

‘So you feel a bit anxious?’
Psychiatrist-patient communication and
treatment adherence in schizophrenia

Laura Thompson

Submitted in fulfillment of the degree of Doctor of Philosophy

Unit for Social & Community Psychiatry, Barts & the London School of Medicine,
Queen Mary University of London

September 2013

Acknowledgements

The completion of this thesis would have been inconceivable without the support of several people. Firstly, I would like to express massive gratitude to my supervisor, Professor Rose McCabe, for her consistent support, encouragement and incisive feedback that has kept me on track during the last three years.

Having regular meetings to talk through progress has also been invaluable - I would like to thank Rose, Chris Howes, Mary Lavelle, Saul Albert, Jemima Dooley and Paula Hermann for attending data sessions and stimulating my ideas. I would also like to thank Professor Paul Drew and Dr Merran Toerien for welcoming me onto their CA module at the University of York and inspiring a fascination with CA. I am also very grateful to Professor Tanya Stivers and Professor John Heritage for allowing me to spend a term at UCLA and providing such a warm and engaging environment.

Finally, I owe a very special thanks to my boyfriend Simon for being an unwavering support in every respect.

I gratefully acknowledge the support of the Medical Research Council who funded my studentship.

Abstract

24 million people worldwide are affected by schizophrenia. Its complex psychopathology, including changes in perception, can incur substantial personal distress and economic burden. Finding appropriate treatment that attracts voluntary adherence is an ongoing challenge for clinicians to prevent relapse and poor prognosis. This thesis conceives the psychiatrist-patient alliance - mediated through talk - as an intervention point that demands analytic attention. Conceptualising 'good' communication is however hindered by a lack of a) conceptual clarity on its constituents b) knowledge of what *actually* happens in psychiatric encounters. Abstract ideals of 'Patient Centredness' and 'Shared Decision Making' are widely endorsed as beneficial to adherence, but do not pragmatically translate into specific practices, conducive to training.

Following a preparatory systematic review, this thesis addresses a gap in literature by observing psychiatric communication in 3 mixed method studies. Synthesising coding methodologies and statistical analyses with principles of conversation analysis, two studies explore the association - and explanatory mechanism - between adherence and *specific* communication practices: patient other-initiated repair and psychiatrist questions. Treatment decisions, the precursor to adherent behaviour, are also examined: alternative resources that psychiatrists employ and their interactional consequences are mapped, with a focus on patients' overt resistance. The findings collectively extend knowledge on medical interaction and demonstrate the utility of a novel approach to outcome research in field dominated by cross sectional studies. Clinical, methodological and theoretical contributions are yielded relating to six themes 1) the consequentiality of psychiatrists' communicative choices 2) the manifestation of alliance and adherence in clinical talk 3) orientations to experiential expertise and the contingencies of antipsychotic medication adherence 4) reconceptualising 'good' communication: misalignment as key to clinical success 5) evidence of the interaction order in schizophrenia 6) reconciling the nuances of naturalistic interaction with global clinical outcomes.

<u>Acknowledgements</u>	<u>2</u>
<u>Abstract</u>	<u>3</u>
<u>Chapter 1.....</u>	<u>10</u>
Introduction	10
1.1 Schizophrenia	10
1.2 Implications for society and health services	11
1.3 Treatment delivery.....	12
1.4 Medication and side effects.....	12
1.5 The problem of non-adherence	13
1.6 Interventions to improve adherence.....	14
1.7 Psychiatrist-patient alliance and communication.....	15
1.8 What is ‘good’ communication?.....	15
1.8.1 Turning abstract ideals into specific practices.....	16
1.9 Aims	17
<u>Chapter 2.....</u>	<u>19</u>
The effect of alliance and communication on treatment adherence in mental health: a systematic review	19
Chapter Abstract	19
Background	19
Methods	19
Results	19
Conclusions	19
2.1 Background & aims	20
2.2 Methods.....	20
2.2.1 Search strategy.....	20
Table 1. Search resources	21
Table 2. Search terms with truncation	21
2.2.2 Inclusion and exclusion criteria.....	22
2.2.3 Screening.....	23
Figure 1. Quorum diagram.....	23
2.2.4 Data extraction	24
2.2.5 Quality assessment.....	24
Table 3. Quality assessment ratings for included studies.....	25
2.2.6 Analysis and findings.....	26
2.3 Results	27

Table 4. Characteristics of included studies	27
2.3.1 Clinician-patient alliance and treatment adherence	29
2.3.2 Communication styles and clinical messages	31
2.3.3 Objectively measured communication	34
2.3.4 Variability in adherence measures.....	34
2.4 Discussion.....	36
2.4.1 Summary of main results	36
2.4.2 Specific communication mechanisms that result in patient engagement.....	36
2.4.3 Comparison to literature	38
2.4.4 Implications for future research.....	38
2.4.5 Conclusions	40
<u>Chapter 3.....</u>	42
Microanalysis of clinical communication.....	42
3.1 A brief history of medical communication research.....	43
3.2 Theoretical background	45
3.2.1 Erving Goffman	46
3.2.2 Harold Garfinkel.....	47
3.3 Principles and methods.....	47
3.4 Strengths of CA.....	50
3.5 Institutional talk	51
3.6 Applications in medicine	52
3.7 Applications in psychiatry.....	53
3.8 Data and approach.....	55
Table 5. Patient Sociodemographic and Clinical Characteristics	55
3.9 Structure of consultations	56
Figure 2. Structure of psychiatric outpatient consultations	57
<u>Chapter 4.....</u>	58
Patient adherence and other-initiation of repair in schizophrenia	58
Chapter abstract.....	58
Background	58
Methods	58
Findings	58
4.1 Background.....	59
4.1.1 Conversational repair: what is it?.....	59
4.1.2 The relevance of repair for adherence in schizophrenia.....	60
4.1.3 The problem.....	62
4.2 Aims	62

4.3	Methods.....	63
4.4	Results	63
4.4.1	How often did patients initiate repair on psychiatrists' talk?	63
4.4.2	Alternative NTRI formats.....	63
	Table 6. Range of patient specificity in locating the trouble-source.....	64
4.4.3	What format of patient repair initiation was most frequent?.....	65
	Table 7. Distribution of patient repair initiation formats.....	65
4.4.4	The form of the trouble-source: psychiatrists' questions	65
4.4.5	The form of patient open-class repair initiations: flagging trouble 'politely'?.....	67
	Table 8. Distribution of different linguistic formats of OCRIs and OISR.....	69
4.4.6	How did psychiatrists repair the trouble?	69
	Table 9. Type of psychiatrist repairs.....	70
4.4.6.1	Psychiatrists orienting to patients misunderstanding their question.....	70
4.4.6.2	Psychiatrists orienting to patients not hearing their question.....	73
4.4.7	The sequential environment of psychiatrists' questions targeted by patient OCRIs.....	75
4.4.7.1	The regularity of patterns	77
4.4.7.2	Psychiatrist questions in topic-initial positions	77
4.4.7.3	Sequentially incoherent questions: pursuing a clinically specified patient response.....	82
4.4.7.4	An additional question element.....	83
4.4.7.5	Justifying the (re)question in 'psychiatric' terms	85
4.4.7.6	'Hearing' the patient's previous answer and the patient's orientation to 'already answering'.....	87
4.4.7.7	A similar case, a different clinical setting.....	89
4.5	Discussion.....	91
4.5.1	Summary of main results	91
4.5.2	The relevance for schizophrenia and patient adherence	92
4.5.3	Limitations	95
4.5.4	Thesis implications.....	96

