, the traditional romance with unity is placed in question. The argument for multiple constructions of the real – each legitimate within a particular interpretive community – renders the concept of the 'single, coherent truth' both parochial and oppressive. Further, with increasing consciousness of the multiple relationships in which people are embedded – each constructing one's identity in a different way – the ideal of a unified self seems increasingly unappealing. Indeed, in a cultural context of rapidly expanding networks of relationships, the call to singularity may be counter-adaptive (Gergen, 2009). To thrive under these conditions of rapid change may require something akin to a protean personality. It is within this intellectual and cultural context that a new range of therapeutic practices has been nurtured or refashioned.

In this context, many therapists within a constructionist frame press towards multiplicity of client realities. As Weingarten (1998) wrote: 'a postmodern narrative therapist is generally uninterested in conversation that tries to ferret out the causes of problems. Instead, she is extremely interested in conversations that generate many possible ways to move forward once a problem has arisen' (p. 114). It is here that the work of Tom Andersen (1991) and his colleagues on reflecting processes provided an important breakthrough. Using multiple observers of a family, for example, each free to reflect on their interaction in his or her own way, family members are exposed to a range of possible interpretations. Further, as the family is invited to comment on these interpretations, they are set free to consider all options – including those they develop as alternatives. There is no attempt here to determine the 'true nature of the problem', but rather to open multiple paths of interpretation and, thus, paths to alternative futures.

In addition to practices of interpretive enrichment, many other therapists have specifically focused on self-multiplicity. Most pointedly, for example, Karl Tomm (1999) has developed a process of 'internalized other interviewing', during which his questions draw out the voice of another person within the client. For example, if a client is uncontrollably angry at someone, the client might be asked to imagine himself or herself in the other's shoes, and speak from the 'position of the other'. Can the client find the voice of the other within himself or herself; to do so is to bring the anger under control. In a more general frame, Penn and Frankfurt (1994) found that many of their clients enter therapy with 'constricting monologues'. As therapists, they encourage the development of 'narrative multiplicity'. They first introduce the possibility of alternative voices – for example, positive, optimistic, or confident – into the conversations with clients. Then, the client is encouraged to write letters to persons living or dead, dialogues, notes to themselves, journal entries, poetry – in a manner that evokes new voices within themselves. Similarly, Riikonen and Smith (1997) focused on the ways in which culturally dominant discourses constrict individual action. Classic are cases of physical or sexual abuse, where victims too quickly embrace conventional views in which they are defined as unworthy or deserving the abuse. In such situations, the therapists ask such questions as the following: 'Where do you think these oppressive descriptions come from? Which other types of descriptions/voices in you have been silenced? Have you been able to listen to other ideas? What might it mean if you were able to listen more to those different ideas?' (p. 123). As Hermans and Hermans-Konopka (2010) have further detailed, the new voices set in motion internal dialogues with significant potential for therapeutic change. The concern with internal dialogue continues to demand widespread attention (Bertau, Goncalves, & Raggatt, 2012).

A contrasting approach to polyvocality comes from therapists seeking means of bringing multiple voices into the deliberations on 'the problem' and 'how to go on'. Specifically attempting to generate an alternative to the monologic orientation of traditional psychiatry is the work of Seikkula and his colleagues (Seikkula & Arnkil, 2006) on *Open Dialogue*. Open dialogue may enlist the voices of multiple stakeholders and emphasises an empathic listening to others' experiences, views, meanings, and interpretations. Through these means a dialogic 'team' is formed. The results in terms of reducing dependence on psychopharmacology and hospitalisation have been substantial (Seikkula et al., 2006).

From problems to prospects

As widely recognised, traditional therapy is based on a medical model of disease and cure. Patients (clients) confront problems – typically indexed as pathologies, adjustment difficulties, dysfunctional relationships, and so on – and it is the task of the therapist to treat the problem in such a way that it is alleviated or removed ('cured'). It is the assumption of 'the problem' that underwrites the process of diagnosis and, indeed, fuels the development of diagnostic criteria (e.g. the *DSM 5*). From a constructionist standpoint, however, this entire array of interlocking presumptions and practices engages in the realist fallacy of presuming that 'problems' (diseases) exist independent of our forms of interpretation. For the constructionist, the term 'problem' is a discursive integer and may (or may not) be used to index any condition or state of affairs. It is not the 'problems of the world' that determine our ways of talking, for the constructionist, but it is through our discursive conventions that we determine something to be a problem. Again, this is not to abandon the term or its conventional usages but, rather, to give us pause to consider the consequences. For, as many reason, 'problem talk' often reifies a world of anguish; to speak of one's incapacities, an irredeemable other, or a dysfunctional family is to create a world in which one's actions are limited and very often in which these very limitations sustain the patterns termed 'problematic'.

With these arguments at hand, therapists have developed a new range of practices that attempt to avoid the reification of problems and shift attention to a discourse of positive prospects. As Riikonen and Smith (1997) put it, 'We have been accustomed to talk about analysing problems as a prerequisite of solving, dissolving or deconstructing them. It seems in most cases more useful to talk about actions, experiences and thoughts which can help to make things better' (p. 25). Most visible in this respect is the work of solution-focused therapies (De Shazer, 1994; O'Hanlon & Weiner-Davis, 1989). The 'miracle question' is essentially an invitation to a new domain of dialogue in which the creation of future realities takes precedence over the reification of past problems.

From insight to action

Traditional therapies, linked to the presumption of individual psychological deficit, have also focused on the individual psyche as the site of therapeutic change. Whether, for example, in terms of the transference of psychological energies, catharsis, self-understanding, self-acceptance, re-construal, or cognitive change, most therapeutic practices have been built around the assumption that successful therapy depends primarily on a change in the mind of the individual. Further, it is typically supposed, this change can be accomplished within the therapeutic relationship. The concept of the 'therapeutic breakthrough' epitomises this point of view; once change is accomplished in the therapeutic chamber, there is hope that the individual will depart emancipated from the preceding burden with which he or she entered therapy. For discussion purposes, let us simply use the phrase 'individual insight' to index this class of practices.

Yet, as we shift the emphasis away from individual minds and to discursive relations among individuals, we find the traditional array of practices delimited, if not short-sighted. From the constructionist standpoint, the process of generating meaning is continuous and its form and content likely to shift from one relationship to the next. The individual harbours multiple discursive capacities, and there is no strong reason to anticipate that the meanings generated within the therapeutic relationship will be carried over into outside relationships. The dramatic insight shared between therapist and client is essentially their achievement, a conversational moment that derives its significance from the preceding interchange, and cannot easily be lifted out and placed within another conversation remote in time and place.

There is a further and more pro-active shift in therapeutic implications derived from constructionist dialogues. When we locate the source of meaning within dialogic process, we are essentially viewing the meaning-making process as social activity. Meaning, then, is not originated within the mind and stored there for future use, but rather is created in action and regenerated (or not) within subsequent processes of coordination. Following Wittgenstein (1953), we might say that meaning is born of social use. Or, in De Shazer's (1994) terms:

> Rather than looking behind and beneath the language that clients and therapists use, I think the language they use is all we have to go on . . . Contrary to the common sense view, change is seen to happen within language: What we talk about and how we talk about it makes a different . . . .
>
> (p. 10)

In this context, two of the primary questions to be asked of therapeutic co-construction are: (1) whether a particular form of discourse is actionable outside the therapeutic relationship and (2) whether the pragmatic consequences of this discourse are desirable. To illustrate, in a Jungian practice, one might acquire an entirely specialised vocabulary of individuation, mandalas, the shadow, and so on. Yet, while this vocabulary will enable a fully harmonious relationship to develop within the therapeutic relationship, it is not easily transportable outside. The vocabulary can accomplish little in the way of conversational work. Or, in primal scream therapy, one may acquire the capacity for dramatic expressions of rage and anguish. And, while these expressions can produce significant effects in the marketplace of social life, the consequences are not likely to be helpful to the client.

These twin criteria – actionability and pragmatic outcome – have been slow to surface in the constructionist literature and practices. In some degree, this relative unconcern is based on the view that therapeutic conversation (along with internal dialogue) yields results in the external world of relationships. Yet, this assumption is largely a promissory note. Much needed are practices specifically dedicated to forging this link. There are good examples extant. For example, White (2011) has generated a variety of authenticating practices for giving life to newly emerging narratives. Therapists may have celebrations, give prizes with significant people in attendance, or generate 'news releases' in which the individual's arrival at a new status in announced to various significant others. White recruits what he terms 'The Club of Your Life', which might include anyone, living or dead, actual or imaginary. Epston and his colleagues (Madigan & Epston, 1995) help clients with eating disorders to develop politically oriented support groups. Social therapists (Holzman & Mendez, 2003) encourage and facilitate social activity as a critical component of practice. The emphasis on practical action also helps us to appreciate certain features of some traditional practices. For example, both group and family therapy practices seem favoured over individual therapy, as in such contexts one's discourse enters directly into a public arena, and its pragmatic consequences are made more manifest.

Table 25.1 Clinical practice highlights

1. From a focus on mind to the development of meaning in relationships.
2. From a focus on the individual to the relational network.
3. From a singular truth to multiple perspectives.
4. From exploring the individual's problems to promising potentials.
5. From developing insights to fostering useful skills.

Further, we find new purchase on role-playing therapies. If properly directed, the client gains skills in forms of social doing; otherwise alien forms of expression are incorporated into one's vocabulary of relationship. Buddhist practices of mindfulness and meditation are welcome additions to the vocabulary of action (Kabat-Zinn, 2005; Kwee, 2013). In our view, the greatest opportunities for future development lie in this arena of pragmatic consequences of therapeutic conversation. For a summary of the clinical implications, please refer to Table 25.1.

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26

The Value of Using Discourse and Conversation Analysis as Evidence to Inform Practice in Counselling and Therapeutic Interactions

Nikki Kiyimba and Michelle O'Reilly

Introduction

The evolution of both discourse analysis and conversation analysis (henceforth DA and CA, respectively) has been a progressive movement from their inception as an inductive focus and unmotivated interest in how language works and what it accomplishes. From their early beginnings, quite sophisticated structures and frameworks have been developed to understand how people use language in interactions to accomplish social actions. With this framework in place, more latterly attention has turned towards the possibility of how these principles might be usefully applied to different settings (we refer you to Chapter 1 of this volume – Lester & O'Reilly – for a good overview). With this second wave characterised by a greater focus on the real-world usefulness of CA and DA findings, there is an exciting opportunity for researchers using these methodologies to interrogate the nuances of institutional interactions in order to make recommendations for changes in practice. This chapter is situated within this cutting-edge movement, which is transposing the scientific rigour and credibility of CA and DA findings into real-world applied settings and evidence-based practice (see, e.g. Kiyimba, Chapter 2, this volume). In our contemporary culture, a primary concern for practitioners across a range of institutional contexts, and particularly within therapy and counselling, is to work within evidence-based models of care and demonstrate efficacy and cost-effectiveness of interventions. We therefore seek to demonstrate that both DA and CA have a great deal to offer the evidence base in this field. It is thus extremely timely and salient for this discussion to take place in a handbook such as this one.

In order to do this, we attend to several issues pertinent to adult mental health, therapy, and counselling. First, we briefly consider the common therapeutic modalities that may be adopted by mental health professionals in order to consider the range and nature of the therapeutic interactions that discourse and conversation analysts may study. Second, we consider how these therapeutic modalities are implemented in practice in relation to the notion of evidence. We examine how mental health treatments are currently conceptualised within ideologies of 'best practice' and take a more detailed examination of the priorities within the evidence-based movement. Within this discussion we explicate how qualitative evidence is positioned within the evidence-based rubric. Third, while we take a critical stance in relation to the low priority of qualitative evidence, we offer constructive alternatives by demonstrating clearly how DA and CA as scientific approaches provide credible and robust evidence that can be relied upon to inform practice. We consider what DA and CA both have to offer in terms of inductive data-driven approaches to illuminating the processes within therapeutic conversations. We make a case for the usefulness of using these analytic approaches in the context of therapeutic interaction as part of an iterative and reflective process.

Differences between common therapeutic modalities for adult mental health

There is a large range of different therapeutic modalities available for 'treating' adult mental health difficulties. For example, in the mid-1980s, the therapeutic modalities were estimated to be of at least 500 types (Karasu, 1986), and there are likely to be even more since then. The relevance of a basic understanding of the broad differences between common therapeutic modalities is that it offers the researcher and the analyst a framework for identifying how the analytic approach fits the epistemology of the therapy. Importantly, there is a spectrum from DA through to CA regarding the relevance of contextual detail and knowledge of the nature of the institutional setting being studied. For example, in CA traditions, context is viewed as emergent from the interaction and, therefore, not something that the researcher needs to be concerned with prior to the analysis. However, in Critical Discourse Analyst (CDA), an appreciation of context is integral to the analysis of the data. For some discourse traditions, this contextual discussion of the differing therapy traditions may therefore be more relevant and useful. Furthermore, we are well known for advocating partnership working between practitioners and academics (see O'Reilly & Kiyimba, 2015; O'Reilly & Parker, 2014) and see this as a valuable research mechanism for promoting the applied relevance of DA and CA studies. Thus, for academics utilising DA or CA in their research with therapy-based data, we suggest that a very basic understanding of the differences between modalities is a beneficial starting point to aid multi-disciplinary communication. With this in mind we have provided a brief synopsis of some of the main therapeutic approaches below.

Psychodynamic psychotherapy

While we acknowledge that there are a range of different psychodynamic traditions, for the sake of space within the chapter we discuss them briefly under one broad rubric, because of their common base. For example, variations exist between traditions that ground their practices in the work of Freud, compared to those who orient to Jung or Klein. Psychodynamic psychotherapy varies in its underlying principles regarding the relationship between the therapist and the client and can be used long term with clients and sometimes with multiple weekly sessions (Jacobs, 2010). As a research analyst, it is useful to know that a core focus for psychodynamic psychotherapy is the client's relationships and interpersonal experiences, with a discussion of how past experiences are paralleled in contemporary relationships, including that with the therapist (Shedler, 2010). According to this perspective, clients tend to repress or suppress distressing thoughts and feelings unconsciously as a defensive mechanism. Psychodynamic psychotherapy focuses on exploring these avoidances (Shedler, 2010) and encourages clients to discuss the feelings that are troubling or threatening (Burum & Goldfried, 2007).

Person-centred therapy

Like psychodynamic psychotherapy, person-centred counselling particularly emphasises the importance of the relationship between the client and the therapist (Mearns, Thorne, & McLeod, 2013). Person-centred therapy was pioneered by Carl Rogers, who placed the client at the centre of therapy. This emphasis of the client's phenomenological world and the need for client-centeredness means that the clients themselves can discover a way forward and access their wisdom to recover self-direction (Mearns et al., 2013). This approach rejects the idea of pathologising people as patients to be cured and, instead, emphasises the self-responsible and autonomous nature of individuals seeking personal growth (Rogers, 2007). Rogers therefore saw the role of the therapist as facilitative rather than directive, fostering a climate for change where the person can move towards a greater self-understanding. Additionally, he argued that clients have an innate motivating force towards self-actualisation, and the therapist is simply the architect to enable the clients to move to developmentally towards this state.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) was influenced by the early behavioural work of Wolpe in the 1950s and the cognitive work of Beck in the 1960s, arising as a reaction of the dominance of Freudian psychodynamic thinking in terms of the importance of unconscious processes (Westbrook, Kennerley, & Kirk, 2011). Typically, those practising CBT do not focus on the developmental history of the client (Rathod & Kingdon, 2009), rather there is a focus on the 'here and now' interactions between cognition, emotion, physiology, and behaviour (Westbrook et al., 2011). Since the early beginnings of CBT, a number of different variants have emerged, and these variants are unified by the proposition that 'psychological problems arise as a direct consequence of faulty patterns of thinking and behaviour' (Enright, 1997, p. 1811). This approach quite squarely ascribes psychological difficulties of the client to an internal mental process which exhibits itself in problematic behaviour. This practice thus has a particular set of underpinning theoretical assumptions about the nature of psychological problems as individual and internal as opposed to interpersonal. These underpinning assumptions are grounded in Western models of illness (Rathod & Kingdon, 2009), which may not necessarily be consistent with other cultural conceptual frameworks such as Eastern philosophies that have a more collectivist perspective (Rathod, Kindgon, Phiri, & Gobbi, 2009).

Systemic therapy

Systemic theory is based on the premise that what is deemed to be a problematic behaviour that is exhibited by an individual should not be attributed internally as originating within the person themselves, but it is the product of a malfunction of the relationship system or systems that the individual is part of. Family therapy sees the family as consisting of a number of systems, including a cultural system, family system, social system, and communication system (Bowen, 1966). Systemic therapy therefore focuses on the relational aspects of an individual's experience and how to understand those relationship patterns (Flaskas & Perlesz, 1996). Thus, family therapy aims to facilitate positive changes in the dysfunctional aspects of the family system (Barker & Chang, 2013). This therapy explores those elements of social life that are co-created through conversation, with a particular interest in the meanings that are ascribed to the behaviours of others (Hedges, 2005). Many systemic therapists have been influenced by social constructionist thinking; which views communication as a social process whereby clients' understanding of the world is created through interaction with others (Gergen & Ness, Chapter 25, this volume; Pearce, 1995).

The multiple axes of difference

These four examples of different types of therapy that we have presented are illustrative of the range and scope of different kinds of therapeutic approaches that are commonly used with adults in contemporary mental health practice. They have been presented to demonstrate that therapeutic approaches vary significantly upon a number of axes. Each of these axes represents a continuum of some form, one of which is the emphasis on past developmental experiences compared to present or even future priorities. Another is a continuum of therapeutic focus between unconscious processes at one end and conscious processes at the other. A further axis is the therapeutic underlying suppositions regarding whether psychological difficulties should be located within individuals or broader systemic networks. Additionally, there has been a more recent focus on the axis, which historically separated mind and body at opposing ends of a spectrum. This contemporary interest in the relationship between mind and body has sought to bridge this gap by illuminating the close relationship between the two or even erasing this conceptual divide. This links with the axis of East and West, with one end of the spectrum holding very Western ideologies about human psychology and the other end including therapies more influenced by Eastern practices.

Interestingly, many modern-day therapies have embraced a middle ground within some of these continuums or are able to tolerate the tensions of these dialectics in a more palatable fashion. They have achieved this by combining aspects from different approaches to form a more holistic framework that attempts to capture the best aspects of different ways of thinking about mental health. While there is not room here to consider all of these, we list some of the more common ones:

- *Cognitive Analytic Therapy (CAT)* – Utilises the core components of cognitive behaviour therapy, but pays more attention to the interpersonal aspects between client and therapist that characterises psychodynamic therapy (Ryle, Kellett, Hepple, & Calvert, 2014).
- *Acceptance and Commitment Therapy (ACT)* – The basic premise of this therapy is not directly to 'get rid' of, struggle against, or avoid symptoms, but to use a number of techniques to mindfully accept them, including taking an observer stance in relation to thoughts and feelings. It also promotes committing to acting in accordance with one's core values (Harris, 2006; Hayes, Luoma, Bond, Masuda, & Lillis, 2006).
- *Solution-Focused Therapy* – This places an emphasis on people's strengths that they bring to therapy and how these strengths may be applied to the change process (Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000).
- *Transactional Analysis (TA)* – TA draws upon the basic principles of behaviourism and humanism (person centred), and its key feature is the conceptualisation that all individuals have the three ego states of parent, child, and adult which interact with the ego states of others (Lapworth & Sills, 2011, Novey, 2002).
- *Dialectical Behaviour Therapy (DBT)* – DBT is an adaptation of CBT that integrates a significant amount of Eastern psychological concepts,

predominantly mindfulness (Feigenbaum, 2007; Linehan, Heard, & Armstrong, 1993; Swales & Heard, 2009).

- *Cognitive Hypnotherapy/Cognitive-Behavioural Hypnotherapy* – Cognitive hypnotherapy combines Neuro-Linguistic Programming with traditional hypnotherapy techniques, and Cognitive-Behavioural Hypnotherapy combines CBT with traditional hypnotherapy (Alladin, 2010; Robertson, 2013).
- *Mindfulness* – Mindfulness is grounded in the Buddhist meditation practice of being consciously aware of the present moment (Hirst, 2003). It has been integrated into Western psychological practices, including CBT, to develop short courses for the treatment of psychological problems (Kabat-Zinn, 2011; Rappaport & Kalmanowitz, 2014)
- *Emotional Freedom Technique (EFT)* – EFT is a type of therapeutic modality which is based on tapping Meridian points in the body while accompanied by verbalisations designed to decrease negative emotions, thoughts, and physical feelings (Baker & Siegel, 2010; Wells, Polglase, Andrews, Carrington, & Baker, 2003).
- *Neuro-Linguistic Programming (NLP)* – NLP is an approach which integrates the dynamics of mind (neuro) and language (linguistic) in order to affect the psychological well-being of the individual (Bandler, DeLozier, & Bandler, 1981).

Evidence-based practice, mental health, and qualitative evidence

In contemporary healthcare, it is broadly accepted that practice and policies should be based on the best available evidence. The nature of evidence however has created some tension and debate within the field and beyond it. The evidence-based practice movement began within the field of medicine where randomised controlled trials are standard procedure for producing evidence to inform medical decisions. Thus, evidence-based medicine was initially presented as a solution to some of the difficulties encountered in treatment practices and was strongly promoted by David Eddy (See Eddy, 2011). Evidence-based medicine was described as the explicit use of available evidence in making decisions regarding the care and treatment of patients, which was combined with clinical expertise (Sackett, Strauss, & Richardson, 2000). This high regard for evidence as a foundation for informing clinical decisions has since become adopted by a much broader field than just medicine and has led the way for all areas of healthcare, as well as in other areas including social care and education. Due to this there has been considerable economic investment in the infrastructure of evidence-based practice, and in the United Kingdom (UK) and the United States (US) (and many other Western countries) practitioners are encouraged to ensure that their patients receive care based on 'the best available evidence' (Rycroft-Malone et al., 2004). This has meant that questions of what constitutes evidence within the field of therapy has become highly politicised (Roy-Chowdhury, 2015). Problematically, therefore, there are tensions regarding what constitutes evidence, and practitioners themselves have raised concerns regarding the dichotomy that has been created between their expertise and the evidence available (Grypdonck, 2006; Rolfe, 2010).

This tension is exacerbated by the fact that expert opinion is viewed as the lowest grade of evidence (Strong, Busch, & Couture, 2008) and therefore tends to favour certain types of research evidence above clinical expertise in clinical decision-making (French, 1999). Clearly, not all evidence is treated equally, and over time the concept of a hierarchy of evidence has emerged. Although these levels of evidence have been published in slightly different forms of hierarchies, they all place randomised controlled trials at the higher level (Brackenbury, Burroughs, & Hewitt, 2008; Kovarsky, 2008), considering them to be the 'gold standard' (Estabrooks, 1998). Nonetheless, a good representation of this hierarchy can be seen in O'Reilly and Kiyimba (2015), which was drawn from a range of sources including Marks (2002) and the UK NICE (National Institute of Clinical Excellence) guidelines. This is reproduced from the original source in Figure 26.1 below.[1]

In this age of austerity, the promotion of an evidence hierarchy is powerful (Rycroft-Malone et al., 2004) and is especially influential in terms of how research is rated in terms of funding applications and quality appraisals (Freshwater, Cahill, Walsh, & Muncey, 2010). This can make it difficult for those advocating other forms of evidence to have a platform to illuminate the value

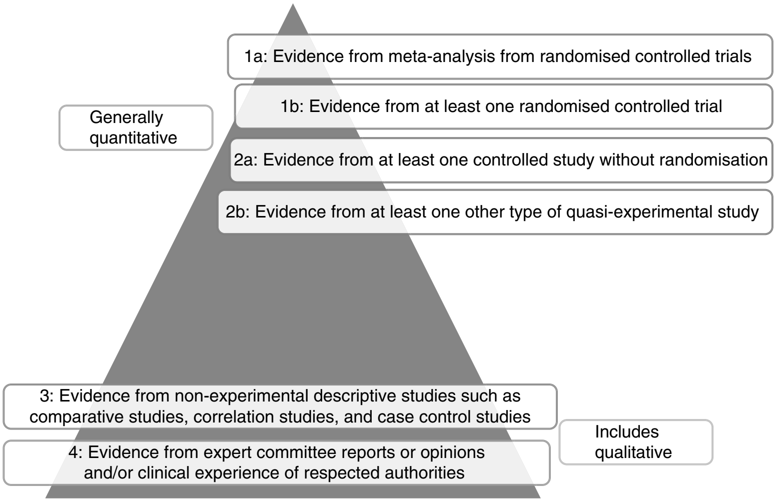

Figure 26.1 Hierarchy of evidence
Source: O'Reilly and Kiyimba (2015, Chapter 5).

of their work (Lester & O'Reilly, 2015). In practice, the evidence-based movement has appealed to managers as it transposes the issues they face into more 'objectively' framed ways of justifying decisions regarding how services are commissioned and delivered (Grypdonck, 2006). However, the tension arises when discourses of evidence move beyond simple efficacy and effectiveness trials of pharmacological treatments. Randomised controlled trials are entirely appropriate for ascertaining whether drug 'A' is more or less effective than drug 'B' in reducing symptomology or other aspects of health and illness. However, assuming these reductionist ways of thinking where human interaction is a cornerstone of care is much more problematic and much less objective. Although it is acknowledged that the evidence-based movement has been highly influential in the field of mental health (Tanenbaum, 2003), we would argue that the straightforward adoption of the medical model hierarchy of appropriate evidence for therapy and counselling is problematic. This is not to say that mental health practitioners should not be guided by the empirical evidence available; rather, we question the appropriateness of the current hierarchy in informing their practice. This is because qualitative research can produce evidence that is of equal standing and is comparable to quantitative (Freshwater et al., 2010). It is important that mental health practitioners are guided in their practice by the available evidence in order that they can provide high-quality care (Melnyk & Fineout-Overholt, 2005). In order to make informed decisions about appropriate interventions, it is essential for mental health professionals to affiliate with and draw upon current research evidence (Rice, 2008). Due to the specificity of the nature of the work that therapists and counsellors are involved in, and because the process of how the therapy works is just as important as understanding outcomes, we argue that qualitative evidence is crucial. It is valuable therefore for clinicians, therapists, counsellors, managers, commissioners, and other healthcare service employees to engage with the qualitative literature and gain an understanding of the human factors that influence therapeutic outcomes, as well as the mechanisms for change. This is greatly facilitated by academic–practitioner partnerships in the field.

Over time, there has been to some extent a paradigm shift in terms of the status of qualitative research, despite the monopoly of quantitative evidence in the healthcare agenda (Freshwater et al., 2010). It is therefore no longer possible for qualitative researchers to exempt themselves from this evidence debate if they are going to make a solid and valuable contribution to healthcare (Morse, 2006). There is a need for qualitative researchers to play a role in informing policy and necessary to illuminate the contribution that can be made by qualitative evidence (Lester & O'Reilly, 2015). Vitally within therapy and counselling it is essential for practitioners to have a good understanding of *why* interventions lead to particular outcomes and that different therapeutic approaches can equally lead to positive outcomes. Qualitative research provides important information regarding how the context, history, and individuality constitute meaning, and this is necessary for clinical insight (Kearney, 2001). Thus, 'clinicians in psychiatric mental health must use qualitative evidence to inform their practice decisions' (Williamson, 2009, p. 207).

While we strongly advocate the benefit of qualitative research in informing clinical practice within therapeutic settings, we acknowledge that there are some challenges to its application. One of the most important considerations is how to assess the quality of a piece of qualitative evidence. This is because of the heterogeneity of qualitative approaches and the tensions and conflicts surrounding the use of universal quality checklists in the field (see O'Reilly & Kiyimba, 2015, for a full discussion and proposed resolutions). In addition to the difficulties of assessing the quality of qualitative research, there are also challenges in relation to finding effective ways to aggregate qualitative findings (Barbour, 2000). In terms of informing policy, therefore, this has ramifications for managers and service commissioners, as systematic reviews and meta-analyses are not as readily available in the qualitative literature as in the quantitative (although there are methods for undertaking synthesis of qualitative evidence – see Dixon-Woods & Fitzpatrick, 2001). Part of this difficulty is the limited frameworks for evaluation and comparison of qualitative studies (Kearney, 2001) and the lack of consensus regarding how to identify, record, appraise, and extract data from qualitative studies (Denzin, 2009).

Part of this difficulty is that qualitative approaches are often treated as a homogenous group, particularly by those unfamiliar with the rubric. However, under this umbrella, there are many different methodological perspectives, each with their own quality mechanisms and different potentials for synthesis. Particularly useful, due to the robustness of the approach and the internal mechanisms of quality, are studies that utilise CA and some forms of DA. This is because of the data-driven strategies for analysis and limited interpretation. Furthermore, within this approach there is a strong community of scholars specialising in promoting quality assurance within the methodologies that ensure that analytic techniques are consistently applied and that the peer-review process encourages and supports development.

The application of DA and CA findings to inform evidence-based practice in therapy

We recognise that ostensibly we are treating CA and DA as part of the same rubric by grouping them together as part of this chapter. However, although they are both part of the critical 'turn to language', we strongly acknowledge that they are different in their approaches, analytic techniques, and ontological positions and that DA in particular has many different strands. Thus, although both CA and DA have an affiliation with the 'discursive turn' (Tseliou, 2013), they actually constitute a fairly diverse field of studies. Within what follows in relation to the usefulness of DA and CA evidence in the therapeutic field we continue to recognise this diversity, but nonetheless for space and simplicity there are occasions where we refer more broadly to these language-based analyses.

Although there is a more comprehensive introduction to both CA and DA in Chapter 1 of this volume (see Lester & O'Reilly, Chapter 1, this volume), we provide a brief overview here in order to contextualise their usage within the fields of therapy and counselling. CA as a methodological approach was pioneered by Harvey Sacks and his colleagues in the 1960s and 1970s. CA begins with the premise of 'unmotivated looking' in order to ascertain patterns and interactional sequences that occur in a number of different conversational contexts (Hutchby & Wooffitt, 2008). It is a methodology that illuminates the ways in which conversations are co-constructed and social actions are performed between particular people, in particular settings, for particular purposes. Additionally, CA acknowledges that responses of interlocutors are contingent upon the previous turns of other speakers within the interaction and has a particular interest in the sequential nature of talk (Schegloff & Sacks, 1973). Thus, CA is not interpretive, but is based directly on the observable properties of conversational data and how the interactional uptakes of interlocutors are shown to have organised, patterned and systematic consequences for how the interaction proceeds (Drew, Chatwin, & Collins. 2001). In relation to therapy and counselling, CA offers a systematic and rigorous approach to investigating the nuances of how therapy unfolds in a turn-by-turn manner between the therapist and client. In other words, CA is used to examine the ways in which clinical processes are constituted in the course of therapy (Georgaca & Avdi, 2009).

Although discourse analytic approaches have been used for a similar length of time to CA, there is a greater heterogeneity within this methodology. While all forms of DA share a broadly social constructionist view in the sense that they see language as context bound, functional, and constructive (Wetherell, Taylor, & Yates, 2001), there are important differences in application and theory. Broadly speaking, DA is a methodological approach to the study of language, with some researchers taking a macro and critical view and others taking a more micro-perspective. For example, those practising a macro-approach, such as critical DA or Foucauldian DA, have a concern with how societal structures and power are co-constructed through language, whereas those practising a micro-approach such as discursive psychology (DP) focus more on the role of language in the construction of psychological processes. In relation to therapy and counselling, DA focuses on the interactional construction of the client's problems and how solutions are shaped through clinical dialogue (Georgaca & Avdi, 2009). Thus, the commonality that discourse approaches have is in the centrality of language as the vehicle for constructing meanings and performing social practices, with counselling and therapy being good examples of a form of social practice (Spong, 2010).

Both DA and CA share the perspective that language is not a transparent view into the mind of the speaker but is a mechanism for performing social actions, which are designed for particular audiences in particular contexts. Therefore, these approaches involve looking beyond the literal meaning of the language to examine how social realities are socially constructed (Shaw & Bailey, 2009). Fundamentally, as methodologies that are based within a social constructionist paradigm, DA and CA treat social phenomena as constituted through interpersonal interactions (Georgaca, 2012). In relation to mental health and mental illness, this perspective emphasises the importance of recognising how these constructs are co-created through language rather than being objective entities (Fee, 2000). For those using DA or CA approaches in the study of therapy and counselling interactions, this presupposition allows for a greater flexibility in understanding the way that therapists and clients make sense of the process and even concepts such as 'recovery' or 'well-being'.

Generally speaking, clients with mental distress tend to draw upon socially available discourses to both make sense of and describe their experiences and to manage their position within the mental health system (Georgaca, 2012). By drawing upon available discourses, the client goes beyond mere description, and their discourses become constitutive rather than reflective of reality (Spong, 2010). As such, the language used by clients within a therapeutic encounter is constructed for that particular setting and carries within it an element of functionality which may be potentially different from alternative settings. Therefore, this functional element of language is a form of social action which serves particular interests (Potter & Wetherell, 1987). Therapists and clients may have different interests regarding what is accomplished in the therapeutic interaction and discursive approaches can help to explicate an understanding of these processes by examining either the client's talk, the therapist's talk, or the interactional process of therapy itself (Georgaca & Avdi, 2009).

Using CA to inform therapeutic practice

Historically, CA was predominantly interested in the interactional processes of mundane conversations and through the devoted efforts of its founders developed a systematic way of understanding everyday interactions (see Sacks, Schegloff, & Jefferson, 1973). It was these structural foundations that have provided CA with the tools to appreciate the sequential components of institutional talk. This increase in applied conversation analytic work has explored healthcare interactions between doctors and patients, therapists and clients, emergency call takers and callers, and psychiatrists and patients (Pilnick, Hindmarsh, & Gill, 2010). One of the attractions of using CA to analyse these kinds of institutional interactions has been its ability to reveal and explicate the collaborative and contingent nature of these encounters (Maynard & Heritage, 2005). Thus, over time, CA-based research has illuminated some of the fundamental organisational features and interactional processes that occur within a range of healthcare settings (Pilnick et al., 2010). It is important to note that CA does not seek to evaluate therapeutic practice or to dictate to therapists how to conduct therapy but rather seeks to reveal how therapy interactions operate in practice (Streeck, 2010). As such, there is an avoidance of focusing on therapist's insights or the assumptions inherent in the therapeutic protocol in favour of an emphasis on how conversations work (Madill, Widdicomb, & Barkham, 2001).

The aim therefore of using CA to understand counselling and therapy is to examine the practices by which therapists and clients produce their therapeutic reality (Streeck, 2010); this is because it is through dialogue that speakers work out new understandings and ways of progressing (Strong et al., 2008). The conversation analyst thus makes no attempt to try to access some kind of objective reality in the mind of the client; rather, they attend closely to the communication sequences and the ways in which both parties respond in ways that are consequential for them (Strong et al., 2008).

Using DA to inform therapeutic practice

The background of DA was a critical analysis of the way that scientific discourses were presented as 'objective truth'. In particular, the seminal work of Gilbert and Mulkay unveiled the mechanisms by which these factual accounts were created as seemingly straightforward descriptions. Importantly, they demonstrated a linguistic quality to these reports, which contained rhetorical features. This work inspired an interest in language, discourse practices, and the rhetorical construction of knowledge. From these sociological roots, DA as a methodological practice has diversified and has been adopted as a legitimate way of analysing institutional discourses.

As we have previously recognised, therapy and counselling are language-based institutional practices and as such are particularly compatible with the DA approach. One of the ways in which DA is particularly useful is that it allows for the analysis of different models of therapy (Spong, 2010) and is especially applicable for the study of mental health (Harper, 1995). The diversity of DA approaches also allows for a breadth of study of therapeutic interactions that can be conceived as a continuum from the micro-level linguistic performances in individual sessions to the macro-level interests of how therapeutic organisation is manifested. For example, macro-level DA has the potential to explicate the links between psychotherapy as a practice and the wider systems of power, meaning, and institutions (Avdi & Georgaca, 2007). Alternatively, micro-level DA allows for an analysis of therapy to explore how the client's specific difficulties are constructed in discourse (Spong, 2010). This versatility of DA as an analytic approach has extremely important implications beyond theoretical appreciation and can thus have important practical applicability within mental health services (Shaw & Bailey, 2009).

The application and usefulness of CA and DA as evidence

Therapeutic and counselling practices, like other areas of health and medicine, are expected to prove their effectiveness and efficiency with an empirical evidence base for both political and economic reasons (Streeck, 2010). As evidence of change is an essential indicator, it is reasonable to argue that the examination of the 'dialogical practices of clients and therapists' is the most direct route for assessing the process (that is conversation) and outcome (i.e. evidence) of change as both are intertwined and inseparable (Strong et al., 2008).

We propose that there are many areas whereby both CA and DA can contribute successfully to the evidence base in therapy and counselling and that this is evidence that should be taken seriously. At a conceptual level, the application of DA and CA to counselling and therapy research has facilitated a renewed emphasis on the importance of locating the client's experiences within interpersonal and socio-cultural processes rather than merely an intrapersonal experience (Georgaca, 2012). Georgaca has also acknowledged that this has resulted in a shift in the ways in which we understand the knowledge and practice of therapeutic disciplines, which has moved away from a discovery-driven objective development of scientific knowledge to seeing them as social practices which serve a range of functions.

More importantly, perhaps, DA and CA are able to provide useful evidence with regards the actual practices within therapy and counselling. A key feature of therapy, for example, is the therapeutic relationship between the client and practitioner. This relationship is argued to be a central feature of the process and equally, if not more, important than the therapeutic modality itself (Kiyimba, 2015). In our own research, we have demonstrated how the process of therapeutic alignment is instigated and maintained for the purposes of facilitating the therapeutic progressivity (Parker & O'Reilly, 2012). Indeed, evidence suggests that clients come to therapy seeking to recruit the therapist into their preferred version of the situation and where each should be placed in relation to their accountability and blame (Stancombe & White, 1997). Research has demonstrated that the mundane features of talk are used in institutional settings to manage certain role-specific activities and potential asymmetries (Madill et al., 2001). DA and CA are approaches that have the scope to closely examine the nuances of conversational turn-taking and discursive devices used in order to demonstrate how these subtle practices which make up the process of alignment are built.

Therapists and counsellors through training, experience, and clinical instinct learn to navigate these intricate interpersonal fluctuations in order to maintain therapeutic balance and alignment. However, DA and CA are scientific methodologies that can robustly demonstrate the specific practices that occur in actual therapy sessions and thus reveal more systematic practices. For example, CA allows the identification of patterns of behaviour, interactional strategies that facilitate patient involvement, and an exploration of the association between interaction styles and outcomes (such as patient satisfaction) (Drew et al., 2001), both in face-to-face therapeutic interactions and those online (e.g. Lamerichs & Stommel, Chapter 15, this volume). Paying close attention to these areas in such detail can be used to help develop training initiatives and programmes for those working in any area of healthcare, but are particularly useful for therapy and counselling, given the focus on language to produce outcomes. DA also has great potential for informing training programmes for therapists. For example, in our own work we have provided evidence of the efficacy of having separate sessions with parents and with children early in the process in family therapy (Kiyimba & O'Reilly, 2015). We have also demonstrated some of the more effective strategies for working with reflecting teams in family therapy and illuminated some of the barriers and challenges therapists face when exiting to consult with the rest of the team (Parker & O'Reilly, 2013).

