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Negotiating roles and making claims as a patient in the psychiatric consultation: A frame analysis

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Submitted September, 2013

I declare that this thesis has not been previously submitted to this, or any other University for a degree, either in this form or any other form.

I declare that this thesis is entirely my own work. This thesis is a re-analysis of recorded discourse. The data used in this study was collected by another researcher for a previous project. This is acknowledged clearly within the text of this thesis.

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NEGOTIATING ROLES AND MAKING CLAIMS AS A PATIENT IN THE PSYCHIATRIC

CONSULTATION: A FRAME ANALYSIS

SUMMARY

My thesis develops an understanding of patient role and identity performances in psychiatric consultations. Recent increased attention to shared-decision making and patient-centred care in psychiatry is in large part influenced by changing ideas about the doctor-patient relationship, challenging power discrepancies and reconsidering notions of 'expert' and 'lay' contributions. Previous work surrounding this field has mostly focused on psychiatrists' talk, asking 'how can psychiatrists improve shared-decision making skills?' While important, I argue that this focus is at odds with the principles behind shared-decision making by failing to consider patients' own performances in their talk with psychiatrists.

I re-analyse recorded interactions in 92 psychiatric consultations with patients prescribed anti-psychotic medication. Drawing on the work of Goffman, I identify frames which are negotiated throughout the consultations and explore how these shape the roles and 'footing' adopted by patients. I demonstrate techniques used by patients to maintain a balance between making credible and influential claims and maintaining an acceptable patient role. Finally I consider the impact of family members attending these consultations. I explore how they collaborate and compete with patients in making claims, and the impact of their presence on patients' own performances.

The thesis makes the case for considering patients as active participants in constructing the interaction in psychiatric consultations and the need to understand the work being undertaken by patients to construct their place in the immediate discourse and in their wider social connections. It moves towards developing this understanding by providing a detailed review of various techniques seen in this data set. In using a frame analysis it also provides a relatively new perspective on considering discourse and demonstrates how this kind of approach can be useful when analysing institutional talk.

Negotiating roles and making claims as a patient in the psychiatric consultation: A frame analysis

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1. Introduction

1.1 Communication in the psychiatric consultation

This thesis explores the complexity of interaction in the psychiatric consultation, looking at the strategies employed by patients and how these are negotiated in interaction with psychiatrists and family members. It starts from the position that the psychiatric setting provides an institutional backdrop which shapes the roles of all participants and helps them to determine both what is appropriate, and what will be effective in achieving their ends.

Communication in psychiatric consultations is often held up as key to best medical practice and good health outcomes (Simpson *et al*, 1991; Cruz & Pincus, 2002). Like other medical consultations they are highly institutionalised with a distinct power structure, are task-oriented and are based upon notions of clinical expertise. Psychiatric settings differ from other health settings, however. Power structures are reinforced by the possibility of coercion in psychiatric treatment and by the 'spoiled identity' which accompanies diagnoses of mental illness (Goffman 1963). While the expert status of psychiatrists is emphasised by the institutional setting, it is also subject to challenge as a result of the highly idiosyncratic response of patients to treatments. The nature of psychosis also makes these interactions unusual: unlike with many physical health problems, psychotic symptoms often cannot be observed independently of the patient's own report.

Psychosis is a term that refers to mental health symptoms which affect the way the sufferer thinks and their ability to distinguish between reality and hallucinations or delusions. Psychotic symptoms are commonly associated with diagnoses of schizophrenia and bi-polar disorder. Psychotic disorders are commonly treated with anti-psychotic medications which address the

symptoms, though generally have a range of side-effects which can severely impact on the patient's quality of life and physical health (Royal College of Psychiatrists fact sheet, 2014).

Over the last few decades, the way that severe mental illnesses are treated by the health system in the UK has changed radically. Shared decision making, patient-centred care, personal recovery and self-directed support have all aimed to transform the role of patients in their own care, as well as the approach of health professionals.

Gravel *et al* (2006) provide a broad definition of shared decision making: "a decision making process jointly shared by patients and their health care providers" (ibid: 2). It is sometimes described as lying "somewhere between the so-called 'traditional medical model' and the 'informed choice model'" (Hamann *et al.*, 2003: 403), emphasising the active role of both clinician and patient. Patient-centred care has been described as consisting of five elements: i) a biopsychosocial perspective that includes consideration of social, psychological and bio-medical factors; ii) understanding the 'patient-as-person'; iii) sharing power and responsibility (including shared decision making); iv) common therapeutic goals and bond between patient and doctor; and v) awareness of the influence of the personal qualities of the doctor (Mead & Bower, 2002). Personal Recovery has been defined as "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. recovery involves the development of new meaning and purpose in one's life" (Anthony, 1993). A commitment to recovery has been included in UK mental health policy since 2009. The latest mental health strategy includes a commitment to "ensuring that people with mental health problems are able to plan their own route to recovery, supported by professional staff who help them identify and achieve the outcomes that matter to them [...] and put them, and their families and carers, at the centre of their care" (Department of Health, 2011). Self-directed support, closely associated with Personal Budgets and Personal Health Budgets, is the principle

under which control for managing mental health care and treatment is held by patients (InControl, 2011). These developments all recognise patients as “experts on their own values, treatment preferences, and treatment goals” (Adams and Drake 2006: 88) and that patients should be more active in decision making alongside health professionals (Hamann et al. 2003).

While efforts have been made to demonstrate improved outcomes from shared decision making, it is fundamentally a values-based approach to medicine (Fulford, 2004) , aimed at “decreasing the informational and power asymmetry between doctors and patients by increasing patients’ information, sense of autonomy and/or control over treatment decisions that affect their well-being” (Charles *et al.*, 1997: 682).

Investigators of shared decision making have highlighted a challenge at the heart of the model. On the one hand there is mixed evidence of the demand for shared decision making in psychiatry. Surveys suggest that some patients prefer a more active role and some a more passive role in treatment decisions (Arora & McHorney, 2000; Adams, 2007). At the same time, attempts to measure shared decision making behaviours show that they are not always related to improved patient satisfaction. Goossensen and colleagues (2007) found that clinicians providing high patient satisfaction are often assessing for themselves the extent and the way in which patients want to be involved.

“We are confronted with a paradox when interpreting these data. At policy levels patient organizations claim that participation is needed. They adopt SDM models and underline the need for change. At the individual level, however, no dissatisfaction with the current situation is expressed, as we find now. A very positive interpretation would be that satisfaction arises from the right approach, that the clinician was taking in an empathic way.” (Goossensen et al., 2007: 55)

Many papers that explore shared decision making have attempted to set out identifiable components of the process. Gravel’s list is broadly typical of these:

“establishing a context in which patients' views about treatment options are valued and deemed necessary, transferring technical information, making sure patients understand this information, helping patients base their preference on the best evidence; eliciting patients' preferences, sharing treatment recommendations, and making explicit the component of uncertainty in the clinical decision-making process.”

(Gravel et al., 2006: 2)

This list of components highlights two ideas that are, often implicitly, central to the concept of shared decision making. First, that it requires a focus on discourse. Decisions are made through interaction between clinician and patient, sometimes including others, particularly family members. Second, it emphasises the role of the clinician in making shared decision making possible. The active components in Gravel's list – ‘making sure patients understand’, ‘helping patients’ with their preferences, ‘eliciting patients’ preferences’ – all rest with the clinician. Charles has highlighted this issue in querying why patients frequently express a preference for shared decision making but do not engage in shared decision making in practice. He suggests that patients are prevented from sharing in decisions by the behaviour of clinicians and a culture of professional control in clinical settings (Charles *et al.*, 1997: 686).

This focus has led to an emphasis on how *clinicians* do shared-decision making, but comparatively little focus on what *patients* do. In doing so, ironically, patients are portrayed as passive in the very literature that argues for them to have a more active role. A key driver of this focus is no doubt that clinicians are the obvious target for implementing changes in the health care system. A great deal of work has gone into promoting shared decision making in clinical practice, including in psychiatric consultations, through clinician training and development of shared decision making aids (Royal College of Psychiatrists, 2012; Duncan *et al.*, 2010).

Where patient communication behaviours have been studied, the focus has been on three specific aspects of the interaction: information exchange, particularly patients asking questions; challenging authority or patient assertiveness; and making treatment decisions (Beisecker 1990: 110). These approaches have tended to predefine the nature of active patient participation. An active patient role in information exchange has often been defined in terms of the number of direct questions asked by patients of doctors. Similarly, Beisecker (1990) studied patient assertiveness by observing interactions for specific instances of sarcastic comments, countering or degrading the doctor's statements, making requests or demands, degrading another doctor, and making complaints.

These are, of course, important and highlight key characteristics of doctor-patient interaction, but they also reduce the analysis of interaction to these elements and to specific, researcher-defined goals. This reductionism is also driven by the need to describe and measure shared decision making in practice. The resulting models have been criticised both for failing to assess patient involvement and for being "situated in a paternalistic paradigm of interpersonal communication" (Elwyn *et al.*, 2001: 17). Some have warned against attempts to provide a prescriptive list of behaviours that constitute shared decision making, arguing that the relationship between clinician and patient, the preferences of either party for involvement in decision making and the many different ways to reach a shared decision make a checklist approach unhelpful (Charles *et al.*, 1997).

While in practical terms a reductionist measurement of shared decision making is attractive and may have real benefits, it requires an oversimplification of what occurs in clinician-patient interaction. It fails to incorporate a sociological understanding of such interaction as being shaped not merely by the adherence to a particular process, but by the joint negotiation and adaptation of patient identities, expectations and interactional goals. Standardised approaches to shared decision making are hard to implement and often inadequate because they fail to

take into account that discourse is not about achieving one, narrowly defined outcome, but about the successful negotiation of many different aims.

In contrast, a constructionist approach allows a focus on the production of identity and meaning in discourse. Building on a symbolic interaction approach (Mead, 1936; Blumer, 1986; Rosenberg, 1984), Goffman adds an attention to the structures and societal relationships in which interaction takes place and the way that these are interpreted (Snow, 2001). Using this approach, as demonstrated in this study, patients can be seen to build and maintain relationships with their psychiatrists, assert multiple roles and identities, justify their own behaviours, build and modify accounts of their illness, and take-up positions in relation to others present, at the same time as influencing decisions about medication. Patients' abilities to influence and to achieve their goals are not limited to direct questions, explicit challenges or stated preferences, nor are these particular behaviours oriented to a single goal.

The observational work undertaken thus far in relation to psychiatric consultations has not adequately examined patients' strategies in the interaction. Another approach is needed to understand how the patient role is understood and negotiated and how people with psychosis work towards their various goals within the constraints of this role. Such an approach would provide a more subtle understanding of patients' performances and how they influence the interaction, including, but not limited to, identifiable instances of decision making.

This focus on patient behaviours is particularly important if efforts to change the nature of the doctor-patient relationship are to be successful. By focusing exclusively on the communication skills of professionals, we are in danger of assuming that interaction can be unilaterally changed by the professional. Gafaranga and Britten argue, "in order to understand the possibilities for shared decision making and concordance, researchers need to go beyond current doctor-centred perspectives and examine the patient's role as well as the doctor's. An

interactional turn in research on doctor patient communication is called for.” (Gafaranga and Britten, 2003: 246)

1.2 Study aims

For patients who experience psychosis, their care and the medication prescribed to help them manage their condition is generally led by a psychiatrist (Cruz & Pincus, 2002). The patient may see the psychiatrist as little as two or three times a year (or more frequently as required) for only 15-20 minutes. Other mental health professionals may spend more time supporting the patient but the psychiatrist has an important role in making clinical decisions about the patient’s treatment. The nature of mental illness poses particular challenges in the role of psychiatrist compared to other specialist doctors, in particular the lack of physiological markers and the difficulty of diagnostic validity (Kendell & Jablensky, 2003; Laing, 1999). The communication skills of psychiatrists have, in part for these reasons, been particularly emphasised (Cruz & Pincus, 2002). In addition, adherence to prescribed anti-psychotic medication is a particular concern (Smith, *et al.*, 1999) and the way that prescribing decisions are discussed and reached is therefore of interest.

By examining the discourse in a set of 92 psychiatric consultations, this study aims to make sense of patterns of discourse, to understand the rules and constraints, as well as the collaborations that allow participants to achieve what they observably do achieve in their talk. Specifically, I aim to build an understanding of how patients position themselves, through their talk, to influence decisions about their treatment. I start from the perspective that psychiatric consultations are social situations. The expectations and social structures shape participants’ contributions, and can be elucidated by examining in detail what participants do in their talk.

Drawing on Erving Goffman, I attempt to shed light on how participants manage the particular challenge of the psychiatric consultation. Goffman’s work on the roles and interactive

performances of patients provides a useful framework for considering what participants do in their talk. His approach encompasses both the presentation of individual personae and the negotiation of roles within specific settings. This encourages consideration of the multi-layered motives of people's talk and the impact of power imbalances on their ability to achieve their aims. Taylor and Van Every argue, through Goffman's approach:

"The individual is no longer just a reactive organism but an engaged actor in a social scene, committed to the ongoing exposition of a persona, acting out (it is hoped) a consistent line over time, and making a claim to a certain social status." (Taylor & Van Every, 1993: 114)

Using an inductive approach, I identify a wide range of patient techniques and explain how they impact on the interaction. Rather than focusing only on those parts of the consultation where decisions are openly discussed and made, I look at patients' performances throughout the consultation and demonstrate both how they are oriented to different interactional tasks and how they manage this within the constraints of the role ascribed to them by the psychiatric institution.

This study does not aim to provide a model of the 'ideal' approach to conducting psychiatric consultations. It does not explore the participants' expressed preferences for the structure and content of the talk. Similarly, I do not attempt to link forms of interaction with psychiatric outcomes. Work has already been done to explore whether outcomes may be affected by changes in discourse (Stewart *et al.*, 2003). There is no data here to indicate whether talking in a particular way is likely to lead to better medication adherence, improved trust or alleviated symptoms. In this sense, the study of talk here is not to be taken as a case for an intervention or as an argument for a change in practice.

Nor is this study an attempt to critique individual psychiatrists' approaches in these consultations. Though I – and readers – may have a personal sense of what looks like sensitive, productive and friendly communication, or what looks like insensitive, obstructive or

aggressive communication, such judgements are not part of this analysis. That is not to say that it is entirely absent from my reaction to these data. Undoubtedly, sections of text which created in me an emotional reaction were likely to attract further examination. This kind of reaction to discourse is an important part of the creative element of analysis. However, my analysis does not seek to explore 'good' or 'bad' communication; to do so would place a greater responsibility on discourse analysis and on analysts than can be justified.

1.3 Study approach

In this study, I re-analyse a set of 92 audio recorded consultations collected between 2003 and 2005 by another researcher (AQ). The consultations were all between psychiatrists and patients taking anti-psychotic medications. Psychiatrists were approached first and AQ identified, with them, likely candidates to approach. Participants were told that the research would investigate "what happens during appointments that people have with their psychiatrists." AQ met with them to explain the purpose and methods of the study and to take consent for the audio recording. Conducting a reanalysis of data creates both opportunities and challenges which are discussed in detail in section 3.6.3 (page 104). Perhaps the most important limitation posed by reanalysis of recorded discourse is the inability of the researcher to return to participants to gather further detail or to check emerging findings. Nonetheless, the data itself provides a window onto the interaction which can be used to explore the discourse itself. This thesis, therefore, focuses on the interactional work which is made evident through participants' talk. As discussed in 3.6.3, I argue that this can provide a valuable insight into how participants achieve their goals in the consultation setting itself.

In my approach to this data, I have focused on the performance of doctor and patient roles within the consultation setting, seeking to elucidate the structures and expectations which shape these. I have not sought to explore the effect of psychiatric diagnoses or associated symptoms on talk. I have several reasons for this. First, the ethical constraints of this research

required that people have capacity to consent to the recording. As a result, patients experiencing severe psychotic symptoms at the time would not be included and this would limit the usefulness of this data to address the effect of psychotic symptoms on talk. Second, in exploring the data, I demonstrate doctor and patient orientation to shared expectations in talk. I found little evidence that this orientation was affected by disordered thoughts or other symptoms that might be attributed to psychosis. Finally, my approach to analysis is not a useful way to explore the cognitive processes of participants in the interaction, thus any attempt to link patients' talk to psychiatric symptoms would require too much of an assumption without additional forms of data, for instance follow-up interviews, to support it.

1.4 A note about terms and labels

Throughout this thesis I use labels in the transcripts and in the text to refer to 'patients' and 'doctors' or 'psychiatrists'. For pragmatic reasons labels are needed when studying relationships and roles, but the choice of labels requires careful reflection. By applying category labels, I – and readers – are encouraged to apply definitions and acknowledge preconceptions. The power dynamics and positioning of participants are in part bound up in the use of value-laden labels, including those of 'doctor' and 'patient'. McLaughlin argues, "different labels are very important, as they all conjure up differing identities; identifying differing relationships and differing power dynamics" (McLaughlin, 2009: 1102). In his discussion of changing trends in terms of social care recipients, McLaughlin lays out the "differing identities" conjured up by terms like 'client' – emphasising a power imbalance and dependency of the recipient on professional expertise – 'consumer' – emphasising a market-type transaction whereby competent consumers could make choices about providers and services – and 'service user' – which emphasises a role of recipients in influencing the service provided at all levels (McLaughlin, 2009). In mental health especially the term 'survivor' has also been coined to describe recipients of mental health services as those who have managed

in spite of their illness or treatment; a term that conjures yet another identity pair more akin to oppressor and victim (Speed, 2006). In studying strategies for claiming positions of influence in one-to-one consultations, the use of these terms must be treated as significant through their construction of these differing identities.

In addition, there is a great deal of dispute about labels and language in mental health. As recipients and past recipients of mental health services have recently been encouraged to express their views on such labels, it has become increasingly clear that there is no consensus on the use of any specific term (Dickens & Picchioni, 2012). For those working in mental health organisations, the use of language is therefore frequently a minefield. I therefore need to justify my own decision to use the term 'patient' throughout this thesis.

First, this use of language is part of positioning this thesis in a broader literature where 'doctor-patient' is a recognised and well-studied dyad. As can be seen in much of the literature reviewed in Chapter Two, the term patient is frequently used, while other terms remain uncommon. There is also evidence from previous studies that 'patient' may be the preferred term of mental health service recipients in the context of the medical setting (Simmons *et al*, 2010; Dickens & Picchioni, 2012)

Second, I am applying the term here in a very specific institutional setting which is founded on the juxtaposition between those it employs for their medical skills and expertise, and those it admits as recipients of that expertise. I recognise the importance of not defining people with mental health experiences that affect all aspects of their lives simply through their interaction with one institution. Nevertheless, in this study that is the distinction that is significant, and to obscure that through less direct language would in one sense be dishonest. It is also important in distinguishing the diagnosed recipient of services from others who may benefit (or not) from these interactions, in particular family members. As discussed in Chapter Six, attending family members may be as much the recipients of psychiatrists' services as the 'patients' themselves.

Finally, I have chosen not to pre-empt findings about patients' performed identities in making a theory-driven choice of terms. I will therefore return to the question of language in the conclusion, to discuss whether the findings of this study support the use 'patient' as a useful description of the performances examined here.

It is also worth mentioning the focus on 'psychosis' in this thesis. This focus is the result of the original data collection and the inclusion criteria for patients in the study, all of whom were prescribed anti-psychotic medication. As explained above, psychosis is not a diagnosis of mental illness but a set of symptoms associated with different diagnoses. In this dataset, diagnoses are rarely discussed explicitly, but symptoms and treatment decisions are a significant part of the consultation discussions. The usefulness and validity of psychiatric diagnoses have been challenged (Kendell & Jablensky, 2003). In this thesis, however, the diagnoses made are not central to the analyses, except where they are explicitly the subject of doctor-patient discourse. Although symptoms are discussed, no assumption is made in this thesis that the ability or techniques of communication within the interaction are themselves attributable to psychosis.

1.5 Thesis overview

1.5.1 Literature review

I provide an overview of some of the sociological thinking in relation to the doctor-patient relationship. I consider the shift towards recognising the patient as part of a therapeutic partnership, how the idea of expertise in health care has been treated in previous work and the implications of these approaches for seeing the patient as an expert in their own care. The work of two scholars has strongly influenced the theoretical basis for this thesis: Habermas's work on the theory of communicative action, and Goffman's conceptualisation of self-presentation and facework as techniques of identity performance. I draw links between these

two approaches and outline how their thinking provides a starting point for considering performances of expertise in the medical setting. Finally, I review some key studies previously conducted in doctor-patient communication, considering the approaches already taken and the insights that these studies have provided.

1.5.2 Methods and data

Goffman's frame analysis, outlined in this chapter, provides a theoretical framework for the analysis presented here. I position my method of analysis within the broad school of discourse analysis. Finally, I discuss the dataset that has been reanalysed for this study, the strengths and weaknesses of this data, and my reasons for conducting a reanalysis of this type.

1.5.3 Framing in psychiatric consultations

Nine key frames feature in this data. This chapter elucidates what framing looks like in this setting and examines how frames are used by participants to influence the interaction and outcomes of the consultation. This chapter also provides the foundations for exploring the specific techniques used by patients in their performances, and offers points of reference for understanding these within frames. I highlight the key features of framing through a detailed overview of participants' orientation to the study. I then describe nine frames which occur across the dataset and explore the impact that these frame shifts have on participants' 'footing', expectations and goal orientation.

1.5.4 Performing expert roles

Using a detailed analysis of talk in the data, I consider how participants negotiate their roles, and what this says about the shared understanding of 'legitimate' performances. I consider both the work that patients do to perform these roles, and the ways in which they challenge at the edges of these roles to allow them to achieve specific aims. Patients use their

performances of the traditional 'good patient' role to make credible claims to expertise and to ward off challenge. Nonetheless, participants are constrained within these roles, and attempts to step outside these, or to encroach on the other's role, risk defensive work from the hearer.

1.5.5 Family members in the consultation

I extend the use of framing and role performance to analyse triadic interaction in a sub-set of consultations which include a family member. I consider ways in which family members' entrance into the talk is negotiated and how this is influenced by framing before exploring the footings which family members take up in relation to the patient performances. I demonstrate instances of 'speaking for' and 'speaking over' patients, and how these impact on patients' own identity performances. I explore how coalitions – particularly those between family member and psychiatrist – are established to influence the patient. I show how co-constructed narratives may be jointly-constructed, complementary or competing. Just as patients perform 'good patient' roles, so family members construct identity performances of their own and which may reinforce or undermine those of the patient.

1.5.6 Conclusion

I summarise the argument of the thesis, highlighting how this work contributes to previous research on psychiatrist-patient interaction and raising implications from the study for psychiatric practice.

2. Literature Review

The aim of the following review is to position this study within a body of literature that has sought to define, explain and describe doctor-patient interaction. I begin by providing a brief overview of the changing sociological understandings of the roles of medical professionals and patients, from Parsons' sick role to recent movements towards shared-decision making and recovery. I explore a key concept in this literature in more depth: the notion of expertise, **outlining** a distinction between two concepts of expertise - a realist and a constructionist approach – which have implications for patients' abilities to influence decisions in medical settings. In articulating a notion of expertise as enacted, I expand the scope of the discussion to draw on notions of power asymmetry and authority which have long been central to studies of medical institutions. Drawing on two influential social theorists – Habermas and Goffman – I make the case for understanding doctor-patient talk as a performance in which participants draw on resources afforded them by the psychiatric setting to negotiate shifting roles and identities. Having laid out the theoretical approach for this thesis, I go on to explore how detailed studies of talk in medical settings have provided insight into these interactional resources.

2.1 Sociological approaches to doctor and patient roles

As a structural functionalist, Talcott Parsons' approach to understanding behaviour was based on the idea of 'socialisation'; the necessary structures of an orderly society are internalised and adopted consensually by its members. In taking this approach, Parsons emphasises the needs and working of society at a systems level, rather than an individual one. Sickness, under this approach, is potentially dysfunctional and Parsons' work attempted to show how people

manage this dysfunction and adopt a role that allows them to re-conform as quickly as possible. In Parsons' (1975) explanation of the 'sick role', the sick are relieved of the duty to fulfil standard social responsibilities and are freed from any blame for this state, but they must also make efforts to remove themselves from the sick role, or at least to regain an expected level of functioning, for instance through co-operation with medical treatment. According to Parsons' model, the role of the physician becomes, in part, about legitimising the patient's right to take on the sick role. To receive the benefits of the sick role, the claim to it must be sanctioned by medical expertise (Giddens, 2009). In addition, the health professional in this model provides treatment, which the individual must access to demonstrate efforts to recover.

Parsons defined the corresponding roles of doctor and patient by arguing that "there must be a built-in institutionalized superiority of the professional roles, grounded in responsibility, competence and occupational concern" (Parsons, 1975: 271). The idea of technical expertise and authority of the medical professional is central to Parsons' argument; "The physician is a technical expert who by special training and experience, and by an institutionally validated status, is qualified to 'help' the patient in a situation institutionally defined as legitimate in a relative sense but as needing help." (Parsons, 1951b: 139)

This places considerable power with the physician, and creates an asymmetrical relationship between doctor and patient (Maynard, 1991). The authority of the physician is not unilaterally constructed, however. It must be accepted by patients and by society more generally. Patients are expected to engage in "the surrender of private judgement" when receiving medical diagnoses or treatment decisions: "when patients get a recommendation from their doctor, they abandon whatever personal beliefs, uncertainties, fears and misgivings they may have about their medical condition, and accept the physician's diagnosis and treatment recommendation" (Heritage and Clayman, 2010: 154). In contrast to the expertise of the

medical professional, the same institution casts the patient as comparatively uninformed and dependent on the medical institution for help.

“By the same institutional definition the sick person is not, of course competent to help himself, or what he can do is, except for trivial illness, not adequate. But in our culture there is a special definition of the kind of help he needs, namely, professional, technically competent help.” (Parsons, 1951b:441)

Moreover, this competence, and the knowledge it assumes is considered to be beyond the understanding of the layperson: “the physician is a technically competent person whose competence and specific measures cannot be competently judged by the layman. The latter must therefore take these judgments and measures ‘on authority’” (Parsons, 1951a: 463).

Parsons’ ideas were based on collective, rather than individual criteria: the extent of ‘sickness’ is determined by generalised criteria and professionals’ competence is similarly based on a generalised set of standards constituting medical expertise (Gerhardt, 1987: 117). In the early 1960s, Parsons’ model was already coming under criticism. Freidson (1961) argued that Parsons’ ‘sick role’ held little relevance when considering actual patient behaviours. Instead, he believed a series of ‘sick roles’ are needed to provide a comprehensive model that can be applied to a range of different illness types, including severe and mild, permanent and temporary. One of the specific areas which Freidson felt to be ill-served by Parson’s model is that of mental illness: “Mental illness and drug addiction [...] are analytically interesting here precisely because many people cannot quite adopt a purely neutral ‘disease’ orientation toward them: indeed, even when one is cured, the stain remains to in some sense segregate the former patient from the normal and acceptable” (Freidson, 1961: 129). Freidson started from the idea that illness-behaviour is essentially ‘problem-solving’; it may entail consultation with others (medical professionals or others) or self-treatment alone. By this argument, Freidson held that the patient role need not be defined in relation to the expectations of

health professionals and of society as Parsons suggested, but may allow for the patient to be a more active agent in relation to their illness.

Freidson also posited that medical professionals may be more susceptible to patient preferences than previous scholars had suggested, pointing to variation in prescribing habits and adjustments of professional practice to incorporate patient preferences as evidence of this. As a result, he argued that physician roles are not stable, but reflect the specific circumstances in which doctor-patient interaction takes place.

The 1960s also saw the rise of a radical new movement which reacted strongly against the accepted conventions of the sick role in relation to mental illness. The 'anti-psychiatry movement', led by Ronald Laing, David Cooper, Joseph Berke and Leon Redler, sought to break down the distinctions between the sick and the medical professional (Crossley, 2005). They rejected psychiatric diagnosis and treatment as it was widely understood. Central to Laing's argument was that psychiatry failed to see the patient as a human being, with all the varied contextual and personal characteristics which contributed to their experience. He was critical of psychiatry for bestowing on psychiatrists a role similar to that of other medicine, but without the physiological basis for justifying it:

"It is the only branch of medicine that treats people physically in the absence of any known physical pathology. It is the only branch of medicine that 'treats' conduct, alone, in the absence of symptoms and signs of illness of the usual kind." (Laing, 1999: 3)

Though 'anti-psychiatry' itself had begun to wane by the mid-1970s, its legacy included a neo-Marxist approach that saw psychiatry as a form of social control (Rogers and Pilgrim, 2010). By the late-1980s, however, there was a move towards decarceration - treating mental illness outside of the asylum - and a growth in the idea of psychological therapies and community care. Post-structuralists emphasised the voluntary nature of relationships between mental health professionals and patients, with patients seeking out help and constructing a co-

operative dialogue in which psychiatrists are perceived as providing benefits to the patient (Crossley, 2005).

This notion of a co-constructed and co-operative relationship between psychiatrists and patients has developed over the last decade or more within the Recovery movement. The shift in mental health services towards a focus on personal recovery – as distinct from clinical recovery - and the acknowledgment of the need for patient expertise and shared decision-making have acted as a challenge to psychiatrists' dominance over what it means to be 'recovered' and, by implication, what it means to be ill. This has a profound impact on the role of the mental health professional and the role of the patient: "the role of professionals is seen in recovery literature as that of a companion or fellow traveller rather than as expert" (Davidson, 2005: 32).

A key element of personal recovery is the idea of patients taking an active role in managing their own health and illness. 'Self-management' has been described as "the ways we cope with, or manage, or minimise, the ways the condition limits our lives, as well as what we do to thrive, to feel happy and fulfilled, to make the most of our lives despite the condition" (Davidson, 2005: 27). Davidson argues that self-management is built around a sense of agency; the patient's belief that she can take some control over her life and the circumstances she faces, including within decisions made about treatment and care for mental illness. This movement offers a stark contrast to the set of dual rights and responsibilities of Parsons' model, in which the patient has a duty to seek and follow help from a recognised 'expert' and where the doctor can expect to be entrusted exclusively with providing treatment (Gerhardt, 1987: 116).

A parallel development is the introduction of dual rights and responsibilities of healthcare. In 2001, the Department of Health launched the Expert Patients Programme, centred on the idea

of training patients with chronic conditions to take an active role in the management of those conditions. They argued that patients:

“can become key decision-makers in the treatment process. By ensuring that knowledge of their condition is developed to a point where they are empowered to take some responsibility for its management and work in partnership with their health and social care providers, patients can be given greater control over their lives.”
(Department of Health, 2001: 5)

The Expert Patient Programme has been criticised for encouraging patients to enact an ideal ‘expert patient’ role within the medical model, through training courses in which “content emphasising a rational approach towards patient–doctor encounters reinforce[d] the discouragement of emotional expression within the medical consultation, thus enhancing the medical view of the expert patient” (Wilson *et al.*, 2007: 44). This is achieved through teaching patients to be ‘succinct, knowledgeable, rational and non-emotional’, characteristics associated with professionalism and expertise, and considered to facilitate discourse between doctor and patient.

The introduction in policy of the notion of ‘expert patient’ sparked discussion about what the term ‘expert’ means in relation to patients with a chronic condition. Some commentators pointed out that self-management is not a new thing, and that outside of intensive care it has always been left for patients to monitor their symptoms and react through, for example, adjusting levels of activity, changing their dose of painkillers or seeking further professional help (Holm, 2005). Notably, these examples of traditional self-management take place outside of clinical consultations. They are what patients do when there is no medical expertise to confirm or contradict these decisions.

This expert patient model was not universally well received by clinicians. A survey conducted in 1999 around government proposals on the Expert Patient, found that 37% of doctors thought this would lead to deterioration in doctor-patient relationship, and 13% thought it

would lead to worse health outcomes (Association of the British Pharmaceutical Industry, 1999). Shaw and Baker suggest that this reflects a mismatch in the understanding of what 'expert patient' might mean among policy makers and health professionals and that the term is itself "prone to provoke hostility" (Shaw and Baker, 2004: 724). It is interesting that the concept of patient expertise should be interpreted as challenging to professional expertise, and the results of this survey suggest that doctors fear patients may perform expertise in a way that is problematic to the therapeutic relationship and to health outcomes.

2.2 Understanding 'expertise'

2.2.1 Realist understandings of expertise

The Expert Patient Programme has generally adopted a realist approach to expertise based on the principle that expertise through knowledge acquisition, particularly through training, is the goal. Realism holds that things have a 'real' existence, independent of our perception or understanding of them: it "is the real and substantive possession of groups of experts and that individuals acquire real and substantive expertise through their membership of those groups" (Collins and Evans, 2007:2-3).

Collins and Evans presented different expertise types, including the ubiquitous expertise acquired through immersion in a social group, for example the ability to speak a native language, and two types of specialist expertise: 'contributory expertise' - the knowledge and skill required to do an activity competently - and 'interactional expertise' - the mastery of the *language* of technical expertise without the practical competence. According to Collins and Evans, this second form of experts includes journalists, critics and sociologists. Finally, Collins and Evans describe levels of meta-expertise, whereby individuals with varying levels of relevant expertise themselves judge the statements of other experts, and meta-criteria by which they make judgements between other expert claims.

In their model, expertise can be objectively recognised as such by other experts. They explicitly distinguish expertise from qualification: "it is possible to have expertise, and that includes specialist expertise, in the absence of qualifications" (Collins and Evans, 2007: 52). Expertise is based on practical competencies, with relevant expertise required to carry out activities with a high level of competence. Collins and Evans are open to the idea that non-qualified persons may obtain expert status. As an example, they describe how non-scientifically qualified AIDS activists acquired sufficient knowledge to become both interactional and contributory experts. This leads Collins and Evans to address the 'problem of extension' - that is, how boundaries are set around the legitimate contribution of technical debate - by suggesting that various types of expertise should be included beyond contributory expertise, including "experience-based experts" (Collins and Evans, 2007:113). However, to qualify as an experience-based expert, their claims need to be acknowledged by specialists.

The implication of their argument is that expert status – including that of 'experience-based experts' - must be recognised by a collective, as in Parsons' approach, discussed above. Collins and Evans acknowledge that experience of AIDS itself added to the knowledge of the AIDS activists in their example, but argue that expert status was achieved through acquiring technical knowledge and competence that was legitimised by other experts. Collins and Evans do not accept an understanding of the condition through personal experience as a form of specialist expertise.

There is a circular argument at the heart of Collins and Evans' model: 'expertise' is only recognisable by 'experts'. They rely on the idea of competency as an independent measure of expertise. While some medical procedures may be done correctly or incorrectly, determined by their measurable outcomes, in other areas competency is less straightforward to assess. In psychiatric medicine, for example, diagnoses and treatments are frequently reassessed and

changed, even by the same 'expert'. There is a danger that competency also becomes defined as such by 'experts'.

A secondary problem follows from this. A body of accepted wisdom may remain entrenched because attempts to challenge it from outside are not accepted by acknowledged 'experts'. This may make it difficult to develop and improve on assumptions held by the professional group. Holm, for example, argues that:

"It seems to imply that expertness in this context is primarily a set of specifiable cognitive skills combined with a specific base of knowledge and that only those who possess these can be expert patients. This rules out anyone who is managing his or her own disease successfully using for instance an idiosyncratic personal heuristic." (Holm, 2005: 160)

Finally, this model reinforces a power imbalance based, not on merit, but on social status. However informed a lay person becomes, expert status can only be granted to them by the dominant professional culture.

One solution to the problems posed by realist conceptions of expertise is to argue that different types of expertise may be deployed by professionals (technical experts) and lay people (non-technical experts). In other words, doctors and patients may both be legitimate experts but in different things. In talking about lay expertise, some commentators evoke the idea of two distinct 'systems of knowledge', for example Prior's (2003) distinction between 'lay' and 'professional' knowledge. In his review of the development of 'lay expertise' in the sociology literature, Prior argues against diluting notions of science by giving equal weight to different ways of 'knowing'. He documents the shift from discussion of patient 'perspectives', 'viewpoints' or 'beliefs' to that of 'lay knowledge' and 'lay expertise'. He argues that there has been a tendency to confuse experiential knowledge with the technical skills and knowledge that constitute expertise. He concludes that "the worthy political aim of ensuring participation

and consultation of the lay public in all matters to do with medicine” (Prior, 2003: 54) should be kept distinct from claims of expertise.

Kivits (2004) emphasises the difference between ‘informed patients’ and ‘expert patients’ by showing that people using online medical forums often sought to bridge the gap between their own experiences and the information received through medical professionals. Kivits found that the ‘informed patients’ in his study rarely described themselves as experts, nor did they generally use this information to challenge the authority of medical professionals.

Civan and Pratt define patient expertise as “the experiential knowledge that patients have gained about effectively accomplishing the work of being a patient”(Civan and Pratt, 2007: 140). Tyreman (2005) argues that patient expertise is about understanding “what the illness means to the patient”, rather than understanding the cause of the condition, which requires bio-medical knowledge.

[...] chronic illness, by its nature, is longstanding and ongoing. If the patient’s suffering is to be reduced, not only must symptoms be controlled, the doctor also needs to know what the illness means to the patient, how it affects their life and how their life can be made as normal as possible. (Tyreman, 2005: 154)

Holm (2005) similarly argues that patients are likely to draw on ‘bodily knowledge’ in relation to a health condition, in contrast to ‘propositional knowledge’. For patients experiencing severe mental illness, an example of bodily knowledge may be the experience of how medications make them feel, both in terms of physical symptoms and their identity and sense of self. This appears in the literature as a reason for non-adherence among patients prescribed anti-psychotics (Clatworthy *et al.*, 2007).

By drawing these distinctions, new problems are posed about the compatibility and usefulness of different types of knowledge in the clinical interaction. According to Holm (2005), ‘bodily

knowledge' may be difficult or even impossible to communicate to others, making it hard for clinicians to value or even to consider such knowledge:

"It is unclear whether health care professionals and patients actually share the same language, or whether there are insurmountable translation problems between patient language and medical language." (Holm, 2005: 163)

Nonetheless, he points out that in other groups of recognised experts, other forms of such 'tacit' knowledge play a key role in making expert decisions.

Where does this realist understanding leave the question of patient expertise in the context of medical interaction? While supportive of values around communication and inclusion, the models presented by Collins, Evans and Prior tends to subjugate 'expertise by experience' to a separate, generally lower, realm of knowing than 'real' expertise. Medical or professional expertise is given a higher standing. The implication of this approach to understanding expertise is that medical professionals are more likely to know what is best for the patient than the patient themselves.

Thus, any approach based on a realist model of expertise inevitably maintains a power imbalance within the clinical relationship. Doctors are assumed to have expertise as part of a structure which already recognises their claim to expert competence as legitimate, while patients must be accepted as expert by emulating them. Importantly, it places claims that fall outside this recognised technical expertise at a lower priority.

2.2.2 Constructionist understandings of expertise

In contrast to the realist approach, some sociologists have taken the view that expertise is constructed or enacted through talk and interaction. By exploring how participants make claims, an alternative understanding of the relationship between lay and professional expertise

has been developed which challenges the realist notion that expertise is possessed and objectively recognisable.

Kerr and colleagues take a critical look at Collins and Evans' model by using a discourse analysis to "[map] out some of the detailed and relational contours of expertise and lay perspectives in context" (Kerr *et al.*, 2007: 389). Their approach is to examine the social positioning and identity construction achieved through discourse in public debates about technical and scientific issues. They identify a number of techniques employed by lay groups to position their contribution to the debates. These included: explicit deference to scientific expertise; justification for the inclusion of an alternative perspective, including a distinction between lived and learned knowledge of disability; signalling competence by evoking non-salient expertise through other social and professional roles; and distancing themselves from other, less informed lay groups.

Kerr concludes that "Claims to expertise and the importance of lay perspectives are dynamic and context-dependent" (2007: 405). Claims are constructed alongside identity with, and in contrast to, others. The implication of this critique is that a realist conception of expertise as a possessed characteristic fails to account for the ways in which claims are made and utilised around individual instances of decision making. On that basis, a constructionist approach can offer greater insight into the roles performed by patient and doctor in the specific context of the psychiatric setting. This is the approach I have taken in this thesis.

By focusing on the way in which expert claims are produced and expert identities enacted, various scholars have moved away from objective criteria for expertise and considered instead the way in which claims are negotiated and made relevant to decision-making (Carr, 2010; Maynard, 1991; Mehan, 1990). Such studies emphasise that the enactment of expertise is dependent upon the context in which it takes place. Being recognised as an expert involves adopting behaviours that produce an impression of expertise to others within the specific

setting. The hierarchy between expert and lay claims to knowledge becomes one that is locally produced rather than being a natural state.

While realist approaches require expertise to be recognisable universally, constructionist approaches focus on the negotiation of expert status locally. Rather than reference to a universal body of knowledge, claims to expertise are made relevant in local contexts. While realist approaches establish a fixed hierarchy of expertise, constructionist approaches hold that power-dynamics are produced within the interaction.

Carr identifies two ways in which expertise is constructed or enacted: the first through locally produced interaction, and the second through ideologically shaped hierarchies.

“Across its many domains, expertise is both inherently interactional, involving the participation of objects, producers, and consumers of knowledge, and inescapably ideological, implicated in the evolving hierarchies of value that legitimate particular ways of knowing as ‘expert.’” (Carr, 2010: 17)

In highlighting the latter, she draws an important link between the idea of expertise and that of authority, through which value-based institutions reinforce power imbalances.

Hugh Mehan’s work on ‘oracular reasoning’ in psychiatric examinations provides a useful insight into how power imbalances influence reasoning and decision-making (Mehan, 1990).

The idea of oracular reasoning comes from the historical accounts of people consulting with oracles when making major decisions. Although the oracle may be inconsistent or later proved to be wrong, the society provides a set of beliefs that allows these to be explained away.

Mehan argues that through established power imbalances, the powerful can dictate the ‘definition of the situation’ (Thomas & Thomas, 1928), which Mehan reformulates as: *“All people define situations as real; but when powerful people define situations as real, then they are real for everybody involved in their consequences”* (Mehan, 1990: 160).

Mehan (1983) demonstrates how lay and expert reports are produced through interaction in an education board setting. He shows how the format and structure of reports, the use of interruption and 'interrogation' (:199) by the people receiving the report, the sources drawn on in making claims, and the roles and responsibilities taken up by lay or expert speakers differ substantially.

The medical institution is a key arena in which the notion of asymmetry of roles has received considerable attention. Maynard states that "studies of the doctor-patient relationship uniformly describe an asymmetry of knowledge and authority that allows doctors to promulgate a bio-medical model of disease and to simultaneously undermine patients' own experience and understanding" (Maynard, 1991: 448). Like Carr, he identifies different levels on which this asymmetry is created: 'professional authority', originating with Parsons' work on the Sick (Parsons, 1951a); 'socio-political structures', macro-level power relationships which "reinforce oppressive arrangements in work, family, recreational and other aspects of social life"; and 'communication structures', in which the talk and interactive frameworks themselves create and maintain disparity (Maynard, 1991: 455).

Carr and Maynard both highlight the significance of treating expertise as constructed on at least two different levels: the social construction of institutions that create an asymmetrical authority across expert and lay roles, and the local construction of identities in the situated talk of experts and lay people. Neither form of expertise exists independently of interaction as argued in a realist approach. Social institutions are constructed at multiple levels and continually re-constituted in the interactions that take place within them.

Ainsworth-Vaughn (1995) uses this distinction between agency and structure to identify four bases for claiming power in a medical encounter. Ainsworth-Vaughn argues that structural power rests almost entirely with the medical professional, but that agency can be used to a greater or lesser extent by both doctor and patient. In addition to structural power, she

deconstructs agency into three categories drawn from earlier work by Brody (1993):

‘charismatic power’ – based on the individual’s personal characteristics – ‘social power’ – based on the individual’s prestige within society – and ‘Aesculapian power’ – based on the individual’s ability to heal, drawing on the name of the Greek god of medicine and healing (Ainsworth-Vaughn, 1995: 279).

Recent scholars have also sought to describe the ways in which medical institutions produce differential rights to expertise and knowledge claims. Heritage identifies four types of asymmetry: asymmetries of participation; asymmetries of interactional and institutional “know-how”; asymmetries of knowledge; and rights of access to knowledge (Heritage, 1997, Loble, 2002).

‘Asymmetries of participation’ are those that provide professionals with more right to ‘take and retain the initiative’ in the interaction. Heritage states that “in many forms of institutional discourse [...] there is a direct relationship between institutional role and tasks on the one hand and discursive rights and obligations on the other” (Heritage, 1997: 237). A similar construct is the basis of Levinson’s ‘activity types’: *“a fuzzy category whose focal members are goal-defined, socially constituted, bounded, events with constraints on participants, setting, and so on, but above all on the kinds of allowable contributions”* (Levinson, 1979: 368). This notion relates directly to Goffman’s concept of ‘footing’ described below. ‘Asymmetries of “know-how”’ refers to claims about how things are done in the specific setting. They confer on the favoured party greater authority to direct the legitimacy of certain actions or claims.

‘Asymmetries of knowledge’ are those linked to the privileged knowledge-base which is generally ascribed to one party over the other. Asymmetries in participants’ ‘rights of access to knowledge’ are described as occurring when a participant has “limited resources with which to answer the questions “what am I entitled to know?” and “how am I entitled to know it?” (Loble, 2002: 239). Once again, in a medical setting this asymmetry disadvantages the patient

who may, as a result, be hesitant to make claims in areas that the doctor has a preferred right to know about, for example in making diagnoses or prescribing treatments.

Heritage argues, however, that these asymmetries are not regarded as a natural or inevitable state of institutions as Parsons suggests, but rather they are constantly reproduced in the interactions that take place within those institutions. This constant negotiation is central to this thesis which explores how the shifting work and goals of participants in the interaction changes the footing which they take up towards each other. A frame analysis offers important new insights into the way these shifts are managed by examining in detail the interaction that takes place in psychiatric consultations.

Carr (2010) argues, it is “only when we rigorously attend to real-time semiotic interaction—where struggles between law, science, magic, and medicine play out in improvisational and contingent, if always already conventionally controlled, ways—that we can also discern just what role institutions play in the organization, authorization, and enactment of expertise” (Carr, 2010: 23). Such rigorous attention is the aim of this thesis. In doing so, I draw in particular on the work of Goffman, and to a lesser extent, that of Habermas to provide a framework for exploring this interaction.

Expertise and rationality: Habermas

Rationality, as Habermas proposes the concept, provides a foundation for understanding claims to expertise in interaction by introducing the idea that a shared rationality allows us to assess the validity of claims made by participants. This shared rationality depends upon a mutual definition of the situation which changes the way in which validity claims are assessed. Habermas’ concept therefore provides a useful point of departure for considering the ways in which doctors’ and patients’ claims are treated in the psychiatric consultation. I draw on these ideas particularly in Chapter Five of this thesis.

Habermas argues that communication and interaction are governed by shared systems of rules. For Habermas (2001) these rules take the form of the principle of Universal Pragmatics. Communicative competence is the ability to understand and employ these rules. In the model of Universal Pragmatics, all communication, implicitly or explicitly requires participants to make claims as to the validity of their statements. Speech acts have both a propositional content – used to communicate something about an object or state of affairs – and a performative content – used to establish the intersubjectivity between the speaker and hearer.

Habermas asserts that all speakers necessarily raise validity claims of four types: that what they say is intelligible; that it corresponds to a real state of affairs; that it is appropriate in the context; and that it is sincere (Habermas, 2002: 137). Identity, roles and relationships between speakers is therefore tied up with the notion of validity claims, since a speaker must demonstrate not only the factual accuracy of a claim, but also that the statement is appropriate, including that they, in their role, have the relevant authority to make that statement.

“The hearer understands the speech act only when [...] she also knows the conditions that authorise the speaker to issue his imperative so that he may expect the addressee to carry out the required action.” (Habermas, 1970: 264)

Habermas argues that communication is premised on the possibility of a rational consensus, in which validity claims are critiqued, defended and agreement reached by strength of argument (Flyvbjerg, 1998). He proposes the idea of ‘communicative action’, that is “action oriented towards reaching mutual understanding” (Habermas and Fultner, 2002: ix). Habermas distinguishes between these ‘communicative actions’ – those aimed at reaching a mutual understanding – and ‘strategic actions’ – those aimed at success in achieving a particular goal.

Strategic action may be openly aimed at success - for example where the speaker is explicitly requesting or persuading - or concealed, through manipulation.

Habermas argues that communicative action is based on speakers and hearers having a set of shared understandings. Since speech acts are contextualised, the ability to reach a mutual understanding depends on establishing a shared 'definition of the situation' (Thomas & Thomas, 1928).

"In communicative action, participants are not primarily oriented to their own individual successes; they pursue their individual goals under the condition that they can harmonize their plans of action on the basis of common situation definitions. In this respect the negotiation of definitions of the situation is an essential element of the interpretive accomplishments required for communicative action." (Habermas, 1984: 286)

Validity claims are therefore assessed differently depending on the negotiated understanding of the context in which the interaction takes place, for instance whether it occurs in a medical consultation or in a supermarket, whether between friends or between doctor and patient. The situation that participants believe themselves to be in shapes the rationality applied to validity claims.

"Communicative rationality is a conception of situated reason that raises its voice in validity claims that are at once context-bound and context-transcendent. Although [...] validity claims transcend given contexts of validity in various ways, they are always raised in specific temporally and spatially defined contexts of communicative action." (Cooke, 1997: 40)

Habermas (1985) takes this idea of situated rationality further by proposing a distinction between what he terms the 'Lifeworld' and 'System'. Lifeworld is the shared, implicit, and inescapable assumptions which produce a 'symbolic space' on which people must draw in communicative action in order to reach a mutual understanding. In the 'Lifeworld', it is possible to adopt different attitudes towards three conceived worlds – objective, social and

subjective. As such, participants in the interaction position their claims in relation to facts (objective world), social norms (social world) or subjective feelings (subjective world). Validity claims can therefore be assessed with reference to any of these three, and participants can move between these different attitudes.

In contrast, 'System' is built on strategic action, based on material reproduction and empirical knowledge. In the System participants relate only to the objective world and do not provide space for social and subjective claims. Validity claims, including those of social norms and subjective experience, are treated with reference to objective fact (Cooke, 1997: 21).

Habermas further argues that the System is 'colonizing' the Lifeworld, and thus areas which should be characterised by communicative action are becoming characterised by strategic action. A consequence of this colonisation into institutional, and particularly medical, settings is that "institutional discourse prevents client validity claims, unless the institutional representative makes room for them" (Agar, 1985: 163). Expertise based on what Freidson (1986) terms 'formal knowledge' is used to legitimise power held by professionals over those who use their services (Scambler, 1987). Professionals use and defend their expertise through, for example, using technical language, asserting boundaries over what is relevant, and claiming organisational rights and powers.

For Habermas, then, expertise is conferred through the empirical, functional and power-structured 'System'. Expertise is claimed by reference to these frameworks and the possession of 'formal knowledge' oriented toward the scientific and technical solution of social problems. Of course, psychiatric patients may in fact possess considerable medical knowledge, acquired either through medical training or through living with a medical condition over a long period of time. They may also actively use such 'formal knowledge' in their validity claims, or speak in a 'medical voice'. Habermas argues, however, that where roles confer power differences in the

interaction, this makes communicative action impossible. In making successful validity claims, therefore, identity and roles within an institutional setting are central.

‘Validity claims’ are a valuable concept within this thesis. According to Habermas, both participants in the consultation must produce and defend validity claims. Habermas’ approach encourages us to consider what speakers are doing through these claims, not simply in the propositional content, but also in how, through these claims, speakers try to bring about an effect on the hearer. The way in which such claims are made, critiqued and defended allows us to examine the mutual understandings of the situation and the rationality that dominates in the psychiatric setting. I will use Habermas’ ideas to consider how claims to intelligibility, truth, relevance and sincerity are made and responded to, particularly by patients. I will also examine how far psychiatrists as ‘institutional representatives’ make room for patient claims of fact, social norm and subjective feeling.

Expertise as performance: Goffman

Goffman’s approach has features in common with Habermas’ theory of communicative action. Both draw on the work of Mead (1934) and Symbolic Interactionism. Both rely on locally negotiated definitions of the situation and both see interaction as governed by communication rules. However, Goffman’s dramaturgical approach rejects the information-driven premise of Habermas’ communicative action, as failing to account for what actors are actually doing in their speech. Much of interaction, he would argue, is not about making validity claims but about impression management:

“what talkers undertake to do is not to provide information to a recipient but to present dramas to an audience. Indeed, it seems that we spend most of our time not engaged in giving information but in giving shows.” (Goffman, 1974: 508)

Goffman argues that social encounters can be understood in terms of ‘front-stage’ and ‘backstage’ performances (Goffman, 1959). Front-stage interactions are those in which

speakers take up formal identities and roles in relation to others. They are bound by what is expected of these roles, and their performance often involves working as a team with others. Backstage, people are not required to maintain these performances. They may act in contrast to the role that they perform on-stage, or they may undertake those activities which are required for the on-stage performance but which are not part of it, for instance preparation or agreeing strategies.

Goffman's work focuses primarily on the concept of social interaction in the "face-to-face domain" (Goffman, 1983: 2). Goffman argues that the interaction order – micro-level social order as enacted in this domain - is governed by rules and is essentially ritualistic. It is characterised by the work of the participants to present and maintain 'face' which he defines as the "positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact" (Goffman, 1967: 5).