Chapter 5.....97

Psychiatrists' questions, the therapeutic relationship and patient adherence 97

	Chapter abstract.....	97
	Background	97
	Method.....	97
	Findings	97
5.1	Background and rationale	98
5.2	Part 1 methods.....	99
5.2.1	Data.....	99
5.2.2	Question coding	99
	Figure 3. Questions coding protocol (larger version: appendix 2).....	100
5.2.3	Question categories	100

Table 10. Question types resulting from coding.....	101
5.2.4 Application of the protocol.....	103
5.3 Outcome measures.....	104
5.3.1 Symptoms.....	104
5.3.2 Therapeutic relationship.....	104
5.3.3 Adherence to treatment.....	105
5.4 Analyses.....	105
5.5 Results.....	105
5.5.1 Sample.....	105
5.5.2 Types of questions asked by psychiatrists.....	105
Table 11. Distribution of psychiatrist question types.....	106
5.5.3 Correlations with outcomes.....	106
5.5.3.1 Symptoms.....	106
Table 12. Correlations with patient symptoms.....	107
5.5.3.2 Therapeutic relationship.....	107
Table 13. Correlations with the therapeutic relationship.....	107
5.5.3.3 Adherence.....	107
Table 14. Correlations with patient adherence.....	108
5.6 Part 2 Qualitative analysis.....	108
5.6.1 Summary of findings from part 1 and analytical focus of part 2.....	108
5.6.2 The corpus.....	109
5.7 Part 2 methods.....	109
5.8 Results.....	109
5.8.1 What are declarative questions?.....	109
5.8.2 Psychiatrists' declarative questions – displays of a shallow epistemic gradient between psychiatrist and patient.....	111
Figure 4. Psychiatrist question designs and epistemic gradients.....	112
5.8.3 Psychiatrists' declarative questions: recurrently so-prefaced.....	113
5.8.4 Making psychological inferences: So- prefaced declaratives as formulations of patients' talk.....	118
5.8.5 What can so-prefaced declarative questions do institutionally?.....	123
5.8.6 Psychiatrists' declarative questions, patient responses and sequence constraint.....	126
Table 15. Responses to so-prefaced declaratives and 3 rd position psychiatrist expansion.....	128
5.8.7 Is sequence constraint associated with amount of patient talk?.....	129
Table 16. Correlation with amount of patient talk.....	129
5.9 Discussion.....	130
5.9.1 Summary of findings.....	130
5.9.2 Clinical implications – explaining the relationship between declaratives, the therapeutic relationship and adherence.....	131
5.9.3 Limitations.....	133
5.9.4 Thesis implications.....	135

Chapter 6.....137

Formulating treatment decisions in schizophrenia 137

Chapter abstract.....137

Background 137

Aims & method 137

Findings 137

6.1 Background and rationale 138

6.1.2 The ideal of shared decision making 138

6.1.2 Choice & responsibility for the expert patient..... 138

6.1.3 The treatment recommendation: an opportunity to invoke patient choice? 139

6.1.4 Aims and research questions..... 140

Part 1: How do psychiatrists initiate treatment decisions in Schizophrenia? A descriptive study..... 142

6.2 Methods.....142

6.2.1 Data..... 142

6.2.2 Screening 142

6.2.3 Coding..... 143

Table 17a. Psychiatrist treatment formulation codes..... 143

Table 17b. Patient uptake response codes 144

6.3 Results 144

6.3.1 Types of treatments decisions for patients with schizophrenia..... 144

6.3.2 How did psychiatrists' formulate these decisions? 144

Table 18. Distribution of treatment formulations 145

6.3.3 Who is accountable? Personal pronouns and decisional responsibility in 145

psychiatrist formulations 145

Table 19. Distribution of personal pronouns..... 146

6.3.3.1 The accomplishment of decisional responsibility 147

Figure 5. 147

Table 20. Examples of treatment offers 148

Table 21. Examples of treatment proposals..... 149

Table 22. Examples of treatment suggestions 150

Table 23. Examples of treatment pronouncements 151

6.3.4 How did patients' respond to these formulations? 152

Table 24. Distribution of patient responses..... 154

6.3.5 What types of treatment recommendations are patients most likely to overtly resist? 155

Table 25. Distribution of patient resistance and recommendation type 156

Figure 6. 156

6.3.6 Summary of findings from part 1 and analytical focus of part 2 156

6.4 Part 2: Patients' overt resistance to treatment proposals and offers: accounts of side effects.....158

6.4.1	Patient resistance and treatment decisions	158
6.4.2	The framework for patient resistance	160
6.5	Part 2 aim and methods	161
6.6	Results	161
6.6.1	Patients' orientation to their own expertise - appealing to negative experience of side effects	164
6.6.1.1	Direct Resistance.....	169
6.6.2	Patient orientation to the psychiatrist's expertise – postponing acceptance.....	174
6.7	Discussion.....	178
6.7.1	Summary of main findings	178
6.7.2	Implications for decision-making and adherence in schizophrenia	179
6.7.3	Limitations	182
<u>Chapter 7.....</u>		<u>184</u>
Thesis discussion.....		184
7.1	Summary of findings.....	184
7.2	Limitations	188
7.3	Clinical, theoretical and methodological contributions	190
7.3.1	The consequentiality of psychiatrists' communicative choices.....	190
7.3.2	The manifestation of alliance and adherence in clinical talk	191
7.3.3	A democratic decision making forum: orientation to experiential expertise and the contingencies of antipsychotic medication adherence	193
7.3.4	Reconceptualising 'good' communication: 'misalignment' as key to clinical success and adherence.....	194
7.3.5	Evidence of the interaction order in schizophrenia	195
7.3.6	A mixed methods approach: Reconciling the nuances of naturalistic medical interaction and clinical outcomes.....	196
7.3.7	Future research and concluding remark.....	197
<u>References</u>		<u>200</u>
<u>Appendices</u>		<u>226</u>
Appendix 1:	Jeffersonian transcription conventions	226
Appendix 2:	Questions coding protocol	227
Appendix 3:	Treatment formulations coding template.....	229
Appendix 4:	Repair coding protocol.....	231