Thus, it is important that therapists and counsellors pay attention to the unfolding interaction within the therapeutic session, which is largely aided by the process of therapeutic reflection. As Schön (1983) has illustrated, there are two ways of engaging in reflective practice: reflecting *on* action (after the experience is finished) and reflecting *in* action (during the experience). Lessons are communicated from the evidence base for training purposes occupy a position whereby the trainee practitioner is reflecting *on* action either before or after the experience. However, practising therapists are require to constantly engage in the process of reflecting *in* action, which expects a continual in situ reflexivity and constant evaluation of the client's impact on the therapist and the therapist's impact on the client. Thus, this activity is a reflection of the therapist's mindful awareness of their use of language (Strong et al., 2008; Strong, Chapter 24, this volume). The use of naturally occurring data which is favoured by CA and by some practising DA (in these cases, recordings of counselling or therapy sessions) provides opportunities for therapists to reflect on those in situ decisions. In doing so, the process is facilitated, whereby the therapist can attend to how meanings are co-constructed and what part the therapist's contribution plays in that process (Avdi & Georgaca, 2007).

In reflecting on their own contributions to therapeutic interactions through the use of such close attention to language, therapists can gain a more sophisticated understanding of the consequences of particular ways that their talk is received. For example, CA research has been influential in demonstrating the consequential impact of different turn designs and thus is able to recommend best practice suggestions for healthcare practitioners (Drew et al., 2001). This is particularly useful in relation to the examination of resistance in therapy and how social actions such as non-uptake, topic shifts, and withdrawal of cooperation can be managed (Madill et al., 2001). Importantly, CA is not just useful for illustrating how to manage difficulties or ruptures within the therapy, but it also is able to illuminate preventative strategies by advising about proactive techniques. One way in which CA can do this is by offering recommendations for practice through demonstrating how certain communicative practices may encourage participation (Drew et al., 2001).

Clinical relevance summary

Throughout the chapter we have demonstrated that both DA and CA have practical usefulness as forms of evidence in the field of therapy and counselling. Evidence drawn from language-based approaches is tangible, empirical, and justifiable and can offer important insights for the examination of therapeutic process and change (Strong et al., 2008). CA particularly is an underused resource in healthcare by both educators and practitioners despite its potential for assessing the effectiveness of practice, making recommendations, and directing policy (Barnes, 2005). This is particularly problematic for therapy which relies on therapeutic conversation to achieve its outcomes, and yet therapists typically look beyond the conversation itself for evidence of change (Strong et al., 2008). There is the potential therefore for a theoretical tension between those who practise therapy and those who practise CA (Peräkylä, 2011). However, due to the homogeneity of CA research, it lends itself extremely well to meta-synthesis of studies that are considered a high form of evidence in the hierarchy. For a simple summary of the practical implications, please see Table 26.1.

Summary

In this chapter, we have argued that CA and DA are both valuable forms of evidence in therapy and counselling and that practitioners, commissioners, and policymakers could find this type of evidence useful in their decision-making. While qualitative evidence is generally rated low, and both DA and CA are forms of qualitative evidence, their internal quality systems, scientific rigour, and practices mean that this form of qualitative evidence could and, we argue, should be rated much higher. There is often a limited understanding of qualitative methodology generally and the role it can play in informing evidence-based practice, and the vernacular of CA and DA for some practising healthcare may feel confusing or too technical (see, e.g. Karim, 2015). We recognise that there is much to be done to raise the profile of what CA and DA have to offer and those practising in these methodological disciplines may need to

Table 26.1 Clinical practice highlights

1. CA and DA have helped to reconceptualise the way we think about mental health and mental illness as an interpersonal experience.
2. Therapeutic relationships and alignment are central to therapy, and attention to language can help us understand how these are achieved, or problems are overcome in practice.
3. These approaches to analysis have a great deal to offer in the training programmes of practitioners as they help to unveil the specific and actual practices that occur with clients.
4. In relation to the important concept of reflexivity within clinical practice, CA and DA offer a valuable mechanism for therapists to reflect on their practice both during and after the sessions.
5. These methodological approaches are a pragmatic, robust, and scientific way of exploring both process and outcomes and have a great deal to offer evidence-based practice.

go much further in illuminating the relevance and usefulness to the healthcare field. Thus, if CA and DA are to become truly applied in the field of therapy and counselling, then it has no choice but to engage with the evidence-based debate, and as a community we need to showcase what we have to offer practice.

Note

1. We thank Sage publications for providing permission to reproduce this image.

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27

Interactional Practices of Psychotherapy

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Introduction

Psychotherapy is done through interaction between the therapist and the client. Obviously, the ways in which psychotherapists interact with their clients are very much informed by the psychotherapeutic schools that the therapists represent. On the other hand – like interaction in any institutional context – also, psychotherapy, in its various forms, is bound in general norms of conversation, for example regarding turn-taking or general preference for agreement (see Sidnell & Stivers, 2012). Based on conversation analytical (CA) research, this chapter discusses relations between the interactional side of psychotherapy and clinical theories concerning psychotherapeutic work. Because CA is independent from any specific clinical theories of psychotherapy, its methodic tools make it possible to investigate how psychotherapy is done through the 'generic' means of social interaction.

We will address four central themes of clinical theory: therapeutic collaboration, therapist's empathy, client's resistance, and therapeutic change. We discuss these themes through examples from one audio-recorded therapy process in cognitive psychotherapy. The data from this therapy include 57 sessions from a time period of one and a half years. In this particular therapy, the client (woman in her twenties who suffered from depression) recurrently talked about difficulty in expressing or even feeling negative feelings such as anger or disappointment in her close relationships. During the process of the therapy, these issues were discussed in terms of a lack of security in her childhood and an inversion of aggression (from other people to the client herself). Within cognitive therapy, the therapist's approach can be characterised as integrative (Norcross & Goldried, 2005): it involved traditional cognitive work of challenging irrational cognitions but also experiential and investigative work that aimed towards expressing emotions in the therapy sessions and observing them in a reflective, interpretative way. Through focusing on this single case we will discuss different interactional practices that are used to work on the same central themes of the therapy – client's problematic feelings of disappointment, anger, and self-blame – and how change in the client's way to relate to these feelings emerged towards the end of the therapy. We will also briefly discuss this therapy process in terms of assimilation of problematic experiences and the zones of proximal development (Leiman & Stiles, 2001; Vygotsky, 1978).

A central aspect in our discussion is the *relation between empathy and challenge* in the therapist's work. We will show how empathy and challenge sometimes are combined in the therapist's responses to the client's talk, and how, in other moments and contexts, there is a more salient tension between what was made relevant by the client's emotional disclosure and how the therapist responds.

In CA, the basic unit of analysis is the relation between two adjacent utterances. In other words, the focus is not only on what is said by the participants but also on how the content, timing, and form of the utterances relate to what was said just before (Schegloff, 2007). In the introduction to a collected volume on CA and psychotherapy, Peräkylä, Antaki, Vehviläinen, and Leudar (2008) suggested that through this core notion of *sequential organization of interaction*, CA can make a specific contribution to understanding psychotherapy. In the context of psychotherapy, this organisation entails that anything a therapist or a client does is done and understood in the context of the other participant's previous turn. Because turns are tied together by nextness, 'the participants inevitably have to orient to and work with the understandings that they each bring about through their actions' (Peräkylä et al., 2008a, p. 16). Thus, through their adjacent utterances, therapist and client inevitably create an intersubjective field – an emergent field of shared understandings regarding each other's actions and the worlds of momentary experience that these actions embody (Heritage, 1984). As in any interaction (and in psychotherapy, perhaps in specific and specifiable ways), this intersubjective field involves gaps, discontinuities, and tensions, as well as moments, where the participants' understandings converge. Therapists' and clients' actions, as specified in CA research in psychotherapy, involve movement in this intersubjective field (Peräkylä, 2012; Peräkylä et al., 2008a). In this chapter, we will show how therapeutic tasks are dealt within this movement, that is, in relations between two turns at talk.

Managing therapeutic collaboration

Psychotherapy researchers and clinicians agree about the utmost importance of the relationship between the therapist and the client. This relationship is understood to be a key aspect of the 'common factors' (features of therapy that do not pertain to any particular therapeutic approach such as psychoanalysis or cognitive behavioural therapy) that arguably explain a great deal of the outcome of psychotherapy (cf. Wampold, 2001). A basic aspect in a successful therapy is the collaborative working relationship between the therapist and the client, often referred to as therapeutic alliance (e.g. Horvath & Symonds, 1991).

One key issue in maintaining the therapeutic collaboration is the therapist's empathetic attitude towards the client. In clinical work, however, sometimes the displays of empathy can be dilemmatic in terms of how the therapist relates herself or himself to the experience that the client has described and expressed. For example, if the client expresses transferential emotions towards the therapist, or if his or her narratives reveal rigid interpersonal patterns, it may be unclear whether or not the therapist should respond affiliatively to the client's affective expressions, and how this responding should be done in order to retain and 'refresh' their therapeutic alliance (e.g. Safran & Muran, 2006). Furthermore, for maintaining the collaboration, it is important that the therapist is able to recognise and work with situations where the collaboration is somehow threatened, that is, in instances of *alliance ruptures*. A rupture in the therapeutic alliance can be defined as a tension or breakdown in the collaborative relationship between the client and therapist (Safran & Muran, 2006). Safran, Muran, and Eubanks-Carter (2011) stated that 'ruptures vary in intensity from relatively minor tensions, which one or both of the participants may be only vaguely aware of, to major breakdowns in collaboration, understanding, or communication' (p. 80).

We will discuss interactional practices that deal with these issues in the case that we have chosen from our data (see also Muntigl & Horvath, 2014; Muntigl, Knight, Watkins, Horvath, & Angus, 2013; Voutilainen, Peräkylä, & Ruusuvuori, 2010a). Our focus is on two *frames of talk* (cf. Goffman, 1974) that usually were both present in the therapy: a frame of affective talk and empathetic response, on one hand, and a frame of cognitive investigation of the client's experience and circumstances, involving therapist's challenging responses, on the other. In one session in the therapy, however, a situation that appeared to us as a rupture of therapeutic alliance emerged through exchanges during which the client recurrently returned to affective expression of anxiety and refused to engage in more investigative elaboration of her experience and circumstances, where the therapist was inviting her to. In other words, there was a continuing disalignment between these two frames.

Extract 1 below shows one segment of disaligning talk. Prior to the extract, the therapist topicalised the client's feelings of anxiety and invited the client to talk about what she thinks might be behind the anxiety. However, in her response, beginning from line 1, the client does not take this kind of investigative position but describes how her experience is like.

Extract 1

1 P: *↑Nii (0.8) #joteki on niinku viime aikoina aina#*
↑Yeah (0.8) #somehow I have these days felt#

2 *.hhh #mh# hhh ollu kauheen (0.3) ahdistunu olo (.)*
.hhh #mh# hhh felt terribly (0.3) anxious (.)

3 *#jatkuvasti ja semmonen huono olo# (1.4)*
#constantly and had like a bad feeling# (1.4)

4 *niiku fyysisesti ja psyykkisesti he.hhh (2.0)*
like physically and mentally he.hhh (2.0)

5 *hirveen väsyny ja,*
awfully tired and,

6 (4.0)

7 T: *Mut onk– #tarkottaaks s–# (0.7) #mth# ahdistus siis*
But is–#does it mean # (0.7) #mth# anxiety then

8 *et enemmän ahdistunu ku masentunu vai et sekä että*
that more anxious than depressed or both and

9 *sekä masentunu että ahdistunu [.hhh*
both depressed and anxious [.hhh

In lines 1–5, the client describes what her experience is like, using several intensifiers (*kauheen*, 'terribly'; *jatkuvasti*, 'constantly'; *hirveen*, 'awfully'). In these ways, the client offers her utterance as an expression of a problematic emotional experience that invites an empathic response from the therapist (Jefferson, 1988). The therapist (lines 7–9), however, does not respond empathetically but poses a question concerning the quality and quantity of the client's anxiety. The therapist formulates her question as one about the meaning of the client's words, indicating that she is not able to recognise fully the experience the client has. The question is marked as a departure from the preceding topical line of talk with *mut*, 'but', and with that question the therapist directs the client away from expressing the affect as such towards investigation of the affect (cf. orientation to professional action vs. troubles-telling in Jefferson & Lee, 1992; Ruusuvuori, 2007).

Through the beginning part of this session, this disalignment between the frames of action of the participants continues: the client recurrently returns to expression of anxiety, inviting empathy, whereas the therapist challenges this frame as she pursues investigation of the reasons for the anxiety. Eventually, this leads to a culmination in the disalignment that is shown in Extract 2. After yet another affective expression by the client, the therapist calls into question the client's way to describe her experience. Prior to the extract, the client has stated that she would prefer to stay indoors, just to close the curtains and sleep. The therapist has asked whether this would really alleviate the client’s problem. The client first partly agrees with the therapist by stating that it probably would not solve anything. In the beginning of the extract, after a gap in the interaction, the client returns to talk about her preference to stay at home.

Extract 2

1 P: *#Emmä tiiä ku: kotona on jotenki niin#.hh*
#I don’t know ’co:z at home it is somehow so#.hh

2 *£turvallinen #ja# (0.5) #hyvä olla#£#semmonen että ei#*
£safe #and# (0.5)£#good to be#£#like that not#

3 *(2.0) #mmm (0.7) #ei tota# (1.5) #jos ei tarvii*
(2.0) #mmm (0.7) #not like# (1.5) #if you don’t have to

4 *mihinkään mennä ei jännitä mitään*
go anywhere you are not nervous about anything you

5 *ni ei oo pahoinvointia#*
don’t feel sick#

6 *(.) #ainakaan niin usein tai#.hff (0.3) #mmh#,*
(.) #at least not so often#.hff (0.3) #mmh#,

7 (.)

8 T: *#Eli sul on oikeesti on sit kotona jos sä panisit*
#So you really feel then at home if you drew

9 *verhot kiinni ni sulla oikeesti olis siellä#.hhh*
the curtains you would really #.hhh feel#.hhh

10 *>#hyvä olo#< [hhh*
>good there# [hhh

The client’s account in lines 1–6 has an affective tone: she utters the expression *turvallinen ja hyvä olla*, ‘safe and good to be’, in a smiley, soft voice and leaves the experiencer unmentioned in the utterance, which all can be heard as inviting a recognition of the experience. In her response (lines 8–10), the therapist, however, reformulates the client’s words in a way that, instead of expressing empathic recognition, calls into question the client’s description of her experience (conveying scepticism through the adverb *oikeesti,* ‘really’, in lines 8 and 9). The therapist thus strongly directs the client to rethink her experience. In contrast to what is typical elsewhere in this therapy, the therapist’s turn is overtly challenging and does not involve empathetic elements. After the extract, the disalignment is maintained in the client’s subsequent talk where she continues to describe a situation in which she indeed feels good at home.

The two extracts above illustrated a disalignment between the participant’s frames. Later in this session this disalignment became topicalised – not as a mismatch between frames, as we have described it, or in terms of alliance rupture – but in terms of the client's unwillingness to talk about another topic: her failure to take up an opportunity in her professional life and her belief that the therapist is disappointed at her because of that. When this became topicalised, the tension that was present in the earlier interaction seemed to be released (e.g. through mutual laughter) and the participants reached a shared frame: reflective talk about their interaction and about emotion in their therapeutic relationship.

In clinical terms, the interactional difficulties, and the ensuing reflective talk about them, could be seen as rupture in therapeutic alliance and its repair. There was an implicit tension in the interaction that was jointly taken under consideration. Through the joint consideration, the tension got released (cf. Safran & Muran, 2006). The rupture occurred when there was a disalignment in the frames of action: the client resisted the therapist's investigative line of action, whereas the therapist, in turn, resisted the client's movements towards an affective frame. This mismatch was consequential: the participants ended up explicating the reasons for it. They treated the mismatch between 'affective frame' and 'investigative frame' and empathetic versus challenging response as observable and accountable (Garfinkel, 1967). Nevertheless, in the latter part of the session, the disalignment became a resource of therapeutic work as the participants reflected upon it and, on the basis of it, went on to discuss therapeutically relevant issues and the therapeutic relationship (for a more detailed discussion on this session, see Voutilainen, Peräkylä, & Ruusuvuori, 2010a).

It should be pointed out that in this particular therapy, mere challenging was not how the therapist normally responded to the client's descriptions of her emotional experiences. It is possible that it was this unusual way of responding, by the therapist, that the client treated as problematic. On the other hand, in these particular moments of interaction (some of which were shown in Extracts 1 and 2 above), it might have been problematic for the therapist to empathise with the client, because there may have been implicit attributions of negative emotion to the therapist in the client's displays of anxiety (that became explicated later). Through keeping her and the client's perspectives separate – by not empathically reflecting the client's frame of reference but speaking from her own perspective (see Stiles, 1992), the therapist perhaps avoided responding to the implicit attributions of negative emotion before they were brought to the surface of interaction (see Voutilainen, Peräkylä, & Ruusuvuori, 2010a).

In the next section, we will discuss the 'normal' way of responding in this therapy: the therapist's responses that combine both understanding from the client's perspective and suggesting a further consideration of the experience in question, thus in this sense challenging the client to reflect her experience.

Combining empathy and challenge

Arguably, in very general terms, there are two basic orientations or facets in psychotherapist's ways to relate to the client: to empathise and to challenge. To empathise means that the therapist attunes himself or herself to the client's experience conveyed by the client's talk; to challenge means that the therapist questions the client's beliefs about self and the world and his or her ways of being with others. Empathy and challenge bring about the change in the patient. These two facets of therapeutic work have been described in clinical literature, using different terms (see, e.g. Beck, 1976; Greenberg, 2004; Greenson, 1967; Stern, 2004; Warner, 1997). Empirical studies suggest that empathy and challenge are 'embodied' in psychotherapy: there are 'empathetic moments' when the therapist reciprocates client's facial expressions and mirrors the prosodic patterns of the client's talk and 'challenging moments' when the therapist's face and prosody are disjunctive in relation to the client's expressions (see Bänninger-Huber, 2014; Weiste & Peräkylä, 2014).

One line of CA work has explored the ways in which empathy and challenge are linked to each other in the therapists' ways of responding to the clients' talk. A central observation from cognitive therapy is that challenging responses (responses that suggest that the clients' experience involves something more than what the client said) are preceded by a response that displays empathy (Voutilainen, Peräkylä, & Ruusuvuori, 2010b; Weiste & Peräkylä, 2014). Turns that combine empathy and slight perspective shifts have been described also from psychoanalysis (Peräkylä, 2011).

The therapist's empathy or challenge is often delivered in interventions that in CA are called *formulations*. Formulations have indeed been perhaps the most extensively researched facet of psychotherapeutic interaction in CA (e.g. Antaki, 2008; Buttny, 1996; Hutchby, 2005; Madill, Widdicombe, & Barkham, 2001; Peräkylä, 2004; Vehviläinen, 2003). According to Heritage and Watson (1979), formulations are utterances in which the current speaker suggests a meaning of what another participant has said in the prior turn or turns. A formulation is inevitably selective: it foregrounds something in the prior talk and leaves something else in the background.

Besides formulations that are framed to display understanding of the client's words, the therapist's responses to the client's emotion can be delivered as *extensions*. These turns are composed so that they as it were continue the client's turn at talk. They convey understanding through, as it were speaking 'from within' the client's experience (Pawelczyk, 2011; Peräkylä, 2008; Vehviläinen, 2003; Vehviläinen et al., 2008; Voutilainen et al., 2010a or b; Weiste, Voutilainen, & Peräkylä, 2015).

Extract 3 below shows a case where the therapist responds to the client's talk, first with an extension that shows empathy, and then continues with a more challenging intervention, delivered as a formulation. Here, the empathetic extension is only one word, but it functions in similar vein as more elaborated empathetic responses: it receives the content of the client's experience as it was offered by the client and displays understanding of it. Prior to the extract, the therapist and the client have talked about the client's depressed mood. The therapist has asked what the client would change in her life if she could. The client has pondered that she might change her childhood. In the beginning of the extract, the client responds to the therapist's question about what she would change in there.

Extract 3

1 P: *.hhhhh ts mhhhhhhhhhhhhhhhhhhhhhhh No #mmmmm#*
.hhhhh ts mhhhhhhhhhhhhhhhhhhhhhhh well #mmmmm#

2 *.hhhhhh (1.2) ssss (0.4) ö–ähhhhhhhhhh ehkä*
.hhhhhh (1.2) sss (0.4) ermhhhhhhhhhhhh mmaybe

3 *just (.) sen et ois (.)*
that very thing (.) that one would feel more

4 *↓turvallisempi olo ja et ois (1.7) ois tota niin*
↓safe and that one would have (1.7.) have erm

5 *like that ca– care and love and*
ni sitä välittämi– välittämistä ja rakkautta ja

6 *semmosta (0.5) ↓hellyyttä (2.3) enempi.*
such (0.5) ↓tenderness (2.3) more.

7 (0.4)

8 T: Saanu.
Received.

9 (.)

10 P: *Ts nii.*
Yes.

11 (0.7)

12 T: *Eli sit sää (.) muuttasit (.) ↓äitiä.*
So then you (.) would alter (.)↓mother.

13 (.)
14 P: *.hhhhhhhh Ehh nii.=*
.hhhhhhhh Ehh yeah.=

15 T: *= Toisenlaiseks.*
To be different.

16 (0.5)

17 P: *Nii (0.5) £kaih£.*
Yeah (0.5) £perhaps£.

The client ponders that in her hypothetical childhood, she would feel more secure and she would receive more care, love, and tenderness. In the original Finnish utterance, the auxiliary verb 'olis' can have the meaning of both 'would be' and 'I would have'. In Finnish, the utterance can be heard as syntactically complete in the sense 'there would have been more care, love and tenderness' but incomplete in the sense 'I would have received'; the client does not say the verb 'received'. Importantly, the turn is prosodically produced as complete and there is a short pause in line 7, indicating that the client's turn is not in progress. In line 8, the therapist does an extension that completes the syntactical construction (cf. Lerner, 1991) with the main verb 'received'. In this way, as it were talking from within the client's turn, the therapist displays empathetic understanding of the content of the client's talk. In a discreet way, the extension also intensifies the emotional content of the turn by making a shift from somewhat passive or abstract voice of 'there would have been' to the form that addresses more directly the client's wish and disappointment 'I would have received'.

In line 12, the therapist does a formulation *So that you would alter mother*. This formulation brings out the critical stance towards the mother that was implicit in the client's turn (the client's childhood memories that have been talked about in the therapy have mainly focused on her relationship with her mother). In this way, the formulation is challenging: it invites the client to talk more directly about her disappointment with her mother. It is important to note that this formulation would have been a possible response already in the place of the extension in line 8. However, the extension and the client's confirmation (line 10) build a more solid ground of mutual understanding on what has been described. That can be seen as therapeutically relevant as such, and as a ground on which the challenge can be more safely built (see Voutilainen et al., 2010b).

The combinations of empathy and challenge generally invite reflective talk about the experience from the client (Peräkylä, 2011; Voutilainen et al., 2010b). In her response starting from line 14, the client confirms the formulation, albeit somewhat hesitantly (there is a long inbreath and some kind of sneer before the confirming *yeah*). After the therapist's expansion of the conclusion in line 15, the client starts to waiver by qualifying her stance with *perhaps* (line 17). After what is shown in the extract, the client backs further off from the conclusion by adding that she would change her father too, and eventually calling into question the assumption that the hypothetical change would make her feel better. In her response to the therapist's formulation, thus, the client does not go further to reflect her experience in ways that were made relevant by the therapist. Importantly, however, the client still orients to what was suggested by the therapist through expressing ambivalence.

The client's response can be seen as a partial resistance towards the issue in question; the client resists further examination of her experience but however produces a relevant next action that takes a position towards what the therapist suggested (Peräkylä, 2005, 2011), and the discussion on the topic continues. In what follows, we will turn to discuss cases in which the client's resistance towards the therapist's agenda is more salient, as well as the ways in which the therapist manages the resistance.

Managing resistance

As Vehviläinen (2008) points out, some mismatch between the professionals' and the clients' actions is common in perhaps all institutional settings: 'professionals encounter moments where clients resist their actions and institutional agendas' (p. 120). In psychotherapy, resistance is particularly important and possibly significant. Client resistance is not only an obstacle (i.e. something that needs to be sorted out in order for the therapy to take place) but, rather, part and parcel of the very activity of doing therapy (Vehviläinen, 2008). CA research on psychotherapy has located resistance, for example, in clients' claims of not knowing (Falk, 2013; Hutchby, 2002) or not remembering (Muntigl & Kwok, 2010) and in client's resistance towards presuppositions in therapist's questions (MacMartin, 2008). Resistance may occur in instances of overt disagreement (Weiste, 2015) or it can be more discreet, embedded in what appears to be agreement (Peräkylä, 2005).

One way in which the clients often resist the therapist's agenda is by changing the topic of the talk. In such instances, the therapists often manage the resistance by responses that do not overtly resist the client's topical shift but do not further the topic either (Koivisto & Voutilainen, 2014). An example is shown in Extract 4. Prior to the extract, the therapist had asked about a discussion in the previous session about the client's mother, which the client obviously had experienced as emotionally stressful. The client responded only briefly to the question that apparently invited a more extensive elaboration, and then moved on to talk about a positive encounter with her mother: how it was nice to talk to her mother in phone in the previous day. The client told that her mother spoke about her stress at work. The extract begins after some talk on that topic.

Extract 4

```
1  P:  =Ja nyt se oli sit lääkäri pakottanu sen jäämää (0.3)
       = And now she has then the doctor has told her to a leave
2      (0.3)
3      stressilomalle että.
       from work because of stress so.
```

(.)
4 T: ↓Mm-hm.=
5 P: *=Että tota niin ni.*
= I mean like.
6 (0.5)
7 P: *Ts mut että oisko sekin sitte just periytyvää toi että*
But I mean would it be inherited too that thing that
8 .hhh £ähhäh [hä että£].
9 T: *[Et se on] se: (.)vatsa joka [reagoi].*
(You mean) it is the (.) stomach that reacts.

The client's talk about her mother's stress in this context can be seen as a way to resist the therapist's suggestion to talk about the previous session – a topic that would involve problematic emotions both in the client's relation to her mother and in her relation to the therapist. During the client's earlier talk, the therapist had responded only minimally. In lines 7–8, the client ends up pondering whether 'it' is inherited, referring to what she has just told about her mother's somatic stress reactions. In her response in line 9, the therapist responds locally to this aspect in the client's talk with an extension that explicates the reference of the 'it' in the client's turn: that it is the stomach that reacts (to stress). In this response, the therapist does not respond to the earlier content of the client's turn: neither to the part in which the client rapidly responded to the therapist's topicalisation of the previous session nor to the part in which the client talked about her positive feelings about the phone call with the mother. In other words, the therapist's response is given very locally to what the client said in lines 7–8. It explicates the obvious, concrete content that was left unsaid in the client's turn (but was clear from the context) without taking up anything more about the topic that the client has now brought to the discussion. In other words, the therapist takes a turn in a relevant place but does not initiate any further aspect on the topic (see Koivisto & Voutilainen, 2014).

After what is shown in the extract, the client continues the talk about her mother and the somatic stress reactions. In her response after that, then, the therapist returns to the question about the client's inconvenience in the previous session. The therapist thus does not take up the topic that was initiated by the client (the positive experience with mother) in any way, but returns to the agenda that she initiated earlier. However, through the local response in lines 7–8, the therapist avoided overtly dismissing the topic that the client introduced (Koivisto & Voutilainen, 2014). It is interesting to compare the therapist's extension in this extract to the one in the previous extract: unlike in the previous one, here the extension is not in the service of a further intervention by the therapist but rather in the service of not furthering the talk on topic introduced by the client. In a way, also this practice can be seen as a version of combining empathy and challenge: through this kind of 'minimalistic' response, the therapist communicates on the one hand that she listens to the client, understands her point, and gives her possibility to continue her talk, but on the other hand also implicitly resists the client's project of moving away from the topic that the therapist was suggesting.

In Extracts 3 and 4, the therapist therapist's agenda, broadly speaking, was to invite the client to express and reflect her negative emotions towards her mother and, in the latter case, towards the therapist also. The client, however, resisted this agenda – in the Extract 3 in a more subtle way, and in Extract 4 by changing topic. As was noted above, this kind of resistance is normal and essential part of the therapeutic process, and we believe that the therapist's subtle ways of dealing with it – combining empathy and challenge – helped the client to move towards the problematic experiences. In this therapy, the client's way of talking about her experiences eventually changed; in latter part of the therapy, the client moved towards expressing negative emotions more openly and expressing less self-blame. Next, we will discuss how this kind of change process can be seen from the CA perspective, that is, in relations between turns at talk.

Interactional practices and therapeutic change

Psychotherapies generally aim at a change in the client, at improved mental health. A fundamental aim in many types of psychotherapy is to increase the clients' contact with their problematic emotional experiences and parts of the self and to increase their self-reflective abilities (e.g. Lilja, 2011). In clinical research, one way to conceptualise this process is the assimilation model of a problematic experience (Stiles et al., 1990). In this model, therapeutic change is seen as a process in which a painful or threatening experience becomes integrated to the client's self. According to the assimilation model, this process can be divided to certain phases, starting from vague awareness of the problematic content and proceeding through seven stages to finally integrating the experience (Stiles et al., 1990).

Despite the longitudinal nature of psychotherapy and the clinical interest in the therapeutic change, most of the conversation analysis of psychotherapy has focused on phenomena that occur in more microscopic time: in the temporality of the turn and sequence, rather than the temporality of a continuum of sessions. Recently, however, the time span of the phenomena of interest in

CA studies of psychotherapy has got wider. Researchers have started to investigate longitudinal, 'across sessions' interactional processes. This has made it possible to address more directly also the question of therapeutic change (Bercelli, Rossano & Viaro, 2013; Muntigl, 2013; Peräkylä, 2011, 2012; Voutilainen, Peräkylä, & Ruusuvuori, 2011). Inspiration for this new line of research has been drawn from studies on learning in interaction (e.g. Melander & Sahlström, 2009; Mondada & Pekarek Doehler, 2004).

In their study on cognitive therapy, Voutilainen et al. (2011) suggested that therapeutic change can be documented from a change in *a particular type of sequence* (pair of particular types of turns) that recurs across sessions. The data of this study were from the same therapy that we have discussed in this chapter. The focus was on change over time in the client's responses to particular types of turns. The therapist's focus turns were conclusions (or so-called upshot formulations, see Heritage & Watson, 1979) in which the therapist challenged the client's tendency to transform her anger to self-blame. The study showed that the client's responses to these interventions were recast over time: from rejection through ambivalence to agreement. (Extract 3 above was one instance from the phase of ambivalent responses.)

The perspective of CA – looking at relations between adjacent turns – offers a way to investigate how the therapeutic process, for example the assimilation of problematic experiences, is bound to particular kinds of social actions. The assimilation of a particular problematic experience is 'embodied' in interactional sequences. It is possible that *an individual patient* is not the right unit of observation for assimilation, because the assimilation of a particular experience may be at different stages *in different interactional contexts*. For example, in our focus therapy, the client talked in different ways about her negative emotions in her turn prior to the therapist's focus conclusions than after the conclusion (Voutilainen et al., 2011). This is shown also in the Extract 4 above: in the beginning of the extract, the client expressed her wish to have different childhood and so talked about her problematic emotions in relation to her mother. However, after the therapist's formulation that explicated the content of the client's turn, the client backed off from this position and started to ponder if the different childhood would have made any difference in her life. In other words, if we look at the clients' talk in terms of assimilation, it seems different in different interactional contexts (e.g. before and after a particular intervention).

This social aspect to assimilation can be considered also in relation to what Leiman and Stiles (2001) suggested about the zones of proximal development: *in joint exchange with the therapist*, clients reach higher levels of assimilation than they reach in their *internal* assimilation. In this view, new ways to relate to an experience are mutually achieved in interaction. In the example case (Extract 4), the client and the therapist jointly, for a moment, achieved an expression of disappointment towards the client's mother: the client offered to the therapist material that the therapist as it were finished in her conclusion, which the client then confirmed – and then again, being again more 'on her own' after the conclusion, the client backed off from what was just mutually achieved. What the therapist did in the conclusion might be seen as a position that was in the zone of proximal development of the client (Voutilainen et al., 2011).

In the longitudinal analysis of the 'conclusion and response' sequences of our focus therapy (Voutilainen et al., 2011), it was shown that towards the end of the therapy, the client's responses to the conclusions changed to acceptance and agreement. This was shown in the client's elaborated response that accommodated what the therapist had suggested in her conclusion: that the way the client's mother reacts to the client is due to the mother's personality and not something that the client should blame herself for. This could be seen as internal assimilation of the problematic experience that was collaboratively worked with in the earlier phases of the process. Even though it may not be possible to connect the change in a social action directly to internal change, it was at that point of the therapy at least possible for the client to agree with the therapist in the surface of social interaction. This change is very salient when the client's response is compared to the beginning phase of the therapy where she responded to the therapist's conclusions with silence and a refusal to say or even think anything negative about her mother.

Clinical relevance summary

In this chapter, we hope to have demonstrated two things: (1) the interconnectedness and possible mismatch of empathy and challenge in the therapist's ways to respond to the client's talk on problematic experiences and (2) the ways in which clinical work is done through particular types of social actions that involve a particular relation to the previous turn, such as formulations and extensions. We hope that CA perspective can give clinical practitioners inspiration to observe the interactional side of the therapeutic process, and the ways in which the clinical work connects with the norms and expectations of conversation in general. For a simple summary of the practical implications, please see Table 27.1.

Table 27.1 Clinical practice highlights

1. Psychotherapy is done in relations between turns at talk.
2. Some interactional difficulties can be seen as mismatch of frames of talk.
3. Empathy can build grounds for challenging actions.
4. Resistance can be managed through local responses to client's narration.
5. Therapeutic change can be observed from social contexts.

Summary

In this chapter, we have described CA research on psychotherapy, pertaining to four themes that are clinically important: therapeutic collaboration, empathy, resistance, and therapeutic change. Compared to clinical literature, CA research is detailed and cumulative and is a useful approach for examining therapy (Kiyimba & O'Reilly, Chapter 26, this volume; Muntigl, Chapter 29, this volume). CA studies have their focus on distinctive practices. The price of the focus on detail has been, perhaps, CA's weakness in global and comprehensive theorising on psychotherapy. Furthermore, CA research is usually descriptive rather than normative in relation to the therapeutic work it describes. This is our stance in this chapter too. The practices that we have described can be seen rather as tools for reflection for clinical practioners than as instructions or suggestions to be applied in clinical work as such. On the other hand, the strength of CA is in the naturalistic, data-driven approach that can be seen to complement the often more abstract and idealised way to describe psychotherapy in clinical literature (see Peräkylä & Vehviläinen, 2003).

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28

Finding the Middle Ground between Therapist-Centred and Client-Centred Metaphor Research in Psychotherapy

Dennis Tay

Introduction

People traditionally view metaphor as a kind of language play where one thing is described in terms of another for literary or rhetorical effect, as when Shakespeare famously wrote *Juliet is the sun*. In the past decades, however, psychologists and linguists have put forward a very different cognitive theory which claims that metaphors in language reflect a fundamental cognitive tendency to understand one concept in terms of another (Gibbs, 2013; Lakoff & Johnson, 1999). This potential link between language and conceptualisation has motivated some psychotherapists to theorise how metaphors could be used to explore and possibly change clients' feelings, values, attitudes, and behaviours (Wickman, Daniels, White, & Fesmire, 1999).

While there is now a considerable body of work on metaphor use and management in psychotherapy, an overreliance on therapeutic lenses to view metaphors might lead one to superimpose familiar conceptual distinctions in psychotherapy research onto less familiar data, and overlook how the data might call these distinctions into question. This chapter illustrates the particular distinction between 'therapist-centred' and 'client-centred metaphor', which is common in therapeutic parlance but may not accurately reflect the discursive complexity of metaphor use in actual therapist–client interaction. I begin by briefly reviewing existing work on the applicability of metaphor to psychotherapy practice, before focusing on the distinction between therapist- and client-centred metaphor research. The therapist-centred end places greater emphasis on therapists utilising metaphor as a resource, while the client-centred end emphasises the potential of clients to contribute to their own treatment with metaphor use.

Although this distinction seems sensible from the therapeutic point of view, I proceed to outline the underexplored 'middle ground' which embodies keywords like *negotiation, co-construction*, and *compromise* and more accurately reflects the interactional and collaborative qualities of psychotherapy. The gist of the middle-ground approach is that metaphor should be observed, analysed, and understood as a product of interaction between the perspectives and intentions of both therapist and client. I illustrate this with analyses of metaphor use in extracts of therapist–client interaction from a range of contextual circumstances and outline some practical implications for therapists. The overarching message of this chapter is that understanding the multifaceted nature of metaphor in psychotherapy requires close attention to the contexts in which the metaphors are used (cf. McMullen, 2008).

The relevance of metaphor to psychotherapy

Although metaphor was noticed early (Freud, 1915), the advent of cognitive metaphor theory opened up new avenues for its therapeutic applicability. Several interrelated observations and claims constitute this theory (cf. Tay, 2014b). First, metaphors are observed to be far more common and systematic in everyday language than traditionally assumed. English speakers, for example, use many conventional expressions to describe purposeful activities in terms of physical journeys (*I'm spinning my wheels, she is facing roadblocks in her life*), and can readily invent and understand novel ones such as *I'm drifting like a feather through the rapid stream of life*. Similar observations can be made for other such pairings as desire and hunger (*I am hungry for success*), affection and physical warmth (*I like her warm smile*), and so on. Second, assuming that the way we speak at least partially reflects the way we think, the apparent pervasiveness of these descriptions suggests that the underlying representations of their respective concepts are also metaphorical in nature. Cognitive metaphor theorists propose with experimental evidence (Gibbs, 2013) the notion of a 'conceptual metaphor' consisting of a target, a source, and mappings between the two. The target is the representation of the concept being described. In our example, this would be the concept of purposeful activities. The source, which is the conceptual knowledge of physical journeys, structures our understanding of the target through the mapping of relevant entities, attributes, and relations. Travellers on the journey are mapped onto individuals going through a purposeful life, obstacles onto difficulties in life, destinations to objectives, and so on. Last, it is claimed that these metaphors are not merely facilitative or enriching, but are in many cases necessary for our understanding of abstract target concepts (Lakoff & Johnson, 1999). Observing that most target concepts tend to be experientially less concrete than their sources, and that it is often difficult to describe them without metaphor, cognitive theorists argue that metaphor is the main mechanism through which we make sense of things we cannot directly experience through the senses.

The therapeutic implications of this cognitive understanding of metaphor are clear. It is noteworthy that both cognitive metaphor theory and psychotherapy have been influenced by 'constructivist' philosophy (Guidano, 1995; Neimeyer & Mahoney, 1995; Taylor & MacLaury, 1995), which holds that our knowledge of the world does not simply reflect its objective characteristics, but is largely constructed by individuals, groups, and cultures. Metaphor is precisely an example of a non-objective yet linguistically and cognitively natural device to construct knowledge and perceived reality. If the metaphors people use in therapy indeed reflect their conceptualisations of therapeutically relevant yet difficult-to-describe targets such as emotions and relationships, they may provide important information for therapists seeking to understand and perhaps replace these conceptualisations, as is often the case in cognitive behavioural therapy (CBT) for instance. A spontaneous client metaphor like *HIV is a dark cloud that will rain AIDS upon me* (Kopp, 1995), if further explored, may reveal key inferential patterns underlying his thinking about his condition, while a therapist may also introduce metaphors drawing from an open-ended variety of source domains to provide alternative and more adaptive ways of thinking (Stott, Mansell, Salkovskis, Lavender, & Cartwright-Hatton, 2010).