This face-work is managed through a complex collaboration in which the careful management of information is crucial. There is the danger in interaction that 'destructive information' could be shared:

"One overall objective of any team is to sustain the definition of the situation that its performance fosters. This will involve the over-communication of some facts and the under-communication of others. Given the fragility and the required expressive coherence of the reality that is dramatized by a performance, there are usually facts which, if attention is drawn to them during the performance, would discredit, disrupt or make useless the impression that the performance fosters. These facts may be said to provide 'destructive information'." (Goffman, 1959: 141)

'Team performance' and collaboration are central to interaction. If participants fail to perform their role in the face-work, the interaction is likely to become one of contest and conflict. Participants' willingness to abide by these rituals is itself a key in establishing identity:

“When an individual becomes involved in the maintenance of a rule, he tends also to become committed to a particular image of self. In the case of his obligations, he becomes to himself and others the sort of person who follows this particular rule, the sort of person who would be naturally expected to do so. In the case of his expectations, he becomes dependent upon the assumption that others will properly perform such of their obligations as affect him, for their treatment of him will express a conception of him.” (Goffman, 1967: 51)

Closely linked to the concept of maintaining face is that of trust, in particular, trust that the other person will follow the conventions of talk in interaction. The rules that Goffman argued are key to social interaction also set up an expectation as to how the other will behave.

Goffman (1967) uses the analogy of traffic rules, which are followed not because they are the end objective but because they guide the means of interaction. The ability to expect and predict that others will abide by these rules makes it possible to maintain behaviour and to manage encounters effectively. Trust, then, is an enabler for social interaction. In doctor-patient encounters, trust may be established through conforming to the norms expected of those actors in that context. Goffman (1959) also uses the term ‘tact’ to describe how actors keep each other in face, e.g. by not drawing attention to any slips or inconsistencies of self-presentation.

In Goffman’s (1971) essay, *The Territories of the Self*, he links claims made in interaction with various types of ‘territory’. These include land, property, personal space, ‘use space’, ‘the turn’, and ‘conversational preserve’. Though he does not focus on the types of roles discussed in this thesis, by including the latter two categories Goffman acknowledges that interactional rights may be conferred through a shared understanding of the rules governing a situation. ‘The turn’ refers to rules that allow an individual, based on a contextually relevant characteristic, to exercise a right or claim (for example the rule ‘women and children first’ in a rescue context). ‘Conversational preserve’ refers to “the right of an individual to exert some control over who can summon him into talk and when he can be summoned, and the right of a set of individuals

once engaged in talk to have their circle protected from entrance and overhearing by others” (Goffman, 1971: 40). In the same vein, institutional roles can be seen as territories which permit individuals to make claims and to act on the basis of those roles. Norms of interaction require that territorial boundaries be respected by others.

Goffman lays out two important issues that follow on from the concept of territories: markers and violations. Markers refer to the ways in which individuals lay claim to territories and demarcate the limits of them. Markers may be physical – such as items left on a seat to indicate that it is being held – or they may be verbal or behavioural. They can also be used to warn another that they are encroaching on a territory or to reclaim a territory following a violation. Violations on territories can also be physical or behavioural. Goffman gives the example of speaking out of turn: “The addressing of words, as when subordinates in an encounter speak up, or remarks are addressed by way of cross-talk from an individual to those with whom he is not in a ratified state of talk” (Goffman 1971: 46). Violations include both intrusion (by another into your territory) and obtrusion (by extending the boundaries more widely than is accepted). I will return to the idea of markers in Chapters Four and Five of this thesis in discussing the way that participants negotiate boundaries between their respective roles and between frames.

Goffman’s model provides a useful way to understand legitimate roles and the ways in which these are managed in the interaction. Territory provides participants with the right to behave in certain ways. When individuals violate these territories they simultaneously claim rights that they are not entitled to in their legitimately held territory, or deny the rights that others legitimately hold. I return to this concept in Chapter Five as a tool for understanding participant’s claims in relation to their interaction rights, and particularly where participants back away from certain types of claim.

Like Habermas, Goffman’s focus on individuals’ behaviour in interaction does not exclude the institutional character of that behaviour. Indeed, Goffman is interested in the way in which

institutions create different sets of expectations and roles, to which participants orient themselves. Therefore, since the situation of doctor-patient talk is institutional, its character is shaped in a way that one-off, social encounters are not.

“When the runs of a situated system are repeated with any frequency, fairly well-developed situated roles seem to emerge: action comes to be divided into manageable bundles, each a set of acts that can be compatibly performed by a single participant. In addition to this role formation, there is a tendency for role differentiation to occur, so that the package of activity that the members of one class perform is different from, though dependent upon, the set performed by members of another category. These kinds of roles, it may be added, differ from roles in general, not only because they are realized and encompassed in a face-to-face situation but also because the pattern of which they are a part can be confidently identified as a concrete, self-compensating system.” (Goffman, 1961: 96)

Power dynamics and the expert and lay roles that may be attributed in these settings contribute both to parties’ presentation of self and to their ability to achieve their objectives (Pollock, 2007). Here, the concept of ‘footing’ is important (Goffman, 1981: 128). Footing refers to the alignment that participants take up in relation to one another. By performing any identity, the speaker not only makes claims about themselves, but also about how they relate to others. By adopting a footing as ‘doctor’ in a consultation, the speaker creates an expectation that the hearer aligns to this footing by taking up the role of ‘patient’. In different contexts, the alignment between two people might be very different – as friends, neighbours, colleagues, etc. Footing is a central concept in this thesis and discussed in more detail in Chapters Three and Four.

According to Goffman, it is important to maintaining face that a person presents evidence that “is internally consistent, that is supported by judgments and evidence conveyed by other participants, and that is confirmed by evidence conveyed through impersonal agencies in the situation.” (Goffman, 1967: 6-7). However, the ability to control information and maintain face

is shaped by the institutional setting. It may, for example, be difficult for patients to strike a balance between revealing sufficient information to justify required treatment or support, and concealing information which might create an unwanted impression or undermine their attempts to achieve their goals. I return to this idea in Chapter Five. Pollock's (2007) study on maintaining face in consultations for patients with depression demonstrates that in clinical settings patients often employ the same strategies that they use in other social interactions by playing down their symptoms. This can lead to other difficulties for patients in performing a role as a 'credible patient'. Werner and Malterud's (2003) study of women with unexplained symptoms describes how the patients strived to maintain an appearance of sickness in order to be taken seriously.

In a similar way, expectations as to participants' roles and behaviours are shaped by the institutional setting of the clinic. If trust is understood as the ability to reliably predict that the other party will conform to norms of interaction, a doctor's trust in the patient may be damaged if they fail to behave as a patient is expected to according to their role, for example, through non-adherence with treatment or non-disclosure of symptoms. Similarly patients' trust in doctors may be influenced by their expectations of the physician role, by previous experience of consultation or by their own sense of 'what works' (Mechanic and Meyer, 2000).

Using Goffman, expertise is conceptualised as constructed through participant performances. In this sense, participants collaborate to create expert identities within a specific interactional context.

"Every person lives in a world of social encounters, involving him either in face-to-face or mediated contact with other participants. In each of these contacts, he tends to act out what is sometimes called a line – that is, a pattern of verbal and nonverbal acts by which he expresses his view of the situation and through this his evaluation of the participants, especially himself." (Goffman, 1967: 5)

Goffman argues that in any given contact, the situation in which participants perceive themselves to be provides for them a pattern of behaviours expected of them in their ascribed roles. Matoesian has applied Goffman's approach to the court testimony of a defendant who is also a medical expert. By attending to participants' 'footing', he examines how "institutional identity emerges in and through discursive interaction" (Matoesian, 1999: 492). Through his analysis, Matoesian argues that the defendant uses footing to project an expert identity, using a range of linguistic techniques and markers:

"the defendant activates a footing shift from that of defendant to an expert identity, linguistically anchored and incrementally realized in stylistic repetition, reported speech, epistemic modality, evidentials, sequential positioning, conditionals, and tokens of the medical register." (Matoesian, 1999: 495)

Matoesian draws a number of important conclusions from his study. First, though the defendant shifts his footing to perform an expert identity, this identity is 'laminated or embedded' within his identity as a defendant. He cannot simply jettison that identity; and he is still understood by those listening to him as being in the role of defendant. He can, however, layer another identity on top of that by emphasising his role as a medical expert. The way in which he works to shift his performance is uncovered through the use of Goffman's (1974) frame analysis.

Second, the use of footing allows character construction, as well as role construction. Through using a number of footing shifts – into and out of an expert footing – the defendant is able to make his point, the denial of the accusation he is answering, while projecting a face intended to inspire confidence and sympathy:

"Embedding powerful expert discourse within a defendant footing avoids fostering an impression of arrogance – something one might associate with rapists, who use force and abuse power." (Matoesian, 1999: 518)

A final point from Matoesian's study – though one made implicitly rather than explicitly in his discussion – is that the footing shifts demonstrate that such performances are not freely structured. They are constructed within the institutional rules that govern a legal trial. Some claims may be deemed inappropriate or even objectionable within the setting, and individual speakers will be judged in part on how well they adhere to the expectations of their role.

Other researchers have taken a similar approach to understanding the enactment of expert identities, not only in the field of medicine, but in education (Mehan, 2001) and social work (Juhilia & Abrams, 2011). Gülich (2003) analysed talk in medical seminars given by health professionals to patients with chronic heart conditions. Like Matoesian, she identifies a range of discourse techniques, including self-categorization ("we doctors"), the use of illustrations or specialist terms, making explicit reference to research or evaluating information from other sources, and even through generating a particular structure of discourse, such as questions and answers. Gülich goes on to examine how patients enact non-expertise, drawing parallels in the techniques used, for example self-categorization as non-expert, and use of uncertainty in claims about health events. Several of these ideas will be explored further through the data used in this thesis, particularly in Chapter Five in relation to the use of personal pronouns.

In examining both doctor and patient perspectives, Gülich emphasises the relative nature of expertise in interaction: the speaker must be expert in relation to a subject and in relation to other participants. She argues that patients, too, are 'experts' in their health conditions and that communication problems arise from an interactional failure to provide adequate opportunities for patients to enact that expertise, an idea that resonates with Habermas' notion of the 'ideal speech situation'.

The psychiatric consultation similarly provides a range of expectations that constrain legitimate roles and behaviours. The idea of collaboration here is crucial. Patients and psychiatrists can successfully adopt the role of expert only with the co-operation of the other

party. Expertise, then, is not merely something that can be objectively acquired, nor something that can be validated through particular claims; it is something that must be jointly constructed by both doctor and patient. Expertise can be claimed as part of the presentation of the self, and it places expectations on both the 'expert' participant and the 'lay' participant to behave in particular ways. Often, the performance of expertise will be collaborative.

Expertise and authority can be usefully considered as constructed through the performances of participants in the psychiatric consultation. Goffman offers a model for understanding these performances, including how they allow participants to produce identities, undertake roles and make knowledge claims through their talk.

2.3 Studies of doctor-patient interaction

The conceptual shift around doctor-patient relationships, described at the start of this chapter, has led to an increased interest in the work achieved by patients' talk, alongside interest in what doctors are doing (Ainsworth-Vaughn, 1995, Beach, 2001, Gafaranga and Britten, 2003, Heritage and Maynard, 2006). Though research into patients' interaction has increased, the frequent attention on medicine as a profession, and on the talk of professionals as medical intervention, leads Heritage and Maynard to conclude that Fox's earlier claim that "Sociologists have written more about health professionals—especially about physicians—than they have about patients" remains true well into the early twenty-first century (Heritage and Maynard, 2006: 358).

In the remainder of this chapter I move from theoretical approaches to examine some of the conclusions drawn from this extensive body of work on doctor-patient interaction. The studies considered here focus on the roles of doctor and patient and their significance in contributing to the goal-oriented practice of the medical consultation.

2.3.1 The psychiatric consultation

Cruz and Pincus describe the role of psychiatrists as “*principally a psychopharmacologist and secondarily a manager of care*” (Cruz & Pincus, 2002). Psychiatrists are responsible for diagnosing and prescribing treatment for people with a mental illness. These are activities which require psychiatrists to gather relevant information and to reach, ideally in partnership with the patient, a decision; both of which depend upon communicative skills (Royal College of Psychiatrists, 2009). Stefan Priebe and colleagues have reviewed the literature on communication in psychiatric consultations and identified five key components for quality interaction: a focus on the patient’s concerns; positive regard and personal respect; appropriate involvement of patients in decision making; genuineness with a personal touch; and the use of a psychological treatment model (Priebe, *et al.*, 2011). Good communication has been found to impact on patient satisfaction and therapeutic alliance (Themistocleous, *et al.*, 2009), adherence to medication (Quirk *et al.*, 2013), and treatment outcomes (Priebe, 2006).

2.3.2 Voices of the lifeworld and of medicine

Following Habermas, Scambler and Britten (2001) argued that while doctor-patient relationships previously took the form of open strategic action, whereby the doctor used their role as expert to openly instruct the patient (a role in keeping with Parsons’ approach), the move toward more patient-centred healthcare has led to more concealed strategic action on the part of the doctor, either consciously (manipulation) or unconsciously (‘systematically distorted communication’ (Habermas, 1984)). Graham and Oakley (2005) demonstrate that physicians employ both open and concealed strategic action in relation to maternity care. They highlight the use of technical language, rejection of patient requests and even hostility as examples of this strategic action (Scambler, 1987: 185-6). Scambler suggests this is evidence of Habermas’ claim that System is colonizing Lifeworld.

In a similar vein, Mishler adopts the term 'voices', which he defines as "relationships between talk and speakers' underlying frameworks of meaning" (Mishler, 1984: 14). In his analysis of doctor-patient interaction, he found that patients tend to talk in the 'voice of the lifeworld', while doctors talk in a 'medical voice'. The tendency for doctors to ignore the lifeworld leads, according to Mishler, to ineffective and inhumane practice.

There have been challenges to this work, however, particularly in relation to mental health consultations. Subsequent studies have suggested that there may be more complexity and variation in how participants use the lifeworld and medical voices than Mishler suggested. Silverman (1987) has cautioned against perceiving these as simplistic, dichotomous voices, whereby the doctor speaks in a medical voice and the patient in a 'lifeworld' voice (Mishler, 1984, Fisher, 1991). Instead, these discourses should be seen as interacting, with either participant able to employ either voice. This is supported by Barry *et al.* (2001) who found different types of interaction between these voices – those in which the lifeworld voice was suppressed or blocked by the doctor; those in which it was ignored and those in which it was used by both doctor and patient. This last type of interaction was found exclusively in discussion of psychological issues; to the extent that where there were also physical health problems these were discussed in the medical voice.

The suggestion from Barry's findings is that there is something qualitatively different about psychological problems that makes them more open for discussion in the voice of the lifeworld. They suggest a number of explanations for this. First, that psychological problems like anxiety and depression are diagnosed by their impact on a person's life and social functioning. Similarly, success in treatment is measured in these terms. Second, the mind-body dualism that appears straightforward in relation to a broken limb is less apparent in a condition where life events are perceived as the trigger or aggravator of the condition. Third,

accepted treatments for psychological conditions include talking and listening, behaviour more associated with the lifeworld than with the medical realm.

Barry also suggests that general practitioners who are not particularly knowledgeable about mental illness may rely more heavily on the lifeworld than on the medical realm because they do not have the resources to draw on in relation to psychological conditions that psychiatric professionals have. Experience of the lifeworld is seen as a shared expertise and language which is open to all, whereas medical expertise must be acquired. A possible implication of this is that the explanations concerning the challenge to mind-body dualism may be less relevant in a psychiatric consultation with a mental health specialist.

The psychological conditions discussed in Barry's study include anxiety, depression and unexplained psychosomatic symptoms. In many of these, there is an acceptance that the condition was, at least in part, caused by a life event, e.g. bereavement and job stress. It is not clear whether the same factors that prompt discussion of the lifeworld in these consultations would also exist where the patient had a psychotic illness.

2.3.3 Structures of medical interaction

As Ainsworth-Vaughn (1995) highlights in introducing her study of power and discourse, most researchers have focused on one element of the medical encounter. Key aspects that have received considerable attention include use of narratives (Ainsworth-Vaughn, 1998); use of questioning; troubles-telling and advice-giving (Jefferson & Lee, 1981); openings and closings (Gafaranga & Britten, 2003); delivering bad news or diagnostic assessments (Byrne & Long, 1976); making shared decisions (Ten Have, 1995a; Robertson *et al.*, 2011).

These different aspects of medical discourse are important topics for study, but they require selectively focusing on relevant aspects of the overall encounter and largely overlooking the remainder of the interaction. They relate closely to concepts of frame, which I discuss in

further detail in Chapter Three, though this perspective is rarely made explicit, perhaps because a shift to a new frame takes the researcher away from relevant material. Nonetheless, I would argue that narratives, questioning, and the other aspects of medical talk listed above are of interest to researchers precisely because they do the work of frames – they shape the way that participants interact, their expectations, and their ability to achieve specific goals through their talk. Researchers are able to focus on one aspect because it is different from other parts of the discourse in relation to these expectations, roles and task-orientation.

Some researchers have suggested that shifts between these task-oriented activities constitute a more or less standard transition through phases of a consultation (Robinson and Stivers, 2001). Despite the consistency with which such structures are identified in studies of consultations, it is equally important to recognise that participants may also draw on resources from outside these ‘ideal structures’, including through using discourse types that are more commonly associated with other settings:

“While participants in consultations structure their interactions most of the time by using the social forms that are ‘typical’ for their settings, i.e. the Ideal Sequence for the consultation, they sometimes ‘borrow’ forms that have their ‘natural’ place elsewhere, in ordinary conversation or in other institutional settings, respectively.” (Ten Have, 1989: 115)

This observation is key to the principle that interaction is negotiated in each encounter. The structure and ordering of discourse is not inevitable, though common patterns may be identified. Participants work up the interaction drawing on multi-layered resources and shared understandings of talk as ‘social action’.

“During consultations, action can be simultaneously and differentially organized by reference to a variety of larger-order activities. Some of these are ‘mundane’, such as the activities of story telling and troubles telling [...] Others are ‘professional’” (Robinson, 2001a: 43-44).

In Chapter Four of this thesis I look in detail at a number of these ‘larger-order activities’ and their application in the psychiatric consultation. Through that discussion I aim to highlight how shifts between these activities allow participants to orient themselves towards particular goals.

Opening and closing sequences

Gafaranga and Britten (2003) studied the openings of GP consultations to establish whether rules exist as to their structure. In keeping with previous studies (Coupland, Robinson & Coupland, 1994), they find that consultations generally started with a variation on “how are you?” greetings. These greetings, they argue, can serve two purposes. They may be a generic opening, and as such may be used by either doctor or patient. Alternatively, for the doctor only, they may be a ‘first concern elicitor’ when used to invite the patient to explain the reason for their visit.

They further identify two broad types of concern elicitation. When the patient is new and has initiated the appointment themselves, the opening takes a ‘what can I do for you?’ form. When the patient is returning, the opening takes a ‘how are you?’ form. The authors argue that these openings are used as a method of aligning participants to a joint interpretation of the situation.

“the use of elicitors such as “How are you?” and “What can I do for you?” is best understood as a proposal made by the doctor to the patient as to how to view their interaction. This proposal may or may not be confirmed in interaction.” (Gafaranga and Britten, 2003: 243)

Similar distinctions were found by Robinson (2006) in his examination of opening sequences. He argues that there are in fact three types of consultation to which the doctor must orientate her concern elicitor: new concerns, follow-up concerns, and routine concerns. Again, he finds that if doctors incorrectly align their opening to the patient’s understanding of the situation, it

may lead to interactional difficulties requiring repair work. I explore similar interactional difficulties in Chapter Four of this thesis in relation to frame disputes.

This identification of ‘rules’ underlines the idea that aspects of interaction in institutional settings carry with them expectations of participant talk. These expectations allow for negotiation and for correction where the alignment has not been successful. Gafaranga and Britten (2003) take this a step further, however, to describe how deviance from these rules may in fact be strategic. By not adhering to the expected form of talk, participants can achieve other goals. Examples from their study include how doctors can create social distance or encourage solidarity through deviating from the standard rule. Again, examples of such deviation, particularly by patients, are explored throughout the later chapters in this thesis.

At the other end of the encounter, closing sequences have been examined. In general, encounters do not simply stop. Endings have to be negotiated and oriented towards in order to reach agreement that business has been concluded and that the interaction can be terminated. One way in which this is achieved is through ‘closing relevant’ activities:

“Participants must create an interactional environment in which warrants for proposing closure can be understood as such (Schegloff & Sacks, 1973). These can be called “closing-relevant” environments. Closing-relevant environments are largely determined by the organization of topics within conversations (Schegloff & Sacks, 1973). [...] In medical encounters, due to the institutionalized ordering of activities (Byrne & Long, 1976; Waitzkin, 1991), the completion of treatment-related topics and actions - such as educating patients about treatment, writing prescriptions, and filling out insurance and laboratory test forms - can constitute closing-relevant environments (Heath, 1986; Robinson, 1999).” (Robinson, 2001b: 642)

Robinson’s examination of closing sequences suggests two ways of negotiating an agreement that the interaction is ending. The first, the ‘arrangement sequence’, is characterized by agreeing the next course of action and checking for patients’ concerns. The second, the ‘final concern sequence’, is characterized by the doctor explicitly asking whether the patient has

additional concerns to raise. According to Robinson the first tends to constrain patients' opportunity to raise further topics while the second provides a formal space for patients to raise anything further while nevertheless being a marker that the consultation is drawing to a close. As such, this form of discourse has implications for whether or not a patient is able to discuss all the issues of importance to her (Robinson, 2001b), and demonstrates how topic and performance are constrained by frame shifts.

Attending to patient concerns

A key function of the consultation is responding to concerns elicited through the kinds of sequence identified above. Studies have explored how concerns are described by patients and attended to doctors. A key concept here is that of 'troubles talk' which has received its most thorough treatment by Jefferson and Lee (1981; 1988) in contexts other than medical encounters. They consider 'troubles talk' to be any talk in which the speaker tells another about his or her own troubles. Such talk is particularly interesting, they argue, because it is characterised by a tension between the need to attend to these troubles and the need to move on to 'business as usual'. Others have highlighted the role of talking about troubles as part of identity construction in talk, for example the construction of elderliness (Coupland, Coupland & Giles, 1991).

Jefferson and Lee identify a number of elements which they saw repeatedly in instances of troubles-telling in general conversation. From these elements, they develop what they call a 'template ordering' which represents an 'ideal type' (Weber, 1949) or 'candidate sequence' (Jefferson & Lee, 1988: 420), though not one seen in reality within their data. This sequence nonetheless represents an overall structure through which "the talk moves from an engagement with business as usual to a focussing on the trouble and then to a re-engagement with business as usual" (Jefferson, 1988: 438). They also consider the structures which allow troubles-telling to be followed by advice-giving. Alongside the shift in segments of talk is a

recognisable shift in participants' orientation toward each other. They describe shifts between role dyads in interactions where troubles-telling and advice-giving take place. These dyads may be co-operatively worked up or may be rejected by one of the participants.

"While the relevant local categories Troubles-Teller and Troubles-Recipient constitute a fitted pair, not only do the categories Troubles-Teller and Advice-Giver not constitute such a fitted pair, but in terms of the general conversational categories, Speaker and Recipient, both occupy the same category, that of Speaker, with each Speaker's co-participant as the intended Recipient. Upon the proffering of advice by a prospective or to-this-point Troubles-recipient, a Troubles-Teller is shifted into incumbency in the appropriate paired category vis-a-vis an Advice-Giver, that of Advice-Recipient, and in more general terms, is transformed from a Speaker to a Recipient in the current interchange." (Jefferson and Lee, 1981: 410)

Jefferson and Lee draw on this idea of dyads to explain why shifts from troubles-telling to advice-giving may be problematic, and to explore the work done to achieve these shifts. Their description highlights the significance of these shifts for participant roles and identity; by adopting one role, another is given up, including the incumbent rights that accompany it, for example, the right to extended turns. This parallels Goffman's construct of 'footing'.

Jefferson and Lee identify a further cause of difficulties in shifting between troubles talk and advice-giving by drawing a distinction between troubles-telling and the service encounter. The latter, they argue, is oriented to accessing help for a problem while the former is oriented to receiving sympathetic attention for the speaker. They describe this as a 'convergence' or 'contamination' of speech activities (Jefferson and Lee, 1981: 411). Ten Have considers this distinction in relation to medical encounters. He suggests that doctors frequently attend to patients' descriptions of problems in relation to a service encounter orientation, rather than as a troubles-telling. He also, however, identifies an alternative form of convergence, whereby troubles-telling meets 'therapy talk'. In this alternative form of discourse, the doctor declines

to provide advice or treatment in response to the patient's concern, instead encouraging the patient to consider the problem and identify a solution for herself.

"Therapy Talk, then, seems to involve as a basic strategy a refusal to answer requests for expert diagnosis and advice, and an invitation to express one's feelings and self-interpretations. It seems to encourage the patient to 'treat' himself or herself by a sustained self-expression and self-reflection." (Ten Have, 1989: 127)

I consider troubles-telling in more detail in Chapter Four of this thesis. In the context of the psychiatric consultation, I consider whether troubles-telling takes on a different significance as part of the patient role. I also explore how troubles-telling may be goal-oriented in this context.

Questioning and history-taking

Ainsworth-Vaughn argues that "the usual conclusion is that medical encounters are an 'interview' genre – highly asymmetrical, with only one person having the right to question" (Ainsworth-Vaughn, 2007: 462). This position is supported by attempts to quantify doctor- and patient-initiated questioning in consultations. Frankel's (1979) work identified uneven use of questions by doctors and patients, concluding that questions initiated by the patient (excluding requests for clarification or repetition, or follow-up questions on a doctor-initiated topic) form only 1% of questions asked. Strong (1979) highlights that the existence of specific circumstances where patients were encouraged to ask questions – for instance after delivering bad news – served to emphasise the norm in which questions were considered the domain of the doctor alone. Later studies have found considerably more patient-initiated questioning, including Ainsworth-Vaughn's (2007) study of cancer patients which found that 38.7% of questions were asked by patients. This may reflect a change in practice over time, or may be the result of variation in types of medical encounter.

In his review, Ten Have identifies a series of conclusions from research that indicate questioning to be a key form of constructing asymmetry. First, those discursive actions which require a particular form of response – e.g. questions, orders and proposals – are mostly used by doctors, and when used by patients are likely to receive a negative response. Second, the type of response required by these actions is often constrained by the way in which they are structured, for example the use of closed questions. Third, that doctors use questions in series which prevents the patient taking the initiative in the interaction by trapping them in a turn-taking pattern where they are responding, not initiating. Fourth, doctors do not generally justify their questions or topic shifts. Finally, doctors do not provide informative responses to patients' answers, so that it is difficult for patients to discern what doctors conclude from them (Ten Have, 1991).

The repeated finding that doctors' questions dominate at least the history-taking part of the encounter leaves little room for doubt. However, others have cautioned against seeing this as inevitable (Ten Have, 1991, Ainsworth-Vaughn, 1994). Stivers and Heritage (2001) describe instances in which patients reject the closed nature of questions and break out of the presumption of turn-taking by offering additional information. These departures from the normal pattern demonstrate patients' attempts to provide additional, unsought information, to pre-empt negative conclusions or to provide space for a personal narrative.

In Chapter Four, I introduce the idea of the 'interview frame' in which particular types of questioning are used by psychiatrists to achieve certain interactional goals. I draw a distinction between this form of 'interviewing' and other types of questioning which serve different functions in the interaction.

Narratives

There has been a great deal of work looking at the use of narrative in therapeutic discourse and in medical interviews. Bamberg (2006) differentiates between two broad approaches to

understanding and analysing narratives: i) as content – “that is, what speakers/writers make their talk about”; and ii) as an activity (sometimes referred to as a ‘localised story’ (Ainsworth-Vaughn, 2007: 460)) – “more strongly focusing on the present of ‘the telling moment’” (Bamberg, 2006: 2). For this thesis, the second approach to narratives in medical encounters is of more interest. As such, narratives are important because of their place and function in the interaction of a psychiatric consultation.

Labov, one of the most influential analysts of Personal Experience Narrative, defines such narratives as a series of utterances which translate experience into discourse. “For Labov, ‘narrative’ is not any talk about the past, or any talk about events; it is specifically talk in which a sequence of clauses is matched to a sequence of ‘events which (it is inferred) actually occurred’ (Labov, 1972: 360)” (Johnstone, 2004).

In medical interviews, narratives may be initiated by patients or explicitly invited by the doctor. For the doctor, patient narratives are one way of accessing relevant information that will help them to assess the patient’s current state and make medical decisions. However, narratives are of particular interest to some scholars because they are not only a way to exchange information, but also a form of identity performance. Mishler distinguishes between two forms of narrative along these lines: narratives which provide a chronicle of the bio-medical symptoms and treatment of an illness over time, and narratives which link the patient’s account to her lifeworld experience of living with the illness (Clark and Mishler, 1992, Hydén, 1997).

The shift into a narrative frame may fulfil a range of purposes already explored in the literature, such as “to give advice, to entertain, to blame, or to achieve solidarity or control” or “to present oneself as the narrator in a particular light” (Bamberg, 1999: 221). The way in which narratives are constructed provides insight into those aspects considered to be significant within the interactional context in which they are told:

“It is not that events present themselves to us in the form of ready-made stories, but rather that stories are constructed by a narrator who chooses from an array of events and orders them in a meaningful way – an order that reflects her own interpretation of that set of events.” (Dyer and Keller-Cohen, 2000: 285)

Dyer and Keller-Cohen show how using personal narratives can allow speakers to do this identity construction even in institutional settings and where the identity being emphasised is that of professional or expert:

“In the narratives of personal experience the professors subtly positioned themselves in relation to the others in the narratives, creating distance through use of pronouns and referring expressions, and through different methods of evaluation of themselves and others.” (Dyer and Keller-Cohen, 2000: 299)

For some scholars, the use of narrative by patients has been conceived as taking an interactional position that is in conflict with that of the doctor. Young suggests that “stories are sealed off from the occasions on which they occur – here the realm of medicine – as events of a different ontological status. For that reason they can be used to insert into that realm an alternate reality in which the patient can reappear in his own person without disrupting the ontological concerns of the realm of medicine” (Young, 1989: 438). As such, attempts to provide narratives are sometimes stymied by physicians who try to keep the interaction within a more medical voice (Mishler, 1984). However, others have shown instances in which narratives are co-constructed by both doctor and patient and used as part of the medical function of the consultation. Ainsworth-Vaughn (1998) shows how localised stories are used as part of the process of diagnosis, and engages both patient and doctor constructing a narrative together. In Chapter Four I consider the use of narrative in the psychiatric consultations. The co-construction of narrative is further explored in Chapter Six in relation to the inclusion of third parties in the interaction.

Key to the production of ‘stories’ in interaction is the presence of the evaluation, the indication of the “cultural, social or personal significance of the events” (Ainsworth-Vaughn, 1998: 151).

Studies of narrative in discourse have identified typical structures. ‘Labovian narrative’ – perhaps the most commonly discussed form – takes a chronological approach to events, and follows a structure containing an abstract (statement of the general theme), orientation, complicating action (what happened), evaluation, and sometimes a coda (relating the story back to the here and now of the interaction) (Labov and Waletzky, 1997). Riessman identifies subtly different forms of narrative: a ‘habitual narrative’ which “tells of the general course of events over time, rather than what happened at a specific point in the past, and thus is constituted with verb tenses and adverbs that mark repetition and routinization, unlike the simple past tense of stories” (Riessman, 1990: 1197); and a ‘hypothetical narrative’ which takes place in an alternative world and which, according to Ainsworth-Vaughn, are “often used by physicians to persuade” (Ainsworth-Vaughn, 1998: 152).

The existence of common structures of narrative has important implications for interactions in which they are used. Narratives can provide space for an extended turn to allow the speaker to invoke the relevant events and to provide the orientation and evaluation work required. Equally, however, orientation to the structure can allow listeners to move towards early closure of a narrative by providing the evaluation on the speaker’s behalf (Ten Have, 1989).

Decision making

The focus on decision-making in medical consultations has increased considerably since the concept of shared-decision making became central to debates on doctor-patient interaction (Rapley, 2008). Researchers have raised a fundamental tension in the concept of shared decision making; that sharing a decision may sometimes run counter to applying best evidence and acting in what the doctor considers to be the patient’s best interest. As Gwyn and Elwyn point out, “there will be times when ‘demand’ will cut across ‘reason’, when patient preference will contradict professional wisdom” (Gwyn and Elwyn, 1999: 446).

Attempts to examine the conversational techniques which characterise medical decision-making demonstrate that even where patients are notionally encouraged to agree or disagree with doctors' proposals, nonetheless considerable interactional work is done to build up a case and minimise the opportunity for resistance. In this way, doctors may focus more on producing the appearance of shared-decision making than on the reality. Robertson *et al.* (2011) identify a series of such techniques, including use of collective pronouns, three-part listing and constructing supportive accounts of events, which work to strengthen the force of the suggestion. They also identify techniques through which patients are able to make requests for particular treatment decisions, for instance through making their requests indirect, using 'active voicing' (invoking another's comments to support their case), and 'stake inoculation' (a term borrowed from Potter (1996), in which speakers pre-empt possible challenges on the grounds that the speaker has a stake in holding the proposed view). Finally, they show how doctors deliver refusals to patients' requests, using hesitations and repair, implied rather than outright refusal and making counter proposals (Robertson *et al.*, 2011: 88-89). Some of these techniques by both doctor and patient will be discussed further in Chapter Five in relation to decisions within the psychiatric consultation.

Paul Ten Have has looked specifically at the idea of negotiation in medical encounters. Drawing on previous work examining more obvious negotiating – such as plea bargaining – he comments that:

“The substantive 'negotiations' of doctors and patients are mostly carried on implicitly, almost furtively, while only sometimes assessment, advice and treatment is given the form of a bid in a 'negotiation'. This suggests important but difficult analytic issues of 'form' versus 'content'. For participants, the interaction in consultations is 'framed' by the fact that it occurs in that particular institutional setting. And specific interactional episodes are for them, in addition to that, situated in their common history, including specifically the course of the consultation so far.” (Ten Have, 1995a: 319)

In fact, Ten Have finds, in keeping with many of the studies discussed elsewhere in this chapter, an 'extraordinary passivity' in patients; he argues that patients show a reluctance to actively engage in negotiation and debate (Ten Have, 1995a: 343). Other studies have also identified patients' hesitancy to suggest diagnoses or treatment recommendations. In Chapter Five I discuss a similar tendency in relation to patients in the psychiatric consultation. Lobley argues that patients are reluctant to claim a 'right to know' when it comes to decisions around treatment: "Professionals are accordingly given the larger share of the 'right to know'. Clients might then be heard as hiding or suspending their rights to knowledge" (Lobley, 2002: 122).

Despite this, Ten Have suggests that patients are engaging in "subtle forms of negotiation, with patients arranging their presentations, information and reactions in such a way, that the doctor provides the service they seem to want, without explicitly asking for it. In other words, without denying that the physician carries the major responsibility for managing their meeting, I have stressed the fact that patients have and often take the opportunity to influence the proceedings in subtle but substantial ways" (Ten Have, 1995b: 247). Patients' negotiation techniques in the psychiatric consultation are discussed in more detail in both Chapters Four and Five.

Reporting a diagnosis

As with treatment decisions, the action of diagnosing a patient reflects the asymmetry of doctor-patient relationships (Parsons, 1951a). Patients rely on doctors to diagnose because they have both the knowledge and the authority to make the relevant judgement. Byrne and Long (1976) suggest that doctors rely on this authority in the delivery of diagnostic statements and rarely provide further information or justification for the diagnosis. This finding was built on by Heath in considering the delivery of diagnoses in primary care. Heath found that little information was provided by doctors on the diagnosis, and importantly that patients rarely

sought further information or challenged the diagnosis. Once again, this finding has been used as evidence that patients take a largely passive role within medical encounters.

“By withholding response to the medical assessment of the condition, or tailoring accounts to embody their subjective orientation to the illness, patients relinquish or subordinate their knowledge and opinion concerning the illness [...] and render the co-participant’s version as the objective, scientific, and factual assessment of the condition.” (Heath, 1992: 264)

In contrast, Peräkylä finds evidence that doctors orient their interaction to reflect their accountability for diagnoses, and for demonstrating the basis for their assessment:

“The delivery of diagnosis is systematically organized so as to treat evidence as observable and intelligible for both the doctor and the patient, and as something for which the doctor is answerable.” (Peräkylä, 1998: 303)

Peräkylä argues that doctors display accountability for their diagnoses in a number of ways. First, diagnoses may be delivered immediately after an examination in which the link between observable evidence and diagnosis is inferable. Alternatively, where that is not possible, or where the diagnosis is uncertain or disputed, the doctor may explicitly state the reasoning and highlight the evidence on which it is based. This finding is supported by subsequent work on delivering diagnoses in other settings (Maynard, 2004). It is possible that the difference in the findings of Peräkylä and Maynard from those of Byrne & Long and Heath represent a genuine change in practice over time.

Peräkylä (2002) also found some differences from Heath’s conclusions about patients’ responses to diagnoses. Although he agreed with Heath that patients gave minimal responses in the majority of cases, in approximately a third of the instances he reviewed, Peräkylä found that patients did cautiously challenge the diagnosis, predominantly by offering additional information about symptoms.

Other scholars have considered the process of delivering a diagnosis from the perspective of labelling theory (Scheff, 1974), which treats labels such as diagnoses as socially constructed. Gill and Maynard (1995) argue that doctors' discourse techniques demonstrate an awareness of the social meanings of diagnostic labels and attempts to bring patients' families (in this case parents of children being diagnosed as having developmental impairments) along with them in the process of diagnosing.

"Clinicians often proceed cautiously when delivering 'bad news' to parents whose children are deemed to have developmental disabilities. In asking for parents' views and then confirming them, inviting parents to infer diagnoses rather than stating them outright, bringing their expressed perspectives into current talk, or offering to fulfil their expressed needs for particular social outcomes through the use of labels, clinicians strategically involve parents in the task of labelling." (Gill & Maynard, 1995: 30)

Diagnoses are very rarely explicitly discussed in the consultations that form the data for this thesis. This may be because in all cases the process of diagnosing has happened at an earlier consultation. It may also reflect the difficult status of diagnostic labels in psychiatry, where diagnoses are often felt to be stigmatising. As a result, I do not discuss the delivery of diagnoses in the later chapters of this thesis.

2.4 Conclusion

In this chapter I have provided an overview of some key concepts and theories which I have argued are important for considering the goal-oriented performances of participants in the psychiatric consultation. Central to this is the idea of expertise and its relationship to power and authority in institutional settings. I began by considering the tensions between professional, evidence-focused expertise on the one hand and notions of personal, experience-based expertise on the other. I have argued that the realist concept of expertise as a legitimised possession, and its emphasis on the distinction between different, incompatible ways of knowing, acts to limit the ability of patients to lay claim to expertise and reinforces the

power imbalance that has traditionally been found at the heart of the doctor-patient relationship.

In contrast, I laid out a constructivist approach to expertise as something that is enacted through institutional discourse. I suggested, following Davis (1988), that this approach requires theories which embrace both a structure and an agency focus; that is, it had to consider both the institutional asymmetries which provide authority to one party in the interaction, and the work done by all participants to make credible claims. In doing so I discussed first the idea of power asymmetries in the medical institution. I then considered two theorists whose work focuses more closely on talk and communicative practices. Both foreground the context in which discourse takes place while recognising the deliberate work done by participants through their talk. They thus offer a bridge between structure and agency. Firstly, Habermas places the idea of rationality at the centre of communicative actions and argues that the 'system' dominates the 'lifeworld' as the basis for legitimate assessment of knowledge claims. As such, in clinical settings medical expertise becomes the only way of 'knowing', and access to such knowledge is the privileged domain of the professional.

Secondly, I discussed Goffman's dramaturgical approach to consider how participants negotiate roles and identities within a shared understanding of the situation. This puts concepts of collaboration and expectation at the centre of Goffman's model. Using this approach, participants may be seen to work up a particular face, and to co-operate with the other participants to maintain this face. The idea of territories which afford speakers particular rights, and which may be encroached upon and defended, provides a useful way to understand how participants negotiate to adopt corresponding roles in the interaction which allow them to orientate to their goals. In the following chapter I explore the implications of Goffman's model further in discussing Frame Analysis and its application to this study.

Finally, I provided a brief overview of some key studies of doctor-patient interaction and what these tell us about the way in which each participant has been observed to construct their roles in actual consultations. These studies provide insight into some common techniques used by doctors and, to a lesser extent, by patients to negotiate the course of the encounter and to achieve their goals. Many of these techniques will be considered in more detail in later chapters. It is significant that many studies have focused on specific stages in the medical encounter, not on the encounter as a whole. In the next chapter I consider how Frame Analysis may provide a new insight into participants' work to shift through these stages and the impact of these shifts on their roles.

3. Methodology and theoretical framework

3.1 Study aims

This thesis aims to understand the way in which patients and psychiatrists construct their discourse in the goal-oriented context of psychiatric consultations. It contributes to a wide literature on interaction in institutional settings – settings with defined roles and social norms that govern the expectations of participants (Drew & Heritage, 1992). Institutions are conceptually bound up with notions of roles and corresponding power structures. The norms and practices associated with institutions, including medical settings, serve to confer rights to one party over another and to privilege the speech acts of the institutional representative. This position is central to the work of theorists like Foucault and Habermas, and is captured in Agar's study of institutional discourse, in which he defines an institution as "a socially legitimated expertise together with those persons authorized to implement it" (Agar, 1985: 164). Though it may be manipulated, resisted or welcomed by the client who comes into contact with the institution, this power imbalance is central to understanding the discourse work undertaken within institutional settings.

As discussed in Chapter Two, the power imbalance in medical settings is continually constructed and reinforced through the 'communication structures' (Maynard, 1991) that exist within them. Benwell and Stokoe argue that this provides a 'theoretical lens' for the analysis of institutional discourse:

“By construing power as a process or action, it is possible to analyse it as an interactionally-produced, moment-by-moment phenomenon. The analyst can chart the ways people are ‘enlisted’ by, demonstrate complicity with, negotiate or resist institutional agendas.” (Benwell & Stokoe, 2006: 89)

This lens has been used by many researchers. The interactional construction of power imbalances has been identified in the use of closed questions (Frankel, 1984, Li *et al.*, 2007), the imposition of bio-medical explanations (Maynard, 1991) and the control of turn-taking (Heritage and Greatbatch, 1991).

In Chapter Two, I also outlined some changing approaches to understanding the doctor-patient relationship, including the more recent development towards personal recovery and the shift in favour of patients taking an active role in their own care. This study uses discourse analysis to explore patients’ talk in the psychiatric consultation. While many previous studies have focused on psychiatrists’ behaviour, this thesis aims to cast light on the strategies used by patients in these interactions, and the constraints of the psychiatric consultation as a particular institutional setting.

In this chapter I will first provide an overview of Goffman’s frame analysis as a theoretical approach and its relevance to the aims of this study. Analysing framing in the interaction offers a useful way to understand the shifting activities and aims of participants within the psychiatric consultation. I go on to describe the discourse analytic methods applied to the data before giving a more detailed description of the data and the value of reanalysis in this study.

3.2 Goffman and frames

Discourse analysts have produced strong evidence that key features of institutional talk construct a power imbalance between doctor and patient, but for the most part they do not explore the distribution of these techniques throughout a single interaction. Within psychiatric consultations a number of tasks may be oriented towards, and a number of topics discussed. If

we accept, as argued above, that power dynamics are constructed at a micro level in the interaction then there is no reason to assume that this is done uniformly throughout.

Furthermore, there is no basis for assuming that patient complicity with or resistance to the institutional power imbalance should be consistent across the interaction. Goffman's frame analysis provides a useful theoretical framework within which to explore the dynamic process by which participants position themselves in relation to one another and to the task at hand.

3.2.1 Definitions of frames

Goffman starts his work on *Frame Analysis* by borrowing Thomas' (1923) term 'the definition of the situation' (Goffman, 1974: 1): how interaction partners tacitly agree to uphold a shared understanding of what is going on in a given context and what their respective role performances will be. Thomas claimed that "If men define situations as real, they are real in their consequences", but he also wrote of the "rivalry between the spontaneous definitions of the situation made by the member of an organized society and the definitions which his society has provided for him" (Thomas, 1923: 572, Perinbanayagam, 1974: 522). Goffman himself argued that "those who are in the situation ordinarily do not *create* this definition, even though their society can often be said to do so; ordinarily all they do is to assess correctly what the situation ought to be for them and then act accordingly." (Goffman, 1974: 1-2).

Goffman's *Frame Analysis* is based on the principle that "definitions of a situation are built up in accordance with principles of organization which govern events – at least social ones – and our subjective involvement in them" (Goffman, 1974: 10). He uses the term 'frame' to refer to these principles of organization. Goffman treats framing within discourse as a joint enterprise aiming to inform participants of the 'traffic rules' and rituals which are expected to apply in this interaction, or this part of this interaction (Goffman, 1967).

Goffman's (1981b) approach to social interaction is structuralist in that it seeks to understand the rituals and patterns through which the meaning of behaviours are constructed, rather than focusing on the motives and subjective meanings of unique individuals. In this context framing guides the behaviour of participants within a situation and the roles they enact within that frame.

"What guides conduct in this structuralist world is not a set of shady core values or the influence of others who are co-present, but the individual's place within the formal social organization of a concrete social activity, or to put it differently, one's place with respect to the social relations of production of a ritual world." (Gonos, 1977: 862)

Framing rests on the idea that participants in a discourse expect others to employ frames and for their behaviour to be understood within those frames. As Ensink states, "People design their contributions to an ongoing interaction so as to fit in a frame, a known scheme or pattern. And people *expect* each other's contribution to fit into frames, the basic function of which is to create schemes of expectation" (Ensink, 2003: 157). As such, participants' expectations of their role and the role of the other party will presumably contribute to the framing employed in the encounter.

"Framing works as a filtering process or membrane through which general values and principles of conduct are reworked to apply to the particular encounter in hand. These frames trigger inferences by constructing possible scenarios." (Roberts and Sarangi, 2005)

Goffman's approach focuses on behaviours within specific interactions rather than in a broader notion of culture. Frames are negotiated within contexts. Those applied to, for instance, psychiatric consultations, may be very different from those applied in seemingly similar interactions, such as a research interview with a psychiatric patient, or a social encounter between psychiatrist and patient. Though these interactions may all be influenced by a broader culture, they are nonetheless different and can be analysed for the particular set

of rules which govern them. Gonos explains, “in the structuralist conception, each realm of activity exhibits, as a system, rules and understandings that may be in contradiction with those of other realms or with the greater society.” (Gonos, 1977: 862)

3.2.2 Relationship with other key concepts: topic, knowledge schema

Ribeiro and Pinto identify three distinct concepts which are used to understand spoken interaction: **topic**, **schema** and **frame** (Ribeiro and de Souza Pinto, 2005: 14). **Topic** is what the talk is about. There are generally shared rules governing the introduction and ratification of topics in the interaction. **Knowledge schemas** are “participants’ expectations about people, objects, events and settings in the world” (Tannen, 1993b: 60). Topic selections flow out of these expectations of what the interaction is to be about. Ribeiro and Pinto argue that in standard psychiatric interaction, both participants share a knowledge schema which includes the doctor controlling the content, focus on ‘official topics’, and alternate turn taking.

*“While topics address the question “What is talk about?” framing establishes a metamessage as “how this talk must be understood.” **Frames** capture the dynamic way participants position themselves, relate to one another and establish multiple contexts for talk. [...] A metamessage (an implicit message) constitutes instructions for the listener on how to understand the messages within the frame. As people speak and perform actions, they signal to each other what they believe they are doing (i.e. what speech act(s) they are performing, what activity they are engaged in) and in what way their words and gestures are to be understood.”* (Ribeiro and de Souza Pinto, 2005: 15)

Ainsworth-Vaughn provides a useful overview of how frame (the “definition of the speech activity underway”) and schema (“mental constructs, organized chunks of information”) can be used in studying doctor-patient interactions:

“Theories of frame and schema suggest that by proffering a frame, a speaker attempts to constitute the self. When the doctor-patient encounter is framed as part of the medical institution, participants are constituted as doctors, patients, nurses. But when

a friendship frame is invoked, participants are constituted as peers. As frames are offered and ratified, a recursive process takes place. In this process, favourable or unfavourable attributes are added to the cognitive schemas participants can refer to during future constitution of their own and others' social identities.” (Ainsworth-Vaughn, 2007: 459)

3.2.3 Frame analysis

In *Frame Analysis* (1974), Goffman, by his own admission, is not presenting a well worked out theory or method for analysis, describing his own work as, “too bookish, too general, too removed from fieldwork to have a good chance of being anything more than another mentalistic adumbration.” (Goffman, 1974: 13) What Goffman is attempting, however, is to lay out a framework which would allow a new understanding of social interaction. Much of his work in *Frame Analysis* is devoted to analysis of atypical social situations – deceptions, games, stage acting, rituals. He has been criticized for this by some, as producing a theory which is at best peripheral to everyday social life (Denzin and Keller, 1981). Goffman is clear, however, that his interest in these atypical events is as a way of revealing what we take for granted in everyday interaction and that frame analysis is a useful way to examine everyday talk and interaction:

“For actual activity is not merely to be contrasted with something obviously unreal, such as dreams, but also to sports, games, ritual, experimentation, practicing, and other arrangements, including deception, and these activities are not all that fanciful. Furthermore, each of these alternatives to the everyday is different from the others in a different way. Also, of course, everyday activity itself contains quickly changing frames, many of which generate events which depart considerably from anything that might be called literal.” (Goffman, 1974: 563)

3.2.4 Keying

Goffman starts to build a (non-exhaustive) model of possible frames, which include both the abnormal and the more commonplace interaction. He starts with what he terms 'primary frames'. The 'natural frame', is formed of 'unguided' or purely physical events; Goffman provides the example of reporting the weather (1974: 22). The 'social frame' is the result of the "controlling effort of an intelligence" (Goffman, 1974: 22). Though he acknowledges that these might overlap, they are the first level of frame on which he builds. Frames are then constructed inside other frames, or 'laminated'. Frames are not merely a static reference point but are used and shifted by participants within an interaction through what Goffman calls '**keying**'.

'**Keying**' or shifting frames allows participants to do different work with their discourse, but it also allows them to change their position in relation to the other participants and to present a different image of self. In this way, frames are not only how participants make sense of the situation, but also how they re-construct what the situation is.

"[...] one can easily turn to a central concept in frame analysis: the key. I refer here to the set of conventions by which a given activity, one already meaningful in terms of some primary framework, is transformed into something patterned on this activity but seen by the participants to be something quite else. The process of transcription can be called keying." (Goffman, 1974: 43-44)

Goffman identifies a range of basic keys under five headings: make believe; contest; ceremonials; technical redosings (e.g. demonstrations or experiments); and regroundings. The last of these is the most relevant to this thesis. Goffman describes regroundings as:

"the performance of an activity more or less openly for reasons or motives felt to be radically different from those that govern ordinary actors. The notion of regroundings then, rests on the assumption that some motives for a deed are ones that leave the performer within the normal range of participation, and other motives, especially when

stabilized and institutionalized, leave the performer outside the ordinary domain of the activity.” (Goffman, 1974: 74)

In the context of this study, therefore, the motives involved in psychiatric consultations are removed from the ‘ordinary domain’ of face-to-face talk. It therefore requires a keying into a psychiatric consultation frame. In other words, there are forms of interaction that would be expected in ‘standard’ talk that would not be expected in the psychiatric consultation (and vice versa), or which take on different meanings as a result of this keying. A common example of such keying in relation to medical discourse is seen in the significance of the term ‘how are you?’. When used in passing when friends or acquaintances meet, this term takes on significance as part of a ritual greeting, a social nicety, rather than as an invitation to provide a health assessment or describe ailments. In a doctor’s consultation, the phrase is keyed. The same words may be used, but by virtue of participants sharing an understanding of the nature of a medical appointment, the hearer knows that the phrase has this different significance and is likely to respond with information about their health.

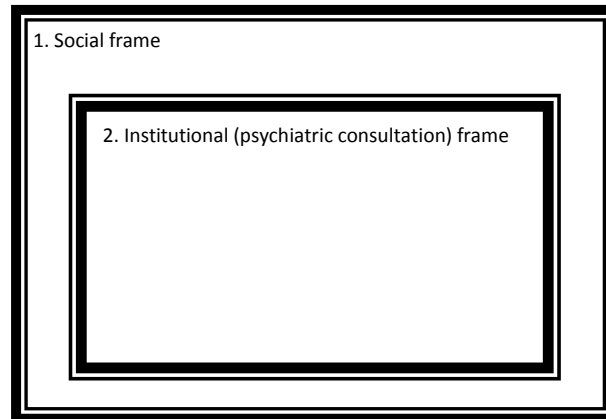
Goffman uses this same example in arguing that neither type of significance should be viewed as standard, though we might overlook some forms of keying because they are so commonplace:

“there are strips of doing which patently involve a keying but which are not much seen in these terms. Thus, as often remarked, our interpersonal greeting rituals involve questions about health which are not put or taken as literal request for information. [...] In order to be careful then perhaps the terms ‘real’, ‘actual’ and ‘literal’ ought merely to be taken to imply that the activity under consideration is no more transformed than is felt to be usual and typical for such doings.” (Goffman, 1974: 47)

Tannen describes different ‘levels’ of frames which represent the interaction of both context and content. There is a broad level context of (in the case she is discussing) the interaction being part of an experiment using an interview mode (Tannen, 1993a: 22). In this thesis, the

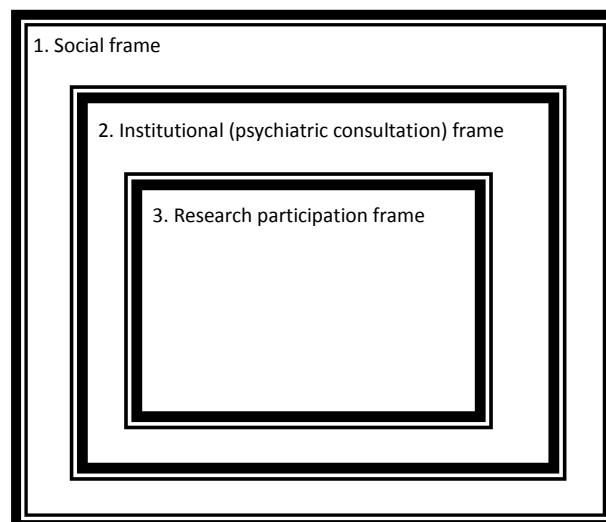
equivalent might be the keying between a broader social frame and the psychiatric consultation, as shown in figure 3.1.