Chapter 1

‘Given that the ultimate goals of interaction in medical settings are the restoration of health and preservation of life, the stakes involved in 'good' communication are very high indeed’

(West & Frankel 1991: 166)

Introduction

Clinical communication and patient adherence in schizophrenia supply the focal themes of this thesis. The following chapter formulates the rationale for this remit: sketching related methodological and clinical challenges. The nature of schizophrenia and available interventions will initially be described, followed by the challenge of non-adherence, the role of psychiatrist-patient communication and the lack of conceptual clarity surrounding the constituents of ‘good’ communication. How this thesis seeks to attend to these distinct – but addressable – deficits will ultimately be outlined via some overarching aims. Specifically, to explore: what *actually* happens in naturally-occurring psychiatric communication; the specific practices related to patient treatment adherence; and the explanatory mechanism of such a relationship – the answers to which could propel the application of findings in clinical practice.

1.1 Schizophrenia

Schizophrenia remains among the costliest and severe of mental disorders. Due to its chronicity, prevalence is high: 24 million people worldwide (WHO) are affected (250,000 in England (The Schizophrenia Commission 2012)), ranking the condition a top cause of global disability. While characterised by changes in perception, thoughts and behaviour i.e. delusions and hallucinations, ‘psychoses’ are not exclusive to schizophrenia, featuring in several diagnostic classes of disorder. Analysis of the psychopathological characteristics of the various psychotic disorders imply that symptoms can be clustered into 5 categories: 1)

psychosis (delusions and hallucinations – referred to as the *positive* symptom dimension) 2) changes in volition and drive (lack of motivation, social withdrawal and reduction in spontaneous speech – labelled the *negative* symptom dimension), 3) neurocognitive alterations (difficulties in executive function, memory and attention – the *cognitive* symptom dimension) 4) & 5) affective dysregulation manifesting as depressive and manic (bipolar) symptoms (Van Os et al 2009). While these categories display overlap in genetic liability (Kendler et al 1993) and with bipolar disorder (Lichenstein et al 2009), suggestive of a common underlying aetiology, the term schizophrenia is applied to a syndrome in which patients may experience a combination of positive, negative and cognitive symptoms. Onset typically manifests in adolescence and early adulthood and is often accompanied by significant occupational and social dysfunction. One or more major areas e.g. interpersonal relations, work or self-care is markedly below the degree achieved prior to its emergence. Diagnosis is based on patient-self report and observed behaviour indicating the presence of symptoms for a significant portion of time during a 1 - 6 month period (DSM IV). The course, clinical presentation and outcome of schizophrenia is however heterogeneous (Van Os & Kapur 2009). Around a quarter of people diagnosed will have one episode of illness, make a good recovery and have no further problems, a further 25% will develop a long-term chronic illness with no periods of remission. The remaining 50% will have a long-term illness that fluctuates with periods of remission and relapse.

1.2 Implications for society and health services

The frequently episodic nature of schizophrenia means sustained contact with mental health services is often required. Clinical and economic burdens are substantial and avoiding relapse and inpatient time is a primary concern for healthcare providers. Costs fall on multiple parts of society, especially on patients and their families. Overall, schizophrenia is estimated to cost England £11.8 billion per year and the public sector £7.2 billion (Andrew et al 2012). Most patients will experience at least one inpatient stay, with a high probability of readmission (Allardyce & Os 2010), equating to a large proportion of all costs associated with schizophrenia (Mangalore & Knapp 2004). The average cost of a night in a mental health inpatient bed in England is £321 (Curtis 2011) and the median length of admission is 38 days (HES online 2011) amounting to an estimated £12,198 per admission. Duration of

admissions under the Mental Health Act are typically even longer. Due to the substantial expense associated with inpatient services, interventions that reduce the probability of admission or length of stay – without compromising patients’ health or quality of life – can translate into significant cost savings. A central factor in avoiding relapse and readmission is ensuring individuals are in receipt of the correct treatment.

1.3 Treatment delivery

Outpatient treatment is delivered by community mental health teams (CHMTs). Using a community-case management model, a collective of professionals engage with patients and carers to collaboratively develop a plan of care. Typically patients will be assigned a keyworker (e.g. a nurse or social worker) to offer practical support and monitor side effects of medication. More specialised services may be assigned depending on the phase of illness or challenges particular to an individual. Assertive outreach teams target enduring mental health problems with those who are difficult to engage, while early intervention services allow detection and treatment of people in the very early stages of psychotic illness.

The emphasis on community care reflects a trend of deinstitutionalisation: a divergence from the historic societal and clinical view of schizophrenia as a debilitating and deteriorating disorder with poor prognosis. While most patients require some level of support, the dominant perspective is now one of recovery: the patient takes an active role in developing purpose and meaning while growing beyond the misfortune of the illness (Frese et al 2009). Where formal support is required, a psychiatrist will be principally responsible for treatment prescription and monitoring, administered in outpatients’ clinics – the focal context here. Schizophrenia is one of the most serious conditions psychiatrists are likely to encounter, but through the marriage of new medications, community case-management and (where possible) psychotherapeutic interventions, remission of approximately 80% of patients can be accomplished (Robinson et al 1999). But what does routine treatment entail?

1.4 Medication and side effects

Clinical practice in mental health has transformed in recent decades, fuelled by pharmacological advances. While Cognitive Behaviour Therapy (CBT) shows efficacy in improving coping and reducing negative affect and distress associated with psychotic

experiences (Wykes et al 2008), specialised psychotherapies are not yet routinely available (Schizophrenia Commission 2012). Medication, for now at least, is the mainstay of psychiatric treatment. Following diagnosis, drugs that inhibit dopamine D2 receptors are the primary intervention (Kapur et al 2003). First generation antipsychotics discovered in the 1950's e.g. Haloperidol and Chlorpromazine are effective in the treatment of psychotic symptoms, but often lead to motor side-effects e.g. tremor. New agents with less severe side effect profiles: 'second generation' antipsychotics have been introduced in the last decade that less frequently induce such effects e.g. Risperidone, Olanzapine, Quetiapine, Ziprasidone and Aripiprazole. While second generation drugs can be effective in treating positive symptoms and temper side-effect burden, similar efficacy against cognitive and negative symptoms has not been evident (Leucht et al 2009). Moreover, a high incidence of metabolic side-effects e.g. increased cholesterol and weight gain can ultimately reduce life expectancy (Schizophrenia Commission 2012). The choice *between* antipsychotic drugs therefore necessitates analysis of the prospective risks, benefits and costs (Leucht et al 2009). This affects the composition and objectives of psychiatric encounters and in turn the roles of clinicians (Cruz and Pincus 2002): a central function of consultations is medication management via regular review and regime modification (Lazarus et al 1998). The main challenge for clinicians is to ensure that patients continue to take medication when required (Van et al 2009).