There has in fact been much research on different thematic areas which has advanced theoretical and practical knowledge of the forms, processes, and effects of metaphor use and management in psychotherapy. These thematic areas include conceptual aspects such as metaphor definition, identification, and classification (Gelo, 2008; Kopp & Eckstein, 2004; Wickman et al., 1999), theoretical models of how metaphor may trigger therapeutic change (Stott et al., 2010), potential therapeutic functions of metaphor (Cirillo & Crider, 1995; Lyddon, Clay, & Sparks, 2001; Witztum, van der Hart, & Friedman, 1988), structured protocols on developing metaphoric conceptualisations (Kopp & Craw, 1998; Sims, 2003), cultural variation and culture-specific attitudes towards metaphors (Ahammed, 2010; Dwairy, 2009; Zuñiga, 1992), as well as modes of metaphoric expression other than language (Burns, 2005; Samaritter, 2009; Sharp, Smith, & Cole, 2002). Relatedly, empirical research on metaphor in psychotherapy include qualitative analyses of metaphor themes identified from actual therapist–client interaction (Angus & Rennie, 1988, 1989), and quantitative studies which investigate associations between aspects of metaphor use and clinical indicators of treatment outcome (Gelo & Mergenthaler, 2012; Levitt, Korman, & Angus, 2000; Rowat, De Stefano, & Drapeau, 2008; Sarpavaara & Koski-Jännes, 2013). Table 28.1 presents a summary of the key thematic areas and some relevant references.

While it remains a challenge to experimentally investigate causal mechanisms underlying the process and outcome of metaphor use because of difficult-to-control covariates like therapist interest (McMullen, 1996), much of the

Table 28.1 Key thematic areas in metaphor and psychotherapy research

Thematic area	Remarks	References
Theoretical models and frameworks of metaphor in psychotherapy	How metaphors can be defined, be categorised, and bring about therapeutic change	(Blenkiron, 2010; Goncalves & Craine, 1990; Kopp & Eckstein, 2004; Lankton & Lankton, 1983; Stott et al., 2010; Wickman et al., 1999)
Metaphoric ways of expression other than language	How modalities such as art, dance, and film, which often bear metaphorical meanings, can be used in therapy	(Samaritter, 2009; Sharp et al., 2002)
The use of 'stock metaphors'	How standard metaphors can be prepared and used in appropriate situations	(Blenkiron, 2010; Burns, 2005; Stott et al., 2010)
Therapeutic functions of metaphor	How metaphors may serve useful functions such as making a point vividly or making the therapeutic setting more relaxed	(Cirillo & Crider, 1995; Lyddon et al., 2001; Witztum et al., 1988)
Incorporating metaphor into structured intervention protocols	How therapists can systematically identify and help clients elaborate upon spontaneous metaphors for therapeutic purposes	(Kopp & Craw, 1998; Sims, 2003)
Metaphor and the therapeutic alliance	How metaphor is relevant to the therapist–client relationship. These include sensitivity towards culture-specific metaphors, or client-generated metaphors	(Ahammed, 2010; Dwairy, 2009; Kopp, 1995; Suit, Paradise, & Orleans, 1985)
Metaphor as marker of change processes	How certain types of metaphors may be related to positive therapeutic engagement and change	(Gelo & Mergenthaler, 2012; Levitt et al., 2000; Rowat et al., 2008)
Metaphor as predictors of treatment outcome	How the use of metaphor correlates with and predicts treatment outcome	(Long & Lepper, 2008; McMullen, 1989; Sarpavaara & Koski-Jännes, 2013)

conceptual and observational work outlined above can nonetheless be situated within the broad imperative of psychotherapy process–outcome research (Orlinsky, Michael, & Willutzki, 2004). Most researchers have attempted to articulate the potential or observed role of metaphor in constituting or facilitating therapeutic processes, as well as attaining localised or major therapeutic outcomes. A recurrent distinction which underlies this paradigm of conceptualising metaphor in psychotherapy is the differentiated role between therapists and clients in authoring, developing, managing, and exploiting metaphors. This can be seen in terminological formulations such as therapist-generated versus client-generated metaphors (Kopp, 1995), the roughly synonymous distinction between communicative and interpretative models of psychotherapeutic metaphor (Muran & DiGuiseppe, 1990), as well as empirical studies which inquire separately into therapist and client metaphors (Gelo & Mergenthaler, 2012). Generally speaking, distinguishing therapist-oriented from client-oriented variables appears to be both intuitive and insightful in process–outcome research. In the case of metaphor, however, which is often conceptualised in its 'native province' of linguistics as involving dynamic interplay between the cognitions, values, attitudes, and so on of interactants (Cameron et al., 2009), insistence upon a split between therapist and client would be tantamount to superimposing a familiar but problematic distinction onto less familiar data, and overlooking new perspectives afforded by the latter. In the following sections, I respectively outline therapist- and client-centred approaches to metaphor before articulating the case for a 'middle-ground' approach – one which takes into account the interactional dynamics of metaphor based on analyses of actual instances of therapeutic metaphor use.

Therapist-centred approaches to metaphor

The major premise underlying therapist-centred approaches is that metaphor, in its many conceptions and forms, can be harnessed as a technique as part of the therapist's repertoire of interventions. Metaphor should in other words be therapist generated. It is consequently the therapist's responsibility to think about the most effective ways to prepare, communicate, and manage metaphor use, just like any other therapeutic intervention. Following Freudian and Jungian notions of the unconscious mind, Erickson and Rossi (1976) have, for example, pioneered an approach for therapists to communicate metaphors indirectly by telling personal stories which appear literal to the conscious mind, but possess some metaphorical therapeutic message at the deeper, unconscious level. A similar storytelling approach is advocated by Burns (2005), who views metaphor as a form of indirect and imaginative communication with clients, and provides practical storytelling techniques. However, metaphorical meanings are not always indirect or implied. Many therapists also exercise their authorship of metaphors in a more explicit manner, as seen in the following extract.

> And you're going to come-*you know how*, like diamonds? They have to-coal has to go through the fire, that pressure. *You know*, has to form and shape the things. *You know?* That's what this is happening-that's what this is about, right here. *You know* you're that gold forming to that diamond, so you're going to have to go through the pressure. But when it's all said and done, and you get that degree that you wanted. It - you are going to look back and like, "Phew, it was worth it." And it's only going to make you a stronger - it's only going to make you a better advisor to other students. *Right?* It depends on what perspective you take on this. Look at this, okay. 'Now I know how I need to be when I'm supervising students.'

Here, the therapist is explicitly using a metaphor of diamond formation to explain to the client that the pressure of getting a degree she currently faces is a necessary process, which will make her a better advisor to other students someday. Expressions which reflect this metaphor are underlined. This can be regarded as a prototypical example of a therapist-generated metaphor, where all its elements; that is, the target concept (the client's pressure of getting a degree), the source concept (the process of diamond formation), the mappings between the two (the client corresponds to the diamond, her academic pressure corresponds to the pressure forming the diamond, etc.), and the function of introducing a new perspective to the client, are attributable to the therapist's intention and effort. Notice also the italicised expressions: *you know how, you know, right?*, which linguists and discourse analysts call 'discourse markers' to distinguish them from substantive content words (Schiffrin, 2001; Tay, 2011a). *You know* in particular tends to convey the speaker's intention to check the hearer's understanding and invite the hearer to make inferences (Fox Tree & Schrock, 2002). The intermittent use of *you know (how)* between the metaphorical expressions may thus suggest that the therapist is not merely communicating the conceptual contents of the metaphor, but also encouraging the client to reflect on it.

While there are many such examples where metaphors seem to be spontaneously uttered and managed by therapists, another significant strand of therapist-centred research focuses on what Blenkiron (2005, 2010) calls 'stock metaphors'. These are 'standard' source concepts prepared and mapped beforehand onto a corresponding set of 'standard' target concepts, which therapists can use prescriptively when the appropriate situation arises. Blenkiron (2005) and Stott et al. (2010), for instance, suggest many concrete source concepts for target concepts at various levels, ranging from the process of therapy itself (cf. Tay, 2011b), to specific disorders including depression, anxiety, bipolar disorder, and posttraumatic stress disorder. The following extract shows how the stock topic of 'coping with depression' can be explained with a car analogy:

> A discussion about coping with depression can include use of the car analogy. Human beings are akin to machines, needing fuel and regular servicing in order to work properly. What is the best course of action to take when a person's car develops a major problem? Give up and stop using it altogether, blame the vehicle, punish it for a few more weeks on the road till it breaks down totally, or take it in to the garage (cf. therapy) to be repaired? Individuals with depression who minimize progress or fail to acknowledge even small achievements may be encouraged to compare their approach to recovering from having a broken leg. Would you be able to run 200 yards? Should an athlete recovering from an injury expect to run a marathon straight off?
>
> (Blenkiron, 2005, p. 51)

It should again be observed that in such discussions, authorship of the major metaphor elements (i.e. source, target, mappings, and discourse function) are presumed to lie with the therapist, who is responsible for optimising their delivery and effect. The agency of clients tends to be restricted to the issue of how different client characteristics would motivate therapists to adjust metaphors accordingly, though client responses to these stock metaphors in actual interaction are seldom discussed. In sum, therapist-centred approaches have sensibly and insightfully conceptualised the therapist as author, communicator, and controller of metaphor in therapist–client interaction and have tended to regard metaphors as unilateral intervention tools, acknowledging but seldom clarifying the role of clients' input. There is much room for fresh inquiry along this line, such as the underexplored question of therapists' perceptions and attitudes towards metaphor, vis-à-vis those of clients. I now move on to outline the conceptually opposite perspective of client-centred approaches.

Client-centred approaches to metaphor

The notion of client-centred metaphor is most consistent with the popular belief that therapists should be 'non-directive' and display positive regard and empathetic understanding towards clients (Rogers, 1951). In other words, therapists should not impose their will on the discussion, but should assist and guide clients to realise the potential or agency to bring about their own change. From this perspective, metaphors produced by clients should be regarded as having inherent relevance and value which therapists should help develop. This is true even for expressions which may not be intended as metaphorical, but have the potential to be elaborated as such (Witztum et al., 1988). For example, a

Table 28.2 Kopp and Craw's (abridged) seven-step protocol for working with client metaphor

Step	**Protocol**
Step 1	Notice metaphors
Step 2	'When you say [the metaphor] what image or picture comes to mind?'
Step 3	Explore the metaphor as a sensory image
Step 4	'What is it like to be [the metaphoric image]?'
Step 5	'If you could change the image in any way, how would you change it?'
Step 6	'What connections do you see between your image of [the metaphoric image] and [the original situation]?'
Step 7	'How might the way you changed the image apply to your current situation?'

client who utters *I feel down* may simply be describing his mood in a conventional way, but a therapist could highlight the potentially metaphoric use of *down*, thereby opening the inferential space of verticality (e.g. responding with *what would it take to climb back up?*) for clients' deliberation. Researchers have systematised the attendant processes of identifying, highlighting, and elaborating client metaphors in the form of protocols, or series of steps to be followed by therapists (Kopp & Craw, 1998; Sims, 2003). Table 28.2 shows an abridged version of Kopp and Craw's (1998) seven-step interview protocol, which starts with therapists noticing intended or potential metaphors from clients' utterances, progresses through different steps of building up the metaphoric image (i.e. source concept) and inferential structure(s), and ends with connecting the built up source with the current situation (i.e. target concept).

The client-centred nature of this protocol is underlined by Kopp and Craw's (1998) insistence that therapists should 'avoid interrupting the client's process with interpretations, emphatic reflections, comments…', and that 'these and other responses or interventions may be introduced after the final step is completed' (pp. 307–308). In other words, clients should be allowed primary authorship of the major elements of a metaphor, that is, the source(s), target(s), and mappings, as they would be more insightful than any conceptualisation or interpretation imposed by therapists could be.

Other than the formulation of protocols which appear to emphasise spontaneity in client authorship, another strand of client-centred metaphor research focuses on issues related to more enduring characteristics of clients. Cultural background stands out among these because of the increasingly intercultural nature of contemporary psychotherapy (Wohl, 1989), and its status as an obvious dimension of metaphor variation (Kövecses, 2005). Zuñiga (1992), for instance, suggests how Latino clients would be receptive towards therapists' use of 'dichos', or metaphorical expressions which embed culture-specific beliefs about the human condition. Dwairy and associates have advanced a similar argument for Arab-Muslim clients who are likely to produce and accept metaphors drawn from the Holy Qu'ran, as well as for clients from 'collectivistic' (as opposed to 'individualistic') cultures in general (Dwairy, 1999, 2009; Dwairy & Van Sickle, 1996). These works are client centred in that although they do not insist on client authorship, they argued that metaphors ought to reflect or capitalise upon clients' cultural background. As with therapist-centred approaches, client-centred research is also poised to move in new directions, including client perceptions of metaphor and practical issues of explaining metaphoricity to clients (Tay, 2012).

Although both therapist- and client-centred approaches have produced insightful conceptual frameworks and intervention strategies, there are good theoretically and empirically driven reasons to explore the so-called middle ground, that is, metaphor-related phenomena which are not exclusively attributable to therapist or client, but a result of interaction between the two (McMullen, 2008). The theoretical motivation for this middle ground is clear, given the keen attention on related ideas such as the therapeutic alliance (Horvath & Luborsky, 1993), and its linguistic manifestations as studied under interactional frameworks such as discourse analysis (Spong, 2010) and conversation analysis (Peräkylä, Antaki, Vehviläinen, & Leudar, 2011; Voutilainen & Peräkylä, Chapter 27, this volume). There is also clear empirical motivation to focus more on the interactional qualities of metaphor in therapist–client talk. This follows from the dearth of studies within the therapeutic literature on how metaphors are actually verbalised, as well as research from comparable discourse domains such as reconciliation talk, where metaphors have been to shown to be emergent outcomes of co-construction, negotiation, and compromise between speakers (Cameron et al., 2009). The rest of this chapter will illustrate the middle-ground orientation in psychotherapeutic metaphor research through brief analyses of sample extracts of metaphor use.

Metaphor in the middle ground: Co-construction, negotiation, and compromise

As outlined above, the middle-ground approach should be based upon scrutiny of actual instances of therapist–client talk which reveal different ways in which metaphor authorship, use, and management are shared. This will now be illustrated by examples respectively demonstrating three broad aspects of metaphor in the middle ground: *co-construction, negotiation,* and *compromise*. Expressions of interest in these examples are underlined.

The first example demonstrates how a therapeutically useful metaphor can be *co-constructed* by therapist and client, who both contribute to its developing inferential structure. While co-construction seems to be an intuitively expectable interactional phenomenon, neither the therapist- nor client-centred approach has fully articulated its characteristics and implications. In this extract of a counselling session in a Chinese university, the therapist and client are engaged in a form of picture-assisted therapy. Clients are shown a picture, encouraged to describe it in vivid detail, and then guided to use it as a metaphoric source domain to explore pertinent target domain(s) issues in their lives. The picture shows a broken-down car in the middle of a road, its owner standing beside it looking frustrated. Translation is provided below each utterance.

1 T: 那这个车走了水路，身上就脏了。
So this car drove past the puddles and became
dirty.

2 C: 然后还比较破，那个水洼可能比较大，然后开得比较快，你看水花都溅到
车上了。
And worn out. Perhaps the puddle was big and the
car was too fast, you can see the sprays all over
it.

3 T: 它的身上已经脏了。
It's now dirty.

4 C: 接下来，嗯，接下来这个车可能是爆灯了，然后主人下来，对它表示不屑的一
种表情。然后车开始祈求他。最后可能是，
主人就要正式的好好对待它，修理它，再走一些好的路。要不然为什么主人要
下来？因为车确实走不了了，他才下来看下。
After that, yes, after that, maybe the car broke
down, and then the owner got off and showed his
indifference. Then the car started begging him.
At last, maybe the owner will seriously treat it
well, repair it, and travel on a better road. Why
else would the owner get off? Because the car can't
move anymore, so he's having a look.

5 T: 为什么车和人，他俩的想法会不一样呢？
主人是想着走这条路，车反而是想着对我好一点。他俩的想法为什么不一致？
Why do the car and owner think differently ?
The owner wants to travel on this road, but the
car wants to be treated better. Why are they not
thinking alike?

6 C: 这个主人可能不在乎这个车，它就是个工具，我想走，想干什么就干什么。而
车嘛，它觉得自己已经付出了很多，应该得到一些好的对待。
Maybe this owner does not care about the car. It's
just a tool, and I can go or do whatever I want.
As for the car, it thinks it has done a lot, and
deserves to be treated well.

7 T: 那他们总要到目的地，接下来他们怎样去？会想出什么样的办法？
So they still have to get to their destination. How will they go there now? What solution will they think of?

8 C: 那主人可能要让它好好修理一下，维修一下，好好对待它。然后车就是罢工就少一些，认真的为主人服务好。
The owner may get it fixed, serviced, and treat it well. And the car will go on strike less often, and serve the owner well.

The way in which the client elaborates the metaphorical feelings of the car and the car-owner relationship (lines 4, 6, 8) may at first glance resemble Kopp and Craw's (1998) client-centred approach of eliciting and elaborating client metaphors (cf. Step 3 of their protocol). However, while Kopp and Craw eschew direct therapist input, we see how this therapist contributes explicitly to the developing metaphorical scenario. In line 3, he suggests that the car is 'dirty', while in lines 5 and 7 he introduces his own interpretation that the car and owner are 'not thinking alike' and that they 'still have to get to their destination'. The client appears to respond positively to these interpretations as the metaphorical scenario develops with both their inputs. It should be noted that unlike many other situations of metaphor use, the intended target(s) and mappings involved in picture therapy are not immediately apparent to clients, who are merely told to use their imagination to describe the pictorial source in the first instance. Since therapists should have a clearer understanding of the intended target(s), it may indeed be prudent to provide substantial input and orientate the description of the source, to prepare for its eventual mapping back onto the target domain(s) of the client's life. Tay (2013) and Ferrara (1994) discussed other similar examples where metaphors are purposively co-constructed, and where metaphor authorship, use, and management cannot be satisfactorily attributed to either therapist or client alone.

While novel metaphors motivate or even necessitate collaborative input due to a lack of pre-existing consensus on their meanings, we can observe interactional qualities even in cases where highly conventional metaphors are used. In these cases, we may speak of a dynamic of *negotiation*, where conventional expressions and interpretations supposedly shared by speakers with the prerequisite common ground (Lakoff & Johnson, 1999) nevertheless undergo some form of reinterpretation. This may accompany evaluative nuances which bear implications for the therapist–client relationship. Consider the following short extracts, this time in the American context, which follow closely after one another within a single counselling session. The therapist and client appear to be facing some tension or breakdown in their collaborative relationship, that is, an ‘alliance rupture’ (Safran, Crocker, McMain, & Murray, 1990), which the therapist feels is partly brought about by the client’s tendency to giggle for unknown reasons. Readers are advised to go through all four extracts first for an overall understanding, before returning to the discussion under each one.

Extract 1

1. T: So you seem to be - do you get the feeling that we both feel kind of stuck?
2. C: Well I don’t know about you, but I do.
3. T: Uh huh. I do too. I think it would be fair to say that in some ways we are at an impasse.
4. C: [laughing] yeah.

In this extract, the therapist uses the metaphor of feeling ‘kind of stuck’ (line 1) and being ‘at an impasse’ (line 3) to describe their difficulty, which the client appears to understand and agree with (line 4). Both ‘stuck’ and ‘impasse’ reflect the conventional metaphorical conceptualisation of attaining a purpose as undertaking a physical journey (Lakoff & Johnson, 1999), where the process of attainment corresponds to the process of physical travel, and difficulties to physical obstacles. Tay (2011b) discusses how journey metaphors are common in therapeutic parlance, with ‘impasse’ in particular acquiring a terminological status (Leahy, 2008). There is little meaning negotiation so far, as both parties readily understand and accept the standard use of a metaphor to describe a problematic therapist–client relationship.

Extract 2

1. T: It is often when you giggle. Yes. And it’s tough. Because you are saying look at this, and I am saying look at this.
2. C: [laughing] you are probably right. I appreciate it. You are probably right.
3. T: Would you say that is a fair characterization of the impasse that we are in?
4. C: I said you are probably right.

Shortly afterwards, in Extract 2, the therapist begins to elaborate on the impasse metaphor. He identifies the client’s tendency to giggle (line 1) as a contributing factor to this impasse, and asks the client if this is a ‘fair characterization’ (line 3). This effectively invites the client to negotiate the interpretation of the conventional meaning of ‘impasse’, which we see unfold in the next extract.

Extract 3

1. C: Right. Well, what do you do at impasses anyway? I don't have a formula for an impasse. I do know that this is, I don't know if it is a problem or not, maybe but it is kind of interesting that you brought up an impasse which is theoretic logic or is a theoretical claim at the same time.
2. T: I think you are right but you know you are smiling again so I am wondering, are we back at the impasse and you are laughing, but I am wondering if we can stop and find out what that smiling is about.
3. C: I don't know, [name], this sucks. I don't know. I have been going all day today, what can I say, this feels like another meeting in some ways.

In Extract 3, we begin to see divergent understandings between therapist and client. While both seem to agree from the previous extract that the impasse is partly constituted by the giggling, the therapist is focused on finding a collaborative solution for what he frames as a 'we' problem (line 2), while the client does not seem to accept or follow this. The divergence is to become even clearer in the next extract.

Extract 4

1. T: So we are back to the impasse.
2. C: Well, it's a different impasse.
3. T: I don't think so.
4. C: It's your impasse. You are the one doing the theory now, not me. But maybe we should avoid it.

Here, the understanding of 'impasse' becomes fully divergent as a somewhat unfortunate outcome of the process of negotiating the meaning of a supposedly conventional metaphor. The client now disagrees entirely with what the term refers to (line 2), and by saying 'it's your impasse' (line 4), he specifically denies the therapist's interpretation that the impasse is shared. The metaphor has over the course of these extracts played both a conceptual role in framing the understanding of difficulty, as well as a means of expressing interpersonal notions such as therapeutic responsibility. The latter role in particular may precisely be facilitated by a prior consensus and subsequent contestation of the metaphor's conventional meaning.

The final aspect of *compromise* pertains not to specific metaphorical meanings, but to how therapist and client collaboratively adopt a measured stance towards the use of metaphor itself. This can often be observed from the use of what linguists call ‘hedges’, or devices which lessen the impact of an utterance. The following example shows how metaphors are hedged in a discussion between client and therapist on how the former perceives his husband.

Extract 5

1. C: You know...he told a story or something about the
husband who went out and cheated on his wife and
stuff.
2. T: Just sort of fed right into your fears that
husbands are really bad all the time anyway,
something like that.
3. C: Yeah, it just did something to the word.
4. T: It sounds like husband is really sort of a
tyranny for you, where you don’t get to
be yourself at all-do your thing. You
sort of get locked in this little box with somebody
else doing everything.
5. C: Yeah and I think so many people though have done
it to-done it to-I think a lot of-just TV has
done it and all these stories...Like even women’s
liberation is coming up with these things against
men that’s affecting them.
6. T: It really seems to you like it would take an
enormous amount of control and stuff to be able
to break out of that mold.
7. C: Yeah, something like that. It’s just-I don’t know

The therapist uses vivid metaphors such as ‘fed right into your fears’, ‘tyranny’, ‘locked in this little box’, and ‘break out of the mold’ (lines 2, 4, 6) to interpret how the client might be feeling towards her husband. In each instance, however, the metaphor is prefaced with hedges such as ‘sort of’, ‘sounds like’, and ‘seems to you like’, which implies that the therapist may be reluctant to ‘push (metaphoric) comparisons too far’ (Blenkiron, 2005, p. 56), seeking instead the client’s (dis)confirmation of these subjective and metaphorically framed interpretations. The client’s response is also hedged (line 7), suggesting an implicit and mutually arrived understanding that metaphors capture important aspects of the discussion, but cannot accurately represent the whole situation. Similar examples have been discussed elsewhere (Prince, Frader, & Bosk, 1982; Tay, 2014a) to illustrate how hedging helps make the assertions of healthcare professionals more plausible and less disputable. For the present purpose, hedging illustrates the important compromise between maximising the impact of vivid metaphors, and ensuring that their ultimately non-objective nature will be acceptable to clients. As with *co-construction* and *negotiation,* this is an inherently interactional process which only emerges upon careful discourse analytic scrutiny.

Clinical relevance summary

The middle-ground approach and its three discussed aspects translate into some practical pointers for therapists who work with metaphors. Most generally, therapists are encouraged to view metaphor not just as an instrument of intervention or a mirror of clients' thoughts but as a process and product grounded in the unfolding therapeutic interaction. The dynamics of co-construction, which often manifests when novel metaphors are introduced, reminds therapists to exercise a measure of flexibility even while adhering to principles and procedures of metaphor use which require either the therapist or client to assume main authorship. The dynamics of negotiation reminds therapists that even unremarkable, taken-for-granted metaphors can provide a meaningful platform to interrogate deep-seated assumptions, which may be especially pertinent for important yet seldom explicitly discussed aspects such as the therapist–client relationship. The dynamics of compromise reminds therapists that the import of metaphor extends to how metaphoricity itself is regarded and that it might be worthwhile to establish a common understanding about its limitations and usefulness. For a simple summary of the clinical implications, please see Table 28.3.

Summary

This chapter has shown how therapeutic research into metaphor use, which has tended to organise itself into familiar conceptual distinctions such as therapist- versus client-centredness, may be complemented with a 'middle-ground' approach which takes into account the complex interactional qualities of metaphor use in actual therapist–client talk. The three discussed aspects

Table 28.3 Clinical practice highlights

1. Metaphor is seldom exclusively therapist- or client centred, but is a collaborative process and product between therapists and clients.
2. Therapists and clients often jointly invest resources to co-construct metaphors.
3. Highly conventional metaphorical meanings can be negotiated to reveal new insights.
4. A holistic approach to metaphor use involves paying attention to how metaphoricity itself is regarded by therapists and clients.

of *co-construction*, *negotiation*, and *compromise* collectively demonstrate that metaphor use and management in psychotherapy is often not exclusively attributable to the authorship and intention of therapists or clients. The examples also showcased various contextual aspects such as the use of metaphor in different cultures, in seemingly effective and less effective therapist–patient interactions, in conventional and novel ways, and to perform conceptual as well as interpersonal functions. Finally, some clinically relevant pointers from the discussion were highlighted.

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29

Storytelling, Depression, and Psychotherapy

Peter Muntigl

Introduction

> *Disclosure is unequivocally at the core of therapy. Psychotherapy usually involves putting together a story that will explain and organize major life events causing distress.*
>
> (Pennebaker & Seagal, 1999, p. 1243)

The health benefits of having people tell stories about their distress and suffering have been recognised for some time in psychotherapy research. For persons with depression, their narratives have been shown to index difficulties at the levels of emotional processing and personal agency in distinctive ways (Angus & Greenberg, 2011; Vanheule & Hauser, 2008). The aim of this chapter is to show, using the methods of conversation analysis (CA), how clients with depression tell stories about their troubles and how, within an emotion-focused psychotherapeutic context, psychotherapists are able to empathically connect with the client's troubles. In performing a fine-grained analysis of how talk between therapists and clients sequentially unfolds, I show how certain therapist responses to the client's story may be more effective at facilitating mutual affiliation. In essence, I claim that by putting more empathy into their responses, therapists are able to facilitate more understanding and endorsement of their discursive intervention.

Storytelling: An interactional perspective

Telling stories serves many important functions in social life. Stories are a powerful resource for conveying to others 'what happened' and, therefore, for sharing experiences and constructing affiliative bonds with others. It was Bruner (1986) who pointed out that narrative offers a unique perspective on human thinking and conduct. Contrasting this with what he calls the *paradigmatic mode*, which is concerned with truth, verifiability, and cause–effect relations, Bruner argues that the *narrative mode* operates under different principles and assumptions. In Bruner's terms, stories reveal a landscape of consciousness that pertains to human intentions, the moral consequences of our actions, and to what we think, feel, and know. Stories, therefore, provide insight into personal experiences and human relationships, topics that are central to psychotherapeutic concerns.

Although stories are certainly based upon former events and thus provide a certain sequential order to our past experiences (Labov & Waletzky, 1967), the view put forward here emphasises the story's emergent character. From this perspective, storytelling in face-to-face contexts is an interactional achievement in which a teller and recipient (or recipient*s*) work together to co-construct narrative events (Mandelbaum, 2013). As Schegloff (1997) has emphasised, tellers not only design their story events with respect to a certain audience, the recipients of the story also perform actions during the telling, which can shape the trajectory of the telling moment by moment.

Narratives are also used to convey a certain kind of *stance*, in which tellers imbue personal events with attitudes and evaluative meaning (Jaffe, 2009; Stivers, 2008). Stances may perform a variety of discursive functions. First, they may perform identity work, by positioning 'story characters' in terms of social categories that index varying degrees of agency (Bamberg, 2012; Hamilton, 1998; Schiffrin, 1996). Second, stance resources – such as evaluative lexis, reported speech, and prosody – provide recipients with access to how the teller thought or felt about what happened (Günthner, 1997; Tannen, 1986, 2007). And third, stances provide opportunities for recipients to empathise or affiliate with the teller's viewpoint (Stivers, 2008).

Narrative-informed psychotherapy research on depression

Narrative studies seem to be increasingly informing psychotherapy theory and practice. Thus, it is not only therapies with a social constructionist leaning that have incorporated the 'narrative turn', but rather a whole range of psychodynamic, experiential, and person-centred approaches as well (see Angus & McLeod, 2004). Emotion-focused therapy (EFT) is one approach that has been drawing extensively from narrative analysis and theory (Greenberg, 2002, 2010). EFT is a distinctive approach that combines elements of client-centred therapy (Rogers, 1951) and Gestalt therapy (Perls, Hefferline, & Goodman, 1951). Whereas the client-centred aspect of EFT stresses the therapist's goal of 'following' the client by displaying empathy and privileging the client's experience, the Gestalt aspect constitutes a more directive therapy style in which clients are guided into various forms of therapeutic activities. As the name suggests, EFT views client emotions as a starting point for engaging in therapeutic work. EFT is also one of the recognised evidence-based treatments for clinical depression. In fact, studies have shown that EFT can be more effective at reducing depression than client-centred or cognitive behavioural approaches (Greenberg, 2010).

Depression is a mental health disorder that significantly impinges on a person's affective state for extended durations. The fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychological Association, 1994), for example, associates this illness with depressed mood, loss of pleasure, feelings of worthlessness, or guilt and thoughts of death. Psychotherapy and cognitive science researchers have recently shown that people who suffer from depression have difficulty disclosing narratives that involve specific details of their life circumstances. In particular, these individuals are found to produce an abundance of *over-general* autobiographical narratives. Over-general narratives have also been related to a range of deficits associated with impaired problem solving, problems in imagining future events and delayed recovery from episodes of affective disorders (Williams et al., 2007).

Recent work in EFT research on depression has begun to explore and shed light on the interrelationship between emotion processes and narrative organisation (Angus & Greenberg, 2011). It is claimed that over-general narratives of depressed clients contain 'minimal' emotional content or that these narratives are constructed in terms of maladaptive emotional schemes. Client stories have thus been characterised with respect to 'problem markers', especially how clients' emotional experience is negatively influenced. It has been found that clients with depression often produce three story types: *same old story*, *empty story*, and *broken life story* (Angus & Greenberg, 2011). Whereas the 'same old story' corresponds to over-general descriptions of interpersonal and behavioural thought patterns or emotional states accompanied by a sense of stuckness, the 'empty story' coincides with the teller's attention focused on external events and a lack of self-focus. 'Broken stories', by contrast, contain conflicting emotional plotlines and are marked by confusion and uncertainty. All three stories, however, seem to share low personal agency and contain expressions of helplessness.

Affectual themes involving feelings of helplessness and hopelessness were also identified in Vanheule and Hauser's (2008) study of clinical interviews with 40 psychiatrically hospitalised adolescents diagnosed with depression. They argued that helplessness can be described in either of two ways: as not being able to grasp what is going on or not being able to manage the situation or, in affective terms, as persons experiencing mild-to-severe despair and/or embarrassment. Based on the analysis of these interviews, these researchers also identified three different narrative themes associated with helplessness: (1) the unbearable riddle of the other; (2) the unbearable emptiness of being; and (3) the unbearable experience of failure. The first narrative theme was most prevalent and refers to instances in which the narrator links the experience of helplessness to unexpected and disturbing encounters with others. In these encounters, a significant other performs a moral transgression, one that creates a stress or strain in the relationship, and further, no plausible account can be given for the other's transgression.

Towards an interactional view of narrative in psychotherapy: Next steps

The work accomplished so far within a narrative-informed EFT treatment of depression has shed important light on 'problem markers' associated with depression (i.e. helplessness, low personal agency, confusion, uncertainty) and the story types that typically contain these markers. What has not been examined so far, however, is the important issue of how such narratives are embedded within the unfolding interaction between therapist and client, or how clients may draw from a range of interactional resources to build up an – at times, quite elaborate – affectual stance. I propose, therefore, that in order to achieve a better understanding of how storytelling relates to the communication of emotional experience in depressed clients, it is necessary to examine these narratives within their emergent context of production. Rather than focusing solely on de-contextualised instances of clauses that contain 'problem markers', attention should be given to (1) narrative *co*-construction and how both client and therapist work at shaping the unfolding story; (2) the discursive practices through which clients perform affectual stance work; and (3) how therapists work to affiliate with the client's story and, further, get clients to recognise and work through their affect-laden experiences of helplessness and low agency.

Project overview

The research upon which this chapter is based is part of a larger project on 'client depression and psychotherapeutic interaction' funded by the Social Sciences and Humanities Research Council of Canada (410-2009-0549).[1] The data for this research consist of 60 video-taped one-hour sessions of EFT and client-centred therapy taken from archival material that was collected for the York I Depression Study (Greenberg & Watson, 1998). Drawing from this data, we have so far examined how disaffiliation is managed within formulation sequences (Muntigl & Horvath, 2014; Muntigl, Knight, & Watkins, 2012; Muntigl, Knight, Watkins, Horvath, & Angus, 2013), how therapists display empathy with clients (Muntigl, Knight, & Watkins, 2014), and how therapists display affiliation with client-complaint stories (Muntigl, Knight, & Angus, 2014).

For this study on storytelling, we selected 15 sessions in total from 5 different cases (3 sessions/cases). All five therapists and clients were female. The mode of practice for each of the female therapists was EFT. Verbal and nonverbal portions of the videos were transcribed and analysed using the methods of CA (see Lester & O'Reilly, Chapter 1, this volume). Instances of storytelling – and the affectual stances communicated during the telling – were also identified using CA methods (see Mandelbaum, 2013; Stivers, 2008). One hundred and five instances of client storytelling were identified from the transcripts. Each of the stories indexed two different forms of *troubles talk* (Jefferson, 1988): complaint stories (Drew, 1998; Günthner, 1997) or negative appraisals of self. Particular focus was also placed on

- how therapists responded to the troubles-telling and the degree to which these responses indexed affiliation;
- the client's subsequent response: Did the client endorse or reject the therapist's talk?

Affiliative responses were identified using the criteria outlined in Stivers (2008) and Stivers, Mondada, and Steensig (2011). In general, these are prosocial actions that (a) match or endorse the affectual stance conveyed in the telling and (b) are 'preferred' in structure, often expressing agreement and/or empathy. As noted in Stivers (2008), affiliative responses often occur in mid-telling through nods and at story completion in the form of an explicit verbal response.

Our reason for examining the two-part sequence 'therapist response to story' + 'client response to therapist' was oriented to practice: *whether certain therapist responses were more effective than others at securing affiliation from clients*.

Findings

We present two sets of relevant findings that have emerged from this study. The first pertains to how clients tended to present themselves with respect to a certain 'trouble' and the second concerns the relationship between the therapist's response type and the client's subsequent (affiliative vs. disaffiliative) action.

Client stance and presentation of self

Beginning with the first point, it was found that clients tended to position themselves in specific ways with regard to the troubling event. First, clients would not overtly express how the trouble impacted them emotionally; that is, whether the trouble caused them to be sad, angry, disappointed, and so on. Second, although it was implied that the 'trouble' had some effect on them and on their lives, clients did not position themselves as responding to the troubling event or as confronting the person who is responsible for the trouble. In this way, clients often expressed a lack of agency, implicating that they have no control over what has happened. Third, clients would often convey surprise, shock, or incredulity at the misconduct perpetrated against them. The implication here is that clients are not able to grasp the motives of the other or of the general event that they have taken part in.

Three types of therapist responses

As mentioned above, client expressions that indicate how the troubling event had affected them emotionally are generally absent. In these contexts, it was found that emotion-focused therapists would respond to the client's telling by drawing attention to what the client felt. We identified three 'core' types of therapist responses that targeted the client's tacit feelings and emotions: *eliciting*, *naming*, or *illustrating* the emotional impact of story events on the client – an explicit overview of these response types are provided in Muntigl et al. (2014). First, we claimed that each of the response types indexed varying degrees of affiliative strength, with eliciting responses displaying the least and illustrating responses the most affiliation. Furthermore, the affiliative strength of each response type could be augmented with a prefacing *formulation* that provided the gist of the client's trouble (see Antaki, Barnes, & Leudar, 2005). What we also noted from our corpora was that the relative affiliative 'strength' of the therapist's response seemed to be matched by the client in her subsequent turn; that is, therapist responses that were lower in affiliation (such as 'bare' elicitations) were often rejected or ignored by clients, whereas responses higher in affiliation (such as illustrations) were often endorsed by clients. Thus, our claim is that the more empathic work that the therapist does in her response, the more mutual affiliation and endorsement will be subsequently displayed by clients.

In the following subsections, three storytelling extracts will be presented to illustrate the following:

1. client displays of low personal agency/inexplicit emotional response in relation to story events;
2. how therapist response types index varying affiliative strengths; and
3. how therapist response type relates to the client's subsequent uptake.

Eliciting emotional impact: Low affiliation

Eliciting responses are designed to get clients to name how they were affected emotionally. Although they most often occurred in *wh-interrogative* format ('what did you feel?'; 'how did it end up leaving you feeling'), they were also sometimes designed as incomplete clauses or *designedly incomplete utterances*

(DIUs; see Koshik, 2002), allowing the client to furnish the ‘missing’ material and provide the emotion (‘so you just felt…’). An example of an eliciting response is given in Extract 1. The client Sofia had been recounting an episode in which she and her husband were visiting Sofia’s niece at her home. Both Sofia and her husband decide to go outside to smoke a cigarette, but rather than remain outside with Sofia to appreciate the beautiful night, the husband immediately wants to return inside because he is cold.