Figure 3.1



In Chapter Four, I discuss in more detail some of the levels of framing which may be relevant to this data, for example, the keying of the 'psychiatric consultation' to the 'participation in a study of talk occurring in the psychiatric consultation' (Figure 3.2).

Figure 3.2



Within the primary and keyed frames many different frames may be laid on top of or overlap with each other. “Talk appears as a rapidly shifting stream of differently framed strips, including short-run fabrications (typically benign) and keying of various sorts.” (Goffman, 1974: 544) Ribeiro describes these as ‘double framing’, in which more than one frame may occur either simultaneously or with one embedded in another.

“For example, within the context of the psychotic crisis several framings emerge. While some are predominant (the framing of the child addressing the mother), others appear to be subsumed under the first one (the child addressing the grandmother, the [childlike] patient addressing the doctor [mother]). These subordinated contexts need the outer framing (the child addressing the mother) to establish the ground against which the inner framings are to be discerned.” (Ribeiro, 1994: 52)

3.2.5 Footing

Goffman develops the notion of footing in *Forms of Talk* (1981) to refer to the positioning of participants to one another:

“A change in footing implies a change in the alignment we take up to ourselves and others present as expressed in the way we manage the production or reception of an utterance. A change in our footing is another way of talking about a change in our frame for events. [...] participants over the course of their speaking constantly change their footing, these changes being a persistent feature of natural talk.” (Goffman, 1981a: 128)

As with framing, alignments can be embedded within one another, so that our general position within the interaction is not given up by shifting into another temporarily. For example, in a consultation, a psychiatrist may answer the telephone. As this happens, their alignment towards the patient is changed. The patient now becomes a bystander in relation to the psychiatrist’s talk. Once the call is finished, however, both participants are able to resume the alignment they had previously, of patient and psychiatrist, or other alignments established. The interaction is not re-started or re-negotiated, but both participants move back out of the

temporary footing established by the interruption. Goffman describes this as “our general capacity to embed the fleeting enactment of one role in the more extended performance of another” (Goffman, 1981a:156).

Footing links to role, identity and power dynamics, since alignment, particularly in an institutional setting, establishes how participants wish to be perceived in relation to others.

“Attention to frame and footing can show how identity emerges through talk. Gender for instance may be enacted through the alignment – of authority, rapport or competition – taken to interlocutors.” (Ribeiro and Hoyle, 2009: 81)

Wortham (1996) has argued that one key way to identify the footing of speakers is through their use of ‘participant and non-participant deictics’ or personal pronouns. The use of personal pronouns is a cue for establishing the position that the speaker takes up, both to the account he or she is giving, and to the other participants in the interaction. The two-levels of a speech event – what Wortham refers to as the ‘narrated event’ and the ‘narrating event’ – are anchored using personal pronouns (among other cues) by establishing the relationship between the people taking part in the interaction, and their role in the event being described. So, ‘we’ can both refer to, and establish, a group in the context of the narration. It can be used to include the speaker in the action, and to include or exclude individual members of the audience. At a more complex level, personal pronouns combine with the setting and other interactional cues to mean more than simple grouping.

“Speech relevant to participants’ footing separates them into groups, and then characterises the groups in social terms. Real interactions are rarely organized simply as ‘us’ vs. ‘them,’ but, more likely, as ‘us, the good guys’ vs. ‘them, the bad guys’.”
(Wortham, 1996: 21)

In the psychiatric setting, we might expect these groups to have other types of character, such as ‘us, the medically trained’, or ‘us, the people living with this every day’, or ‘us, the partnership of doctor and patient against the psychotic symptoms’.

3.2.6 Frame disputes

Goffman identifies '**frame disputes**' where the parties to an encounter do not agree on its frame (Goffman, 1974: 325). This is differentiated from 'misframing' in which one party makes a mistake about what is going on. Goffman acknowledges that "when participant roles in an activity are differentiated – a common circumstance – the view that one person has of what is going on is likely to be quite different from that of another." (Goffman, 1974: 8) This notion that the frame used will depend in part upon the person's role within the encounter is a useful position for examining the different frames used by clinicians and patients with a mental health condition. In the following chapters I explore circumstances in which frame disputes occur within the psychiatric consultation.

3.2.7 Contextualisation cues and bracketing

In describing footing, Goffman wrote "I believe linguistics provides us with the cues and markers through which such footing become manifest, helping us to find our way to a structural basis for analyzing them" (Goffman, 1981: 157). Gumperz, a contemporary of Goffman, offered an insight into how such markers as prosody, tempo, pauses, code switching and use of formulaic expressions show how interpretation and mutual understanding is achieved in participants' talk. Gumperz himself links this work to Goffman's work on framing. He argues that "contextualization may raise expectations about what is to come at some point beyond the immediate sequence to yield predictions about possible outcomes of an exchange, about suitable topics, and about the quality of interpersonal relations" (Gumperz, 1992: 233). In other words, identifying and understanding these cues can help us to see how participants reach a 'shared definition of the situation' through their talk. Schiffrin, in combining the work of both scholars, argues that this combination of perspectives provides a useful way to identify the techniques used in discourse to achieve different footings:

“The kinds of devices identified by Gumperz as contextualization cues are exactly what indicate shifts in participation statuses [...] Thus, what Gumperz’s linguistic analyses add to Goffman’s dissection of the self are a knowledge of some of the devices that convey changes in participant status (i.e. footing) and a view of how the way an utterance is produced allows the situated inference of a new participant alignment.” (Schiffrin, 1996: 318)

Gumperz’s work focuses on how mutual understandings, and importantly misunderstandings, occur through shared cultural resources for interpretation. In a collection of essays edited by Gumperz, others who have taken a similar approach offer examples of this type of analysis in practice. Hansell and Seabrook’s (1978) study of an interview with two black teenagers provides a useful demonstration of how shifts are achieved:

“The tone is now unequivocally joking, as shown by M and G giving false information [...] without intending to be believed. The banter continues until line 30, where a sudden shift occurs. W breaks the previously established rhythmic pattern by starting in line 30 before 29 is finished; furthermore, 30 is much louder than preceding utterances, and he makes an upward shift from conversational give-and-take to a more formal ‘public address’ style similar to that used by black preachers and politicians. He signals his change of speech activity with a sharp upward pitch register shift (on the word ‘now’)

That this style shift is a significant use of a black-specific discourse strategy whose meaning is lost on the whites is clear from the different reactions to W’s ‘sermon.’ B, who has not spoken previously in this episode, utters the formulaic back channel response ‘right on’ in line 33, exactly in keeping with black audience call-response conventions [...] The formulaic nature of B’s interjection, the appropriateness of its timing, and the fact that he chooses this point to enter the conversation all indicate that a shift has occurred to a ritualized speaking style which W and B drawing on shared cultural knowledge cooperatively produce”. (Hansell and Seabrook, 1978: 584).

This passage demonstrates the way in which inferences are drawn from detailed analysis of contextualization cues. The changes referred to in this passage mirror frame and footing shifts. They are marked by changes in pitch, volume and rhythm, and use of markers like ‘now’ that

can be identified as 'shift-implicative' (Beach, 1993). They also show how framing is achieved through reference to recognisable forms of discourse (e.g. the public address style of black preachers and politicians), even where those forms may not be obviously appropriate for the *prima facie* interactional context. Finally, this passage shows how footing is changed, including bringing new participants in to the discourse with new types of positioning available to participants through the frame shift (e.g. B's entry through the available footing of 'mimicked audience' to W's 'mimicked sermon').

Several researchers have considered openings to interaction using a frame analysis. This has frequently been a focus because frame shifts are common and can highlight the manoeuvring and negotiation required in what has been described as 'frame attunement' (Hutchby, 1999). Rodham cites Branaman's description: *"framing involves bracketing an activity and providing some sort of cue as to what the bracketed activity means ... events, actions, performances and selves do not always speak for themselves, but rather, depend on framing for their meaning"* (Rodham, 2000: 73).

Goodwin identifies two broad ways in which framing in interaction has been analysed: "one involves the construction of typologies or 'grammars' of participation categories that define the possibilities for meaningful participation in any given setting. The other [...] concentrates on detailed description of the practical accomplishment of mutually ratified participation." (Hutchby, 1999: 48) Frame analysis itself does not provide a method for analysing data, but rather a theoretical structure within which to understand what is identified through either of the methods Goodwin suggests. Some frame analysis studies have used a detailed, conversation analytical method, for example examining markers and cues, while others have focused more on the interaction as a whole.

"Contextualisation cues are the hidden underbelly of this meaning making. They are the signs that invoke the context that gives each utterance a specific meaning. They

channel the inferencing processes in a particular direction by calling up the frames and affecting the footing of each moment of an interaction.” (Roberts and Sarangi, 2005: 634)

“Frames are encoded and understood linguistically, paralinguistically (i.e. intonation, pitch, rhythm etc) and nonverbally. Topic is a key component in defining frames and part of the definition of an interactional situation.” (Ribeiro and de Souza Pinto, 2005: 15)

In this thesis, my method for analysing the discourse is strongly influenced by Potter’s (1996) approach, which – drawing on Potter’s own analogy of a building structure – conceives of interaction as a structure which can be best understood by taking all its components, from rafters and walls to nuts and bolts, as potentially important for assessing how the structure is successfully built. In doing so, I start with those aspects which participants in the interaction appear to treat as significant. As Wood and Kroger argue, “the most appropriate strategy is to begin with participants’ concerns, with the way that they themselves work up the issues at hand, before claiming, for example, that a piece of text demonstrates a particular discourse or facework or the operation of power” (Wood and Kroger, 2000: 25). More detailed discussion of the method of discourse analysis used here is included later in this chapter.

3.3 Methods for conducting a Frame analysis

Goffman himself gave no description of how his theory of frame analysis could be applied to data as a method of analysis. His interests were in laying out the universal generalisations of framing in interaction, outlining broad, overarching frames (natural and social), and exploring the ways in which frames are transformed and replicated. As described above (section 3.2.3) he often focused on somewhat unusual examples and settings, for example stage plays, practical joking, rehearsals and deceptions. While these allow him to provide a useful understanding of the concepts central to framing, they give less insight into the frames and frame shifts seen in everyday life (Strong, 1979). Those who have followed Goffman’s lead

have gone further in examining frames in bodies of observed and recorded data and have started to identify and delineate specific frames. However, although frame analysis has been used in a range of studies, descriptions of methodologies used for identifying or validating frames are rarely explicit. Thus in the next section I consider some of the approaches that have been applied, and outline my own approach to frame analysis used in this thesis.

3.3.1 Frame validation

The method of identifying and analysing frames for this thesis is informed particularly by the descriptions of two scholars who have conducted frame analyses in very different settings and on very different data. The first of these is Strong (1979), who examined the ‘ceremonial order’ of the medical clinic; the second is Koenig (2006) who applied a frame analysis to transnational public discourse. Both provided explicit discussions about how to deal with a central problem in qualitative analysis in general and frame analysis in particular; that is, “How can we be certain that such and such really did mean what I said it meant?” (Strong, 1979: 230).

Strong’s question is at the heart of questions of validity in qualitative research which have been debated by others (Whittemore, 2001). While quantitative research can rely on a realist approach that defines validity as the closest possible approximation to reality, a constructivist approach emphasises, instead, understanding and elucidation, recognising that this may be only one of a number of valid interpretations (Cohen & Crabtree, 2008). In taking a constructivist approach, I favour the position proposed by Eakin & Mykhalovskiy that validity in qualitative research should be considered less in terms of procedure and practice, and more in terms of how the analysis is “rendered convincing”, drawing on appropriate data and making claims for which evidence can be reasonably claimed (Eakin & Mykhalovskiy, 2003).

Strong answered his own question by pointing out two fundamental premises for using any kind of discourse analysis as an approach to studying social phenomena. First, that because the social world relies on shared access to resources for interpreting actions, these resources should also be accessible to the researcher, and to readers of that research. The same principle guides Silverman's approach to his analysis of 'social relations in the clinic':

"Inevitably, I must concede that, in highlighting situational factors, I have drawn tacitly on everyday knowledge about forms of talk and what they mean. Thus, if readers are able to detect the patterns in talk which I depict, this will be because we are using the same commonsense resources." (Silverman, 1987: 21)

Second, that through detailed examination of several instances of the phenomenon being studied - contrasting, quantifying, looking for differences and similarities, seeking to explain deviations – it is possible for the analyst to make explicit those bases of action and interpretation which govern interaction but which are rarely explicated by participants themselves.

Strong describes the process by which he generates and tests hypotheses concerning the rules of interaction which he observed. He uses analytic induction to generate his theory from the data itself, rather than from existing literature or a pre-formed system of codes:

"Explanations are tested out all the time, trying them on one case to see if they fit, then moving on to another, and so on. Where the proposition does not cover the particular case, it may be reformulated or else the phenomenon redefined until a universal relationship is established which fits all the cases." (Strong, 1979: 234)

The process for this testing is a continuous questioning and re-evaluation of the codes being developed from the data. The categories developed are applied to each part of the data to see if they fit. Where they do not fit, categories are reformulated or added, to incorporate the new data. In this way, the ideas brought by the analyst are tested against the data and changed. The process is reiterated until a consistent set of codes is found which adequately fits the data.

With the large dataset at Strong's disposal – a total of 1,120 consultations were observed – he was able to conduct this process on one half of the data, using this to formulate an argument as to his findings. The other half was then analysed to test and refine this argument.

Koenig (2006) attempts to address a perceived lack of rigour in applying frame analysis by proposing a four step model. He recognises the criticism of frame analysis that new frames are often identified – “or even fabricated” (Koenig, 2006: 62) - by each researcher with little attempt to establish validity of these frames.

Koenig recommends that initially a sample of the data is analyzed using a discourse analytic approach until no new frames and themes are identified. Koenig's focus is on constructions of identity through the text. This may involve detailed analysis of language used, for example the usage of first person plural pronouns (Koenig, 2006: 65). Identification of frames needs always to address the broader theoretical aims of the research. Step two involves testing and developing the emerging frame model on larger datasets. Koenig proposes using software to facilitate this process across a very large dataset. From this stage, a reliable frame model is developed which can then be applied to the entire dataset systematically in step three. For Koenig, this stage relies on the identification of keywords that represent frames. While acknowledging the difficulty of identifying and validating these keywords, Koenig depends on these to explore how frames are distributed across a very large dataset. Finally, Koenig proposes a form of statistical validation based on the occurrence of these keywords. The use of keywords in this sense is helpful where large datasets is involved, and may produce a useful numerical overview, but the validity relies heavily on being able to identify useful terms and to reduce concepts to single words or short phrases. I would question the ability to do this with many datasets, and certainly I do not feel that this would be possible with data like that which is drawn on in this thesis.

Both Strong and Koenig are attempting to develop and describe a systematic process for identifying and validating a structure of frames. While Koenig takes a statistical and in many ways reductionist approach, Strong's analysis is more qualitative and exploratory. However, both highlight some key principles for conducting a frame analysis:

1. This form of analysis is not about imposing a predetermined set of frames upon a dataset, or fitting the data into a preformed theory. Frame analysis works best as a form of analytic induction, informed by the participants' actions and the significance they apparently attach to them;
2. Frames do not take an identical form in every instance. As Strong points out, "the same rule may be embodied in a great variety of very different behaviour according to circumstance" (Strong, 1979: 232). As such, the more data that is analysed, the more these rules and categories can be refined and tested, so that they begin to approach generalisability.
3. For findings to be credible, the process of analysis should be made as visible as possible.

3.3.2 My approach to data analysis

In accordance with these principles, the method of analysis used in this study is explained step-by-step below. My initial focus changed to some degree throughout the study as assumptions were tested and discarded. Key among these was the experience of stigma from mental health professionals which has been reported by mental health service users in other studies. Initially, I was interested in exploring whether these experiences could be better explained in the light of frame disputes. During the analysis, however, it became clear that there was little evidence of psychiatrists behaving in ways that could be easily identified as stigmatising or patients reacting in ways that suggested they felt stigmatised. Such an approach would have required the creation of a definition of 'stigmatising' behaviours in the interaction which would have lacked validity without access to either participant to assess intention and reaction. Whether because of the nature of these particular psychiatrists (see further discussion on the data

below) or because of the fundamental challenges of attributing attitudes to behaviours, it became clear that this focus could not be supported by the data.

Two broad questions did remain throughout the study. The first focused on participants' – particularly patients' – construction of identity and role within the clinical setting and how these related to influencing decisions and performing credibility. The second concerned family members' roles in the interaction and the effect that they had on each participant's performance. The analysis was oriented to these questions throughout, though my understanding of what they encompassed changed as more data was considered. As well as identifying frames, I explored the data for techniques and actions which appeared significant in addressing these performances.

Step 1: Identifying frames inductively

Working through the data from the earlier consultations to the later ones, I applied an inductive analytic approach to identify possible frames and techniques. The choice of where to begin with the data was not theoretically driven. Instead I began with the earlier recorded consultations, supplemented with a sub-set of 21 consultations in which a third party was present since this was a particular interest of the research. I started from the assumption that all the spoken interaction (and non-verbal interaction, though due to the nature of the data, this could not be analysed in this study) was oriented to one or more frames, though some of these might be of more interest in relation to the study questions than others.

As each new consultation was analysed, codes were added or amended. Identified frames were labelled and key characteristics of these frames were attributed. I initially used printed data for this process, which allowed me more freedom to adjust and expand on the codes. Once a number of core categories started to take shape, I moved to using the software NVivo to capture these frames, allowing a more systematic approach and easy retrieval and comparison of data by frame.

Step 2: Validating frames against set criteria

In order to qualify as a valid frame, data had to demonstrate that participant roles, expectations and behaviours were influenced by the construction or shift of frame; frame shifts must be shown to alter the understanding of what is going on *for the participants in the interaction*. This is not as straightforward as merely noting the actual response of the hearer to a shift in frame. These responses may be the result of mis-framing or a frame dispute, or the influence of another factor such as an external interruption. It is for the analyst to ascertain how the framing shifts expectations, informed by the actual response, the first speaker's response to *that* response, and my own communicative competency to hear these changes.

Having identified a series of potential frames from the data I revisited each frame and tested it against four key criteria to assess the usefulness and consistency of the coding. By laying out these criteria, my definition of frames should be transparent, though they may still be open to challenge and critique. The four criteria listed below for frames to be considered valid were drawn from Goffman's (1974) descriptions of how they may be seen to govern social interaction:

a) The frame should alter the expectations of how the hearer(s) should react to the speaker

By framing, Goffman argues, the speaker places obligations on the other participants. For example, in relation to everyday conversation:

"What the individual spends most of his spoken moments doing is providing evidence for the fairness or unfairness of his current situation and other grounds for sympathy, approval, exoneration, understanding or amusement. And what his listeners are primarily obliged to do is to show some kind of audience appreciation. They are to be stirred not to take action but to exhibit signs that they have been stirred." (Goffman, 1974: 503)

One way of evidencing a frame shift is to ascertain that there is a change in the expectation of how the other participant will respond. For example, they may be expected to offer advice or to listen; to answer or to acknowledge; to sympathise or to challenge. Expectations are detected through a combination of the participant's actual response, the first speaker's acceptance or non-acceptance of this response, and my own reactions drawn from my communicative competence. Evidence of expectations are discussed more fully below (see, for example, section 4.2.1, 120).

b) Shifts of frame and footing should change the way that participants are aligned to one another

As explained above, through footing, participants change the alignment they take up to one another. In doing so, relationships between the participants change. This is closely related to the idea of expectations. As Ribeiro notes:

"[Footing] conveys a metamessage about what kind of relationship is being enacted at that point in the interaction. Thus in a standard psychiatric interview [...], the footing between participants may shift from a more personal conversation (a "woman-to-woman talk") to a formal interaction in a professional stance." (Ribeiro, 1994:55)

c) The frame should allow participants to emphasise and construct different identities and roles

Goffman relates his frame analysis back to his theory of interaction, in which participants express a face to others. Keying allows participants to shift roles and project different faces.

"The individual comes to doings as someone of particular biographical identity even while he appears in the trappings of a particular social role. [...] There is a relation between persons and role. But the relationship answers to the interactive system – to the frame – in which the role is performed and the self of the performer is glimpsed." (Goffman, 1974: 573)

d) Shifts between frames should be identifiable through participants' talk

If frame shifts influence communication between two people, it should be possible to identify what participants are doing in the interaction to initiate, negotiate or reject frames.

Identification of frame shifts requires a more conversation analytic approach to identify ways in which activity is bracketed.

This step of re-examining the identified frames also involved returning to the initially analysed transcripts and checking the refined model against the data. At this point, identified frames were merged, split or re-defined based on the criteria applied.

Step 3: Applying frames to more data

Having developed and checked the coding model in step 2, I then applied these codes across the whole dataset. Every transcript was coded in full using these frames. This allowed me to test whether the identified codes stood up to application across more cases or whether it required further development. Some further refinement was conducted at this stage, both to the definition of frames and to their content. For example, a loosely defined 'administrative frame' was clarified and changed at this stage to 'stage direction' (see section 4.2.3, page 153) which reflected a crystallising in my understanding of the data through seeing and comparing more examples. A full transcript with frames identified and applied is given in appendix B as an example. In this case, much of the transcript takes place in a Troubles-telling frame (see 4.2.1, page 120), but shifts between frames are indicated.

Step 4: Micro-level analysis of discourse techniques

Having identified a robust set of codes and coded all the consultations, I then used a micro-level analysis to identify how frames were shifted through participants' talk. This stage resembled more closely a conversation analysis approach to those parts of the data which I had identified as containing a change of footing. The analysis focused on the use of contextualisation cues and bracketing.

Step 5: Drawing links between techniques and identified frames

The final stage of the coding was to explore the distribution and relationship between codes, in particular between frames and the various participant techniques identified.

3.4 Discourse analysis

This thesis relies on using a detailed analysis of talk in context to review, deconstruct and make sense of the data. Discourse analysis is a broad church containing numerous distinct approaches. In this study I have taken a pragmatic approach, which is common in many discourse analysis studies. It is cross-disciplinary, drawing on sociology, linguistics and social psychology. It combines detailed analysis of the data with theories that offer the most helpful explanations for that data (Wodak, 2009). This pragmatic approach is applied within the framework of the overarching theoretical approach provided by Goffman's frame analysis and discussed above.

Hodges et al. (2008) outline three broad categories of discourse analysis: formal, linguistic approaches which focus on the grammatical and language rules governing talk; empirical approaches, including conversation analysis, which look for similar patterns and structures in talk of a particular genre; and critical discourse analysis, including Foucauldian analysis, which focuses particularly on power structures that form institutions and social practices. These three 'types' of discourse analysis are very broad and loosely defined. Within each group there are distinct approaches and debates. Studies have combined these approaches in different ways to strike a balance between linguistic and intertextual analyses (Fairclough, 1992: 194).

The term Critical Discourse Analysis (CDA) is often applied to a rather narrower approach, epitomised by the work of Ruth Wodak and Norman Fairclough, which has been criticized for being too ideological and theory-driven. Schegloff, for instance, argues that there is too much of a tendency to take an a priori stance on the significance of interactional techniques, rather

than attempting to identify the significance to the participants themselves (Schegloff, 1997). The broader sense in which Hodges et al. use the term Critical Discourse Analysis would not exclude more endogenous approaches, such as that advocated by Schegloff, but the focus is on macro-level interpretations, looking at societal discourses, structures and norms.

In this study, I use a social constructionist approach, which focuses on how participants and the subjects of their speech are constructed through talk (Burr, 1995). Social constructionist claims are not cognitive. The analysis does not aim to access participants' beliefs, thoughts or attitudes. This type of approach has been used and developed through a number of disciplines, including sociology and discursive psychology. What these approaches have in common is treating discourse as a "domain in its own right" (Edwards, 2005). Though taking on psychological topics, the aim of Discursive Psychology is not to access a hidden world of cognition, but to treat mental constructs (such as attitudes, intention, and emotion) as "constructed by people conceptually, in language, in the course of their performance of practical tasks" (Edwards, 2005: 2).

The approach that I have taken in this thesis is heavily influenced by the work of Potter (1996). The aim of discourse analysis as Potter applies it is to "make visible the ways in which discourse is central to action, the ways it is used to constitute events, settings and identities, and the various discursive resources that are drawn on to build plausible descriptions" (Potter, 2004: 609). In doing so, he takes discourse to be "talk and texts as parts of social practices" (Potter, 1996:105).

He proposes a form of analysis that builds on the work of three constructionist approaches: linguistic constructionism, post-structuralism and conversation analysis. In doing so, he recognises the weakness in relying exclusively on any one of these when seeking to understand how descriptions are constructed in social interaction. Linguistic constructionism argues that people's perceptions of the world are determined by the use of language, such that different

terms produce a different understanding of reality (see, for example, my own note about terms in section 1.3, page 14). Post-structuralism is concerned with how realist claims about the world are produced through discourse. This production draws on institutional and cultural resources to determine its realism. Conversation analysis focuses on the detailed techniques used in speech to create accounts, and seeks to understand why this is sometimes done successfully and at other times not. Potter argues that by drawing on the strength of each of these approaches, a fuller description of the way in which the world is constructed through discourse can be achieved.

He draws a further distinction between two 'orientations' for discourse analysis: epistemological orientation – with a focus on the way in which accounts and descriptions are constructed – and action orientation – with a focus on the things that people are doing through their discourse in relation to one another (Potter, 1996). The three constructionist approaches he describes above (linguistic constructionism, post-structuralism and conversation analysis) may be more or less suitable for each of these orientations.

The idea that discourse is multi-functional is central to social constructionism, and provides a range of ways in which analysts might approach data. Schiffrin argues that through our discourse we demonstrate the ability to communicate on a number of levels: expressive (the ability to convey aspects of self), social (the ability to negotiate relationships and perform social activities), cognitive (the ability to represent concepts and ideas in linguistic form) and textual (the ability to organise speech in accordance with grammatical and linguistic rules) (Schiffrin, 2008: 54). She explores how talk may orient to these aspects, and may be analysed with a focus on any of them.

A final concept that is central to Potter's analysis is the idea that discourse is situated. An understanding of what is achieved through talk requires orientation to the context in which that talk is produced. This is an idea that lends itself to the focus on 'definitions of the

situation', central to the work of both Habermas and Goffman, as discussed in Chapter Two. For Potter, three levels of context are important. The first involves seeing an utterance in the context of other speech turns, as embedded within the talk of others. Secondly, attention is paid to the rhetorical orientation of speech; that is, recognising that in producing one description, argument or account, the speaker is building up a contrast with alternative positions. Finally, discourse may be situated in institutional or other settings which influence the social construction of identities and roles. In accepting the last, Potter also draws a contrast between seeing discourse as constructed in a context, and assuming a form of determinism based on the discourse setting:

"When analysing talk that takes place in a doctor's surgery or a school classroom, the researcher will not assume that the talk is therefore necessarily medical or pedagogic (Heritage, 1984). This approach to analysis moves away from assuming contextual relevance by analytic fiat." (Potter, 2004: 610)

As Edwards points out, "rather than being made presumptively omni-relevant by the analyst, institutional activities and identities are made relevant by participants themselves, by being invoked and oriented to, or indeed subverted and ignored" (Edwards, 2005: 2). The many previous studies of interaction in institutional settings provide a guide for the analysis by highlighting questions and parallels that help in interpreting the discourse as recorded, but do not provide the structure within which the significance of talk must be understood.

The strength of Potter's approach is in combining different foci of analysis to understand how descriptions and accounts are constructed. He does not deny the usefulness of conversation analysis or linguistic analysis as a single focus, but by examining data on different levels he is able to produce a richer explanation of what is being achieved through talk and how.

This approach has particular merit in carrying out a frame analysis. As discussed above, Goffman's theory of frame analysis indicates that what people do in their talk has a multi-functionality which lends itself to a focus on both the action and the epistemological

orientation of talk; on both the identities or roles being constructed and the syntactical rules that inform how these are negotiated; and on the situated nature of talk.

In summary, Frame Analysis offers a way to understand what is happening in interaction, how participants relate to each other, how negotiations and conflict are managed and resolved. Potter's discourse analysis allows us to identify those frames which are frequently tacit rather than explicitly formulated (Koeing, 2006). This method makes it possible to elucidate how frames are manifested through talk, and how a frame shapes the expectations and behaviours of participants. Potter has therefore provided a useful tool for conducting a frame analysis, where Goffman himself did not offer a clear method.

3.5 Framing medical discourse

The idea that the doctor's consultation is 'framed', and that everyday discourse is transformed through this framing, is implicitly recognised as demonstrated in this stand-up routine by comedian Andy Zaltzman¹:

Extract 3.1

- 1 AZ: *So, hello, how are you all?*
- 2 Audience: *[whoops and cries of 'yeah']*
- 3 AZ: *I hope you're more specific than that when you go to see the doctor.*
- 4 Audience: *[laughter]*

The joke works because the audience are aware that the question 'how are you?' carries different expectations of response when framed as part of a comedy performance than when framed as part of a medical setting. This awareness is sufficiently widespread to work on an international audience and be generally understood.

¹ Extract of comedy performance in Trondheim, May 2013, featured on The Bugle podcast, 31st May, 2013 - <http://thebuglepodcast.com/bonus-bugle-andy-in-norway/>

Goffman himself used a wide array of examples from medical settings, including psychiatric settings, to demonstrate his argument. Despite this, framing has rarely been discussed explicitly in studies of doctor-patient interaction. In Chapter Two, I provided an overview of some key research findings from previous studies of medical interaction. These studies have focused on different aspects of medical discourse, often in a way that nods to the concept of framing. Despite this, and perhaps because studies tend to focus on one aspect of the discourse at a time, few explicitly apply the concept of frame, though similar concepts can be seen in Mishler's work on 'voices', defined as "relationships between talk and speakers' underlying frameworks of meaning" (Mishler, 1984: 14) and Wodak's 'disorder of discourse', described as 'frame conflict', in which "worlds of knowledge and interests collide with one another" (Wodak, 1996: 2).

There are however, a few studies of medical discourse that explicitly apply Goffman's models of interaction and framing (Ainsworth-Vaughn, 2003). In the next section I give a brief review of some of the key studies using frame analysis to explore medical discourse.

3.5.1 Institutional discourse

Much frame analysis work has focused on institutional settings of various sorts, ranging from Hutchby's analysis of how participation is mutually ratified at the beginning of calls into talk radio shows, to Coupland's (1994) study of 'How are you?' type exchanges at the start of geriatric patient-doctor consultations. Ribeiro and Hoyle argue that frame analysis provides a valuable way of reassessing the nature of institutional discourse by revealing the way in which institutional activities are constructed by participants.

"It is increasingly noted that institutional talk [...] is institutional not because of the setting in which it is produced or because of the pre-existing institutional identities of its producers. Rather, participants themselves construct its nature by displaying their

orientation to institutionally relevant activities and identities on a moment-to-moment basis.” (Ribeiro and Hoyle, 2009: 83)

Van Dijk (1997) highlights the challenge of identifying institutional discourse. Institutional interaction is not confined to easily identifiable institutional settings, nor is discourse in institutional settings such as hospitals, schools and offices necessarily institutional discourse. Van Dijk argues that institutional discourse is that which is oriented to institutional roles and identities. Thus sociable chat between doctor and patient, including those pleasantries often exchanged at the start or end of an appointment, generally remains within an understanding of discourse that is appropriate for the identities of doctor and patient.

Institutional discourse can thus be seen as the product of framing. Interaction takes place within an institutional frame that informs participants as to which identities and roles they are expected to orientate towards. Deeper frames, such as an informal, social frame within an institutional interaction, do not occur in isolation of the larger one but are layered over it, producing additional but not contradictory levels of expectation.

3.5.2 Medical and social frames

Some frames have been considered in detail by previous researchers of medical discourse, in particular frames of bio-medical and socio-relational concepts of health and illness (Fisher, 1991, Coupland *et al.*, 1994, Coupland and Coupland, 2001). These frames or discourses have been found in numerous studies and have generally been considered to create an asymmetry in doctor-patient relationships. Ribeiro and de Souza Pinto (2005), in exploring psychiatric interactions, identify two broad frames: medical inquiry and narrative or personal frames. These are closely associated with topic and schema, and discussed above. They argue that in a standard psychiatric interaction, there is a shared expectation that the doctor will control the structure and topic of the consultation. The doctor therefore introduces officially sanctioned

topics through medical inquiry frames. The patient uses narrative frames to dictate the topic of the interaction and introduce new themes and information.

3.5.3 Framing meaning

Peräkylä (1989) used Goffman's work on frames to examine models of understanding death in a hospital. In his ethnographic fieldwork he identified four frames: medical, psychological, lay and practical, and he explored why and how each frame is employed by the staff members and patients. He argued that parties to an encounter negotiate a frame around it. This frame leads to expected identities and roles. Any deviance from these identities and roles causes participants to shift the frame they are applying in order to fit the behaviour into predetermined expectations. He concludes that:

The crucial point lies in the relationship between different discourses, or frames. The meaning of discourses, of frames, and the workings of power mediated through them, cannot be understood if they are taken separately. It is in the relationship between discourses, 'where effects of power are constituted and challenged' (Silverman 1987:135). Instead of arguing for or against the use of social-psychological models in medicine, sociology should explicate the way those models are used, the circumstances that they are applied in, and the intended and unintended consequences of their use. These are social issues, permeated by power relations. (Peräkylä, 1989: 121)

Further evidence of this use of different frames in medical consultations come from Nessa and Malterud's (1998) investigation of a single interaction between a patient with depression, her doctor and her husband. They highlight the use of different models to explain her depression, with the husband and doctor collaborating to produce a medical model, which is only partially accepted by the patient. Mishler also identifies similar frames in his study of medical discourse where he finds the 'voice of medicine' and the 'voice of the lifeworld' (Mishler, 1984: 14). As

noted above, Silverman (1993) has cautioned against perceiving these as simplistic, dichotomous voices, whereby the doctor speaks in a medical frame and the patient in a 'lifeworld' frame (Mishler, 1984, Fisher, 1991). Instead, these discourses should be seen as interacting, with either participant able to employ either frame.

3.5.4 Framing participation and roles

Tannen and Wallat (1987) used interactive frames and schema to understand an interaction between a paediatrician, a child with cerebral palsy and the child's mother. They demonstrated how different frames are used with different participants, and particularly how these are influenced by the differing knowledge schema they possess. In exploring this they demonstrate how conflicting frames can create unsatisfactory and emotionally distressing results.

"According to this mother, many doctors have informed her in matter-of-fact tones of potentially devastating information about her child's condition, without showing any sign of awareness that such information will have emotional impact on the parent. In our terms, such doctors acknowledge only one frame – examination – in order to avoid the demands of conflicting frames – consultation and social encounter." (Tannen and Wallat, 1987: 212)

In her analysis of children during medically-themed playing, Buchbinder (2008) identifies three broad frames: clinical, play and personal. She demonstrates how the shift between frames changes the footing between participants, including herself as part of the play. For example, in the clinical frame, children ask Buchbinder, as a clinical expert, to identify the medical toys. In doing so, their alignment to her is as child and adult, or lay and expert. In contrast, during the play frame, Buchbinder is aligned as patient to their doctors.

“Although the girls assigned me to the patient role for much of their doctor play, within the clinical frame, they shifted footing to treat me as a knowledgeable adult who could answer their questions about the medical equipment and supplies.” (Buchbinder, 2008: 144)

Rodham’s frame analysis, which is based on interviews, rather than naturally occurring interaction, focuses entirely on the framing of a professional role. The frames identified are not interactional frames per se, but are labelled by the perceived role in which the occupational therapist positions herself or is positioned by others. Identified frames include: medical frame, medic with managerial skills, and manager with medical skills (Rodham, 2000: 78).

3.6 Data

The data used in this study consists of 92 audio recorded consultations between psychiatrists and patients who had been prescribed anti-psychotic medication. The purpose of the original study for which the data was gathered was to explore, using Conversation Analysis, the ways in which prescribing decisions were made, including how medication was initiated, changed and discontinued. The researcher who gathered the data (AQ) recruited, gained informed consent from and interviewed all the participants in the study. Consultations were recorded between 2003 and 2005. Ethical approval was obtained for the study by AQ through an NHS Research Ethics Committee. I gained access to the data initially by being brought into the study team to conduct analyses as part of the original study, and later through explicit permission to use the data granted by AQ and the study sponsor.

For the purposes of this study, I have chosen not to access the interview data collected by the original researcher. My reasons for this are two-fold. First, the focus of this study is on the use of framing and the performances of participants within the interaction itself. In taking this stance, I wanted my conclusions to be drawn from what appears in the data directly, rather

than through indirect reflection. This is particularly important since what participants actually do in an interaction and what they intend to do may be very different. Second, the interviews were conducted for a specific purpose which had a different focus to this study. Since interviews are co-constructed by participant and interviewer, the accounts given in those interviews will be shaped by the original question. It is likely that this different focus would limit the usefulness of the interview data for my own analysis. That said, there may be value for future studies in conducting carefully focused interviews to aid understanding of performances in a doctor-patient consultation.

3.6.1 The sample

The participating psychiatrists were recruited because they had previously taken part in another study where they had been interviewed about their perceptions of decision-making in consultations. A total of nine psychiatrists from two NHS mental health trusts took part in the study. Of these, three were women and six were men, all were white, and all but one had English as a first language. The mean age was 48 (range 43-52).

Patients who might be eligible for the study were identified through discussion between the researcher (AQ) and the participating psychiatrists. They were sent information about the study in advance and were then approached by AQ at their next appointment. Consent was taken from all participating patients and any attending family members. Those who consented to take part were invited to complete a questionnaire with AQ before and after the consultation, and the consultation itself was recorded by the psychiatrist without the researcher present.

3.6.2 The data

For this study, I have conducted a re-analysis of these 92 psychiatric consultations. The transcripts were provided by the original researcher in an anonymised form. Permission for

using the data was sought through the original research institution and the research team, and ethical approval for the reanalysis was obtained through the University of Sussex. My access to this data was facilitated by my late involvement with analysing the data for publications from the original study. The analysis I was involved in at that stage was a Conversation Analysis of specific sections of the data in which changes to prescriptions were decided on (Quirk *et al*, 2012). The analysis at that stage was conducted with the original researcher (AQ), and for this study AQ was also involved in ensuring that the use of the data did not contravene the stated objectives of the data collection and abided by the ethical requirements of the original NHS ethics approval.

The audio recordings had been typist-transcribed and were identified only by an ID code. I also had access to the original recordings and listened to these at the start of analysis to provide me with an overview of the data. Detailed analysis was conducted using the transcripts, however I was then able to return to the original recordings to check the accuracy of the transcripts. I did this particularly where sections of the transcript made little sense, or were recorded as 'unclear', or where small changes in the wording may have had a significant impact on the interpretation. This was particularly important where I was looking in detail at how framing was achieved (see section 4.3, page 161). In addition, I had an overview of each consultation which provided basic characteristics of the participants; gender, age and ethnicity. I did not have access to the names or other personal details of the participants in this study.

Transcripts

Edwards (1991) identifies five properties which should be aimed for in choosing a system of transcription: minimally-theory committal; easily readable; computationally tractable; minimally time consuming to learn and to use; and expandable for specific research use. In this study, the decisions concerning transcription have been informed by these criteria, and by the

specific aims of this study. Importantly, the data came to me already transcribed which meant that decisions made were around adapting these transcripts, rather than taking a particular approach in transforming audio to written data.

The transcripts used were originally typed up by a typist and then checked by AQ. The data was transcribed using an orthographic approach, using conventional English spelling for words, rather than attempting to capture accent and pronunciation in the transcript (modified orthography). Audible pauses were included in the transcript, along with hesitations (er, um, etc). Views differ on the use of orthographic or modified orthographic transcription. My decision to use orthographic transcripts for this study were partly pragmatic – that is the form they were in when I accessed them – and partly theory-driven. An important criticism of modified orthography is that by capturing the nuance of dropped consonants, strong accents and mispronunciations, participants can often appear less fluent and coherent (Edwards, 2003). In this study particularly, I was conscious that the psychiatrists were likely to have higher levels of education and would be more likely to use a form of Received Pronunciation than some of the patients. By emphasising pronunciation, the transcripts themselves may contribute to an asymmetry between participants' talk, which might influence both my analysis and the interpretations of readers when presented with extracts. A final reason for avoiding modified orthography was the recognised difficulties of being consistent in this approach. Certain types of pronunciation are more likely to be picked up in transcription than others, based in part on the researcher's own accent and what they hear as unusual. This adds a level of bias to the data that does not contribute usefully to the analysis.

My analysis was based on these orthographic transcripts, allowing me to identify aspects of talk and conventions that were of interest to this study. When exploring these sections in more detail I returned to the original audio recordings. In doing so I was able to check for errors in

the transcript and to ensure greater consistency in the level of transcript, to ensure that pauses and hesitations were treated the same throughout.

I have not used Conversation Analysis transcription symbols in this study, since I have not been conducting a Conversation Analysis. While valuable for identifying nuances in the text, these detailed transcripts have disadvantages. First among these is the practicality of attempting this level of transcription across such a large dataset, which would be a monumental and hugely time consuming task (Silverman, 1987: 8). Second, it is suggestive of a type of analysis that I have not conducted. I am using a different approach to analysing discourse from that of pure Conversation Analysis, and my focus is on the use of framing, rather than the micro-analysis of turn-taking and utterances. Finally, transcriptions can be difficult for the reader to follow when presented using Conversation Analysis conventions. While the use of symbols can help the reader to follow the writer's argument if it is based on this detailed analysis, where this is not the focus of the study it is likely to be a distraction, rather than an aid.

Though I have not applied conventional transcription symbols, I have used symbols to indicate structures in the text that are central to this analysis. In particular, I have used a number of marks to indicate shifts in frame. These are not conventional symbols but my own indications of frame shift patterns, which I hope will aid the reader in following the arguments made in the following chapters. These are as follows²:

ℓℓ : Indicates participant attempt to shift frame

⊥ : Indicates participant rejecting an attempted frame shift

⊤ : Indicates participant realigning to frame shift

² The symbols are repeated in Appendix A for ease of reference.

⌞ : Indicates an alternative reframing to the one made by the other speaker

|| : Indicates a frame break or out of frame activity

The significance of these is discussed in more detail in Chapter Four. It should be noted that these symbols were added during and after the analysis. They were not part of the transcriptions initially used for analysis.

Finally, as discussed in the introduction to this thesis, transcripts have been labelled with the terms ‘doctor’ and ‘patient’. I will not repeat here my reasons for this decision. However, it is important to recognise that this choice of labels is as much a methodological decision as the use of orthographic transcription techniques, and its influence on reading of the data must be acknowledged.

3.6.3 Strengths and weaknesses of the data

The data explored here provides an opportunity to explore interaction as it takes place in situ. The aim of a study of naturally occurring talk is to gain insights that can, to a greater or lesser extent, be generalised to talk in the same or similar settings outside of the research. However, caution should be taken in interpreting these findings as somehow ‘standard’ of psychiatric consultations. There are several reasons why the size, scope and other characteristics of this data do not necessarily lend themselves to representativeness or replicability in other psychiatric encounters. The weaknesses discussed below are not uncommon for studies of discourse (Heritage and Maynard, 2006) and it is important that claims made on the basis of discourse analysis are appropriate to this methodology. This data may be very different from other consultations and has some limitations in providing wider insights. This study is not, for example, an attempt to characterise the typical consultation, nor to provide a template for conducting a psychiatric consultation.

Recruitment bias

These 92 consultations involve a total of nine psychiatrists who may be atypical in a number of ways. The psychiatrists were identified initially because they had taken part in a study in which they gave their views on decision-making in consultations. In this previous study, the psychiatrists involved described themselves as patient-centred. Although self-describing in this way is no guarantee that these psychiatrists in fact behave any differently from other psychiatrists, it implies a commitment at some level to principles of patient-centred care. On top of this, the psychiatrists were all willing to have their practice recorded and scrutinised by external researchers. It is very likely, on this basis, that the psychiatrists included in this study represent an approach to psychiatric practice that may not be reflected across the whole profession.

Similarly, the patients recorded in this study are only those who gave their consent to take part. There are various reasons why patients may choose not to take part in such a study, including concerns about the quality of relationship or trust with their psychiatrist, and the extent to which they were intending to discuss distressing or sensitive matters in the consultation. As a result, it may be that this study has excluded consultations in which specific types of interaction or behaviour are displayed by participants. Notably, there are few examples in this data of complaints (see 4.2.3) which may indicate the quality of relationships between these psychiatrists and their patients, or may reflect the challenging nature of such interaction and an unwillingness on the part of participants to open this up to external scrutiny, or to add what may be perceived as an extra pressure on themselves by participating in the study.

While the sample may not be representative, the extent to which this is a weakness of the study should be assessed in relation to its aims and its conclusions. Unlike in quantitative studies, representativeness is not necessarily the most important characteristic of a qualitative

study's sample. Indeed, due to the in-depth nature of discourse analysis, it is unusual for samples to be large enough to satisfy the criteria of statistically generalisable claims. The aim of this study is to explore the various ways in which performances and roles may be constructed in one specific setting, a psychiatric consultation. As such, it follows other qualitative researchers in arguing that:

“the criteria, then, for selecting a sample is not that it be representative of some larger population, but that it be relevant or interesting to developing theory (Glaser & Strauss, 1967) or that it service as a good ‘take-off point’ for ‘finding one’s way into the phenomenon’ (Schwartz and Jacobs, 1979:293).” (Davis, 1988: 25)

In drawing conclusions, then, it is not possible to extrapolate from the frequency of occurrences in this data to the frequency of the same occurrences in psychiatric practice more generally. However, the presence of phenomena here, where they provide insight into patterns of behaviour across my data, does reflect something significant about psychiatric discourse that allows us to draw interesting and valuable conclusions.

Audio recordings

Recorded interaction allows a detailed record of what was said, and how it was said with a high degree of accuracy. This is, however, only one part of an interaction. The absence of visual data limits the extent to which I can observe what is going on. Visual data can provide a wealth of additional information about body language, expression and reaction, as well as the ways in which participants relate to the physical setting of the consultation room. There are various points in the data here which suggest this ‘missing data’ may be significant. Long pauses may suggest that a participant is undertaking some activity – for example writing out a prescription or reviewing medical notes – but it is not possible to verify this.

This limitation is particularly significant in relation to third party interactions because of the lack of data about participant gaze. Though it is possible to infer who is addressed from the

words spoken and the response of others in the room, this is a weakness and important data may be missing as a result of not having visual data.

Although this is a limitation, it is not fatal to the interests of this study. The richness of the audio data provides a wealth of resources from which to draw insights. Though conclusions drawn without access to visual data must be treated with caution, they are nevertheless built on a robust source of data capable of supporting my claims. In the future, video recordings may allow further development or refinement of the insights offered here.

Re-analysing discourse

This study is a re-analysis of pre-existing data, collected for a separate study using different methods of analysis and answering different questions. Reusing data throws up a number of conceptual and practical challenges which it is useful to discuss, both in understanding my approach to the data and in providing a perspective on a broader debate about the usefulness of reanalysing qualitative data.

Since the late 1990s, there has been a conscious effort to facilitate the reuse of qualitative data (Corti, 2000). In doing so, many researchers have highlighted concerns about re-analysis including issues of ownership, ethical concerns, potential challenge to previous findings, and the validity of new findings.

In this study, the re-analysed data is not part of a national archive, but remains under the control of the research team who collected and owns the data. This has made it possible to conduct a re-analysis since concerns of data ownership have not been a barrier. This has been possible due to two key factors. First, the researcher and their institution are supportive of the re-use of their data and recognise a value in providing further analysis of this rich and sizeable dataset than was possible in the original study. Second, the aims of this study fit well within the stated aims for which the data was collected, i.e. to understand the process of decision-

making through studying naturally-occurring talk. This re-analysis offers a different method and underlying theory, but it continues to address the questions for which participants agreed to take part in the study.

Re-analysis potentially raises considerable ethical concerns, and these have been well-rehearsed in the literature previously (Parry and Mauthner, 2004, Bishop, 2005). For the most part, these concerns are based around the concept of data archiving, in which reanalysis is conducted independently from the original researcher. In this study, by working under the supervision of the original researcher, it was possible to ensure that this research abided by the commitments given to the participants. Data was provided to me in an already anonymised form. Transcripts had names and places removed. Although I had access to the original recordings, these also did not contain any information that could have been used to identify individual participants. The recorded data did not indicate which of the two sites they originated from and full names were not used in the consultations, though first names were.

Due to the anonymity of the data and by ensuring that the use of the data in this study was in line with the purpose stated to participants at the time of data collection, and under the control of the researcher to whom consent was given, I did not attempt to re-seek consent from the participants themselves for this reanalysis. In part, this is in recognition that it is common in qualitative research for research teams to return to data to seek further insights, beyond those found in the first analysis, and nothing in the initial set up of the study precluded this. In addition, seeking consent again was not practical since the length of time (up to 7 years) between collection and reanalysis for this study, which would have made finding and contacting the participants impossible. The approach I used here was reviewed and approved by the University of Sussex's ethics review panel.

As long as all precautions are taken to protect participants' anonymity and to ensure that data is only used in the ways that they have permitted, it is worth considering the arguments in

favour of data re-analysis. Access to settings such as medical consultations is extremely difficult to obtain, limiting the amount of research that is possible regarding important practices. When access is achieved, it is important that data is used as fully as possible to provide the maximum return, both on the time invested by the researcher and for the commitment given by those who chose to participate. By reanalysing in different ways, as much as possible can be learned from data without requiring additional demands on patients or consultants. In general, qualitative data is analysed only in limited ways, leaving considerable scope to gain more understanding, and to challenge or confirm conclusions by examining the data from a different angle.

Beyond the ethical concerns, several researchers have discussed the challenges to validity and usefulness of re-analysing qualitative data. In his discussion of challenges to qualitative reanalysis, Van den Berg identifies a perspective from some researchers that:

“an intense personal involvement in the fieldwork constitutes a necessary prerequisite in order to grasp the relevant context and to interpret interview transcripts. From this viewpoint, secondary analysis of qualitative interviews amounts to doing the impossible.” (Van den Berg, 2005)

This perspective, which is at the heart of much criticism of reanalysis, focuses particularly on qualitative research interviews. There are a number of strands to this criticism. On the one hand, it recognises that interviews are co-constructed accounts involving the interviewer themselves (Silverman, 1993). They are theoretically-driven and as such the interviewer influences the scope of the data – what is included and excluded, where more detail is sought and how participants are asked to consider the topic – and the way the participant’s account is constructed – for example use of language and terminology and the extent to which rapport facilitates more or less open narratives. Equally, this viewpoint highlights the extent to which researchers draw not only on the transcripts and recordings but also on having been present at the interview itself. This allows the interviewer to draw on privileged knowledge about the

setting, the chat before and after the recorder is on, the memories of gesture and facial expression not captured by the recording, and the general feel of the interaction. In this sense, the qualitative interviewer also acts as ethnographer in observing the interaction first-hand.

These criticisms may be more or less justified, depending on the study. It is worth noting that it is not at all uncommon for at least some of the people analysing an interview not to have been present at the time, due to collaboration between more than one researcher and turnover of research staff. More importantly however, these perspectives, while relevant, do not apply so directly to the recording and analysis of naturally-occurring talk. In the case of the data analysed here, the researcher was not present during the recorded interaction. Rather than being part of the co-construction of the talk, the researcher does as much as possible to reduce their influence on the interaction and to preserve the natural course of interaction in this setting. This is not to say that the researcher does not impact on the data. It is important to acknowledge the ways in which the data has been influenced, including through the pre-consultation questionnaire, and the presence of a recording device. This is discussed further in Chapter Four. However, in this type of analysis the aim is to minimise and to acknowledge the researcher influence on data, rather than to use it to inform the analysis.

4. Framing in psychiatric consultations

This chapter describes how frames are constructed and negotiated in psychiatric consultations.

I identify and describe eleven frames which occur within the psychiatric consultation. These are loosely grouped as Information sharing frames, Influencing frames, and Other frames. As Information sharing frames I identify 'Interviewing' (where the interaction is predominantly managed by the questioner); 'Narrative' (where the narrator provides an account of an occurrence situated in a time and space); 'Troubles-telling' (where the troubles-teller provides an account oriented to explaining an ongoing difficulty); and disclosure (where personal information, rather than accounts, are provided). Influencing frames include 'Negotiation' (in which preferences are indicated and argued for); 'Directing' (in which one party offers instruction or indicates that a decision has been made); 'Advice-giving' (in which participants provide suggestions, generally oriented to a Troubles-telling) and 'Lecture' (in which the 'lecturer' makes de-personalised knowledge claims). Finally, in other frames I describe 'Complaints' (in which talk is oriented to a concern for which responsibility is laid on one of the participants); 'Stage direction' (in which talk is aimed at managing the immediate interaction) and 'Informal' (in which participants step outside institutional roles).