1.5 The problem of non-adherence

Anywhere from 25% - 80% of patients discontinue their medications at some point in the course of treatment (Battaglia 2001; Conley and Kelly 2001). Weiden and Olfson (1995) estimated that this accounts for approximately 40% of rehospitalisation in the two years post-discharge from inpatient treatment. Meta-analyses of multi-national data concluded that a 50% improvement in patterns of medication-taking could reduce one-year rehospitalisation rates by 12% (Weiden & Olfson 1995). Adherence, defined as the extent to which the patients' behaviour coincides with medical or health advice (Adam & Howe 1993), therefore constitutes a crucial intermediate outcome and concern of psychiatrists. Partial or non-adherence to medication prescribed for chronic conditions is common across medical specialities in different countries (WHO 2003). The reasons for patients not (or partially)

adhering to antipsychotic treatment are not dissimilar to those in other chronic illnesses: determinants may span several factors relating to patient demographics, illness, attitudes towards treatment and psychosocial issues (Pinikahana et al 2003). Two issues however may be schizophrenia-specific: the possibility that dopamine-blocking antipsychotic drugs dampen motivational propensities (Artaloytia et al 2006) and the stigma of being labelled as psychotic (Thornicroft et al 2009). Side effects, like those described, also present a consistent and understandable challenge for patients. Discontinuation of assigned treatment may owe to inefficacy or intolerable experiences of medication (Lieberman et al 2005) that are often underestimated by the prescribing doctor (Nose et al 2012) e.g feelings of tiredness and sedation. Finding appropriate treatment that attracts voluntary adherence thereby represents an ongoing clinical challenge for clinicians. Interventions that are successful in reducing non-adherence rates will have sizeable benefit for patients, their families, and the health and social care systems.

1.6 Interventions to improve adherence

While adherence interventions have been evaluated including reminders, special pill bottles, and economic incentives, exhibiting some efficacy in experimental contexts (Nose et al 2003), none are widely available. Targeted ‘compliance therapies’ have also been trialled by clinicians, based on cognitive behavioural techniques. Trained clinicians deliver specific therapeutic interventions relating to medication cessation and relapse, normalising rationales for stigma and recognition of characteristic prodromal symptoms (Kemp et al 1998). These appear to retain benefits in the short term (Kemp et al 1996). However, they are not routinely offered, with standard psychiatric encounters involving non-specific counselling (e.g. clinician-patient discussion of medication) to stimulate positive attitudes towards treatment, found to be equally as effective in the longer term (O’Donnell et al 2002). As such the psychiatrist-patient relationship or ‘alliance’ as it will be referred to hereafter represents one potential intervention point and indeed has been found to impact patients’ attitudes towards treatment (Day et al 2005).

1.7 Psychiatrist-patient alliance and communication

The primary mediator of a beneficial alliance is clinician-patient communication. Talk forms the vehicle for achieving clinical objectives: developing therapeutic goals, assessing symptom severity and deducing diagnostic hypotheses. Alliance and communication are thus inherently interrelated, yet simultaneously distinct. Communication refers to components of the behavioural exchange between clinician and patient (Priebe & McCabe 2008) with the potential to be described either subjectively and objectively e.g. information giving, collaboration (Bultman et al 2000) and questioning. Alliance however is a subjective psychological construct held by participants on each another and their interaction (Priebe & McCabe 2008) e.g bond, goals, rapport or agreement (Hovarth et al 1989). Disentangling the directionality of the alliance-communication relationship, or how features of a positive alliance may be enacted or oriented to through interaction itself is a complex task. However, communication can be observed directly, presenting an empirical starting point from which to explore such issues. A link between communication and patient adherence has been observed extensively in general medicine. A recent meta analysis synthesising results from correlational and experimental studies found the odds of a patient adhering to be 2.16 times greater if their doctor is a good communicator (Zolnierek et al 2009). However, such reviews of communication typically exclude studies of psychiatric patients (Williams et al 1998). Moreover, if communication in psychiatric encounters represents an intervention point, how should 'good' communication be construed and measured?

1.8 What is 'good' communication?

No practical or definitive theory of the constituents of 'good' communication in psychiatry has been developed (Priebe et al 2011). Instead, it is viewed more generically through the lens of 'patient-centredness' (PC), posited as the primary method of mental health service delivery (O' Donovan 2007). Various conceptual definitions of PC exist, but its hallmark is providing care that is responsive to patients' psychosocial context i.e. individual preferences, needs and values (IOM 2006). This translates to putting the patient and their experience at the heart of healthcare. According to this model, clinical encounters should centre on the patient's concerns and wishes (Priebe et al 2011). Providers should work to solicit the patient's agenda (Coulehan 2007) in open and non-directive interactions facilitating patient perspective and

experiential expertise (Lawn 2007). Accordingly, Epstein et al (2005:1517) presented an operational definition of patient-centred communication as including four domains:

1. Eliciting and understanding the patients' perspective, concerns, ideas, expectations, needs, feelings and functioning.
2. Understanding the patient within his or her unique psychosocial context.
3. Reaching a shared understanding of the problem and its treatment with the patient that is concordant with the patients' values.
4. Helping patients to share power and responsibility by involving them in choices to the degree they wish.

Such principles represent a marked shift from the traditional paternalistic form of the doctor-patient relationship involving a passive patient and dominant clinician (Roter et al 2006). This dynamic sees a highly directive task-oriented interaction with an agenda principally controlled by the doctor and distinct asymmetries in power and involvement (Mishler 1984). One impetus for a shift from 'outmoded' paternalism is that democratising the clinical encounter will empower patients, increase self determination and lead to better patient outcomes including adherence (Duncan et al 2010). Collaborative communication and inclusion of the patient's perspective in relation to treatment decisions specifically i.e. 'shared decision making' (SDM) has emerged as especially important in policy for mental health (IOM 2006). Deemed ethically laudable and found to yield improvements on outcomes in physical health (Joosten et al 2008), both parties are encouraged to take steps to reach consensus about treatment, engaging in patient-centric communication that accounts for individual preferences. This is based on the expectation that it will increase self-determination and in turn patient treatment adherence (Duncan et al 2010).