Extract 1

```
 1  Sofia:  den I fell like smoking, ((sniffs)) my niece house is not a
 2          smoking house.
 3   Ther:  [°uh huh,°]
 4  Sofia:  [so:      ]I s-I asked him. lehs- can we go for a walk so I
 5          can ↑smoke and he want to smoke too. .hhh ((sniffs)) so
 6          >he say ok lets go out< for a ↑cigarette so we started
 7          walking an (.) Saturday night. (0.5) ih was
 8          BE::AU:::dee:ful night. e:::xcelle:nt.
 9   Ther:  [mm hm,]
10  Sofia:  [.hhh  ] ((sniffs)) and I:: ↑love walking
11          (0.3)
12   Ther:  so here you are >in these really< pre::tty (.) kind’ve
13          [surrounding.]
14  Sofia:  [admo      ph]e:::re,
15          (0.4)
16   Ther:  uh huh,
17  Sofia:  AND thew moo:n was a ↑foo:::ll moo:::n, the stahs were
18          cle::ar,=the was no one cloud.=
19   Ther:  =yea::h?
20          (0.6)
21  Sofia:  ((clicks tongue)) an I said lehs go WAlk for a- for a >lil
22          longer,<
23          (0.8)
24  Sofia:  an he walked for about (0.3) ↑tree minutes an den. I’m
25          co:ld. (0.5) [I’m co:l=le]hs go back. [an I said] .hhh how
26   Ther:               [°uh    huh,°]            [.hhh     ]
27  Sofia:  can-it wasn’t ↑co::l=it wasn’t ↓really ↑co::ld
28   Ther:  so he says (0.2) I’m co:ld and you jus fee::l li::ke
29          (1.3)
30   Ther:  ↓hm:: what,
31          (0.4)
32   Ther:  °disappointe::d, or°
```

```
33  Sofia:  th-anader b-anader wa-anather-ana::ther .hhh wa:::y? (.)
34          that he i::s? (0.3) that stops me: (.) from having fun.
35          (.) [with] him.
36   Ther:     [.hhh]
37          (0.2)
38   Ther:  oh so a[gain   ju:st   just   da:::shed.] o:::r:::.=
39  Sofia:         [for esample he doesn't he ha::tes]
40  Sofia:  =he hates: walking,
41          (0.4)
42   Ther:  mm hm,
43  Sofia:  hates walking, .hhh (0.2) an hates (.) co:ld.
```

At the beginning of the extract in lines 8, 10, 17–18, Sofia draws from evaluative lexis to depict the evening as something to be appreciated (‘BE::AU:::dee:ful night. e:::xcelle:nt’; ‘↑love walking’; ‘↑foo:::ll moo:::n’; ‘stahs were cle::ar’; ‘no one cloud’). This categorisation of the scene makes the strong implication that anyone who enters such a scene would be compelled to take the time to appreciate and enjoy these surroundings. Later on in the extract in lines 21–27, however, Sofia delivers her complaint by recounting how her husband does not seem to take notice of his surroundings and seems more concerned about returning inside because he is cold. Sofia’s direct reported speech in which she verbalises her husband’s account (‘I’m co:ld. (0.5) I’m co:l=le]hs go back.’) is left without explicit comment or evaluation, thus implying that the husband’s action is a transparent instance of a misconduct (see also Drew, 1998). By formulating her complaint in this manner, Sofia presents herself in a specific way: first, she is portrayed as the victim of the husband’s misconduct; and, second, she does not display an emotional reaction to what the husband had done. Thus, her use of language indexes low agency (i.e. the husband acted against her interests, but she did not attempt to counteract his misconduct) and low emotional involvement (i.e. she does not explicitly convey how she may have felt in that situation).

In line 28, the therapist attempts to elicit the emotional impact brought about by the husband’s statement that he is cold (‘so he says (0.2) I’m co:ld and you jus fee::l li::ke’). What this response does is orient directly to the therapist’s emotion-focused aim of getting Sofia to reflect on her feelings (Greenberg, 2010). But on the other hand, the elicitation seems to challenge the ‘completeness’ of the client’s narrative, thus creating an implication that there is more to the client’s story than was said. It also does not remain focused so much on what the husband did, but rather turns the focus more on Sofia. Thus, by not endorsing Sofia’s project of complaining about the husband, the therapist's elicitation does not affiliate with Sofia's affectual treatment of the story events.

The ensuing conversation is marked by further disaffiliation. Sofia, in line 29, does not immediately respond, which produces a significant 1.3-second silence and which leads the therapist to make another elicitation attempt ('`↓hm:: what,`'). But, as a response from Sofia is still not forthcoming, the therapist then in line 32 names the emotion that Sofia may have felt ('`°disappointe::d, or°`'). Sofia, however, does not take up the therapist's attempts and instead remains focused on the husband's negative influence on her ('`stops me: (.) fron having fun`') and on his negative attributes ('`he hates: walking`'). Thus, the therapist's project of getting emotion talk underway has not been successfully realised.

Prefacing + eliciting emotional impact: Mid-affiliation

A different kind of sequence tends to unfold when therapists first do some affiliative work before launching into an elicitation that targets the emotional impact on the client. Most commonly, therapists would preface their elicitations with a formulation that summarises and displays an understanding of the client's complaint or trouble. Consider Extract 2, which involves a different client named Paula. At the heart of Paula's storytelling is a complaint about her current boyfriend's lack of communication towards her. Paula recounts a specific episode in which she observed her boyfriend easily conversing with others at a cafe and, further, that she seemed unable to approach him (see also Muntigl et al., 2014 for a detailed analysis of this extract).

Extract 2

```
 1  Paula:  ↑we:ll, I guess like one of the things is that. (4.3)
 2          uh:(hh) (0.6) this guy, (0.3) doesn't talk to me.
 3          (5.7)
 4  Paula:  u:h he doesn't, (0.7) want to talk about feelings? (0.8)
 5          u:m:, (1.1) or (.) uh- (0.2) about ↑too many things. (1.3)
 6          and what has happened in the pa- o::h. (.) °it's just (.)
                                         throws head back, looks up
 7          such a s::- uh (.) ridiculous story,°
 8          (1.3)
        P:  gazes forward
        T:  shallow double nod
 9  Paula:  and it's, (3.2) like I w- I didn't, (0.9) I don't f:eel
10          want to <take o:n like this:> (0.5) nurturing role, this
11          like I mother role of like- (1.4) tr:ying so hard like to:,
12          to make him: (0.3)talk or make him relax. (0.3) .hh and
```

13 what- (.) actually happened this afternoon is, (2.6) that I
14 w(h)alked around this ↑corner and here he is sitting like in
15 a group of people having obviously no problem talking to
16 ↑them.
17 (0.3)
18 Ther: °h:m.°
slow double nod→
19 (2.8)
P: *blinks, mouth agape, holds palms up*
T: *nod*----->
20 Paula: and it's just like, (0.8)(h)h:old on a moment (.) here.
T: *shallow double nod*
21 (.) like- (0.3) it (0.3) uh(hh). (0.9)
smiles, circles hands in
T: *slow shallow nod*---------------->
22 Ther: somehow that really got to you:,
P: *shakes head*
23 (0.4)
24 Paula: y↑eah.
shallow nod
25 (0.4)
26 Ther: °that he has no problem talking to th↓em,°
27 (1.0)
28 Ther: .hh >so maybe before you thought well maybe this is just
29 the way he i:s< an- .hhh (.) somehow now you see him there
P: *fast shallow double nod*
30 totally comfortable.
31 (1.3)
P: *fast shallow multiple nods*
32 Ther: °and wha:t.°
33 (0.8)
34 Ther: what did that feel like? (.) somehow,
35 (1.0)
36 Paula: uh. well it's almost like with my father like. (.) he
looks away, multiple nods, flips palms up
37 never, (0.4) I hh (.)he never talked to me, he never, (.)we
shakes head
38 never had like- (2.2) an honest decent convers↓a:tion,
looks at T
T: *slow*
39 (1.3) with each other, >where I really could say< well this
T: *shallow......double nod*

40 is what I think and this is like how how I feel about it,
41 (1.0) and this is like the same way I feel:, (1.8) with
42 this gu:y? (0.7)

Paula's complaint story is structured in the following way: First, she conveys a critical stance in lines 2–5 not only by highlighting the boyfriend's failure to communicate with her ('doesn't talk to me') but also by depicting his lack of openness as *purposeful* ('he doesn't, (0.7) *want* to talk about feelings'). She then, in lines 13–16, provides an example that markedly contrasts with his usual behaviour towards her. While she was out walking, she inadvertently observed her boyfriend casually and easily talking to a group of people at a cafe. This contrast is made even more poignant through Paula's statements in which she juxtaposes her 'tr:ying so hard like to:, to make him: (0.3)talk or make him relax.' in lines 11–12 with him 'having obviously no problem talking to ↑them.' in lines 15–16. Thus, because the boyfriend apparently does not speak to her and because Paula goes to great efforts in trying to create a positive communicative environment, the observed scene in which the boyfriend is conversing freely with others may be seen as an offence or transgression.

Similar to Sofia's story in Extract 1, Paula also does not explicitly convey the emotional impact that the boyfriend's misconduct had on her, and nor does she position herself agentively, as someone who is able to confront the wrongdoer. Instead, following a continuer from the therapist in line 18 that is realised in 'soft voice' – and which may be working to resonate with and display empathy with the client's expressed affectual stance (Fitzgerald & Leudar, 2010) – Paula first conveys astonishment or shock non-verbally (*blinks, mouth agape, holds palms up*) and then verbally ('it's just like, (0.8) (h)h:old on a moment (.) here'). Thus, Paula not only seems unable to explicitly verbalise how she felt, but she also expresses a numbing inability to fully grasp the situation. In this way, Paula becomes immobilised and powerless to act.

Following Paula's telling, the therapist in this extract does not immediately attempt to elicit how Paula had felt, but instead begins her turn with a formulation that provides a general summary of Paula's astonishment ('somehow that really got to you:'). Then, in line 26, the therapist continues by specifying what may be troubling Paula ('°that he has no problem talking to th↓em,°') and then moves on to more explicitly point out Paula's potential worry; that is, his lack of desire to talk may have more to do with her than with his general character. It should be noted that while the therapist is delivering her formulation, Paula makes numerous affiliative displays both verbally through an upgraded confirmation (line 24) and non-verbally through a series of enthusiastic nods, thus displaying token affiliation with the import of what the therapist had said. Thus, the prior sequential context for the upcoming elicitation is largely affiliative: The therapist has worked empathically by displaying an elaborate understanding of Paula's dilemma, and Paula, in turn, affiliates with the therapist through a series of actions that endorse the therapist's understanding. In lines 32–34, the therapist then proceeds to elicit how Paula's experience of seeing her boyfriend as someone who can communicate, compared to her past experiences of him not communicating with her, may have impacted upon her emotionally ('°and wha:t.° (0.8) what did that feel like? (.) somehow,'). In this way, the therapist seems to be attempting to get Paula to consider something beyond her initially articulated emotional reaction of astonishment, such as, for example, feeling sadness or anger that he speaks easily with others but not with her.

The therapist's response in this extract is characterised as 'mid-affiliative' for the following reasons: First, the preceding formulation displays a specific understanding of Paula's distress that her boyfriend refrains from communicating with her. Thus, this response is more affiliative than a mere questioning elicitation of the emotional impact on the client. Second, the therapist's formulation only makes implicit references to Paula's feelings; that is, utterances such as 'somehow that really got to you:' and 'so maybe before you thought well maybe this is just the way he i:s< an- .hhh (.) somehow now you see him there totally comfortable.' only imply and do not explicitly state how Paula may have been feeling in that situation. We contend that a response in which the therapist would more directly specify and engage with how the client had felt would constitute a higher degree of affiliation. Third, the appended eliciting question provides an opportunity for Paula to provide the emotional impact. Although this is potentially an affiliating move, especially if Paula complies with the therapist's prompt, it may also work in the opposite direction by engendering *dis*affiliation if the client has difficulty in recognising and naming her emotions.

Paula's subsequent response in line 36 onwards does work to engage with the therapist's prior turn by pointing to similarities between the boyfriend's and the father's behaviour; that is, both have a tendency to not communicate with her. But we would also note that by making comparisons with her father, Paula seems to be skirting the issue of the direct emotional impact that these kinds of actions have on her and therefore places the focus of talk slightly away from her and onto the significant others being targeted in her complaints. Thus, although Paula displays more affiliation than Sofia did in Extract 1, it would still appear that the therapist's goal of getting Paula to identify how the boyfriend's behaviour makes her feel has not been fully realised.

Illustrating emotional impact: High affiliation

The other therapist practices identified from our data that were used to draw attention to the story event's emotional impact were *naming* and *illustrating*. Whereas naming practices provided a specific emotion term (e.g. '`so you were just feeling pre:::tty:: frustra:te:d`"; "`you felt really. (.) ashamed of it`'), illustrations provided vivid or metaphorical descriptions of how the client may have felt and were thus ranked higher than 'naming' with regard to their degree of affiliation. An example of an illustrating response is given in Extract 3. The general context involves a troubles-telling from the client Sofia in which she complains that her laugh has changed since she became married.

Extract 3

1 Sofia: .hhh ((sniffs)) before I married him.
2 (0.4)
3 Ther: yeah.
4 (1.2)
5 Sofia: at work. (0.5) I used to ↓be (0.8) known. (0.7) b(h)y my
6 laugh. (0.6) .hhh when I was laughing? (1.0)
7 people will? (2.7) ((clicks tongue)) .hhh wi:ll (1.0)
8 ((sniffs)) (1.3) pass by, .hhh ((sniffs)) an come back
9 an say I heard Sofia laughing.
10 Ther: (h)hhh .hhh
laughing
11 Sofia: an now. I miss Sofia laughing, ((sniffs)) (0.4) an like my
12 laugh was- everybody said it was contagious?
13 Ther: hhh
multiple nods
14 Sofia: .hhh
15 Ther: mm hm,
16 Sofia: ah one ↓time (0.9) ((swallows)) after I got married an I
17 was married for about three (0.9) I was married for one
18 hhh (0.9)↑NO .hhh not even a year. ((sniffs)) (0.9) an the-
19 the girls told me:, (0.8) that my laugh had changed.
20 (1.1)
T: *nod*
21 Ther: mm [hm,]
22 Sofia: [that] they did not he:ar me laughin anymore that much?
23 Ther: mm hm,
24 Sofia: an my my (0.4) tone of voice. an my: laugh was different
25 (0.6)

```
26  Sofia:  [.hhh that was ((sniffs))]
27   Ther:  [so someho:w you ended   ] up (1.2) putti:ng something of
28          yourself asi:de.
29          (       2.2       )
        S:  looks at T. looks up
30  Sofia:  yea:h?
            slow multiple nods, looks at T
31          (1.8)
        S:  slow multiple nods
32   Ther:  it's like .hhh [you're dampening yourself.]
33  Sofia:                 [even my mo:ther      tells] my mother tells
34          me that my personality ((blows nose)) that my personality
35          has changed a lot.
36   Ther:  feels li:ke you've- there's something of yourself missing?
37          or you've ha- you've tucked it all ↑awa:y.
38  Sofia:  it changed. in a way? it changed.
            shakes head, shrugs;     looks at T
        T:                                    double nod
39          (0.4)
40   Ther:  changed yeah. but sort of like .hhh ho:w. what- what
41          happened. some- some[thing Sofia  ] got
42  Sofia:                      [what ha:ppen?]
43   Ther:  .hhh (0.4) this is some of the feeling
44  Sofia:  ((sniffs)) [what happen?  ]
45   Ther:             [sadness right?] sadness at [something] that you
46  Sofia:                                         [yeap,    ]
47   Ther:  lo:st.
48          (3.3)
49  Sofia:  ((sniffs)) (0.5) ((lip smack)) I don know wha happen with
50          the=other Sofia=probably is ↑repressed all the time.
51   Ther:  mm hm. (1.2) always (1.5) pulling (0.4) yourself in or.
            double nod
52          (2.0)
53   Ther:  putting your[self away or.]
54  Sofia:              [yeah. putt   ]in, .hhh he makes me put it an I
55          make- make myself.
56          (0.3)
57   Ther:  .hhh yeah.
```

Central to Sofia's telling is the juxtaposing of pre- versus post-marriage time frames. The pre-marriage phase is valued as highly positive: Sofia was known at work by her laugh; her laugh was contagious and people would make a point of mentioning that Sofia had laughed. The post-marriage phase, by contrast is negatively valued. In essence, her laugh had changed (i.e. less frequently, different tone of voice) and others missed her prior way of laughing. Sofia also emphasises the speed at which this change occurred: '`↑NO .hhh no̲t even a ye̲ar..`' This different laugh also implies profound differences in Sofia's personality. Whereas before marriage, she was happy and was even able to spread this emotion outwards to her social context, she now no longer laughs – or not in the same way – and this implies sadness and dissatisfaction. Note also that in Sofia's delivery of her telling, she frequently sniffs, thus making a vocal display of sadness. Housed within Sofia's troubles-telling is also a complaint. At one level, she is complaining that she is no longer her 'easy going' self, but at another level the complaint is directed at the marriage, and by implication the husband, as having caused her to become distressed.

Sofia's story indexes a lack of personal agency in which her change in character is brought about by something outside of herself (i.e. the marriage). Thus, helplessness seems to be a central component of this telling and, further, Sofia does not seem able to verbalise how this change affects her emotionally in the present. In lines 27–28, the therapist attends to the implicit emotional component of Sofia's telling by first addressing Sofia's change in character ('`so someho:w you ended up (1.2) putti:ng something of yourself asi:de.`') and later, in line 32, characterises Sofia's emotional state of sadness in metaphorical terms ('`it's like .hhh you're dampening yourself.`'). These two utterances are empathic, not only because they display the therapist's understanding of the client's trouble, but also because they remain close to the client's point of view that (a) her behaviour has changed and (b) her infrequent laughter references a depressed mood or *dampening*. The therapist does, however, initiate subtle transformations by placing Sofia in subject position ('*you* `ended up...`', '*you*`'re dampening` *yourself*') and thus as having agency over the personal events in her life.

Following the therapist's responses, Sofia expresses both acknowledgement and token affiliation through nodding (lines 30–31). Sofia, however, seems to remain on the topic of change, without explicitly acknowledging her own agency or identifying the emotional impact of this change (lines 33–38). The therapist then performs an interesting rhetorical move by first endorsing Sofia's persistent talk of change ('`changed yeah.`') and then attempting to elicit the emotion brought about by the change ('`but sort` `of like .hhh ho:w. what- what happened. some- something Sofia got .hhh (0.4) this is some of the feeling`'). What then ensues are two sequences displaying mutual affiliation. In the first, lines 45–50, Sofia ratifies her feelings of sadness and in the second, lines 51–57, Sofia endorses the therapist's claim that she is taking an active part in this change process. To conclude, the illustrating response seemed to foster affiliation from Sofia and, further, seemed to set the stage for further affiliative work in which Sofia was able to recognise the role of her emotions and agency in her marital experiences.

Clinical relevance summary

The focus of this study was on client troubles-tellings, and most commonly on complaint stories in which the depressed client is portrayed as a victim of another's moral transgression. The findings are consistent with the general claim made in psychotherapy research that depressed clients portray themselves as helpless and as having low agency (Angus & Greenberg, 2011; Vanheule & Hauser, 2008). One of the contributions of this work was to show how they do that by drawing on certain discursive resources during storytelling. The findings presented here are restricted to the sequential context examined.

A broad recommendation that could be made for psychotherapeutic practitioners is that because displays of empathy are accomplished and influenced by the moment-by-moment progress of therapeutic interaction, therapists should closely monitor that progress and respond in accordance with its development. This kind of practice is well illustrated in Extract 3. At various places within the interaction, the therapist provides empathic responses (e.g. illustrating emotional impact, confirming/reflecting client talk, naming emotion) not only to endorse the client's experience of having changed, but also to push the conversation towards more elaborate talk about the emotional relevance of her experience.

Some of the more important findings for clinical practice can be shown in the analysis of the 'post-story' sequence; that is, the therapists' response to a client's story, followed by the client's response to the therapist. In brief, therapist responses that are low in affiliation (e.g. elicitations) are often rejected by clients, whereas responses that are more affiliative receive more endorsement. Furthermore, therapists who preface their responses with an empathic formulation tend to increase the chance of a subsequent affiliative uptake from clients. Thus, as a general principle, it would appear that the more empathy or affiliation therapists invest in their response, the more empathy/affiliation they get back. These potential benefits for clinical practice are summarised in Table 29.1.

Table 29.1 Clinical practice highlights

1. Therapist responses that are low in affiliation tend not to be endorsed by clients in next turn.
2. Therapist responses that are higher in affiliation tend to get strongly endorsed.
3. Preceding a response with a formulation increases degree of empathy and is likely to be affiliated with.
4. The more empathy or affiliation therapists invest in their response, the more empathy/affiliation they get back.

Table 29.2 Therapist response type, response affiliation, and subsequent client affiliation

Therapist response type	**Response affiliation**	**Subsequent client affiliation**	**Examples**
1. Eliciting	Low	Low	*so he says (0.2) I'm co:ld and you jus fee::l li::ke...*
2a. Formulation + eliciting 2b. Naming	Mid	Mid	*somehow that really got to you:,...°and wha:t.° (0.8) what did that feel like? (.) somehow,*
3a. Illustrating 3b. Formulation + naming 3c. Formulation + illustrating	High	High	*so someho:w you ended up (1.2) putti:ng something of yourself asi:de....it's like .hhh you're dampening yourself.*

Summary

By examining storytelling of depressed clients that focused on a certain trouble, it was shown that these stories were designed to convey helplessness and low personal agency. Furthermore, clients often did not identify how the trouble or a significant other's misconduct affected them emotionally. Emotion-focused therapists have different response options available to them for targeting the emotional impact of the story event on the client: eliciting, naming, or illustrating the client's feelings. These response types were claimed to differ in the degree to which they affiliate with the client's prior telling, with eliciting conveying the least and illustrating the most affiliation. Furthermore, the degree of affiliation of each response type could be augmented if prefaced by a formulation that displayed understanding or empathy with the client's trouble. Finally, it was argued that the degree of empathy of the client's subsequent response seemed to match the degree of empathy of the therapist's response type; thus, eliciting would garner disaffiliation, naming somewhat more affiliation (clients would sometimes disagree with the emotion term offered by the therapist) and illustrating the highest endorsement. The relationship between therapist response type, response affiliation, and subsequent client affiliation is shown in Table 29.2. Thus, it seems that the more empathy or affiliation emotion-focused therapists invest in their response, the more empathy/affiliation they get back from their clients.

Note

1. I am the principal investigator of this project, but I have had the immense privilege of having two excellent co-investigators, Adam Horvath (Simon Fraser University, Canada) and Lynne Angus (York University, Canada), who have contributed significantly to this research. Naomi Knight and Ashley Watkins, who have worked as research assistants in the early stages of this project, have also made substantial contributions to this work.

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30

Using Discourse Analysis to Develop Understanding of Suicide Risk Assessment

Ric Bowl and Andrew Reeves

Introduction

In the United Kingdom (UK), we live in a society in which we are now much more concerned than we once were about the risk of something undesirable – for example, injury, illness, and physical and sexual abuse – happening to someone (e.g. Fowlis et al., Chapter 9, this volume). An idea has also grown that all such risk should, and perhaps can, be prevented. This has had an impact on a wide range of aspects of national life from children's play to formal health and safety policies (Gill, 2007; Neuberger, 2009; Woodruff, 2005). It was reflected in the emphasis on public safety within government policy such as *Modernising Mental Health Services: safe, sound and supportive* (Department of Health, 1998). Death is seen as the ultimate undesirable outcome and arguably suicide as its most undesirable cause. So much so that it has had its own policy strand – National Suicide Prevention Strategies that focus on reducing the prevalence of suicide and which stress it to be a concern that straddles organisational responsibilities and boundaries (e.g. Department of Health, 2002, 2012, 2014; Scottish Government, 2013).

Despite the emphasis on suicide prevention as an interdepartmental concern, it has become a particular focus for professionals working within or around mental health services. It is often a significant element of what psychiatrists and other professionals must consider when planning admission to or discharge from hospital, and it has been of particular concern to psychiatrists and Approved Mental Health Professionals when considering whether or not service users should be compulsorily detained.

While they are not always placed within mainstream mental health services, suicide is also a significant concern for counsellors. Granello (2010) highlights not only that encountering a suicidal client is a relatively common experience for counsellors but that, if suicide occurs, it can be profoundly disturbing.

Within this chapter, it is our intention to first look more closely at the clinical role of risk assessment – for mental health professionals and for counsellors. Then we examine the context in which discourse analysis can enhance and augment existing research and provide guidance on enhancing our clinical practice. This is followed by a detailed example of how discourse analysis has helped explore how counsellors work with risk and then consideration of how it might contribute to future research on suicide risk assessment.

Clinical relevance

Keeping people safe and enhancing their well-being and safety are among the explicit goals of most organisations working with mental health. In consequence, assessment of risk – including the risk of suicide – is an important feature of the work of a range of mental health professionals. This is driven in part by professional role. While not in their exclusive domain, Bowl (2009) has, for example, identified risk assessment as a key element of a mental health social worker's role and argues also that they have significant experience of it. Indeed, in the Scottish Executive's review of the future of social work (Scottish Executive, 2006), risk assessment was identified as intrinsic to the work of all social workers.

In addition to the exhortation of policies such as the Suicide Prevention Strategies, another driver for risk assessment is primary legislation – deciding whether someone meets the criteria for compulsory detention within the Mental Health Act 1983, for example, requires an explicit assessment by Approved Mental Health Professionals and Psychiatrists of the implications for the health and safety of the individual being assessed. Hewitt (2013), in examining the unresolved controversy over whether or not suicide can be a rational act, also highlighted a propensity within mainstream psychiatry to see suicidal feelings as a symptom – a consequence of mental illness – and that, therefore, identifying a suicide risk and taking action to prevent suicide as a consequence follows naturally from a treatment imperative.

Finally, there is public scrutiny through the medium of inspection and public inquiries and ultimately within the legal system – for example, the Supreme Court's 2012 ruling on the case of Melanie Rabone, who was a voluntary patient in a psychiatric hospital and who hanged herself after being given leave (Callaghan, Ryan, & Kerridge, 2013). The Trust was found to have breached her right to life under Article 2 of the European Convention by not taking appropriate steps to protect her. Decisions like these serve to reinforce – even extend – organisational responsibility for the management of risks to those for whom they have a responsibility. Organisational accountability is in turn another driver for risk assessment.

Risk assessment in counselling and psychotherapy

Counsellors and psychotherapists, regardless of working context, are generally required by virtue of professional and ethical guidance to act to safeguard their client's well-being, including when at risk of suicide. This includes therapists working independently, although a small number of third sector organisations have decided at a policy level to respect the client's confidentiality in the event of suicide potential. The level and extent of training to help therapists work effectively in response to risk is uncertain and generally under-researched. However, some indications suggest that therapists are generally poorly prepared by their core training experiences to use core knowledge and skills effectively in response to suicide risk (Reeves, Wheeler, & Bowl, 2004b). This places challenges upon therapists who often see clients with complex mental health problems and who, as a professional group, are not always as embedded in mainstream services as other professionals. For example, mental health services have been populated by social workers, nurses, psychologists, and psychiatrists for many years, and yet it is a relatively recent phenomenon for therapists to routinely work alongside these other groups.

As such, counselling and psychotherapy at a professional level, and counsellors and psychotherapists at a practice level, are in the process of negotiating their own position and working practices to ensure they are suitably and appropriately aligned to wider protocols. In the context of working with suicide risk, this involves ensuring confidentiality agreements with clients remaining respectful of client autonomy while, at the same time, meeting professional, procedural, policy, and ethical expectations of good practice.

The use of discourse analysis in understanding risk assessment

A quantitative research industry has developed, which attempts to identify factors that increase the risk of undesirable outcomes, particularly suicide, and maybe even uses these factors to predict its likelihood and thus identify prevention strategies that can be adopted to reduce the number of suicides.

The approaches to risk assessment and prediction arising from this research have taken two broad forms. First is the idea that the risk of suicide can be assessed as actuarial risk – in a similar way to how car insurance premiums are calculated. That is that a profile can be taken of an individual's characteristics, which are then measured against known vulnerabilities to suicide. For example, young and middle-aged men, psychiatric in-patients, people in the criminal justice system, medical professionals, and farmers have all been identified as high-risk groups (Department of Health, 2012). However, whatever their success at predicting broad trends within groups of the population, they have been of relatively little use in helping identify which particular individual within a vulnerable group is most at risk of taking their own life. Moreover, the knowledge that among the groups most likely to commit suicide are young men or farmers does not help us predict the likelihood of an older woman service user or client taking her own life. Nonetheless, statistical evidence of links between particular experiences and suicide should not be dismissed out of hand – it is useful to know that the experience of childhood sexual abuse heightens the lifetime risk of suicide (McIntyre et al., 2008) as this is something we can look to explore in working with the individuals before us.

Risk assessment protocols and procedures within mental health services, however, are rarely based upon an actuarial approach alone. They are likely to be augmented by structured professional judgement – that is the judgement about levels of risk made by experienced professionals based upon knowledge of the broad socio-demographic indicators, warning signs and protective factors, and their own knowledge of the service user. Warning signs might include having a coherent practical plan to carry out, having access to the means to do so, and disposing of valued possessions. Protective factors might include the support of close friends, value commitments, beliefs, and so on.

The limitations of clinical judgements about the likelihood of suicide can be illustrated by an example from the UK. Shergill and Szmukler (1998), in a large sample study in Camberwell, asked practitioners to identify whether service users within two sectors were at low, moderate, or severe risk of committing suicide within the following six months. They predicted 26% as at moderate or high risk – 81 people (with at least 16 at high risk). Yet the prevalence rate of suicide is much lower – over the previous three years, there had only been two completed suicides. Nor should we imagine that simple actuarial calculations would have done better, as the predictors in this study correlated highly with established actuarial predictors, and other research has also reinforced these to be of limited value in predicting suicides (Madsen, Agerbo, Mortensen, & Nordentoft, 2012; Madsen & Nordencroft, 2012). The question facing us, of course, if we are interested in prediction is which of the 81 will not just be at risk but will complete suicide. And therein lies the rub; the feared behaviour does not happen very often in the study population, whereas identified risk factors are common. The fundamental problem is that predicting low-frequency events such as suicide is almost impossible.

Qualitative research has offered us other avenues, and we now look at the contributions that discourse analysis has made to our understanding of counselling and in particular work with the risk of suicide. First, although discourse analysis is discussed more fully within earlier chapters, we would wish to recognise our view of it as encompassing a wide range of analytical techniques, not all of which are even described as discourse analysis by the authors whose work we review (see, Lester & O'Reilly, Chapter 1, this volume). They all, however, focus on the use of language, on how language helps define our role and identity, on how language both shapes and reflects cultural and social practice. Hodges, Kuper, and Reeves (2008) make a useful distinction between three forms of discourse analysis:

- Formal linguistic discourse analysis – involving a highly structured analysis of text (written or spoken) and looking at the structure of the text and analysing every word for meaning – aiming to find the underlying rules governing it as communication.
- Empirical discourse analysis – not examining the text or conversation in such detail but focusing on broader themes within it – trying to categorise elements of the language used identifying their specific character and purpose – and looking at how they shape the participants' social practices and interactions.
- Critical discourse analysis – which adds consideration of the institutional context and how discourses shape and limit what is possible for those institutions and for the people within them to think and say.

Each individual study, however, may draw on aspects of more than one approach. Interactions between physiotherapists and stroke patients have been criticised for being too 'expert-driven'. Talvitie and Pyoria (2006) provide an example of an empirical discourse analysis in their examination of counselling interactions between them – looking unsuccessfully for evidence of more broadly interactive or co-operative approaches. Strong, Busch, and Couture (2008) make an interesting argument for seeing conversational evidence from counselling interventions as providing useful feedback on therapeutic outcomes (usually outcomes are seen as best evaluated using measures external to the therapeutic process). Their work is interesting to us because, while this too might be seen as an example of empirical discourse analysis, they could also be seen as drawing on the other approaches – both looking closely at the significance of small elements of the dialogue and also placing their whole discussion in the context of the American Psychological Association's (APA's) limiting conception of evidence-based practice.

Similar approaches have been shown to enhance our understanding of suicide. Roen, Scourfield, and McDermott (2008) examine suicide among young people. In this field too, much of the research is quantitative and focuses on identifying risk factors. This research often links youth suicide with mental illness and/or individual difficulties in coping with development, yet the precise implications of this for prevention are not clear. Roen et al. argue for a different approach. Their research looked at the discourse of suicide among young people in general, and they argue that we need to understand this context if we are to usefully support young people who may be contemplating suicide.

Their findings highlight the complexity of understandings of suicide. Attempting it is as likely to be seen as a trend; part of the testing of the meaning of life as it is not coping with emotional stress that adolescence brings. The authors focus on the tension between the construction of suicide as a distinct imaginable and indeed almost ever-present possibility and the 'othering' of suicidal subjects – 'it's not something I would do'; 'that is not something that happens in normal families'. They also focus on a search for a rationale for youth suicide – because otherwise it threatens our ordered world – our certainties – if seen as irrational, chaotic, and so on. The rationales are largely common sense explanations – those permitted/enabled by the prevailing discourse. There is no room here for 'the chaos and irrationality of suicidal feelings and behaviours' (Roen et al., 2008, p. 2095). Relationships were also seen as an important factor – as a constraint (because of responsibility through relationship) or protective factor – or as a precipitating factor.

No simple recipe for intervention follows from this research. However, it does highlight that if we are to work meaningfully with a young client contemplating suicide, we should not be looking for simple indicators of levels of risk. We need to give them space to explore the complexities of their own feelings towards suicide and to be prepared to actively engage with those. This may help us as therapists to reach conclusions about the level of risk posed for particular individuals. However, that should not be the principal aim. Facilitating clients working through these complexities should rather be seen as one strategy that can lead to a reduction in the risk itself.

White and Morris (2010) are also interested in the prevention of youth suicide. Theirs is a case study of a school-based suicide prevention programme based upon observation of classroom interaction and interviews with community educators and students. They too identify the dominant discourses around youth suicide as seeing it as an individualist act with relatively simple cause and effect. They rather see suicide as a discursive event shaped by multiple historical and cultural factors – and just one component of a difficult passage in young people's lives when they are trying to make sense of their existence – conceptualising what a worthwhile life might be like. Theirs was a study of language use and how that language constructs the identity of 'at risk' suicidal youth. They also examined the complexity of the processes in which participants engaged. Like Roen et al. (2008), they found dominant constructions of risk to be deep rooted – so much so that other ways of thinking about it could be silenced within the programme. That dominant discourse identifies suicide as a sad, tragic, personal event often linked to depression and an inability to cope. A medical diagnosis of depression and a struggle to cope with stress are seen as key, and suicide emerges as an option when stress builds up and young people do not have the resources to deal with that. White and Morris (2010) identified two consequences of this. First, the dominance of this medicalised and individualistic focus diverts attention from broader externally constructed factors that may contribute to the hopelessness that may precipitate suicide – such as bullying and homophobia. Secondly, it leaves little room for other unstable, contingent understandings of suicide which participants expressed. They identified, for example, the contested nature of the knowledge base around how to intervene, the contradictions between the links to adolescent development and the feeling that this is not something that happens in stable families, and an overwhelming uncertainty about why people do kill themselves as all part of the complexity that made up their views of suicide. White and Morris argued that creating spaces within suicide prevention programmes for unpicking these different ways of conceptualising suicide is potentially a force for prevention – opening up consideration beyond the black-and-white thinking that may leave people feeling they have no choice. For us, their findings further reinforce our view that engaging clients in exploring the complexities of their feelings towards suicide is a more important concern than finding how well their characteristics match the actuarial indicators for vulnerability.

Another layer of understanding is offered by Owen et al. (2012), who identified how most people who kill themselves are not in touch with mental health services but they do tell someone directly or indirectly. Drawing on pragmatics – 'the study of meaning as communicated by a speaker . . . and interpreted by a listener' (Owen et al., 2012, p. 421) – they provide a microanalysis of the narratives provided by those at the receiving end of such 'Suicide Communication Events' – friends, relatives, colleagues, and some counsellors and GPs. Not perhaps surprisingly, given that only 1 in 200 of people who experience thoughts of suicide do kill themselves, the participants in the survey had found the 'Suicide Communication Events' difficult to interpret. They were not sure how seriously to take direct threats or plans to commit suicide; they struggled to interpret indirect references to suicide; and they did not penetrate the face-saving strategies sometimes adopted in communications with them by those who were later to kill themselves. The authors identify how this must have been particularly difficult for the laypeople, who formed the majority of participants, perhaps at least in part because they would have lacked knowledge and confidence about intervening. They also identify an ambivalence or reluctance to interrogate the talk about suicide further – which has parallels with what we found in our own research (Reeves, Bowl, Wheeler, & Guthrie, 2004a).

So where does this research take us? First, we think that it helps us to see that assessment of suicide is not just about prediction. Given the lack of evidence for the accuracy of prediction of suicide or of its value as a preventive strategy (Large & Nielssen, 2011; Wand, 2012), this may be a good thing! Wand (2012) even argued that a pre-occupation with risk assessment may actually increase the danger of harm. Certainly our conception of assessment of the risk of suicide is that it should be interactive and should seek to explore the client's (or service user's) understanding of suicide and so develop a platform for intervention. There is no need for intervention to be conceptualised as 'prevention' – but rather focus on working with what is causing them pain and supporting their process of recovery.

Discourse analysis: A practical example

If, therefore, risk assessment should be more about risk exploration – collaboratively and interactively seeking out the client's own sense of their risk and their relationship to it – we move to focus on the aspects of counselling and psychotherapy that might facilitate that endeavour. With that in mind, it is important to note that research over many decades has indicated the quality of the working alliance – the relationship – as the predominant factor in indicating good therapeutic outcome (Gaston, Thompson, Gallager, Cournoyer, & Gagnon, 1998; Hovarth & Bedi, 2002). How the relationship is shaped by external factors is of great importance to practitioners, whether that be through intrapersonal factors (transferential dynamics and personal history), interpersonal factors (difference, diversity, and wider demographics), or institutional factors (working policies and procedures and organisational culture).

Working with suicide risk in counselling and psychotherapy, therefore, is vulnerable to a range of aspects that might facilitate or hinder how a therapist responds to risk. Intrapersonally, the therapist may be very fearful of the likelihood of suicide, or may have their own experience of feeling suicidal, or of completed suicide in their family. Interpersonally, the therapist may be very aware of the presence of risk 'factors', as outlined earlier, but have insufficient information to make an informed decision as to the likelihood of suicide in that particular instance. Finally, institutionally, the therapist may well work to an organisational policy that places high expectations on the capacity to predict risk, which, as we have discussed earlier, is unlikely to be achievable.

Discourse analysis provided an invaluable opportunity to understand particular aspects of the therapeutic process in relation to suicide risk and consider, in some depth, how the nature of the discourse was constructed around suicide and the implications of that construction. The full details of the study have been reported elsewhere (Reeves et al., 2004a), but the primary aspects will be revisited here.

The method

The study, making use of an empirical discourse analysis approach, was specifically interested in several key aspects: how suicidal 'clients' talked about their suicidal feelings, how their counsellors responded specifically to this 'talk', and the implications for identification and prevention strategies around working with risk. At that time, a wider study was being undertaken to explore the efficacy of short-term training for therapists in Psychodynamic Interpersonal Therapy (PIT) (Guthrie et al., 2004), and learning was measured across three competency areas: the counsellor's ability to identify and respond to depressive symptoms, their capacity to work with somatised presentations, and identifying suicide risk.

