10
Diagnosing as an Interactional Achievement in Psychiatric Interviews

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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.

M. O'Reilly et al. (eds.), *The Palgrave Handbook of Adult Mental Health*

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]

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 1  T1:  Well I have introduced myself before Maria
 2       Antonia=
 3  P1:  =Yes=
 4  T1:  =Right? I'm the doctor who is going to supervise
 5       you during your admission together with doctor
 6       Barjuan though you don't know him yet (0.8) right?
 7       and she's Sofia [and is a nurse so any problem
 8  P1:                  [Yes I know her
 9  T1:  Well so can you explain (to us) a bit wha::t what
10       happened why were you admitted yesterday
11                           (2.5)
12  P1:  So what really happened
13  T1:  Yes
14                           (1.3)
15  P1:  So what happened is one of the many cases that
16       used to happen (1.0) er: I've: been suffering for
17       a long time er: in a very unusual way because the
18       truth is that (                ) the thing is that
19       you don't carry around your story written down nor
20       do you explain it every day (0.7) the reason o:f
21       of what happens (0.9) I: um have been a happy:
22       person er:: dynamic: hard working (1.1) a very
23       good mother better than a daughter (1.1) as a wife
24       mh: I wasn't very good becau:se well (1.7) er:
25       (1.8) I found a man that was from a good family
26       um:: er: the youngest of a family a spoilt child
27       [and
28  T1:  [So you are married?
29  P1:  Yes=
30  T1:  =And you've got how many children
31  P1:  I've got a twenty-three-year-old son and a
32       nineteen-year-old daughter
33  T1:  Nineteen
34  P1:  Yes
35  T1:  So: you live with them now?
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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?
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20  P3:  No I was going to France to take the train when I
21       fell over I (              ) I had to take the
22       train
23  T1:  Mh hm hm
24  P3:  I fell over on my way (                       )
25       because I was walking a lot (                 )
26  T1:  But um do you live at France or do you live at
27       Morocco=
28  P3:  =I live in France
29  T1:  In France usually
30  P3:  In France yes
31  T1:  In France in France [mh hm so:=
32  P3:                      [Yes
33  T1:  =you live with his family (0.6) in France
34  P3:  On my own
35  T1:  On your own
36  P3:  Mh hm
37  T1:  Mh so you work in France
38  P3:  Yes for many years
39  T1:  So where do you work
40  P3:  For many years
41  T1:  For many years bu::t (1.0) what is your job
42  P3:  Bricklayer
43                       (0.9)
44  T1:  Bricklayer?
45  P3:  Mh hm=
46  T1:  =What is that?
47  P3:  Yes bricklayer bricklayer=
48  T1:  =I don't know what that is
49  P3:  Construction
50                       (1.0)
51  T1:  Construction you is doin::g
52  P3:  Constructing yes
53  T1:  Uh huh so to:: like this=
54  P3:  =Constructing [constructing
55  T1:                [Like a
56  T1:  Constructing constructing
57  P3:  Construction=
58  T1:  =Mh hm (0.8) you is: is well in France?
59  P3:  Mh?
60  T1:  Are you happy?
61                       (0.9)
62  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
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 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-
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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]

```
 1  T1:  You'll go but not er three or four days you'll
 2       have to stay here
 3  P3:  (            ) stay here [for four days
 4  T1:                           [(                )
 5       four days
 6  T1:  Yes
 7  P3:  Not three?
 8  T1:  Um but it's Satur Saturday not er: Saturday not
 9       in French Saturday? Saturday
10  P3:  Saturday
11  T1:  Friday Saturday Sunday
12  P3:  No I don't know that
13  T1:  Yes the next days
14  P3:  Yeah
15  T1:  We're not here
16  P3:  You're not here?
17  T1:  Because i::t's
18  P3:  Bank holiday
19  T1:  Yes yes
20  P3:  [Christmas Christmas
21  T1:  [Right?
22  T1:  Yes that's why that's why the social worker
23       won't be able to do (0.7) [er=
24  P3:                            [Mh
25  T1:  =thi[ngs (0.8) do you understand?=
26  P3:      [(                         )
27  P3:  Yeah
28  T1:  We'll hav: have to wai: wait
29  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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