1.8.1 Turning abstract ideals into specific practices

While the models of PC and SDM are widely endorsed as mechanistic to high quality care and patient engagement, little research has systematically examined their impact on adherence in mental health (Duncan et al 2010, Hamaan et al 2003). Moreover, application of these concepts is hampered by a lack of conceptual clarity (Epstein et al 2005) and measurement,

rendering the specific behaviours and communication practices underlying PC care - and better adherence - unclear. Despite the appeal of a single organising set of principles to guide health care, these are *abstract* concepts that do not easily translate into *specific* communication techniques. To understand the constituents of 'good' communication, and its relationship to adherence, the *actual* practices that psychiatrists and patients use in naturally occurring talk must first be examined, enabling consideration of how they may, or may not, advance the values of patient. To accomplish this in the treatment of schizophrenia may be particularly important. The nature of symptoms, involving changes in perception, may present additional challenges in the implementation of PC communication. McCabe et al (2002) showed how discussing the content of psychotic experiences poses a challenge for psychiatrists. A reluctance to engage with patients' concerns about symptoms was identified, resulting in each speaker attempting to realign the focus of the consultation in opposing directions. Such findings can derive interventions to address specific – true-to-life - problems defined by participants' orientations. To develop methods of improving patient adherence, clinical talk itself demands analytic attention.

1.9 Aims

The overarching aims of this thesis are to explore: what *actually* happens in naturally-occurring psychiatric communication; the specific communication practices related to patient treatment adherence; and discuss the explanatory mechanism of such a relationship. The utility of a mixed methods approach to capture the nuances of communication while exploring associations with adherence, is also evaluated. Relevantly drawing across the disciplines of psychiatry, sociology and psychology, contributions are therefore made in applied, theoretical and methodological respects. The thesis develops inductively - one chapter and its findings form the impetus for the following. Each chapter therefore has both standalone value and collective significance.

This introduction has sketched the thesis rationale. To further provide background and inform the design of the ensuing research, **Chapter 2** is both a review of literature and the first study. Using a replicable search strategy, the effect of clinician-patient alliance and communication on treatment adherence in mental health care (Thompson & McCabe 2012)

is reported: establishing the validity of clinical encounters as an intervention point. The state of knowledge and methodological shortcomings in this arena are identified.

Chapter 3 delineates the guiding methodology for this thesis: conversation analysis. Its theoretical underpinnings, utility as an approach relative to other methodologies for researching doctor-patient communication and applications in psychiatry are outlined.

Chapter 4 describes the first focal communication practice in relation to patient adherence. Building on McCabe et al (2013), the only study to find a specific rather than abstract practice of psychiatric communication - 'repair' - to be associated with adherence, is built upon. Using conversation analysis to contextualise the statistical finding that patient other-initiated repair is related to better adherence, this phenomenon is examined in situ.

Prompted by findings from Chapter 4, **Chapter 5** explores the structure of a second practice: psychiatrist questions. The association between various question forms, patient adherence and the therapeutic alliance are reported. Conversation analysis is used to analyse significant question types – here declarative questions – and explore this relationship contextually.

Chapter 6 forms the final study. Here, the necessary precursor for adherent behaviour, treatment decisions themselves, are inspected. A range of practices that psychiatrists use to initiate decisions are mapped and further analysed in relation to their design and consequentiality for patient uptake: focussing on overt resistance.

Chapter 7 is an overarching discussion. While each chapter outlines study-specific issues, these are drawn together in terms of their collective significance for the initial research questions. Clinical, theoretical and methodological implications are discussed.

Chapter 2

The effect of alliance and communication on treatment adherence in mental health: a systematic review

Chapter Abstract

Background

Chapter 1 conceived the clinician-patient alliance, mediated through talk, as a point of intervention for improving patient adherence. However, recent medical reviews of communication and adherence exclude studies of psychiatric patients. The following review examines the impact of clinician-patient alliance and communication on adherence in mental health and the specific mechanisms that result in patient engagement.

Methods

A systematic search was conducted in Pubmed, PsychInfo, Web of Science, Cochrane Library, Embase and Cinahl, yielding 6672 titles. A secondary hand search was performed in relevant journals, grey literature and references.

Results

23 studies met the inclusion criteria for the review. The methodological quality overall was moderate. 17 studies reported positive associations with adherence, only four of which employed intervention designs. 10 studies examined the association between clinician-patient alliance and adherence. Subjective ratings of clinical communication styles and messages were assessed in 12 studies. 1 study examined the association between objectively rated communication and adherence. Meta-analysis was not possible due to heterogeneity of methods. Findings were presented as a narrative synthesis.

Conclusions

Clinician-patient alliance and communication are associated with more favourable patient adherence. Further research of observer rated communication would better facilitate the application of findings in clinical practice. Establishing agreement on the tasks of treatment, utilising collaborative styles of communication and discussion of treatment specifics may be important for clinicians in promoting cooperation with regimens. These findings align with those in health communication. However, the benefits of shared decision making for adherence in mental health are less conclusive than in general medicine.

2.1 Background & aims

Chapter 1 sketched the clinical and economic burdens that nonadherence to mental health treatment can incur. A critical invention point was further presented as the clinician-patient alliance: negotiated through clinical communication. Reviews of communication however have typically excluded studies of psychiatric patients (Zolnierek et al 2009, Williams et al 1998). Against this background, the following article presents an integration of evidence about the empirical grounding for relationship variables, behaviors and messages instrumental to promoting engagement with mental health treatment. The primary objective is to identify the existence of an association between clinician-patient alliance or communication and adherence in mental health. Secondary objectives are to discern specific aspects of the therapeutic encounter that may be harnessed to improve treatment and describe the characteristics of literature. Methodological shortcomings in the field will inform the design of subsequent research, detailed in the following Chapter.

While alliance and communication are interlinked they represent distinct phenomena. Associations with adherence are differentiated in this review accordingly. The term alliance is broadly used to represent the clinician-patient relationship. However, it may be construed elsewhere as the ‘therapeutic relationship’, ‘therapeutic alliance’, ‘helping alliance’ or ‘working alliance’ (Catty 2004).

2.2 Methods

2.2.1 Search strategy

A rigorous journal screening was undertaken including all electronically registered references up to December 2010. An additional hand search in key journals for relevant professional categories, grey literature and dissertations was also performed. Table 1 denotes the sources used.

Table 1. Search resources

Databases	Hand Search	Grey Literature
Pubmed	The British Journal of Psychiatry	System for Information on Grey Literature (SIGLE)
PsychInfo	The American Journal of Psychiatry	British National Bibliography for Report Literature
Web of Science	Schizophrenia Bulletin	British Library Direct
Cochrane	Archives of General Psychiatry	Proquest Digital Dissertations
Embase	Acta Psychiatrica Scandinavica	
CINAHL	Journal of Psychiatric & Mental Health Nursing	
	Journal of Mental Health	
	Journal of Advanced Nursing	
	Issues in Mental Health Nursing	
	Journal of Psychosocial Nursing	
	Health and Social Care in the Community	
	British Journal of Occupational Therapy	
	Canadian Journal of Occupational Therapy	
	American Journal of Occupational Therapy	
	Journal of Occupational Science	
	British Journal of Social Work	
	Social Work in Mental Health	
	Journal of Social Work Practice.	