The participants were initially 24 counsellors (17 female), with three dropping out of the study, leaving a final total of 21 counsellors. All were qualified and experienced practitioners. The discourse analysis made use of the transcribed versions of video-recorded sessions as part of this wider research that were generated pre-delivery of the PIT (so as to ensure the discourse reflected general practice, rather than post-training effect).

The outcome

An important outcome of this wider study was that the researchers noted improvements in competency for the participants in practice around working with depression and somatised presentations, but no change in competency around working with suicide risk. The authors noted, 'Our results suggest that counsellors may require more intensive training in the assessment of suicide risk before they should be expected to work with patients who threaten self-harm' (Guthrie et al., 2004, p. 161).

The discourse analysis focused on the feature of 'suicide' in naturally occurring dialogue and, as such, the discursive object for the analysis was 'suicidal', where both explicit references to suicide ('I want to kill myself', 'I wish I were dead', etc.) and implicit references ('I want to get out of everyone's way', 'I want to go to sleep and not wake up') were identified (Reeves et al., 2004a). What is noteworthy in the first stage of analysis, (i.e. how the clients talked about their suicidal thinking) was that explicit references to suicide were rare occurrences, with most clients talking about their suicidal thoughts from an implicit position through the use of metaphor or imagery. Table 30.1 illustrates some brief examples from the text.

Counsellor responses to the explicit and implicit references to suicide were then tracked and analysed. Table 30.2 illustrates some of the predominant counsellor responses at the point of client reference to suicide.

What became quickly apparent was that, regardless of the counsellor's theoretical orientation and training (psychodynamic, humanistic, cognitive–behavioural, etc.), almost all used predominantly reflective interactions in response to their client's disclosure of suicidal thinking. This included counsellors who might ordinarily have been expected to be more 'active' in their actions, such as cognitive–behavioural counsellors actively exploring the nature of suicidal thinking. Instead, all counsellors appeared to 'retreat' into a reflective position without instead moving to an explorative one; this dynamic occurred in all but one transcript. One outcome from the discourse analysis

Table 30.1 Client references to suicide

References to discursive object	**Example from transcript**
'Stopping/Stop it'	*'In a way, if I was on my own you know, I wouldn't be here – I would have stopped it. I would have stopped it'.*
'Too tired . . . '	*'Yeah. If I was on my own that's what I'd do now* (taken tablets) *cos I'm just too tired'.*
'There's nothing keeping me here . . . '	*'There's nothing keeping me here . . . so what's the point'*
'What's the point . . . ?'	*'It's useless, just a waste – there's no point'*
'Black/blackness'	*'It's just like . . . I dunno . . . just a black, blackness . . . '*
'Too heavy – to manage . . . '	*'It's heavy. I just . . . I know that my mum, I know she worries about me . . . I sometimes just think, well she'd be a lot better off if I wasn't around'.*
'Do myself in . . . '	*'Might get away – do myself in'.*
'Just too much . . . '	*' . . . it's too much now – just too much'.*
'Carrying on . . . '	*'There's no point in carrying on if this doesn't work'.*
'Feel really alone in it . . . '	*' . . . yeah. (pause . . . .). I just feel really alone in it'.*
'Way out'	*'It* (taking an overdose) *was the only way out . . . '*
'Going somewhere else . . . '	*'It's about going away from everything, and everything that is going on in your life and being somewhere else'.*
'Continuing with it'	*'I don't see the point in continuing that much longer to be honest if it's going to be the same . . . I don't see what reason to continue at all for any of it'.*
'Don't exist . . . '	*'It's kind of like there's nothing . . . there's a blank . . . it's almost like I don't exist – anyway'.*
'Empty and dead'	*'Yeah . . . I feel really empty and dead inside and . . . '*
'Don't belong in the life I live in . . . '	*'Yeah. Feel like I'm er . . . I don't belong anywhere in life'.*
'Can't move forward – really stuck'	*'It just feels like I'm stuck in it and it's gone on for ages and its going to go on for ages – there doesn't feel like there's any . . . any way out of it'.*

was the generation of three interpretive repertoires to attempt to provide some understanding of the clients' suicidal narratives, all of which were outlined as an intrapersonal phenomenon, but also contextualised through the context of therapy, such as institutional power and societal presumptions around suicide:

- Suicide as a mechanism of ending existential crisis
- Suicide as a mechanism of avoiding a feeling of being 'stuck' rather than dynamically engaged with life
- Suicide ends apathy and fatigue generated through the burdensome nature of life

Table 30.2 Predominant Counsellor Responses to Expressed Suicidal Thinking

Wonder how you're feeling about that...(I wonder if...) (I'm [just] wondering...)
I'm getting the impression...I guess that this is...(I guess there's...) (I guess you're...)
So, almost as if...
It sounds like...(So it's sounding like...) (It sounds as though...) (You sound a bit...)
It feels as though...(You're feeling that...)
Can you help me understand...
I can't help noticing...
So I think I'm hearing...(What I'm hearing is that...)
This is the sense that...(I am sensing that...) (I'm [almost] getting a sense that...) (I get a real sense that...) (I really get a sense that...)
Somehow though it seems...(So it seems that you're saying)
I could be wrong here but...I'm aware that...

Additionally, the study provided some important clues into the possible dynamics that might inform and shape the therapeutic discourse when suicidal thinking emerged:

- Clients were generally not asked about the detail of their suicidal thoughts, even though all had at least hinted at suicide as a possibility.
- Counsellors' preferred *modus operandi* of practice did not inform how they then responded to suicidal potential, with most therapists using reflective responses almost exclusively (perhaps due to fear and anxiety as outlined in the literature [Pompili, Manchinelli, & Tatarelli, 2002a, 2002b; Reeves & Mintz, 2001]).
- At the end of each assessment session, the counsellors did not know any more about the nature of their client's suicidal thoughts and, therefore, did not have any deeper understanding of the extent of risk (lack of risk assessment).
- The clients were potentially given an implicit message by their counsellors that suicide was not okay to talk about (closure of the discourse).
- The clients were not provided with an opportunity to understand their own suicidal process and thus be provided with opportunity to be supported to take steps to support themselves (lack of risk exploration).

As we have noted earlier, the response to risk in mental health services often focuses primarily on actuarial levels of risk, privileging evidence-based information about risk factors that describe general trends but are more difficult to apply to individual circumstance. Arguably one of the key tasks of counselling and psychotherapy is to provide clients with opportunities to enhance self-understanding and agency and, in doing so, help them re-position to a point of potential change (if change is possible). Likewise, in relation to suicide potential, it is not the therapist who will ultimately keep the client alive, but rather the client himself or herself. While a minority of clients may need the intervention of statutory services through the application of mental health legislation to support them through a crisis, the overwhelming majority of people need to be supported to support themselves.

The discourse analysis provided for an invaluable opportunity to witness how the anxiety and fear of working with suicide potential among mental health professionals, as outlined in previous research (Pompili et al., 2002a, 2002b; Reeves and Mintz, 2001), perhaps led to a form of discourse that potentially compounded the nature of silence that can exist around 'suicide-talk', while at the same time removed possibilities for suicide exploration. After all, a therapist who predominantly reflects the position of the client without challenge, empathy, or exploration runs the risk of being positioned similarly to the client: if the client feels existentially backed into a corner, the predominantly reflective counsellor is likely to end up there too.

The policy, procedural, philosophical, and personal context that shapes and influences the nature of work with people at risk of suicide, is so fundamentally important to practice. This research imperative has, to date, been largely overlooked, and while the predominance of quantitative research into suicide risk – the *who* of suicide potential – has certainly enhanced understanding, we are arguably reaching a saturation in our understanding of the *who* and, instead, need to focus on the *why*. While several qualitative methodologies can usefully contribute to that process, discourse analysis perhaps provides us with a particularly intimate insight into how suicide is talked about: how it features in the narrative of mental health and how clients and professionals alike can be liberated from the 'fear of getting it wrong' culture. The insights achieved through this study have informed developments in training strategies for counsellors and psychotherapists when working with clients at risk of suicide. These have included textbooks, articles, and the development of a one-day training workshop in addition to a training DVD (Reeves, 2010; Reeves, Wheeler, & Shears, 2010).

Discourse analysis: Future opportunities

In addition to the replication of the above study, both for counselling and psychotherapy, and also for other mental health professionals to further explore these particular questions, discourse analysis provides an important opportunity to develop new initiatives. There may be an opportunity for a philosophical shift from a potentially two-dimensional activity of risk assessment, through to more multidimensional process of risk exploration that demands an interactive and collaborative process to understanding suicidal potential. If mental health services truly wish to be person centred, patriarchal assumptions that 'clinician knows best' need to be dismantled and, in their place, replaced by approaches that privilege the experience of the client.

Discourse analysis provides a framework to achieve this through further exploration as to how people talk about their suicidal experience – an insight into the intrapersonal dynamics that shape that narrative – as well as the intrapersonal and interpersonal dynamics that shape the narrative of the clinician. Additionally, critical approaches to discourse would allow for the context of the institution to be incorporated, as well as systems of power, control, and the impact of difference. In many ways, working with suicide is about working with power; as suicide can be a very powerful act, its potential can be equally powerful too. The discourse of policy, procedures, and practice is informed by and, in turn, informs that process. Using discursive methods might help provide opportunity to understand that to a much greater degree than we do now.

Summary

This chapter has focused on the use of discourse analysis as a particular methodological approach in the specific context of working with suicide risk, with a particular example of its application in understanding the work of therapists with their suicidal clients. While the more general influence of discourse analysis has been discussed in other chapters, here we argue that the approach holds the potential to be used to challenge long-held assumptions about mental health, risk, and responsibility. How we conceptualise risk needs to move away from a binary understanding: that risk exists or it does not and, instead,

Table 30.3 Clinical practice highlights

1. Suicide risk assessment needs to be informed by the presence/absence of key risk and protective factors.
2. Risk and protective factors are insufficient in of themselves to fully inform an assessment of risk, but rather need to be seen as contextualising information for a discourse-based exploration of risk.
3. Clients may be reluctant to talk openly about their suicidal thoughts and will require an active and explorative approach.
4. Mental health practitioners may feel a number of difficult responses when faced with suicidal potential, including fear, anxiety, and a reluctance to talk openly about suicide with their client, instead taking a more reflective position in the discourse.
5. The shape, nature, and form of the discourse are crucial in working effectively with suicidal clients.

focus on the multilayered aspects of risk that arguably can only be reached through the process of communication, of which discourse is a significant part. We hope to have demonstrated, through an example of research, the power of discourse analysis to open doors on new perceptions and, in turn, new practices in mental health with people struggling at the very edge of their existence. For a simple summary of the practical implications, please see Table 30.3.

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31

Communicative Practices in Staff Support of Adults with Intellectual Disabilities

Charles Antaki, W. M. L. Finlay, Chris Walton, and Joe Sempik

Introduction

This chapter is about some of the ways in which adults with intellectual disabilities (such as, e.g. those with Down syndrome) communicate with those around them – most specifically, with staff who are charged with supporting them. Such staff help service users live independently, by overseeing their day-to-day household activities, arranging travel, planning leisure outings, and providing accompaniment to institutional appointments. In the United Kingdom (UK),[1] recent government policy places great value on the activities of support staff in the promotion of choice, control, and empowerment. The Care Act 2014 (UK Government, 2014) placed a duty on local authorities to promote an individual's well-being, which includes 'control by the individual over day-to-day life (including over care and support)' and 'participation in work, education, training or recreation'. In doing this, the authority must have regard for 'the individual's wishes, views, feelings or beliefs', with the individual 'participating as fully as possible in decisions . . . and being provided with the information and support necessary to enable the individual to participate'.

Efforts to promote participation and empowerment in support services for people with intellectual disabilities have taken many forms, including the development of self-advocacy groups, increasing the accessibility of information, direct payments and personal budgets, and the personalisation of support planning. Additionally there has been representation on committees and input into research (Williams et al., Chapter 4, this volume). The focus on assuming capacity to make decisions in these contexts is enshrined in the Mental Capacity Act 2005 (UK Government, 2005).

The difficulties of translating policy goals of listening to, and respecting, people's choices and preferences have been examined by many writers in the field (e.g. Beamer & Brookes, 2001; Edge, 2001; Harris, 2003; Jenkinson, Copeland, Drivas, Scoon, & Yap, 1992). The report *Improving the Life Chances of Disabled People* (Prime Minister's Strategy Unit, 2005) identified a 'culture of care and dependency' (p. 73) in health and social care services, in which those with 'significant cognitive and/or communication impairments are particularly at risk of being denied choice and control in their lives' (p. 78). This chapter discusses obstacles to the promotion of choice and control, drawing on examples from an ethnographic study of two different kind of agencies offering support to adults with intellectual disabilities, and offers suggestions as to how some of the communication problems they encounter might be overcome.

Interaction as central to empowerment and disempowerment

People with intellectual disabilities fall under the heading of 'disadvantaged', given their difficulties in finding employment and housing, living independently, and forming and sustaining relationships. The guidance in *Improving Services, Improving Lives* recognises that the interactions between 'disadvantaged people and frontline staff are crucial to how successful services are in meeting people's needs' (Social Exclusion Unit, 2005, p. 57). While this is true in general, it is particularly the case for those with multiple, complex support needs, who have often benefitted least from policy initiatives (HM Government, 2005; Learning Disability Task Force, 2004). The way in which we conceptualise empowerment here is in terms of what happens between people moment by moment, in the mundane details of everyday interaction. Power permeates everyday life; we see it in the way people talk to each other, in who chooses which lines to pursue and which to shut down, in who decides when a decision has or has not been made, in which options and consequences are presented for consideration, and in whether people make adjustments to allow each other to participate (Jenkinson et al., 1992). This is recognised in recent models of supported decision-making, which point out that for many people with intellectual disabilities, dynamic models of choice which acknowledge the role of sensitive supporters are the most appropriate (e.g. Beamer & Brooks, 2001; Edge, 2001; Harris, 2003).

It appears that the ways people talk and what they talk about when they interact with people with intellectual disabilities often simply reinforce inequalities and make it difficult for the less articulate speaker to assert themselves. This is even found in situations in which supporters are attempting to promote empowerment. The research that we will report here illustrates how power is a dominant feature of interactions between people with intellectual disabilities and those employed to support them, to such an extent that even in forums set up to provide opportunities for service users to speak out, subtle interactional dynamics may act to disempower them.

Project overview

In what follows, we shall illustrate our theme by reporting on a case study of two service facilities that we studied over a six-month period in the mid-2000s. In one, in a residence which we pseudonymise as 'Comber Hall Way', Chris Walton undertook a long series of visits, gradually getting to know the staff and the residents, gaining their trust, negotiating access, making ethnographic notes, and, eventually, recording what were to be about 30 hours of video. In the other case study, in a horticulture therapy centre offering activities to a range of clients ('GardenSpace'), Charles Antaki and Joe Sempik made about 20 hours of video recordings of interactions between therapists, clients, and volunteer helpers. From analysing the video records, three communicative issues stood out:

- how service users were involved in making choices and indicating preferences;
- how service users' engagement in even quite simple physical tasks afforded useful opportunities for meaningful social interaction; and
- how staff's questioning styles could either empower or disempower their clients' attempts to reflect on their experiences.

The way in which we accumulated evidence about these practices was to move around the research sites, shooting footage at appropriate moments, and capturing key encounters between staff and service users. These moments involved staff instructing the service users in daily activities (cooking, cleaning, washing up, etc.), asking them questions about their preferences (in such domains as menu items and leisure activities), and engaging them in educational conversations (e.g. about using appliances, what they had learned that day) and in general casual conversation.

Qualitative methodology: Conversation analysis

It is worth here explaining our chosen methodology. Because we wanted to see exactly how everyday interactions actually ran off, we preferred not to rely on retrospective interviews (with either staff or service users): the detail that interviews provide is limited, subject to demand characteristics and filtered through imperfect memory. Instead, we captured the action on tape and subjected it to the very close and painstaking methods of conversation analysis (CA). CA's strength is in approaching the recorded data with a range of analytical concepts to do with the organisation of talk (see, e.g. Sidnell, 2010, for a recent authoritative guide to its main principles and methods): how one utterance projects a certain kind of next utterance, how its internal design achieves a certain social action, and how an utterance can be marked as expected or unexpected, sufficient or insufficient, tentative or final, and so on. CA's sensitivity to the sequence of talk as the interaction unfolds arguably gives it an advantage over systems of content analysis which seek to identify given taxonomies of speech types (open vs. closed question, etc.).

In what follows, then, we shall not be reporting the outcome of a coding system, but rather analysing the details of the exchanges between residents and staff as they play out in real time. CA has been used to analyse interactions between service staff members in dealing with people with ID during activities (Finlay, Antaki, & Walton, 2008b): how people make choices (Antaki, Finlay, & Walton, 2008a), how they engage with staff questions (Antaki & Finlay, 2012), and how people with ID manage interactions with personal support workers whom they employ (Williams, 2010). The promise of CA is that it will contribute to the understanding of how each of these key areas of interaction is successfully accomplished – or, where it is deficient, it might be improved. In the research projects below, ethical approval was obtained from the University Ethics Committee of the first author's university, and informed consent, or assent where language deficiency precluded this, from each participant who appears in the data extract.

Making choices and indicating preferences

It was part of the 'mission statement' of the residential service that we studied ('Comber Hall Way') to offer the service users as much choice as was feasible in the day-to-day management of their affairs. Indeed, there was a good deal of such choice offering in the video records. However, not all of it was as empowering, as it might be. Based on work we report in more detail[2] in Antaki, Finlay, Walton, and Pate (2008), these were the main conversational vehicles that staff used:

(i) Closed (yes/no) questions
(ii) Open question + immediate single option
(iii) Open question + immediate multiple-option alternatives
(iv) Open question repaired to one-at-a-time alternatives
(v) Two-option simple alternative in one question

We will illustrate the more common of these with transcripts taken from a variety of interactions between adults and care workers, video recorded in their everyday settings – the kitchen, dining room, and living room of the house that was the adults' home.

(i) closed yes/no questions

Consider this yes/no exchange between Dave, a support worker, and Dominic, a service user (all names are pseudonymous, and any identifying detail has been changed; all participants gave informed consent, or assent, to the data being published in this form).

Extract 1. VD4 1.40. *Present?*

(Talk between other people round the table has been left out of this transcript)

```
 1      Dave   ((to Alec)) Party tomorrow night?
 2             [          (3.5)              ]
 3             [ ((Alec continues eating)) ]
 4      Dave   Alec.
 5                        (2.0)
 6      Dave   ((taps Alec on the hand, he turns)) Party t'morrow
 7             night, [(Brian Connolly)
 8      ?              [ (    )
 9                        (2.0)
10  →   Dave   we goin'ta buy him a present?
11             [          (4.0)                ]
12             [((Alec looks away from Dave)) ]
13  →   Dave   Are we buying him a present, yes or no.
14      Alec:  (    )
15                        (3.0)
16      Alec:  (    )
17      Dave   Yep.
```

Dave solicits Alec's choice of whether to go to a party, and whether to buy its host a present, by a simple closed question (line 10) – but even such apparently simple formats may not always succeed. We see Dave require Alec to repair his apparent non-response in a subsequent turn (line 13). Inspection of evidence from conversations between cognitively typical people shows that reissues of yes/no requests (among many other kinds of things that might misfire on first attempt) are common enough. However, what may be unusual, and institutional, is the call for repair when there is no obvious extrinsic reason for the misfiring. Is this really unusual? Questions are often reissued if someone doesn't hear or isn't attending surely?

(ii) Open question + understanding check

A commonly used practice was to present the resident with a simple open question (such as 'What would you like to do?' or 'Where do you want to go?') leaving space for an immediate answer. In principle, that is certainly consistent with a policy imperative to promote free choice. However, it was notable that if an answer did come, it was only infrequently accepted and recorded without further elaboration. This is a very different practice from that of survey interviewers, who are mandated to accept any properly formatted answer and move on (Houtkoop-Steenstra, 2000), but is not unknown in ordinary conversation. More common was for the staff to check the answer in a series of confirmatory questions – that is, questions which presented for confirmation a candidate answer (Pomerantz, 1988), which had some relation to the resident's spoken or mimed utterance. In the example below, staff member Kath is asking residents, in turn, about what leisure activities they would like to pursue.

Extract 2. VC-17; 07:31 minutes. *Horse-riding.*

1 → Kath: *((turns to Vic))* What about you Vic.
2 Vic: *((makes gesture with both hands, nods at Kath))*
3 → Kath: [You want [ho:rse-riding]
4 [*((nods head once))*]
5 Vic: [*((nods at Kath, makes sign again))*]
6 Kath ((to other staff member, writing)) he wants
7 horse-riding.

This practice requires the staff member to interpret the resident's answer, whether in speech or (as in the case above) in gesture. Note that Kath here reads Vic's gesture as a 'horse-riding' sign, but then instead of following up this interpretation with an open check, she proposes 'horse-riding' in a declarative assertion (line 3), inviting confirmation; this is a less cautious practice.

We often observed situations where staff failed to recognise the resident's response on first attempt. Faced with unintelligible or non-answers, or answers which the staff rejected as incorrect or mistaken, the staff faced the dilemma of repeating the open question again (possibly many times), or moving to the next kind of format (i.e. 'Open question + immediate multiple-option alternatives', below), which short-circuited the procedure by providing specific answer alternatives. Short-circuiting what might be a lengthy process does solve one problem for staff: it allows them to dislodge an obstacle and move on with other, possibly pressing, business in hand; but, inevitably it risks being seen as not giving the resident time to think and reflect. As ever, these are real dilemmas which staff must solve in real time. For reasons of space, we skip over open-question repeats – which could be very lengthy – and move to see these examples of explicit alternatives.

(iii) Open question + immediate multiple-option alternatives

In this format, the staff member left no gap for the resident to answer an open question (e.g. *what would you like to do* or *what do you want*) before immediately (that is to say, without allowing a potential transition-relevant space to open up for the next speaker) providing a list of possible alternative answers.

Extract 3. VC-12; 38:58. *Peaches (1)*.

1 Tim: *((looks at Alec))* Alec *((looking down))*
2 → what d'you want for pudding=look there's (.8)
3 → pru:nes, peaches,
4 (1.0)
5 Tim: *((points down at something and looks at Kath))*
6 °we haven't got Angel Delight° *((looks down))*
7 *((picks up packet and looks up holding packet))*
8 Alec: [peaches Tim]
9 [*((taps tin of peaches))*]

Notice, at the arrowed line, that the staff member (Tim) leaves no hearable gap between the end of the open question (*what d'you want for pudding*) and the immediate projection of a list of alternatives (*look there's*…). Indeed, the absence of a gap where the clause end makes it possible requires us to mark the transcript with a 'latch' symbol at that point (line 2), indicating that for the ordinary hearer the two words seem to run together, and in marked contrast to the .8 of a second gap once the new turn construction unit (*look there's prunes*) has been launched. This buffering of the open-ended offer away from ready uptake seems to be successful, insofar as the resident (Alec) does (after Tim addresses an aside to the other member of staff) apparently opt for one of the alternatives (*peaches Tim)*. However, this was not always treated as definitive; the staff member might decide that the resident's answer was somehow inadequate and restate the question or ask for clarification. Immediately running on from the exchange above, another care worker, Kath, asks Alec to specify his choice, as if *peaches* was insufficient:

Extract 4. VC-12; 38:58. *Peaches (2)*.

10 Kath: Which one do you want Alec?
11 Alec: *((picks up a packet and holds it toward Kath))*
12 that one

In spite of Alec's apparently clear previous choice of *peaches*, Kath's repeated request for a choice seems to make him change his mind. This particular episode continued for some minutes more.

(iv) Open question + immediate single option

As above, in this variant the staff member left no gap for the resident to answer an open question. But here what the staff immediately provided was a *single* option, rather than two or more alternatives. In Extract 5, for example, staff members Kath and Oonagh are asking residents about their holiday preferences. Oliver has a holiday brochure in front of him.

Extract 5. VC-17. *Beach.*

```
 1     Oliver: ((turns brochure round, points to a picture in
 2             the brochure and looks up at Kath briefly))
 3     Kath:   [Y:::es                      ]
 4             [((puts her hand on brochure)) ]
 5                     (.4)
 6 →   Kath    where do you want to go, on the beach?
 7     Oliver: ((looks up at Kath))
 8     Kath:   ((taps brochure)) [(in) the beach, (1.0)     ]
 9     Oliver:                   [((looks down at brochure))]
10     Kath:   is it,
11     Oliver: ((nods))
```

We can see in line 6 that Kath has interpreted Oliver's pointing as indicating some kind of choice, but rather than issuing a general enquiry with an open question, she bolts on a candidate answer without pause (presumably based on the picture he has pointed to). To this, Oliver makes no unambiguous response (he merely looks up at Kath, without indicating assent or dissent). Kath then has the opportunity to put the choice more openly, but in fact she repeats the directive question/suggestion (line 8): *the beach,* and when this gets no obvious answer, she adds *is it*, as a further pursuit (line 10). Such tag questions strongly project agreement, and so makes it interactionally troublesome for the resident to demur. Nevertheless, if Kath's interpretation is correct (as it seems to be from Oliver's nod in line 11), then this is an efficient way of getting Oliver to indicate that this is indeed the holiday choice he has in mind.

(v) Two-option simple alternative in one question

In the following extract, a house meeting is in session, and the support worker's task is to solicit residents' preferences for their leisure activities. As an example of a two-option simple alternative in one question, Dave presents two alternatives (venues for visits) to Dom.

Extract 6. VC-03; 11:19 minutes. *Rose House or Pardew's?*

```
1 →  Dave: Which is (0.8) [ which is better,      ]
2                         [((holds out left fist))]
3 →        [Rose House      ] or [Pardew's.          ]
4          [((taps left fist))] [((taps right fist))]
5    Dom:  ((points toward Dave's right fist))
6    Dave: [Pardew's is better?                       ]
7          [((taps right fist four times, looking at Dom]
8    Dom:  ((nods))
9    Dave: [((points to his left fist))Rose House?]
```

```
10          [((shakes his head minimally))        ]
11   Dom:   ((shakes his head and right hand))
12   Dave:  [No:                            ]
13          [((shakes his head))            ]
14   Dave:  [Pardew's                       ]
15          [((points to his right fist))]
16   Dom:   ((nods and points toward Dave's right fist))
17   Dave:  Okay.((nods, picks up pen, leans back in chair
18          and writes))
```

The question stem in line 1 orients the resident to the upcoming choice (line 3). This is a highly recognisable choice format in both 'ordinary' talk and more institutionalised forms of soliciting preferences. Although a 'normal' practice, this turns out to be a worthwhile help to people with an intellectual impairment, as it makes it easy to identify what, in the staff member's potentially complex utterance, counts as the choices on offer. That this staff member seems to have developed the practice himself – it is used by no other staff – is testament to his ingenuity and sensitivity to the residents' needs. We might also note that he makes the separation of choices more graphic by locating them physically as being (literally) on one hand or the other. This, too, is a welcome aid to clarity.

In sum, our research into the everyday exchanges between staff and the adults they support – although necessarily highly circumscribed to this service, and these individuals – suggests that there are a range of ways of offering choices and involving people in decisions. But they are not all equally empowering; some, especially those that involve multiple questioning, may actually be counterproductive in sowing uncertainty in the service users' minds.

Meaningful social engagement may be afforded by physical tasks

In institutions which support people with intellectual disabilities, everyday life is punctuated by episodes of interaction, many of which can be characterised as based on a physical task or a verbal exchange. Adults with ID are often faced with considerable challenges when it comes to verbal exchanges, as the examples in the section above have perhaps already shown. Might physical tasks offer any better prospect for interactional success?[3] Performing a light physical job and engaging in an apparently simple question-and-answer exchange may seem equally easy, but their interactional structures – what opportunities they offer by their rhythm, scope, and timing – may provide radically different possibilities for collaboration and achievement. In this section, we address this question by means of a close qualitative study of interactions between members of support staff and people with ID as they engage in everyday physical and verbal tasks.

Physical task

Consider the progress in the following interaction, in which garden therapist Carl is overseeing a small group of service users who are potting seedlings. Carl moves around the group and at one point comes to stand by Rory, who has a volunteer beside him.

Extract 7. GardenSpace: C group/glasshouse2. *Plant-potting*.

Carl need this hand to help you ((touches R's right hand))
Rory this one hh ((R brings right hand up))
Carl thass right
((4 seconds, in which R removes some soil from the pot, with both hands))
Carl (s'mthing in) there, in here ((adjusts seedling))
(1.0)
Carl now that's it, (.5) goo:d, (1.5) (th's) goo:d, excellent.
(3.0)
Carl [this one here,
[((puts finger very close to plant))]
Carl (I think that's a wee:d) (.5) (we said that we'd have to) pull them out
Carl ((to volunteer standing by) yeah, it'son;y the iris (°that we want to keep°)
(1.0)
Carl >use this hand.< ((touches R's right hand))
(.3)
Carl °two hands°
(2.0)
Vol (   )
(1.0)
Carl [just go ca:refully because that's an iris
[((puts finger very close to plant))
(1.0)
Carl >°use that hand?°<
(1.0)
Carl two hands, [this hand as well,
[((touches R's right hand))
(1.0)
Carl you ( ) (out) the weed, with [this hand as well
[((touches R's right

```
35        hand once very lightly))
36  Carl  that’s it.
37                (2.0)
38  Carl  alright, lovely Rory ((moves off))
```

The real-time unfolding of the task gives Carl the occasion to do three things with Rory: to guide, enhance the meaning of, and assess his performance. The guidance, or instruction (Zinken & Ogiermann, 2011), is visible in lines marked line 1: ‘need this hand to help you,’ etc.), the enhancing commentary in line 12: ‘this one here, (I think that’s a wee:d,)’], and the assessments in lines 9–10: ‘now that’s it’; (0.5) ‘goo::d’; (1.5) ‘(th’s) goo::d, excellent,’ and so on.

The benefit of seeing the transcript is that one sees the reciprocal development between what the participants are doing. Instruction episodes such as this one, in which there are objects to be manipulated and elements to be named, afford great scope for the interplay between learner and teacher, and the details of pointing, touching, and gesturing can be very instructive (for recent work on bodily ‘quoting’ and the use of the visible environment in instruction, see Haddington, 2010; Keevallik, 2010).

How Carl intercedes is tailored to the task of instructing, correcting, teaching, or assessing how Rory has done. Space constraints prevent going through the episode as a whole, but see, for example, how at line 24 Carl intervenes in Rory’s current, and presumably faulty, action to mix instruction (‘just go carefully’) with an educative account (‘because that’s an iris’). Carl further instructs Rory to use both hands, complementing the verbal instruction with touch (lines 29 and 32) and again giving an educative account of the meaning of what Rory is meant to do [‘you (take out) the weed’].

This short episode is entirely typical of the interactions between the garden staff and the service users, especially in one-to-one activities when doing inside work (outside work, such as digging, tended to be interrupted by comings and goings of other users and staff). The user is launched on a simple, repetitive task and left to proceed; support staff come in to guide, enhance the meaning of, and assess the performance in sequence. Before analysing in more detail the opportunities such physical task- based episodes provide, let us consider and compare what happens when the task is a verbal one.

Verbal task

Let us take the example of what turns out to be a reasoning task, in which the staff member requires the resident to show that he understands what to do if someone were ever to cause him harm. In the Comber Hall Way house, which provided us with the opening examples in this chapter, most interactions between staff and service users were based on verbal tasks – answering staff questions, making choices, expressing preferences, reporting on experiences, and so on. These did not always run off smoothly. In the example below, support worker Kath and resident Henry are among others in the kitchen. Henry is drying and putting away crockery. Kath has turned the conversation to what Henry was doing earlier in the day (something that she already knows the answer to, namely, that he attended a role-play of what to do if someone harms you). Extract 8 shows how the episode starts.

Extract 8. Comber Hall Way: V. 18, Kath and Henry (kitchen), *Police*.

```
 1  Kath   tell me what happened today at Rose House then
 2  Henry  (       )
 3  Kath   so who was there, (1.0) what did they do:, (1.0)
 4         what did you lea::rn,
 5  Henry  (stood on a chair)
 6  Kath   so you were stood (in) the chair, an' what
 7         happened, what were they talking about,
 8  Henry  (what-)
 9  Kath   what were they talking about (    )
10  Henry  (acting)
11  Kath   acting, and who was acting, (.8) and what were
12         they acting.
13              (1.5)
14  Kath   what were they acting. (.2) can you remember.
15  Henry  (ner )
16  Kath   you don't remember >do you remember what we were
17         talking to you about the other night.
18  Henry  (    [)
19  Kath        [with the leaflet
20              (1.0)
21  Kath   you know the leaflet,
22              (.5)
23  Henry  ((turn and points into another room))
24  Kath   yeah=what was it-what's it about.
25  Henry  err:::
26  Kath   >what's it about<
27              (.5)
28  Henry  (eeyeh) p'li:ce, (.3) (youh) (an') the sta:ff,
```

It is clear that the verbal task being asked of Henry is too much for him: he can remember that he was 'stood in a chair' and that there was 'acting', but beyond this he is unable to satisfactorily answer Kath's questions. She tries various measures to jog his memory, and a reference to a leaflet that they have in the house does prompt Henry to mention the police. This gives Kath a basis to build back to the answer she had been aiming for (i.e. that you must tell the police, or a member of staff, if someone has hurt you). On such unstable foundations, she presses on, but as we will see, she only succeeds in confusing Henry still further.

Extract 9. CHW Vd. 18 *Police (2).*

29 Kath and wha- what would you tell the staff.
30 Henry ( ) the p'lice) ( )
31 Kath (would they::?) *((leans towards Henry as if*
32 *to confirm what she's heard))*
33 Henry (, yeh)
34 Kath yeh, and what else,
35 (.3)
36 Kath What would you be telling them.
37 (1.0)
38 Henry ( )
39 (.7)
40 Kath What would you be coming and telling me then.
41 (.5)
42 Kath Or what would you be coming and tellin the police.
43 (2.0)
44 Henry (ohm) *((turns away to pick something up))*
45 Kath What would you tell the police.
46 Henry *((fixes gaze on Kath))*
47 Kath Would you be ha:ppy, would you be
48 sa:d, would you be angry, would
49 you be annoy:ed, would you be
50 up [set,
51 Henry [ha:ppy, *((points to lips))* happy (.3)
52 (there:h) [happy
53 Kath [you'd be happy
54 Henry ((nods)) yeah ((walks away from Kath))
55 Kath oh you'd ring the police and tell them
56 that you'd be happy is it? *((swings round to*
57 *follow Henry))*
58 Henry (er yeah)
59 Kath >no I don't< think so:,
60 *((both go out of shot))*

Henry is being given two verbal tasks: one, to presume a scenario in which he would go to the police, and second, to then reason out why he might do so. (The answer that Kath is aiming for of course is, 'because I had been hurt or upset by someone'). Kath tries to help with hints and prompts. But in spite of all these, Henry ends up apparently claiming that what he would tell the police is that he was happy. This provokes a withering response from Kath: *oh you'd ring the police and tell them you be happy, is it? No I don't think so.*

The common denominator in both the plant potting and the police examples is that the staff member set the service user a task. But the difference in what the two tasks required, and what opportunities for meaningful engagement they afforded, are markedly in contrast. The physical activity format – potting seedlings, as Rory successfully did – provides for easy, repetitive tasks, with visible requirements, for which the service user can at least make an approximately successful start; thereafter, her or his actions can be encouraged, fine-tuned, enhanced, and appreciated. On the other hand, the format of verbal tasks – like explaining or recounting events, as Henry was trying to do – is, or can be treated as being, a complex set of actions that will be well or ill formed according to the questioner's criteria, with more potential for confusion during the guidance process; such tasks will be more difficult from the start, because they are less easily broken down into subcomponents without risking confusion. Compare the opportunities that Carl, on the one hand, and Kath, on the other, had for guiding, enriching, or positively assessing how their clients were getting on in their respective tasks: the discrepancy is as marked as 'good, excellent . . . lovely, Rory' *versus* 'oh you'd ring the police and tell them that you'd be happy is it? No, I don't think so'.

Encouraging clients to reflect on their experiences

Services which seek to empower their clients will try to encourage them to reflect on their lives and articulate their successes, even if these are comparatively minor. Such reflection is meant to celebrate individuals' achievements and nurture their sense of self – and, when shared in a group setting, to foster their confidence in others. In principle, the most direct way for practitioners to get clients to reflect would be to ask them questions about what they know, or can recall, about their experiences, and what they make of them. To allow the respondent the greatest freedom in choosing what to report and how to describe it, the question would need to be open ended. However, a person with ID may find such lack of structure challenging. As we saw in the case of Henry's interrogation by Kath (see Extracts 8 and 9), open-ended questions, without a good deal of help and structured support, can be intimidatingly difficult.

In this section,[4] we examine two practices by which staff deal with clients' initially unsatisfactory responses about matters meant to encourage reflection. In both cases, they begin with open-ended questions. But they run off in very different ways, and provide for very different outcomes.

We will see two sets of data to illustrate the practices involved. One of these we have already seen: in Extracts 8 and 9, we saw an (unsuccessful) attempt at encouraging reflection by a staff member in the Comber Hall Way residential service. We can contrast that, below, with more structured attempts by GardenSpace therapy staff, who strategically use end-of-day meetings to solicit clients' accounts of their day's activity. There are many differences between occasional question-and-answer exchanges and exchanges in a group-oriented set-piece meeting, and we do not mean to imply that there are not major differences in the styles and range of the talk that goes on in the two settings; but one crucial difference is the sequence of questions asked, and it is on this that we concentrate.

Let us compare Kath's practices in Extracts 8 and 9 with these therapists' attempts to get one of their clients to remember something. In both cases, the staff know what the service user did that morning; Kath's strategy, in an off-the-cuff way, was to fire questions at Henry with very little scaffolding of his answers. By contrast, in GardenSpace, the solicitation of client's reflections is institutionalised in routine debriefing meetings at the end of the working day. The aims of the meetings, according to the therapists' account, are to end the day with a show of group solidarity and cohesion, to make sure that everyone reflects on their day, and recognises the contribution of the other clients. Once the day's work is done, the team (of about eight clients, led by two therapists and supported by two or three volunteers, and occasionally by a personal paid support worker) regroups round a table in the common room.

The extract below is taken from one typical reflection session. What happens in such sessions differs from the more casual exchanges that happen in the residential service in a number of ways, but we shall concentrate on the way that open-ended questions are followed up. In Extract 10, we see how staff can use conversational alternatives to yes/no questions, by hinting using deliberately incomplete utterances. In the following scene, staff member Bill is asking client Owen to reflect on his contribution to the day's tasks. Owen has not so far managed to come up with a full answer spontaneously, so Bill is guiding him:

Extract 10. GardenSpace v001 2.140 *Bucket*.

```
 1  Bill  and then what did we put around the
 2        bottom of the post.
 3        [    (3.0)
 4        [((Owen looks at Bill, brings finger pointing
 5        upwards to face level))
 6  Owen  (uh upuh hur) ((jabs finger up and forward))
 7                (2.0)
 8  Bill  you got it, yeh, you got the (vase) from
 9        up the top,
10  Owen  (    ) ((moves finger round and left))
```

```
11  Bill  yep.=a yellow bucket (through 'n) to
12        [the workshop,
13  Owen  [(    )
14                  (1.0)
15  Bill  some water from the,
16  Owen  [(    )
17  Bill  wuch- what didju put water in.
18  Owen  erh (4.0) ( )
19  Bill  watering:::
20                   (.5)
21  Owen  boh- uh (bottle)
22                   (.3)
23  Bill  watering can.
24  Owen  yeh.
```

At line 8, Bill receipts Owen's inarticulate response and his gesture as if confirming a clear answer (*you got it, yeh*) and begins elaborating it (*you got the vase from up the top*). Owen produces a further response that is hard to understand, but Bill continues with the elaboration (see line 11). On this basis, Bill then issues two hints in the form of deliberately incomplete utterances (Koshik, 2002). In fact, Owen does not correctly guess the hint (choosing *bottle,* not *can* to complete Bill's long-drawn out *watering:::*). But Bill – unlike Kath in Extracts 8 and 9 – does not call attention to the failure, merely producing the right answer, allowing Owen to confirm it. Again, the use of elaboration and hinting to follow up inadequate first answers provides for a more satisfactory interactional outcome than does following up with test questions, alternatives, and yes/no questions.