These frames are not necessarily equivalent in their status or analytical focus. Goffman argued that "any event can be described in terms of a focus that includes a wide swath or a narrow one and – as a related but not identical matter – in terms of a focus that is close up or distant. And no one has a theory as to what particular span and level will come to be the ones employed" (Goffman, 1974: 8). It could be argued that the frame of significance in this data is simply that of 'psychiatric consultation'. This frame category is consistent with the criteria outlined in the previous chapter: the setting for the frame is boundaried (usually physically, as

well as by the social construction of the activity) in a way that distinguishes it from other social interaction; it has its own set of rules for appropriate behaviour and talk; it assigns specific roles for the people taking part; and it is oriented to a particular goal or goals. There is value, however, in focusing on the use of more narrow framing. By applying Goffman's concept of frames systematically, it is possible to provide a fine-grained analysis of discourse and how it changes within the confines of a single setting.

4.1 Framing the research setting

First, to help the reader to follow how frames are identified and examined in this study, it may be useful to discuss a specific example of framing that occurs in this data, but which is not typically part of the psychiatric consultation; the framing of participation in a research study. This frame is not considered in detail alongside the eleven discussed later because it is not significant to the conduct of psychiatric consultations more generally. It is important, however, in considering this data, to examine how this frame may influence participants' talk.

As well as being participants in a psychiatric consultation, the patients and psychiatrists in this study are also participants in an audio-recorded research setting. As with the broader psychiatric consultation frame, this frame provides participants with an orientation to roles, expectations and behaviours. This type of framing has been identified in previous studies. For example, in introducing her work on framing film narratives, Tannen identifies the layering of research interview onto other contexts:

"the larger context is the one in which the speaker is the subject of an experiment, and the context in which that experiment is being carried out is an interview mode, in which the speaker knows that her voice is being tape-recorded." (Tannen, 1993: 22)

Keying into a *research participation* frame alters the footing of the interaction. In addition to being 'doctor' and 'patient', both are now also 'research participant', with the specific rights and expectations associated with that role. Research participants have the right to withdraw

from the study if they wish to, by requesting that the recorder is turned off. Similarly, participants are expected to continue with the consultation *as though the tape were not there*, since the study seeks to understand what consultations are like, not simply what research settings are like.

In this data the shift into research participation frame is not generally captured since a significant element of that shift undoubtedly occurs prior to - and at the point of – switching the tape recorder on. This marks a keying of the ‘psychiatric consultation’ frame, into a ‘study of the psychiatric consultation’ frame. As a result, the lamination of the *research participation frame* on top of the *psychiatric consultation frame* is not directly observed. There are, however, times when this frame slips and keying can be observed, for example, the psychiatrist’s ‘aside to camera’ in extract 4.1 where she describes the activity for the tape.

Extract 4.1 (consultation 63)

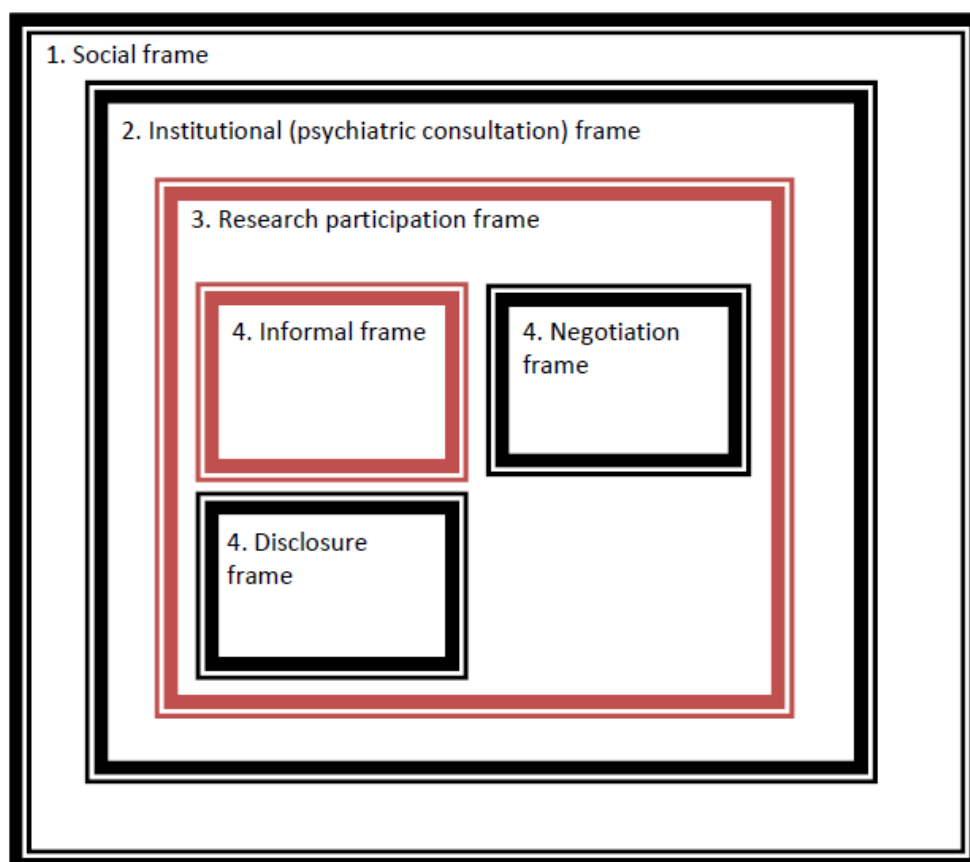
- | | |
|--|--|
| <p>1 <i>Doctor: Which, what's the name of the anti-depressant</i></p> <p>2 <i>again? Have you got them with you?</i></p> <p>3 <i>Patient: No, I I wrote the name</i></p> <p>4 <i>Doctor: Oh fantastic that's great</i></p> <p>5 <i>Patient: They're me tablets I take [patient passes note to</i></p> <p>6 <i>psychiatrist]</i></p> <p>7 <i>Doctor: Thank you very much.</i> ‖ <i>([talking to tape recorder])</i></p> <p>8 <i>[Name]'s just handed me a piece of paper with er the names</i></p> <p>9 <i>of her medication and the dose on, for the sake of the tape</i></p> <p>10 <i>heh heh</i></p> <p>11 <i>Patient: Yeah right. I'd forgotten it was there</i></p> | <div style="border-left: 1px solid black; padding-left: 10px;"> <p>Frame shift:</p> <p>Research</p> <p>Participation</p> </div> |
|--|--|

The keying, marked in line 7, does a number of things to the interaction. First, it shifts the footing of the participants. In lines 7-10 the ‘addressed recipient’ becomes the researcher

(mediated through the recording device) and the patient becomes 'overhearer' (Potter, 1996: 148). The purpose of the turn is not for the benefit of the patient but the absent, future audience. Second, it draws attention to the broader research setting frame, reminding the patient of the tape's existence. The patient's comment at line 11 suggests that she may not have been as attuned to the research setting frame as the psychiatrist appears to have been.

Since frames are laminated, orientation to the research participation frame can also be used to create other frame shifts. Some examples of this are seen in the extracts 4.2, 4.3 and 4.4. Using the simple pictorial form suggested in Chapter Three, we might show these by highlighting frames to which participants are explicitly oriented in their talk (figure 4.1). A broader frame may be highlighted in order to facilitate shifts at a narrower level.

Figure 4.1



In extract 4.2, the patient jokingly asks the doctor not to reveal her weight to the tape (or to the researcher as non-participant audience). Here, rather than orienting to the tape as ‘addressed recipient’, it is oriented to as ‘over-hearer’. In this instance, the frame shift is used light-heartedly to build rapport between the two participants, as indicated by the laugh in line 4. By making reference to the research participation frame, the patient also shifts into an informal frame where light-hearted comments and jokes are legitimate because of the comparative equality of participant roles. The research setting places them both in an equivalent role – that of research participant – in contrast to an absent researcher.

Extract 4.2 (consultation 32)

1	<i>Doctor: Do you want to jump on the scale for me?</i>	
2	<i>Patient: If Don't say it out loud when the tape is on</i>	Frame shift:
3	<i>Doctor: Do you want me to write it on a piece of paper?</i>	Research
4	<i>(laughs)</i>	participation /
5	<i>Patient: No I don't mind.</i>	Informal

Here the effect of orienting to the research frame and shifting the footing accordingly is to create a form of light-hearted collusion that allows them both to ‘put one over’ on the researcher. This kind of collusion is possible because of the frame shift, but the effect of creating a friendly and relaxed relationship may have longer-lasting benefits for the interaction and for the ongoing relationship. Throughout this chapter, we will see other examples of how framing is used to create a positive relationship between psychiatrist and patient.

Extract 4.3 demonstrates how attuning to the research study frame is used by the participant to legitimise introducing a topic shift. In this case, the participant makes explicit reference to the purpose of the original research in exploring how changes in medication are negotiated and decided upon. The ‘out of character’ (Goffman, 1959: 167) reference to the tape

recording, in which the patient openly refers to the performed activity, is used to draw attention to the study as a frame which makes discussion of his medication preference relevant to the interaction and facilitates a shift into a Negotiation frame (discussed below, section 4.2.2, page 135).

Extract 4.3 (consultation 83)

1	<i>Patient:</i> <i>This tape recording it's about initiations and</i>	Frame shift:
2	<i>changes and non-changes in medication isn't it, you were</i>	Research
3	<i>explaining to me? And I hope and when I mentioned this to</i>	Participation /
4	<i>[Name] yesterday, she hopes too that there will be no</i>	Negotiation
5	<i>change. I'm very happy on what I'm on.</i>	
6	<i>Doctor: Well that's fine.</i>	

This same technique is seen in extract 4.4. Using an 'aside to camera' similar to that in extract 4.1, the patient creates the space to bring up medication issues.

Extract 4.4 (consultation 33)

1	<i>Patient:</i> <i>I know that and I appreciate that, and I have got halfway</i>	Frame shift:
2	<i>down the road a few times, and I've turned round and not bothered.</i>	Research
3	<i>But it is reassuring that you're, someone or yourself is going to be</i>	Participation /
4	<i>there.</i> <i>Shall I say for the sake of the tape medication's fine?</i>	Disclosure
5	<i>Doctor:</i> <i>I was going to ask you that. Any medication issues?</i>	Frame shift:
6	<i>Patient:</i> <i>No, it's fine.</i>	Interview
7	<i>Doctor:</i> <i>With the Olanzapine.</i>	

In extract 4.4, the footing of the participants is again shifted. Ostensibly, the psychiatrist remains the addressee, while the researcher becomes the target of the message although a non-participant in the interaction - what Levinson (1988) described as a 'targeted overhearer'.

Footing is further complicated, however, when we consider the purpose of the patient's statement. In fact, the patient has already met with the researcher, as described in section 3.6, and explained his preferences in relation to medication to him. Although the researcher is the explicit target of the statement, the psychiatrist, I would argue, remains the actual intended recipient of the talk. The patient again uses 'communication out of character' (Goffman 1959: 167) to disclose information not requested by the psychiatrist (see below re Disclosure frame). The psychiatrist responds accordingly in line 5 by ratifying the topic shift. Instead of orienting himself to the Disclosure frame, however, the psychiatrist is prompted to re-frame the interaction again in order to explore the medication topic further in an interview frame.

The patients' decisions to shift the footing in this way suggest that they might not consider their statements concerning the medication as legitimate in their footing as patient. The change in alignment to the speech recipients allows the speaker to make different statements. In this way, participants deliberately use the frame shifts available to them to meet their own goals in the interaction.

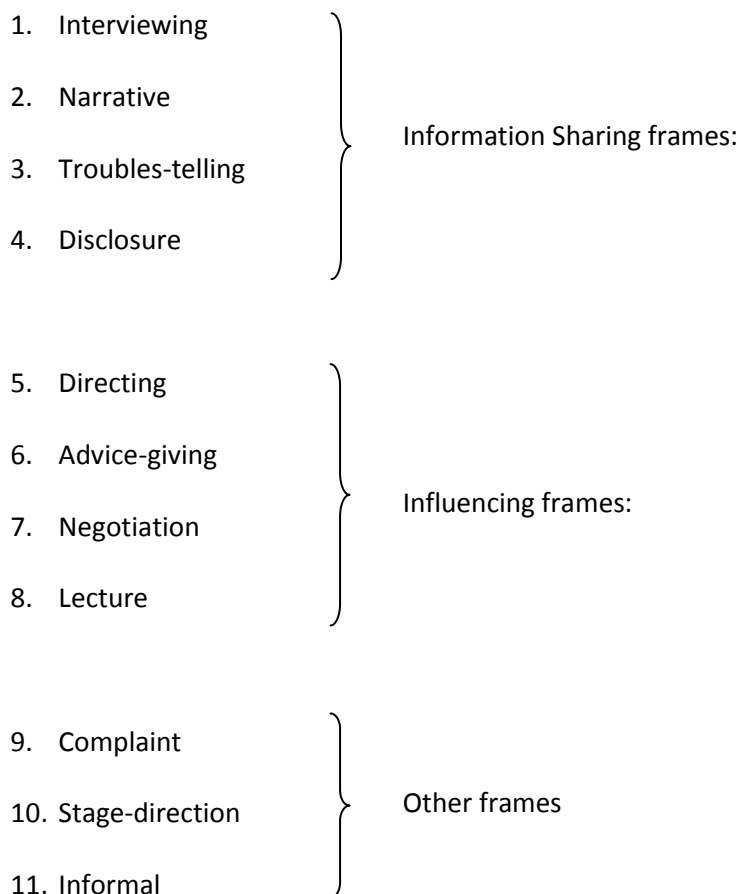
This brief overview of the research participation frame highlights key premises discussed in this chapter. First, these extracts demonstrate how frames are laminated and attuned to. In each case participants refer to the research participation, and in doing so also manoeuvre other frame shifts. Additional frames are placed on top of the research participation frame: in extract 4.1 orientation is to the Research Participation frame itself; in extract 4.2 talk shifts to an Informal frame; in extract 4.3 the shift is to a Negotiation frame; in extract 4.4 the patient prompts a shift into a Disclosure frame. The shifts do not *replace* the existing frames but are layered on top of them and interact with them. These frames are each discussed in more detail below.

Secondly, frame shifts adjust the expectations and rights of participants, but participants should not be assumed to be at the mercy of these frame shifts. Speakers build up and shift

frames *precisely because* they result in these changing expectations. As in extracts 4.1 and 4.2 the shift can allow participants to adopt a different footing to one another, changing the relationship and dynamics between them. Equally, as in extracts 4.3 and 4.4 frame shifts can facilitate the participant in addressing a new goal in the interaction by providing space to make statements that may otherwise be rejected as inappropriate or irrelevant.

4.2 Framing the psychiatric consultation

This chapter shows in detail the way in which framing is actively used and negotiated through a number of sub-frames. The eleven substantive frames listed below sit within the consultation frame and, in this data, also within the Research Participation frame:



As described in section 3.3.2 (page 85), these frames were derived through careful reading of the transcripts to identify what was going on at each stage of the consultation. I identified common patterns in the data, where participants appeared to orient themselves to different

tasks and establish specific roles in relation to the discourse. Initially identified frames were refined as further data was explored.

To provide additional overall structure, I have loosely categorised these frames by goal orientations: information sharing, influencing and others. These categories highlight some similarities among the frames that sit within them, but they should not be seen as absolutely distinct or mutually exclusive. An information-sharing frame may be used to influence a decision, and an influencing frame may provide a great deal of information. Nevertheless, the *prima facie* similarities in purpose make these useful categories for presentation here.

Many of these frames have been the focus of previous studies, several of which were discussed in the previous chapters. They identify functions of talk such as interviewing, advice-giving and narrating. I draw on some of the key concepts and definitions of previous studies where they are relevant to the conclusions reached.

Frames are broadly distinguished by two characteristics: 1) the roles, or footing, that participants take up and the behaviour expected of those roles; and 2) the goal orientation of the talk. These relate directly to the change in expectations of the other participant, changes in alignment to one another and presentations of self.

In considering goal orientation it is important to recognise that all of these frames may have a wide variety of end goals in relation to specific decisions, actions or behaviour changes. However, for the purposes of this analysis, frames are identified by their orientation to a goal within this particular consultation as a situated encounter. Equally, people may use frames to obscure the distal goals oriented to. For example, a narrative frame indicates information sharing but may also be oriented to influencing a decision. I will argue that using frames in this way helps different participants to work towards goals that it would not be legitimate to approach in other ways, particularly by making their claims relevant. At the same time, legitimate negotiation of footing is constrained by the overall frame of consultation, including

the permitted roles and relative status of each participant. Patients are unlikely, for example, to be able to take on the 'lecturer' role (see section 4.2.2, page 135, for discussion of this term), but may take on the narrator role as a way to meet similar goals in the interaction.

The main section of this chapter will describe the frames listed above and discuss their significance for footing and goal orientation. In relation to each frame I indicate the corresponding participant footing. I go on to explore *how* frames are shifted and where these shifts are not successful. Finally I explore in depth how participants break established frames and use 'out of character' discourse (Goffman, 1974) in which participants step outside their institutional role performance, as already seen in extracts 4.1 to 4.4 (see section 4.4, page 168).

4.2.1 Information sharing frames

Interview frame

Footing: Interviewee (typically the patient) / Interviewer (typically the psychiatrist)

In keeping with previous findings (Ainsworth-Vaughn, 2007; ten Have, 1991), interviewing makes up the largest part of consultations collectively in this study (see Chapter Two for further discussion). The interview frame can be seen as achieving two goals: to elicit information the interviewer perceives as relevant, and to manage the interaction in terms of both topics covered and time spent on them (and in doing so to establish dominance in the interaction). Both goals are important in psychiatric consultations, and tend to reflect the doctor's agenda. There are likely to be several topics on which it is necessary to elicit information in a limited time, including medication use, potential risks to the patient or others, health status and symptoms.

The interview frame has previously been discussed largely in terms of power imbalance (see Chapter Two). I draw a distinction between 'questioning' per se and the interview frame.

Questions may occur in other frames and be oriented to different goals. In the extracts

throughout this chapter there are questions that seek to elicit preferences, obtain confirmation, make suggestions, re-evaluate accounts, establish rapport, and stage-direct activity. The interview frame is specific in that it consists of one party seeking information from the other, where the interviewer controls the topic and structure of the interaction and the interviewee is expected to follow.

Extract 4.5 is an example of a structure that often occurs when a patient has indicated that there may be a risk of them harming themselves. The psychiatrist elicits very specific information to allow him or her to assess the severity of the risk – intentions, opportunity and any relevant factors exacerbating or mitigating the risk. The structured nature of the interview frame allows the doctor to systematically ensure that he has this information as far as possible.

Extract 4.5 (consultation 04)

- 1 *Doctor: So what, you're saying there is a high (1.4) likelihood that*
- 2 *you're going to take a, an overdose?*
- 3 *Patient: Yeah*
- 4 *Doctor: $\overline{\text{f}}$ Ha-how (1.8) high do you think that chance is,*
- 5 *if you*
- 6 *Patient: $\overline{\text{T}}$ ((in overlap)) Very high*
- 7 *Doctor: Very high*
- 8 *Patient: Soon as I get the chance*
- 9 *Doctor: (1.0) You say as soon as you get the chance. You've*
- 10 *always got the chance haven't you because the tablets are always*
- 11 *there?*
- 12 *Patient: I have but my, my mum's always around*

Frame shift:

Interview

- 13 *Doctor: Okay. So if your mum was away for a day?*
- 14 *Patient: I would take 'em*
- 15 *Doctor: You'd take them. A-and are the tablets, w-w-where are they*
- 16 *kept in the house?*
- 17 *Patient: Just in the cupboard*
- 18 *Doctor: (7.2) And how many are in the house at the moment?*
- 19 *Patient: Loads*
- 20 *Doctor: (9.0) Er is it just your mother at home?*
- 21 *Patient: Yeah*
- 22 *Doctor: Does she know how you're feeling?*
- 23 *Patient: Yeah*

The patient as interviewee in this extract provides answers directly relevant to the questions asked without expanding on them. The psychiatrist uses more or less closed questions that encourage short, specific answers.

Despite the apparent power imbalance intrinsic to the interview frame, it should not be assumed that the patient is passive in accepting the frame. As discussed in Chapter Three, frames are negotiated jointly, and it may suit the interviewee to be in this role. In this consultation, for example, the patient appears to adopt a performance oriented towards being admitted to hospital. This becomes evident later in this consultation when the patient is directly challenged on this intention (see extract 5.5). The patient has disclosed a serious risk of a suicide attempt. In order for the risk to be taken into account, the patient needs the psychiatrist to know about it, but not to consider that the patient is proactively managing it for himself. The interviewee role, then, may be used as part of a deliberate performance of passivity by leaving the initiative with the psychiatrist while providing information that he wants considered.

Despite this, the interview frame may also be used to delineate the topics for discussion and to control relevance. Extract 4.6, shows how topic management is maintained by the doctor in the interview frame despite the patient's indication that other topics are relevant to her. The patient's attempt to move the topic on to talk about Christmas is resisted by the doctor with a holding phrase, "Let's come back to that" (line 6).

Extract 4.6 (consultation 03)

1 Doctor: Are you feeling a bit fitter?	Interview frame
2 Patient: I feel a lot better. Yeah I feel lot better	
3 Doctor: (Yeah)	
4 Patient: in myself I can (0.6) go out and do shopping and things	Resisted frame shift:
5 like that. [¶] Like I'm looking forward to Christmas	possible Narrative
6 Doctor: (1.2) [‡] Let's come back to that. D-d'you keep a check	frame?
7 on your weight? Because th-that's the thing (c4 words)	
8 Patient: ((in overlap)) Yeah, I weigh myself all the time	Interview frame
9 Doctor: Wh-wh-what's, what's happening with your weight	
10 Patient: Well I'm eleven stone. Like when I was on the Zispin, I was	
11 twelve and a half stone	
12 Doctor: So you've lost, you've, a stone and a half?	
13 Patient: ((in overlap)) Stone and a half, yeah	

Psychiatrists' use of 'coming back to' a topic which threatens to disrupt the interview frame is seen in several other consultations. Another example is shown in extract 4.7 where the patient attempts to shift the frame from interview to troubles-telling, a re-keying that would put her in greater control of the floor (see below). In both of these interactions (extracts 4.6 & 4.7), the topic is raised by the participant and postponed by the psychiatrist (see extract 4.8), suggesting that this is not about preventing discussion of these issues, but about controlling the flow and timing of the interaction.

Extract 4.7 (consultation 10)

- 1 *Doctor: Well I I was just wondering I don't know. I mean have, you*
 2 *have been eating properly?*
 3 *Patient: Here and there, here and there. Erm (1.8) gone off food*
 4 *a little bit, for- not a lot to worry about. Erm (3.0) ¶ I've got quite*
 5 *a few problems at the moment, with my daughter. And that's not*
 6 *helping. She's pregnant (2.3)*
 7 *Doctor: ‡ Coming back to weight...*

Resisted frame shift:**Troubles-telling****Narrative frame****Footing:** Narrator (typically the patient) / audience (typically the psychiatrist)

Narrative frames provide the opportunity for the narrator to take an extended turn in the interaction and to control the topic and level of detail. While in the interview frame information is elicited under the control of the interviewer, usually the psychiatrist, in the narrative frame the information shared is controlled to a greater extent by the narrator, usually the patient. As Riessman argues, “*narrators control the terms of storytelling, they occupy ‘privileged positions in story worlds of their own creation’ (Patterson, 2002: 3)*” (Riessman, 2002). The audience for the narrative is expected to allow the storyteller to hold the floor and responses will generally be to clarify details and meaning or to otherwise demonstrate that they are listening.

Participants who wish to shift to a narrative frame may have to indicate their intentions to take the floor. In extract 4.8, taken from the same consultation as 4.7, the psychiatrist returns to the topic of her daughter's pregnancy which was previously placed on hold. The patient creates space for an extended turn in lines 7-8 and in line 9, the psychiatrist marks acquiescence to the narrative frame shift.

Extract 4.8 (consultation 10)

1	<i>Doctor: Coming back to what, what you just said about [Name] I</i>	Interview frame
2	<i>mean you say that</i>	
3	<i>Patient: Mm</i>	
4	<i>Doctor: that's sh-she's pregnant. Wh-when</i>	
5	<i>Patient: Yes</i>	
6	<i>Doctor: did you, h-how, when did you find out about that?</i>	
7	<i>Patient: Erm ¹ (0.6) the thing was, I'll start from, quickly from the</i>	Frame shift: Narrative
8	<i>beginning because</i>	
9	<i>Doctor: ² Mm</i>	
10	<i>Patient: I know you're busy. Erm (1.9) while I was in the hospital</i>	
11	<i>last year she (0.6) came across a guy that was in there (1.0) and</i>	
12	<i>through the months her visiting me, she was also visiting him.</i>	

The patient's explicit efforts to create space for her account, including her reference to the psychiatrist being busy (line 10), suggest that she considers narratives to be somewhat out of place in consultations; they are not a 'standard' institutional frame and therefore require more open negotiation. Despite this, narratives occur frequently across this data. In other instances, narratives are invited by the psychiatrist, as in extract 4.9 where she asks the patient to say more about the reported difficulty of feeling extreme fatigue. While the psychiatrist could have asked closed questions, within the interview frame, in this case he invites the patient to control the account and the patient responds with an extended narrative.

Extract 4.9 (consultation 65)

- 1 *Doctor: Right so that's really the main thing at the moment then?*
- 2 *Patient: Yeah, yeah other than that everything else is getting on*
- 3 *really well and I'm coping you know, everything*
- 4 *Doctor: Yeah Yeah. ^{FF}Tell me a bit more about it then. You're*
- 5 *feeling tired and?*
- 6 *Patient: ^Twell, it started years ago. You know, when I think back,*
- 7 *when I was at school and quite often at certain lessons and I can't*
- 8 *remember, I think they were the first period in the afternoon, just*
- 9 *after dinner I would end up falling asleep.*

Frame shift:**Narrative**

Previous studies of narratives in medical settings are discussed in Chapter Two, including the potential purposes for using narrative (Bamberg, 1999) and the elucidation of common narrative structures (Labov & Waletzky, 1997). Where a shift to the narrative frame is successful, all of the stages Labov identifies can be seen in these consultations. Orientation of both parties to the structure of narratives can be seen in attempts to 'move the story along' by skipping to later stages. In extract 4.10 the patient provides an abstract ("What I've done"); orientation ("In February for about six weeks"); and a series of complicating actions (acid indigestion, depression, consultation with the pharmacist etc). In line 29, the psychiatrist introduces the evaluation and coda stages by suggesting the significance of the account - that the patient has stopped taking the Quetiapine. In line 30, the patient rejects this evaluation, though accepting she has stopped, and offers an alternative evaluation – that the patient did all she could to seek the psychiatrist's approval and ultimately had to act as she did.

Extract 4.10 (consultation 88)

1 *Patient: What I've done. Um, how, well I'll go back. In February for*
 2 *about six weeks I had this awful (unclear) and at the same I was*
 3 *getting all this acid indigestion and Dr. Miller put me on this drug*
 4 *called Rantstadine?*
 5 *Doctor: Ranitidine (unclear)*
 6 *Patient: That's it. And all of a sudden I just started to get quite*
 7 *depressed but not really, really worried. Anyway, I phoned, I*
 8 *phoned the team but the answer phone was on and then I thought.*
 9 *Well, I don't know, I'll just see, perhaps maybe I'll try again and I*
 10 *tried again and they still couldn't get through and I thought well, I'll*
 11 *ring, I'll ring the pharmacist to see if any of my drugs could do this.*
 12 *And I spoke to this pharmacist a little more and he said well, he*
 13 *said that the acid indigestion, it can cause depression but he said it*
 14 *could be that because you're come the end, you're at the end of a*
 15 *very nasty virus, that could be it. And then he said, of course, it*
 16 *could be the Quetiapine. So anyway, I stopped the anti-indigestion*
 17 *stuff and then I saw [GP] and he put me on to something else*
 18 *which hasn't, you know, so I mean, well I didn't feel depressed after*
 19 *that. So, I don't know whether it was that or it was the virus really.*
 20 *But then with the Quetiapine I was finding over the last couple of*
 21 *months that um I was becoming, I was, you know, it was OK to*
 22 *take it at night and generally I have a pretty good sleep but in the*
 23 *morning I was finding that, about an hour and a half after I'd taken*
 24 *it, I'd just have this overwhelming tiredness and I'd go back to bed.*
 25 *So we're talking about going back to bed for, you know, at least*
 26 *three hours. And I just thought to myself, after a while, I can't cope*
 27 *with this. My exams are coming up soon and*

Narrative frame

- 28 *Doctor: so you stopped the morning dose?*
- 29 *Patient: Well, I didn't. I didn't, yeah I have now but I didn't*
- 30 *immediately I thought well, I'll try this. Cos I was meant to be*
- 31 *seeing you a bit sooner but we've had a few, you've not been free.*
- 32 *Doctor: sorry*
- 33 *Patient: No, I know but that's why I would have asked you but I*
- 34 *thought I can't bear this*

This extract highlights a key purpose of the narrative frame in consultations in contrast to other information sharing frames. The narrative allows the patient to offer an interpretation of the narrated events. By controlling the account, they are able to orient it to various purposes, including identity performances. In extract 4.10, for example, the patient uses his narrative to perform a 'good patient' role in which he makes sensible decisions about his treatment and seeks to follow medical advice wherever possible. The narrative frame is therefore important for patients in managing these performances, as discussed further in Chapter Five. There is a caveat on this privileged position, however. Where narratives take place in the patient's wider social life, family members present may also stake a claim to control of the narrative. In such cases, the patient's ability to shape and interpret an account may be challenged. This is discussed further in section 6.4.4, page 259.

Troubles telling frame

Footing: Troubles-teller (typically patient) / troubles-recipient (typically psychiatrist)

Troubles-talk has been considered in previous studies of interaction, particularly the work of Jefferson and Lee (see Chapter Two). Troubles-talk in the clinical setting is a keying of troubles-talk in ordinary conversation that was the subject of Jefferson and Lee's work. Troubles-telling in care settings has been explored in the discourse of the elderly (Grainger, Atkinson, & Coupland, 1988), building on Coupland, Coupland and Giles' concept of Painful Self-Disclosure,

whereby elderly people make intimate and problematic disclosures to younger people (Coupland, *et al.*, 1988).

While it retains many of the characteristics identified by Jefferson and Lee, troubles-talk takes on another significance within the clinical setting. Instead of being in tension with “business-as-usual” (Jefferson 1988), troubles-talk forms part of the business of the psychiatric consultation.

There are significant overlaps between narrative and troubles-telling frames. The troubles-telling may take the form of a narrative and may contain all the structural elements described above. Troubles-talk, however, need not necessarily take on the chronological structure that marks out narratives. Troubles-telling is, however, characterised by its orientation to a problem or difficulty which has an ongoing impact on the troubles-teller. The full transcript provided in appendix B shows an example of Troubles-telling. In this case, the Troubles-telling forms the majority of the consultation.

Like narratives, troubles-talk may be used to achieve a number of different goals in the interaction, for example to present a particular ‘face’, to support the case for a course of action, to prompt a specific suggestion from the doctor, or to provide context for information relevant to decision-making (e.g. justifications for not taking medication or taking additional medication). The structure of troubles-telling can often be seen to attend to several of these goals.

The similarity between narrative and troubles-telling is demonstrated in extract 4.11 where the patient describes troubles with her housemates which have affected her mood.

Extract 4.11 (consultation 91)

- 1 *Patient: I felt as though, you know, I felt really upset because they*
- 2 *weren't talking and not even saying hello. So I started it, and they*
- 3 *didn't like it. I went quiet, I just walked upstairs, did a bit of*
- 4 *drawing...*
- 5 *Doctor: Is that how you lost your weight as well.*
- 6 *Patient: Walking about.*
- 7 *Doctor: And the upset, were you eating alright?*
- 8 *Patient: Not a lot. Put me off food.*
- 9 *Doctor: Goes to show doesn't it how important it is where you're*
- 10 *living, the people you're with.*
- 11 *Patient: I think I brought them to their senses. Because I said it's*
- 12 *really getting nasty here. I said you're pushing me out the way*
- 13 *every time. I'm actually getting pushed from here to there you*
- 14 *know physically. It's like, get out the bloody way. I said, 'what*
- 15 *have I done? Nothing (at all) except talk to you about something*
- 16 *that should have been dealt with'. 'Couldn't have it.*
- 17 *Doctor: The way you felt...*
- 18 *Patient: I felt really suicidal.*
- 19 *Doctor: Absolutely awful, yeah.*
- 20 *Patient: I just felt really bad.*
- 21 *Doctor: Did you get in touch with anybody else about it?*
- 22 *Patient: No I just left it. 'Couldn't talk to anybody because I was so*
- 23 *down. You know. Just went a bit quiet myself. I dealt with it*
- 24 *myself. You know, put myself on extra med to quiet me down.*

Narrative frame

The narrative in extract 4.11 provides important historical information on the patient's health, explains her decision to increase her dose, and presents a face as more reasonable than others in the house and capable of managing her own troubles. The account is not, however, presenting an ongoing trouble; the narrative takes place entirely in the past tense and later in the consultation the participant states that "we have sorted it out now".

In contrast extract 4.12 shows an example of troubles-telling as context for the patient's preference for no change to their treatment. Towards the end of the extract, the patient shifts into a negotiation frame (see below), having worked to justify his position through troubles-talk. The psychiatrist's minimal responses are similar to those identified by Jefferson and Lee as 'continuers': utterances which indicate their expectation that the speaker will continue since insufficient information has yet been shared to suggest that the conclusion or evaluative element of the talk has been reached (Jefferson, 1988). As discussed in Chapter Two, troubles-telling invites the hearer to take on the role of troubles-recipient in which indications of listening, rather than active contribution are expected.

Extract 4.12 (consultation 20)

- 1 *Patient: I've felt mentally I realised that my income is not, is not*
- 2 *going to increase, not, not until I can prove good health over a*
- 3 *matter of years. Because, because I was medically retired*
- 4 *Doctor: Hmm*
- 5 *Patient: there is, at a young age, and there is a possibility of re-*
- 6 *employment if only if I can prove well-maintained health*
- 7 *Doctor: Yeah*
- 8 *Patient: in the future, and that's the only goal I've, that's a goal in*
- 9 *my mind*
- 10 *Doctor: Yeah, yeah yeah*

Troubles-telling frame

11 *Patient: for the future if that means five to ten years down the road,*
 12 *I can probably go back and do 10 years' service. Or 20 years'*
 13 *service. If I could prove good health. At the moment I can't enter*
 14 *the working world, because I've got two illnesses that um, I've got*
 15 *indefinite stamps on.*

16 *Doctor: Yeah*

17 *Patient: So, mentally I seem to be absorbing all this information, uh*

18 *Doctor: Hmm*

19 *Patient: I mean it's sort of patterning a future for me uh, not a*
 20 *working future, not yet, 'cos I feel that all my ex health problems*
 21 *(not my mental health)*

22 *Doctor: Hmm*

23 *Patient: All my ailments I feel that they are on the borderline. I've*
 24 *just made it to the borderline. So if I was to increase, put any*
 25 *pressure or change in my life in the next 12 months, I don't think*
 26 *that would help me*

27 *Doctor: No, I understand you*

28 *Patient: I, I*

29 *Doctor: No I appreciate that*

30 *Patient: I think keep everything the same*

Negotiation frame

Troubles-telling, then, provides many of the same functions for the troubles-teller as narratives do for the narrator. They allow the speaker to take an extended turn in order to expand on their account, to offer their own interpretation of the information provided and to indicate its relevance to the task at hand. Troubles-telling need not take a narrative structure however. Significantly, troubles-telling establishes a different set of expectations of the hearer. As described in detail by Jefferson and Lee (1981, 1988), troubles-telling requires the hearer to attend to the problem, to acknowledge it and to respond to it. Rather than working towards a coda that identifies the significance of an account, the trouble-telling works towards alignment

of speaker and hearer towards the issue described as a problem, and from there, potentially to an agreed way of addressing this problem. As such, this frame makes different demands of the hearer and establishes a different footing from that of the narrative frame.

Disclosure frame

Footing: Information-giver / information-recipient

As described above, the Interview frame allows the interviewer - normally the psychiatrist - to control the interaction and the exchange of information while patients make space for their own accounts through the Narrative and Troubles-telling frames. In a small number of cases, however, the patient provides statements of information not requested by the psychiatrist. In contrast to the frames discussed above, however, these 'disclosures' do not take the form of a personal account, but of potentially relevant information claims for the *prima facie* benefit of the information recipient. An example of this relevance-making was seen in extract 4.4 (section 4.1, page 112). In claiming relevance, the speaker faces the possibility that the recipient will either ratify that relevance, for instance by asking follow-up questions or relating the information to the task at hand, or reject the relevance, for instance by not responding to the disclosure.

In extract 4.13, in response to the psychiatrist's 'final concern sequence' (line 1) (Robinson, 2001b), the patient offers health-related information concerning her smear tests. The psychiatrist does not immediately ratify this disclosure – a non-committal 'yeah' in line 4 - prompting the patient to further justify the statement in lines 5 and 11.

Extract 4.13 (consultation 31)

1	<i>Doctor: Anything else we need to discuss?</i>	(Final concern
2	<i>Patient: ^{II}Oh I just thought I'd let you know I have been having</i>	sequence)
3	<i>smear tests.</i>	Frame shift - Disclosure
4	<i>Doctor: Yeah.</i>	
5	<i>Patient: Thought I'd let you know about that. It was abnormal but</i>	
6	<i>it's sort of carrying normal now, getting back to normal. I had an</i>	
7	<i>infection just before Christmas but that seems to have sorted itself</i>	
8	<i>out.</i>	
9	<i>Doctor: ^TSo they've repeated it have they?</i>	
10	<i>Patient: Yeah, yeah. I just thought I'd let you know, so that you</i>	
11	<i>know what's going on</i>	

The purpose of this disclosure does not appear to be related to any medical decision made in this setting. Instead, the unsolicited disclosure allows the patient to perform a particular patient role. The explicit reference to medical compliance and the show of co-operation with the doctor form part of the patient's performance of the 'good patient'. Furthermore, the patient's repeated use of "just thought I'd let you know" is a form of stake inoculation (see Chapter Two) in which the patient distances themselves from potentially ascribed self-interested motives. The use of disclosures in this way is discussed in more detail in Chapter Five.

4.2.2 Influencing frames

An important part of the psychiatric consultation is making decisions about prescribing and other interventions. Both participants may come to these consultations with specific goals and preferences for these decisions, and framing can form part of their strategies for achieving these goals.

Negotiation frame

Footing: Lead negotiator / secondary negotiator

Where decisions are made in the consultation, participants may shift into a negotiation frame in which both psychiatrist and patient are expected to express preferences and work to influence the other to reach the preferred decision. The extent to which this frame is characterised by ‘communicative action’ and ‘strategic action’, as discussed in Chapter Two, may vary considerably (Habermas, 1984). As seen in the example below, negotiations are often characterised by power imbalance with a ‘lead’ negotiator - often but not always the clinician - pursuing agreement to a proposal, rather than open negotiation between equal participants.

The negotiation frame is characterised by a) its proximal goal of reaching agreement on the decision in the face-to-face interaction, and b) its distal goal of ensuring the other’s commitment to the action beyond the immediate consultation. The two goals are highlighted in extract 4.14 in which the doctor proposes a talking therapy for the patient.

Although the doctor obtains the patient’s agreement to the suggestion in line 5, she probes the patient further to ensure that this agreement takes into account other relevant information, in this case recognition of how hard therapy might be.

Extract 4.14 (consultation 01)

1	<i>Doctor: Have you (1.2) ever had the chance to, talk about these,</i>	Negotiation frame
2	<i>early experiences that you had?</i>	
3	<i>Patient: No not really</i>	
4	<i>Doctor: What would you think about (1.9) that as an option?</i>	
5	<i>Patient: I would (1.2) I think that's the only option I've got left really</i>	
6	<i>Doctor: You've come to the point in your life where you (0.9) you-</i>	
7	<i>you might be prepared to tackle those</i>	
8	<i>Patient: ((in overlap)) Yeah</i>	
9	<i>Doctor: It would be pretty painful wouldn't it I'd have thought?</i>	
10	<i>Partner: ((in overlap)) (Yeah)</i>	
11	<i>Doctor: For someone who was lifting the lid on this and, helping</i>	
12	<i>you look inside (1.1). You're willing to</i>	
13	<i>Patient: Yeah</i>	

Since the proximal goal of this frame is to reach explicit agreement it can be used by the lead to maintain the exchange on the given topic until a relevant response, whether agreement, disagreement or further negotiation, has been given. Nonetheless, the psychiatrist's pursuit of the negotiation beyond the point where agreement has been indicated suggests that the goal is to have a degree of considered approval rather than simply following advice. This is potentially in contrast to other influencing frames as discussed below.

In extract 4.15, the doctor's proposal – that the patient change medications while in hospital – is initially refused by the patient (line 9). The doctor maintains the negotiation frame until the patient's agreement is given.

Extract 4.15 (consultation 04)

<p>1 Doctor: So if you come in, if you come into hospital, we start the</p> <p>2 Clozapine, if it helps (1.5) then the condition for you continuing on</p> <p>3 the Clozapine is that, get to those (1.0) that, is that you get your</p> <p>4 blood taken every couple of weeks. And unlike Warfarin there'd be</p> <p>5 no ifs and buts. If you can't get to the blood tests we'd stop the</p> <p>6 Clozapine.</p> <p>7 Mother: Mm hm</p> <p>8 Doctor: Erm</p> <p>9 Patient: And then there's no point in me starting it then. Cos there's</p> <p>10 no way I'd go to get it checked</p> <p>11 Doctor: Well, (let me tell you) the point in starting it. If you start it</p> <p>12 and you find that it helps, and that you're better</p> <p>13 Patient: Yeah. Oh</p> <p>14 Doctor: See what I mean?</p> <p>15 Patient: Yeah</p> <p>16 Doctor: If we start it and you're no better, there's no point in</p> <p>17 continuing it</p> <p>18 Patient: Yeah</p>	Negotiation frame
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Where agreement is not initially given, the lead may subtly change the proposal to make it more acceptable – in extract 4.15 the proposal is changed from ‘you must get blood tests’ to ‘you must get blood tests if the medication works’ – or may use other techniques to persuade the other to agree with the original proposal, as in extract 4.16. Again, the patient here is reluctant to accept the clinician’s proposal. He offers a counter-proposal, that he accepts the prescription but only takes the medication if he feels he needs it.

Extract 4.16 (consultation 74)

- 1 *Doctor: Can I give you a prescription?*
- 2 *Patient: One tablet, tablet. (1.4) OK you can give me a prescription*
- 3 *but I won't take them unless I'm going a bit (unclear)*
- 4 *Doctor: Ah! Now (that's not quite what I had in mind!*
- 5 *Patient: (overlapping) (Ah, that's not a good deal is it, aaahh*
- 6 *Social worker: It's a better deal*
- 7 *Patient: He's a hard man, (he's a hard man)*
- 8 *Doctor: ((overlapping talk)) (I was thinking) about your neighbours*
- 9 *as well and I was thinking*
- 10 *Patient: Heh, I I've improved greatly, I have improved greatly*
- 11 *Doctor: You have but you risk, but you're risking throwing, throwing*
- 12 *that all away, that's the problem*
- 13 *Patient: I know. No, no, I I have improved greatly that way yeah, er*
- 14 *since I've stopped taking all those tablets and I just take every*
- 15 *(unclear) one or two*
- 16 *Doctor: Yeah, I'm not doubting that for one minute. ^{IF} But, the*
- 17 *schizophrenia does not come straight away. If you're gonna get*
- 18 *schizophrenia it creeps up on you.*
- 19 *Patient: ^T Does it?*
- 20 *Doctor: Yeah, and before you know it you're under the spell of it*
- 21 *and you'll be a changed person*
- 22 *Patient: Yeah*
- 23 *Doctor: and there could be something dangerous happens (1.7)*
- 24 *And I'm just thinking particularly if you've drunk as well, you could*
- 25 *put your safety severely at risk*
- 26 *Patient: OK*
- 27 *Doctor: That's my worry*

Negotiation frame

**Frame shift: Lecture
frame**

- 28 *Patient: Alright*
- 29 *Doctor: And that of your neighbours. (1.0) You know if there was a*
- 30 *fire and you'd had something to drink who knows what would*
- 31 *happen to you*
- 32 *Patient: (4.0) ^{ff}OK I, I, I, I dunno really, I don't know all these*
- 33 *things you know but erm, as I say I feel alright now and I'm not I'm*
- 34 *not going off the rails or anything, but if you if you think I might do*
- 35 *you think I might do in time*
- 36 *Doctor: I think you might*
- 37 *Patient: Yeah OK alright then. I I'll take your advice*

Negotiation frame

In extract 4.16, the psychiatrist starts by inviting the patient to accept or refuse the medication within a negotiation frame, which shares the decision making between both participants. As the talk unfolds, however, he uses a frame shift to reassert the difference between his clinical expertise and the patient's lay role. The lecture frame (section 4.2.2, page 135) allows the psychiatrist to make general, authoritative claims relevant to the decision. The corresponding shift in footing reduces the patient's ability to influence. In line 31 the patient shifts back to the negotiation frame, this time to give his assent to the suggestion.

As extract 4.16, and the other examples of negotiation show, while the frame makes explicit space for agreement or disagreement, the power imbalance also allows the lead to push for her preferred outcome by not allowing the negotiation to end earlier, or by moving the decision into a more power imbalanced frame. The variety of techniques used by speakers, particularly patients, to achieve the agreement of the other party is discussed in more detail in Chapter Five of this thesis. In Chapter Six, I also consider how the power balance may be changed by the presence of a third party that can be called upon to form alliances with either party.

Directing frame

Footing: Director (typically psychiatrist) and directed (typically patient)

Direction is often used to bring to a close a negotiation frame by indicating that a decision has been made and no further discussion of the decision is required. In this data the director is always the psychiatrist. Direction is possible only because of the authority one participant has to direct another. The directed patient, within this frame, is expected to agree to the direction, or may clarify or seek further information. The use of directing does not, however, necessarily imply coercion. Generally, directing is used by a psychiatrist only once agreement has been reached (or believed to be reached), such that the patient's agreement is considered likely.

A fairly typical example of directing is shown in extract 4.17. Prior to this extract there was a period of negotiation in which the patient stated that they had previously had psychological therapy but not found it helpful. In the opening of this extract, the psychiatrist indicates that the patient's view had been considered, but he shifts the talk to show that he is now indicating what he *will* do, rather than seeking the patient's opinion. The patient follows the frame shift by agreeing throughout with minimal responses.

Extract 4.17 (consultation 01)

- 1 Doctor: [⌈]Now let me (1.0) I'll make the referral anyway and
- 2 discuss it with the psychologists and (1.2) tell them your point of
- 3 view about the therapy. Erm, and but the person, who (1.4) er
- 4 considers your referral will probably discuss it with [Name],
- 5 because he-he-he's the kind of, he's actually the head of the
- 6 Psychology Department
- 7 Patient: [⌋]Oh right

Frame shift - Directing
frame

- 8 Doctor: *Erm they'd want to discuss it with him to kind of get his*
 9 *view. But, but I'll put very clearly across to them the fact that you're*
 10 *looking for something that's much more active*
- 11 Patient: *Yeah*
- 12 Doctor: *and what you specifically want, is to be able to work though*
 13 *those early experiences you had and try and sort of (0.5) put them*
 14 *into (a) place in your mind. That's what you're looking for isn't it?*
- 15 Patient: *[in overlap] Yeah, yeah*
- 16 Doctor: *Erm (1.2) okay. So we'll take this dual approach. With the*
 17 *medication what I suggest is you're taking, if you're taking fifteen*
 18 *milligrams one-five milligrams*
- 19 Patient: *Yeah*
- 20 Doctor: *once a day*
- 21 Patient: *Yeah*
- 22 Doctor: *I'd like to suggest that you, switch to ten milligrams twice a*
 23 *day (1.2)*
- 24 Patient: *Right*
- 25 Doctor: *((in overlap)) which is an increase from fifteen to twenty*
 26 *(0.7) initially (1.0). And what we'll then do is is (0.9) I'll meet you in*
 27 *a couple of weeks (0.8). We can, I can hear whether it's been*
 28 *helpful at all. Er and then we ca-can consider whether increase the*
 29 *dose (0.6) any further. Is that alright?*
- 30 Patient: *Mm hmm*

The use of pronouns is often marked in this frame. The psychiatrist uses phrases like "I'll make the referral", "we'll take", "I suggest". These are very direct phrases, using "I" or "we" to

indicate that the psychiatrist is the - or a – principal actor in the decisions being made. The use of ‘we’ here differs from that used in the lecture frame (section 4.2.2, p.135) where it is used to encompass the psychiatrist as part of a wider profession rather than as part of a doctor-patient alliance. In doing so, “we” can either decrease or increase distance between speaker and hearer. This idea of ‘inclusive’ and ‘exclusive we’ has been applied in other contexts, including in academic writing (Hyland, 2001), and in clinical settings (Coupland & Coupland, 1998). There is further discussion of how “I”, “you” and “we” are used in section 5.1.4, p.199.

A further example of directing occurs in extract 4.18 and follows a similar pattern. Again, the psychiatrist uses ‘I’ and ‘we’ (lines 1-2). The psychiatrist repairs his utterance in line 1, apparently rephrasing what was initially a suggestion – “Can I” - into a direction – “I think what you need”. The patient again offers minimal, compliant responses to indicate assent to the directions throughout.

Extract 4.18 (consultation 03)

- 1 *Doctor: Okay. Can I- I [↑]I think what you need now is is a, stable*
- 2 *period. So, we make no changes to medication*
- 3 *Patient: [↑]Okay*
- 4 *Doctor: erm, keep you as you are over the Christmas period*
- 5 *Patient: Yeah*
- 6 *Doctor: and, shall we meet in about eight weeks, after*
- 7 *Patient: Yeah*
- 8 *Doctor: after Christmas?*
- 9 *Patient: Yeah*

Frame shift - Directing

As with the Interview frame, the Directing frame provides the psychiatrist with a means to control the structure and timing of the consultation. The frame draws negotiation to an end

and moves the talk along. It also serves to reinforce the authority of the psychiatrist by allowing her to sanction the final decision, even if it was reached through negotiation with the patient.

Advice-giving frame

Footing: Advice-giver and advice-recipient

Advice-giving often follows Troubles-telling frames, as discussed in previous work by Jefferson and Lee, who have demonstrated the potential difficulty of moving between these two frames and their corresponding troubles-recipient and advice-giver roles (Jefferson & Lee, 1988). In these psychiatric consultations, the troubled participant is always the patient, and the advice-giver role correspondingly tends to fall to the psychiatrist, or occasionally a third party in the interaction, as discussed in Chapter Six. An exception to this norm is discussed in Chapter Five where patients use an advice-giving frame to make treatment recommendations.

Advice-giving is distinct from directing because the role of 'troubled' participant does not place the same degree of expectation on the patient to accept the advice in the way that the 'directed' role does. Typically, in an advice-giving frame, the 'troubled' participant acknowledges the advice but may accept, reject or indicate further consideration of it.

Within the interaction, advice-giving can act to bring troubles-telling to an end, or to shift possession of the floor. Like directing, advice-giving may also have a larger goal of influencing the troubled participant to take a course of action. Notably, advice-giving is used where directing may be inappropriate due to the topic of the conversation, e.g. marital advice, as opposed to medication advice. Taking a position as director in relation to topics where such a role is not institutionally legitimised may lead to frame dispute. Equally, advice-giving can be used to provide a mitigated way to influence than directing. By allowing space for the other

participant to reject the advice, it can be a way to ascertain the participant's willingness to follow the suggestion and to invite shared-decision making.

Extract 4.19 shows a situation where 'directing' would be inappropriate. The psychiatrist cannot claim authority to direct the patient since there is "no bar" on the patient driving.

Extract 4.19 (consultation 02)

1 Doctor: <i>But I but I wonder whether your (1.1) anxiety</i>	Advice-giving frame
2 Patient: <i>((in overlap)) –anxiety, hm</i>	
3 Doctor: <i>means that your-your concentration at the moment is up to</i>	
4 <i>driving</i>	
5 Patient: <i>Mm yeah</i>	
6 Doctor: <i>Erm</i>	
7 Patient: <i>Mmm</i>	
8 Doctor: <i>so I would s-, I-I I'm not s-, you know I'm not, there's no</i>	
9 <i>bar on you</i>	
10 Patient: <i>Mm</i>	
11 Doctor: <i>driving on that dose of Amytriptolene but I think while</i>	
12 <i>you're feeling this kind of, jittery</i>	
13 Patient: <i>Hm yeah. That's what it is</i>	
14 Doctor: <i>((in overlap)) th-tha- that you might for your own safety</i>	
15 Patient: <i>Mm, hm</i>	
16 Doctor: <i>erm</i>	
17 Patient: <i>Mm</i>	
18 Doctor: <i>just not drive until you're better</i>	
19 Patient: <i>((in overlap)) Mm yeah</i>	
20 Doctor: <i>(1.5) [⌈]But erm (1.7) you're making a distinction between</i>	Frame shift – Interview frame
21 <i>the feelings of (0.9) anxiety and jitteriness and the</i>	
22 <i>depression</i>	

Advice-giving is generally offered more tentatively than directing. This can be seen in the corrections and hesitations throughout (lines 6, 8, 14 and 16). This hesitancy underscores what Goldsmith describes as the 'face-threatening' nature of advice-giving (Goldsmith, 1999), drawing on Brown and Levinson's (1987) idea of 'face threatening acts' or FTAs. Goldsmith draws a distinction between contexts of advice-giving, whereby advice given by a supervisor may be deemed appropriate, while the same advice offered by a friend may be perceived as 'butting-in'. In these consultations, the legitimacy of the psychiatrist's position in relation to advice-giving is explicitly oriented to, through the psychiatrists' hesitancy, their circuitous approach, and ultimately through their open acknowledgement.