Table 2 depicts the terms used in the search process, how they were combined and where truncation was used in order to capture all relevant variants of the terminology. Terms were categorised in four groups based on the research question, representing synonyms or specifications of; ‘communication’ or ‘alliance’ (group 1) between patients diagnosed with a ‘mental disorder’ (group 2) and ‘professionals’ (group 3) and its impact on ‘adherence’ (group 4). In databases where limits were imposed on search terms, the key terms i.e. communication/alliance and adherence were used. The search process was augmented by personal correspondence with experts, advising on appropriate terms and relevant literature.

Table 2. Search terms with truncation

Group 1	Group 2	Group 3	Group 4
communicat*	Psychosis	psychiatr*	Adher*
talk	Psychotic	Doctor	compliant*
interact*	schizophr*	mental health nurs*	concordan*
expressed emotion	Schizoaffective	psychiatric nurs*	nonadher*
conversat*	Delusional	social work*	noncompliant*
discourse	depress*	psycholog*	concordan*
dialogue	dysthymi*	care coordinator	Persistence

relationship	Bipolar	counsel*	treatment usage
alliance	cyclothymi*	therapist	Attendance
shared decision making	Panic	support work*	Engag*
	Agoraphobia	Psychosocial intervention work*	rejection of therapy
	Phobia	employment coach	DNA
	obsessive compulsive disorder	nurse practitioner	drop out
	post traumatic stress disorder	case manager	medication possession ratio
	Stress	vocational rehab specialist	Service use
	Anxiety	psych tech	
		Physician	
		Provider	
		Practitioner	

<-----Group terms combined by 'AND'----->

combined by "OR"
→ group term 1

combined by "OR"
→ group term 2

combined by "OR"
→ group term 3

combined by "OR"
→ group term 4

2.2.2 Inclusion and exclusion criteria

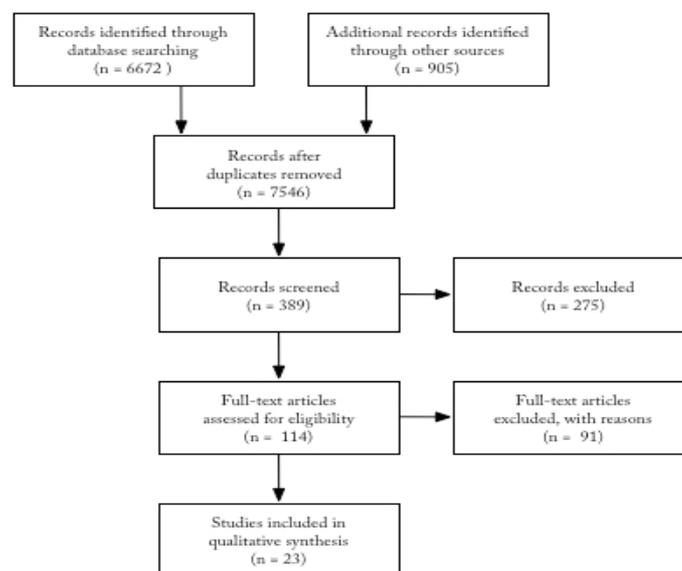
Prior to the screening, strict inclusion criteria were specified to orient the search filtering process. For studies to be deemed relevant, they included patient (or professional-patient) samples where participants were aged 18–65 and receiving treatment for psychotic disorders, anxiety disorders or mood disorders. The search was constrained to the main clinical disorders (Axis 1) according to DSM 1V (APA 2000) to limit heterogeneity. Professionals were defined as any clinician in contact with this group within inpatient, community, primary care or outpatient settings. Pertinent data were that which had been collected via a subjective rating of the clinician-patient alliance/interaction using a validated scale or where a clear description of measurement was provided e.g. via a single item assessing the state of the relationship (Shigemura et al 2010). Alternatively, an objective record and assessment of naturally occurring communication was necessary (e.g. with ratings by independent researchers of audio or video taped recording). Also required, was an assessment of patient adherence, via direct (e.g. pill count, blood test) or indirect (e.g. patient or clinician self-report) measures. ‘Adherence’ in this review pertained to medication-taking behaviour and/or appointment attendance. The resulting analysis was considered appropriate if it, at minimum, assessed the relationship (correlation) between alliance/communication and adherence, or

tested for a significant difference between adherers and nonadherers in relation to these variables.

2.2.3 Screening

Following searching, the resulting titles from each database were screened in accordance with the research aims. Potentially relevant abstracts were obtained for further examination, a random selection of which (20%) were screened independently by a secondary researcher to check reliability and minimise potential bias. Full texts of the selected abstracts were then retrieved for more rigorous inspection and application of the exclusion criteria. 6672 titles were found of which 6283 abstracts were considered irrelevant, leaving a total of 389 abstracts for screening after the removal of 31 duplicates. Following further filtering, 114 full texts were examined in their entirety of which 20 met the review's inclusion criteria. While review articles were automatically excluded in the search, reference sections were inspected for potentially applicable citations. Three studies were also retrieved from this additional search process. Reasons for exclusion were recorded and discrepancies discussed between independent researchers until consensus was met. Figure 1 outlines the results of the screening protocol using Quorum guidelines (Moher et al 1999). Only studies fulfilling all inclusion criteria were reported in the final review (n= 23).

Figure 1. Quorum diagram



2.2.4 Data extraction

Data extraction was conducted using an instrument designed for this review to elicit all relevant aspects of included articles. This allowed for both qualitative and quantitative accounting of the study including author, title, year, country, treatment setting, sample, aims, data source, measures used, analysis, results, specific alliance/communication variables associated with adherence, and limitations of the study. While numerous articles referred to general predictors of adherence, only outcomes relating to alliance or communication were extracted.

2.2.5 Quality assessment

Quality assessment (QA) of the included studies was problematic as there is no 'gold standard' design for studies of clinician–patient alliance or interaction. A review of QA for non-randomised trials demonstrated six tools applicable to systematic reviews (Deeks et al 2003), from which Downs et al's (1998) was selected as a guide for its comprehensiveness. The studies were assessed on four dimensions; reporting, external validity, internal validity and power. The tool required adaptation to make it more applicable to the nature of papers reviewed. For example, as the majority of studies (n=18) had no 'interventions', control groups or blinding, questions pertaining to these issues were removed. Instead, an additional QA variable was added to assess the study design and its potential to allow for causal hypotheses. Overall, study ratings for each category were denoted as percentage score. The QA criteria are outlined below.