Clinical relevance summary

Successful communication between service users and the professionals who support them is vital if the aims of the service are to be achieved. The greater the service's commitment to the empowerment of their clients, the greater the need is to attend to their wants, desires, and choices. This, of course, poses problems when the service users have impairments which interfere with the clear expression of their feelings and views. Staff must perforce adapt their 'ordinary' communication practices so as best to remedy the difficulties that service users face.

Several suggestions follow from the examples we have seen. In the matter of choices, offering a list of more than two alternatives verbally can sometimes result in confusion to all concerned. This may depend on the particular choice offered or on the individual who is being addressed. When there is no alternative to verbal presentation of multiple options, two strategies from our examples seemed useful: (1) finish with an open question that does not contain any of the options in it, or (2) if the person has named a small number of options, present just these two or three options and ask the person to select one. Simply asking for confirmation of the last option the person has named is the least useful strategy. With regards to asking a person to choose between two options, a physical display seems a good one – for example, as we saw in Example 6, representing each choice by a fist. This allows the resident to either point or name their choice, and to some degree bypasses problems of memory and reliance on complex language.

In terms of episodes of joint activity that offer opportunity for interaction, Extract 7 suggested that a simple physical task (potting plants, for example) can, if closely and sympathetically monitored, offer greater opportunities for meaningful social engagement than a verbal task. The demanding interview we saw in Extracts 8 and 9, where a staff member tried to engage a service user in the task of articulating what lesson he had learnt about personal safety, showed how such a task can descend into a fault-finding exercise. We used the same example to illustrate different ways of attempting to empower people with intellectual disabilities by encouraging them to reflect on their achievements; insistent questioning would be far less successful than a more graduated, scaffolded approach, using incomplete utterances, longer pauses, and more praise for even imperfect responses.

We acknowledge that altering communication practices is not easy, and that staff have multiple constraints on their time – and that training regimes in many counties (including the UK) provide very little in the way of communication training to support staff at junior grades. We also acknowledge that a great deal of research is necessary to move from the small-sample case studies that we gather together here to more generally based evidence. Nevertheless, such qualitative evidence as we have used does have the benefit of identifying, in sometimes graphic detail, the snags and stumbles that go unrecorded in institutional accounts of support for people with intellectual disabilities. Bringing them into the light can facilitate a conversation about how such problems may be addressed and solved. For a simple summary of the clinical implications, please see Table 31.1.

Summary

The dilemmas facing staff are real and driven partly by matters on the ground – the approaching end of shift, the pressing need to record an answer, the competing jobs around the dinner table, and so on, not least of which is the residents' own frequent (but certainly not constant) lack of conventional conversational clarity. To some degree, and despite service providers' official aspirations, such matters resist policy recommendations if they are phrased at

Table 31.1 Clinical practice highlights

1. Institutional interaction with adults with intellectual disabilities (ID) can be challenging.
2. Some of these challenges are matters of inappropriate choices of communicative practices by staff.
3. When offering service users choices, complex alternatives should be avoided and repeated and yes/no questions used with care.
4. When seeking opportunities for meaningful interaction with a service user, a simple, monitored physical task may afford great success than a complex verbal task.
5. When encouraging a service user to reflect on their experiences, direct question and an interview style may be less productive than a supported style with more explicit structure for the service user's responses.

the general level. But certain parameters could, in our judgement, be relaxed if they were to be translated into the local scene. The kind of evidence we see here ought to be helpful to policymakers and practitioners in finding ways to move from principle to practice.

No one who works in the field of intellectual disability can fail to recognise the contingencies facing support staff. They themselves are not always well supported by training and may have difficult conditions of employment. Nevertheless, the way they interact with their clients may benefit from examination. Changing interactional practices is not an easy matter, and requires an investment of time and resources – both of which will probably be in short supply in publicly funded or commissioned services – and the goodwill of staff at all levels of the service. These are real difficulties, but even the kind of single-case evidence that we have presented in this chapter may be helpful in raising consciousness about the issues involved and possible benefits of change.

Notes

1. Some of the introductory part of this chapter is a modified version of material previously published in Finlay et al. (2008a).
2. Some of the text in this section is based on material in Antaki et al. (2008).
3. The data and analysis in this section are largely dependent on material in Antaki (2012).
4. Data and analysis in this section are largely dependent on the work reported in Antaki (2013).

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32

Discovering Mental Ill Health: 'Problem-Solving' in an English Magistrates' Court

Timothy Auburn, Cordet Smart, Gisella Hanley Santos, Jill Annison, and Daniel Gilling

Introduction

In this chapter, we examine one particular approach to problem-solving in the English criminal justice system. The incorporation of problem-solving into Magistrates' Courts for low-risk offenders has been called a 'window of opportunity' (Donoghue, 2014) insofar as it provides an opportunity to engage with 'hard-to-reach' social groups. It aims to identify any problems which are acting as barriers to a better life and signpost the person to services which can help address these problems. One of the aims of the project that we have been conducting on community justice is to examine how problem-solving works as a specific set of practices for those with mental ill health problems.

Mental ill health and criminality

The association between mental ill health and criminality has been noted for many years (Bradley, 2009; Herzog, Chapter 5, this volume). Though estimates vary, many studies indicate that there is a higher-than-normal incidence of people with mental ill health problems processed through the criminal justice system. The Centre for Mental Health (2014) suggested that the incidence is 70%, while others suggest that it is closer to 90% with considerable co-morbidity (Scott & Moffatt, 2012). In contrast, based on a stricter clinical definition of 'severe mental disorder', Fazel and Seewald (2012) reviewed studies of prisoners from 24 different countries and found a pooled prevalence for psychotic illness of 3.7% and for major depression of 11.4%.

These statistics largely relate to incarcerated offenders. However, in the United Kingdom (UK), the majority of those convicted of an offence appear in the lower courts or are processed out of court by the police (Ministry of Justice, 2014a). There are fewer statistics on the mental ill health status of these people.

Cattell, Mackie, Prestage, and Wood (2013) estimated that 29% of offenders who were placed on a community order had a mental health condition.

In sum, poor mental health has been identified as a significant pathway that leads into criminality, alongside other life circumstances associated with social exclusion, such as substance misuse, debt, lack of or poor housing, and relationship problems (Byng et al., 2012; Ministry of Justice, 2010, 2014b).

Community justice

In part, as recognition of the likelihood of multiple problems affecting those appearing in the courts, there have been initiatives designed to do more than simply prosecute and sentence offenders (Rogers & Pilgrim, 2014). One such intervention has been through community justice courts (Attorney General, 2009). These types of court originated in the United States (US) during the 1990s, and the principles established there have in turn influenced a number of similar developments in England and Wales, most notably the North Liverpool Community Justice Court (Mair & Millings, 2011). Community justice emphasises solving crime problems and improving public safety in the community, addressing the needs of victims, and solving problems associated with the individual offender in order to prevent them from committing further crimes (Berman & Fox, 2009; Gilling & Jolley, 2012).

Project overview

The Magistrates' Court, which formed the focus for this project, is a community justice court which has a procedure for problem-solving. Magistrates have the option of offering offenders who have pleaded guilty a 'problem-solving meeting' on the day of their hearing. This meeting is conducted away from the courtroom by a separate problem-solving team who identify any underlying problems experienced by the offender and which may have contributed to their current offence. It is during this meeting that any mental health issues may be raised with a view to identifying an appropriate course of action. The problem-solving team report back to the magistrates about any outcomes from the meeting, which are then taken into account when sentencing.

The meeting is structured around a form which identifies a number of topics related to social exclusion including general and mental health. Other questions identify issues such as accommodation, finances, relationships, and substance misuse. Over two-thirds of those who undertook a problem-solving meeting in a one-year period reported that they experienced more than one of these problems and also self-identified as having a mental health problem. The aims of the support service which runs the problem-solving intervention are to identify vulnerable clients and their problems, to signpost them to appropriate services, and to monitor and follow up their progress. It offers a combination of practical help with administrative issues such as benefits and fines and support in accessing long-term support for chronic problems.

A corpus of 22 audio-recorded meetings was assembled; most meetings lasted between 20 and 40 minutes. From these meetings, we made a collection of 42 extracts in which mental health was referenced by the participants. We focus on how mental health issues were raised by members of the problem-solving team members and then how signposting is implemented. Overall, our question is, How is this meeting implemented in practice in terms of the identification and signposting of mental ill health problems?

Findings

In the prior section, we provided a brief summary of the evidence on the prevalence of mental ill health in the criminal justice system. Though there is debate about the extent and nature of this relationship, we also argue that it forms part of the background social and cultural knowledge that those working in and for the courts have for sense-making and suggesting courses of action. For those involved in court cases, there is the issue of particularisation: ‘Does this particular person have a mental health problem, if so what is it and what is the appropriate course of action?’ This particularisation requires a form of ‘practical epistemology’ (Kidwell, 2009) which engages everyday interactional procedures to accomplish agreement (for all practical purposes) on the state of mind of the offender. It is particularly salient for those conducting problem-solving meetings as they have been charged with the institutional job of identifying ‘problems’ and the courses of action which might follow. This practical epistemology is built around the topics identified in the meeting form and the type of questioning it generates.

Within conversation analysis, questioning has been a widely researched practice particularly in institutional settings (Freed & Ehrlich, 2010). The complexity of questions as discursive objects has been noted by, among others, Steensig and Drew (2008): ‘[It's] plain that whilst an utterance may be formed interrogatively, and indeed may “question” the recipient, the utterance simultaneously does or “performs” another action. “Question” is therefore only a minimal characterization of an utterance, interactionally’ (p. 6). Moreover, questions can take a wide range of forms (Enfield, Stivers, & Levinson, 2010), which, in turn, interact with the action orientation of the question (Raymond, 2003). Heritage (2003, 2010) has identified four key dimensions of question delivery which are relevant to different institutional encounters: agenda setting, embodying presuppositions, conveying epistemic stance, and incorporating preferences. These dimensions will form the basis for our own analysis of the practices for the identification of mental ill health status among offenders who appear before the Magistrates' Courts and undergo problem-solving. In the first part of the analysis, we examine the questioning formats through which problems of mental ill health are identified. In the second part, we examine how questioning is designed as part of 'diagnostic procedures' which lead into advice giving.

Questioning and the discovery of mental ill health

Overwhelmingly, potential cases of mental ill health were constituted through being raised as a topic drawn from the problem-solving form. Of the 22 problem-solving meetings in our corpus, only 5 did not include a sequence about mental health which was not form initiated. The form on which the problem-solving team member recorded summaries of answers structured the 'institutional noticing' (Ehrlich & Freed, 2010) of potential problems or criminogenic factors in the offenders' lives. To this extent, they conform to Heritage's (2010) identification of questions as agenda setting devices. Here, we give three different question formats through which mental health was topicalised; these formats are differentially oriented to optimisation or problem attentiveness. Consequently, they generate different trajectories for the identification of mental ill health.

Content question topicalisation

Extract 1: (PS04:11)

```
327          (0.7)
328 PS[1]    okay (0.3) er↑::m (0.4) wha- ho::↑w's <you:r> (.)
329          general health (.) ↑↑good
330 Off      >fine< (.) yes
331          (6.1)
332 PS   →   and ↑mental ↑health?
333 Off      fine >in my< opinion y[es
334 PS                             [yea:h,
```

Extract 2: (PS18:36)

```
135           (15.6)
136  PS       what's your ↑general health like,
137           (1.5)
138  Off      I see:m alr↑ight .pss
139  PS       ye::h you look al↑ri:ght
140           (5.7)
141  PS →     an' whaddabout you::r (.) me:ntal health
142           (0.5)
143  Off      fine as far as I'm a↑ware
```

In both these extracts, the topic of mental health is raised through a content question either 'how's your-' or 'whaddabout your-'. Both these questions come after a lapse in the progressivity of the meeting, and both questions are tied to a prior question on 'general' health through the tying conjunction '*and*' (Heritage & Sorjonen, 1994). Mental health in these sequential contexts is constituted as part of a larger package on health status.

Fox and Thompson (2010) distinguished two types of content question: specifying and telling. Specifying questions request specific types of information, whereas telling questions seek extended responses. The distinction between 'specifying' and 'telling' mirrors that of Kidwell (2009), who identified 'filling-in' questions, in which the task of the responder is to specify or fill in an item of information, and 'filling out', which is designed to elicit a more elaborate answer from the responder's perspective.

In the extracts here, the questions are both formed as and treated by the recipient as specifying questions. In Extract 1, the type of specifying response is indicated by the candidate answer that immediately follows the '*wh-*' question (1:329: 'good'), which is then mirrored in the response to the first question and its tied follow-up (1:330, 1:333). This response indicates that the delivery of the question was understood as 'optimizing': 'This principle embodies the notion that, unless there is some specific reason not to do so, medical questioning should be designed to allow patients to confirm optimistically framed beliefs and expectation about themselves and their circumstances' (Heritage, 2010, p. 52). There are two clues as to why these sorts of questions are optimistically framed. First, the questioner gives a candidate answer tilted towards an optimistic assessment (1:329) or gives a second assessment to the epistemically downgraded first assessment (2:139). This second assessment has an agreement token and upgrades the evidential 'seem' to the stronger 'look'. It is also delivered as a straight declarative which implies that this was an assessment made independently by the questioner (Heritage & Raymond, 2005), thus ratifying the offender's assessment. Second, Fox and Thompson (2010) suggested that there can be two types of response to specifying *wh*-questions: phrasal and clausal. Following Schegloff, they argue that the standard response to specifying questions is phrasal. Where a clausal response occurs it is inferenceable as identifying problems with the presuppositions in the question. In both extracts here, the response is phrasal ('fine', 1:333, 2:143), although they are both then epistemically downgraded through an evidential qualifier.

Topicalisation through question cascades

Question cascades were identified by Clayman and Heritage (2002) as a package of questions which normally start with a content question but are immediately followed by second or third questions which 'revise and tighten' the presuppositions in the first question. Moreover, the second or third questions are usually formatted as yes-no interrogatives (YNI). They proposed this type of questioning is a particular practice in political interviewing designed to challenge the interviewee.

Extract 3: (Clayman and Heritage, 2002, p. 757)

Int: Mr. President, you mentioned a moment ago your
receiving reports of apathy among voters.
Q1 To what do you ascribe this apathy?
Q2 Is it a disenchantment with the program of the
last 2 years, Sir?

We do however find that question cascades are a frequent way in which mental health is topicalised and identified in the problem-solving meetings. Though not necessarily an adversarial move as in political interviewing, they do take the initiative in specifying the categories of mental ill health expected as candidate responses.

Extract 4: (PS05:12)

(1.2)
PS Q1 (or) >what about< your mental health
Q2 do you suffer from any kind
of dep↑ress:ion or anx↑i:ety: or::
Off °°no gh°°

Extract 5: (PS10:21)

(6.5)
PS Q1 °okay↓° >and what about< you:r me:ntal health hh .h
Q2 have you ever suffered fro:m depression <o:r
.hhh anx↑iety, >panic attacks<,
Off no:::
PS ↑no
(2.1)

In these extracts, there is an opening content *'wh-'* question, which does the initial work of topicalising mental health. The content question is immediately followed by a YNI formatted question. There are two noticeable features of these YNIs. First, in common with other ways of topicalising through question cascades, the second question revises and tightens the available categories of mental health. Just as in the presidential questioning, the 'apathy' is presupposed in the second question to be attributable to 'disenchantment', so, here, the mental health problem is constrained to specific categories of mental ill health: in this setting, normally depression and anxiety.

The second noticeable feature is the preference organisation of the second questions. Questions which contain negative polarity items (e.g. 'any', 'ever') prefer disconfirming responses (Heritage, 2010). Again, the principle of optimisation underlies the design of these second questions. They are oriented towards a no problem or positive outlook for the offender. In each case, the responses are disconfirming, delivered with preferred turn shapes with the responders aligning themselves with the presuppositions of the question (Raymond, 2003), suggesting that both participants are oriented to the optimistic presuppositions of the question.

In contrast to second questions with negative polarity items, question cascades also allowed for more elaborative responses. In these cases, the second question was a straight interrogative which can be heard to favour a confirming response. In addition, these questions more clearly orientate to an 'unknowing' stance on the part of the questioner which can in turn '...invite elaboration and sequence expansion' (Heritage, 2010, p. 49).

Extract 6: (PS01:02)

```
498                (12.6)
499  PS    Q1      °°okay°° ↑what about your me:ntal health (0.4)
500        Q2      ↑d'you ↑suffer ↑from ↑de↑pression?
501                (1.6)
502  PS    Q3      or ↑stress,
503  Off           ↑no:t
504  PS    Q4      you seem quite lo:::w (0.4) °if you don't mind° me saying,
505  Off           °it's cos I've got (    )° (.) I'm ↑not saying I (feels)
506                depressed but I do: (.) they reckon I'm (.) au↑tistic,
```

Extract 7: (PS08:19)

```
102                (2.0)
103  PS    Q1      okay (.) and ↑how's your mental health,
104        Q2      (.) do you have ↑anxiety or ↑depression
105                or [↑stress (  )?]
106  Off           [no I suffer ] from a
107                bit of depression °but°
```

Extract 8: (PS15:29)

```
315  PS1           ↑I'll get you an >ayay< leaflet as well which tells you
316                about [the-] [the (.) al anon]
317  Off                 [okay]
318  PS2   Q2                    [.hh is ↑↑you:r ] general health and (.)
319                °mental health okay°,
320  Off           I d- I::er ye:ss I erhm I'm fi:ne in that res↑pect,
```

```
321          er >I get a bi,t< (0.4) depressed
322          >because of the< (0.4) [sss s] [ss:]
323   PS2                           [↑yeah]
324   PS1                                  [>wh]at your living with<
```

The key question is the YNI-labelled Q2 in the extracts.[2] In Extracts 6 and 7, the second question similarly revises and tightens the categories of mental ill health to depression, anxiety, and then, more generally, 'stress'. However, these second questions do not have the negative polarity items identifiable in the previous set of extracts; as a consequence, they elicit more elaborative responses.

In Extract 6, the turn initial discourse marker (*okay*) and the *wh-* question establish mental ill health as a new topic and set up a slot for the immediately subsequent YNI cascade question. The cascade question provides for a preferred response as constrained to confirming or disconfirming 'depression' as a category of mental ill health. The gap (6:501) can be heard as preliminary to a dispreferred response, one which is likely to take issue with the presuppositions in the question (Raymond, 2003). The problem-solving team member then asks a second YNI ('or stress') as an alternative candidate response, though this term has moved away from a strict mental ill health category towards a more quotidian source of distress. The offender makes a move to respond with 'not', again anticipating a dispreferred response, the problem-solving team member offers an assessment of the offender's state of mind using another quotidian term ('low') rather than a 'technical' psychiatric term. It is also qualified by the use of the evidential 'seem' and acknowledges the sensitivities around making claims about other people's state of mind. This can be heard as a third question, insofar as it indexes the lower epistemic status of PS and although delivered as a declarative is oriented to confirmation or disconfirmation. The three cascade YNIs move from a steep epistemic gradient in terms of the stance of the two actors to a more shallow gradient, where PS makes a tentative 'B-event' claim to know the state of mind of the offender, thus intruding onto the epistemic territory rightly known by the offender (Heritage, 2012).

These steps in the cascade and the final assessment (Q4) display PS's receptivity to the likelihood of a mental ill health problem. The systematic downgrading of the category term used, as well as the move to a declarative format in the final assessment, displayed the work to elicit a suspected problem. Thus, in contrast to the earlier optimising formats for topicalising mental ill health, this format is more 'problem attentive' (Heritage, 2010). Though the nature of the problem is eventually formulated in quotidian terms, the use of the descriptor 'low' affords the possibility of any agreement with this assessment to be recategorised formally as 'depression' or related mental ill health term.

Further, in Extracts 7 and 8, the offender has the opportunity to elaborate their response to the YNI. The initial response to PS's question is *pro-forma* agreement with the presuppositions of the question (7:106; 8:320), followed by an elaboration of a mental ill health problem. Probably as a concession to the preference organisation of the question, this elaboration is produced using a palliative format (Schegloff, 2007) so that the full force of the mental ill health claim (depression) is downgraded by the qualifier '*a bit (of)*'. Nevertheless, this question design provides more opportunity for the recipients to identify and elaborate their mental ill health problem.

Prior-informed topicalisation

With this format of questioning, PS is fully engaged in a problem attentive exchange. Built into the question is PS's own understanding of the mental ill health problems of the offender. At some point earlier, PS's epistemic status with regard to the state of mind of the offender has been upgraded; so, at the point of this exchange there is evidence of a mental ill health problem. This upgrading most often occurred either through evidence given in the court hearing or through a claim made by the offender earlier in the meeting.

Extract 9: (PS03:07)

```
370  PS       okay: what's your general health like <you look (.)
371           fairly healthy ↑yeah no iss[ues ]
372  Off                                [no::] yeah. °juss-°
373           (2.1)
374  PS       ↑no ↑anything [(ongoing ↑no)]
375  Off                    [no  I'm  fine] just erhh
376           depression and anxiety
377           (and stuff) [(    )     ]
378  PS                   [oh well th]at's mental health
379           we'll come to that in a second
380 [7 lines omitted]
381  PS       so (0.3) ↑mental health
382        →  you've got (.) >depression and< anxi:ety,=
383  Off      =hmm (0.7) at the moment (yes I think that's) (  )
384           (1.2)
385  PS       right.
```

Extract 10: (PS02:05)

```
545           (9.1)
546  PS       okay and as a result of that (.) your >me:ntal health<
547        →  (1.1) did you say you- you suffer from depression,
548  Off      yea:h uh:m I've [suffer-
549  PS                       [(is that ↑medi↑cated)
```

In both these extracts PS gears their question to specific categories of mental illness attributable to the offender. These categories have been claimed earlier in the meeting by the offender and when the orderly slot for addressing mental health arises (9:381) PS issues a question which acknowledges and displays their understanding of the offender's claim to a mental ill health problem. These question designs have a strong preference for agreement and are problem attentive aligning with the offender's prior claim and as such allow for further elaboration and expansion in the responsive slots.

Problem attentiveness was also evident when PS brought to bear their own understanding of the sort of world that the offender might occupy, which allowed them to make inferences about the likely problems experienced by the offender. Thus, PS's epistemic status as knowledgeable and experienced in criminogenic matters allowed them to display insight into the offender's own lifeworld and so probe for a particular 'ontogeny' (cf. Kidwell, 2009) of how a mental ill health problem came about.

Extract 11: (PS13:25)

```
310 Off     =an' I said [(Elizabeth) (ba- off)]
311 PS                  [    what    about    yo]ur mental and
312         gen- your- your general health <is that ↑good?
313      →  have you got any issues because of [thuh (.)] ↑drugs?
314 Off                                        [pwhhhhhh]
315         (0.8)
316 PS      has i[t left you with any↑thing?]
317 Off          [na-     not     cuz    of ]drugs b[ut, ]=
318 PS                                              [↑no?]
319 Off     =I would say (.) emotionally (.) I'm a wre:ck,
320         (.)
321 PS      right so your ↑mental hea:lth
322 Off     done in (.) I am- I'm done in (.) I ca- ca- can't
323         believe (0.4) you a::sk someone for help an- and
324         they screw you over like the:y 'a:ve
325 PS      so it's a de↑pression
326         (0.4)
```

Extract 12: (PS16:33)

```
234 PS      ↑ri:ght
235         (0.4)
236 Off     [(  )      ]
237 PS      [what dju-] your >↑general ↑health
238      →  and your< me:ntal health obviously very much affected by
```

```
239      your alcohol[ism °aren't they° so] you've got=
240 Off              [yeah yeah it is (  )]
241 PS   =<depre::ssi::on> (0.5) ↑↑yeah (0.3) [ ↑pa]ranoi::a,
242 Off                                       [yeah]
243      (0.6)
244 Off  very paranoid (tha:t's) [smoking   w]eed and=
245 PS                           [well that's]
246 Off  =[shi:t like tha]t<(I got to put me hat) (  )=
247 PS    [(    )  yeah   ]
```

In both these extracts, PS uses a cascade question form where the follow-up questions (arrowed), tighten the ontogeny of any mental health problem through a question which presupposes the likely role of various forms of substance misuse. In Extract 11, the offender can be heard to be moving towards a dispreferred response (anticipated, for example, by the loud outbreath; 11:314), negating the presupposition that his mental health is 'good' and then goes on to counteract the presupposition that the 'drugs' have been implicated in his problems. Nevertheless, the orientation of the cascade question towards confirmation and the identification of a likely source of the problem allow the offender to elaborate his problems. It is worth noting here too that PS receipts the offender's account with a formulation (Heritage & Watson, 1979) which deletes many characteristics of the problem as described by the offender and transforms those problems into a clear mental ill health category (11:325: 'so it's depression').

In Extract 12, the cascade questions are strongly oriented towards confirmation displayed by the qualifier ('obviously') and the negative tag question. The 'so' (12:239) is a causal conjunction which links the substance use to specific mental ill health categories. This offender orientates to and affiliates with the criminogenic ontogeny proposed by PS and sequentially expands upon this proposal (12:244–246: 'that's smoking weed and shit like that').

Summary

These question formats are recipient designed, and their probabilities of eliciting a claim to a mental ill health problem are quite different (see Table 32.1). Through these question formats, there is a continuum from optimisation through to problem attentiveness, and this continuum is indexed in the syntactic and lexical design of the questions. In addition, the issue of epistemic status and stance are evident, insofar as problem attentiveness is often accompanied by an epistemic encroachment into the territories of knowledge which are rightly the domain of the offender.

Table 32.1 Question type and identification of mental ill health

	Question type	**Mental ill health problem claimed or ratified in next turn**	
		Yes	**No**
Optimising	Content question	1	3
	Cascade with negative polarity item	1	3
Problem attentive	Cascade – straight interrogative	4	0
	Prior-informed interrogative	7	0

'Diagnostic procedures'

In the previous section, we saw the practices through which mental ill health problems are identified; a second function of problem-solving is to 'signpost' offenders to other specialist services. For problems associated with mental ill health, these services were dominantly general practitioner, voluntary counselling services and drug and alcohol services. Elsewhere, we have identified that over 75% of signposted referrals arising from problem-solving meetings were to the person's GP.

Signposting can be thought of as delivering advice whereby one participant 'describes, recommends or otherwise forwards a preferred course of future action' (Heritage & Sefi, 1992). Heritage and Sefi identified three discursive dimensions of advice delivery: stepwise progression into advice, a normative dimension, and a competence or epistemic dimension. First, advice is rarely delivered 'cold', but there is a lead in which establishes the nature of the problem or whether past actions have been taken to address it (Butler, Pooter, Danby, Emmison, & Hepburn, 2010). Second, advice constructs an obligation on the part of the recipient to undertake it. Third, advice is delivered on the basis of the superior knowledge and competence of the advice giver. Subsequent studies have confirmed the generalisable status of these features across different institutional and informal settings (Pilnick, 2003; Shaw, Potter, & Hepburn, 2015; Vehviläinen, 2001).

In our collection, one of the standard ways in which 'signposting' is accomplished is a stepwise, 'diagnostic procedure' which acts as a pre-sequence to the delivery of the advice itself. This diagnostic procedure tended to have a sequence of yes-no interrogatives, tied together with standard conjunctions '*and*', contrastive '*but*', and causally connective '*so*' (Heritage & Sorjonen, 1994; Schiffrin, 1987). The question contents and the sequential way in which they were linked displayed an 'expectable standard' (Heritage & Sefi, 1992) against which advice can be fitted. The main functions to which this diagnostic procedure was addressed were as follows: identifying particular aspects of the problem which were potentially actionable and which give entry to advice delivery, normalising an initial claim to mental ill health, and identifying more precisely a mental ill health problem (see Extract 11).

'No problem' claims

We start with claims made by offenders in responsive turns that there is 'no problem' with their mental health. Despite this claim, PS embarks on a diagnostic procedure, which draws upon their own epistemic status as knowledgeable about criminogenic matters to explore candidate factors associated with mental ill health problems. These factors bring together prior information that the offender has provided with the current agenda item on mental health. This diagnostic procedure, embarked upon despite a no problem response, displays the institutional constitution of problem-solving as one which requires checking of all aspects of the person's current life circumstances.

Extract 13: (PS05:12)

```
286  PS   (or) >what about< your mental health
287       do you suffer from any kind
288       of dep↑ress:ion or anx↑i:ety: or::
289  Off  °°no gh°°
290  PS   you look pretty chilled a:ctually (.) °to me°
291       ↑after you've been out on a bit of a bender
292       on the alcohol do you feel a bit low the ↑next ↑day,
293       (0.5)
294  Off  °°no (I'm ok)°°
295  PS   ↑no
296  Off  no
297       (1.7)
298  PS   °okay°
299       (6.1)
```

In this extract, PS identifies a potential source of trouble which may defease the no problem claim founded on prior lifestyle information but reinterpreted as a cause of or allied to mental ill health. After the offender's 'no problem' response (13:289), PS independently assesses the offender's mental state aligning with this no problem claim. Within the same turn, however, PS proposes a candidate cause of depression (excessive alcohol can lead to feeling 'low'), although the term used is one drawn from a non-technical emotion language game. Following its denial, PS provides an other-initiated repair designed to invite a revision of that response. It receives the same negative response, and

PS receipts this with a newsmark leading to closure of the topic and a lapse in the progressivity of the meeting.

There are two noticeable features of this extract. First, there is a background presumption that mental ill health is present for these clients, and, as such, there is an imperative to explore all avenues which might confirm that presupposition. Second, in cases of no problem responses, the offenders are required to do more than simply deny having a mental ill health problem; they have to respond to further questioning embedded within the diagnostic procedure implemented by PS. The upshot of the trajectory of these diagnostic procedures is to 'normalise' the current lifestyle of the client.

Diagnostic procedure as stepwise move into advice

Our final extract shows more clearly how an extended diagnostic procedure explores different aspects of the mental ill health problem with a view to identifying an anomaly which is amenable to the delivery of advice.

Extract 14: (PS11:23)

```
268  PS   oka:y u:m (.) ↑what (0.4) ↑what about your mental health_
269       (0.6)
270  Off  [i:t's]
271  PS   [(    )] depre↑ssion or ↑anything ↑like ↑tha::t?
272       [↑has ↑doctor ↑William] ever picked up on anything=
273  Off  [(    ) I thi::n-     ]
274  PS   =li[ke tha:t, ]
275  Off     [yea:h I've] ↑bin e::r, (0.6) er depressed (where)
276       I'm feeling do:wn an- that a few ↑times,
277  PS   what ↑recently or in the p[a:st]
278  Off                            [yea:]::h la:st yea:r was
279       the last time ↑like, (0.6) I we[nt there,]
280  PS                                  [did ↑you ] ↑speak to
281       ↑doctor ↑William a↑bout ↑↑i::t?
282  Off  °yeah°
283       (0.4)
284  PS   .hh did he, (0.4) medicate you? [↑or ↑any]thing?=
285  Off                                  [yea::h,]
286  PS   =>°↑give ↑you ↑anything?°<
287       (1.4)
288  PS   and ↑that's ↑done no:w is ↑i:t?
289  Off  yess, (0.6) but obviously I, (0.4) [(    )        ]
290  PS                                      [but you think]
```

```
291            you’re sti:ll, (0.4) (suffering from a) bit of
292            de↑pression
293  Off       maybe I do[::]=
294  PS                  [ye]ah,
295  Off       =↑some days I feel alright and some da:ys I, (.) just
296            feel ↑down ↑l[ike (ho]ne:st)
297  PS                     [↑mm::: ]
298  PS        ↑I ↑would ↑ad[vise you↑ go ↑back ] tuh yea::h,=
299  Off                    [(    ) really but,  ]
300  PS        =go back to hi:m, (0.6) if ↑he’s been your gee pee
301            for a num[ber ] of years then [there’s probably] ↑nobody=
302  Off                [yeah]               [yeah he ↑has,    ]
303  PS        =.hhh medically (0.4) qualified there’s [nobo]dy better=
304  Off                                               [yeah]
305  PS        =.hhh than hi::m,
306  Off       yeah yea::h
307  PS        because he knows your situation he’s watched you grow up
308            he knows w[hat ] ↑whe:re you’re at no:w, .hhh (0.4)=
309  Off                 [yeah]
310  PS        ↑so ↑do ↑you think you might make another appointment
311            with [↑hi:m?]
312  Off            [yea::h]
313  PS        ↑yeah? (0.8) it’ll certainly he:lp,
314            (19.2)
```

This is a lengthy extract with many noticeable features. We, however, draw particular attention to the following features of this exchange. First, following the claim of a mental ill health problem (14:275–276), PS launches a series of questions concerned with identifying any problems with the offender’s current mental state. These questions are typically YNIs or alternative questions, and for the most part they receive straightforward confirmations. In this case, this series of questions reveals a potential problem whereby the treatment received was over a year ago (14:278–279), implying that the mental ill health problem might be unresolved or might have returned.

This implication about the potentially problematic current state of mind of the offender is picked up in series of questions linked through the conjunctions ‘*and*’ (14:288) and *‘but’* (14:290). These questions are both designed to prefer a ‘yes’ response (14:288: tag question ‘is it’ and 14:290–292: declarative question) displaying the problem attentive orientation of the diagnostic procedure. Moreover, the questions convey an ‘expectable standard’ of what the offender’s current state of mental health should be and how it should be addressed (e.g. 14:284–286, 14:290–292). Once the offender has confirmed the current problem, PS responds with advice delivery (14:298–300: to make a return visit to the GP). PS uses a term of overt recommendation softened by the use of the modal auxiliary (14:298, I would advise).

The next move by PS displays some of the dilemmas of providing advice in this context. Though there is a normative orientation to taking up the advice, PS team members do not have any official powers to enforce that recommendation (cf. Butler et al., 2010). Problem-solving is only likely to be effective if the person follows through on the advice. The normative pull of this advice is upgraded through an account of the expertise of the GP in terms of the benefit to the recipient. PS articulates the qualifications of the GP as a medical practitioner as well as the personal knowledge that the GP has of the offender, implying that the GP can tailor any treatments specifically to the offender. The advice is then reissued as YNI about the offender's future intentions, which in turn is accepted and then evaluated in positive terms by PS (14:314: it'll certainly help).

Summary and clinical relevance

This analysis has aimed to show how claims and attributions of mental ill health are interactionally constituted. The identification of categories of mental ill health and the advice that is built out of a diagnostic procedure is accomplished through the action sequences in which both the offender and the problem-solving team participate. The background to the identification of mental ill health problems is the widespread understanding that those with such problems are over-represented in the criminal justice system. This assumption is often displayed in cross-cutting preferences (Schegloff, 2007) in the sequences analysed here. On the one hand, 'optimisation' can be built into the question form preferring a 'no problem' response; on the other hand, such a response is often followed by a diagnostic procedure which invites revision of that response. This suggests that there is a conflict between the interpersonal dynamics of presuming no problem and the institutional presumptions of 'problem-solving'.

There are a number of clinical implications of this project. First, there are implications arising from the analysis itself which would allow those involved in problem-solving to reflect more fully upon the practices currently used to identify mental ill health. There were different questioning formats which were related to different response trajectories, from optimising 'no problem' responses to problem attentive expansion of mental ill health problems. These formats were clearly recipient designed, though the motivation for these designs was likely to stem from different sources. At one level, they would be contingent upon the sort of information that had been gleaned from earlier interactions, at another, they would arise from the degree of cooperativeness of the offender, and at yet another, the problem-solving team members are constrained by the institutional requirements to provide a summary and feedback to the court within a short time frame. A current model of training which would be applicable here are those based on the principles of Conversation-Analytic Role-play Method (Stokoe, 2011).

The second implication arises from recent developments in the clinical professions themselves, which could be used to develop problem-solving team members' understanding of how mental health assessments are made. Thus, it is possible that training could be developed which builds on current clinical psychology understandings of mental ill health in terms of formulation as opposed to diagnosis (Johnstone & Dallos, 2013) and so avoiding over-prescriptive psychiatric categories.

A third implication is that those within the clinical professions can gain a better understanding of how mental ill health is assessed and identified among largely hard-to-reach social groups. The problem-solving meeting is a particularly good opportunity to engage with such groups in settings outside the surgery or clinic. A recommendation which followed the Bradley Report was the establishment of the Mental Health Treatment Requirement (NOMS, 2014) as a community order option available to magistrates. However, Scott and Moffatt (2012) noted that this order is chronically underused (less than 1% of all community order requirements), suggesting that in most Magistrates' Courts those with mental health problems are not obtaining specialist intervention as part of their sentence. The arrangements we have investigated here, where problem-solving is undertaken by a non-specialist team, are an important corrective to this gap in mental health provision and suggest that a greater level of co-operation could be initiated between these teams and clinical professionals. Please refer to Table 32.2 for a summary of the clinical implications.

Table 32.2 Clinical practice highlights

1. Incorporating a problem-solving procedure into the lower courts provides an opportunity to engage with 'hard-to-reach groups' and to explore mental health issues.
2. It is worth considering how 'problem attentive' questioning can be incorporated more fully into the problem-solving meetings.
3. Form-initiated questioning could be used more flexibly. Information about mental health is often revealed through discussion of life stories, where the offender is more likely to focus on the realities of their experience.
4. A wider range of services might be considered for signposting.
5. Improved training for these front-line non-clinical staff in formulating mental ill health as a biopsychosocial phenomenon rather than simply a medical phenomenon.

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Notes

1. In all extracts, 'PS' refers to a member of the problem-solving team; these members included police officers and members of a third sector organisation. 'Off' refers to the offender who has been sent out by the court to engage in problem-solving.
2. We have included Extract 8 in this section as, although it does not strictly conform to a question cascade format, it has the straight interrogative format of second cascade questions and, as such, can be seen to be doing similar work insofar as it allows for elaboration and sequence development.

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33

Discourses of Abuse and Recovery: Talking about Domestic Violence and Its Implications for Therapy

Henderikus J. Stam, Michaela Zverina, H. Lorraine Radtke, and Robbie Babins-Wagner

Introduction

Research has generated considerable knowledge about the prevalence, nature, and consequences of abuse of women by their male partners. Specifying what constitutes intimate partner violence (IPV) is still controversial however (e.g. Adams, Sullivan, Bybee, & Greeson, 2008; Fawole, 2008; Follingstad & Bush, 2014; Hines & Malley-Morrison, 2001; Johnson, Leone, & Xu, 2014; Statistics Canada, 2011), and the predominant line of research has served to increase the complexity by adding categories and subcategories. Within a social constructionist and discursive framework, the instability of meanings becomes a topic for research, and a productive line of inquiry is to explore the meaning of IPV within a specific social context.