The patient in extract 4.19 – who later in the consultation indicates more clearly that he does not intend to follow this advice – acknowledges the psychiatrist's suggestion but does so in a way that is non-committal. In contrast to extracts 4.17 (p. 140) and 4.18 (p. 142) in which the patients use 'yeah' and 'Okay' without hesitation, here the patient uses 'mm hmm' as a neutral response which does not indicate assent. The psychiatrist does not push for agreement, or for a commitment to follow the advice as he might in a negotiation frame, but instead he shifts the frame following a pause in line 20.

The sequence of extracts 4.20 to 4.22 are all taken from the same consultation and follow a similar pattern to that seen in 4.19. In this case the advice relates to a family dispute, a personal topic that again is explicitly stated to be inappropriate for psychiatrist direction. Similar techniques are used as those seen in extract 4.19: the psychiatrist provides the advice tentatively; he provides reasoning for his advice; he generalises the situation (extract 4.21, lines 1-2) to provide authority for his advice; and he acknowledges that he does not have the right to insist on the advice being followed (extract 4.22, line 1). In extract 4.22 the patient openly refuses the advice offered.

The sequence here reinforces Jefferson and Lee's argument that when a participant moves into the role of 'advice-giver', she requires the other party to move into the role of 'advice-recipient' (Jefferson and Lee, 1981). Part of the work-up to advice-giving is for the speaker to "take a *circuitous*, rather than *straightforward* interactive pathway" in which advice-givers "first elicited the interlocutors' perspectives on the discussed matter and then fitted their ideas or advice into the offered information" (Couture, 2007: 333). This is what we see at the start of extract 4.20.

Extract 4.20 (consultation 07)

1 Doctor: H-how're gonna break the dead-, how'ya gonna break the	Troubles-telling frame
2 deadlock?	
3 Patient: It's not my fault [laughing] he sold the car to [Name]. I	
4 mean i-it wasn't my car	
5 Doctor: ^{lf} But it might not be your fault but she obviously feels, she	Frame shift – Advice-giving
6 obviously feels upset	
7 Patient: [in overlap] (1 word unclear)	
8 Doctor: That's right. Um and she's probably thinking 'I'm not	
9 phoning her (3 words)'	
10 Patient: [laughs]	
11 Doctor: So one of you's got to, you're like, you know you've got to	
12 crack	
13 Patient: [in overlap] (1 word unclear)	
14 Doctor: don't you. And erm (1.3) it's not necessarily a question of	
15 admitting, that you're at fault but it might, i-it someo- one of you's	
16 got to break the ice	
17 Patient: Yeah well I'm not going to this time	

In extract 4.21 the doctor uses techniques to influence the patient and reinforce the legitimacy of his position as advice-giver. In lines 1-2, he describes having seen similar situations in the past, emphasising his authority through experience and knowledge. In lines 16-17 he brings the problem into his realm of authority by associating it with mental health problems previously described.

Extract 4.21 (consultation 07)

1	<i>Doctor: But I've seen I have seen these sort of fairly minor</i>	Advice-giving frame
2	<i>arguments lead to people not talking to each other for a very long</i>	
3	<i>time. Somebody's got to-</i>	
4	<i>Patient: Mm</i>	
5	<i>Doctor: -try and er take the first step (c3 words)</i>	
6	<i>Patient: ((in overlap)) Well I thought I'll wait till Mothers' Day and</i>	
7	<i>see if she gives me a present! ((laughing))</i>	
8	<i>Doctor: Well, the trouble is if she doesn't you'll be even more cross</i>	
9	<i>Patient: Ha ha!</i>	
10	<i>Doctor: and even less likely to phone her.</i>	
11	<i>Patient: Yeah ha</i>	
12	<i>[9 turns removed – querying the date of Mother's day]</i>	
13	<i>Doctor: I (thought of giving) you the phone now and see if you'd</i>	
14	<i>ring her</i>	
15	<i>Patient: ((laughing)) She's at work</i>	
16	<i>Doctor: (1.8) Oh honestly! (2.1) I really I-I really think that this is,</i>	
17	<i>I'm sure that this is, I'm sure this is making it, worse the problem</i>	
18	<i>(1.0) er cos you're you're both cross but also upset that you're not</i>	
19	<i>talking to your daughter.</i>	

Finally, in extract 4.22 we see the psychiatrist explicitly acknowledge that his position does not give him authority in relation to this subject. In line 3, the psychiatrist uses the conditional “If I were to give advice” to indicate that he is not in fact doing so. This strategy mirrors Brown & Levinson’s concept of ‘off-record’ talk, defined as “the avoidance of unequivocal impositions” (Brown & Levinson, 1987: 2).

Extract 4.22 (consultation 07)

1 <i>Doctor: Okay (3.0). I ca- I can't meddle in family affairs</i>	Advice-giving frame
2 <i>Patient: No I know</i>	
3 <i>Doctor: but, but, if I was to give advice it would be that, that, that,</i>	
4 <i>someone of you (I think) one of you's got to break the ice, that you</i>	
5 <i>can't, you don't want to (be seen) to recover a family feud</i>	
6 <i>Patient: Mm</i>	

The tentative nature of the advice offered in these extracts is again shown by the psychiatrist’s hesitancy, with repetition and repair used in several places throughout (extract 4.20, lines 1, 5, 11 & 15; extract 4.21, lines 16-19; extract 4.22, lines 1 & 3-5).

In this consultation, as in extract 4.19, the patient rejects the position of advice-recipient: responses given are minimal; there is no further probing of the advice offered; and no commitment to follow it. In contrast, in extract 4.23 the patient orients himself to the role of advice-recipient.

Extract 4.23 (consultation 64)

1 Patient: This morning I got up at six and then I went back to bed 'til	Troubles-telling frame
2 about a quarter to nine and then I got up. I couldn't sit still for 5	
3 minutes. It's awful. A horrible feeling but	
4 Doctor: What, what did you do with yourself?	
5 Patient: I... I erm. What did I do? (2.5) Watched television (laugh)	
6 'cause I'm not, I'm staying with the parents at the moment, but I'm	Attempted frame shift – advice giving?
7 going to go home over the next few days, 'cause I think I'm better	
8 off getting used to my own surroundings.	
9 Doctor: $\overline{\text{F}}$ I think if you/	
10 Patient: $\overline{\text{F}}$ /'Cause there's a bit of pressure at home with dad getting	
11 annoyed because my mental state hasn't been too good but it's far	Troubles-telling frame
12 better than what it was so it isn't our fault, it's it's it's mine, because,	
13 because I should really be at home but I'm sort of hanging out.	
14 Doctor: it's not anybody's fault but it's difficult, it's difficult for you to	
15 live with first hand and difficult for them to live with second hand	
16 and it is going to put some strains on everyone $\overline{\text{F}}$ but I think it's	Frame shift – advice- giving
17 been, helpful that you've been able to be there and I think if you	
18 can, rather than just, the flat sit, just build it up and get used to	
19 having more time there	
20 Patient: $\overline{\text{T}}$ Yeah, you're right, I will do that. I think I'll go down	
21 tomorrow night and spend the night at mine and then come up	
22 Sunday for dinner or something like that. Yeah you're right.	

In lines 6-8, the patient incorporates potential solutions within his troubles-telling by suggesting that he would be better not being at his parents' house. In line 9, the psychiatrist appears to start a shift into an Advice-giving frame but is cut off by the patient, indicating that

the frame shift was not adequately marked or that the patient was not yet willing to shift out of the troubles-telling frame. The psychiatrist works up to offering advice by re-evaluating the problem in lines 14-16 in a way that saves face for the patient before making the suggestion that he tries to spend more time in his own flat. The patient actively accepts the advice (lines 20-22), perhaps facilitated by his earlier indication that this was his view.

Lecture frame

Footing: Expert (psychiatrist) and lay person (patient)

The lecture frame offers the possibility to impart generalised knowledge of relevance to the situation. In generalising, the knowledge is made impersonal. This has the effect of distancing the patient's 'expertise by experience' and emphasising the 'expertise by training'.

Depersonalising the claims can also be seen as a form of stake inoculation by reducing the potential for accusations of personal motivation or bias (Potter, 1996). The lecture frame heightens the power imbalance by claiming significance of professional knowledge for the decisions at hand, and emphasises that one party has this knowledge (expert) while the other does not (lay person).

The term 'lecture' is used here to emphasise specific characteristics of this frame. First, the power imbalance associate with the speaker making claims to expertise. The depersonalisation of this information mirrors that in an educational setting. The implicit assumption behind a lecture frame is that the speaker has privileged knowledge of the subject, over that of the lay person (hearer). Second, it reflects the speaker's ability to claim the floor through the lecture frame, just as a lecturer does through the interactional space afforded to a lecturer.

The lecture frame often forms part of a negotiation and is used to influence decisions. This frame creates an expectation that the lay person will not challenge the expert's claim. An example of this is shown in extract 4.24. The lecture frame is indicated by the generalised

construction of the information: references to what is usual or unusual, to 'people' (lines 1, 2, 6 & 13) in similar situations, and the presentation of information that might be controversial in other parts of the interaction as plain facts (e.g. "it is a delusion, I've got to say that").

Throughout this extract, the patient provides minimal and assenting responses, despite previous disagreements in the same consultation about the nature of the patient's symptoms.

Extract 4.24 (consultation 01)

- | | |
|--|-------------------------------------|
| <p>1 Doctor: ¹It's unusual because people'll have had, the-there are</p> <p>2 peo- a lot of people unfortunately who've had the experiences that</p> <p>3 you've had in early life (1.2). But not everybody's responded the</p> <p>4 way that you have</p> <p>5 Patient: No no</p> <p>6 Doctor: Some people are very damaged by this, but they don- they</p> <p>7 haven't developed these s- (1.1) what you and I think are strange</p> <p>8 beliefs</p> <p>9 Partner: Yeah</p> <p>10 Doctor: ((in overlap) erm, the beliefs that other people know what's</p> <p>11 happened to you</p> <p>12 Partner: Yeah</p> <p>13 Doctor: Er, people feel shame but it doesn't it doesn't manifest itself</p> <p>14 in the way that it does with you</p> <p>15 Partner: (Yeah)</p> <p>16 Doctor: which is that you-you kind of develop this (1.0) it is a</p> <p>17 delusion I've gotta say that. It's-it's-it's a belief that we don't share</p> <p>18 Partner: Yeah</p> <p>19 Doctor: that other people are talking about you. Erm</p> | <p>Frame shift - lecture</p> |
|--|-------------------------------------|

In lines 7-8 of extract 4.24 there is also an example of alliance building between the psychiatrist and the patient's partner. This technique is discussed in more detail in Chapter Six.

Extract 4.25 shows how lecture frames form part of a negotiation around medication changes. This exchange has many of the same characteristics as extract 4.24. The psychiatrist seeks the patient's permission to 'look things up', as he uses either book or online resources in the consultation. The use of written information adds both authority – it is institutionally sanctioned through being written and distributed widely – and neutrality (another form of stake inoculation as discussed previously). This neutrality is emphasised by the psychiatrist's use of 'they' (line 5) to refer to the authors of the text, thereby distancing himself from this expert perspective, perhaps to build rapport with the patient. He shortly moves to using the pronoun 'we', however - "we tend not to"; "we found that". In line 15 this is further underlined by use of professional terminology: "what we say, a low pro-convulsive effect". This shift allows him to lay claim to authority himself through membership of this expert group, and to use this authority in negotiation with the patient.

Extract 4.25 (consultation 50)

1 Doctor: Well I mean what I'll do, I'll just check. You don't mind me	Stage-direction frame
2 looking things up do you? Because we get new information all the	
3 time. Um.....	
4 (17 seconds pause - sounds of pages turning)	
5 Doctor: ¶ Now what they're saying with two or three other	Frame shift – Lecture
6 medications which are safer at causing seizures at causing fits, two	
7 of them are ones that we tend not to use so much because they	
8 cause more problems like shaking and (unclear) but one of them	
9 Sulpiride (unclear) a French drug which we used to use a lot before	
10 Olanzapine came along but we found Olanzapine was much	
11 more... we found that actually one might work better but um it had	
12 few side effects and was very successful so we tend not to use	

- 13 *Sulpiride so much now but there is a medication that I could*
 14 *recommend that, this is saying, it's got what we say a low pro-*
 15 *convulsive effect. That means it's got a low causing seizures effect,*
 16 *causing fits. But it's not saying it's without an effect. Yea?*
 17 *Patient: because I don't want to have any epilepsy again.*
 18 *Doctor: No*

4.2.3 Other frames

This final group of frames do not have the commonalities seen across information sharing and across influencing frames. They are also less common across the dataset than those discussed above. However, each has an important function in the interactions where they do occur.

Complaint frame

Footings: 'injured-party' and 'offending party'

There are very few examples of this in the data investigated here. Although the distal goal of a complaint may be to change the other party's behaviour, either to improve their own future experiences or those of others, the proximal, interactional goal is to seek an adequate response to the complaint from the offending party.

Complaining is a difficult frame to manage, in part because the injured party (who generally will have initiated the frame) requires the other participant to take on a less powerful or prestigious role in the interaction by accepting the role of offending party. In extract 26, the result of this goal orientation is for the injured party to seek to continue the frame until they have received a response they are happy with, while the offending party seeks to shift the frame. This is an example of a frame dispute, discussed in more detail later in this chapter.

Extract 4.26 comes from a consultation which is dominated by the patient's complaint about the way in which her treatment has been managed. The psychiatrist notably avoids responding directly to the complaint, by attempting to shift the topic back to the patient's progress, rather

than the treatment that she is complaining about. By returning to the patient's reports of low energy (lines 22 & 25) the psychiatrist attempts to reassert his professional status in the interaction, rather than adopt the diminished status which the patient requires. The patient resists these attempts (lines 24 & 27).

Extract 4.26 (consultation 57)

1 Doctor: Er [Name] told me that you feel you have enough energy	Interview frame
2 now is that right?	
3 Patient: Erm, well no not everything is OK because I don't think it's	
4 levelled out properly and erm there's sometimes when I feel the	
5 Risperidol's good but I don't know if it's enough actually. Because	
6 sometimes I don't feel – at first when I got it I felt kind of erm, it was	
7 good, and er all I know is somehow I seem to have some	
8 symptoms that are the same. Like, feeling tired sometimes, coming	
9 back at the end of the day. And I wondered if the level was levelled	
10 off properly and I need an increase. ¶The thing is I'm not gonna	Frame shift - complaint
11 hang around for another three months, six months, while you make	
12 me wait and erm tell me that you may give me an increase, or not	
13 Doctor: No, well there's no reason why you should do that	
14 Patient: Yeah but so far my experiences of everything, I felt like	
15 erm, that erm I had a lot of problems and you made me just all	
16 hang around. I'm not talking about you personally I'm talking about	
17 my actual care package. And er I didn't feel it was adequate and I	
18 felt you left me outside, yeah, to survive on my own quite ill. You	
19 know that, and I felt that you know it wasn't acceptable	Attempted frame shift – interview frame
20 Doctor: But you've done very well, you lost weight you know	
21 Patient: Well that that that's	
22 Doctor: ¶you were complaining of lack of energy, not got enough	
23 energy...	
24 Patient: †I'm not talking about that	

25 *Doctor: you seem a lot better since I've last seen you, six or nine*
 26 *months*

27 *Patient: † Yeah yeah I know but the process, I'm talking about the*
 28 *process. Sometimes it would be nice if you were given a little bit of*
 29 *support at the end. I had to go through that process without any*
 30 *support hardly. You know the support that I got was actually just*
 31 *checking up to see that you were still alive*

32 *Doctor: Hm*

33 *Patient: Do you think that – when you asked me how do I cope and*
 34 *I said to you I don't know whether to laugh or not? I don't know*
 35 *whether to laugh, I think it's kind of, incredibly that's you know me*
 36 *there deteriorating. And at the end of the day, yes weight is a good*
 37 *loss at the end of the day I'm not complaining about that, that's one*
 38 *good factor.*

39 *Doctor: Yeah, † OK, can we weigh you?*

Complaint frame

Stage Direction

The difficulty of making a complaint is marked in this extract, despite the clear imperative for the patient to have her concerns heard and acknowledged. This can, in particular, be seen in the patient's statement at line 16-17 that she is 'not talking about you personally'. Despite this, she uses 'you' – whether collectively or individually - throughout the complaint. This depersonalising of complaints is less challenging to the deference performances expected of the patient towards the psychiatrist (cf. Goffman, 1967), and a similar technique is seen in extract 4.27.

The example above is unique in this data in being a strong complaint that dominates the interaction. In other cases patients may shift into a complaint frame over a specific aspect, as in extract 4.27, which concerns the patient getting access to their own medical records. The

patient's reference to 'they' (rather than 'you') 'messaging me about' suggests his own speculation that *someone* may be to blame for the situation without directly accusing the psychiatrist. The psychiatrist aligns with this distinction in lines 9-12.

Extract 4.27 (consultation 80)

1 <i>Doctor: So when did you make, when did you contact medical</i>	Interview frame
2 <i>records about it?</i>	
3 <i>Patient: About a month or two ago, ¹⁷I hope they're not messing</i>	Frame shift - Complaint
4 <i>me about, I'll make a complaint.</i>	
5 <i>Doctor: Right, because I've not, I've not got anything here</i>	
6 <i>actually. I don't remember seeing anything.</i>	
7 <i>Patient: Well how long's it going to take? What's going to happen</i>	
8 <i>now? (unclear) I need to see my medical records.</i>	
9 <i>Doctor: What I can do [Name] is, I will contact medical records</i>	
10 <i>after our meeting and ask them if they have received an enquiry</i>	
11 <i>from you and if they're going to be making a formal request from</i>	
12 <i>me. Because I have to say I haven't got anything here, I don't</i>	
13 <i>remember seeing anything.</i>	
14 <i>Patient: No, they should have done, unless they've messed me</i>	
15 <i>about.</i>	
16 <i>Doctor: Right.</i>	

In contrast to extract 4.26, the psychiatrist does accept the shift into a complaint frame and seeks to fulfil the interactional requirement by responding to the complaint with a plan to address it.

‘Stage Direction’ frame

Footing: Stage director and follower

This specific form of direction allows the stage director to manage the activities and interaction at the micro-level within the consultation. Once again, the stage director is always the psychiatrist in this data, indicating their authority in the physical setting of the consultation, akin to the authority of a host towards a guest. The frame is primarily functional, being used to achieve local activity within the setting, for example getting the patient onto weighing scales or managing entries and exits. Like the directing frame, however, the right to issue stage directions and the expectation that the other will follow them, is part of the doctor’s performance, marking the ‘asymmetry of know-how’ (Heritage, 1997) about the way in which things are to be done in the local setting.

Much stage direction may be done through non-verbal cues, such as the psychiatrist’s use of props or gesture. Since I only have audio recordings, the visually indicated stage direction is missing from this data, and as such I am limited to those verbal cues which form the stage direction frame.

The pattern of this frame is in some sense similar to that of the directing frame. The directed party is expected to acquiesce with the direction which is generally given only within the bounds of what would be an expected direction following a preamble to indicate that a decision has been made that results in the direction given. The distinction between directing and stage directing is that the latter relates to the performance in the situated encounter itself, rather than to the patient’s behaviour outside this encounter. In extract 4.28, for example, the psychiatrist’s directions – ‘take your shoes off and your coat off’, ‘jump on the scale’ – are acceptable because agreement to be weighed has already been attained, and these directions follow from that agreement.

Extract 4.28 (consultation 16)

1	Doctor: Shall we give it a ... $\overline{\text{F}}$ take your shoes off and your coat off	Frame shift – stage direction
2	and step on the scales. Ah, I've lost track of things $\overline{\text{F}}$ are you due	
3	for a blood test?	Frame shift – interview
4	Patient: $\overline{\text{T}}$ Probably.	
5	Doctor: Yea – $\overline{\text{F}}$ let me bring the scale here, hang on. Right, go on,	Frame shift – stage direction
6	jump on the scale.	

In extract 4.29, the psychiatrist's initial stage direction is not recognised as such, and the patient fails to orient to the frame by not taking up the direction. In line 3, therefore, the psychiatrist has to reinforce the direction more bluntly.

Extract 4.29 (consultation 04)

1	Doctor: $\overline{\text{F}}$ Do you want to go downstairs get a cup of tea? (0.9)	Frame shift - Stage direction
2	Patient: $\overline{\text{T}}$ I'm alright thanks	
3	Doctor: (in overlap) You're okay. You-you wait downstairs, and I'll	
4	I'll need to see someone first, then I'll make the um, I'll make the	
5	phone calls and make all the arrangements	
6	Patient: $\overline{\text{T}}$ Alright	

Informal frame

Footing: Conversants

The informal frame is identified by Ribeiro as a ‘non-institutional frame’. In these frames the patient “performs (and is ratified in) her non-official social identities” (Ribeiro, 1994: 78). By using these frames, the participant is able to evoke identities beyond that of ‘patient’, for example parent, student, friend. In doing so, they initiate a change in footing between participants.

The informal frame may be initiated by either patient or psychiatrist to step outside their institutional roles and adopt another role from their identities. This has the effect of playing down the power imbalance. One way in which this is done is through enquiries about the psychiatrist’s health. Within the typical doctor-patient interaction, the patient is not expected to enquire about the psychiatrist’s family and personal life (though the psychiatrist can legitimately ask the patient). Goffman discusses this type of enquiry in relation to deference performances; in displaying deference, speakers of lower status generally avoid behaviours that may be seen as a breach of privacy:

To ask after an individual’s health, his family’s well-being, or the state of his affairs, is to present him with a sign of sympathetic concern; but in a certain way to make this presentation is to invade the individual’s personal reserve, as will be made clear if an actor of wrong status asks him these questions (Goffman, 1967: 73)

By making such enquiries, the patient therefore acts outside the deference performance and adopts a more equal and personal footing. In extract 4.30, for example, the patient enquires after the psychiatrist’s health in the opening of the consultation, the reverse of the typical opening.

Extract 4.30 (consultation 95)

- | | |
|---|-----------------------|
| <p>1 Patient: \overline{F} OK. How are you been anyway?</p> <p>2 Doctor: \overline{T} I'm fine thank you.</p> <p>3 Patient: I bet you're stressed out. This weather's not very...</p> <p>4 Doctor: It's very dreary today isn't it?</p> | Informal frame |
|---|-----------------------|

The informal frame most often occurs at the beginning or end of the consultation. It may also be done to fill time while another activity is taking place. For example, in extract 4.31 the patient initiates the shift into an informal frame while the psychiatrist is writing out a prescription. In this extract, both participants step outside their institutional roles and adopt personal ones.

Extract 4.31 (consultation 06)

- | | |
|---|---|
| <p>1 Patient: \overline{F} Did your Christmas go alright?</p> <p>2 Doctor: \overline{T} Yeah it was it was good quite</p> <p>3 Patient: Good</p> <p>4 Doctor: ((tears off prescription)) lots of, lots of family came for</p> <p>5 Christmas</p> <p>6 Patient: ((in overlap)) Oh lovely</p> <p>7 Doctor: ((in overlap)) so it was quite a quite busy time</p> <p>8 Patient: ((in overlap)) That's what it's all about isn't it?</p> | Frame shift –
personal frame |
|---|---|

This supports Goffman's argument that "there will be a kind of backstage period before the activity begins and after it is over. Individuals are not merely out of role at these times, but they are unguarded in ways they won't be as soon as the activity proper begins" (Goffman,

1974: 466). While it may be ‘unguarded’ it does not seem to be unconsidered. There are many reasons why participants might make use of this ‘backstage period’ to step outside their institutional roles, for instance to build rapport between the participants, to establish a more equal footing, or to project a preferred self-presentation that may be hard to project while in the patient role. These spaces in the interaction which are less confined to institutional goals may offer the opportunity for such presentations while other parts do not.

4.3 Frame shifting and keying

In Chapter Three I described Goffman’s concept of keying and the corresponding shifts in participant footing which are initiated through keying. As seen in the extracts above, by keying activity, participants can vacate the role required by the previous frame and move into a new role through which they can pursue different activities and aims.

In the following section I briefly identify some basic markers which indicate a move – or an attempted move – into a new frame, and a corresponding shift in footing between participants. Schiffrin argues that when used in this sense, markers form a type of contextualization cue, as discussed in Chapter Three (Schiffrin, 2008). Markers, such as ‘now’, ‘alright’, and ‘OK’ (see for example the start of extract 4.30) have been shown by Schiffrin and others to have a multitude of purposes, including as ‘brackets’, a concept which Goffman uses in his work:

“These markers, like the wooden frame of a picture, are presumably neither part of the content of activity proper nor part of the world outside the activity but rather both inside and outside” (Goffman, 1974: 502)

As well as spoken brackets (e.g. “kidding aside”), Goffman identifies ritualised brackets like the banging of a gavel at the start of a meeting, and spatial brackets, such as the stage, or a psychiatric consultation room. In this audio-only data, it is not possible to accurately identify most of these non-verbal brackets, though the switching-on of the recording device is one such

bracketing activity. As a result, some of the bracketing which is probably occurring in these consultations is not fully captured. However, there is evidence of how spoken brackets are used in marking the beginning and end of frames and in negotiating a shift of frame.

4.3.1 'Natural' and 'negotiated' frame shifts

Extract 4.32, taken from the same consultation as extract 4.26, shows two shifts by the psychiatrist (lines 5-6). The extract begins in a negotiation frame, with the psychiatrist taking a lead position. As described above, the negotiation frame is characterised by its goal of reaching agreement on the issue in question, in this case an increase in the medication. Having attained agreement, the psychiatrist shifts into a directing frame. This shift is characterised by the presentation of two options, both of which involve an increase in medication. The psychiatrist still uses 'we', indicating that this is a joint activity. However, before the patient can ratify this realignment, the psychiatrist immediately indicates a shift into the lecture frame, where the dominance of his expertise alone is marked by use of "I" (line 6).

Extract 4.32 (consultation 57)

1 Doctor: I'm not asking you to remember, talk about now, today – do	Negotiation Frame
2 you, do you think that you would benefit from an increase in your	
3 medication or not?	
4 Patient: Yes I do, or something, yeah	
5 Doctor: ¶ Alright. Now, erm we can either increase your	Frame shift – Directing
6 Carbamazepine or we can increase your Risperidone. ¶ Now can I	Frame shift - lecture
7 talk about the pros and cons of each? Generally for people who are	
8 bi-, suffer from bi-polar illness erm, most people manage to get	
9 away with just being on Carbamazepine. Most people don't need	
10 both.	

Both frame shifts are indicated using 'now' as a discourse marker. In line 5 one frame is brought to a natural conclusion and another is opened. The conclusion of the negotiation frame is emphasised by the psychiatrist's 'Alright'; the start of a new frame is indicated by the psychiatrist's 'Now'. The frame shift is relatively straightforward and is unlikely to meet with opposition from the patient because his agreement in line 4 was the immediate goal of the negotiation. This type of shift may be termed a 'natural' shift; after a frame has reached a successful conclusion, with the interactional goals of the frame achieved, a new frame must open for the interaction to continue. The term 'natural' is used to highlight the unforced nature of the shift. This does not mean that the shift is undirected; participants must still manage the shift, but both participants acquiesce in the closing of one frame and the opening of another.

In contrast, the shift into the lecture frame is not a 'natural' one. The patient has not ratified the shift into the directing frame and nor indicated acquiescence with the direction given; the goal of the directing frame has not yet been achieved. The psychiatrist's move into a lecture frame, though not inconsistent with the task at hand, requires additional marking to acknowledge the rapid shift and to secure the patient's co-operation. This is seen in the psychiatrist's request in lines 6-7 – "Now, can I talk about the pros and cons of each?" The request serves to reference the performance and to change the patient's alignment to his statements. Instead of being required to agree or challenge the psychiatrist's direction, the patient is now required to grant an extended turn to the psychiatrist. The use of the generalised information given in the lecture frame makes it difficult for the patient to challenge.

In this particular example, the extract should be considered in the context of the preceding exchanges (see extract 4.26 and extract 4.37), in which the patient has made an extended complaint and the psychiatrist has sought to regain control of the interaction by shifting the

frame on a number of previous occasions. The rapid shift may be a deliberate attempt to reduce the opportunity for the patient to reject the realignments proposed.

These two types of frame shift are seen in a number of contexts and the distinction between the ‘natural’ and the ‘negotiated’ frame shift is a useful one in understanding the collaboration of participants in the interaction. The terms ‘natural’ and ‘negotiated’ are used to emphasise the distinction between these two, though negotiated shifts may be relatively straightforward or strongly contested.

4.3.2 Natural frame shifts

As in extract 4.32, natural frame shifts occur when the goal of the previous frame is felt to be achieved and a new goal can be attended to. Extract 4.33 shows another straightforward shift from Interview – where the psychiatrist gathers information required from the patient to complete a blood test form – to Informal frame (line 7).

Extract 4.33 (consultation 02)

1 Doctor: And you go to [Hospital A] or [Hospital B]? Which is the	Interview frame
2 most convenient	
3 Patient: ((in overlap)) [Hospital A]	
4 Doctor: Okay	
5 (18 second pause. Rustling of paper as Consultant completes	
6 blood test form)	
7 Doctor: \uparrow Have you got your Christmas plans made?	Frame shift - Informal
8 Patient: $\overline{\uparrow}$ Yes, we're going to my daughter's.	

Having completed his questions, the psychiatrist uses a closing bracket ('okay') to mark the end of that task and move to the next. The pause while the psychiatrist completes the form acts as a marker in itself, and so does not require an additional opening bracket.

Markers such as 'now', 'alright' and 'so' are commonly used as opening brackets to indicate natural frame shifts, particularly following a brief pause. In the following example, the patient opens the consultation saying that he has increased his medication dose and is doing better.

The doctor responds by asking further questions about how the patient feels, before turning to the decision about medication (line 10).

Extract 4.34 (consultation 03)

1 <i>Doctor: And how's your energy, has that returned a bit?</i>	Interview frame
2 <i>Patient: Erm it's not too bad, y'know, Erm I get a lot of help off, off</i>	
3 <i>erm (1.1) [Name's] Dad. He helps me still quite a lot around the</i>	
4 <i>house. 'Cause I hate to think of, about what I would be like if he</i>	
5 <i>wasn't helping me</i>	
6 <i>Doctor: Mm</i>	
7 <i>Patient: around the house, y'know</i>	
8 <i>Doctor: He-he's in every day isn't he just about?</i>	
9 <i>Patient: Yeah</i>	
10 <i>Doctor: Yeah. (1.4) ⌈ Now you say you've increased the dose to,</i>	Frame shift - negotiation
11 <i>six- to three a day</i>	

Natural endings of particular frames can sometimes be manoeuvred by participants to facilitate a shift in alignment. This is most clearly seen where psychiatrists work to close a patient's narrative and regain control of the interaction by offering the evaluation before the patient reaches it (see above re Narrative frames). In extract 4.35, for example, the patient's narrative is brought to an end by the psychiatrist summing up the narrative's central point,

“that family ties are stronger than that”. The participant’s agreement and the subsequent pause allows the psychiatrist to shift into a new frame (in this case ordering a blood test).

Extract 4.35 (consultation 06)

1 <i>Patient: I was frightened erm, if I would get rejected from ‘em or</i>	Narrative frame
2 <i>anything and erm</i>	
3 <i>Doctor: No, and you discovered that that family ties are stronger</i>	
4 <i>than that</i>	
5 <i>Patient: Yeah (6.0)</i>	Frame Shift - Stage direction
6 <i>Doctor: ^{lf}Let’s have a look (paper rustling)</i>	

4.3.3 Negotiated frame shifts

Negotiated frame shifts occur when the realignment is a less obvious one. In these cases, the bracketing of the shift becomes more emphasised: “Bracketing becomes an obvious matter when the activity that is to occur is itself fragile or vulnerable in regard to definition and likely to produce framework tension” (Goffman, 1974: 255). Examples of such a shift were seen in the transitions to Narrative frames in extracts 4.8 and 4.9. In the latter, the psychiatrist explicitly invites to the patient to tell their story, going so far as to start them off on their account. The patient responds with an orientation statement, “Well, it started years ago”, a stereotypical narrative opening that demonstrates alignment with the proposed frame.

A similarly marked narrative opening is seen in extract 4.36, where the patient uses ‘Right’ as a marker of the frame shift. Here, the doctor has been asking the patient about alcohol use, and then about current prescriptions. Here the shift to the narrative frame is initiated by the patient who, in doing so, deviates from the usual expectations of an established Interview frame. She uses an opening statement which both forms part of the narrative and acts as a boundary marker to emphasise the shift to the story-telling realm (Young, 2004).

Extract 4.36 (consultation 59)

1 <i>Doctor: Are you on any other medication apart from the</i>	Interview frame
2 <i>Olanzapine?</i>	
3 <i>Patient: yeah</i>	
4 <i>Doctor: what else are you on?</i>	
5 <i>Patient: Calpoldimol</i>	
6 <i>Doctor: Calpoldimol. OK, what do you take that for?</i>	
7 <i>Patient: ¶ Right. Last year about summer time I started</i>	Frame shift -
8 <i>experiencing a throbbing pain in my pelvic area</i>	
	Narrative

4.3.4 Unsuccessful frame shifts

In a number of cases, attempts to shift the frame are unsuccessful, leading to a frame dispute in which participants are not aligned to each other's footing. Examples of this kind of unsuccessful shifting were seen in extract 4.6 and extract 4.7 above, where patients attempt to move from an interview frame to a troubles-telling one. In those instances, the psychiatrist does not realign to the requested footing, in which he would give the patient the floor to steer the interaction, but instead he retains control by going back to the interview frame.

In extract 4.37, taken from a consultation discussed earlier in this chapter (extract 4.26), the psychiatrist attempts to shift the frame away from the complaint being made by the patient. Here, the complaint frame has not achieved its interactional goals. Equally, the psychiatrist does none of the additional work seen in extract 4.8 to seek permission to shift the frame, though he does use brackets ('yeah' and 'OK').

Extract 4.37 (consultation 57)

1 <i>Patient: Do you think that – when you asked me how do I cope and</i>	Complaint frame
2 <i>I said to you I don't know whether to laugh or not? I don't know</i>	
3 <i>whether to laugh, I think it's kind of, incredible that you know me</i>	
4 <i>there deteriorating. And at the end of the day, yes weight is a good</i>	
5 <i>loss at the end of the day I'm not complaining about that, that's one</i>	
6 <i>good factor.</i>	
7 <i>Doctor: Yeah, ¶ OK, can we weigh you?</i>	Attempted shift – stage direction
8 <i>Patient: ‡ But you know, erm, you know that I was probably gonna</i>	
9 <i>say these things. You know how could I not sit there all that time,</i>	Complaint frame
10 <i>nine months, the process that I went through, dumped in a flat and</i>	
11 <i>then mixed up with all my different medications. And then you tell</i>	
12 <i>me that take a prescription over the phone. I mean, are you</i>	
13 <i>allowed to do that? It's not even acceptable</i>	

In response to the attempted frame shift, the patient continues in her complaint without acknowledging the psychiatrist's question. The marker 'but' has been identified in previous studies as having multiple functions at the start of the turn, including as a display that one speaker is not aligned with another (Schiffrin, 2008). Here it emphasises that the patient is retaining the complaint frame despite the psychiatrist's non-alignment to it.

4.4 Frame breaks and 'out of character' talk

'Communication out of character' and 'out of frame' behaviours are described separately in Goffman's work, but the parallels between them are apparent from the way in which they are described. Goffman describes out-of-frame behaviour as follows:

"During the performance of any particular role, the performer will apparently have some right to sustain or fall back upon a self that is separate from the one relevantly projected. Role gives way to person." (Goffman, 1974: 272)

Communication out of character is described in Goffman's earlier work on self-presentation:

“while a performer may act as if his response in a situation were immediate, unthinking and spontaneous, and while he himself may think this to be the case, still it will always be possible for situations to arise in which he will convey to one or two persons present the understanding that the show he is maintaining is only and merely a show.”

(Goffman, 1959: 168)

For both definitions, discourse sustained within any setting is made up of performances negotiated within the rules of social interaction and occasionally, participants will fail to maintain these performances. Goffman describes various circumstances in which this communication out of character may occur, sometimes as a result of crisis and other times as a deliberate strategy. By ‘crisis’, Goffman is referring to ‘sudden disruptions of a performance’ (1959: 167); that is, happenings outside the person’s control, which make it impossible for them to sustain their part, perhaps because of an emotional reaction, or because something has come to light which undermines the performance, for instance the sudden realisation that a premise for the performance was incorrect, e.g. Goffman’s example of misidentification of another performer (1959: 167). An example which appears to be a reaction to a crisis is shown in extract 4.38 where the patient slips out of character in his reaction to the psychiatrist’s statement that he will be leaving the clinic.

Extract 4.38 (consultation 44)

- | | |
|---|--|
| <p>1 Doctor: ¶ Alright then now [Name] I’m going to tell you something.</p> <p>2 I’m leaving [Place].</p> <p>3 Patient: ¶ Oh my God.</p> | <p>Frame shift -</p> <p>Disclosure</p> |
| <p>4 Doctor: In the next few months or so, so when I next see you I</p> <p>5 won’t see you probably.</p> <p>6 Patient: Oh fucking hell.</p> | <p>Communication out</p> <p>of character</p> |
| <p>7 Doctor: ¶ Well there’s other psychiatrists out there.</p> <p>8 Patient: Yeah, but I’ve known you for years [Dr Name].</p> <p>9 [12 turns removed discussing patient’s notes]</p> | <p>Frame shift –</p> <p>Negotiation</p> |

10 *Doctor: It's just a different person you'll get to know them. And*
 11 *you'll know [Name], they'll have the notes.*
 12 *Patient: It takes a long time to get to know someone Dr [Name] and*
 13 *trust somebody. I trust you and I know you. I've got to start*
 14 *building that trust up again haven't I? 'Have you been drinking?' I'll*
 15 *say 'no', when I have. (Unclear) I'll say 'no' when I am. You know,*
 16 *it's just so shitty keep changing all the time, I'm going to miss you*
 17 *when you go, and it's as simple as that.*

The communication out of character is marked initially by the patient's reactions "Oh my god" and "Oh fucking hell". These forms of outburst are noted by Goffman as being "a performer's admission that he has momentarily placed himself in a position in which it is patent that no performed character can be sustained" (Goffman, 1959: 167). The communication out of character is further marked by the patient's declaration that he would lie to a new psychiatrist (lines 14-16). By making this admission, the patient highlights that the interaction he has had with the psychiatrist is a performance which he has sustained not only within the psychiatric setting but within the relationship with that particular psychiatrist.

Goffman does not argue, however, that these slips are necessarily beyond the participant's control, or that they reflect a more authentic identity than the role being previously performed. This form of communication out of character, where participants acknowledge the role that they are playing is merely a performance, occurs in a number of places through the dataset and the purpose of these 'slips' appears to be three-fold.

First, it acts as a form of 'team collusion' (Goffman, 1959: 174). By acknowledging the performative aspect of the interaction, a form of trust is established, in a similar way to the sharing of a secret. In extract 4.39, for example, the doctor and patient break into communication out of character to comment on her nervousness in the interaction, and

subsequently to comment on the ‘audience’, a member of the psychiatrist’s team who is present in the room.

Extract 4.39 (consultation 90)

1	Patient: ¶ No, but I do get nervous seeing you, so I [would]	Troubles-telling frame
2	probably be a bit over the top rather than under	
3	Doctor: Ok yep. Ok so why are you nervous seeing me?	
4	Patient: ‘Cause you’re a big chief.	Out of character talk
5	Doctor: ¶ Right, [spoken to member of psychiatrist’s team present]	
6	I hope you’re listening to this	
7	Patient: (laughs)	
8	Doctor: Doesn’t seem to have any effect on you	
9	Patient: They’re sensible. They don’t have transferences ³ and	
10	things.	
11	Doctor: That’s what they think	Troubles-telling frame
12	Patient: Well alright	
13	Doctor: ¶ Carry on. Issues you said you’ve got issues?	

³ ‘Transferences’ here refers to a psychological phenomenon in which feelings are redirected from one person to another.

This out of frame activity creates an alliance between patient and psychiatrist (the performing team) in contrast to the third party (audience), and to ‘de-construct’ the institutional power imbalance. A clear marker – “carry on” - indicates a return to the relevant frame and to ‘in-character talk’. A similar example was seen previously in extract 4.2 where patient and psychiatrist perform as a team for the audience of the absent researcher.

Second, comment on the interaction can allow speakers to distance themselves from institutional roles, particularly where those roles may be acting as a barrier to achieving goals

or to maintaining a desired footing, for example establishing rapport. In extract 4.40, taken from the same consultation as extract 4.38, the doctor distances himself from the institutional footing of the interview frame (line 5), excusing questions that might be intrusive in another context. The patient responds to this ‘out of frame’ talk by acknowledging the psychiatrist’s claim.

Extract 4.40 (consultation 44)

1	<i>Doctor: Any strange ideas or</i>	Interview frame
2	<i>Patient: No</i>	
3	<i>Doctor: feelings of being followed or watched or anything like that?</i>	
4	<i>Patient: Nothing like that Dr [Name], no.</i>	
5	<i>Doctor: No voices.</i>	
6	<i>Patient: No.</i>	
7	<i>Doctor: ¶ I have to ask these questions.</i>	Out of frame activity
8	<i>Patient: ¶ I know you do, yeah.</i>	

Thirdly, communication out of character may be used to comment on the interaction in a way that helps the speaker to control it. In extract 4.41, taken from the same consultation as extract 4.12, the patient’s communication out of character again reinforces that the patient is performing a role where they are expected to share relevant information and to seek appropriate guidance, the ‘good patient’ role described further in Chapter Five. Here, however, the patient indicates that this is a role that she cannot sustain without the use of her written notes.

Extract 4.41 (consultation 20)

- 1 *Patient: I've realised I won't be seeing you sort of like every month*
- 2 *or every week so I wanted to talk to you about*
- 3 *Doctor: Yeah*
- 4 *Patient: a few things*
- 5 *Doctor: Yeah yeah go on*
- 6 *Patient: I wrote them down*
- 7 *Doctor: Yeah go on*
- 8 *Patient: 'Cos it gives me, it helps me to follow, follow things*

Out of frame activity

This comment on the interaction provides the patient with an opportunity to justify the use of written notes as a form of script, something which is not a standard part of the patient role, though it is part of the psychiatrist's role. Furthermore, by laying out her intention to follow her notes, the patient attempts to take control of the interaction, to ensure that they address an agenda laid out by her.

4.5 Conclusions

I do not argue that the frames identified in this chapter are the only frames that occur in psychiatric consultations generally, or that all of the discourse can be neatly divided into these eleven 'types' of talk. The characteristics of these frames, which can be directly seen in the transcription, are those used by participants to understand what is expected of them within their interactional roles - for example, when a closed response is required and when to allow or take extended turns - not only in the consultation as a whole, but in the shifting segments of interaction;

I have demonstrated participants' ability to orient their talk to the structure of these frames, including the typical structure of narratives and negotiations, as well as to the participant rights and obligations inherent within them. Orientation to these frames is made possible because participants have an understanding of what frames might, and should, occur within a psychiatric consultation; they share 'background expectancies' (Garfinkel, 1967: 226).

Participants may have a harder time orienting to a 'practical joke' frame, or to a 'ceremonial recitation', since neither are frames that would be typical in this setting.

These frames have at least two functions: establishing footing between the participants, and orienting to a goal, whether proximal, distal or both. The footing undertaken by participants in a given frame may emphasise power imbalance or equality, reinforce expert status or foster co-operation. As a result, these frames are also about performing a 'face' and an identity; they demonstrate the type of doctor or patient - or person – that the speaker chooses to portray. Within the doctor-patient roles, characteristics may be downplayed to allow participants to emphasise other identities and forms of relationship. They also work to establish a performance team and to portray an identity within that team, sometimes emphasising their competence as a doctor-patient team, at other times sustaining more informal, or even more combative performances. The co-operation generally seen between doctor and patient to uphold the interaction order of the psychiatric consultation is marked. It is through this co-operation that smooth, effective interaction is made possible.

Beyond the collective goal of maintaining a smooth running performance, the goal orientation of specific frames allows speakers to shape the response of the other party through their shared expectations. This is seen in providing brief, direct responses to questions, securing extended turns for narration, and ending negotiations when agreement is reached. Orientation to these can help participants to achieve their personal goals, whether to alter medication, secure approval for a previous decision, or make a commitment to changing behaviour.

5. Performing ‘expert’ roles in psychiatric consultations

5.1 Legitimate roles in the psychiatric consultation: medication decisions

As the previous chapter showed, the consultations in this study provide evidence of how expectations about legitimate performance shape the behaviour of both participants. The patient and psychiatrist roles ascribed through framing do not provide equity when it comes to identity performances or control over the interaction. This was seen in the dominance of the interview frame, the work required by patients to negotiate space for narrative, and the imbalance in the frequency with which patients and psychiatrists took up lead footing in frames, including Advice-giving, Directing, Lecturing and Stage direction. The shared expectations of the clinical setting and specific frames demarcate ‘legitimate’ roles for each participant.

Orientation to legitimate roles can be most clearly seen where participants are acting at the edge of these roles, or where the role ascribed makes it difficult for either participant to achieve their intended outcome. At these points, boundary work – whereby participants challenge or defend the edge of their roles – helps to identify the understanding of where these boundaries lie (Foley, 2005; Young, 2004). This chapter demonstrates how participants manage these roles and constraints, particularly how patients’ performances of expertise and persuasion are negotiated within the boundaries of the patient role.

The powers to diagnose and prescribe medication are institutionally conferred on the psychiatrist (Ainsworth-Vaughn, 1995). Research into these activities supports a model in which

the doctor's authority is dominant and patients are expected to follow advice. Heritage and Clayman (2010) describe three important studies that support this conclusion: Byrne and Long's (1976) examination of diagnosis and prescribing interactions, demonstrating that the majority of these decisions are unexplained and unnegotiated; Heath's (1992) study of patient responses to diagnoses which uncovered considerable passivity in the face of doctors' decisions; and Peräkylä's (1998) conclusion that doctors balance their authority to diagnose and prescribe with a requirement to provide evidence or justification to patients for their decisions. Heritage and Clayman draw a distinction between *diagnosing*, which is perceived as requiring little collaboration between doctor and patient, and *treatment decisions*, where there is a greater need to elicit acceptance from the patient.

More recently, the role of patients in resisting decisions, or in self-management has received further attention (Heritage and Clayman, 2010; Koenig, 2011). Gill (2005), in her single case-study analysis, shows a sequence in which a patient subtly suggests the ordering of a diagnostic test and the doctor's response to this 'request'. Gill's analysis shows that patients do take an active role in initiating specific treatment and diagnostic decisions, even in primary care consultations. Stivers (2005) found that parents resist doctors' recommendations and even press for particular forms of treatment for their children.

In psychiatric consultations, where patients have often had previous experience of several different medications, patients do sometimes initiate discussions and indicate preferences about prescription changes. Across the 92 consultations, patients suggest changes to treatment in 16 and report autonomous changes in a further 12 instances (see table 5.1). Unfortunately, I do not have information about the length of time participants have been in psychiatric treatment, nor their medication history (section 3.6.3, page 104). In this chapter I outline examples of the interaction surrounding these medication decisions. First, I draw on extended sequences to demonstrate how patients 'work up' (Potter, 1996: 115) a category entitlement

that is more traditionally ascribed to the psychiatrist. Later in the chapter I explore some of the key features of these sequences in more detail.

Table 5.1

<i>Patient suggested changes to treatment...</i>	<i>N</i>
New or additional meds	5
Increase dose	1
Reduce dose	7
Seeking admission	2
Seeking other interventions	1
Patient reports changes already made	12

5.1.1 Patients as experts

By suggesting medication changes, patients move into a role more generally ascribed to a psychiatrist. One way for patients to do this is to take on a role of ‘advice-giver’ in relation to medication decisions.

Jefferson and Lee describe an appropriate Troubles-Telling Sequence segment as “a work-up initiated by the troubles-teller, and emerging as the logical outcome of a diagnosis offered by the troubles-recipient and concurred in [sic] by the troubles-teller.” (Jefferson and Lee, 1981: 408) In the situations they examine, the troubles-teller and the advice-giver are two distinct, ascribed roles. In the psychiatric consultation, however, we see occasions in which the patient is both troubles-teller and advice-giver, with the psychiatrist in a new role of ratifying - or not - the advice offered (advice-ratifier). Despite this difference, the sequence itself is broadly the same in these instances of patient-led medication decisions - troubles-telling; ‘diagnosis’ (used in a general sense as a conclusion reached from analysis of the problem, rather than in its

medical sense); advice as logical conclusion of the diagnosis – but the patient performs all parts. The patient thus strays into two roles traditionally performed by the doctor - offering a diagnosis and recommending a treatment – and runs the risk of being challenged for adopting either.

In extract 5.1 the patient introduces the need for assertiveness training. In a parallel to the troubles-telling sequence suggested by Jefferson and Lee, the patient does his own troubles-telling, diagnosis and advice-giving (lines 1-8). In this case, the proposed solution is not framed as a request by the patient, but as a rational conclusion following from his diagnosis of the problem as being caused by the previous “shock”.

Extract 5.1 (consultation 06)

- 1 *Patient: Erm (1.0) and what (with) (0.6) (I) I did snap at someone,*
- 2 *yesterday 'cause of the shock I received like you know? I feel like*
- 3 *erm, I was listening to, like last year I tried to get in on an assertion*
- 4 *course like assertiveness course. And I didn't have much luck like I*
- 5 *rung, Talkline and, I went to the library but I never quite found a*
- 6 *place that I could go along to and have assertiveness training you*
- 7 *know which I feel like I'm er I need really you know. Erm*
- 8 *(1.7)*
- 9 *Doctor: But the, you said you had a go at someone the other day.*
- 10 *Ta- t-tell, was that at work?*
- 11 *Patient: Yeah, (soon as I)*
- 12 *Doctor: ((in overlap)) (Tell me) what happened*

**Troubles-telling
frame**

At line 10, following a pause, the psychiatrist chooses not to accept the role of advice-ratifier but seeks further information about the event described instead. By doing so, the psychiatrist rejects the patient's adoption of the diagnostic role, though in fact, later in the consultation the psychiatrist does approve the patient's suggestion. This kind of sequence occurs in several consultations, with psychiatrists appearing unwilling to concede the diagnostic role to the patient.

Several of the consultations in this study suggest that patients approach suggestions about treatment cautiously, and are often reticent to make recommendations that might not be approved. I suggest that this reflects the interactional difficulty faced by patients when approaching a role boundary where they want to avoid either their suggestion – or, more importantly, their right to make such a suggestion – being rejected by the psychiatrist.

Extract 5.2 demonstrates this challenge. The patient's starting position is that he is happy with the medication as it is (lines 11-12). Nonetheless, the patient raises the question of reducing the medication in future and towards the end of the extract is open about that being his longer-term preference. Notably, discussion about reducing the dose is initiated by the patient after the psychiatrist has concluded, in agreement with the patient's initial stance, that it is "sensible to not rock the boat" (line 23). I have condensed the extract here for reasons of space.

Extract 5.2 (consultation 83)**Negotiation frame**

- 1 *Doctor: Well, let's just go back to thinking about the medication.*
- 2 *Just remind me again what you're on.*
- 3 *[list of medication and doses discussed]*
- 4 *Doctor: Yeah. OK. And you find that that works for you?*
- 5 *Patient: That's a good cocktail for me.*
- 6 *Doctor: OK, yeah. Do you think there's anything there in*
- 7 *particular that really completed it?*
- 8 *Patient: Well to answer your question with a negative first I don't*
- 9 *think the Depixol's helping me. It was taken away three years ago*
- 10 *and I got very ill. But I don't feel any different when I've had it on*
- 11 *Tuesday. But the new drugs, the modern drugs, the other two*
- 12 *have really helped me. I find Risperidone, I have the impression*
- 13 *that Risperidone raises my mood and Valproate stabilises it. I'm*
- 14 *more quiet and more stable nearly all the time. I've had no*
- 15 *depression for three years ever since I started on them.*
- 16 *Doctor: Well that's excellent.*
- 17 *Patient: And I, yeah I was getting dreadful long, long days of*
- 18 *going to bed depression for years and years before that. (unclear)*
- 19 *Doctor: So I hear what you say, you're very happy with this*
- 20 *combination. But on the other hand*
- 21 *Patient: It's a bit of a chore to take them all.*
- 22 *[...]*
- 23 *Doctor: Well all the time that you've been to see me which is over*
- 24 *the last year, things have been pretty steady haven't they. Patient:*
- 25 *Yeah.*
- 26 *Doctor: So it would seem sensible to not rock the boat.*

26 Patient: Yes. Dr [Name] talked, before she left of eliminating the
27 Depixol in the end. Because I actually was doing so well on the
28 modern drugs. But I'm in no hurry to do that even though I'm not
29 keen on it. I've been on it over thirty years or so.

30 Doctor: Yeah. Well that's fine.

31 Patient: I've been on much smaller doses at times, about 25 or
32 30mgs every month (**unclear**)

33 [...]

34 Doctor: I wondered why it should be that every week rather than...

35 Patient: It can be up to a month.

36 Doctor: Yeah it can be.

37 Patient: I'll leave that in your court, I'll do whatever

38 Doctor: Well I was going to say, you know, is that something that
39 you would like changed or would you rather leave it as it is?

40 Because I don't want to do something that you wouldn't be happy
41 with.

42 Patient: Well I'm easy. I've got no strong opinion, I mean I, if you
43 are a patient you, it can be a drug not taking drugs if you see what I
44 mean. Coming off your drug.

45 Doctor: Well at the moment I would be just thinking about
46 changing the timing.

47 Patient: Yes true.

48 Doctor: And not necessarily total dose. But like I say this is
49 something to think about, we could go ahead, we could just leave it
50 as it is.