1. **Reporting:** Do studies provide a clear description of aims, outcomes, characteristics of patients, findings and actual probability values? (Total/5)
2. **External validity:** Are those patients asked to participate in the study representative of the entire population from which they were recruited? Patients would be representative if they consisted of the entire source population, an unselected sample of consecutive patients, or a random sample (Total /1).
3. **Internal validity:** Are the statistical tests used to measure the outcomes appropriate? Are both adherence and alliance/communication measures validated and reliable?

Was there adequate adjustment for confounding in the analyses from which the findings were drawn? (Total /3)

4. **Study design:** To what extent can the study identify causality? Scores differentiate between cross sectional, prospective/longitudinal and experimental designs (Total /2).

Table 3. Quality assessment ratings for included studies

Paper	Reporting	External Validity	Internal Validity	Power	Study Design	Study Quality Score %
Sajatovic et al (2006)	5/5	0/1	1/3	0/1	0/2	50%
Weiss et al (2002)	5/5	1/1	2/3	0/1	½	75%
Corriss et al (1999)	4/5	1/1	2/3	0/1	½	67%
Lecomte et al (2008)	5/5	0/1	2/3	0/1	0/2	58%
Startup et al (2006)	5/5	0/1	2/3	0/1	0/2	58%
Olfson et al (2000)	5/5	1/1	1/3	0/1	½	67%
Frank et al (1990)	5/5	0/1	2/3	0/1	½	67%
Zeber et al (2008)	5/5	0/1	2/3	0/1	0/2	58%
Perron et al (2009)	5/5	0/1	2/3	0/1	0/2	58%
Madsen et al (2009)	4/5	0/1	2/3	0/1	½	58%
Shigemura (2010)	5/5	0/1	1/3	0/1	0/2	50%
Yeh et al (2008)	5/5	0/1	1/3	0/1	0/2	50%
Bull et al (2011)	5/5	0/1	1/3	0/1	0/2	50%
Lin et al (1995)	5/5	0/1	1/3	0/1	½	58%
Gonzalez et al (2004)	5/5	0/1	2/3	0/1	½	67%
Bultman et al (2000)	5/5	0/1	1/3	0/1	½	58%
Mahone et al (2008)	4/5	0/1	2/3	0/1	0/2	50%
Hamann et al (2006)	5/5	0/1	2/3	0/1	2/2	75%
Loh 2007 et al 2007 (1)	5/5	0/1	2/3	0/1	2/2	75%
Loh et al 2007 (2)	5/5	0/1	2/3	0/1	2/2	75%
Ludmen et al (2003)	5/5	0/1	2/3	0/1	2/2	75%
Von Korff et al (2003)	5/5	0/1	2/3	0/1	½	67%
Sleath et al (2003)	5/5	0/1	2/3	0/1	½	67%

Overall, Table 3 suggests a moderate quality of evidence in this field. Of the 23 studies, 5 had low quality scores ($\leq 50\%$) 12 had moderate scores ($>50\%$) and 6 obtained high scores ($\geq 70\%$) according to the determined threshold for high quality (Downs et al 1998). All studies exhibited a strong standard of reporting and used appropriate statistical tests. However, a number of collective limitations can be identified. Validated measures were not consistently implemented and external validity was low. Often random sampling or consecutive admissions were not used to recruit participants or detail was often insufficient to establish whether those who agreed to participate were representative of the entire source population. All studies also incurred weak ratings in relation to power due to a lack of formal sample size calculation. Furthermore, identifying directionality of effect was problematic in the majority

of research reviewed. Most studies adopted cross sectional designs and only four studies examined the effect of communication on adherence experimentally. The complexity of adherence determinants are well documented, but studies inadequately captured or discussed confounding in the analyses. For example, most studies failed to adjust for side effects, consistently identified as one of the most significant reasons for drug treatment failure across a range of mental health disorders (Pinikahana et al 2002, Matson et al 2006).

2.2.6 Analysis and findings

Criteria for conducting meta-analysis were not fulfilled due to variability in the statistical procedures and measures used to analyse relationship, communication and adherence outcomes. The findings of the systematic review are therefore synthesised below in accordance with the original research questions. Seventeen studies reported positive associations with adherence. Results were considered positive if study authors reported a statistically significant ($p < 0.05$) association between adherence and at least one relationship/communication variable, or a statistically significant difference between adherent and non-adherent patients on such measures.

The majority of studies focussed on patients diagnosed with depression ($n=16$). The remaining studies investigated participants with a psychotic disorder ($n=8$) or, least frequently, bipolar disorder ($n=3$). Literature was conceptualised as three categories on the basis that alliance and communication may differentially influence adherence: Group 1: global measures of clinician-patient alliance ($n=10$). Group 2: specific communication styles and/or or messages communicated by the treating clinician (demonstrated via subjective measures or experimental interventions) ($n=6$). Group 3: Independently coded recordings of naturally occurring clinical communication ($n=1$). Discussion of the studies and their pertinent results are reported within the proceeding narrative synthesis.

2.3 Results

Table 4. Characteristics of included studies

Author	Sample & Setting	Study Design	Measure of Adherence & Rater	Measure of Alliance/Communication & Rater	Findings
Sajatovic et. al (2006)	323 Veteran inpatients with a diagnosis of Bipolar disorder	Cross-sectional design	Patient self-report interview	The Working Alliance Inventory (WAI), patient & clinician version	No significant difference was found between full adherers and those reporting substantial nonadherence on WA scores from both patient and clinician report (p= 0.241)
Weiss et. al (2002)	162 outpatients with schizophrenia (47.5%), schizoaffective disorder (45%) or other psychotic disorders (7.5%)	Cross-sectional and longitudinal prospective design	Therapist self-report	The Working Alliance Inventory, Short form, therapist version	Adherence difficulties were significantly associated with weaker WA (p=0.30). WA also predicted the length of time adherence was maintained (p <0.001) and the length of time it took patients to develop active adherence (p < 0.05)
Corriss et. al (1999)	87 outpatients with schizoaffective disorder (48%) schizophrenia, paranoid type (38%), schizophrenia, undifferentiated type (12%) or affective disorder with psychotic features (2%)	Cross-sectional design	Therapist self-report	The Working Alliance Inventory, Short form, therapist version	Low agreement regarding the tasks of treatment were associated with with poor adherence (p<0.05) For adherence to non medication all three alliance variables were associated with poor adherence. (p < 0.05).
Lecomte et. al (2008)	1118 patients from early intervention psychosis services with schizophrenia (56%), schizoaffective disorder (11%), bipolar disorder (10%) or psychosis NOS (10%)	Cross-sectional design	Patient self report- assessed with a combination of the MAS/MCS . Dosage frequency also assessed.	The Working Alliance Inventory, Patient version (Hovarth et al 1989)	Alliance did not emerge as a predictor of adherence (F= 1.22 (df 2,100) n.s.)
Startup et. al (2006)	29 patients from a controlled CBT trial with schizophrenia (n=25), schizophreniform (n=4) or schizoaffective disorder (n=1)	Not stated (observational)	Premature termination of therapy (those who leave before session 12 considered 'drop outs', others stay ins'	Working Alliance Inventory, Observer version and the Active Engagement (AE) Scale	Stay ins were significantly more engaged with treatment as per the AE scale (p =0.01) and showed significantly more agreement on the goals (p=0.05) and tasks (p=0.04) of treatment, but did not differ significantly on the bond subscale (p= 0.08)
Olfson et. al (2000)	213 inpatients with schizophrenia or schizoaffective disorder	Not stated (longitudinal prospective design)	Patient self-report interview at 3 month follow up post-discharge.	The Active Engagement Scale	Noncompliant patients received significantly poorer mean scores on 4/6 of the AES subscales: optimism about usefulness of treatment (p=0.006), meaningful involvement in therapy (p=0.09) interest in understanding their illness (p=0.015), realistic perceptions of the therapist (p=0.004).