One such context is women's abuse towards men within intimate relationships, a highly controversial topic that has produced considerable debate concerning the extent and nature of such abuse in comparison to men's abuse towards women (e.g. Dasgupta, 2002; Migliaccio, 2002; Miller, 2001; Straus, 1999, 2012; Tutty, 1999). At issue is the constitution of abuse in relation to the context of the violence (see Saunders, 2002), motives and severity of consequences (see Hamberger, 2005), and appropriate sources of data (see Seamans, Rubin, & Stabb, 2007) and data collection methods (see Jackson, 1999; Kimmel, 2002). Thus far, research has failed to resolve these disputes.

Those who contend that women's victimisation is the greater problem argue that men's and women's victimisation are qualitatively different. Men perpetrate more controlling and extreme abuse than women (see Johnson, 2005; Johnson & Ferraro, 2000, Straus, 2005); women's violence is often motivated by self-defence or retaliation (see Swan & Snow, 2002). This has led to further categories of IPV, including 'intimate terrorism', aimed at controlling and manipulating the partner (Johnson, 2005); 'coercive controlling violence' (Stark, 2007), a pattern of violence, intimidation, isolation, and control; 'common-couple violence', minor violence perpetrated by both partners at similar rates (Johnson, 2005; Straus, 2005); and 'violent-resistance', perpetrated for purposes of retaliating or defending oneself from the other partner's violent and controlling behaviour (Swan & Snow, 2006). Thus, rates of IPV among men and women must be interpreted in light of the context (DeKeseredy, 2006; Kelly & Johnson, 2008; Stark, 2007).

Understanding those on the receiving end of IPV has also been contested differently for women and men. Walker's (1979) theory of battered woman syndrome positioned women as victims who became helpless and hopeless in the context of IPV. Other researchers, however, have focused on women's resistance, positioning the women as survivors (e.g. Davis, 2002; Hyden, 2005; Jackson, 2001; Leisenring, 2006; Todd & Wade, 2004; Wade, 1997, 2000). When men are on the receiving end, barriers that deter help-seeking and their identification as victims of IPV have been identified. These include societal perceptions of men's physical capacity to repel abuse and their financial and physical ability to resolve their own issues; men's struggles to reconcile their victimisation with the norms of masculinity (e.g. McKelley, 2007; Noone & Stephens, 2008); public perception that violence towards men perpetrated by women is more acceptable than vice versa (Lehmann & Santilli, 1996); and men's fear of being humiliated or accused of being the abuser (O'Brien, Hunt, & Hart, 2005). At stake for both women and men is the legitimacy of their positions, which is often the case for all kinds of violence and abuse (e.g. in child sexual abuse, see Fowlis et al.; Chapter 9, this volume).

A growing body of research has provided insights about the ways in which language and narrative are used to construct experiences of abuse and victimisation and exposes some problematic cultural discourses. In particular, the discursive constructions of *gender*, *victims*, *perpetrators*, and *abuse* are multiple and often contradictory, performed through social interaction, responsive to the social context, and rhetorical (Boonzaier, 2008; Boonzaier & de la Rey, 2003; Jackson, 2001; Leisenring, 2006; Williston & Wood, 2009). Moreover, being positioned as a victim has varied consequences depending on the conversational context and the participants' stake in the interaction. For example, when women successfully position themselves as victims, they may gain access to support (i.e. psychotherapy and counselling) and understanding (Leinsering, 2006). Simultaneously, however, they may be devalued as helpless, passive, weak, and powerless (Lamb, 1999), putting them at risk of being blamed for their victimisation (Leinsering, 2006). Also, research has identified discursive resources, including common-sense notions of patriarchy, equity, individualism, and collectivism that silence women and make it difficult to leave their partners (Towns & Adams, 2009). When considering men, discursive research has focused almost exclusively on men as perpetrators, noting that men's use of language serves to 'isolate and threaten the victim, manipulate public appearances, and avoid responsibility' (Todd & Wade, 2004, p.145). Men also resist being positioned as 'abuser/perpetrator' through the use of gendered discourses and other rhetorical strategies (Adams, Town, & Gavey, 1995; Anderson & Umberson, 2001; Boonzaier, 2008; LeCouteur & Oxland, 2011; Wood, 2004), but how men account for their victimisation remains under-studied. Exploring IPV from a discursive perspective offers the promise of insights that move beyond debates concerning the 'reality' of IPV.

Few discursive studies have explored the psychotherapeutic contexts for IPV (see Kurri & Wahlstrom, 2001; Todd & Wade, 2004). One problem is that women are often positioned as powerless victims of powerful perpetrators, while violent men are positioned as responsible for IPV (Augusta-Scott, 2007). Further, therapists hear men's accounts of being abused as attempts to avoid responsibility and working towards alternative ways of relating to others. A discourse analytic study of group psychotherapy for men who have been abused within a heterosexual relationship showed that men were not positioned as victims by virtue of their participation in the group and instead had to actively work with the facilitators to be positioned as 'true victims' (Zverina, Stam, & Babins-Wagner, 2011). The therapeutic language of 'resistance', which has been advanced as important for therapy with women, precipitated extensive negotiation within the group as it put the men at risk of being positioned as abusers when their acts of resistance were interpreted as aggression. Thus, the negotiation of meanings within therapy seems a fruitful context for research.

This brief overview establishes a lack of consensus regarding the meanings of abuse, its consequences, the categorisation of peoples' experiences (e.g. victim or survivor), and effective interventions. Nevertheless, some understandings have become accepted 'truths' within common sense and within the academic community and other relevant institutions (e.g. psychological therapy groups, legal systems, women's shelters, medical contexts). As well, the dominant meanings produced through research have informed the development of victim programmes and therapeutic services for women and men who have been abused. In particular, the professionals who lead such programmes are knowledgeable about this research literature and therefore their delivery of therapeutic services, including the language they use to talk about abuse, is shaped by the available meanings. From the perspective of discursive psychology (Potter & Wetherell, 1987), this is not a problem per se. It is important however to understand how the meanings associated with IPV come into play and shape the interactions between those seeking help and those dedicated to providing that help.

Discourse analytic research (Potter & Wetherell, 1987) has the advantage of being able to explore the *process* of *how* domestic violence therapy is performed – in particular, how abuse accounts are constructed, how therapy clients position themselves and how facilitators position and reposition group participants. We examine how both participants and professionals working in the field of IPV construct abuse and responses to abuse during group therapy interactions, providing new understandings about the nature of therapeutic discourse in the context of domestic violence and the gendered nature of this talk. The therapy groups we studied were single-gender, and therefore the analysis sheds light on differences and similarities between the groups, while also exposing the socio-political context that was negotiated between the therapists and the group participants. Furthermore, the privileging of social interaction as the data source drew attention to the construction of identities, the possibilities related to responding to abuse and the therapeutic interventions aimed at helping the participants move past the abuse.

Project overview

We analysed video-taped sessions from two 14-week, psycho-educational group programmes for victims of IPV that were offered by the Calgary Counselling Centre in 2009: one for men, 'A Turn for the Better' programme (TFTB), available since 2002, and the other for women, 'You are Not Alone' programme (YNA), available since 1986. According to the TFTB programme's manual, the aim is therapeutic change for men who have been abused and want to pursue non-abusive futures and develop healthy relationships. To qualify for the programme, the men first attend a minimum of four individual counselling sessions, which include an interview-based assessment of the men's 'primary victim status'. A man–woman team facilitated the 2009 group. The manual for the YNA programme describes its aims as helping women understand the impact of their partner's violent behaviour on their mental, emotional and physical health and the health of other family members, especially children, with an emphasis on learning how to deal with the effects of violence and be in abuse-free relationships. Again, the two facilitators in 2009 were a man and a woman.

Participants

Six men (ages 24–55 years) participated in the TFTB group. Four identified themselves as 'single' and not living with their abusive ex-partners. Two were living in a common law relationship with their abusive women partners for the duration of the group. Two were previously married. Four had fathered children with their abusive partners and one had fathered a child with an ex-non-abusive partner. Five indicated that they were heterosexual and interested in women partners. One (age 24 years) shared during the second week of the group that he was gay. Five had a university degree, and one had completed full military education and training. Five were employed full time (peace officer, nurse, teacher, paralegal, oil and gas consultant), and one was on long-term disability (previously employed in Pharmaceutical Sales). All identified as European Canadian with English as their first language.

Twelve women (ages 24–52 years) participated in the YNA group. Seven identified themselves as 'single', three as 'separated' and two as 'married'. Three were living with their abusive partners for the duration of the group. Eight had mothered children with their abusive partners and one shared that her children were apprehended by social services. The women's sexual orientation was never explicitly discussed; they only discussed experiences that concerned men partners. Four had achieved an education level between Grade 9 and 12, four had completed a technical/vocational programme at the post-secondary level and four had a university education. Six were employed full time, one part time, three self-employed and two were unemployed. Their occupations included aesthetician, server, bartender, registered nurse, administrator, house cleaner, teacher, artist, accountant and assistant manager. With the exception of one European American, all women identified as European Canadian, and all spoke English as their first language.

Procedure

All participants provided verbal and written consent to have the groups' sessions digitally recorded and used for research purposes. The recordings were transcribed based on a simplified version of the conventions recommended by Potter and Wetherell (1987) and anonymity of participants was preserved through the use of pseudonyms. The analysis entailed the following steps: reading, coding, analysis and writing (Potter & Wetherell, 1987). Multiple readings of the transcripts were followed by coding, which involved selecting segments of text that related to our interest in constructions of abuse and responses to abuse. Analysis involved searching for patterns, that is, both variability and consistency, in *how* group members discussed what happened to them and how they responded, the features of these constructions, and how they positioned themselves and others. The transcripts for the men's and women's sessions were fully analysed separately before comparing them.

Analysis

Two questions guided our analysis. First, how do the separate analyses of the 'abuse' negotiations in each gender group compare to one another? And second, what does the language of resistance to abuse accomplish and how do its discursive consequences compare between men's and women's groups? In addressing these questions, we provide extracts that exemplify patterns evident across the sessions.

Producing abuse accounts and victim subject positions

What counts as abuse was an explicit topic in both groups and was continually negotiated. The men provided play-by-play (or 'he said, she said') narratives that were lengthy and detailed and in which they worked to position themselves as victims. Extract 1 is taken from the beginning of the men's third session.

Extract 1

Ted: Why were you fighting?

Ken: Well you know, it was everything, it's hard to condense six hours into a few minutes but (1.0) later on in the night Kathleen wanted to get her stuff packed and (3.0) she gets really bossy, and she says 'Ken, get your suitcase organized, do it **now**' and I said 'listen, I don't need to do it right now', I looked at the clock, we got home at 9:20 and the game is on until 9:30 I **just** sat down, I **just** came back from the store and I sat down and I said 'I will just look at the score (hockey game score) and then I will do it'. And at 9:26 she says to me like 'okay **Ken**, now do it' and I said '**Kathleen**, I'll do it at 9:30'. And **then**, at 9:30 and thirty seconds I start to do it (3.0) well, she starts **ragging** on me about something and I can't remember exactly what it was and we just started yelling back and forth and then she **claims** at the time that um, I didn't start, um, packing until 9:40, you know? I was like 'what?' so now we are getting all the times confused and she's saying 'you know, I wished you participated in the family instead of sitting your **ass** in front of the computer' and she just starts going off (1.0) and I said to her, you know what? It's not appropriate that we are fighting in Jo's apartment like this. If you want to fight like this or have a conversation then we need to step outside and go for a walk. And uh, she basically **pushed** me out of the way and stomped down the hall (2.0) and said '**fine** let's go for a walk' and maybe that's what stood out the most because she was acting like her mom was, and I was like 'this is **BS**, like I could throw you out of a window'. Like I'm a strong guy but **you women** you're acting like (1.0) you're wearing the pants, **you** have the **balls**, like you know? Like what the hell is going on?

Linda: I wonder if when you use the term 'You women' you are talking about your partner?

Ken: Yeah my partner and **her mother**. Because it's almost (2.0) like it occurred to me at that moment that they were cut from the same cloth.

35 **Ted**: You didn't mean all women
36 **Ken**: No no, I didn't mean, to **rampage all females**. But no, just
37 those two women (2.0) like my mother, I love her, and my sister,
38 we are close too. I have female friends (4.0) **I** don't know, the
39 thing is, and I don't know if I'm answering your question I don't
40 think

Ken's detailed narrative created the impression that he was both knowledgeable and accurate in his account of the events (Edwards & Potter, 1992). He included direct quotations (e.g. line 5), which signals verbatim recall and hence accuracy and 'objectivity' in the description of events (Goffman, 1981; Potter, 1996). The absence of any clarification questions from the facilitators (Linda and Ted; lines 2–29) supports our claim that Ken provided a believable account. He built his identity as reliable and blameless by making specific reference to the order of events (e.g. 'and then', line 14) and times of occurrence (e.g. line 7), but failed to provide any reasons for his wife's actions. Throughout, Ken switched between positioning his wife as the instigator and abuser (lines 13, 18, 23) and positioning himself as engaging in mutual verbal abuse (lines 14, 24)). Notably, he positioned himself as the one attempting to end the conflict (lines 19–23). In describing his wife's physical aggression, he minimised her actions, offering a credible narrative in the face of the physical size difference typical of women and men (line 23). Until line 26, Ken's discursive manoeuvring positioned him as the victim of abuse and a reasonable man. When however he explicitly drew on the membership category (Sacks & Jefferson, 1995) 'women' to claim an inappropriate reversal of gender roles and positioned himself as a 'strong guy' (lines 26–29), the facilitators responded. While not explicitly accusing him of sexism, Linda questioned his reference to 'you women' (lines 30–31) and Ted sought clarification that Ken was not referring to all women (line 35), a line of questioning that could have re-positioned Ken as a misogynist and potentially an abuse perpetrator. In this case, Ken maintained his victim position by resisting Linda's positioning and re-positioning himself as reasonable.

The pattern evident in the extract centred on Ken was not unique to him or to this specific extract. The men's positioning as victims was not taken for granted by the facilitators or the other group members. As in the extract above, when the men were working to position themselves as authentic victims, they offered lengthy, play-by-play, vivid accounts that utilised a variety of rhetorical tools, including direct reporting/quotations and chronological organisation that were evident in Ken's account.

In contrast, the women oriented to IPV in their accounts, but did not actually describe their experiences. Commonly, abuse was referred to simply as 'it' or 'what I was going through', language that is ambiguous without a detailed explanation or shared understanding of its meaning. When the word 'abuse' was explicitly used, the conversation continued smoothly with no questions and no elaboration. Thus, their positioning as victims of abuse was taken for granted. Extract 2 is an example of the use of 'it' and is taken from a moment in Session 6 when Lora was talking about her relationship with her partner before he became abusive.

Extract 2

Lora: And we did very simple things, because we didn't have a lot
of money at that time **BUT but** and it was just really fun (2.0)
Anyways yeah, then he got a really stressful job aaand the whole
dynamic changed because he was gone like three weeks of the month
at work and um **when** he did come back, he was really stressed out
(2.0) so, (3.0) **and** then I took a job where um I was stressed
out, and, so, I should work **less** at the job I was doing and focus
more time on my art which is what I went to school for, so I mean
at the **time** it was probably not the best idea financially because
I couldn't really (2.0) **do** it by **myself**, so that's probably **when**
it started. That's when **it** (1.0) got (2.0) **bad**, well okay

Adam: How were you dependent on him?

Lora: Well I moved in with him and...

'It' was used throughout this extract to refer to Lora's life with her partner. As a word with no direct referent, 'it' can be used in a flexible way, and in this case, the specifics varied from referring to their life together (line 2) to Lora's prioritising making art over a job (line 9) and the abusive relationship (lines 10–11). In order to make sense of what she was saying, the other participants, including the facilitators, had to draw on shared knowledge about IPV (as researchers analysing this extract, we did the same). Demonstrating this, Adam, the facilitator, did not question what 'it' meant. Instead, he focused on Lora's dependence on her partner, a condition explicitly associated with abuse in the professional literature, taking for granted that what Lora experienced constituted abuse and that she was the victim.

Another example of how the women's positioning as victims was taken for granted was their unchallenged claims about how they knew that they had been abused through feminine intuition and their bodily responses. For example, see Extract 3.

Extract 3

Diana: You know when you're being abused and you don't want to be a
part of that anymore, so you know when you sense it, you smell it,
you touch it, you feel it, you can hear it, even if it's just **way**
down the road, **way** before you ever used to, and so when you see it,
you can go 'ahhh', you recognize that

Diana used 'you', an ambiguous pronoun, to include the other women in the group, herself and possibly all women experiencing abuse. She attributed a metaphysical quality to the process of recognition, that is, women carry this knowledge with them even before they have experienced abuse (lines 3–4). None of the group participants nor the facilitators took issue with this.

As an exception, the women spoke in detail about physical abuse and danger when the conversation focused on avoiding re-victimisation. This often occurred when a woman positioned herself as indecisive about whether to leave an abusive relationship or return to one and was focused on convincing the woman to leave or not return. At no time was the woman's position as a victim in doubt. These conversations exclusively involved the group participants with no intervention by the facilitators. Notably, they did not always result in the desired re-positioning, that is, three women remained with their abusive partners throughout the programme.

Constructing appropriate responses to abuse

The men's accounts of responding to their women partner's abuse varied from avoiding such situations and attempting to leave to verbally retaliating and physically engaging in mutual violence. They were worked up to justify their actions and to level blame at the abusive partner. They also constructed a number of problems that made it difficult for them, as men, to respond effectively or appropriately to their partner's abuse. One of these was the norm that men should never hurt or hit women, which is produced in Extract 4 from Session 1.

Extract 4

1 **Richard**: ...because a **man** is stronger than a woman, like in most
2 cases, so like when she tries to (3.0) take you by force, it just
3 doesn't seem **fair** that you can't use that **same** force back. It's
4 always this fear in your mind that if you do anything you are in
5 deep deep shit, so then your hands are tied behind your back, and
6 you are thinking 'great, you know, I used to work out you know
7 and do all this stuff you know and this chick is steering me' and
8 there's nothing I can freakin do. It's BS you know, so...

Richard emphasised his helplessness (lines 5, 10) in the face of a woman's abuse (lines 2, 9) because as a man, who is physically stronger than most women (line 1), he ought not to use physical force towards a woman (lines 3–5) (Connell, 1996; Lea & Auburn, 2001; Stobbe, 2005; Wood, 2004). The conversations in the men's sessions frequently centred on this dilemma – how to respond to a partner's aggression in non-aggressive ways – and the men's accountability became a major focus. Importantly, the facilitators, Ed and

Linda, frequently through asking questions, positioned the men as accountable for their own conduct and responsible for how they responded to abuse (Extract 5).

Extract 5

Ken: I (2.0) here's the problem side of this, it's when you're in an abusive relationship, **I** find that when I'm in it I almost **mirror** that behavior? So if she's aggressive I'm aggressive back, it's **tough** to stay in a healthy triangle when you're living in an unhealthy triangle. Do you know what I mean?

Chris: I I totally know what you mean, it's almost like you're **forced** into it, because you can't communicate with crazy

Ken: No (laughs)

Chris: So you just decide to stop

Ken: (laughs) **That** that makes me see that you understand. You can't communicate with crazy. When you're trying to be a **rational** person trying to communicate on a **logical** plane and you're **not** getting through, that's why, because they are on a **completely** different realm

Ed: So where does that put you on the triangle? If they are?

Ken: They are judgmental and I I guess that's where I feel like I'm judgmental because I'm calling them on their crazy.

Ed: **Exactly**, if you're calling someone crazy you're being aggressive, you're acting aggressively. Um, I think that when people interact (1.0) in these roles (2.0) they're **inviting** those other people they're with into these roles, I think what you're saying is, if my partner is acting aggressively, it makes **me** want to act aggressively back

Ken: Yeah

Ed: And (2.0) you're saying that when someone is acting in that role that's inviting you into that triangle

Ken: Yeah totally, exactly

Linda: So how do you **choose** not to go into that triangle?

Ken: Exactly?

Chris: But **they** may decide not to disengage no matter what you do

Linda: Your partner may not

Chris: Yeah (2.0) so you can be trying to be in the good triangle for hours and hours and hours and (4.0) you know, and then it might not help

Ken worked up the problem of being in an abusive relationship as his tendency to mirror his partner's aggressiveness and the difficulties of responding in a healthy, non-aggressive way (lines 1–5). Chris offered corroboration (lines 6–7). Ed, the facilitator, then asked a question involving Karpman's Triangle, an educational resource that describes ways of responding that serve to maintain an abusive relationship (line 15), which redirected the conversation to Ken's accountability in the abusive situation. Ken initially positioned himself as 'judgmental' (line 17), but Ed positioned him as aggressive (lines 18–23), and as the conversation continued, Ken accepted responsibility for being aggressive and agreed with Ed (lines 24, 27). This was a discursively difficult topic as the men's accounts of abusive incidents frequently opened up the possibility of their being positioned as perpetrators (Extract 5, lines 21–23). Linda, the other facilitator, then asked a question that challenged the men to consider alternatives to acting in ways that perpetuate conflict (line 28). Chris however mounted a convincing argument against such an alternative (lines 30, 32–34), and the topic ended with no resolution. Negotiating how men should respond to women's abuse without using aggression (as in this extract) was a frequent pattern in the men's sessions as was the failure to establish a non-violent alternative solution.

Thus, the topic, responses to abuse, was negotiated around a gendered problem – that men should not be aggressive with women. The men used this 'rule' to defend their positioning as helpless in the face of their partner's abuse, and although they positioned themselves as reasonable and their partners as 'crazy', the facilitators held the men accountable for their actions and sometimes positioned them as aggressive. Although the men positioned their women partners as accountable, the facilitators refocused attention on the men's actions and re-positioned them as responsible for their actions and capable of effective, non-violent responses even though the nature of those responses was never worked out.

Within the women's group, on the other hand, women's accounts of being aggressive produced a different kind of talk compared to the extracts from the men's group above. This is shown in Extract 6.

Extract 6

1 **Lanette**: But I'd be pushing him and pushing him. And you know what?
2 This is when this is when (1.0) I started thinking (1.0) of how
3 stupid it all was. I'll **push** him and **push** him until he whacks me in
4 the head or punches me in the arm. Oh my **god**, I can't believe I just
5 said that, that's how high it goes
6 **Jody**: Here is another **dynamic**, where, sometimes, the abused person
7 in the relationship will **invite** the abuse, but has control over

8		where it happens, how it happens
9	**Adam**:	It's like you are **seeking** to take **control** of the **situation** by
10		inviting (2.0) that abuse (**Lanette**: Um hm), by saying 'go ahead do
11		it' and you'll get charge, get in charge
12	**Diana**:	Why do we do that?
13	**Tara**:	Because we want to end it
14	**Diana**:	Yeah
15	**Tara**:	Because we wanna wanna uh **control** when it happens, right? We
16		want to control **when** it happens because you have plans right? Like
17		you have plans for tomorrow you have plans and you know what? I just
18		wanna get it over with and by the time the weekend comes I'm happy
19	**Elyssa**:	I didn't
20	**Tara**:	**I** used to do that, I used to do that
21	**Lora**:	I know it's hard to hear you say that but like it's **true**
22		(**Tara**:Yeah) it's just sad though
23	**Tara**:	Yeah
24	**Lanette**:	And it's like he is bigger and stronger but at least I got
25		to do that, and then somebody's like hey and you want to stop it

Lanette positioned herself as 'pushing' her partner until he becomes physically aggressive with her, but also questioned her actions and held herself responsible (lines 3, 5). The facilitator's (Jody's) interruption initiated the repositioning of Lanette and the reconstruction of Lanette's reported experience as part of a general 'dynamic' within abusive relationships (line 6). Adam, the other facilitator, bolstered Jody's claim by attributing the motive of seeking control by 'inviting abuse' to women in this situation (lines 9–11). Positioned as experts in the area of abuse given their roles, Jody and Adam oriented to the 'official' discourse of IPV and how victims respond to abuse in order to protect themselves by controlling 'where' and 'how' the abuse occurs (line 9). Rhetorically, the generalisations ('the abused person', lines 6–7; 'you', line 9) served to build a strong case that Lanette's initial account reflected a protective and useful purpose. When Diana questioned why 'we' invite abuse (line 12), most group members supported the facilitators' claims. In turn, they argued that inviting abuse is a strategic and useful way to end and control abuse. However, they also constructed it as 'sad' and putting them at risk of being blamed for perpetuating the abuse (lines 22–27). Thus, while the facilitators took for granted the women's victimhood and did not propose non-violent alternatives, Lanette held herself accountable and pointed to others who might do the same.

In reconstructing the women's accounts of aggression as justified to ensure their safety and protect themselves, the facilitators drew from a well-established discourse within the field of IPV (Coates & Wade, 2004). Thus, they positioned the women as victims and survivors and re-constructed the women's accounts as resistance to the abuse and acts of defiance and independence. Although the women positioned themselves as accountable and challenged their victim identities (i.e. blamed themselves), the facilitators countered by re-positioning them as survivors who did what was needed to survive. The women's self-questioning is understandable given that in various contexts women who position themselves as survivors risk having their victimhood called into question (Dunn, 2005; Leisenring, 2006); the facilitators' re-positioning of them is equally understandable given that the problem of victim blaming in the context of IPV is part of the discourses of IPV that circulate in the field.

The differences between the women's and men's groups point to the gendered meanings of IPV, that is, the facilitators constructed the problem of women who are victimised as passive and dependent; for men, it is aggressiveness and a negative attitude towards women and femininity. In each case, however, a potentially productive conversation was foreclosed by the facilitators' failure to engage with the participants' concerns. In the case of the men's group, these included having their victimhood questioned and the absence of convincing, non-violent strategies for responding to an abusive partner. The failure here is understandable given the lack of clearly established expert discourse related to abusive relationships where men are the victims and women the perpetrators (generally, the meaning of men's victimhood is hotly contested). In particular, the discourse of resistance, which dominates in services for women, was not useful as there was no need to 'empower' the men, since they did not position themselves as passive, self-blaming victims. However, a challenge for the facilitators was that the men's accounts bear strong similarity to the accounts of men who are positioned as violent and use claims of victimhood to avoid positioning themselves as perpetrators (Edin, Lalos, Hogberg, & Dahlgren, 2008). Thus, it is not surprising that the facilitators understood the men's accounts as attempts to avoid responsibility for questionable conduct and ignored their concerns about the lack of means to deal with an abusive partner. In the case of the women's group, the discourse of resistance was used to reposition them as having agency, but it also meant that the facilitators offered a one-sided response to the women's concerns about the ethics of their aggressive conduct. Moreover, the facilitators and other participants took for granted the women's positioning as victims and the commonality of their experiences, which glossed over the possibility of differences.

Clinical relevance summary

This study highlights specific group therapy features that may be particularly helpful for women, but not men, and vice versa. The facilitators of the men's group faced an implicit therapeutic dilemma. On the one hand, the men had voluntarily sought help and positioned themselves as victims, and on ethical grounds, their accounts should be taken in good faith. On the other hand, at times the men's use of language was similar to the talk of perpetrators who seek to re-position themselves as victims and avoid taking responsibility for their own actions. Furthermore, although the men positioned themselves outside of traditional discourses of masculinity in claiming to have been hurt by their women partners, they did so in ways that reproduced traditional masculinity. Consequently, they positioned themselves as potential abusers, a tension the facilitators worked to manage. Making such a dilemma explicit and visible should help facilitators better understand the dynamics of their group work. In particular, the facilitators might have introduced the topic of gender and how it shaped the men's accounts as a way of opening up possibilities for envisioning a different future, but they did not do so. Making gender relevant to how problems and solutions are worked up in therapy may contribute to the development of therapy approaches addressing men's victimisation and women's perpetration of abuse.

The analysis also points to the limitations associated with adapting a gender-specific model based on discourses of women's victimisation to men who are positioned as victims of IPV. Three distinctive features of the men's group included (a) the challenges faced by the facilitators in positioning the men consistently as victims or survivors; (b) men's concerns about how to respond to their partners' abuse; and (c) the discourses of gender and relevant power relations specific to men. Programmes for men need to take these distinctive features into account.

Features specific to the women's group are also important. First, positioning women as having the intuitive ability to recognise abuse reproduces discourses of traditional femininity and may put them at risk of further victimisation, especially in light of research noting the difficulties women have in recognising and labelling abuse as such. A discourse acknowledging the importance of others' interpretations, for example, front-line workers in the domestic violence field, sympathetic friends, and police, might contribute to greater safety. Second, the lack of descriptive accounts of abuse within the women's group may have prevented their exploration of the aspects of their lives that make them vulnerable to abuse and the various ways they have responded to improve or escape abusive situations. Exploring the women's accounts of abuse in a more detailed manner (similar to the men's) would provide an opportunity to acknowledge and address their victimisation and their responsibility. For a summary of the clinical implications, please refer to Table 33.1.

Table 33.1 Clinical practice highlights

1. Following Todd and Wade (2004), establish a therapeutic practice wherein abuse resistance talk that explicitly incorporates discourses of gender becomes the main topic of therapeutic conversations to provide victims of abuse with a sense of control and agency.
2. Therapy for men who self-identify as abused needs to focus on concerns of particular interest to the men, for example, how to respond to abuse without putting oneself at risk of being positioned as abusive; safety is not a concern in the same way as it is for women.
3. Women's accounts of abuse may rely heavily on 'intuition', whose meaning needs to be clarified and critically discussed in therapy.

Summary

This chapter illustrates how group therapy clients and their facilitators used discourse in multiple ways to position and reposition themselves with regard to responsibility for abuse and responding to that abuse. It also shows how they negotiated the various, often gendered, discourses available to them within therapeutic contexts and has implications for therapeutic clinical practice. Finally, it points to the difficulties of translating abuse-related discourses from women victims to abused men.

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34

When Assistance Is Not Given: Disaffiliative Responses to Therapeutic Community Clients' Implicit Requests

Marco Pino

Introduction

Therapeutic Communities (TCs) are residential rehabilitation services for people with diagnoses of mental illness (Campling, 2001). TCs are programmatically removed from hospitals; they are set up in home-like settings; and they host a relatively small number of clients. Clients are expected to be actively involved in the practical management of the house by sharing responsibilities with the staff (such as cooking, cleaning, and the like) hierarchical demarcation between staff and clients is expected to be reduced compared to more traditional mental health institutions (Campling, 2001). TC clients also enjoy more freedom than in more traditional mental health institutions (e.g. hospital wards), particularly by being allowed to exit the TC unaccompanied, having a job, taking part in free-time activities, and entertaining relationships outside the TC. This is unlike psychiatric hospitals, particularly forensic-care hospitals, where patients have little free movement (Bone & Marchant, Chapter 23, this volume; Dobbinson, Chapter 22, this volume).

Although in TCs the hierarchical separation between staff and clients is reduced, it is not completely levelled out. Previous research has shown how TC staff members' conversational practices implement the institutionally relevant task of encouraging TC clients' adherence to expectations about appropriate conduct (Mortari & Pino, 2014). In this chapter, I examine another way that the asymmetrical distribution of prerogatives between TC staff and clients is oriented to and implemented in conversational interactions. By examining group meetings recorded in an Italian TC, I focus on cases where the TC clients bring their needs and desires to the attention of the TC staff members and how, by doing this, the clients give the staff members opportunities to offer assistance in fulfilling those needs and desires. I then focus on a practice that the TC staff members use to disaffiliate with (i.e. to show that they do not endorse; Stivers,

2008) the clients' project to obtain some goods or services: treating the clients as lacking entitlement to those goods or services.

Data and method

The data for this study consist of four group meetings (each lasting approximately one hour) audio-recorded in a TC in Italy in 2008. The TC was residential and could host 12 clients. During the data collection period, the majority of clients were diagnosed with schizophrenia. The meetings took place on a weekly basis and were attended by the TC clients, a nurse (Massimo), an educator (Barbara) and occasionally other staff members (healthcare assistants).

In the recorded meetings the participants engage in a range of activities, including sharing recent events experienced by the clients (and associated thoughts and feelings), reviewing the clients' performance (e.g. in specific tasks and responsibilities they have been given), planning for future events (e.g. a seaside vacation), and also small talk. Clients' requests emerge in all these activities. The participants gave written consent to publish the data. All names used in this chapter are pseudonyms.

The method used in this study is Conversation Analysis (CA) (Sidnell & Stivers, 2013). For this study, I collected all the sequences where the clients more or less explicitly issue a request. The original conversations are partly in Italian and partly in the local dialect; I transcribed them following the conventions commonly used in CA (Hepburn & Bolden, 2013) and illustrated in Table 1.3. In addition, I used the period ('.') for unit-final falling intonation, the question mark ('?') for rising intonation, the comma (',') for slightly rising ('continuing') intonation, the underscore ('_') for level intonation and the inverted question mark ('¿') for a pitch rise that is stronger than a comma (',') but weaker than a queston mark ('?'). The hashtag ('#') represents creaky voice and the tidle ('∼') represents tremulous voice. In this chapter, the data are presented in a double line: original language and English idiomatic translation. In the next section, I present an overview of the clients' requests and the staff members' responses. Subsequently, I illustrate how the clients' descriptions and displays of need or desire can be understood as implicit requests. Then, I focus on the staff members' practice of treating the clients as lacking entitlement to the goods and services targeted by their implicit requests.

TC clients' requests for goods and services

Previous research has found that requests can be formulated by explicitly enunciating the type of action that the speaker is asking the recipient to perform. An example is the *Can you do X* type of utterance (e.g. 'Can you come over in the morning?', Curl and Drew, 2008, p. 137, Extract 2, lines 5–6). This request format overtly conveys the expectation that the intended recipient performs an action. The TC clients use explicit request formats, either the imperative or, more commonly, the interrogative (e.g. 'Will you give me X' or 'Can I do X'; see Rossi, 2012) to request goods that the staff members ordinarily administrate and dispense (e.g. money and cigarettes) or permission to engage in activities that the staff members ordinarily authorise and supervise (e.g. group activities outside the TC). The staff members' responses either grant or deny the provision of what the clients requested, or they defer the decision to a subsequent time after the meeting. Through these responses, the staff members treat the clients' requests as actions that make relevant an accepting or a rejecting response (Schegloff, 2007), either now or at some other time.

In this chapter, I focus on cases where the clients issue requests less explicitly, by describing or displaying a need or a desire for something (e.g. through the *I need X* type of utterance; Couper-Khulen, 2014; Stevanovic, 2011). Through assertions and displays of need or desire, the clients do not overtly demand some goods and services; instead, they provide the staff members with *an opportunity to offer* assistance in obtaining them (Curl, 2006; Gill, 2005; Kendrick & Drew 2014). Assertions of need and desire therefore have request implications, which are left to the staff members to infer and to act upon. The next section examines the conditions under which the participants treat expressions of need or desire as performing implicit requests.

TC clients' expressions of need and desire as implicit requests

Previous research has shown that the treatment of expressions of need and desire as implicit requests is contingent upon the participants' orientation to a speaker–recipient social relationship where the recipient has the ability to satisfy the speaker's needs or desires and where the recipient can be expected to be willing or obliged to do so (so-called benefactive relationship, Clayman & Heritage, 2014; see also Stevanovic, 2011). The following example demonstrates that a client's assertion of desire can but need not be treated as an implicit request; different ways of treating the assertion (as a request or as different type of action) are linked to different understandings of the social relationship that exists between the clients and the staff members.

Before the start of Extract 1, Massimo (the TC nurse) has reported that the staff members suspect that Franco (a client) has not taken his medication for some time. Relevant for the understanding of this exchange is that the clients' pharmacological regimes are prescribed by psychiatrists who do not work in the TC. The TC staff members have a duty to administer the medication, but they cannot change prescriptions. In Extract 1, I reproduce only some parts of a lengthy exchange, which are relevant to the argument made here (for a more extended treatment of this episode, see Mortari & Pino, 2014). In all the extracts, the letter preceding the participant's name stands for their role (S for staff and C for client).

Extract (1a): [Rg1A:35] 'Medication'

31 C-Fra: *°(Ma io)/(Io) (non le voglio)*
°(But I)/(I) (don't' want to)

32 *prendere le terapie.°*
take the medicines.°

33 (1.6)

34 C-Fra: [°( ][ )°

35 [(0.7)]

36 S-Mas: *[Non le vuoi più prendere?*
[You don't want to take them anymore?

At lines 31–32, Franco states that he does not want to take some drugs he was prescribed. Being designed as an assertion of desire (in this case, a desire *not* to do something), this turn can be heard as an implicit request. However, staff member Massimo treats Franco's turn as providing information (line 36), not as making a request (Stevanovic, 2011). Later in the meeting (Extract 1b) it emerges that Franco's unwillingness to take the medication is treated as his own problem to solve, rather than a request that the staff do something about it (Barbara is another staff member):

Extract (1b)

143 S-Bar: *E hai provato a parlarne con la dottoressa?*
And have you tried to discuss it with the doctor?

144 C-Fra: *Ha detto che (ci) sarà mercoledì prossimo...*
She said that she will be (there) next Wednesday...

Barbara's turn at line 143 elects 'discussing it with the doctor' as an appropriate course of action for trying to sort out Franco's problem. The doctor (i.e. Franco's psychiatrist) is thereby treated as the appropriate recipient for a request to stop taking the medication. Barbara (who is an educator) does not treat herself or any other of the co-present TC staff members (i.e. a nurse, and two healthcare assistants) as having the prerogative to do something for Franco's stated desire. This suggests that a client's assertion of desire is not treated as an implicit request when its recipients (here, the staff members) treat themselves as lacking the ability to satisfy that desire. However, later in the meeting, it emerges that another client (Clara) may have heard Franco's assertion of desire as an implicit request and that she oriented to the possibility that the staff members *have* the power to grant that request.

Extract (1c)

159 S-Bar: *Va bene dai allora staremo a vedere cosa succede.*
Alright then so we'll wait and see what happens.

160 (0.9)

161 S-Bar: *M[:h?*
M[:h?

162 C-Cla: *[(Ma) non gli da[te più la terapia?*
[(But) are you not gi[ving him the medication anymore?

163 C-Car: *[Un pandemonio.*[1]
[A pandemonioum.

164 *Un pan°demonio.°=*
A pan°demonium.°=

165 S-Bar: *=No: (.) intanto, (0.2) è la dottoressa che dec–*
=**No: (.) first of all, (0.2) it's the doctor who dec–**

166 *sono i medi[ci.*
it's the doctor[rs.

167 C-Cla: *[Sì.*
[Yes.

After Barbara makes a move to close the topic of Franco's medication at line 159, Clara asks whether the staff are going to stop giving him the medication (line 162). This suggests that she heard Franco's expression of desire ('*I don't want to take the medicines*') as an implicit request to discontinue the medication, and that she treats the staff as having the ability to grant that request. Barbara subsequently corrects Clara's understanding. At lines 165–166, Barbara starts and abandons the utterance '*it's the doctor who dec((ides))*' where she refers to Franco's doctor (as demonstrated by her use of the feminine Italian noun '*dottoressa*') and she replaces it with the more categorical reference to 'the doctors'. With this substitution, Barbara clarifies that the doctors are the professional group entitled to address requests for changes in the clients' pharmacological regime and that the TC staff members are not. She thus re-establishes a socio-relational framework where the staff members cannot be expected to satisfy Franco's desire to stop the medication,[2] precisely because they do not have that prerogative. This re-constitutes a context where Franco's stated desire *cannot* be treated as a request. This has important implications for how the TC staff members present themselves in this exchange: it is not they do not want to assist the client; they simply cannot do it.