51 [...]

52 *Patient: This was, when she took me off it three years ago that was*
 53 *the third time in thirty years that I've come off. The other two times,*
 54 *well once was with the agreement of my GP across there, I talked*
 55 *him into it, got very ill had a breakdown. And once was years ago*
 56 *at [Place] and I did it unilaterally and got very ill. So it's a thing to*
 57 *be done gingerly from my point of view for any actual reduction.*

58 *[...]*

59 *Patient: And then if you can get it down a bit absolutely I'd be*
 60 *pleased. Because it is a tranquiliser and I suppose at my age you*
 61 *can't expect to be so lively and alert and lamb like, spring lamb like*
 62 *as a twenty year old.*

63 *[...]*

64 *Doctor: ¶ Well what I would suggest is that we could make that*
 65 *change and just see how things go.*

66 *Patient: ‡ Then knock it down to 75?*

67 *Doctor: Yeah, maybe next time you come, see what you think. I*
 68 *can say I won't make any change if you're not happy.*

69 *[...]*

70 *Patient: Really I would like in the end to get off it altogether, or*
 71 *down to a minimum dose. Because it's far more than I've been on*
 72 *at times in my life.*

Attempted frame

shift: directing

Negotiation frame

The patient's clear statement, "that's a good cocktail for me", contrasts with his more hesitant stance when discussing possible changes later in the sequence. He emphasises that he doesn't want to rush into changes, and suggests that he has "no strong opinion" despite his clear preference expressed elsewhere. This suggests awareness that the proposal to change the medication is more vulnerable to challenge than the proposal to leave things as they are, since the psychiatrist has previously approved the current medication. Nonetheless, the patient returns to the question of reducing the medication several times (lines 24, 42, 50-55, 57, 64, 68), without getting a clear approval or rejection from the psychiatrist. This persistence with a tricky proposal suggests that this issue is important to the patient, even if he is content with an immediate decision to maintain the current dose.

These two examples demonstrate how patients carefully encroach upon the psychiatrist's recognised role by suggesting treatment changes themselves. Several features highlight patient techniques for managing higher risk proposals: attribution of the suggestion to a medical expert (5.2 lines 24-5 & 50-2); performing 'deference' (Goffman, 1967) to the psychiatrist (5.2 line 35); evidence from previous experience (5.1 line 3-7; 5.2 lines 9-10); normalising the patient's perspective (5.2 line 40). These techniques appear throughout many of the consultations and are discussed at greater length later in this chapter.

In extract 5.3 similar techniques are used by a patient who is arguing to maintain the current level of medication while the psychiatrist indicates that he is considering increasing it.

Extract 5.3 (consultation 85)

1 Doctor: A lot of people...let's say if they're not well and medication	Lecture frame
2 isn't very effective then you end up with that sort of picture going up	
3 and down, up and down very frequently and quite often medication	
4 can help get us into this 2nd pattern where you're going up not so	
5 much, not down so much and not so frequently.	
6 Patient: $\overline{\text{F}}$ I don't think I should mess about with the medication that	Frame shift – negotiation frame
7 I'm on.	
8 Doctor: $\overline{\text{T}}$ Right. You're comfortable with it?	
9 Patient: I'm comfortable with what I'm taking.	
10 Doctor: OK.	
11 Patient: And I feel that that is sufficient.	Frame shift –
12 Doctor: Right ok so	
13 Patient: If you feel when you've done your chart that I need an	
14 extra piece just to help me then I will take it.	
15 Doctor: $\overline{\text{F}}$ Well let's just check what you're on at the moment.	
16 [7 turns removed, patient lists medication]	Interview Frame shift - Negotiation
17 Doctor: Haloperidol, fluoxetine, olanzapine and sinthistatin (?) So	
18 that's quite a complicated mixture.	
19 Patient: It is but you know I do tablets every week and I get them	
20 right every time as I'm so used to doing them.	
21 Doctor: For me what I ..	
22 Patient: What you've got to look for is where you can cut back on	
23 certain things and not on others because if you cut back too quickly	
24 I find I'm going like this and it's doing me no good. You know you're	
25 just making me feel worse.	
26 Doctor: Well I wouldn't want to make any change if you didn't feel	
27 comfortable.	
28 Patient: No I'm quite happy as things are.	

29 *Doctor: Well that's fine. 'Cos what I can look at is thinking well*
 30 *would it be helpful to try something in addition 'cos that's probably*
 31 *what I would be thinking of. Another tablet on top of that...maybe*
 32 *altering some of the doses. I did just wonder how useful you felt*
 33 *each of these are?*
 34 *Patient: I find them quite useful.*
 35 *[13 turns removed, patient discusses sedating effects of meds]*
 36 *Doctor: Right. How do you feel about that one [Haloperidol]?*
 37 *Patient: I'm quite happy with it. 5 milligrams. I think that's just right.*
 38 *For me.*
 39 *Doctor: 'Cos I think we did talk about it before.*
 40 *Patient: Yes we did. We talked about putting 10 on there but I said*
 41 *no I wanted the 5 'cause it's just right.*

As with extract 5.2, the patient here demonstrates deference to the psychiatrist (lines 13-14) and evidence from previous experience (throughout). He also highlights that the psychiatrist has previously agreed to the patient's position (line 40-41). This is a similar technique to that seen in extract 5.2 where the patient attributes the suggestion to another medical expert. This patient makes his case more strongly and is less hesitant than those in the previous examples. He rejects the expectation set-up by the psychiatrist's use of the lecture frame (lines 1-5) by shifting into a negotiation frame. Later in the extract he even uses phrases which suggest a lecture frame himself in his use of generalisations ("What *you've* got to look out for...", line 22), though he rapidly returns this to his own personal experience. He expresses autonomy in this decision through his use of 'I' – "I don't think I should mess about with the medication" (lines 6-7). This is very different from the patient's stance in extract 5.2 where medication changes are described as things *done* to the patient by the psychiatrist – "And then if you can get it down a bit" (line 58). In extract 5.3 the patient demonstrates his agency over medication use, while in extract 5.2 agency is attributed to the psychiatrist (see discussion of agency in sections 2.1

(page 20) and 2.2.2 (page 30). The use of pronouns in such negotiations are discussed further later in this chapter. (section 5.1.4, page 199).

5.1.2 Framing and legitimate roles

Legitimate roles within an interaction are not static. They are governed in part by institutionally ascribed powers, and in part by the work done by participants through framing (see Chapter Four). Through framing, participants negotiate the roles they can take up within the interaction. Shifts between frames can also be a way to assert or reassert preferred roles for both participants. An example of framing being used in this way is given in extract 5.4.

Extract 5.4 (consultation 58)

1 Patient: <i>It feels kind of like a trap, like it's something you, you</i>	Troubles-telling frame
2 <i>have feelings of wanting to do but you feel that you can't do them,</i>	
3 <i>you can't become a woman</i>	
4 Doc: <i>Umm</i>	
5 Patient: <i>Because it's not socially acceptable</i>	Frame shift – Advice- giving
6 Doctor: <i>Umm, I understand (12 seconds pause) I'm hoping that</i>	
7 <i>the therapy with the [hospital] can help you with these issues</i>	
8 Patient: <i>Yeah</i>	
9 Doctor: <i>And er hopefully try and get some er er way forward for you</i>	Frame shift – Negotiation
10 Patient: <i>I was wondering, if, if maybe I could go on</i>	
11 <i>antidepressants as well?</i>	
12 Doctor: <i>Do you think you are depressed, currently?</i>	

13 *Patient: Yes I am*

14 *Doctor: Hmm*

15 *Patient: I, I do feel quite depressed.*

16 *Doctor: Right. What I would like to do is... Would you mind filling*
 17 *out a questionnaire for me?*

18 *Patient: O.K.*

19 *Doctor: ¶ Its questions of, 21 questions, it's a questionnaire about*
 20 *depression.*

21 *[3 turns removed describing how to complete the questionnaire]*

22 *Now there's two important points about this questionnaire. Umm,*

23 *I've got some points to address. So this questionnaire of 21*

24 *questions, each question has got four parts, you need to read the*

25 *parts and choose the part that applies and put a circle around the*

26 *number.*

27 *Patient: O.K.*

28 *Doctor: If none of them applies choose the part that's closest.*

29 *Patient: O.K., O.K.*

30 *Doctor: Now there's two important parts about the question. The*

31 *first important part is uh when people fill in questionnaires like this*

32 *they often feel the need to overstate their case to make an*

33 *impression of it*

34 *Patient: OK*

35 *Doctor: You don't have to do it though. It's very sensitive. Just*

36 *answer exactly how you feel.*

Frame shift: Lecture

37	<i>Patient: O.K.</i>	
38	<i>Doctor: And the second part looks to your feelings of the last two</i>	
39	<i>weeks only,</i>	
40	<i>Patient: O.K.</i>	
41	<i>Doctor: Just , the last weeks</i>	
42	<i>Patient: O.K.</i>	
43	<i>Doctor: Now you understand what I am asking?</i>	
44	⌈ (11 pause while patient fills in form)	Frame shift –
45	<i>Doctor: Now take your time (4.0)</i>	Interview frame
46	<i>Patient: ⌋ I feel so nervous</i>	Out of frame activity
47	<i>Doctor: that's, just try your very best.</i>	
48	<i>Patient: O.K.</i>	
49	<i>(131 seconds pause while patient completes questionnaire)</i>	
50	<i>Patient: There</i>	
51	<i>Doctor: O.K. thank you very much</i>	
52	<i>(15 seconds pause)</i>	
53	<i>Doctor: ⌈ Right, O.K. Well, from that you you clearly are quite dep-</i>	Frame shift -
54	<i>I don't know quite a lot depressed. Umm And I think you probably</i>	Directing
55	<i>would benefit from an antidepressant. Now, have you ever been on</i>	
56	<i>Prozac?</i>	

In extract 5.4, the patient makes it clear that he⁴ would like anti-depressants due to self-diagnosed depression. The patient introduces a Troubles-telling frame (“It feels kind of like a trap”) which, under the adapted Jefferson and Lee model allows the patient to offer a diagnosis and advise a course of action in response. In this case the sequence is disrupted as

⁴ Despite the patient’s described difficulties around gender conformity, the consultation does not indicate that the patient is transsexual or that the patient has expressed a preference to be described using female pronouns. For that reason, I have continued to use a male pronoun in reference to this patient.

the psychiatrist offers his own advice (that therapy at the hospital should address this). The psychiatrist does not manage the shift to advice-giving as outlined in Chapter Four. Instead, the advice appears dismissive. As a result, the patient's recommendation is given as a counter proposal, suggesting anti-depressant in addition to the doctor's recommendation ("maybe I could go on antidepressants as well?"). Rather than the request for anti-depressants following logically from the patient's suggested diagnosis, the patient's opinion that he is depressed comes after the medication request in response to the psychiatrist's question (line 15).

This sequence feels clumsier than that seen in earlier consultations. Unlike the examples above, and those found by Gill (2005) in her study, the patient makes an outright, though hesitant, request for medication rather than the carefully constructed and subtler suggestions in extracts 5.2 and 5.3. Similarly, the psychiatrist's response appears initially sceptical of the patient's claims as demonstrated, in line 16, by his introducing a diagnostic questionnaire.

Part of this sense of interactional messiness comes from a failure to successfully negotiate the frames in which the consultation is taking place. This extract occurs directly after discussion about getting blood tests, which is dominated by medical concerns. A pause immediately prior to this extract, in which the doctor is dealing with paperwork, provides the patient with an opportunity to shift the frame into Troubles-telling, allowing him to take more of an interactional lead (see Chapter Four).

As discussed above, adopting the role of troubles-teller requires the other to take up the role of troubles-recipient. It also serves to privilege the patient's position in the interaction, both in terms of his right to an extended speaking turn and his credibility, since the psychiatrist cannot legitimately challenge the validity of the patient's personal feelings. In extract 5.4, however, the psychiatrist does not fully ratify this frame. Instead of taking up the troubles-recipient role, he moves straight to advice-giving by suggesting that the therapy should help. This frame shift indicates that the topic has already been adequately discussed and a suitable action agreed.

The psychiatrist's "I understand" (line 6) does not serve as encouragement but rather indicates that the psychiatrist does not require further information (as suggested by the long pause that follows it). The statement is 'shift-implicative' (Beach, 1993) and acts to close down the frame initiated by the patient (see Chapters Three and Four for further discussion of contextualisation cues and markers).

The patient's request for anti-depressants comes, then, in the midst of this frame dispute. Instead of being a carefully managed move into the advice-giving role (suggesting treatment for depression), the patient's request has more of the characteristic of a challenge to the psychiatrist through its directness. From line 19, the psychiatrist successfully keys the talk into a lecture frame by asking the patient to complete a diagnostic questionnaire. This shift is a clear indication to the patient that his encroachment is not supported by the psychiatrist, in that his expertise is not accepted without the support of a clinical tool. The shift into a Lecture frame (see Section 4.2.2, page 135) and the use of a diagnostic questionnaire emphasise medical expertise over the subjective perspective of the patient.

The questionnaire itself can be seen as a structured form of the Interview frame in which psychiatrists ask closed questions to control the exchange of information. This is an example of Habermas' colonization of the 'lifeworld' by 'system' rationality. Instead of the shared, lifeworld understanding that the patient relies upon of subjective feelings and norms, the psychiatrist imposes a formal way of knowing whether the patient is depressed that does not rely on the patient's own expression of how he feels. In doing so, the psychiatrist re-emphasises the asymmetry in the interaction.

The psychiatrist further undermines the patient's claim at lines 28-34 by advising him not to overstate his case in answering the questions. The psychiatrist challenges the authenticity of the patient's claim. The directness of the patient's request and the absence of any stake inoculation work (see section 2.3.2, page 48) perhaps leave the patient more exposed to the

challenge that his claim is personally motivated and biased instead of being based on an objective assessment of the situation. The whole sequence has the feel of a test, which the patient could pass or fail, and which is adjudicated by the psychiatrist. This is reflected in the patient's nervousness (line 44) and the psychiatrist's use of statements like "try your very best" and by his unexplained interpretation of the results in lines 51-54.

This is also an example of the use of props as a symbol of power and authority in the consultation. Latimer argues that the use of materials in interaction "help position subjects within the relation(s) they make manifest. For example, the potency of discursive practices can never be disassociated from the specificities of the materials through which they make relations visible." (Latimer, 2004: 760) In her study, Latimer shows how clinicians use props to "move others around, magnify their own presence and help to (re)accomplish their authority." (:761) In this instance, the use of a physical prop – the questionnaire given to the patient – helps the psychiatrist to reassert his authority and re-establish a footing in which he retains the power to diagnose and the patient is expected to accept this.

In this extract, the patient succeeds in getting the medication decision he was seeking – being prescribed antidepressant – but the psychiatrist resists his attempt to take on an expert role by and using the reasserted medical focus to emphasise the institutional identities of doctor and patient.

5.1.3 Boundary negotiations

The concept of role boundaries, and the rights and responsibilities associated with them, is helpful in understanding the work done by participants both to maintain and challenge roles. Goffman's *territory* and *markers* (see Chapter Two) provide a way to explore participants' work to defend or encroach upon the edges of their roles.

A common example of such work is seen where patients actively try to influence decisions but back away from explicitly claiming to know what to do. In extract 5.5, the psychiatrist goes so far as to challenge the patient's claim that they 'haven't got a clue' what action should be taken. Even here, where the patient is explicitly invited to make a recommendation, he remains reluctant to do so, suggesting that this is a boundary he is unwilling to cross.

Extract 5.5 (consultation 04)

	Negotiation frame
1 Doctor: What do you think (1.2) should happen?	
2 Patient: I haven't got a clue	
3 Doctor: (4.3) Well you say you haven't got a clue. Y-you're telling	
4 me that you're, at immediate risk of killing yourself	
5 Patient: Yeah	
6 Doctor: The thought must have crossed your mind that I would	
7 suggest you go into hospital for a period	
8 Patient: I think that would be about the best option	
9 Doctor: Yeah	
10 Patient: (Right now	
11 Doctor: ((in overlap)) (So-so that's something that you'd thought,	
12 you had thought about	
13 Patient: Yeah	

Lobley (2002) similarly identifies reluctance on the part of patients to claim a 'right to know' (see Chapter Two). This 'right to know' is strongly associated with territory typically held by the doctor in medical settings. Here, the patient makes his preference apparent without claiming such a right, through expressing suicidal intentions and thus orienting his talk towards clinical judgements about risk. The suggestion is thus ultimately voiced by the psychiatrist.

Research into professional identities has used the concept of 'boundary negotiations' to show how participants in an interaction emphasise distinctions between themselves and others. Boundaries are not fixed, but produced by speakers who emphasise, de-emphasise or shift them depending on the context (Foley, 2005). Ashforth *et al* suggest two ways of describing a participant role: "in terms of its interface with the environment (role boundary) and its nature or content (role identity)" (Ashforth, *et al*, 2000: 473). Role boundaries are characterised by the limits of that role and may be spatially, temporally or functionally defined, for instance a doctor steps outside the professional role when she goes home, takes a lunch break etc. Role identities are those characteristics which are generally ascribed to someone acting within their role, for instance those commonly described as 'professional' – e.g. impartial, impersonal, knowledgeable. Participants may encroach on each other's boundaries either by taking on the functions of the other party, or actively displaying characteristics of the other role. Appearing knowledgeable about medical constructs might thus be seen as a breach of 'role identity', while suggesting a course of action may be seen as breaching a 'role boundary'. Below, I show how participants i) acknowledge, ii) defend, and iii) violate role boundaries in my consultations.

Acknowledging

Patients acknowledge the role boundaries they are approaching through hesitancy, or by immediately and pointedly retreating once the encroachment is done. In extract 5.3 the patient responds negatively to the psychiatrist's suggestion of increasing the medication, but then retreats by saying that he would take what the psychiatrist recommended. Patients may be

even more explicit in crossing, or not crossing, role boundaries. In extract 5.6, the patient says “I’m not trying to diagnose myself, but...”, followed by deference to the psychiatrist, “maybe you can correct me”.

Extract 5.6 (consultation 28)

<p>1 <i>Doctor: Sorry just getting back to what you were saying about</i></p> <p>2 <i>then, how you’re feeling in yourself. Are you feeling normal most of</i></p> <p>3 <i>the time, or is it just sometimes that you cry in the afternoons?</i></p> <p>4 <i>Patient: Sometimes I cry, sometimes I’m quite emotional at the</i></p> <p>5 <i>moment about music or something lovely or if something has...</i></p> <p>6 <i>Doctor: Are you getting pleasure from some things?</i></p> <p>7 <i>Patient: Yes, yes,</i></p> <p>8 <i>Doctor: You are.</i></p>	Interview frame
<p>9 <i>Patient: ¶ I’m not trying to diagnose myself but I’m trying to be</i></p> <p>10 <i>more self-aware. And I wonder, but maybe you can correct me, if,</i></p> <p>11 <i>because I’ve been as unwell as I was for a long time and then sort</i></p> <p>12 <i>of numbed in a way from bereavement or all the things that have</i></p> <p>13 <i>happened, both my parents died, last year and the year before.</i></p> <p>14 <i>And because I was so concentrating on being unwell and coping</i></p> <p>15 <i>with the difficulties in the family did I not let out the emotions</i></p> <p>16 <i>enough and is it in fact a wrong thing to stop this crying, is it</i></p> <p>17 <i>actually...</i></p> <p>18 <i>Doctor: You think...</i></p> <p>19 <i>Patient: I’m wondering, I’m asking.</i></p> <p>20 <i>Doctor: Well I suppose that’s possible in the sense, in that I know</i></p> <p>21 <i>that around the time of your father’s death in particular you weren’t,</i></p> <p>22 <i>you really were quite unwell, so it may have been that you saw the</i></p> <p>23 <i>grieving was delayed from that</i></p>	Advice-giving

The patient's denial that she is diagnosing herself is an acknowledgement that she *should not* diagnose herself; such a claim falls outside the patient role. In contrast, being 'more self-aware' can be viewed as a positive aspect of her role and something that she should get credit for. Despite the denial, by introducing the word 'diagnosis' here, she shapes the way that her description is to be understood, highlighting the boundary between 'diagnoser' and 'non-diagnoser' and prompting the psychiatrist to orient himself to his role as 'diagnoser'.

Defending

In parallel to a patient's boundary work, a psychiatrist may use markers to emphasise boundaries around her own role identity. In the Lecture frame, for example, psychiatrist use professional generalisations through statements about what is 'likely' or 'usual' and what is true for 'people' in general terms (see Section 4.2.2, page 135). These statements rely on the doctor's professional authority. Extract 5.7, which follows immediately from extract 5.6, in which the patient shifts into an advice-giving role, demonstrates such markers.

Extract 5.7 (consultation 28)

- | | |
|---|----------------------|
| <p>1 <i>Doctor: Well I suppose that's possible in the sense, in that I know</i></p> <p>2 <i>that around the time of your father's death in particular you weren't,</i></p> <p>3 <i>you really were quite unwell, so it may have been that you saw the</i></p> <p>4 <i>grieving was delayed from that. I don't want to make that</i></p> <p>5 <i>assumption that it's just that. If most of the time you feel reasonably</i></p> <p>6 <i>good in mood or able to enjoy things then it's less likely to be a</i></p> <p>7 <i>depressive illness than emotional reaction.</i></p> <p>8 <i>Patient: Less likely to be a depressive...</i></p> <p>9 <i>Doctor: It's more likely to be an emotional reaction to things if it's</i></p> <p>10 <i>not persisting all the time. Although depression can be an</i></p> <p>11 <i>intermittent thing. People who are depressed don't always feel</i></p> <p>12 <i>depressed all the time.</i></p> | <p>Lecture frame</p> |
|---|----------------------|

The psychiatrist states that because the patient sometimes feels pleasure, it is 'less likely to be a depressive illness' and 'more likely to be an emotional reaction'. This assertion is qualified by saying that 'depression can be an intermittent thing' and that 'people who are depressed don't always feel depressed all of the time'. These broad claims to knowledge could be based on, for example, medical training, published research professional experience, or 'gut instinct'. They are constructed, however, as things known to him as a member of the psychiatric profession, but not to the patient as a lay person. As Heritage (1997) identified, the psychiatrist is using the benefit of the asymmetry of know-how to make claims based only on his professional authority. Freidson argues that it is through this kind of generalised knowledge that "such disciplines establish the power of the norm, statistical or otherwise, which is used as a 'principle of coercion' in a variety of standardized institutions" (Freidson, 1986: 6).

After a patient's attempt to offer a diagnosis or treatment decision, these privileged claims to knowledge are often used by psychiatrists to resist such encroachments and to reinforce the distinction between the two performances. Another example of such marking was seen in extract 5.4 through the use of the diagnostic questionnaire, preventing the patient from claiming knowledge about whether or not he was depressed.

In extract 5.8 a similar technique is used as part of the psychiatrist's defence of his role boundaries against encroachment by the patient.

Extract 5.8 (consultation 12)

1 <i>Doctor: So you take 2 milligrams in the morning and 2 milligrams at</i>	Interview frame
2 <i>night.</i>	
3 <i>Patient: Yea. ¶ I was wondering if it was a good idea to lower the</i>	Frame shift: Advice giving
4 <i>doses, but, I'm sure, I'm not really sure because I felt myself being</i>	
5 <i>a little bit more depressed, but I'm not sure. If I go out more, then</i>	
6 <i>maybe</i>	

7 Doctor: ^{FF}I don't think so. I think that if you are going to, because 4
 8 milligrams is not a high dose. You used to take 6 milligrams and it
 9 has already been cut down, hasn't it? Um, yes, you used to take 6
 10 milligrams, and I fear that if you cut it below then the kind of the
 11 psychotic symptoms will get worse, and that you won't be able to
 12 function any more. I'm sceptical as to 4 milligrams of Risperidone
 13 will make the OCD symptoms worse. I'm sceptical about it, really.
 14 Now when you take a high dose of Risperidone it can make people
 15 a bit restless – or you're going to be tense, indeed. But not on 4
 16 milligrams. You will need to take at least 6 milligrams to get those
 17 withdrawal – with those side effects, really. But if you take below 4
 18 milligrams there is a risk that your psychotic symptoms could get
 19 worse – like the voices and the paranoid ideas and so on. So I
 20 think you would be taking a bit of a risk.

21 Patient: Yea. ^{FF}The thing is, um, no, it's not, it's making me tense.
 22 And it's been making me tense for a long time. And it's hard to

23 Doctor: ^{FF}How is your sleep?

24 Patient: It's fine.

25 Doctor: You're sleeping okay?

26 Patient: Yea.

27 Doctor: You're eating okay?

28 Patient: Yea.

29 Doctor: He's eating alright, is he?

30 Parent: Yes.

Frame shift: Lecture
 frame

Frame shift:
 Negotiation

Frame shift:
 Interview frame

At line 3, the patient tentatively suggests an alteration to his prescribed medication, again using 'wondering' to play down the knowledge claim inherent in such a recommendation, as seen in extract 5.6. The doctor reacts negatively to the suggestion and uses professional generalisations to dismiss the patient's belief that the medication might be causing additional stress (lines 7-20). The psychiatrist's claim that the dose is too small to have the effect described gives the impression of this being evidence-based, though without reference to specific evidence.

The patient continues to resist the psychiatrist's argument and attempts to reassert his claim to personal, 'lifeworld' knowledge about the medication effects (Barry *et al*, 2001). The psychiatrist uses further markers to reinforce the boundaries to the patient's role and the asymmetry this produces: interrupting the patient (line 23); using closed, standardised, questions (lines 23-27); and undermining the patient's authority by asking the same question of the patient's parent (line 29) (see Chapter Six). These techniques re-establish control of the consultation and close down the patient's attempt to steer the medication decision.

Violating

Goffman describes violations of role boundaries occurring in two ways – 'intrusion' into another's territory or 'obtrusion' of one's own territory beyond the accepted limits (Goffman, 1971: 51-2). An example of obtrusion was seen in extracts 4.20, 4.21 & 4.22 (pages 146, 147 & 148) where the patient describes an argument with her daughter which is exacerbating her psychotic symptoms. The psychiatrist responds by encouraging the patient to expand on the trouble-telling and, at the start of extract 4.20, by moving into an advice-giver role.

In this example the psychiatrist moves into the role of advice giver without the patient accepting the role of advice recipient (Jefferson and Lee, 1981). The patient recognises that the psychiatrist has pushed the boundaries of his role by offering advice about family relationships, and rejects this obtrusion. When the psychiatrist finally acknowledges the boundary that he

obtruded on by admitting that “I can’t meddle in family affairs”, the patient agrees. The psychiatrist consequently moves firmly back within his role boundaries by discussing the medication increase already agreed.

This example demonstrates the limits to the asymmetry produced by professional authority; it does not extend outside the medical and into the personal. The techniques evident in patients’ talk are paralleled in psychiatrists’ talk: hesitancy at the edge of roles, acknowledgement of the boundaries, and backing down when the other party defends those boundaries.

5.1.4 Ascribing activity in the interaction: significance of pronouns

Previous research highlights how distinctions between ‘I’, ‘you’ and ‘we’ are used to claim and acknowledge participants’ rights and responsibilities, and to include or exclude others. Nevile’s study of airline pilots shows the extent to which participants have discretion in their use of pronouns and how their choices allow participants to *“invoke and make salient, relevant individual and shared cockpit roles”* (Nevile, 2002: 69). Nevile argues that this can impact on a sense of teamwork or partnership and explicitly share responsibility and accountability for specific tasks. This idea of ‘teamwork’ is relevant for both decision-making and maintaining a ‘team performance’ (Goffman, 1959).

The significance of pronouns has been alluded to earlier in discussion of the Lecture and Directing frames, highlighting how ‘we’ can be used to indicate a joint-venture between patient and psychiatrist when decisions are made, or to indicate a wider professional body when making claims to expert knowledge.

Patients also use pronouns to build alliances and draw distinctions. Extract 5.9 is an example of a patient using ‘we’ to position himself in partnership with the psychiatrist against his problem with alcohol (to see this extract in context, see extract 5.19). ‘We’ encompasses the psychiatrist not only within the alliance but also within the futility of those efforts. Rather than asking for

1 Patient: I don't know what we can do about that. I just don't know.
2 I just know I need it.

1 Doctor: And the Depot?⁵

2 Patient: No problem. I have that every month and I always will,

3 (unclear) and that's it. ¶ But we tried, we tried to reduce it, it was a

4 mistake. I do need that and I do need those Stelazine, whether it, it

5 must be the Stelazine that helps me, it stops the paranoia.

Negotiation frame

In a similar way, psychiatrists use pronouns to include patients in decisions, foster a sense of team, and reduce the likelihood of challenge. In extract 5.11, the patient ascribes previous medication changes solely to his hospital doctor, using 'he' to refer to the doctor who made the medication changes, and 'I' to refer to the effects of those changes. In doing so he emphasises that the change in medication was a medical decision. In lines 3-4, the patient

apparently corrects himself from saying what the doctor ‘wanted’ to ‘what he thought would be alright’. Both phrases emphasise that the psychiatrist made an individual judgement. The repair (Schegloff *et al*, 1977) may indicate the patient’s awareness that to ascribe personal preference - a ‘stake’ (Potter, 1996) - rather than professional judgement as motivation for the changes might be seen as criticism of the doctor. The psychiatrist’s statement that it is ‘always the way’ could also be defensively oriented to this distinction, suggesting that this is a standard professional judgment. Though not claiming the decision for himself, the patient is supportive of the changes (lines 4-6). In contrast, when the psychiatrist offers the narrative’s ‘evaluation’ (see Chapter Four), he emphasises the joint work being done by patient and psychiatrist together by using ‘we’ in line 9.

Extract 5.11 (consultation 02)

- 1 *Patient: He was, he was hovering about the Amytriptolene*
- 2 *(unclear) the, the ‘C’, drug. He was (hovering?) about that. And*
- 3 *then I, when he sort of stabilised what he wan- what he thought*
- 4 *would be alright, I then began to make improvements. Because I*
- 5 *think he was, mi- mixing the tablets just to see what er (1.2) the*
- 6 *best result for me. Hm*
- 7 *Doctor: Which is always the way. Tha-that’s in a way*
- 8 *Patient: Yeah*
- 9 *Doctor: that’s what we were doing before you went into hospital*

Narrative frame

Participants may also ascribe decisions to the single person pronouns ‘you’ or ‘I’ when they want to locate the decision with one participant. There are various reasons why a participant may wish to do this. By implying that the decision was made by the other party, a speaker may attempt to reduce the likelihood that the decision will be challenged or changed by that same person. By claiming the decision for herself, a speaker can emphasise her autonomy over the decision. The use of pronouns therefore feeds the performance of chosen roles – deferent patient, autonomous decision maker or active advisor. In extract 5.12, the patient begins by referring to his conversation with the researcher immediately prior to the consultation. The patient explains that he told the researcher about a previous occasion in which he autonomously changed his medication. The psychiatrist invites the patient to describe ‘what *you* did’ to a trainee attending the consultation. Following this lead, the patient uses ‘I’ to reinforce his autonomy over medication decisions (underlined).

Extract 5.12 (consultation 18)

- 1 *Doctor: Would you like to explain to (unclear) what you did or how?*
- 2 *Patient: Yeah well I was originally on Risperidone I can't remember*
- 3 *the dosage it was quite low, but I thought, I figured it out, that I was*
- 4 *getting totally and utterly anxious on it. Really, really anxious. And*
- 5 *my wife, she had previously before I changed, she tried*
- 6 *Risperidone as well. And she freaked out sort of thing and within*
- 7 *two weeks she was a nervous wreck, she couldn't work, she*
- 8 *couldn't do anything. So she changed back to Olanzapine which*
- 9 *had given her diabetes, that's why she changed she went back to*
- 10 *it, she's monitoring it OK and she seems to be going OK. And I*
- 11 *thought to myself you know, it must be making me paranoid that*
- 12 *much, I feel like anxious all the time I was up*

Narrative frame

13 and down. Going out at like 2 or 3 o'clock in the morning driving
 14 and driving and driving till I don't know two or three hours later,
 15 coming back going to work, going back home, going to bed by 2
 16 o'clock in the morning couldn't sleep couldn't do anything. And um,
 17 then I took one of my wife's Olanzapine basically. And after a few
 18 days' time I just felt wonderful. I really do. And you know, I really do
 19 want that change don't want to come off them

Choice of pronouns can emphasise disagreement as well as alliance. Extract 5.13 shows how participants switch between the inclusive 'we' and the exclusive 'I' or 'you', locating responsibility for decisions in different places. Here the psychiatrist alludes to what 'we' had been considering around the medication changes (underlined). Using 'we' the psychiatrist positions this consideration as something in which both participants were engaged. This attempt to include the patient in consideration of a decision he does not appear to want, prompts the patient to return to 'I' in line 12. The 'I' allows the patient to reassert some autonomy of preference, if not of action. Without directly challenging the doctor's use of 'we' the patient emphasises that he had a clear preference, and underlines it with reference to his own longer term plans to come off Risperidol.

Extract 5.13 (consultation 03)

1 Doctor: Yeah. (1.4) Now y'say you've increased the dose to, six- to
 2 three a day. Erm
 3 Patient: Yeah
 4 Doctor: clearly the higher dose suits you and I think you should
 5 stay on that for
 6 Patient: Yeah

Negotiation Frame

- 7 Doctor: (now). Erm (1.0) because we were thinking, weren't we,
 8 that we might, switch you back to (1.3) Zispin if that hadn't worked
 9 Patient: Yeah that's right
 10 Doctor: ((in overlap)) but clearly it has
 11 Patient: ((in overlap)) Yeah. But, I wasn't too keen to go back on
 12 that because of the weight gain. Like I'm sort of looking, to come off
 13 of the the Risperidol, and hope to lose a bit more weight. But like
 14 I'm still taking it

Another example of this switching between pronouns is shown in extract 5.14 (this extract is shown in context in extract 5.2, page 180). As discussed earlier in this chapter, the patient and psychiatrist have agreed to change the frequency (though not the dose) of the patient's Depot injection. In line 1, the patient refers to the pre-consultation interview held with the researcher, in which he had said there would be no change to his prescription.

Extract 5.14 (consultation 83)

- 1 Patient: Go to 100mgs every fortnight. I told the researcher
 2 there'd be no change.
 3 Doctor: Well we're not looking at a change in dose but we're
 4 looking at a change in...
 5 Patient: And then if you can get it down a bit absolutely I'd be
 6 pleased. Because it is a tranquiliser and I suppose at my age you
 7 can't expect to be so lively and alert and lamb like, spring lamb like
 8 as a twenty year old.
 9 Doctor: You're, don't want to be (unclear)
 10 Patient: No, I'm feeling groggy because I've got a cold. That's the
 11 only reason.
 12 Doctor: ¶ Well what I would suggest is that we could make that
 13 change and just see how things go.

Negotiation Frame

Attempted frame

shift - Directing

<p>14 Patient: † Then knock it down to 75?</p> <p>15 Doctor: Yeah, maybe next time you come, see what you think. I</p> <p>16 can say <u>I won't make</u> any change if you're not happy.</p>	<p>Negotiation frame</p>
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The pronouns referring to decision-making about the medication are underlined in this text. In line 3, the doctor includes the patient in the decision using 'we'. The patient distances himself from this decision, however, by ascribing the ability to reduce the medication to the doctor alone (line 5), and reinforcing his preference for reduction. In lines 12-13, the doctor uses 'I would suggest', positioning himself as advisor or director, rather than decision-maker and still assigning the act of changing the medication to 'we'. Finally, the psychiatrist returns to I – "I won't make any change...", re-emphasising that he does hold the power to make changes, while reassuring the patient that he would do so only with his agreement.

These extracts demonstrate how, through the use of pronouns, participants can claim decisions for themselves, ascribe them to others, or include both parties in them. When negotiating roles in the consultation participants respond to these subtle shifts and the footing they establish.

5.2 Patients' techniques for performing credibility

I have shown that patients frequently attempt to step outside the traditional patient role to influence decisions that generally rest with the psychiatrist, and that they are cautious in doing so. While psychiatrists' authority to make expert claims is implicit within the context of a psychiatric consultation, patients must do more work to give their claims credibility.

Counter-intuitively, a key technique by which patients construct legitimacy for their claims is to emphasise conformity with the traditional patient role – what I describe as a 'good patient' performance. This provides a basis whereby patients can extend their role into more contested territory through explicit validity claims (Habermas, 2002), 'active voicing' and vindication.

5.2.1 Performing the ‘good patient’

The idea of a ‘good patient’ performance closely links to Parsons’ ‘sick role’ and the demands made upon patients to seek to get well. When making recommendations that might be seen as encroaching on psychiatrists’ expert roles, patients often emphasise the extent to which they are fulfilling their legitimate role as patient by seeking and following medical advice, demonstrating insight into their condition and making active attempts to recover.

On the face of it, this strategy may be seen as emphasising power asymmetries. However, it is particularly evident at points where patients seek to influence treatment decisions. Rather than passively accepting the decisions of others, these patients actively demonstrate competence in the role conferred upon them by the institution. This supports Badcott’s (2005) argument that choosing to adopt a traditional patient role is in itself exercising patient decision-making, and should not be treated merely as a default position.

5.2.2 Seeking and following medical advice

In extract 5.15, taken from the same consultation as extract 4.13, the patient has been given new medication by (presumably) her GP. The patient narrates the events and highlights steps that portray her as a responsible patient.

Extract 5.15 (consultation 31)

- 1 *Patient: No, I did feel like as if I was losing the plot and I was just, I*
- 2 *was anxious and even when things were sorted out, Dr [Name], I*
- 3 *was still anxious. So I thought, ‘no there’s something wrong’, and I*
- 4 *listened to my husband and I went to the doctor, went to the doctor*
- 5 *straight away and he put me on them.*

Narrative frame

By constructing her behaviour in line with her patient role, she justifies her proactive decision to change the medication. As discussed below in relation to active voicing, the authority to

change the medication rests with a doctor, and the decision to seek it originates, in part, with her husband.

Patients often emphasise the 'good patient' performance, particularly when they are either reporting a change not previously authorised by the doctor, or are seeking to initiate a change. In extract 5.16, which continues directly from extract 5.13 (page 203) the patient is suggesting to the consultant that she comes off one of her medications. In doing so, she highlights specific aspects of her claim: that her motives are valid in health terms (lines 2-3); that she is nonetheless compliant with her medication and has not acted unilaterally (line 4) although she does not give up the idea completely in the face of the consultant's scepticism.

Extract 5.16 (consultation 03)

- 1 *Doctor: ((in overlap)) but clearly it has*
- 2 *Patient: ((in overlap)) Yeah. But, I wasn't too keen to go back on*
- 3 *that because of the weight gain. Like I'm sort of looking, to come off*
- 4 *of the, the Risperidal, and hope to lose a bit more weight. But like*
- 5 *I'm still taking it*
- 6 *Doctor: Yeah the, certainly, the reason we switched to Flurox- to*
- 7 *the Prozac was because it it if anything it helps people lose*
- 8 *weight. (1.1) You say you're s- thinking of stopping the Risperidone*
- 9 *t-tell me, (c 2 words)*
- 10 *Patient: ((in overlap)) No, like I'm I'm hoping to, to stop it like in*
- 11 *Doctor: ((in overlap)) In the future*
- 12 *Patient: Yeah, in the near future*
- 13 *Doctor: ((in overlap)) Yeah*
- 14 *Patient: because I've been on it a while now*
- 15 *Doctor: Yeah*
- 16 *Patient: I'd like to*

Negotiation frame

5.2.3 Confessions

While at times patients work to demonstrate deference to medical opinion, and to operate within the power structure and expectations within the consultation, there are nonetheless times when patients are not following medical advice, or are behaving in ways they think likely to be counter to medical advice. Instances where patients are not following medical opinion are only known about, in relation to this data, when they are openly discussed by participants in the interaction. It is possible that patients are not following advice but do not reveal this in these consultations. There are, however, a number of instances in this data set where patients are upfront about behaviours of which the psychiatrist is likely to disapprove. In this section, I examine instances of these confessions, how they show patients' motives of identity work, and how both patients and psychiatrists manage their impact.

Reports of unhealthy behaviours or failure to follow doctor's advice threaten to be a form of 'destructive information' as described in Chapter Two (Goffman, 1959: 141), in that they carry with them a risk of discrediting the patients' performances. We would expect, then, that where such information is revealed, it is generally done so strategically by patients, either to gain something or to mitigate against a higher risk. In this way, patients can sacrifice an element of a favourable impression in order to secure credibility in relation to their broader role performance.

One potential risk to be avoided is that the psychiatrist will become aware of the information from another source. If that were to happen, the patient runs a double risk to their performance – on the one hand as someone who has behaved in a way that is incongruent to the identity they are performing, and on the other hand as someone who has not been honest in their performance. As Goffman highlights, "a discreditable disclosure in one area of an individual's activity will throw doubt on the many areas of activity in which he may have nothing to conceal" (Goffman, 1959:71). In some instances, therefore, confessions appear to

occur where patients anticipate that the information is likely to become known through another source.

One example of these pre-emptive confessions occurs in extract 5.17, which is discussed in more detail in Chapter 6 (extracts 6.6, 6.19, 6.21 & 6.22). Later in the consultation, the partner is open about her role there being to “grass him [the patient] up”. In the extract below, the immediacy of the threat of revelation about the patient’s drinking is evident. The partner’s interjection at line 4, and the conspiratorial laughter between patient and his partner, act as prompts for the patient, who responds by revealing at line 5 that he had ‘had a drink’.

Extract 5.17 (consultation 21)

1 <i>Doctor: Those things aside how would you say things are in</i>	Interview frame
2 <i>general?</i>	
3 <i>(5.3 pause, laughter)</i>	
4 <i>Partner: Well. He didn’t want me to come and see you.</i>	Narrative frame
5 <i>Patient: I had a drink last Tuesday didn’t I?</i>	
6 <i>Partner: And he wasn’t not well, he went and done it through,</i>	
7 <i>literally just because he wanted to buy a drink and it caused</i>	
8 <i>absolute havoc.</i>	

Extract 5.17 is an example of a pre-emptive confession, but the consultations in this study contain a number of confessions where it appears unlikely that the psychiatrist would come to have ‘destructive information’ from another route. In these cases, patients choose to reveal information that could risk their role performance despite concealment being an apparently viable alternative. Exploring some of these instances below, I suggest that confessions in the doctor-patient relationship form part the ‘good patient’ performance.

Extract 5.18 (from the same consultation as discussed above in extract 4.7 and 4.8) shows a confession aimed at providing a possible explanation for the patient's current problems with feeling 'jumpy'. In line 17-18, the patient accounts for her confession by saying that her social worker told her to make it, suggesting that the comment required further validation of its relevance to the task at hand, particularly in the light of the psychiatrist's relatively unconcerned response. As discussed above, such relevance-making is a common feature of the Disclosure frame.

Extract 5.18 (consultation 10)

- 1 *Patient: And also (like) I'm getting very jumpy I get um, if someone*
- 2 *comes in the room I go 'Ooh!' like that. I don't know why that's*
- 3 *happening to me but, I just get a bit jumpy*
- 4 *(14 sec pause – Doctor writes prescription?)*
- 5 *Patient: I did have a little bit of speed at Christmas (2.5) only a little*
- 6 *bit (2.0) only the once*
- 7 *Doctor: Right*
- 8 *Patient: ((in overlap)) (1 word), that's all*
- 9 *(2.5)*
- 10 *Doctor: How d'you get on with that?*
- 11 *Patient: (0.6) It frightened the life out of me really. (1.3) Only a*
- 12 *minute fraction I had, that's all*
- 13 *Doctor: (2.5) I've no idea what that would do to you but it wouldn't*
- 14 *do you any good I wouldn't have thought*
- 15 *Patient: (1.1) No I don't think it would do you any good either*
- 16 *(5.0)*
- 17 *Patient: I thought I'd say it to you because [Name] told me to say it*
- 18 *to you so, so I thought I'd say that to you*

Disclosure frame

The confession in extract 5.18, as well as providing potentially relevant information, serves to demonstrate that the patient is giving an honest account, and co-operating fully with the psychiatrist. The next section describes how, rather than simply being discrediting information, confessions can earn space for the patient to be autonomous while maintaining the 'good patient' performance, through highlighting honesty and insight.

5.2.4 Performing honesty and insight

In extract 5.19, taken from the same consultation as extracts 5.9 and 5.10) the patient tells the psychiatrist that he is drinking too much in response to a general health enquiry. Although this heavy drinking is known to other professionals, and may be apparent to the psychiatrist (line 57), this confession does not appear to be pre-emptive, in that there is nothing to indicate that the information is likely to be revealed by another source. Nor is the patient apparently raising the issue in order to get the psychiatrist's advice or action on it, since he rejects all suggestions and is adamant that he intends to keep drinking. Instead, the patient is building his drinking into his identity performance by playing up the fact that he drinks, his awareness of it, and the deliberate and autonomous nature of this activity.

Extract 5.19 (consultation 25)

- 1 *Doctor: OK, so how do you feel you are yourself?*
- 2 *Patient: ¶ I'm drinking too much. I don't feel right. I don't know*
- 3 *what's going on, all I'm getting is a blood test and they say that's*
- 4 *alright, that's alright, that's alright, so I really don't know what's*
- 5 *going on. But I am not right.*
- 6 *Doctor: Do you think the drink could be doing it?*
- 7 *Patient: Oh that doesn't help. But I have to have it though.*
- 8 *Because I can be very jittery and I have a whiskey (laughter). I*
- 9 *know it's crackers.*

Frame shift -

Troubles-telling

10 Doctor: Could you be jittery because you're not drinking because
11 of your (overtalking)

12 Patient: That is probably what it is. Yes. ^{||}But I don't actually
13 admit to that, yes^{||}. I'll wait till I need a liver transplant. No I'll go
14 on. The... the other doctor what was his name, [Name] that's right,
15 the gastronomic-y one, he said, I said (unclear) I said 'I've had six
16 cheap lagers a week- a day'. He said 'if you continue like that
17 you'll be dead in three years time'. I said 'in that case I'll be dead
18 in three years time'. I didn't tell him about the whiskey because I
19 was having half a bottle of whiskey as well now. So it's probably
20 about two years.

21 Doctor: Yes. What half a bottle of whiskey and six lagers a day.

22 Patient: Yeah, no, I mean at the moment I'm drinking Guinness.

23 Doctor: Just Guinness.

24 Patient: And whiskey.

25 Doctor: Whiskey and Guinness.

26 Patient: I've got to say about, what, four Guinness a day and say,
27 half a bottle of whiskey, something like that. I know it's ridiculous
28 but what else can I do?

29 [4 turns removed here, discussing financial cost of alcohol use]

30 Doctor: So back to the alcohol a bit.

31 Patient: I don't know what we can do about that. I just don't know.

32 I just know I need it. You're quite right, imbalance, giddy feelings

33 all this. I have to... to be truthful it is the drink, but then I have to

34 have one to get straight again. To say I'm an alcoholic, I think I'm

35 turning into an... I've always said I'm not an alcoholic I have a drink

36 problem. But I think now it's come to the point where I would have

37 to actually say that I'm really a bit alcoholic.

Communication out
of character

38 Doctor: \uparrow Would you consider getting help, taking help with that?

39 Patient: \uparrow Well I said that years ago, and I wasn't drinking
 40 much back then because I was driving. You see I don't have a car
 41 now, so I don't have to worry. In those days I had a car and I of
 42 course I wouldn't drink then. But I said I was going to see these AA
 43 people something in [Place], something like that. And he said you
 44 don't have to go and see them, you sort yourself out. I said, he
 45 could be right, I mean it wouldn't do me any good.

46 [3 turns removed, discussion of local AA group]

47 Patient: I don't want to stop.

48 Doctor: and ...

49 Patient: No I don't want to stop, I just don't.

50 Doctor: \uparrow Whether you need a kind of, what they call a

51 detox regime, whether you need some medication.

52 Patient: \uparrow I can't see myself coming off it. Even,

53 whatever. I really can't Doctor. I need that booze, I couldn't get by
 54 without it. I just don't feel right without a drink. And as I said to [my
 55 wife] and she agreed with me, I mean all the bills are paid, we eat
 56 well, rent's sorted out, heating and lighting is all in order, paid the
 57 electric and the telephone that's all going through, so. I mean if I
 58 wasn't paying the rent and we were threatened to be slung out or
 59 something like that, [wife] has every right to say (unclear). But
 60 while everything's being paid and I don't actually get drunk as such,
 61 I mean I'm a bit tiddly as you can probably tell from my voice, but I
 62 don't get drunk or thrash around the place, or nothing like that.

63 Doctor: So what you're saying, there's no real incentive to give up.

64 Patient: Not really, no I mean I do need it. I do need it.

Attempted frame

shift – Advice-giving

Troubles-telling

frame

Attempted frame

shift – Advice-giving

At first glance, this extract seems to contradict Goffman's arguments about maintaining face. Instead of collaborating to maintain face, the patient volunteers information which is likely to undermine it. However, the patient's strategic revelation of his drinking in this consultation can be understood as part of a 'good patient' performance. The patient emphasises this role by revealing voluntarily information which he explicitly constructs as a difficult truth, one that he does not admit to (lines 12-13). In this 'communication out of character' (Goffman, 1959) he claims that such an admission is not normally part of his identity performance, and makes his current admission more significant as part of an honest performance. The patient describes having discussed his drinking with another doctor previously, and indicates that he lied about the amount of alcohol he was drinking. While suggesting the possibility of dishonesty, he emphasises that in this context, to this psychiatrist, the patient is committed to being truthful, even about something which he might lie about in other situations.

This is an example of what Goffman describes as 'role distancing' (Goffman, 1961) whereby participants distance their 'real selves' from the role that they are performing in the interaction. In this case, the participant expresses commitment to the patient role within the institutional setting, but distances his drinking behaviour from this role; it is something separate and which he is unable to alter to fit the current performance. Goffman argues that role distancing behaviour constitutes "a wedge between the individual and his role, between doing and being" (Goffman, 1961:103). The role distancing, however, also allows the patient to maintain and even enhance his role credibility in spite of his 'real' life behaviours. A similar example of enhancing credibility through role distancing was seen in the 'out of character' talk in extract 4.38.

By creating such distance between his drinking self and his patient role, he also creates distance between his drinking self and the doctor's role; it is beyond the doctor's remit to address. Through this performance of honest confession, the patient makes it possible for

himself to refuse the doctor's advice on this issue. He is 'playing straight' with the doctor, and indicates that he has sufficient insight into his situation to manage it on his own terms. To make this possible, however, the patient does a great deal of work to build up credit with the psychiatrist. In the consultation he emphasises his adherence to medication, his care over financial management, and his commitment to not driving because of the risk of combined drinking and medication use.

Further examples of confessions used in this way are provided in extracts 5.20 and 5.21, taken from the same consultation (see also extract 5.12, above, taken from the same consultation).

The patient makes a series of confessions here: a) flying a helicopter despite being on medication, b) forgetting to take the medication that day, and c) doctoring a sheet used by the doctor to order medical tests. These are all carefully managed confessions. The patient emphasises that they are confessions by reminding the doctor that people on medication are not allowed to be pilots, by using phrases like 'to tell the truth', and by suggesting that he was avoiding another doctor because he didn't want to get into trouble for altering the sheet.

Extract 5.20 (consultation 18)

- 1 *Patient: Guess what I did? You know the people with, like, take*
- 2 *medication aren't supposed to fly.*
- 3 *Doctor: Yes, what do you mean not supposed to fly?*
- 4 *Patient: Well, they're not allowed to fly are they?*
- 5 *Doctor: You mean, be pilots?*
- 6 *Patient: Yeah. (laughs)*
- 7 *Doctor: So what, you having flying lessons?*
- 8 *Patient: I got bought a helicopter lesson for my birthday, for our*
- 9 *anniversary (laughs)*
- 10 *Doctor: m'hm I don't honestly know if you're barred from flying.*
- 11 *Patient: You are. Gliding you're OK but to actually get a pilot's*
- 12 *licence*

Disclosure frame

13 *Doctor: pilot's license, yeah, no, you probably couldn't get a pilot's*
 14 *license, no*
 15 *Patient: But [Name] bought it for our anniversary and we went*
 16 *down to [Name] airport and the guy was then like... To tell the truth*
 17 *I actually forgot to take my medication for that day. I got back like*
 18 *afterwards and it got to the evening 'oh no wonder I'm so chilled*
 19 *out' sort of thing. I don't know.*

Extract 5.21 (consultation 18)

1 *Doctor: Going back to the medication and we talked about the risk*
 2 *of diabetes. I know that your blood sugar, when you had it done*
 3 *last year, July, was OK*
 4 *Patient: Right. I think it's about time I had maybe the blood sugar*
 5 *test done again*
 6 *Doctor: Done again 'cause it's been over six months so, it would be*
 7 *a good idea. Are you happy to have that done?*
 8 *Patient: Yes of course, yes. ¶ I actually didn't really want to*
 9 *see Dr [Name] about it because um... you know the little sheet,*
 10 *Doctor: Which sheet?*
 11 *Patient: That, one of those, I ticked another couple of things.*
 12 *Doctor: (laughs)*
 13 *Doctor: Had blood tests done on the sly do you mean?*
 14 *Patient: Yeah I ticked on the A1c, like the total blood sugar*
 15 *(unclear) He actually hadn't ticked the blood sugar count as well so*
 16 *you know I ticked that as well.*
 17 *Doc; Uh hu.*
 18 *Patient: I won't touch it, I promise I won't alter it.*

Negotiation frame

Frame shift –

Disclosure

None of these confessions pre-empt information likely to reach the psychiatrist in another way, and none have a direct bearing on the patient's current health or treatment. Instead, these confessions are part of the performance as an honest patient. This is another example of 'role distancing', through which the patient distinguishes between the behaviours which he is committed to in his current role - in *this* consultation with *this* psychiatrist - and the earlier behaviours he has confessed to. This is particularly emphasised by his promise not to alter the test sheet again (line 18).

5.2.5 Evoking third parties: "active voicing" and 'borrowing' status

Horton-Salway's (2001) analysis of a narrative of ME highlights the use of corroborative evidence in participant's talk. He points to the use of "active voicing" – "*where speakers use the voices of others to 'warrant the factual status of claims and undermine the possibility of sceptical responses'*" (: 253).

In Goffman's (1974) terms, the patient becomes the *animator*, but not the *principal* of the remark, placing the patient on a new footing in relation to their own claims and other participants. 'Active voicing' displays neutrality, and makes it less likely that the participant will be held accountable for the view being expressed (Potter, 1996). It also allows participants to trade on the credibility of other sources, particularly when they themselves are perceived – or are concerned about being perceived – to have a 'spoiled identity' (Goffman, 1963). 'Active voicing' is often used retrospectively to justify a patient's decision to change their treatment or behaviours, by demonstrating that they were acting on advice.

As Potter (1996) argues, 'active voicing' acts as 'stake inoculation' by lessening the risk of potential challenge on the basis of the speaker's 'stake'. By distancing herself from the opinion, the participant indicates that any potential stake she may have in the opinion being true is less relevant. This effect can be amplified by choosing a more objective origin for the

talk, for instance a family member, as seen in extracts 5.22 (taken from the same consultation as extract 5.8) and 5.23 (taken from the same consultation as extract 5.13).

Extract 5.22 (consultation 12)

- | | |
|--|---|
| <p>1 <i>Patient: Yes, yes, it's just the, the emotion sort of ... it's here, sort of</i></p> <p>2 <i>thing. And it's like anxieties, you know, and I'm not sure if it is the</i></p> <p>3 <i>Risperidone, but I've tried it 'cos my mum said it aggravates the</i></p> <p>4 <i>compulsive obsessive.</i></p> | <div style="border-left: 1px solid black; padding-left: 10px;"> <p>Troubles-telling</p> <p>frame</p> </div> |
|--|---|

Extract 5.23 (consultation 31)

- | | |
|--|---|
| <p>1 <i>Patient: Yeah, I was feeling so anxious and so worried about things</i></p> <p>2 <i>that I was just totally, I know my husband ain't here, but he kind of</i></p> <p>3 <i>saw the way I went and he suggested that I went [on anti-</i></p> <p>4 <i>depressants]</i></p> | <div style="border-left: 1px solid black; padding-left: 10px;"> <p>Troubles-telling</p> <p>frame</p> </div> |
|--|---|

Similar to 'active voicing' participants may draw on the opinions of medical professionals in order to borrow 'category entitlement' (Potter, 1996). Borrowing expertise in this way is particularly used in cases where the patient tries to trump the psychiatrist's expertise. In extract 5.24 the doctor opens the consultation by explaining to an observer present that there has been some disagreement about the patient's diagnosis. The patient responds by saying that she has sought a second opinion about her diagnosis, directly challenging the psychiatrist's expertise. The patient emphasises the seniority of the other doctor, allowing her claims to benefit from the category entitlement of 'Professor' and 'senior' doctor.

Extract 5.24 (consultation 17)

- 1 *Patient: I got a second opinion from the [hospital name].*
- 2 *[6 missing turns, concerning letter to consultant]*
- 3 *Doctor: OK (2.0) and was it with...*
- 4 *Patient: Professor [Name]...*
- 5 *Doctor: Professor [Name]*
- 6 *Patient: and his senior houseman, I think it is, whatever they're*
- 7 *called, you know, one of his doctors. I saw both of them.*
- 8 *Doctor: Uh hu and how did you feel it went?*
- 9 *Patient: Oh it was really good, it went really well and I was very*
- 10 *pleased with the way things went. They were very thorough and I*
- 11 *was there an awful long time about an hour and a half or more and*
- 12 *I felt it went really well. I was very pleased and they said to me that*
- 13 *there was nothing wrong with me.*
- 14 *Doctor: OK*
- 15 *Patient: So I was quite pleased with that. But you haven't heard*
- 16 *from them?*

Narrative frame

The patient emphasises a number of elements in her account that act to strengthen not only her credibility, but also that of the other psychiatrist, including her satisfaction with the consultation (lines 9-10) and its thoroughness (lines 10-11).

5.2.6 Vindication

One way that patients try to secure changes in treatment is to make the change first and seek approval afterwards (see, for example, extract 5.15). In doing so, patients shift the type of expertise needed away from a generalised knowledge about what is *likely* to happen (in which the psychiatrist is likely to have the upper hand, as discussed earlier in relation to the Lecture frame) and towards a specific knowledge about what *has* happened (which the patient is best

placed to know). This represents a shift in ways of knowing, in Habermas' (1985) terms, from 'system' to 'lifeworld'. By bringing in 'lifeworld' knowledge about real experiences, the patient privileges her own knowledge over the psychiatrist's 'professional' knowledge, making it harder for the psychiatrist to challenge legitimately.

A key way in which patients express this lifeworld knowledge is through reporting positive outcomes from their own experience as a way to vindicate prior decisions. Two examples of this technique are seen in extracts 5.25 (partially presented in extract 5.23) and 5.26. In both instances, the patient has made their own decision to change their medication or dose.

Extract 5.25 (consultation 31)

- 1 *Patient: Yeah. I was feeling so anxious and so worried about*
- 2 *things that I was just totally, I know me husband aint here, but he*
- 3 *kind of saw the way I went and he suggested that I went...*
- 4 *Doctor: But you're on, so you've been put on, what have you been*
- 5 *Patient: Ciprolax or whatever it's called.*
- 6 *Doctor: Cipramil?*
- 7 *Patient: No not Cipramil. Ciprolex.*
- 8 *Doctor: Ciprolex yes.*
- 9 *Patient: Yeah. It's a different, another name for it but I can't*
- 10 *pronounce.*
- 11 *Doctor: Yeah, Ciprolex.*
- 12 *Patient: And that's 10mg. And yes, I do feel 100% better with*
- 13 *them, I really do."*

Negotiation frame

Such expertise is similar to Ainsworth-Vaughn's concept of Aesculapian power (see Chapter Two). The patient is demonstrating her own ability to 'heal' herself by making effective medical decisions (Ainsworth-Vaughn, 1995). This claim must also be supported by the patient's performance.

5.3 Conclusion

Most institutional discourse studies have focused on ways in which institutions maintain power asymmetries through discourse, rather than on the techniques of clients to achieve their goals within these settings. As Agar argues in his review of institutional discourse studies:

“the client has been neglected, just as he/she has been in most of the studies reviewed here. Clients come with varying degrees of sophistication in the institutional frameworks, with wildly different client frameworks, with different abilities to psych out an Institution, and with different personal styles and manipulative abilities. [...] Interpersonal manipulation— the classic strategy of the powerless—belongs in the framework as well.” (Agar, 1985: 164)

Though the term is somewhat loaded, I would argue that it is this ‘interpersonal manipulation’ that I have elucidated in this chapter. Through their talk, patients make claims to expertise and influence decisions from within the institutionally constructed patient role.

Habermas’ (1985) claim that the system has colonised the lifeworld has been interpreted as meaning that validity claims are not open to patients in the medical setting; that *“institutional discourse is organized to prevent raising validity claims”* (Agar, 1985: 162) Nevertheless, the data presented here demonstrates that patients do find ways to make validity claims and use role performances to build credibility. In doing so, they draw on resources available to them, including the shared expectations of the patient role. The techniques highlighted here – ‘good patient’ performances, confessional talk, borrowing category entitlement, active voicing, role distancing and vindications – are examples of this type of work.

Still, the boundaries of these roles strongly influence behaviours. Patients are cautious about encroaching into the psychiatrist’s role, and when they do approach role boundaries they are hesitant. However, boundaries work in both directions and, as shown in extracts 4.20-4.22, patients occasionally also defend their roles against psychiatrists’ obtrusion.

6. Triadic interactions: the impact of family members present in the consultation

6.1 Analysing the triadic interaction: Footing

In chapters 4 and 5, I have focused upon footing as a pairing that occurs in a dyadic interaction. It is not uncommon for theories to be built around a dyadic model of interaction. This is particularly true of medical encounters where simple categories of doctor and patient are often utilised (Brown *et al.*, 1998). In these situations, participants are defined by this single relationship; the role of 'doctor' in the interaction is dependent upon the role 'patient' and vice versa. Interaction between the two is considered in relation to various footing pairs, each based on a simple speaker-hearer pairing, as I have done in the previous chapters. In this chapter I extend the analysis by exploring consultations in which family members are present as third parties in the consultation.

In Chapter Two I highlighted the lack of attention in the existing literature to what patients do in their talk (Heritage & Maynard, 2006). To an even greater degree, the work of family members and other third parties in the interaction has been largely neglected, with a few exceptions. Hymes argued that theories developed around social interaction, while sometimes productive, cannot be taken literally because of a general idealised dyadic approach:

"All such schemes, e.g., appear to agree either in taking the standpoint of an individual speaker or in postulating a dyad, speaker-hearer (or source-destination, sender-receiver, addressor-addressee). [...] Some rules of speaking require specification of three participants (addressor, addressee, hearer (audience); source, spokesman, addressees; etc.)" (Hymes, 1972: 40)

Goffman also highlighted this weakness in interaction theories:

"Traditional analysis of saying and what gets said seems tacitly committed to the following paradigm: Two and only two individuals are engaged together in it. During any moment in time, one will be speaking his own thoughts on a matter and expressing his own feelings, however circumspectly; the other listening [...]" (Goffman, 1981: 129)

Goffman argued that, although the dyadic model is common in face-to-face talk, basing interaction studies on this simplistic model is inadequate. By exploring the way that participants position themselves in a more multi-dimensional interaction, one-to-one discourse can also be better understood. This challenge of developing a theory that incorporates more variety than the simple 'speaker-listener' dyad was addressed by Goffman in his work on footing.

"A two-person chat sustained in a sequestered place implies, on first analysis, a full sharing of ratified participation status and, overlaid, an exchange of speaker and recipient roles.

But expand on these possibilities. Add a third participant, and allowance must be made for the speaker addressing the participants as a whole or singling out a particular other, in which latter case one is forced to distinguish between addressed and unaddressed recipients." (Goffman, 1974: 565)

By taking this stance, Goffman identified additional types of footing: colluder and ex-colluder; participants and bystander; performers and audience. Goffman thus distinguishes between three broad categories of speech producer and four categories of speech recipient. Under this model, a speaker may be in the role of *animator*, producing speech as heard; *author*, constructing the script as spoken; or *principal*, being the party who holds the position to which

the speech relates. A participant may be in one or more of these positions when speaking. When a speaker quotes another party, or attributes the point to another, they are stepping out of the role of author or principal. Recipients may be ratified (addressed or unaddressed recipients) or unratified (overhearers or eavesdroppers). Participants in an interaction shift their footing frequently, allowing a participant to move between these roles as the interaction moves between frames.

Levinson builds on Goffman's work to describe a more complex breakdown of participant roles. He delineates seven recipient roles, broken down into participant and non-participant recipients, and ten producer roles, again divided into participant and non-participant types (Levinson, 1988: 172-3). In doing so, Levinson attempts to create a set of universal categories designed to allow analysis of complex and even somewhat contrived categories.

While Levinson's critique is valuable, the framework he creates is unwieldy and overly complex for useful application in this setting. In this chapter, I take a slightly different approach from that of Levinson, by building third party footings into the frame analysis approach taken in the earlier chapters. I start from the assumption that in any given footing pair, a third party may also be negotiated into a footing relative to that utterance.

I also, in relation to Goffman's categories, take all participants to be ratified at least insofar as their presence must be both known and consented to. In doing so I explicitly exclude a key 'third party' who nonetheless has an impact on the interaction: the researcher. I described in Chapter Four how footing is sometimes oriented to the absent researcher. In general, the researcher remains a ratified but unaddressed hearer, but occasionally the researcher – via the recording device – becomes an addressed recipient. This area of research could be further developed elsewhere in relation to recorded natural interaction.

In this data set there is a very small number of consultations in which other third parties are present, though mostly silent. This includes trainees and other professionals involved in the

patient's care, including social workers or CPNs. There are too few examples of active involvement, however, to produce a useful analysis of these. Instead, I focus here only on family members attending with the patient.

Family members may attend consultations for a number of reasons (Coupland & Coupland, 2001). They may attend to support the patient, either emotionally or practically (for instance by driving them to clinic). They may attend to seek or provide information on their own roles and needs as carers. They may attend to support or challenge the claims made by the patient, offering an alternative perspective or ensuring that topics are covered that are of importance to them. Importantly, patients must consent to the family member's presence, either explicitly or passively. Patients may have similar reasons for wanting to be accompanied, though it should not be assumed that these reasons are always the same.

6.2 Summary of consultations with family members present

Table 6.1 provides an overview of the consultations considered in this section. There are 19 consultations in which an adult family member is present. In addition, but not considered here, in two consultations a young child (pre-speech) is present. I have also excluded those consultations in which only a professional third party is present (e.g. a social worker or nurse) since their roles are likely to differ substantially from those of informal supporters and family members.

Table 6.1

Consultation ID	Family member present	Number of turns (% turns) [% transcript coverage]		
		<i>Doctor</i>	<i>Family member</i>	<i>Patient</i>
1	Partner	158 (45%) [61%]	72 (21%) [15%]	119 (34%) [19%]
4	Mother	136 (50%) [68%]	35 (13%) [8%]	103 (38%) [20%]
5	Mother	68 (50%) [54%]	29 (21%) [23%]	39 (29%) [11%]
8	Partner	80 (46%) [53%]	46 (26%) [22%]	48 (28%) [18%]
12	Mother; father	79 (46%) [55%]	13 (8%) [5%]	77 (46%) [37%]
15	Father	30 (52%) [80%]	3 (5%) [5%]	25 (43%) [12%]
21	Partner	69 (35%) [24%]	52 (26%) [44%]	79 (40%) [29%]
23	Partner	40 (32%) [15%]	31 (25%) [12%]	55 (44%) [72%]
27	Father	73 (48%) [62%]	34 (22%) [25%]	45 (30%) [11%]
35	Mother; father	39 (46%) [61%]	25 (30%) [24%]	20 (24%) [13%]
46	Husband	58 (38%) [55%]	69 (45%) [35%]	26 (17%) [5%]
47	Husband	38 (35%) [25%]	22 (20%) [22%]	49 (45%) [52%]
49	Mother	86 (44%) [44%]	43 (22%) [25%]	66 (34%) [29%]
53	Mother	10 (39%) [61%]	11 (42%) [35%]	5 (19%) [3%]
54	Carer (unknown)	49 (54%) [61%]	4 (4%) [3%]	37 (41%) [13%]
63	Daughter	116 (47%) [42%]	3 (1%) [1%]	127 (52%) [46%]
69	Wife	73 (40%) [37%]	37 (20%) [21%]	72 (40%) [38%]
72	Sister	94 (47%) [53%]	27 (13%) [14%]	81 (40%) [28%]
73	Mother	120 (41%) [45%]	69 (24%) [28%]	102 (35%) [23%]
Range	<i>Turns Coverage</i>	32%-54% 15%-80%	1%-45% 1%-45%	19%-52% 3%-72%

Table 6.1 shows the degree of participation, in percentage terms, for each participant type.

This is presented primarily to demonstrate the wide variation in the participation of family members and patients across these consultations. At the extremes, in consultation 63, where the 18 year old daughter of the patient is present, (as the patient describes, because “I just wanted her with me today”) the family member makes almost no spoken contribution. In contrast, in consultation 53, the patient makes comparatively little comment, with the patient’s mother taking on a far more active participation, albeit in a fairly brief recorded section of consultation.

In about two-thirds of the consultations, the doctor does most of the speaking (based on coverage of typed transcript, as a proxy for time). In half of these cases the patient takes the second largest proportion of speaking time and the family member third largest; and in half the cases this is the other way around. The family member has the smallest proportion of

speaking time in a little over half of the consultations (11 out of the 19). Family members occupy the smallest number of speech *turns* in 16 out of the 19 consultations. This is significant in relation to participants' right to speak. These figures suggest that, in most consultations, much of the interaction takes place with the doctor and patient alternating turns. When family members do take the floor, they may have longer turns, such that their speaking takes up a larger part of the overall transcript. The issue of negotiating the right to take a turn is returned to below.

These figures are based on a small number of recordings but they indicate the variation in family member participation in psychiatric consultations. The distinction between proportion of speaking time and number of turns is interesting when considering the participant standing of family members and their right to 'hold the floor' or to enter the discourse.

6.3 Family member entry into the interaction

Miller and Silverman point out that "not all interactants have equal opportunities to initiate entrance into institutional discourses or guide them in preferred ways" (Miller and Silverman, 1995: 729). Although families may sometimes take on a large part of the speaking in a consultation, this does not necessarily mean that they have equal rights to shape the discourse or to claim the floor. The first section of this chapter considers the ways in which family members negotiate entrance into the discourse, and particularly examine how specific frames may open up opportunities for participation. Understanding turn taking in a triadic consultation is important, since it "determines how opportunities to speak arise, and hence how successive turns at talk are produced and allocated to the participants. (...) [They] shape the resources that interviewers and interviewees have to pursue their objectives, and they do so asymmetrically" (Heritage and Clayman, 2010: 214).

Previous studies examining the standard consultation opening were discussed in Chapter Two of this thesis, particularly the use of broad ‘how are you?’ openings to elicit patient concerns. This standard opening is also typical of the consultations in this data set. In consultations where the patient is accompanied, the doctor continues to direct opening questions at the patient as in a dyadic consultation. Of the 19 consultations in which an adult accompanied the patient, the psychiatrist’s opening was recorded in 15. All use a patient-directed opening question - 14 of which follow the identified pattern of broad ‘how are you?’ type questions - and all were responded to by the patient.

These openings suggest that psychiatrists continue to orientate themselves to a typical dyadic interaction structure, even when a third party is present, at least in respect to the initial elicitation of concerns for discussion. The opening establishes a footing in which the doctor is the enquirer and the patient is the responder. In extract 6.1, for example, a clear frame shift is indicated to negotiate this footing. The psychiatrist uses markers to indicate these shifts; “right, welcome” to indicate that the initial introductory frame is over and “And [Patient Name]” to establish the new frame which includes the standard opening enquiry and with it the footing between doctor and patient.

Extract 6.1: (consultation 54)

- 1 *Doctor: My name’s Dr [Name]... you’re...*
- 2 *Family member: I’m [Name], I’m [Patient Name]’s Carer:*
- 3 *Doctor: Right, welcome. ¶ And [Patient Name] how are you*
- 4 *getting on?*
- 5 *Patient: Not too bad, apart from me hands keep shaking.*
- 6 *Doctor: That would be very annoying.*
- 7 *Patient: It is.*

Frame shift:

Interview

This common pattern of opening sequences, illustrated by extract 6.1, highlights that it is oriented to as a dyadic, doctor-patient based interaction. This assumption is built into the frame of the psychiatric consultation and informs the joint understanding of the situation. Third party participation thus requires negotiation to establish a legitimate footing and role.

A key area for investigation is, therefore, how and when family members initiate participation in the interaction. Exploring how third parties negotiate entry into the discourse can provide insight into the role they are negotiating for themselves alongside the patient and psychiatrist. In the following section I identify four broad categories of third party entry into the talk: addressed by the psychiatrist; addressed by the patient; unaddressed; and controlled entry (i.e. when the family is invited to attend only part of the consultation).

Third parties' entry into interaction is constantly renegotiated as the participants engage in keying the talk. The extracts here do not focus, therefore, exclusively on family members' initial contribution, but also on later entries into the discourse following a period of talk between doctor and patient only. For the purposes of broad analysis, I have operationalised this as 10 consecutive turns between doctor and patient without family contribution, but this provides only a starting point for focusing on sections of data for more in-depth analysis.

6.3.1 Addressed by psychiatrist

On 17 occasions across eight of the 19 consultations, the family member or partner is invited to contribute by the psychiatrist. With one exception, where the psychiatrist invites the family member to express any concerns of their own, the invitation to talk takes place either within an ongoing doctor-patient interview frame or negotiation frame. In the former, this takes the form of seeking confirmation or challenge for the patient's already stated views. At the end of extract 5.8 (page 196), for example, the psychiatrist invites the patient's father to give his perspective on a question already answered by the patient.

A similar pattern appears in extract 6.2, where the psychiatrist seeks the parents' opinion following the patient's own response.

Extract 6.2: (consultation 15)

- 1 *Doctor: Right. Okay. [Name] thinks he's 80% back to normal –*
- 2 *would you agree with that?*
- 3 *Father: Yea, I think he's improved a lot. But (unclear) and then he*
- 4 *gets down.*

Interview frame

Psychiatrists' use of family participation to confirm the patient's own statements is found in a total of six consultations. The father in extract 6.3 enters the discussion unprompted, but having done so the psychiatrist invites him to respond to a question already answered by the patient.

Extract 6.3: (consultation 27)

- 1 *Doctor: A couple of questions just to come back to you about a little*
- 2 *bit more. But would you say over the last few months things have*
- 3 *been just much the same as they were, have always been, better*
- 4 *than they've been?*
- 5 *Father: I think he's better than he's been. I think maybe there's still a*
- 6 *bit to go and [Name] thinks that as well I think but I think really he's*
- 7 *stopped making excuses for example not to come down for a meal.*

Interview frame

A similar type of questioning is identified as 'circular questioning' by Miller and Silverman in their study of family therapy (Miller and Silverman, 1995). They argue that this technique is used to "recast the troubles at hand as aspects of family systems that might involve complex patterns of interrelation and/or diverse perspectives" (ibid: 733). In the context of systemic family therapy, however, the relevance of diverse perspectives embedded within family relationships is explicitly emphasised in the institutional discourse. Eliciting the family members' differing viewpoints is intended to reveal the troubles being presented more fully and to help find solutions.

I would argue that the technique used in these six consultations achieves a different purpose. It allows the psychiatrist to check on the participant's statement and to provide a means of challenge where the family member offers a different opinion. As seen in Chapter Five, patient performances of honesty and insight are important parts of building credibility in the consultation. This is one way in which patients' self-presentation may be threatened by a family member attending. This is discussed in more detail later in this chapter.

Psychiatrists also invited family participation during negotiation frames in which they were seeking to influence the patient's perspective or behaviour. In extract 6.4, the psychiatrist challenges the patient to consider whether his view that strangers are talking about him is justified, and receives minimal responses from the patient. In lines 8-9, the psychiatrist invites the patient's partner to support his argument.

Extract 6.4: (consultation 1)

1	<i>Doctor: And the second question is (2.5) why should people pick on</i>	Negotiation frame
2	<i>you in this way</i>	
3	<i>Patient: I don't know</i>	
4	<i>Doctor: Because my guess is (1.6) you don't look at people and,</i>	
5	<i>think terrible things about (them). So why-why should other people</i>	
6	<i>do it, to you</i>	
7	<i>Patient: ((in overlap)) I don't know</i>	
8	<i>Doctor: No (1.9). Because I imagine you-you you, very frequently,</i>	
9	<i>try to argue [Name] out of this</i>	
10	<i>Partner: I mean I, yeah I do. Erm</i>	
11	<i>Doctor: And offer him (reassurance)</i>	
12	<i>Partner: ((in overlap)) (I'd think) I'd say [Name] how on earth can</i>	
13	<i>strangers, you know people around you, how do they know what's</i>	
14	<i>happened (do you know what I mean?)</i>	

The consultations in which psychiatrists invite family members to speak suggest that they are ascribed a particular role and function by the psychiatrists. In both frames where it occurs, family members are given the opportunity to challenge the patient – either by offering conflicting information or by supporting the psychiatrist’s position in a negotiation. Family members are therefore available as a potential ally for the psychiatrist in achieving her goals in the interaction. This works as a parallel to the use of ‘active voicing’ by patients as discussed in Chapter Five. In those instances, the patient draws on support from an absent third party (often a family member) to lend support and credibility to their views. Here, the psychiatrist directly invites an alternative form of ‘active voicing’ to co-opt the family member as support. The idea of alliance building is discussed further later in this chapter.

6.3.2 Addressed by patient

On eight occasions in three consultations family members were addressed by patients. I have here excluded one consultation in which the patient invited her husband to translate for her since the interaction in that instance takes on a very different form. In all eight instances this was to confirm the patient’s responses. In parallel to the technique by psychiatrists of checking the family perspective, patients appear to use family corroboration to build credibility. As previously discussed, invoking third parties to reinforce the factuality of a claim (‘active voicing’) is a common technique among patients. In this respect, the presence of a family member can help in making objective validity claims (Habermas, 1984) and in ‘stake inoculation’ (Potter, 1996) by garnering the ‘independent’ corroboration of another party.

In extract 6.5, for example, the patient invites her sister to confirm her description of how she has been.

Extract 6.5: (consultation 72)

- | | |
|---|--|
| <ol style="list-style-type: none"> 1 Doctor: $\overline{\text{F}}$ Tell us what the problem is then 2 Patient: I still have headaches and the voices keep talking to me. 3 And I still sleep downstairs. Um 4 Doctor: Why do you sleep downstairs? 5 Patient: And I get really upset. Don't I? 6 Sister: for no reason | <p>Frame shift –</p> <p>Troubles-telling</p> |
|---|--|

In this consultation, the patient continues to seek confirmation from her sister throughout.

These invitations appear to play two roles, first to corroborate factual claims – reinforcing the objective validity claims made - and second to form an alliance between patient and family member vis-a-vis the psychiatrist.

Inviting a present family member to provide corroboration carries risks since the invitation may prompt a contradiction that undermines the patient's claim. In extract 6.6, the patient invites his partner to support his claim that he has answered the telephone, as he has been encouraged to do by his cognitive therapist. His partner offers only partial support for the claim in line 3.

Extract 6.6: (consultation 21)

- 1 *Doctor: Are you working on it or...*
- 2 *Patient: Yeah, I answered it a couple of times, haven't I?*
- 3 *Partner: Yeah, sort of.*
- 4 *Patient: Sort of.*
- 5 *Partner: Usually just left for me to run down and do.*
- 6 *Doctor: Is that true of all phone calls or would it just be people you*
- 7 *don't know or people you do know.*
- 8 *Patient: No, any phone calls.*
- 9 *Doctor: What was the other thing he was going to get*
- 10 *you...wanted to (do) more of, answering the door, what happened*
- 11 *about that, how's that?*
- 12 *Patient: Have I been answering the door?*
- 13 *Partner: No you do not.*

Interview frame

This extract invites the question as to why the patient should choose to seek corroboration if he knows that his partner may in fact challenge his initial account. In considering this, it is noteworthy that the patient does not challenge his partner's response, but echoes it in line 4. Then, in response to the second question, the patient directs the question to his partner straight away, rather than offering his own perspective first.

This interaction demonstrates how the presence of a third party can disrupt the attempts at 'good patient' performance that were discussed in (section 5.2.1, page 206). In response to a direct question, the patient appears to be keen to sustain a 'good patient' role by demonstrating efforts to become 'well' and following medical advice. The invitation to the partner, however, shows that the patient is aware of the presence of a witness who could undermine this performance, and may be likely to do so. This limits the potential for the patient to make his performance credible.

Here, it is useful to consider Goffman's discussion of 'passing' and information control in relation to stigmatised persons (Goffman, 1963). Goffman argues that where a person is 'discreditable' – that is, that he has characteristics which may be stigmatised, but which he may be able to conceal – it is common for that person to 'pass'. In 'passing' the person chooses not to reveal the discrediting information to others in the interaction. While stigma is often discussed in relation to broad characteristics, it is also possible to apply the concept to more context-confined roles. Here, there is, in effect, the problem that the patient is not behaving in the way that a 'good patient' should behave (i.e. not fully following the advice of medical professionals). This information, if known to the psychiatrist, may be discrediting to his performance. In other circumstances, this may pose little threat to the performance, but the presence of a family member makes it likely that this discrediting information will be revealed.

"Apart from the fact that the individual's current actions can discredit his current pretensions, a basic contingency in passing is that he will be discovered by those who can personally identify him and who include in their biographical record of him unapparent facts that are incompatible with present claims." (Goffman, 1963: 95)

The presence of a family member therefore makes it difficult to maintain the division between the different 'worlds' (ibid:104) in which the patient's social and personal identities are managed. Using this understanding, the patient's claim at line 2 can be seen as an attempt at 'passing', and the hand-over to his partner in line 10 is a recognition that he cannot safely pass with her there. The invitation to the partner may be seen, then, as an attempt to save face by showing that he is not passing. As with 'pre-emptive confessions' (section 5.2.3, page 208), this may help to mitigate the 'discreditable disclosures' made by the family member.

6.3.3 Family member contributes unaddressed

In eleven of the consultations, family members are found to contribute without direct invitation, either as their first contribution or following a period of doctor-patient turn taking.

These sections are of particular interest in establishing the family member's own understanding of their role in the interaction, while others' responses to these contributions help to ascertain how successfully this contribution is negotiated.

The potential difficulties of entering the talk unaddressed are seen in several examples. Participants are seen to orient themselves to the potentially weak footing this places them in. In extract 6.7, for example, from the same consultation as extract 6.4, above, the family member indicates that she has something to add but waits for the psychiatrist's encouragement at line 4 before continuing.

Extract 6.7: (consultation 01)

- | | |
|---|-------------------------------|
| <p>1 <i>Doctor: Yeah. Th-This aggressiveness wh-wh-what's that (0.5)</i></p> <p>2 <i>down to?</i></p> <p>3 <i>Patient: I dunno. I'm not sure</i></p> <p>4 <i>Partner: I think (sorry, can I...)</i></p> <p>5 <i>Doctor: No you, you come in, absolutely</i></p> <p>6 <i>Partner: Um, you said you feel that it started from what happened</i></p> <p>7 <i>as a child</i></p> <p>8 <i>Patient: (overlapping talk) As a child</i></p> | <p>Interview frame</p> |
|---|-------------------------------|

A similar 'permission to speak request' (Heritage & Clayman, 2010: 221) appears in extract 6.8 where the patient's mother prefaces her challenge to the patient's presentation in the consultation with "can I just say", again suggesting that the speaker is acknowledging that she does not have an automatic right to contribute in the consultation. Heritage and Clayman suggest that, in the context of news interviews, such phrases are in fact 'token requests'. By making a request, it becomes difficult for others to challenge. Such statements then may be not so much requests as orientation statements, indicating that the family member is oriented to the ongoing doctor-patient talk and is justifying her contribution within that discourse. At the same time, it is used as a marker for keying as she shifts the frame from Directing to

Disclosure. This extract is expanded later in this chapter in relation to ‘speaking over’ (extract 6.15)

Extract 6.8: (consultation 35)

1 <i>Doctor: I think it might make sense if we give it a little bit longer at</i>	Directing frame
2 <i>(unclear) maybe just taking the (unclear) on a regular basis</i>	
3 <i>(unclear) doesn't even start, just nips it in the bud. That might be</i>	
4 <i>the (unclear)</i>	
5 <i>Mother: ¶ Can I just say</i>	Frame shift - disclosure
6 <i>Doctor: yep</i>	
7 <i>Mother: she's alright now, she's sitting here, but when she's at</i>	
8 <i>home you know you said like that constant movement, there is that,</i>	
9 <i>it is a continuous thing. So if she's on the Procyclidine would that</i>	
10 <i>(unclear)</i>	
11 <i>Doctor: It certainly should, no it should help.</i>	

Despite the examples above, however, most instances where family members speak without explicit invitation do not have such a preface, and there are no instances of their right to speak (as opposed to the view they express) being challenged.

There are two dominant frames in which family members enter the discourse unaddressed; first, in response to an Interview frame where the psychiatrist's questions are directed toward the patient, but the family member offers their own comment (as in extract 6.7), and second within a Narrative frame, usually in relation to a patient-initiated narrative. The character of these contributions is quite different, just as the power balance between doctor and patient is different in either frame.

In the Interview frame, family members offer responses which either differ from the patient's response or supplement it. In extract 6.7, above, for example, the patient's partner encourages

the patient to respond more fully to the psychiatrist's questions by evoking a previous conversation between patient and partner. The family members' talk is thus oriented to the psychiatrist's goal of eliciting relevant and accurate information.

In the narrative frame, family members orient themselves to the patient's goal of providing a personal account. In this frame, the family member generally offers not corrective information but additional details and perspectives about the account. In extract 6.9, for example, the husband's contribution to the patient's narrative about stigma in the workplace serves to reinforce the patient's account. He enters at a point where the patient appears to be struggling with the narrative ("this is horrible", line 3) and they go on to jointly construct a lengthy narrative. This is discussed in more detail later in this chapter in relation to jointly constructed narratives.

Whether oriented to a Narrative or an Interview frame, the family member's legitimacy for entering the discourse is drawn from their ability to add further information or clarification in relation to either the psychiatrist's or the patient's agenda. They do not, in this data, interrupt the dyadic discourse with a shift in frame or in topic. Instead, their entry is assistive; that is, it is explicitly oriented to aiding the existing participants in their communication goals.

Extract 6.9: (consultation 23)

- 1 *Patient: And he actually thought I was exaggerating or I don't know,*
- 2 *but he actually (unclear) you can tell can't you. This is like being*
- 3 *interviewed, this is horrible.*
- 4 *Husband: This guy was a CPN as well.*
- 5 *Patient: Yeah, he was actually a CPN.*
- 6 *Husband: But he'd never had experience of working with*
- 7 *somebody that he knew had a mental health problem.*

Narrative frame

1	Doctor: <i>But I susp- suggest that that's what we consider. That that</i>	Directing frame
2	<i>we get you into hospital for your safety (0.8) and then think about</i>	
3	<i>Cloz-, when you're in there think about starting Clozapine</i>	
4	<i>because er generally, Clozapine should be started while you're in</i>	
5	<i>hospital (5.0). ¶ Shall we talk to yer mum?</i>	Frame shift - Stage-direction
6	Patient: ¶ Yeah	
7	Doctor: <i>Do you wanna ask her to come in?</i>	
8	Patient: <i>Yeah</i>	Informal frame
9	<i>((13 sec gap - patient leaves room to speak to his mother outside))</i>	
10	Doctor: <i>Hello</i>	
11	Mum: <i>Hello</i>	
12	Doctor: <i>We've met before haven't we, I think</i>	
13	Mum: <i>Yeah we have yeah</i>	
14	Doctor: <i>Yeah hi. (1.6) ¶ Well I expect er, you're at least</i>	
15	<i>as worried about [Name] as I am</i>	

Through this careful control of the family member's presence, the mother has no opportunity to impact on the patient's presentation of himself or contribute to the construction of his narrative prior to the decision being made. While it is not possible to ascertain whether this is deliberate, or on whose part, it is notable that the patient in this consultation does considerable work to present himself as being at high risk of suicide (see discussion of extract 4.5, page 121). The 'high stakes' nature of this performance may contribute to a decision not to risk the exposure of discrediting information.

As with consultation 4, consultation 5 begins with the patient and psychiatrist only and the mother waiting outside. The start of the recording suggests that this might be at the instigation of the doctor (Doctor: "Let's just chat first, you and I"), but this conclusion cannot be made with any confidence since the recording again does not capture any negotiation which may have preceded it.

Once again, the psychiatrist makes the suggestion to bring in the patient's mother part way through the consultation. The role of the mother in this consultation is quite different, however. While in extract 6.10 the mother is presented with information about a decision that has already been reached, in extract 6.11 the mother is invited to share information by adding her perspective to that already given by the patient.

Extract 6.11: (consultation 05)

1	<i>Doctor: Good. (2.4) $\overline{\text{f}}$ Do you mind if we-er, d'you want to ask</i>	Frame shift - Stage direction
2	<i>your mum whether she'd mind, popping in-is that okay? D'you</i>	
3	<i>Patient: $\overline{\text{f}}$ Yeah</i>	
4	<i>Doctor: want-go and ask her to, join us for a bit ((paper rustling))</i>	
5	<i>(9.0 pause while patient steps outside to bring his mother in)</i>	
6	<i>Doctor: Hallo</i>	
7	<i>Mother: Hello</i>	
8	<i>((3.0 second pause - sound of door being closed))</i>	
9	<i>Doctor: $\overline{\text{f}}$ How's it been going from your perspective?</i>	Frame shift - Interview
10	<i>Mother: $\overline{\text{f}}$ Erm, he's getting there slowly ...</i>	

In both these cases, the consultation takes the form of two largely dyadic consultations; the first half takes place between doctor and patient, the second between doctor and family member. Despite the patient's presence in the latter part of the consultation, the doctor's comments are addressed primarily to the family member who is also the main respondent; both patients remain largely silent during these discussions.

In this sense, the character of these consultations is very different from the others in this data. The talk in these second-half consultations is oriented to the psychiatrist informing the family members and eliciting information from them. In effect a substantial frame-shift has occurred in which participants' footings are renegotiated to the extent that the patient is now placed primarily in the role of audience. The patients in these two instances limit their validity claims to the section of the consultation where the family member is not present. In one sense, the patient may be less likely to be challenged in his performance if this is conducted primarily

without the family member there. However, the risk remains that discrediting information will be revealed subsequently, as demonstrated in extract 6.17 and discussed below (page 253).

By exploring the way that family members are shifted from bystanders in a dyadic discourse to participants in that discourse, I have attempted to discover the perceived third party functions which allow legitimate shifts of footing to include them. The most marked conclusion is that in general all three participants – patient, psychiatrist and family member – ascribe a function to family members of correcting, confirming or challenging the views stated by the patient. This is seen in psychiatrists' use of family members to check on patients' answers, in patients seeking confirmation from family members for their own statements, and in family members offering unsought clarifications and additions. This has important consequences for participants' ability to present their preferred 'face' and to make validity claims using the techniques discussed in Chapter Five. In the next part of this chapter, I will consider this further in laying out two functions of the family members' footing: 'speaking for' and 'speaking over' (Coupland & Coupland, 2001: 127). In the final part of the chapter I consider two further types of contribution: building alliances and co-narrating events that take place outside the consulting room.

6.4 Negotiating roles and footing for third parties

In their analysis of consultations with elderly patients and their 'chauffeur' (family or other carer), Coupland and Coupland (2001) distinguish between a kind of co-operative 'speaking for' and a more dominant 'speaking over', while acknowledging that the family member's contribution may in either case serve to limit that offered by the patient. Adams and Gardiner (2005) make a similar distinction in relation to triadic communication between doctors, dementia patients and their informal carers. They identify strategies used to "enable dementia communication" or "disable dementia communication". Enabling behaviours are those that help the patient to express their own opinions and feelings, and portray the patient

as capable of making their own decisions. Disabling behaviours, by contrast, prevent the patient expressing their own views and portray them as incapable of decision-making.

Examples of both ‘speaking for’ and ‘speaking over’ are found among these consultations. In the following section I discuss these different forms of contribution in relation to participants’ footing and performance.

Before discussing these behaviours in more detail, it is important to note how the negotiation of footing may be influenced by what Goffman refers to as ‘backstage’ talk, i.e. the interaction that members of a team engage in when the audience is absent (Goffman, 1959). One form of backstage work is referred to as ‘staging talk’ (Goffman, 1959: 172), whereby a speaker or speakers in an interaction discuss how that interaction is to be managed. It is possible that some of the interactions involving family members are the result of such staging talk, in which participants have agreed how they will collaborate – or not collaborate – in their performances to the psychiatrist. Without access to this backstage talk, it is impossible to say with certainty, however in examples such as extract 6.23 (page 267) there are clear indications that the patient and his partner have discussed the consultation in advance and prepared their performances in accordance with this staging talk.

Equally, there are examples of what looks like ‘team collusion’ (Goffman, 1959: 174), whereby patients and family members exchange signals concerning the immediate performance. One such example was seen in extract 6.9 where the patient’s remark that sharing her narrative was ‘horrible’ prompted her partner to intervene with support in telling the account.

A final form of backstage talk is the ongoing relationship and discourse between patient and family in relation to their shared lives and experiences. It is to be expected that many of the things discussed in a consultation are also relevant to the patient and their family outside the consultation. This was seen in extract 6.7, above, where the patient’s partner spoke up in response to the patient’s apparent reluctance to offer his own view about the cause of his

feelings of aggression. The partner's contribution here encourages the patient to express a view that has apparently been previously discussed between them. In this instance the patient does support his partner's view and goes on to expand on it.

While it is not directly observable in this data, it is very likely that patients and families engage in backstage talk that is relevant to or directly used in the psychiatric consultations to a more or less traceable degree. The significance of such talk, while not always elucidated in this analysis, must be considered as a hidden but important dimension of the triadic – and indeed the dyadic – discourse.

6.4.1 *'Speaking for'*

Several of the consultations in this study contain instances of 'speaking for', where the family member's talk is apparently aimed at facilitating the patient's own communication. The facilitation aspect of this talk refers to the family members' performance of the talk, not necessarily its outcome. In extract 6.12, taken from the same consultation as extract 6.5, the patient, her sister and the psychiatrist are discussing a possible change in medication which would require the patient to go into hospital. Throughout the discussion the patient expresses concern about the hospital admission and uncertainty about whether to accept the change.

Extract 6.12: (consultation 72)

- 1 *Patient: Shall I go on them?*
- 2 *Sister: I think you should give it a go. No harm in that.*
- 3 *Patient: I have to stay in hospital did you say?*
- 4 *Doctor: You'd probably be in for a few days.*
- 5 *[3 turns removed, discussion of patient transport to hospital]*
- 6 *Sister: Do you want to try it or not? It's up to you I'm not saying for*
- 7 *you.*
- 8 *Patient: So will it make me better then?*
- 9 *Sister: Well, we don't know do we until you try it*
- 10 *Patient: I don't want this tablet no more do I?*
- 11 *Doctor: Is this tablet causing you problems in terms of side effects?*
- 12 *Patient: Basically/*
- 13 *Sister: (Interrupting) /What she wants. What I think she thinks,*
- 14 *'cause just recently she's been really tearful, crying for no reason*
- 15 *whatsoever, and she won't even say what she's crying about and I*
- 16 *think she thinks that she needs a change.*

Negotiation frame

The patient's sister is seen to shift her footing throughout this extract. In response to the patient's direct question, she expresses a personal opinion ("I think"). In line 6 she emphasises that the patient needs to state her own preference. Then in line 13 the sister interrupts the patient's response to the psychiatrist's question, explicitly articulating her own perspective on her sister's view. The phrase "I think she thinks" (lines 13 and 16), allows the sister to place the patient in the role of principal. As with extract 6.7, by emphasising that the view is one that comes from the patient, the family member makes it pertinent in response to the psychiatrist's question, which was aimed at the patient. In contrast to 6.7, however, the family member has interrupted the patient's own response, undermining the patient's role in articulating her own experiences.

In extract 6.13, in contrast to 6.7 and 6.12, the patient challenges his wife's authority to speak on his behalf (line 5). The patient does not say that his wife is wrong but challenges her emphasis and the impression this creates of him. This is the only example of such an open challenge to a family member's attempt to articulate a view ascribed to the patient, but it serves to highlight the interactional risk of making this kind of attribution, since the suggested principle is on hand to confirm or deny the claim.

Extract 6.13: (consultation 69)

1 <i>Doctor: Yup, what happened last time with it then? What was so</i>	Interview frame
2 <i>terrible about it? Did it give you side effects or...</i>	
3 <i>Patient: Yes it did actually.</i>	
4 <i>Wife: it made you sleep a lot, didn't it? A lot</i>	
5 <i>Patient: No no, no. You're not taking it.</i>	
6 <i>Wife: No I know but that was the effect I observed.</i>	
7 <i>Patient: Yes the effect you observed but also I observed other</i>	
8 <i>things in the fact, I'm trying to think what it...</i>	

I have chosen these three examples to show how footing is negotiated by the family member when speaking on behalf of the patient. In 6.7, the partner clearly attributes the position stated to the patient himself. The reference to a previous discussion between patient and partner appears to be significant here. The partner ascribes the role of principal for the statement to the patient, not to herself, which allows the comment to have relevance in response to a question directed at the patient. A similar technique is used by the sister in extract 6.12 to differentiate between statements that express her own view, encouraging the patient to speak for herself, and finally expressing a position attributed to her sister. In extract 6.13, the partner initially states the view as unproblematic 'fact' (line 4), but when challenged, the partner reasserts her view in line 6, as a witness to the event under discussion.

Potter (1996) argues that footing is an important way to display neutrality in making claims, providing the example of a news interviewer who distances herself from the assertions adopted within her questioning by attributing them to a (specific or generalised) third party. These examples highlight the difficulty that family members in a psychiatric consultation may experience in adopting an appropriate footing. A balance is struck between articulating a view that is credible (the family member is in a position to know), pertinent (the family member is justified in speaking), and goal-oriented (the family member seeks to achieve something through the talk; the 'perlocutionary act' discussed in Chapter Two).

6.4.2 'Speaking over': Challenging patient self-presentation

As discussed earlier in this chapter, Goffman argued that each participant's talk in interaction should be viewed as a performance through which they project their preferred impression, and that this impression should be 'supported by judgments and evidence conveyed by other participants' (Goffman, 1967). As a result, the presence of family members in the consultation poses a risk of challenge to self-presentation. They may disrupt the patient's ability to control information about themselves and therefore to present their preferred 'face' (Goffman, 1959:141). I showed in Chapter Five that patients sometimes reveal information that apparently threatens their self-presentation but which allows them to perform the 'honest' patient. Where the threat comes from a third party, however, this presentation may not be available.

Extract 6.14, taken from the same consultation as extract 6.8, shows how a patient's performance may be impacted by a family member presenting competing validity claims. In lines 1-12 the patient demonstrates techniques highlighted in Chapter Five in relation to good patient performances, including offering new information about her health status and demonstrating an informed understanding of her medication use by, for example, using the medication name and describing proactive changes in response to her side effects. At line 13,

however, the patient's mother interjects to correct the patient about the change in prescription. The changing use of pronouns here serves to place the mother in the active role of managing the medication rather than the patient; she uses "we" in line 15-17, suggesting a joint activity, and moves to "I" in line 19, suggesting that in fact she is the principal actor in relation to resolving the problem with the prescription. This mirrors the work of psychiatrists and patients described in Chapter Five in relation to ascribing activity.

Extract 6.14: (consultation 35)

1 <i>Doctor: And you're back to pretty much on your normal... great.</i>	Interview frame
2 <i>Where do you think compared to your normal self, do you think</i>	
3 <i>you're fully back to normal or</i>	
4 <i>Patient: I'd say so.</i>	
5 <i>Doctor: Good.</i>	
6 <i>Patient: But my eyes have been going quite a lot recently.</i>	
7 <i>[4 turns excluded, patient provides more detail]</i>	
8 <i>Doctor: Yeah, I think that's very much to do with the medicine, with</i>	
9 <i>the Olanzapine. Where are you with that because we'd started</i>	
10 <i>gradually running down. How much Olanzapine are you taking?</i>	
11 <i>Patient: Well because they've changed now, (how I take them)</i>	
12 <i>because the prescription was changed, (I'm on the big ones)</i>	
13 <i>Mother: The prescription hasn't changed it's just...¹⁷ you know when</i>	Frame shift - Narrative
14 <i>you first prescribed them she was on 10mgs, well what happened</i>	
15 <i>was she, when we put in a new repeat prescription it was an old</i>	
16 <i>one which actually had the 10mgs still on there. So when we</i>	
17 <i>picked up the tablets, that's what we got.</i>	
18 <i>Doctor: Right.</i>	
19 <i>Mother: This was yesterday, but I sorted it out so I'm going to</i>	
20 <i>collect the proper ones in the morning, but she's still on the 3 a</i>	
21 <i>day, one in the morning 2 at night, of 2.5.</i>	

- 22 *Doctor: Of 2.5, so a total of 7.5.*
- 23 *Mother: Yes and she's still on that.*
- 24 *Doctor: And you've managed to get some more 2.5.*
- 25 *Mother: Not at the moment, we haven't got them in for today. Is*
- 26 *that OK?*
- 27 *Doctor: That's fine yeah. I have to let your GP know about the*
- 28 *change but I shouldn't imagine it's been a bit confused.*
- 29 *Mother: It's on their computer because I checked it up today, what*
- 30 *happened was the repeat prescription slip that we put in is actually*
- 31 *an old one, that's what it was.*
- 32 *Mother: He's just got a question to ask you.*
- 33 *Doctor: We can do that in a minute. So really things are back to*
- 34 *normal, (talk overlapping - unclear)*
- 35 *Mother: You're more tired aren't you.*
- 36 *Patient: Yeah, I do get a lot more tired.*
- 37 *Doctor: And you're still taking the (unclear)*
- 38 *Patient: Yeah.*

The effect of the mother's entry in the extract above is three-fold. First, additional information is shared which may or may not have been provided by the patient in the mother's absence, and which may be at odds with the impression that the patient wishes to give. Second, the footing between doctor and patient established in the interview frame is disrupted and the psychiatrist directs her questions to the mother for the following turns. This further reduces the patient's ability to control the information shared. Thirdly, the fact that the psychiatrist addresses the next three turns to the mother and not to the patient suggests that the psychiatrist sees the mother as the more reliable, or perhaps more forthcoming, source of information, at least in relation to this topic, undermining the patient's previous work to establish an informed patient identity which lend credibility to her validity claims.

This interpretation is reinforced a few turns later (extract 6.15, which follows directly from extract 6.14, see also extract 6.8) when the psychiatrist asks for the mother's perspective on how the patient is doing, having already asked the patient at the start of extract 6.14. Extract 6.15 starts with the doctor seeking the patient's permission to ask her mother's perspective. This mirrors the 'permission to speak' requests (Heritage & Clayman, 2010) discussed above. Again, these negotiate a turn-taking which might not be considered 'naturally' legitimate. At the same time, the request makes it very difficult for the patient to object despite the inherent suggestion that the patient's own validity claims may be open to challenge.

Extract 6.15: (consultation 35)

- 1 *Doctor: Do you mind me just checking with your mum what she*
- 2 *thinks*
- 3 *Patient: yeah, that's fine*
- 4 *Doctor: is that alright? Do you think things are back to normal?*
- 5 *Mother: Umm. Well I don't know how, when you say back to*
- 6 *normal, because she's still actually on the lowest dosage. So that's*
- 7 *keeping her, you know*

Interview frame

- 8 Doctor: *Right.*
- 9 Mother: *Yeah, she's still a bit up and down. Like I said there's*
- 10 *changes going on at home and with my daughter and at the*
- 11 *moment we've had another big change. So you know she's just a*
- 12 *little bit...*
- 13 Doctor: *Yeah. No, I think when things are changing that can just*
- 14 *make it all a little bit more unsettled*
- 15 Patient: *I'm really happy though. I don't feel like scared or*
- 16 *anything. I'm OK in myself.*
- 17 *[11 turns removed – doctor and patient discuss side-effects]*
- 18 Mother: *⌈ Can I just say*
- 19 Doctor: *yep*
- 20 Mother: *she's alright now, she's sitting here, but when she's at*
- 21 *home, you know you said like that constant movement, there is*
- 22 *that, it is a continuous thing. So if she's on the Procyclidine would*
- 23 *that affect...*
- 24 Doctor: *It certainly should, no it should help it, it should make it*
- 25 *better, yeah.*
- 26 Mother: *OK.*
- 27 Patient: *Is that about my moving?*
- 28 Mother: *Yeah, constant, yeah*
- 29 Patient: *It's changed, because when I'm out, I'm now out, and at*
- 30 *the meetings, I don't move, but at home I start moving and I don't*
- 31 *know why*

Frame shift -

Disclosure

The patient's responses, at lines 15-16 and 29-31, while not contradicting the mother's claims, provide a different perspective, giving a more positive interpretation of how things have been and emphasising that things are sometimes better than her mother's account suggests. The patient then adjusts her account in response to the mother's contribution, but has less

freedom to maintain the performance she started. The family member can be seen to work at providing her own account in order to (successfully in this instance) influence the decision being made around medication. The psychiatrist shifts her footing to place either the mother or the patient in the role of active bystander to facilitate access to both perspectives.

The example presented in the following two extracts (taken from the same consultation as extract 6.11) shows how a patient's performance may be even more directly challenged and the tension that can arise in the interaction as a result. In the first part of this consultation only the patient and doctor are present; the patient's mother waits outside (an example of entry-controlled participation). Before the mother enters, the doctor asks the patient directly about when he last changed his T-shirt. The potential for interactional difficulties arising from this question is already acknowledged by the doctor's 'out of character' talk describing the question as 'very personal'. The patient replies that it was on new this morning, and the psychiatrist collaborates – while indicating scepticism – with this presentation.

Extract 6.16: (consultation 05)

1 <i>Doctor: How long have you been, it's a very personal question but</i>	Interview frame (Out of character talk)
2 <i>how long have you been, wearing that T-shirt?</i>	
3 <i>Patient: (I just got into it)</i>	
4 <i>Doctor: Today? (2.2) Is that-what's that yer breakfast down the</i>	
5 <i>front?</i>	
6 <i>Patient: Yeah</i>	

Shortly afterwards the patient's mother is invited to join, and the psychiatrist directly challenges the patient's response by asking her this same question. The mother contradicts the patient's previous response – though without knowing what his response had been. The patient makes no further comment.