The analysis of Extract 1 suggests that the staff members and the clients treat a client's assertion of desire as performing an implicit request when (and only when) the assertion targets a good or service that the staff can provide as part of their insititutional remit. The next section examines how the staff members deal with expressions and displays of need and desire that they treat as performing implicit requests.

Treating the TC clients as lacking entitlement to some good or service

Whereas the clients' explicit requests target relatively straightforward matters (e.g. authorising a phone call or buying a specific type of cake for a birthday celebration), their implicit requests target things that are arguably more complicated for the staff to provide. In the examples that follow, they involve extending a client's work hours (outside the TC), renewing a long-time expired driver's license, providing an internet connection, and buying a car. The clients do not overtly request the staff members' assistance in obtaining these things. Instead, they provide the staff members with opportunities to offer assistance (Curl, 2006) by asserting or displaying that they need, want, or have some interest in those things.[3]

In one case (not examined in this chapter) a staff member (Massimo) treats a client's expressed desire to engage in a group activity as a request, and he eventually grants it. In all the other cases, the staff members respond to the clients' assertions and display of need and desire by treating the clients as lacking entitlement to the needed/desired goods (on entitlement, see Curl & Drew, 2008). In this way, they disaffiliate with the clients' project to obtain those goods. In this section, I examine this practice, which is overwhelmingly (although not exclusively) employed by Barbara (the TC educator).

The analysis of the following extracts is organised as follows: for each case, I first examine how the client's turn can be heard as conveying an implicit request. Then, I describe the sequence initiated by the client's turn and focus primarily on the staff member's turn that treats the client as lacking entitlement to some needed/desired good (the corresponding lines are arrowed). The clients' implicit requests are conveyed through turns that either claim (Extracts 2 and 3) or display (Extracts 4 and 5) that the clients want or need something.

Extract 2 illustrates how the staff members deal with a client's implicit request conveyed through an expression of desire.

Extract (2): [Rg3D] 'Work'

1 C-Dan: *A mi piaseria:: eh >lavorar sempre< col computer, (1.2)*
I'd li::ke eh >to always work< with the computer, (1.2)

2 *però: lavorar un po'::: (.) un po' di più in°somma°.*
bu:t ((I'd like to)) to work a bi:::t (.) a bit more I °mean°.

3 (0.7)

4 S-Mas: *Un po'– ↑no un po' meglio.*
A bit– ↑not a bit better.

5 (0.5)

6 C-Dan: *(E) anche un po' me:glio.*
(And) also a bit be:tter.

7 S-Mas: Eh_
Eh_

8 (1.0)

9 S-Mas: *(°Te°) piasaria lavorare col computer, (.)*
You'd like to work with the computer,

10 *un po' de più.*
a bit more. (.)

11 (0.6)

12 S-Bar: -> *Beh pri↑ma me:gli[↓o*
Well ↑first be:tt[↓er
13 S-Mas: *[un p[o' me:glio.]*
[a b[it be:tter.]

14 S-Bar: -> *[e poi di più.]*
[and then more.]

In line 1, Daniele (a client) refers to his part-time secretarial job in a local self-help organisation (this information is available to us from other parts of the recorded meetings); he claims that he would like to carry on doing that job (this is conveyed through the use of 'always'), but that he would also like to work more hours ('a bit more'). Being designed as an assertion of desire ('I'd like'), this turn can be heard as an implicit request (Couper-Kuhlen, 2014), providing the staff members with an opportunity to offer assistance in the fulfilment of the client's desire. This understanding is supported by the contrastive 'but' in line 2, which singles out something that the client values ('working a bit more'), which is not accessible to him in the present (as opposed to 'working with the computer', which the client is already doing). The qualifier 'a bit' in line 2 also supports the understanding of the turn as doing an implicit request, insofar as it minimises the possible burden apportioned on the recipients of the request (Clayman & Heritage, 2014). In addition to its grammatical design (Couper-Kuhlen, 2014), this turn can be heard as an implicit request against the background of a social relationship where the staff members have the ability to assist the clients in obtaining some goods and services (Clayman & Heritage, 2014; Stevanovic, 2011) and where they might be willing or expected to do so. In this case, we know that Massimo and Barbara are not Daniele's employers and that, for this reason, they are not in the position of accepting or rejecting a request to work more hours, strictly speaking. Notwithstanding, in their role as support workers, Massimo and Barbara are regularly in contact with the clients' employers (as is suggested in this case by their display of independent knowledge about Daniele's performance at work; see lines 4, 12, and 14). It is in the TC staff members' remit to advocate an increase in Daniele's working hours, or at least to express a favourable opinion when talking to his employer. It is against this socio-relational backdrop that Daniele's turn can be heard as an (implicit) attempt to enlist the staff members' assistance. Although Daniele does not request anything explicitly, his assertion of desire provides the staff members with an opportunity to offer assistance (Curl, 2006).

At line 4, Massimo suggests that Daniele should prioritise the goal to work 'a bit be̲tter' over the goal to work more, thereby alluding to Daniele's performance at work as not satisfactory. This utterance can be heard as an interrogative due to the rising intonation on the penultimate syllable of '*me̲glio.*'/'be̲tter.', represented here through the underlining (see Rossano, 2010), and as proposing a correction to the client's expression of desire in lines 1–2. At line 6, Daniele accepts Massimo's correction, but he treats it as an addition to a list of goals, thereby refusing to relinquish his stated desire to work more. Relevant for the analysis of Barbara's turn at lines 12 and 14 (the focal turn in my analysis) is that, after an acknowledgement token which may provide for Daniele to elaborate (line 7) and the 1.0 second gap at line 8, Massimo apparently relinquishes the attempt to challenge Daniele's stated desire and acknowledges it through a formulation or summary of the client's position (lines 9–10).

At lines 12 and 14, Barbara, another staff member, resuscitates Massimo's suggestion that Daniele should focus on working better rather than aiming at working more hours. However, unlike Massimo's turn at line 4, Barbara's turn is framed as an assertion, which sharply departs from Daniele's position. Another difference from Massimo's turn is that Barbara treats 'working better' as a necessary precondition for 'working more'. By introducing this precondition, which the client allegedly does not meet (he does not work well enough), the staff member treats him as *lacking entitlement*, at least temporarily, to the desired outcome of working more hours. In this way, the staff member disaffiliates with (i.e. conveys that she does not endorse or support) the client's project to work more hours. What is the relationship between this action and the request implications of the client's expression of desire? By expressing the desire to work more hours, the client provided the staff with an opportunity to offer assistance (although he did not overtly demand it). Now, Barbara does not deny the provision of assistance in any overt manner. However, her claim that the client lacks entitlement looks very much like a reason for not offering assistance (i.e. it would be unreasonable for the staff to support the client in achieving something to which he is not entitled). The non-provision of assistance is strongly implied at lines 12 and 14 where Barbara claims that Daniele should start working better *first*; any plan to increase his work hours can thus be considered as postponed until this precondition has been met ('first better and then more', lines 12 and 14). At the end of the exchange, assistance has not been formally asked, nor has it been formally denied. At the same time, the client created a context where the staff members could have offered assistance, and one of the staff members (Barbara) made it available that such assistance is not going to be provided.

Before the start of Extract 3, the participants have talked about the renewal of Daniele's driver's license. This discussion occasioned Dina's turn at lines 1–2 where she states the need to gather information about her own expired driver's license.

Extract (3): [Rg3G] 'Driver's license'

1 C-Din: *Io Massimo devo andare al palazzo della sanità*
Massimo I need to go to the health centre

2 *a vedere se è ancora là la mia pate:nte.*
to see if my driver's license is still there.

3 (0.9)

4 C-Din: *Col computer lo trovano.*
Will they find it with the computer.

5 (1.2)

6 S-Mas: *tk=.hhh Eh più che il palazzo sanità: Dina*
tk=.hhh Eh rather than to the health centre Dina

7 *bisognerebbe andare:::=m::::[::*
it would be necessary to go:::=m::::[::

8 S-Ann: *[Alla motorizzazi↑one.*
[**To the road traffic ↑office.**

9 S-Mas: *Alla motorizzazi↑one_*
To the road traffic ↑office_

10 (0.2)

11 C-Din: *Che sia andata a finire li?*
((Is it possible)) that it ended up there?

12 (0.9)

13 S-Mas: *Eh. Loro ce l'hanno.=Ce:rto_*
Eh. They have it.=Ce:rtainly_

14 (1.4)

15 S-Mas: *tch Ma quanti anni fa ti era scadu(°ta°).*
tch But how many years ago did it expi(°re°).

16 (0.6)

17 C-Din: *E:::h saran passati: nove s–ette otto a:nni_*
E:::h they must have been nine s-even eight years__

18 (3.4)

19 ???: °Mh°

20 S-Mas: *È [dura.*
It's [((going to be)) tough.

21 C-???: [( )

22 S-Bar: .h[hh

23 C-???: *[(dipende da[ )]*
[(it depends on [ )]

24 S-Bar: *[Ma poi sì::] ne abbiamo parlato*
[But then yes::] we talked about it

25 *anche stamattina.*
this morning as well.

26 *Che diceva che ha questi problemi alle ga::mbe.*
She said that she has these problems with her le::gs.

27 -> *>Dicevo< che prima è meglio risolvere_ (0.2)*
>I said< that first it's better to solve_ (0.2)

28 S-Ann: *M:h.*
M:h.

29 S-Bar: -> *i problemi alle GA:mbe.*
the problems with her LE:gs.

30 *Perché noi (.) non le sente:::: (.) il piede no?*
Because we (.) she doesn’t fee::::l (.) the foot right?

(0.4)

31 S-Bar: *>#Perché se no a< fre#nare accelera:re Di:na, (.)*
>#Because otherwise< to bra#ke to accelera:te Di:na,(.)

32 *pri:ma[:-*
fi:rs [t-

33 C-Dan: *[No bisogna stare attenti...*
[No it’s necessary to be careful...

By claiming the need to gather information about her expired driver’s license, Dina can be heard as implicitly trying to enlist her nominated recipient (‘Massimo’, named in line 1) to help in that course of action (Couper-Kuhlen, 2014). In addition to its grammatical design, Dina’s turn can be heard as an implicit request against the background of a social relationship where the staff support the clients with the bureaucratic procedures required to obtain a document (other parts of the recorded meetings indicate that the staff recurrently provide this type of assistance).

After a gap, at line 4, Dina issues a question about the feasibility of her plan (going to the health centre to inquire about her expired driver’s license), which is corrected by the staff at lines 6–9 (she should go to the road traffic office instead). Massimo confirms the correctness of this information at line 13, following a confirmation request by Dina (line 11). After a question about the time elapsed since the expiry of her driver’s license (line 15) and Dina’s answer at line 17, Massimo negatively assesses the overall feasibility of the plan at line 20 (he seems to suggest that, after all this time, Dina may not be allowed to renew her driver’s license). Up to this point, the staff members have introduced reservations about the feasibility of Dina’s plan, not about its validity. After some non-discernible words by another client, staff member Barbara addresses the validity of Dina’s implicit request (this is the focal turn of my analysis).

Through the turn initial ‘But’ at line 24, Barbara frames her turn as embodying a disagreeing stance. She then introduces a reservation about Dina’s plan to renew her driver’s license: she has a health problem (lines 30–31), which would prevent her from driving safely. By claiming that the client lacks this necessary precondition, Barbara treats Dina as lacking entitlement (at least temporarily) to the desired outcome of driving a car. Barbara does not disaffiliate with the client’s project as strongly as she does in Extract 2; in Extract 3, Barbara’s disaffiliation is somewhat mitigated by her conveyed solicitude for Dina’s health. Notwithstanding, Barbara clearly shows that she does not support Dina's project and this can make available to Dina that assistance will not be provided in the achievement of her goal. That assistance will not be provided is strongly implied at line 27, where Barbara suggests that Dina should take care of her health problem *first*; any plan to gather information about her driver's license is, by implication, postponed until this precondition has been met. As in Extract 2, the client's (alleged) lack of entitlement works as a warrant for not offering assistance (i.e. although Barbara does not deny assistance in any overt manner, her claim that Dina is not fit to drive comes across as a reason for not assisting her in a course of action that could lead her to renew her driver's license). After some further discussion on this matter (data not shown), staff member Massimo suggests that Dina could ask her ex-husband to gather information about her expired driver's license ('Why don't you send Rossi there to see?'). This move provides further evidence that Dina's expression of need was heard as an attempt to enlist someone to assist her and, furthermore, that the staff are not going to provide that assistance.

Before the beginning of Extract 4, staff member Massimo has announced that a new computer room, which will be made available to the clients, has nearly been completed.

Extract (4): [Rg3C] 'Internet'

1 S-Mas: *E:::: .hh ade:sso: m:h c'è (0.8) quel computer=*
A::::nd .hh now: m:h there's (0.8) that computer=

2 *= il terzo computer che >eh< funziona.=*
=the third computer which >eh< is working.=

3 *=E mi ha detto la Bruna che: tra l'altro*
=And besides Bruna told me that

4 *è anche molto valido.*
it's also very efficient.

5 C-Car: *Ma c'è inter°net anche su que[llo.°*
But is there Inter°net access too on that [one?°

6 S-Mas:: [No:.

7 (.)

8 S-Mas: *[per quan–]*
[altho-]

9 C-Car: *[Ah non ha] mia internet.*
[Oh it doesn't have] Internet access.

10 (0.7)

11 S-Ann: *Per ora_*
For now_

12 (0.2)

13 S-Mas: *Per ora_*
For now_

14 (0.7)

15 S-Mas: *'desso co::n (.) Però >se uno vuol mettersi lì<*
Now wi::th (.) But >if one wants to go there<

16 *imparare a usare il mouse, accenderlo spegnerlo,*
learn how to use the mouse, to turn it on to turn it off,

17 (0.3)

18 S-Mas: *oppure far qualche gioche:tto_ (.)*
or to play some little ga:me_ (.)

19 *penso >che ci sono< i giochi dentro,=*
I think >that there are< games on it,=

20 *=spider, solitario, quelle robe [lì?*
=spider, solitaire, those things [*ADV*?

21 ???: [( )

22 (0.4)
23 S-Mas: *Tanto da usar qualco:sa.*
Just to do so:mething.

24 S-Bar: -> *Perché (.) per [andare su inter]net,=*
Because (.) to [go on the Inter]net,=

25 S-Mas: *[Potete fa:rlo eh?]*
[You can do it eh?]

26 S-Bar: -> *=bisogna:=~en:h (.) saperlo usa:re il computer eh?*
=it's necessary=~en:h (.) to know how to use the computer eh?

27 C-Car: *Sì [sì.*
Yes [yes.

28 S-Ann: *[Eh sì*
[Eh yes

At lines 1–4, Massimo singles out one of the computers in the new computer room as particularly 'efficient'. This is followed by a client's question about whether this computer is equipped with Internet access, which possibly displays his interest in having access to the Internet (line 5). Carlo's display of interest (possibly reinforced by his disappointed-sounding receipt of the information that Internet access is not available, at line 9) has request implications, to which the staff members orient at lines 11–13 by implying that Internet access might be provided in the future. At lines 15–23, Massimo seeks to compensate for Carlo's conveyed disappointment by suggesting alternative recreational uses of the computer room (Kendrick & Drew, 2014). As in the previous cases, the interaction reaches a point where the staff members have introduced reservations (Extracts 2 and 3) or pointed to barriers (Extract 4) to the satisfaction of the client's conveyed desire or need, but they have not contested its intrinsic validity. At lines 24 and 26, Barbara targets the validity of Carlo's conveyed interest in using the Internet.

In this case, Barbara's turn links back to Massimo's previous turn (as suggested by the initial 'Because') and supports the points made therein (lines 13–23). By describing a necessary precondition for using the Internet, which the clients allegedly do not meet (as conveyed through the impersonal construction 'because to go on the Internet it's necessary to know how to use the computer'), Barbara treats the clients (including Carlo) as lacking entitlement to that desirable outcome. This provides a warrant for not making Internet access available (i.e. there is no point providing it if the clients do not know how to operate a computer).

In an exchange preceding the start of Extract 5 (data not shown), Daniele said *Eh io son poco autonomo ancora* ('Eh I'm still not independent enough'). Staff member Massimo took this to refer to the fact that Daniele does not go to work on his own and that he needs to be taken there by the staff. Massimo encouraged Daniele to start using the bus. This suggests that, for Massimo, using the public transportation is a way of solving Daniele's problem of 'not being independent enough'. In the continuation of the conversation (shown in Extract 5), it becomes apparent that for Daniele 'being more independent' has a different meaning, namely owning a car.

Extract (5): [Rg4E] 'Car'

1 C-Dan: *Mio padre dice "cosa vai a prenderti la macchina*
My father says "why do you want to buy a car

2 *che dopo:::: (0.3)*
if the::::n (0.3)

3 S-Mas: *Ha ragione!*
He's right!

4 (0.6)

5 C-Dan: *spendi di tutto, e dopo te ne fe niente".*
you spend a lot ((of money)), and then you have no use for it".

6 (0.7)

7 S-Bar: *No ma soprattutto a cosa ti se↑:rve_*
No but above all what do you need it for_

8 (1.3)

9 C-Dan: *(Odio) servirebbe per il lavo:ro,* (h)*e: (1.0)*
***EXCL* I would need it to go to wo:rk[4], (h)a:nd (1.0)**

10 *per andare in giro un po' con gli amici e: (2.9)*

to hang around a bit with my friends a:nd (2.9)

11 S-Bar: *Quali amici Daniele?*

What friends Daniele?

12 (2.2)

13 C-Dan: *Quelli di vecchia da(h)ta.*

The old o(h)nes.

14 (0.5)

15 S-Bar: *Hai mantenuto conta↑:tti.*

Have you kept in tou↑:ch with them.

16 C-Dan: *Pro: (.) (°poco°)*

***Pro*:[5] (.) (°a little°)**

17 (0.4)

18 C-Bar: *Come faresti a rintracciarli_*

How would you manage to find them_

19 (1.0)

20 C-Dan: *So dove abitano.*

I know where they live.

21 (8.0)

22 S-Bar: *Ma il lavoro non ti serve la macchina per andare_*

But ((to go to)) work you don't need the car to go ((to work))

23 (2.8)

24 C-Dan: *So el serve se voglio comprare una macchinetta¿*

I know what it's for if I want to buy a small car¿

25 (0.4)

26 S-Bar: *No ma (.) al lavoro.*

No but (.) to work.

27 (0.3)

28 S-Bar: -> *È più importante il lavoro (0.4) che andare a spa:sso=*

The job is more important (0.4) than hanging arou:nd=

29 -> *=~eh nell'autonomia di una perso:na no?*

=~eh for the independence of a perso:n right?

30 (1.4)

31 S-Bar: *E allora al lavoro potresti andare anche*

And so you could go to work also

32 *senza la ma:cchina_*

without the ca:r_

33 (3.3)

At lines 1–2, Daniele reports that his father disagrees with his project to buy a car. At line 3, Massimo takes a turn before the completion of Daniele's turn to endorse Daniele's father position. Relevant to the focus of this analysis is that Massimo orients to the client's turn at lines 1–2 as displaying a desire or a need for a car. With his turn at line 3, Massimo conveys that he has reservations about Daniele's project to buy a car (although Massimo does not articulate what those reservations are). At line 5, Daniele completes his turn by reporting his father's reasons for disagreeing with his project: the expense would not be justified because Daniele does not need a car. At line 7, Barbara also orients to Daniele's turn as conveying a desire or need to buy a car; she challenges it by inviting the client to support his need for a car, while implying that such reasons may not exist (Koshik, 2003). At lines 9–10, Daniele supports his desire for a car by saying that he could use it to go to work and to hang around with his friends. Across lines 11–18, Barbara challenges Daniele's second argument by implying that he has no friends. However, Daniele resists this challenge by claiming that, although he has not been in touch with his friends a lot (line 16), he could get in touch with them again in the future (line 20). After a gap, at line 22, Barbara changes tack and disagrees with Daniele's first argument (produced at line 9) that he could use the car to go to work. At line 24, Daniele rejects Barbara's overall attempt at dismantling the legitimacy of his stated desire for a car by claiming that he knows what the purpose of having a car is (here Daniele clearly expresses his desire for a car alongside the need for it). However, Barbara refuses to relinquish her line of action (line 26) and claims that having a job is more important than hanging around (lines 28–29) and that Daniele does not need a car to go to work (i.e. she implies that he could use the bus, as Massimo previously suggested; lines 31–32). Here Barbara refers back to Daniele's original complaint (before Extract 5, data not shown) that he is not 'independent' enough and she suggests that, to be independent, Daniele should prioritise working over having a car.

Admittedly, there is a difference between what Barbara does at lines 28–29 of Extract 5 and what she does at the arrowed turns in Extracts 2, 3, and 4. In this case, she does not tell the client what he should do *before* aiming for the desired good or service; she introduces something that is *more important* and, hence, completely alternative to the client's displayed desire (owning a car). The satisfaction of the client's desire is thus not postponed to an indeterminate future (after a necessary precondition has been met); in this case, the idea that the client needs this particular good (a car) is integrally contested. However, the outcome is very similar: Barbara treats the client as lacking entitlement to the desired outcome (owning a car). Although Barbara does not overtly deny the provision of assistance, this can be inferred from the staff member's overt disaffiliation with the client's expressed need for a car (lines 31–32) (i.e. because she disagrees with the idea that the client needs a car, the client can infer that she is not going to assist him in the achievement of that goal).

Discussion

The clients of the TC display sensitivity to the contingencies involved in granting different goods and services by employing different request formats (Curl & Drew, 2008). They use explicit request forms (e.g. imperative and interrogative formats) for goods and services that the staff can grant or reject in a relatively straightforward manner. In this chapter, I focused on cases where the clients' requests focus on goods and services that involve more complicated or less immediate granting processes. For instance, in Extract 2, Daniele expresses a desire to work more hours. The staff members cannot directly fulfil his desire (this is the prerogative of his employer); however, they could try to facilitate the process (e.g. by advocating for an increase of his work hours with his employer). In this context, an explicit request would arguably be vulnerable to rejection on the basis that it is not the staff members' prerogative to make such decisions (as it emerges in Extract 1c in a relation to an implicit request about medication, lines 165–166). By describing his desire to work more hours, the client provides the staff members with an opportunity to offer assistance, but he does not overtly demand it; in this way, he does not risk getting an outright rejection.

The staff members can find themselves in a delicate position in the situations exemplified in this chapter. Because the clients do not produce overt requests for assistance, the staff members are not formally bound to address them (in conversation analytic terms, the non-provision of an offer of assistance following an expression of need or desire is not accountably absent in the way that a missing response to an explicit request is; Curl, 2006). However, in their role as professional helpers, the staff members can be expected to provide assistance when they become aware of the clients' needs and desires. By ignoring the request implications of the clients' conveyed needs and desires, the staff members would be vulnerable to be seen as unwilling to help. At the same time, the staff members may be reluctant to offer assistance when there are doubts about the reasonable character of the clients' conveyed needs and desires (such reservations emerge in Extracts 2–5; additionally, the staff members may have further unstated reasons for being reluctant to offer assistance[6]). Through the practice examined in this chapter (treating the clients as lacking entitlement to some good or service and, by way of this, disaffiliating with their projects to obtain those goods/services), the staff members can make available that assistance will not be provided without saying it in so many words. The clients can infer that the staff members will not provide assistance in the achievement of their goals because the staff disaffiliate with (i.e. they show that they do not endorse) the clients' projects to achieve those goals. Furthermore, this practice allows the staff members to avoid being seen as unwilling to help the clients. The clients' alleged lack of entitlement to some good or service works as a warrant for not providing assistance in obtaining that good or service. The underlying logic is that it would be unreasonable to assist the clients in achieving things that they are not entitled to obtain. In the sequences analysed in this chapter, then, the clients create opportunities for the staff members to offer assistance, which in turn the staff members do not offer. All of this is handled by the clients and the staff members without overtly requesting assistance or overtly denying it.

Clinical relevance summary

This study did not address issues of interactional effectiveness (i.e. the potential of an interactional practice to occasion specific outcomes in interaction). Therefore, its results cannot be straightforwardly applied to clinical practice. However, mental health professionals could reflect on how the interactions illustrated in this chapter resonate with their own clinical experience. Do they experience situations where their clients seem to exert pressure for an offer of assistance without making overt requests (Gill, 2005)? How do they usually address such implicit requests? The mental health professionals' responses analysed in this chapter reflect a marked asymmetry whereby the staff members evaluate the clients' needs and desires in terms of their validity. Other professionals could reflect on how their own practices for addressing their clients' requests reflect different types of professional–client relationship and different levels of relational asymmetry. These potential benefits for clinical practice are summarised in Table 34.1.

Table 34.1 Clinical practice highlights

1. Therapeutic Community (TC) clients can use expressions of need ('I need X') and desire ('I would like X') to convey their interest in obtaining some good or service (e.g. renewing a driver's license)
2. Through these practices, TC clients provide TC staff members with an opportunities to offer assistance in obtaining those goods or services
3. TC staff members can make available that assistance will not be provided without saying it in so many words
4. TC staff members can make available that assistance will not be provided by treating their clients as lacking entitlement to the good or service in which they expressed some interest
5. This practice reflects a marked relational asymmetry between TC staff and TC clients

Summary

The clients of the Therapeutic Community (TC) examined in this study sometimes use expressions of need ('I need X') and desire ('I would like X') to convey implicit requests for assistance. Instead of overtly demanding the staff members' help, the clients thus provide the staff members with opportunities to offer assistance in the achievement of their goals. This can put the TC staff members in a delicate position when, for several reasons, they may be reluctant to assist the clients in the achievement of particular goals (such as renewing a driver's license, buying a car, etc.). The staff members sometimes deal with this problem by disaffiliating with the clients' projects to achieve particular outcomes (e.g. renewing a driver's license) on the basis that the clients (allegedly) lack entitlement to those outcomes. This practice enables the staff members to make available that assistance will not be provided, without saying it in so many words.

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Notes

1. Apparently, this client's verbal production is not connected to the ongoing talk (or at least it does not seem to be treated in that way by the other participants).
2. For reasons explored elsewhere (see Mortari & Pino, 2014), Barbara's actions convey the assumption that Franco cannot independently decide to stop taking the medication.
3. This is not to claim that the clients always do this intentionally. This study is concerned with the observable effects of the clients' claims and displays of need and desire.
4. This is an attempt at an idiomatic translation but, literally, the client says 'for the job' (in Italian 'lavoro' can mean 'job' or 'work', hence the ambiguity). Given the context of the conversation, it is quite clear that he means that he would be using the car to go to work.
5. This cannot be translated because it is not clear what the client might be going for with the aborted 'Pro:'.
6. For instance, in a continuation of the exchange in Extract 3 (data not shown), Massimo asks Dina 'So you'd still feel up to driving the car' and, following her affirmative answer, he asks 'Are you sure?' With this, Massimo implies that he has reservations about her ability to drive the car (this could be either because of her mental illness, the medication she is on, or other unstated reasons).

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Glossary

Accounts: Within conversation analysis, to account for an action is to provide an explanation, justification, or rationale.

ADHD: Attention deficit hyperactivity disorder is one of several labels used to describe a collection of characteristics, behaviours, and 'symptoms'.

Affectual stance: Refers to verbal and non-verbal expressions through which tellers imbue personal events with attitudes and evaluative meaning.

Affiliative response: Pro-social actions that match or endorse the affectual stance conveyed in the telling and are 'preferred' in structure, often expressing agreement and/or empathy.

Agency: Refers to utterances that portray the speaker as instigating an action.

Anorexia nervosa: An eating disorder which results in the individual severely depriving themselves of food and nutrition in order to remain thin and low weight.

Assertive community treatment: Team-based case management model for adults with serious mental illness, widely used in the United States. Similar programmes in the United Kingdom are denoted 'assertive outreach'.

Bio-psychosocial: Relating to biological, psychological, and social factors.

Blame: The act of holding another person responsible and claiming that those actions are socially or morally irresponsible.

Blunted affect: A clinical description of a lack of emotive facial expression, with no change with topic of conversation.

Borderline personality disorder: A serious mental illness marked by unstable moods, behaviour, and relationships.

Bulimia nervosa: This is an eating disorder where the individual utilises laxatives and purging (typically through vomiting) to promote weight loss, usually following a binge eating session of high-fat, high-sugar foods.

Category-bound activities and predicates: Activities, rights, obligations, knowledge, attributes, entitlements, and so on commonsensically bound to a particular membership category.

Cloze: A passage used for didactic purposes which has words omitted to be filled in by the pupil.

Cognitive theories: Explanations relating to mental processes.

Conceptual metaphor: A set of mappings between two knowledge structures, or conceptual domains, which allows the understanding of one (target) in terms of the other (source).

Conversation analysis: The study of the organisation of verbal exchange and its relation to the performance of social action. See Chapter 1 for a more detailed exposition.

Critical discourse analysis (CDA): An interdisciplinary set of analytic approaches grounded in the assumption that social identities and power relations between persons, groups, and systems are created, reproduced, and transformed through discursive practices. CDA researchers critically analyse power relations and explicitly resist the domination of oppressed groups by seeking to transform relationships and practices that contribute to their domination.

Critical discursive psychology: A perspective which seeks to examine cultural discourse resources and the types of power differentials which are created when they are employed.

Critical realism: An ontological perspective which acknowledges the reality of the material world, while understanding that this is constructed and mediated through discourse.

Depression: A mental health disorder that negatively impinges on a person's affective state for extended durations.

Designedly incomplete utterance: An utterance designed as incomplete to allow and prompt the client to furnish the 'missing' material.

Dialectical behaviour therapy: A type of cognitive-behavioural psychotherapy developed in the late 1980s to treat borderline personality disorder. It is now also used for the treatment of other kinds of mental disorders.

Diagnostic interview: Conversation between a mental health professional and a patient during which the professional asks questions in a systematic way to elicit information and statements from the patient in order to get to a valid diagnosis of the patient's problems.

Discourse marker: A word or phrase which is relatively meaningless compared to other content words, does not have a fixed position in a sentence, and functions as a connector of different parts of a sentence, for example, *oh, well, you know, I mean.*

Dis- and re-engagement: Ongoing talk may lapse when a participant in a conversation redirects attention to other objects or engagements; talk-in-interaction may recommence when the participant's attention is re-directed again to the focus of the encounter.

Documentary method (see Garfinkel, 1984[1]**)**: This is a method in which attributes of a phenomenon (such as ADHD) are provided to 'point to' the existence of the phenomena but are also used to further constitute the phenomenon.

DSM: *Diagnostic and Statistical Manual of Mental Disorders* used in diagnosing mental health conditions.

Eliciting emotion: Actions designed to get clients to name how they were affected emotionally.

Emotion-focused therapy: An emotionally informed approach to psychotherapy based on two treatment principles: the provision of a person-centred therapeutic relationship and the facilitation of therapeutic work.

Empathic response: Actions that endorse and display an understanding of prior talk.

Euthymia: Ordinary or 'normal' mood; neither depressed or euphoric.

Exploration: Collection of information about a patient's biography, cognitive and emotional characteristics, and prehistory of illnesses during a psychiatric interview.

First-part pair: The first part of a two-part sequence in conversation, for example, a question in a question and answer sequence. The answer would be the second-part pair.

Flight of ideas: A clinical description of the speech content denoting that the topics of conversation change extremely quickly, without transition, and before an interlocutor can engage on any single topic.

Forensic: Pertaining to the law, in the context of UK psychiatric medicine it usually refers to the Mental Health Act.

Formulation: Utterance that provides the gist or upshot of prior talk.

Gender: Gender refers to culturally constrained meanings of male and female, masculine and feminine. It can be thought of as a system of power relations, a means of structuring social relationships and a constraint on our identities and social practices.

Genetic theories: Explanations relating to genes and heredity.

Global capitalism: A system of politics and economics that crosses national boundaries, where trade, industry, and services are run for profit transnationally.

Governmentality: A term coined by Michel Foucault to refer to the way in which the state exercises control over or governs the body of its populace.

Hedge: A word or phrase which is used to lessen the impact or certainty of an utterance; for example, It's two o'clock, *I think*.

Illustrating emotion: Actions that provide vivid or metaphorical descriptions of how the client may have felt.

Information-eliciting telling: See: my-side telling.

Interdictory flavoured language: An authoritative way of using language that emphasises what can or cannot be done.

Interpersonal patterns: Person's recurrent ways to relate to others.

Interpretative repertoire: A key theoretical concept of critical discursive psychology referring to a patterned collection of commonly used expressions and ways of explaining and interpreting the social world.

Intimate partner violence: Violence perpetrated by one or both members of an intimate relationship. That violence can be physical or psychological (e.g. involve coercive control, expressive aggression or intimidation).

Magistrates' Court: The Magistrates' Court is the lowest level of court in England and Wales. All criminal cases begin in the Magistrates' Courts, which hear the less serious 'summary cases', such as common assault or motoring offences as well as some 'triable either way' cases such as theft. More serious cases (indictable offences) are forwarded to a higher level of court – the Crown Court.

Medicalisation: The interpretation of social phenomena in medical terms.

Membership categorisation analysis: A type of formal analysis that seeks to describe the apparatus through which members' descriptions are produced.

Membership category: A type of reference form used to describe persons.

Membership categorisation device: A collection of membership categories (such as 'male' and 'female' in the device 'gender') and some rules about how to apply these categories.

Minimal turn: A turn containing a minimal amount of vocal content, for example, mmm.

Moral imperative: A prescriptive social recommendation to act, think, or feel in a particular way.

Motivational interviewing: A non-confrontational style of clinical interaction that relies on evocative, open-ended questions, reflections, and affirmations that seek to explore areas of common ground.

Multiple-option alternatives: A request for a preference includes more than a simple yes or no to a single item.

My-side telling: Indirect questioning format in which the telling of an experience serves as a possible elicitor of information (Pomerantz, 1980[2]).

Naming emotion: Actions that identify the specific emotion that the client had felt.

Open-ended questions: Questions (typically using *what*, *where,* and other *wh-* forms) that require fuller answers than *yes* or *no*.

Paedophile (paedophilia): Paedophilia is a psychiatric disorder and a paedophile is an adult who has primary sexual attraction to prepubescent children under the age of 13 years.

Participation framework: Any contribution in a social gathering provides for each of its participants a particular 'participation status'; the relation of all the persons in the gathering is the 'participation framework' for that moment of interaction (Goffman, 1981[3]).

Participatory action research: A collaborative approach to inquiry within communities that focuses on solving community-based problems through critical reflection and collective action.

Poverty (of speech): A clinical description of a noticeable lack of speech, particularly a lack of spontaneous speech, such as the use of single-word responses.

Preference (preferred vs. dispreferred responses): A conversational organisation that describes structural relationship between an initiating action and a responding action. Preferred responses promote or agree with the initiating action and are immediate and brief; dispreferred responses block or disagree with the initiating action and are delayed, non-minimal, and accountable.

Pressured (speech): A clinical description of speech that is difficult to interrupt.

Pro-ana: A source of 'support' for those with eating disorders, where abnormal low body weight is promoted.

Projection/projecting: Where a turn constrains the turns which follow on from it, for example, a question *projects* a response.

Proto-morality: Deep layer of mutual obligations through which interlocutors hold each other accountable for their actions and for the successful accomplishment of their encounter.

Proto-professionalism: The appropriation of expert knowledge by lay people.

Psychiatry: Subdiscipline of medicine devoted to the diagnosis, treatment, and prevention of mental and behavioural disorders.

Psychiatric diagnosis: The outcome of exploring a patient's mental state. It is based on common-sense knowledge or moral reasoning.

Psychiatric intake interview: A type of psychiatric interview in which the psychiatrist's official task is to determine whether a person should be – voluntarily or involuntarily – hospitalised as a mental patient on the basis of the person's observable behaviour during the interview.

Psychogenic non-epileptic seizures (PNES): Episodes of paroxysmal impairment of self-control associated with a range of motor, sensory, and mental manifestations, which represent an experiential or behavioural response to distress.

Psy-sciences: A term used by Nikolas Rose (Rose, 1998[4]) to refer to the disciplines of psychology, psychiatry, and their descendant psycho-based sciences because of their significant role over the last 200 years in bringing into existence new ways of understanding what it means to be human.

Psychosocial: Relating to both psychological and social factors.

Recovery: A personal journey of transformation from an illness-dominated identity marked by helplessness and hopelessness to a positive identity marked by meaning, self-determination, independence, and holistic well-being.

Recovery-oriented practices: A group of holistic clinical practices that promote the recovery of a person diagnosed with a mental health concern. Recovery-oriented practices reduce the traditional power differential that exists between service users and providers by encouraging these actors to be collaborative partners and engage in a process of shared decision-making.

Repair: A set of conversational practices for dealing with problems of hearing, speaking, and understanding of talk.

Resistance: Passive or active forms of responding to IPV which can take the form of leaving the situation or responding in other ways to forms of IPV to thwart the intent of the violence. Violent resistance is also referred to as self-protective violence since its intent is to protect oneself from injury.

Restricted affect: A clinical description of a narrow range of emotive facial expression.

Sexual abuse: The forced sexual behaviour of one individual onto another. This can include the sexual abuse of a child if the individual being forced into the sexual act is under the age of 16.

Social construction: As *a general theory of knowledge*, it is proposed that all accounts of the real, the rational, and the good find their origins in social communities. Thus, all candidates for truth – whether in science, religion, or everyday life – are the outcomes of culturally and historically situated social interchange. As a *vocabulary of practice*, the attempt is to put such views into social use, for example, in furnishing insights and inspiration in developing new forms of research, along with dialogic and collaborative practices in therapy, organisational change, education, and conflict resolution.

Stake and interest: A personal reason for taking a particular viewpoint.

Subject position: A key theoretical concept of critical discursive psychology, meaning an identity position taken up or attributed in discourse while explaining and interpreting the social world.

Subsequent psychiatric interview: A type of psychiatric interview in which the psychiatrist monitors the behavioural progress of a psychiatric in-patient, with a view to a possible future discharge.

'Tales of the unexpected' (see Wooffitt, 1992[5]**)**: A common linguistic device to manage possible accusations of prior motive.

Tangential (speech): A clinical description of the content of speech denoting that conversation topics move from one to the next without discernible logical connection and without a complete response to the initial topic.

Theory of mind: Simon Baron-Cohen's term for the ability to mentalise[6] or imagine the mental states of others.

Transferential emotions: Emotions associated with one person (e.g. parent) redirected to another person (e.g. therapist).

Treatment planning: A process by which a service user and provider identify relevant problems and goals and map out their plan to achieve those goals in a specific time period.

Troubles talk: Utterances/activities that often involve complaints or negative appraisals of self.

Turn construction unit (TCU): Units which make up a turn at talk. They can be identified by noting whether or not after a TCU the turn could be possibly deemed complete.

Understanding check: Turn in conversation which offers the previous speaker the opportunity to confirm the current speaker's understanding of what has been said.

Victim: A person who is physically or psychologically harmed injured or killed by another.

Notes

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Index