Extract 6.17: (consultation 05)

- 1 *Doctor: I've just been commenting on his T-shirt*
- 2 *Mother: (1 word)*
- 3 *Doctor: I can't believe that's only one breakfast down there it must*
- 4 *be several breakfasts*
- 5 *Mother: ((in overlap)) Well I was quite annoyed because I said last*
- 6 *night I-, put his clean trousers out and er- (1.9) you know we*
- 7 *(washed up) this morning and when I got here I said 'what on earth*
- 8 *have you got that on for?' you know (2.1)*
- 9 *Doctor: That's*
- 10 *Mother: You had a shower last night didn't you but you put your*
- 11 *clothes (back on)*

Narrative frame

This contradiction serves to undermine the impression that the patient tried to project in the previous extract – it acts as discrediting information as discussed above. This example also highlights the way in which performances might be incompatible. The patient is constructing a performance to combat the suggestion of 'deviance' inherent in the doctor's question. In contrast, the mother is constructing a performance as a 'good mother', one who would not by choice allow her son to wear dirty clothes to an appointment. Depending on the role and the stake of the speaker, deviance and responsibility are constructed through the choice of details in an account (Smith, 1978). This is discussed further later in this chapter in relation to competing narratives.

6.4.3 Coalitions

Within the literature on dementia, the idea of coalitions and collusions within the triad of care has received considerable attention (Adams and Gardiner, 2005). Coe and Prendergast (1985) offer an approach to understanding the role of family members in consultations with elderly patients based on the formation and shifting of coalitions. They define a coalition as "an effort

by two members of the triad to achieve a mutually desired goal, despite the (active or passive) resistance of the third member” (ibid: 241). They identify the formation of several different coalitions within single consultations and emphasise that attempts at a coalition are not always successful.

The concept of coalitions fits closely with Goffman’s description of performance teams (Goffman, 1959). This idea was briefly discussed in Chapters Two and Four in relation to communication out of character. A ‘performance team’ refers to “any set of individuals who cooperate in staging a single routine” (ibid: 85). At one level, then, all three participants in the consultations act as a performance team. However, where more than one participant cooperates to establish the definition of the situation, or to sustain an impression, this may sometimes exclude other members present. This is the situation I discuss in this section as coalitions.

In this data there are examples of family members creating such coalitions with the psychiatrists. One example was presented earlier in extract 4.24 where the doctor and the patient’s partner form a coalition aimed at challenging the patient’s belief that people on the street knew things about him. This example also highlights that coalitions may reach outside the interaction and into relationships and decision-making between the family members (into ‘backstage talk’).

In extract 6.18, the psychiatrist has raised concerns about the patient’s weight. The patient herself appears to resist the doctor’s comments. Prior to this extract she has argued that she has already been restricting her diet. In lines 4 and 7 the doctor speaks ‘out of character’ to highlight the possible tension surrounding these questions, in a similar way to that seen in extract 4.40 (page 172).

Extract 6.18: (consultation 8)

1 Doctor: <i>⌈ Have you thought about (1.2) something drastic like</i>	Negotiation frame
2 <i>weightwatchers?</i>	
3 Patient: (2.6) <i>No I haven't</i>	
4 Doctor: (3.3) <i>Are you frowning at me or are you um</i>	Out of frame activity
5 Partner: (laughs)	
6 Patient: <i>No</i>	
7 Doctor: (laughs) <i>I was wondering whether you, i-i-is it okay having</i>	
8 <i>this conversation?</i>	
9 Patient: ((coughs)) (3.5)	Negotiation frame
10 Doctor: <i>⌈ Ha-ha-has your doctor talked to you, about your weight</i>	
11 Patient: <i>No</i>	
12 Doctor: <i>and your diet. No (1.1) no</i>	
13 Partner: [Name] <i>doesn't go to the doctor, you see</i>	
14 Patient: <i>He just makes fun of me</i>	
15 Doctor: <i>Does he? What way?</i>	
16 Partner: <i>Gentle, gentleness (coughs) Like I do. I say if she was a</i>	
17 <i>horse we'd shoot 'er wouldn't we (laughs). But er if-if she could</i>	
18 <i>perhaps you could (0.8) persuade her to take, just a little, once a</i>	
19 <i>day even, then (2.1) and (0.7) being as she's sitting down all the</i>	
20 <i>time the thought of food must be (0.7) er (1.0) nice. Rather than</i>	
21 <i>her just, one piece of bread and one potato, kind of thing</i>	
22 Doctor: <i>No I agree I-I absolutely right. And erm, you're-you're</i>	
23 <i>probably burning very very few calories</i>	
24 Partner: <i>Yeah</i>	
25 Doctor: <i>Erm (1.4) ⌈ I mean exercise, there's- there is not just</i>	Frame shift - Lecture
26 <i>(0.7) anecdote there's a lot experien- a lot of research now that</i>	
27 <i>shows that exercise very good for you in many respects including</i>	
28 <i>your mental health</i>	

The partner here suggests that the psychiatrist could “persuade her”, implying not only the need for persuasion (i.e. that the patient does not agree with this position) but also suggesting that he had himself been unsuccessful in doing so. The patient, throughout these exchanges responds minimally. A common effect of coalition forming of this kind is to ‘cut out’ (Smith, 1978) the patient in the face of joint opposition; explicit resistance to this form of persuasion appears, at least within the interaction, to be difficult for patients.

Coalitions, as with other aspects of interaction, fulfil multiple functions. On the one hand, a coalition may lend additional weight to the argument put forward and increase the likelihood of achieving the intended goal. Coalitions may form part of a strategy to support ongoing attempts to influence the patient either on the part of the family member or the psychiatrist. In extract 6.18, for instance, the psychiatrist shifts into a lecture frame to draw on a more neutral, ‘professional’ knowledge. This use of framing – far more readily available to the psychiatrist than the partner – provides this additional weight, and does so in a way that appears less personal (see discussion of lecture frame, 4.2.2, page 135).

At the same time, coalitions also form part of an identity performance. By forming coalitions with the psychiatrist, family members are taking up a particular footing in relation to the patient and their care. There is evidence that family members are building up a ‘good carer’ role, equivalent to that of the ‘good patient’ role. This was suggested earlier in relation to extract 6.17 (‘good mother’ performance). It is further seen in family members demonstrating medical knowledge (e.g. extract 6.18 & 6.19) and active participation in care. In extract 6.19, a coalition is initiated by the family member. In doing so, as well as performing the role of ‘eyewitness’, the partner positions herself in a medical role, as adviser and active participant in the patient’s treatment (for example by monitoring medication adherence).

Extract 6.19: (consultation 21)

Partner: The thing is with [Patient] it's like anything, he can't do one of nothing. He tries to kid himself: 'I'll just have it on Fridays', but I know what'll happen, he'll end up wanting it more. Like Valium he wanted that more and more, now he's got a new number for Valium, it's got to be 8 Valium at a time, so that's what I said to you, there's no Valium. Because it's just another circle, it's just another thing to fight. The drink, the Valium, smoking draw. They're all things you know, that aren't good anyway, because he's addictive person. He's not having that the draw will make him paranoid and unwell, which (unclear) we had the book through, 'The Voice', and it's actually done studies on it, saying about it, with cannabis and that, and mental illness and he's read it as well, but

Patient: But I'm already mentally ill so it don't matter.

Partner: It does matter because it can make it worse.

Doctor: It makes it worse.

Partner: It does, thank you, it does [Patient]. I know that you feel

Doctor: Do you not think it does?

Patient: Um I think if any harm's being done it's only to myself not to no-one else. Not like when I'm drinking and causing havoc all round everywhere. I'm only causing harm to myself and not no-one else.

Partner: That's not true though [Name].

Patient: I'm not causing harm to no one else.

Partner: You do, because in doors when you start smoking draw and you smoke too much of it you start getting paranoid, then you start saying you need a drink, or you'll need Valium.

.

Negotiation frame

Patient: I don't smoke too much of it though

Partner: Name, talk to me, stop telling fibs. I know you want to believe that you'll keep it every Friday, but and I know you're getting angry as well with me saying it but the truth of the matter is it won't stay as a Friday.

Patient: It will.

Partner: And you shouldn't have it at all, full stop, it's not going to do you any favours.

Patient: What am I supposed to have then, I can't have nothing, been coming, let's see, September...

Patient: I didn't have a drink for three months, the last three months before the last time. I went three months without no, no I can't do it.

Doctor: You've been doing it with nothing for a while now. You've

Throughout this extract the partner adopts similar techniques to those identified among patients and discussed in section 5.2.1 (page 206) as supporting 'good patient' performances. The patient's partner adopts a medical 'voice' which she might reasonably expect to align with the position of the consultant in relation to cannabis use, including reference to studies that support her zero tolerance approach (lines 5-7). Though she is not able to speak with authority as part of a professional body of knowledge, she can draw on that knowledge as an outsider and through coalition with the psychiatrist she can co-opt his authority to support her argument. She highlights the health repercussions for the patient demonstrating alignment with the consultant's aims. The coalition is accepted by the psychiatrist in line 11 and reinforced at lines 29-30 where he supports the partner's contention that the patient does not need to depend on alcohol or drug use.

I identified seven examples of coalition forming in this data set, all of which were coalitions between family members and psychiatrists in 'opposition' to the patient. I found no examples of coalition forming between patient and psychiatrist in this data, nor between patient and family member. This is not to say that these pairings do not collaborate in other ways, as I go on to discuss in relation to joint narratives. In these instances, however, the collaboration is not in opposition to the other party. This may be chance; Coe and Prendergast (1985) found examples of all three possible pairings in gerontology consultations.

However, it may also stem from the power imbalances in the participants (Caplow, 1959). Coalitions, in this data and in previous studies, focus around negotiations and decision-making; they are goal-oriented. In psychiatric consultations these decisions generally fall into two groups: decisions about treatment and decisions about patient behaviours. All of the examples here fall into the latter category. It seems likely that psychiatrists have no need of coalitions in relation to treatment decisions since they already hold the balance of power in this respect. In contrast, patients hold the power in relation to their own behaviours. As such, the natural coalition would seem to be between family member and psychiatrist. Equally, as discussed above, family members may have the most to gain in relation to identity performance through their coalitions with psychiatrists. Though this may indicate a possible explanation for the discrepancies here, it cannot be stated with confidence from this study alone.

6.4.4 Co-constructed narratives

So far in this chapter I have discussed the way in which family members offer contributions through speaking for or speaking over patients and through building alliances. In the next section I discuss a fourth way in which family members contribute, through the co-construction of narratives.

Narrative has most frequently been treated as an individual's construction. Key to the way that narrative is treated is the idea that "narrators control the terms of storytelling, they occupy 'privileged positions in story worlds of their own creation'" (Riessman, 2002).

However, in situations where other parties are present, and where those parties also play a role in the account being told, this privileged position may be threatened. In addition to the collaboration between narrator and listener, such situations are complicated by the addition of another listener and another narrator.

As discussed in Chapter Two, narratives in medical settings function partly to share important information about the patient's life and circumstances, and partly to construct identity performances. Narratives are part of how patients and others make sense of the condition and their own roles and identities in relation to it. Narratives are constantly reconstructed and are not isolated to a specific telling. Narratives told within a consultation may have been told before, in different settings, to different audiences and for different purposes. The account seen in a consultation provides a snapshot of an ongoing account which is being renegotiated with each telling and which encompasses others.

"How someone experiences and interprets the body's signals of "danger" depends not only on what kind of person he or she is, but also on what everyone else around that individual is like. A central factor is the agreement between one's story about oneself and the stories others have about you, about themselves, and about themselves in relation to you." (Lee and Dwyer, 1995:74)

The presence of a family member can make explicit some of this negotiation. As patients construct identities through their accounts, they must negotiate this with the narrative constructed by those around them. In doing so, the family member may challenge or shape the narrative. At the same time, family members are shaping their own narratives as family, friends or carers and articulating and constructing their role in this process. As Hall *et al* argue in relation to social work discourse, "throughout the story there are alternative versions

lurking in the background which threaten to disrupt the balance of blame and responsibility” (Hall *et al.*, 1997, quoted in Baldwin, 2004: 207).

The significance of these social constructions of accounts is demonstrated in Dorothy Smith’s (1978) detailed analysis of one story in which the teller constructs a friend as ‘mentally ill’. This analysis demonstrates how evidence of norms and deviations – of ‘self’ and ‘other’ – are created in the telling to lead the audience to the narrator’s conclusion. Smith also shows how an alternative structuring and selection of events could lead the audience to an entirely different conclusion, showing how narratives are significant as much for their omissions as for their content.

The three extracts discussed below exemplify three different types of co-constructed narrative: joint narratives; complementary narratives; and competing narratives.

Jointly constructed narratives

Extract 6.20, a small section of which was shown in extract 6.9 above, is an example of what I describe as a ‘joint narrative’. In this consultation the patient is describing her experiences in the workplace. It is important to note that the co-construction of this narrative includes not only the patient’s partner but also the psychiatrist who, in the first turn shown here, invites the patient to tell her story to a trainee who is present and in doing so defines the patient’s account to be about stigma, a term she had not used herself, and legitimises that as a useful topic. Such definitions at the outset serve to inform the audience about how they should treat the content of the account (Smith, 1978). As a result, the purpose of the narrative has changed from being a patient-driven account to being a teaching tool.

Extract 6.20: (consultation 23)

1	<i>Doctor: You mentioned there something about how people treat</i>	Narrative frame
2	<i>you would you mind telling... it's her first introduction to psychiatry</i>	
3	<i>so maybe you could talk about stigma and things like that.</i>	
4	<i>Patient: Yeah. Interestingly enough I had to tell, I was followed in</i>	
5	<i>the prison, shouldn't say I was in prison should I, my dad used to</i>	Out of character talk
6	<i>tell me off about that. When I was working in [Place] I had a</i>	
7	<i>medication change and I didn't take any time off but I went from</i>	
8	<i>nothing to Risperidone and then back to Olanzapine and I felt that I</i>	
9	<i>should actually tell my boss what was going on. Actually he said</i>	
10	<i>he hadn't even noticed anything and I was fine but I felt like I was</i>	
11	<i>all over the place in my mind I couldn't concentrate I was just</i>	
12	<i>everywhere. And I told him and I was actually very good friends</i>	
13	<i>with him and for about three months I'd say to him (unclear) and</i>	
14	<i>he'd look at me like that. And I'm like [Name] I'm telling the truth.</i>	
15	<i>And he actually thought I was exaggerating or I don't know, but he</i>	Out of character talk
16	<i>actually (unclear) you can tell can't you. This is like being</i>	
17	<i>interviewed, this is horrible.</i>	Narrative frame
18	<i>Partner: This guy was a CPN as well.</i>	
19	<i>Patient: Yeah, he was actually a CPN.</i>	
20	<i>Partner: But he'd never had experience of working with</i>	
21	<i>somebody that he knew had a mental health problem.</i>	
22	<i>Patient: Yeah. He's on the end of actually dealing with a patient</i>	
23	<i>but he's never been on the end of actually working with somebody.</i>	
24	<i>So he didn't know where his role was. And he we see each other</i>	
25	<i>outside work you know, we're good friends.</i>	
26	<i>Partner: To a certain extent that's a lot of what it's like trying to</i>	
27	<i>get employment in normal</i>	

- 28 *Patient: Yeah, if I walked into a job interview and I said to*
 29 *somebody, 'yeah you mentioned that you've got a mental health*
 30 *problem, schizophrenic'*
 31 *Doctor: Out the door.*
 32 *Patient: 'no way'. But if you think about it, would you. And my*
 33 *brother actually said a good point when I was first diagnosed would*
 34 *you, I'd rather employ somebody with one arm than a mental health*
 35 *problem and he works in the City.*
 36 *Doctor: He wasn't...*
 37 *Patient: No he wasn't talking about me.*
 38 *Partner: He wasn't being nasty just being practical...*
 39 *Patient: He was just talking generally. Because that's what it's*
 40 *like, that sort of stigma is.*

The constructed nature of the narrative is reinforced at two points where the patient engages in 'out of character' talk: the first when she corrects herself for saying that she had been in prison, and the second where she comments on the interaction as being 'like being interviewed'.

The partner's contributions form a part of the same narrative with the patient remaining the principal narrator throughout. The interjections serve to support and reinforce the account and to offer an additional perspective by stressing elements of the account which the patient had not mentioned (e.g. the colleague's professional background working in mental health, line 18) or offering a different interpretation to that taken by the psychiatrist (e.g. the brother's motives, line 41).

The high level of agreement between the patient and her partner suggest a narrative that has already been worked up between them, and perhaps others, in the past, a conclusion reinforced by the reference to discussions with the patient's brother. As with Horton-Salway's analysis of a joint narrative given by a woman with ME and her husband, the account may be

fairly described as *their* story (Horton-Salway, 2001). The partner's contribution does not challenge the patient's credibility and may serve as corroboration for her account.

Complementary narratives

Prior to the exchange in extract 6.21 (from the same consultation as extracts 6.4 and 6.7) the patient explains that for as long as he can recall he has been uncomfortable going out of the house because he felt that people were talking about him. In this extract the patient's partner picks up the narrative. In doing so, the narrative is reconstructed from an individual account, focusing on the history of this experience for the patient, to a complementary account in which the partner becomes both narrator and principal character.

Extract 6.21: (consultation 1)

- 1 Doctor: *Is that right? So you either don't go out at all or you you/*
- 2 Partner: */Well I try, I try to encourage, you know, try to encourage*
- 3 *[Name]. But I, you know I I (0.7) don't know how to, I mean I don't*
- 4 *feel (these sort of things obviously) and, you know I try and*
- 5 *encourage [Name] to kind of like come out with me or come out*
- 6 *with my family or friends but he just can't do it*
- 7 Doctor: *Does he um (0.9) does he tell you directly about it when*
- 8 *he's out. He says-he says those blokes are talking me*
- 9 Partner: *No, erm, if we go out, [Name], I mean it's not very often,*
- 10 *that we do it, but when, on occasions we do, [Name] will just*
- 11 *completely clam up, will go very quiet. And, i-it's not until we get*
- 12 *home, that he says to me, you know, how he was feeling. And (you*
- 13 *feel so bad) you know (that he gets to hear it all the time) (c. 3*
- 14 *words) you get he's like "I can't, stand it" you know, "these, these*
- 15 *feelings that people are talking about me". And he gets very upset*
- 16 *about it, and that he can't (do it) you know, go out*

Frame shift -

Narrative

The partner's contribution provides two important functions: first, by acting as witness to the patient's difficulties she corroborates and reinforces the patient's own account. Second, it reconstructs the narrative to include additional 'personages' (Smith, 1978: 31) who are meant to be considered as significant to the account. In particular, the partner includes in her account the impact of the patient's behaviour on her and her role in supporting and encouraging him, part of the 'good carer' role discussed above.

These complementary narratives, therefore, allow the family member to situate the personal narrative into a social narrative. This may help to widen the gaze of the psychiatrist and to consider this wider impact within decisions. It also allows the family member to engage in their own identity work. These alternative constructions do impact on the patient's own narrative since, as mentioned earlier, the decision to omit (or not to select) this content is part of their account. Significantly, however, both narratives can be held simultaneously to be valid; they do not contradict each other.

Competing narratives

The final type of co-constructed narrative discussed here is 'competing narratives'. As well as contradicting in relation to content (what happened), narratives may compete around interpretation and agency (who was responsible); or evaluation (what message the audience is expected to take from the account). Two examples, both from the same consultation demonstrate the latter types.

Extract 6.22 is taken from near the start of the consultation already cited in extract 6.19. The narrative is initiated by the patient in response to the psychiatrist's question about cognitive therapy (see extract 6.6). Through his narrative the patient can be seen to undertake a 'good patient' performance (5.2.1). His choice of account demonstrates insight into previous problems and efforts to comply with therapeutic recommendations, in this case to socialise more.

Extract 6.22: (consultation 21)

- 1 *Doctor: Those things apart do you find that in cognitive therapy*
 2 *you're doing things you can use.*
- 3 *Patient: Yeah. We've just got a small puppy, a little dog and um.*
 4 *The other dogs I had weren't socialised you know, because I used*
 5 *to take them to where there was no people, to the woods and that.*
 6 *Um. This one we're socialising now aren't we?*
- 7 *Partner: yeah*
- 8 *Patient: yeah?*
- 9 *Partner: He's, yeah but he's not realised it but he's trying to really*
 10 *go out where there's not people. So he's trying to go back to that*
 11 *way of you know the park and that. If he thinks there's going to be*
 12 *a lot of people you'll go let's go down the bottom park.*
- 13 *Patient: Yeah, because people stop and chat to you when you've*
 14 *got a dog. And, because they might have a dog as well, so it's*
 15 *something to, but, when they start talking I feel like I'm being*
 16 *interrogated by them. It doesn't, I know it's only, I know it's only*
 17 *conversation at the end of the day but at the time it's happening I*
 18 *feel like it's an interrogation more than anything...*

Narrative frame

In this extract, the patient's female partner challenges the accuracy of the account, and the patient's attempt to portray compliance with the recommendations. As a character in the partner's narrative, the patient is not as successful in changing his previous behaviour as he had suggested. As a narrator, the patient is constructed as having less insight into his own behaviour than he claims – "he's not realised it, but". This alternative construction also serves to emphasise her own credibility as a narrator in contrast to the patient.

In extract 6.23 (seen previously in relation to confessions, extract 5.17) a co-constructed narrative is offered around a specific occasion in which the patient had too much to drink. The

problematic nature of this account is highlighted in line 3 where the partner indicates that the patient would prefer her not to have been there to tell it.

Extract 6.23: (consultation 21)

- 1 *Doctor: Those things aside how would you say things are in*
- 2 *general?*
- 3 *Partner: Well. (partner and patient laugh) He didn't want me to*
- 4 *come and see you.*
- 5 *Patient: I had a drink last Tuesday didn't I?*
- 6 *Partner: Yeah. And he wasn't not well, he went and done it*
- 7 *through, literally just because he wanted to buy a drink and it*
- 8 *caused absolute havoc. And it really has took a long, long time for*
- 9 *like the atmosphere to go away indoors because you know, he.*
- 10 *he's got to stop knocking on people's doors and giving them grief,*
- 11 *like my family and that. He's frightened the children, like, you know,*
- 12 *the kids. And they was all upset with him and where they're older*
- 13 *they're not so forgiving now because they're saying that, which is*
- 14 *true, he's admitted it himself, that he wasn't ill, he was going up*
- 15 *town to an AA meeting and I've been, I've had to go and see*
- 16 *someone about counselling because like I've not been able, I've*
- 17 *been a bit like anxious lately. So Dr [Name]'s put me on tablets*
- 18 *and she wanted me to see someone. And she's, I've been told like*
- 19 *that I've got to let [Name] try and do things for himself because I've*
- 20 *mollycoddled him really and I do everything, everything gets put*
- 21 *back to me. Well I've been trying to do that haven't I [Name], like to*
- 22 *let you go up to meetings and it's been hard, because I know I'm to*
- 23 *blame as well, because it's easier for me to go along then I think,*
- 24 *oh I'll be there if he does feel like (unclear) I'll try and stop him. But*
- 25 *he went off last Tuesday to the AA meeting and he just didn't come*

Narrative frame

26 *back and I knew he'd gone off drinking but it was, he'd gone to me*
27 *sister's firm, caused trouble there, so she's got a warning now*
28 *about him going round there. Went to her house, didn't you and*
29 *went to me other sister's house, went to me brother's house and*
30 *the whole thing, he does it, he knows he does it all the time but you*
31 *know, it's just really the drink is a massive problem*
32 *Patient: Just start wandering places you know.*
33 *Partner: But he didn't need to go and drink.*
34 *Doctor: Had you been to the AA meeting.*
35 *Patient: No, no, I didn't go.*
36 *Doctor: You went drinking instead.*
37 *Patient: No I went to the gallery, the art gallery and then I went to*
38 *the pub. The thing is I went into this pub at Charing Cross and*
39 *there was this guy there who kept looking over at me and I thought*
40 *oh, he's a spy and that and then so instead of coming back to my*
41 *area on the train from Charing Cross I went to [Place] area and*
42 *there he was in the very pub that I went into at [Place]. And so...*
43 *Patient: But I didn't think that at the time. At the time it was*
44 *causing me to be psychotic about it you know. And...*
45 *Partner: Yeah but the drink was causing you to be psychotic.*
46 *Patient: Yeah I know.*

The competing nature of these narratives is not directly in the truth of the account or the action described. Instead, the conflict can be seen at the level of what Bamberg describes as agentive and non-agentive positioning:

“this type of analysis aims at the linguistic means that do the job of marking one person as, for example, a) the agent who is in control while the action is inflicted upon the other; or (b) as the central character who is helplessly at the mercy of outside (“quasi-natural”) forces” (Bamberg, 1997:337)

In this extract the partner positions the patient as agentive and disputes earlier positioning by the patient as victim of his illness - *“he wasn’t not well”* (line 6); *“literally just because he wanted to”* (line 7); *“he didn’t need to go and drink”* (line 34). In contrast, the patient positions himself as victim of a chance encounter and of his condition - *“it was causing me to be psychotic”* (line 44).

Mirroring the conflict over the patient’s responsibility, the partner talks about her concern that she has ‘molly-coddled’ the patient. Again, this is evidence of working up a ‘good carer’ identity – actively engaged in supporting the patient, but aiming not to smother him. Similarly, the reference to the children’s reaction lends credibility to her own account (she is not the only one to interpret it this way) and positions her as concerned and protective mother. In the construction of her narrative, however, the partner also positions herself as non-agentive. She is the victim of the patient’s behaviour, of her own anxieties (11-13) and of the judgements of others about her role.

This last extract highlights the interactional difficulties for patients when a family member is present. ‘Good patient’ performances may be undermined not only by a challenge to the validity claims made, but also by the family members’ own identity performances.

6.5 Conclusion

In interpreting the findings of this chapter, it is important to consider the limitations of audio data and the lack of information about gaze. The interactional work done through body language is not present in this data and this means that the analysis can be only tentative. Further work should be undertaken using video data to review these findings.

Family members may feel that they have a difficult role to negotiate, not just in relation to clinical interactions but also more generally in relation to their caring role. They tread a fine line in their performances between overbearing and supportive; respecting confidentiality and being an active partner in care; putting the patient first and meeting their own needs.

These challenges are mirrored in the interaction itself where family members have to negotiate a role within the usual dyadic structure of talk where they speak neither from the position of patient nor as medical expert. I have discussed the ways in which family members attempt to legitimise their speaking roles when entering the discourse (section 6.3), and how they navigate shifts in footing to make their claims credible and relevant.

There is a clear correspondence between framing and the participation of third parties. The footing that each participant adopts to the others is influenced by the shifts in frame.

Beyond that, however, there appear to be particular frames in which family members take on specific roles in the interaction. I have shown how family members are invited to challenge or corroborate in the interview frame; form coalitions in negotiation frames, and offer complementary or competing accounts in the narrative frame.

The presence of family members adds complexity to the interaction. Their talk may support or challenge patients' claims and facilitate or undermine their presentation of 'face' in the interaction, as demonstrated above in relation to competing narratives (section 6.4.4, page 259). At the same time, family members construct their own identities which are necessarily

interdependent with those of the patient. The performance of 'good wife', 'good mother' or 'good carer' may create tensions with the patient's own identity construction.

Focusing on family members in the consultation also serves to remind us that the psychiatric interview should be viewed as a snapshot within a broader discourse. Where a family member is present, ongoing discourse may be evoked and made to some degree explicit. In these transcripts, there are frequent references to previous exchanges of views outside of the consultation which impact on the team performances of patient and family member, as seen in relation to 'speaking for' participants (section 6.4.1, page 244). This broader discourse is altered by bringing it into a different context – a medical interview – but it is not distinct from it. From this perspective, instead of seeing the partner as an addition to the typically dyadic interaction between doctor and patient, we may view the psychiatrist as an addition to a continuing discourse between patient and partner.

7. Conclusion

This thesis opened with a discussion of shifts in both sociological theories and psychiatric practice towards recognising patients' contributions to treatment decisions and acknowledging them as experts in that care. This laudable approach requires not only closer scrutiny of psychiatrists' language, but also that of patients.

In Chapter Two, I considered ways of understanding 'expertise', particularly in relation to patients. I argued that a realist approach – whereby patients had to demonstrate an array of knowledge and technical competence comparable with that of doctors – did not adequately explain what expertise might look like in an institutional setting. Expertise is more usefully understood as built up through validity claims (Habermas, 1985) and identity performances (Goffman, 1959). I have shown how such claims and performances are constructed in patients' and psychiatrists' talk (demonstrating human agency), but also how the ability to make certain expert claims are therefore significantly shaped by institutional roles and identities (micro-social structure). Expertise, then, manifests itself in the credibility of these performances – the participant's ability to demonstrate not an objective *competence at psychiatry*, but their *role competence*. The role of Expert Patient remains a *patient* role and requires performances and validity claims that correspond to that role.

Through my analysis, I have shown some of the techniques used by patients to build credibility, make validity claims, and work towards their own goals in the interaction. Some of these techniques have been identified in previous research but not in the particularly

challenging context of the psychiatric consultation. I have also shown how patients acknowledge and sometimes challenge the boundaries of their roles, and how boundaries are defended by psychiatrists. If shared decision making is to be a reality for patients, psychiatrists need to understand how the boundaries placed on the patient role by the institutional setting shape patients' contributions. Such explicit understanding is usually lacking from discussions of current shared decision making.

The study also addresses the question of whether patients want an active role in decision making. Their considerable efforts towards this are seen in these consultations, including persistence where they meet psychiatrist resistance. The care patients take to maintain the situation's interaction order (Goffman, 1983) by respecting role boundaries should not be confused for indifference or for a preference for the asymmetrical status quo. Equally, psychiatrists can learn why some techniques for shared decisions making may not always be successful, in particular asking patients to step into the role of psychiatrist by recommending diagnoses and treatments. Examples shown in section 5.1.3 (page 192) demonstrate how patients are reticent to openly make recommendations, even where their discourse suggests that they have a preference.

In this conclusion I briefly summarise the argument of this thesis before highlighting the contributions made in: i) conducting frame analyses; ii) understanding patient performances; and iii) understanding the impact of family members' presence in the interaction.

7.1 Summary of Findings

The findings presented here make a case for a new way of looking at how patients participate in the psychiatric consultation. This argument can be broken down into a series of premises supported by the data presented in Chapters Four, Five and Six.

1. The nature of the psychiatric consultation is not uniform throughout, but shifts as participants orient themselves to different interactional tasks and frames. As the discourse shifts, so do the speaking rights and expectations of participants in relation to one another.
2. Participants manage multiple tasks within their interactions. These include tasks aimed at achieving both proximal and distal goals, including shaping decisions, projecting personal identities, maintaining appropriate relationships with other speakers, and making sense of their own experiences by co-constructing accounts. A focus on only one of these tasks, for instance influencing treatment decisions will provide only a limited understanding of what patients are doing through their talk. While previous research has focused on single frames or goals in doctor-patient discourse, this often over-simplifies the picture by not recognising the shifting and overlapping aims of institutional talk. This study has built on that work by showing how the interactional work identified builds into broader performances – how ‘Troubles-Telling’ can be used to allow the patient to suggest a diagnosis; how confessions and disclosures can be used as part of a face-saving performance.
3. The social relations and behavioural expectations established by medical institutions strongly shape what can be seen as appropriate behaviours by patients. This can be seen in patients’ and family members’ explicit work to create space for taking the floor and patients’ reluctance to make outright treatment recommendations. Boundary work is central to efforts to encourage patients to take an active role in decisions. Shared decision making may require psychiatrists to encourage encroachment, rather than defending boundaries.
4. Patients can be seen to work towards influencing psychiatrists less through bold statements of preference and more by cultivating a performance of an ‘expert’ or ‘informed’ patient within the constraints of the institutional role. A key element of

this is the work undertaken to construct a 'good patient' identity through their performances in which they can be trusted to follow medical advice, share relevant information and demonstrate insight into their condition (section 5.2.1, page 206).

Recognising this important aspect of the patient performance can help to understand patients' deference to psychiatrists not as passive submission but as strategic identity work and a demonstration of agency.

5. Patient performances require a careful balance between personal goals and institutional requirements. These performances may be supported or disrupted by the psychiatrist and by family members present in the consultation. I do not argue that family members should not have a place in psychiatric consultations. These consultations clearly show family members providing support and valuable insight. However, when considering what role family members may have, psychiatrists need to recognise the importance of shared performances. Equally, they need to understand how patients' efforts can be affected by a family member or other third party, including how family members can prompt pre-emptive confessions, undermine identity performances, and collaborate in the building of patients' accounts. The different techniques for including these others show how the impact may be managed. They also show how psychiatrists sometimes form alliances with family members to disrupt patient performances.

This argument leads to the conclusion that patients carefully manage performances in psychiatric consultations, and that they do so to influence the psychiatrist. They *are* active in making treatment decisions. Psychiatrists respond to this either by encouraging these efforts – by inviting narratives, responding to frame shifts and collaborating in patients expert performances – or by discouraging them – by defending their territory, rejecting frame shifts or collaborating with others to undermine their expertise.

7.2 Frame analysis

Through offering an understanding of the relation between discourse frames and power shifts, this thesis adds a new perspective on previous studies of doctor-patient relationships. Frames within the medical setting are both institutionally shaped and individually constructed. They are therefore a tool that is available to patients and other participants to change the dynamics between speakers.

I have applied a frame analysis to this dataset in a way that has rarely been used previously. As discussed in Chapter Three, the move between Goffman's theoretical outline of frame analysis to a method of applying this approach to naturally-occurring, face-to-face talk has been made by only a handful of researchers previously, and some have been criticised for a lack of rigour. In Chapter Four of this thesis I offered a typology through explication of a range of frames seen across the data and demonstrated the multiple activities undertaken via framing within the psychiatric consultation. By exploring these different types of activity alongside each other, it is possible to see how they are negotiated and linked into ongoing identity and role performances.

By applying a systematic methodology, as laid out in section 3.3 (page 81), and laying out specific criteria for identifying frames, I have made my analysis transparent to the reader. Of course, frame analyses are still subject to the boundaries imposed by the researcher. Additional frames could no doubt be identified, either at a broader or a narrower level. My analysis is not, therefore, exhaustive, but it offers a valuable contribution to understanding the forms of talk that occur most commonly across this dataset.

I also examined the way in which these frames were constructed and negotiated in the detail of participants' talk, explaining not only *what participants do* through framing but also *how they achieve* it. The use of bracketing and creating space for longer turns have been

identified in previous studies, but the examination of framing provides a different perspective on the purpose of these techniques to shift the alignment (or 'footing') of participants and their orientation to interactional tasks.

Chapter Four laid the foundation for understanding the participants' use of identity work and strategic action in Chapters Five and Six. In these later chapters I have drawn links between the frame and the individual turns that form participants' talk. In applying this particular approach to discourse I have shown how frame analysis can raise different types of questions for discourse analysts. I would argue that it provides a finer grain analysis of the shifts in dynamics than is produced by studying only one aspect of discourse, such as those discussed in Chapter Two. It allows us to ask not just 'how is this aspect of talk managed?' but also 'how does this aspect of talk differ from other aspects?' and 'how does this aspect of talk materialise?'

Through framing, participants open and close opportunities for themselves and others to behave in particular ways. Within the psychiatric consultation – as with other medical encounters – there is evidence that the scope for controlling frame shifts is balanced in favour of the professional, but I have shown in this thesis that it is not only doctors who use frame shifts to meet their goals. Patients also employ numerous techniques for frame and footing negotiation.

In Chapter Four I described eleven frames which occurred most frequently across the dataset: Interview, Narrative, Troubles-telling, Directing, Advice-giving, Negotiation, Lecture, Complaint, Stage Direction and Informal. For each of these frames I have demonstrated how participants' change their alignment to each other and shift their orientation towards specific goals and tasks. I also discussed the extent to which each of these frames were available to participants within the broader frame of the psychiatric consultation.

In my descriptions I have emphasised how, by shifting from one frame to another, both psychiatrists and patients change the expectations of the interaction. For example, by using an Interview frame, the expected responses are short and focused, leaving the initiative with the interviewer. In contrast, a Troubles-telling frame creates expectations on the hearer to act as sympathetic audience. Negotiations are framed to allow participants to contribute to a discussion of preferences and rationality, while direction frames discourage further discussion and present a decision as final.

These shifts are significant when considering how talk in medical settings encourages or discourages the patient from taking a central role in their own care. More attention could be given by medical professionals to those frames which give the patient greater control over the interaction and greater freedom to expand on topics of relevance to them. This type of approach is not new. It can be seen in the work on narrative-based medicine and is central to talking therapies (Launer, 1999).

Alongside demonstrating important frames that constitute the consultation, I have also shown how participants can step outside these frames through out of character talk and demonstrated what these 'lapses' in performance achieve for the speaker and for the 'performance team'. Psychiatrists and patients in this data both use such techniques to build trust and manage their performances (section 4.4, page 168).

The analysis of frames presented here demonstrates that shifting between frames is part of existing patient strategies for managing interaction and achieving goals. The examples discussed in Chapter Four suggest that patients sometimes negotiate frames which leave the directive authority with the psychiatrist and that this may be part of a deliberate performance.

7.3 'Patient' performances: techniques for negotiating roles and making claims

In Chapter Five I looked in more detail at the types of performance that patients build up through dramaturgical techniques, both through the use of frames, and through techniques available to them within the discourse. I focused primarily on how patients perform credibility; how they seek to influence decisions both by pushing at the edges of the patient role, and by emphasising their adherence to it.

These data show a vast resourcefulness of patients in their interactional capabilities. However, they also show that these actors are constrained within the institutional role of the 'patient'. Perhaps the starkest example of this is the reluctance of patients to answer psychiatrists' direct requests for a preference around treatment decisions. While they can be seen to work deliberately and effectively to influence the psychiatrist, they are reluctant to step outside the boundaries laid out by the institutional roles of 'doctor' and 'patient'. This also has significance for improving shared-decision making and patient-centred care.

Clinicians may believe that they are inviting patients to participate in their treatment decisions without recognising the institutional barriers that prevent them from doing so.

In the last part of Chapter Five I considered how patients work to perform the patient role in a way that is both valid with the expectations of the institution and which builds up credit for them to pursue their own agenda by influencing decisions and warding off challenge. I showed how patients work up a 'good patient' performance, in which insight, deference, following medical opinion and striving to recover are explicitly emphasised. These techniques are particularly used when the patient's goals require them to influence the psychiatrist, for instance in making or ratifying changes to treatment. Through this explication, I argue that the patient role – though the less powerful of the doctor-patient

dyad – nevertheless can be manipulated by the patient to achieve a favourable performance and to meet personal ends.

7.4 Family performances: the impact of a third participant

In the final chapter of the thesis I extended the analysis to include third parties, and specifically family members, including partners. Family members are a crucial part of what has been called the ‘triangle of care’ (Worthington & Rooney, 2010). Nevertheless, the triad as an interactional form has been largely neglected in discourse analyses of medical settings.

I sought to understand the roles that family members negotiated for themselves in a typically dyadic interaction. By exploring the ways that family members enter the talk I suggest that a number of functions are expected by participants: providing confirmation or challenge to patient information; building alliances within a negotiation, and offering joint, complementary or competing narratives. I show how within these functions, family members, just like patients, are performing identities as ‘good carers’, and beyond that as ‘good parents’, ‘good partners’, etc. As with patients, these performances are negotiated within the available resources offered by the frames in which the interaction takes place.

In laying out the roles that family members perform in the interaction, I also explore the impact that their presence has on the patient’s own performance. I show how patients can be supported or undermined in their identity work, and how they develop team performances, often drawing on the ongoing discourse that takes place outside the consultation room.

7.5 Implications for doctor-patient communication

This thesis has not argued for or against particular models of doctor-patient communication. Nevertheless, the argument I have built through this thesis is an important one in

understanding and developing patient-centred care. The psychiatrists in this study all considered themselves to be patient-centred, and I do not have data to explore whether or not their discourse differs from that of other psychiatrists. However, in better understanding what patients do with their talk, useful lessons can be drawn for psychiatrists and policy-makers for improving psychiatric practice.

First, the findings in this study suggest that any attempts to encourage active patient participation should take into account the institutional expectations which constrain their performances. These expectations are not simply overcome by asking patients for their recommendations or 'allowing' them to make their own decisions. As seen in Chapter Four, such explicit opportunities are frequently turned down by patients. This needs to be acknowledged in training for psychiatrists to avoid the all too easy inference that patients want to be told what is best for them.

Patients work hard to influence decisions and can be aided in this by psychiatrists recognising and making space for these efforts. An understanding of framing in consultations can help to do this. Psychiatrists need to recognise how tensions in frame shifts and frame disputes may close down important avenues for patients to share information and demonstrate expertise. More than that, they may impact negatively on the interaction as a whole by undermining patients' efforts to project a particular face. The projection of individual identities may be especially important for people with psychosis since this condition frequently threatens people's identities through stigma, isolation and the loss of social roles.

Second, the role of family members needs further attention in improving doctor-patient communication. The presence of a third, active partner in care creates new interactional challenges for all participants to help to disambiguate the place of carers in the doctor-patient dyad. Psychiatrists have been criticised for failing to communicate with family

members adequately, particularly because of inappropriate application of confidentiality rules (Rapaport *et al.*, 2006). Psychiatrists need to be aware of the potential tensions and benefits of having a family member present in the discussions, and strategies they can use to manage these. First, they need to recognise that, like patients, family members may come to the consultation with a variety of goals from identity management to decision-making. These goals may coincide or conflict with those of the patient.

The presence of a family member needs to be understood in the context of two discourses meeting: the ongoing discourse between doctor and patient, and that between the patient and their family. Using this understanding, psychiatrists can be more aware of how and when to draw the family member into the talk and to assess when the patient may find this difficult. Existing training for psychiatrists around dealing with carers and confidentiality issues could draw on these findings to take the lessons beyond application of legislation and policies, to help psychiatrists further consider the situations surrounding family involvement. The Royal College of Psychiatrists cites concerns about addressing the different needs of carers and patients, and not having sufficient time for both in the consultation, as barriers for psychiatrist to engage family members as partners in care (Royal College of Psychiatrists, 2010). Using the analysis and data presented here, psychiatrists could be encouraged to identify ways in which family members contributions may enhance, rather than distract from, their ability to meet patients' needs. Further research into the triadic interaction would help to further explore these challenges. In particular, data exploring how both patient and family member perceive these interactions would be valuable and was not possible in this study.

Importantly, these findings can influence messages to patients and family members about involvement in the former's care. While patients may indeed benefit from knowledge and training on medical perspectives as offered by the Expert Patient Programme, described in

section 2.1 (page 20), particularly around managing their health outside the consultation, it should not be assumed that these skills will be easily applied in interactions with doctors. Encouraging patients to consider what they personally want to achieve in a consultation, and to recognise these goals as legitimate, may help them to be clearer when expressing themselves to psychiatrists. Family members similarly may benefit from a more explicit awareness of what they want to achieve when attending a consultation and consider how far this should be agreed with the patient in advance. The Expert Patient Programme and its specialist mental health equivalents run by various charities (Davidson, 2005) is one important route through which the findings from this thesis could reach patients in the future, by expanding its focus from technical to interactional knowledge and expertise. The EPP already emphasises the need for improved communication with health professionals, though focusing on primary care. These findings could usefully contribute to this training by demonstrating how discursive techniques may be used to build effective alliances with others in the consultation.

A third important implication of these findings is that eliciting patient preferences may sometimes be more effective outside of the doctor-patient dynamic. The constraints on the patient role may not be easily reduced through psychiatrist training. An alternative is to introduce new roles into psychiatric care, as is seen in the introduction of Peer Support workers. It is possible that such roles can build new expectations of patient behaviours that are less constrained and may therefore be a good place to ascertain patient preferences in psychiatric treatment. The positive outcomes of Peer Support work noted in previous studies (Repper & Carter 2011) suggests that more research could be useful here, for example to explore the interactions between Peer Support Workers and patients.

Finally, I would make a case for the term 'patient' to be maintained, and reclaimed, in relation to the psychiatric consultation. To dismiss the term as disempowering or

constraining is to undermine the importance of the patient role and the work done within it. The patient role brings an important perspective which, while not equivalent to the medical professional role in institutional authority, is nonetheless capable of demonstrating an authority of its own. By explicitly moving the term patient away from its original connotations of the passive bearer of misfortune, towards an active role more in keeping with recent moves towards self-care and public health priorities, patients themselves may be supported in the efforts highlighted here.

This thesis adds a new perspective on interaction in psychiatric consultations, but the approaches and insights offered here have relevance in other settings. Frame analysis allows the researcher to explore the subtle variations of talk oriented to specific goals within the shifting patterns of talk that occur in a single encounter. Applying such analysis to other settings can provide new understandings of how people achieve their aims in talk. I have shown how such analysis can be undertaken and demonstrated how researchers can identify participants' techniques for influence, even among those groups assumed to be more passive in interactions. This sociological contribution therefore has wide implications for the study of talk, particularly in institutional settings. The typology I have offered, while not definitive, provides a valuable foundation for exploring discourse. The focus on triadic interactions is also an important addition to the literature. I have shown in greater detail the impact of a family members' presence, not simply in contributing to the talk, but in altering the performances of the others. Again, this is relevant not only in the medical setting but in any typically dyadic interaction.

This thesis, and the presentations based on these findings (Hamilton, *BSA MedSoc Conference, 2011*; Hamilton, *Communication and Medical Ethics Conference, 2011*), provide a starting point for further research, including applying these findings in other mental health settings and professional relationships. It would also be of value to test the findings in relation to family members using video data to allow consideration of gaze and body language.

Finally, it would be helpful to repeat this study in the future with new data to see whether developing practice and patient expectations result in changes in psychiatrist-patient interaction.

In practice terms I have addressed a fundamental inconsistency at the heart of shared decision making in psychiatry – that virtually all the research into how it is achieved in talk has focused exclusively on what psychiatrists do. This thesis throws out the challenge not only to attend more closely to patients' talk, but to understand it as carefully managed and interactionally competent efforts to influence their care from within an institutional role that constrains these performances considerably. This shift may help to produce a more fundamental change to the roles of 'doctor' and 'patient', in psychiatry and elsewhere.

Appendix A: Extract symbols

⌈ : Indicates participant attempt to shift frame

⊥ : Indicates participant rejecting an attempted frame shift

⌋ : Indicates participant realigning to frame shift

⌋ : Indicates an alternative reframing to the one made by the other speaker

⌋ : Indicates 'communication out of character'

⌋ : Indicates a return to 'in character talk'

Appendix B: consultation 9

Consultation 9

- 1 *Doctor: I've not seen you since the New Year. (0.7) Erm (2.5)*
- 2 *⌈ How's it been going?*
- 3 *Patient: Well it's just been going the, the same as it usually is. (0.7)*
- 4 *Er, I've I'm still erm suffering with these terrible nightmares. And er*
- 5 *I do, jump up screaming in the middle of the night. (1.2) Not*
- 6 *screaming for a long period of time I just initial sort of shock, think it*
- 7 *is, and er so my-my sleeping patterns (1.0) is a bit disturbed*
- 8 *Doctor: How often do the nightmares, occur?*
- 9 *Patient: Well. Erm (1.9) most (1.3) most nights it can occur. I mean,*
- 10 *I-I can't put a finger on it and say it's gonna, I'm having a nightmare*
- 11 *about this or, at what time but they do, occur. I think it's not very*
- 12 *pleasant I mean I, s-some of them are particularly violent and, er*
- 13 *not but I-I've bought a book on dreams, and it says that erm a lot of*
- 14 *people have similar types of nightmares, or dreams, as they put it*
- 15 *(1.0)*
- 16 *Doctor: Are they what's called stereo-typical in the sense that it's*
- 17 *the same exactly the same dream every night or are they different*
- 18 *every night?*
- 19 *Patient: They are different*
- 20 *Doctor: But they have the same sort of horrible content do they?*

Troubles telling

21 *Patient: Mm s-yeah sometimes I mean occasionally I'd have a*
 22 *dream, and it'll be quite pleasant like for instance I might be seeing*
 23 *a sparkling water or gold coins. But erm (1.1) then I might, I might*
 24 *wake up and I feel a bit refreshed after that but, a lot, that's very*
 25 *rarely occasionally, and most of them are nightmares and, when I*
 26 *do wake up I feel groggy, tired erm (1.1) sort of*

27 *Doctor: And how long have, you've had been having these*
 28 *because I know you told me about them before but, but how long*
 29 *have they been a problem?*

30 *Patient: Few years now*

31 *Doctor: Few years*

32 *Patient: Yeah*

33 *Doctor: And it's not been related to to, medication has it they i-i-it*
 34 *they they don't (0.6) because we changed medication several times*
 35 *during that period*

36 *Patient: Yeah I don't think it's the medicine*

37 *Doctor: No I think not*

38 *Patient: ¶ Erm I think the medicine I'm on is alright at the moment I*
 39 *mean, I do take it (0.7) every day*

40 *Doctor: It seems to be the best that that you've- that we've tried*
 41 *isn't it*

42 *Patient: Well it's good for my anxiety and my er paranoia. It relieves*
 43 *those symptoms. I mean, it doesn't stop the hallucinations*
 44 *completely. But erm, I*

45 *Doctor: ((in overlap)) It makes them kind of manageable*

46 *Patient: Well yeah, makes th- makes me feel a bit er easier to*
 47 *manage with them yeah*

48 *¶ Doctor: So the so the main problem is the the main distressing*
 49 *thing is the dreams isn't it what you're describing*

Negotiation frame

Troubles telling

50 *Patient: (0.6) Well really, things that frighten me, I do get this, I*
 51 *mean fright. And it's er, hallucinations that I see. (1.0) Er which can*
 52 *become very, er, the more I look at them the worse they become*
 53 *Doctor: Th-these are str- the things that happen in your flat where*
 54 *you see things and they they*
 55 *Patient: Yeah*
 56 *Doctor: appear different from how they are*
 57 *Patient: Demons*
 58 *Doctor: Yeah*
 59 *Patient: Demonic type monsters, whatever. (1.4) I just see them*
 60 *and (1.0) it can become quite a, frightening experience. I mean on*
 61 *more than a few occasions I thought I was, gonna have a heart*
 62 *attack I was so scared (0.9) of them. Erm and they do, they haven't*
 63 *they haven't gone anywhere*
 64 *Doctor: But w- h-how does that pass? I mean wh-wh-what do you*
 65 *do, to get rid of that fear, that you have with these hallucinations*
 66 *Patient: Erm, well I turn, I mean I turn the light on (1.2) erm I get*
 67 *up, sit in front of the TV, try and, well s-s- occupy myself so that,*
 68 *I'm not taking much notice of them. (1.4) And then er after that after*
 69 *it subdues a bit and I start to relax a bit (1.0) erm and-er the*
 70 *medicine does help me to relax, as well. I do take the medicines*
 71 *before I go to bed usually*
 72 *Doctor: (Mm)*
 73 *Patient: Er, or in the morning, first thing. Because I if I don't get*
 74 *enough sleep right, then I I tend to start going to sleep in the early*
 75 *hours of the morning*
 76 *Doctor: Mm*
 77 *Patient: and I take the medicine. And occasionally I'll have a drink,*
 78 *like alcohol. I don't mix my tablets, with the beer. So I wait for the a-*
 79 *alcohol to wear off*

80 Doctor: Because you you you'd resolved at New Year that you
 81 were gonna not- you were gonna stop drinking spirits
 82 Patient: Yeah yeah, yeah. I mean a-after drinking last night, and
 83 that was the first drink I'd had for seven days
 84 Doctor: Yeah. A-and also you were gonna to, going to college, to
 85 study the history of the (1 word) have you been doing that?
 86 Patient: No I haven't got round to that yet
 87 Doctor: Yeah
 88 Patient: I've (got) all all the erm, pap- papers and, stuff like that I
 89 mean, it's just I mean the thing now I was gonna study history, at
 90 erm, there's a college down the road that they do local history. But
 91 I've got er, a history channel, on my- er Freeview, and erm (0.8) i-
 92 it's quite good as far as historical (0.8) facts or whatever are
 93 concerned about the war whatever, Napoleon, er, well King James
 94 whatever (and) all sorts of things yeah. Er Watergate, and Kennedy
 95 Doctor: ((in overlap)) No tha- that does sound interesting. That
 96 does sound interesting
 97 Patient: Yeah
 98 Doctor: Yeah. Alright
 99 Patient: ((in overlap)) I mean I yeah, i-it's erm I mean even my
 100 watching these history programmes I feel a bit depressed but I'm
 101 trying to, erm the more I get used to watching 'em (1.0) i-it, yeah
 102 ((casenote pages being turned))
 103 ¶ Doctor: Are you mixing much are you getting out and socialising?
 104 Patient: Well I don't go to the drop-ins really. Er I I've I've, think I'm
 105 not getting another Freedom Pass
 106 Doctor: You kind of stopped that since you, broke up with [Name]
 107 have you
 108 Patient: ((in overlap)) Yeah, yeah
 109 Doctor: Mm

Interview frame

110 *Patient: 'Cos she's sort of like, quite popular there so*

111 *Doctor: Sh-she still goes there does she?*

112 *Patient: I don't know*

113 *Doctor: (Right)*

114 *Patient: I s-see [Name] every now and again*

115 *Doctor: Mm*

116 *Patient: But I I go down er, I mean I'm not, 'cos I don't think I'm*

117 *Catholic as far as I'm aware I'm not but I've, I go to the Catholic*

118 *club sometimes*

119 *Doctor: Mm*

120 *Patient: have a drink there. Well, chat with some people*

121 *Doctor: Yeah*

122 *Patient: (they're friendly in there)*

123 *Doctor: ¶ Alright, well, I-I'm not gonna suggest any changes to the*

124 *medication I think it is the best that we've found*

125 *Patient: Mm*

126 *Doctor: So shall we, carry on with that. Shall we meet in another*

127 *eight weeks just to keep a check on things?*

128 *Patient: Yeah*

129 *Doctor: Yeah. Okay [Patient Name]*

130 *Patient: (Alright)*

Directing frame

131 *Doctor: ¶ Cheers mate*

132 *Patient: That's alright. ((gets out of chair to leave)) And er see you*

133 *in eight weeks*

134 *Doctor: See you in eight weeks, yeah. Bye bye*

135 *Patient: All the best*

136 *((Patient exits))*

Informal frame

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