Frank et. al (1990)	143 hospital patients with schizophrenia	Not stated (longitudinal prospective)	Therapist reports, patient reports and medical records of psychotherapy utilisation and medication compliance for a two year period or until patients dropped out.	The Active Engagement Scale, therapist rated	The more actively engaged in therapy the patients became, the more likely they were to take their medication as prescribed ($r = .37$, $df=70$, $p < .01$)
Zeber et. al (2008)	435 Veterans inpatient/outpatients with bipolar disorder, cyclothymia or shizoaffective disorder-bipolar subtype	Cross-sectional design	Patient self report: 1) patient report of no. of days within the past 4 dose has been missed. 2) Morisky scale:	Health Care Climate Questionnaire (HCCQ), patient rated	The overall HCCQ score demonstrated a significantly positive relationship with adherence outcome 1) ((OR 1.03, 95% CI 1.01-1.03, $p=0.022$), but not 2) . For the individual HCCQ items 4 items were statistically significant in relation to outcome 1) and 5 in relation to outcome 2)
Perron et. al (2009)	429 Veterans inpatient/outpatients with bipolar disorder, cyclothymia or shizoaffective disorder-bipolar subtype	Not stated (Cross-sectional and longitudinal prospective design)	Patient Self report: Morisky Scale administered at baseline and 1 year follow up.	Health Care Climate Questionnaire, patient rated	Medication adherence exhibited a significant association, but a small effect size with therapeutic alliance at baseline ($p=0.15$, $p=0.011$), but not follow-up ($p=0.02$, $p=0.799$)
Shigemura et. al (2010)	1151 individuals with major depressive disorder participating in an internet based survey	Not stated (Cross sectional design)	Patient self-report	1 item patient-rated scale	Low adherence was associated with a neutral/negative doctor-patient relationship ($P < 0.001$) and in a multivariate model low adherence was predicted by neutral/negative doctor-patient relationship ($p=0.020$)
Yeh et al (2008)	401 outpatients with major depression or depressive disorder	Cross-sectional design	Patient self-report	Patient-rated questionnaire	The professional-patient interaction was a significantly correlated with medication adherence ($p < 0.05$), however did not emerge as a significant predictor of adherence.
Bull et. al (2011)	181 outpatients with major depression or dysthymic disorder	Not stated (Cross-sectional design)	Patient self-report	Patient & physician questionnaire	Patients who reported they were told to take their medication for less than 6 months had higher odds of discontinuing antidepressant therapy than patients who reported being told to take their medication for more than 6 months (OR 3.12 95% CI 1.21-8.07). Communication regarding adverse effects significantly decreased the odds discontinuing antidepressant (OR 0.49 95% CI 0.25-0.95).
Lin et. al (1995) [44]	155 primary care patients with major depression, minor depression or dysthymia	Observational cohort (longitudinal)	Patient self-report (early and late phase adherence – 1 & 3 months)	Patient rated questionnaire	Patients reporting having received more educational messages regarding medications and discussions of behavioural strategies were more likely to adhere to their antidepressants ($p=0.008$.)
Gonzalez et. al (2004)	95 veteran outpatients with depression (or with comorbidity) 2 groups: newly prescribed antidepressants or newly referred to clini	Prospective cohort study (longitudinal)	Short term adherence (1 month) assessed by pharmacy records (med group), chart notes (referral group). Intermediate adherence (6 months): medication possession ratio, chart notes	Patient rated participatory decision making style and patient-rated..questionnaire	Provider participatory decision making style was significantly associated with adherence at 6 months ($p=0.03$), but not 1 month in both groups. Those with a mental health referral reporting that their doctor had more characteristics of a participatory decision making style were more likely to attend their initial appointment ($p=0.04$)
Bultman et. al (2000)	100 patients from community pharmacies receiving antidepressants.	Not stated (prospective observational)	Patient self report adapted from the Brief Medication Questionnaire (BMQ) at 2 month follow up.	Patient-rated scales at baseline and follow-up (2 months)	Physician initial communication style was positively correlated with medication adherence ($p < 0.05$) as was the physician's follow up style ($p < 0.001$). Collaborative communication style predicted follow up communication style ($p < 0.02$), more positive initial beliefs about the antidepressant by the client ($p < 0.0004$) and better medication adherence ($p < 0.03$).

Madsen et. al (2009)	50 veterab outpatients with major depressive disorder	Not stated (longitudinal prospective design)	Patient self-report based on the Anti-depressant Questionnaire and Proportion of Days Adherent calculated	Physician Assessment Questionnaire, patient-rated	Associations between the 6-item PAQ collaboration subscale and adherence at 3, 6, 9 and 12-week postbaseline, were not statistically significant (all ps> .10)
Mahone, I. et al (2008)	85 patients community mental health centre	Cross-sectional correlational	Patient self-report using the Schizophrenia Outcomes Module Medication (SCHIZOM) Use questionnaire.	Participation preferences and actual participation were measured using the Control preferences scale (CPS)	Neither client participation, SDM preference nor preference-participation agreement was found to be associated with better rates of medication adherence for the past month or past 6 months.
Hamann (2006)	107 psychiatric state hospital inpatients with a diagnosis of schizophrenia (ICD-10)	Cluster-randomized control trial	Composite measure of adherence consisting of the MARS questionnaire (patient-rated, derived from DAI and Medication Adherence Questionnaire (MAQ)), doctor rating of compliance and plasma levels of antipsychotics at 6 month and 18 month follow up .	Intervention: A decision aid and planning worked talk was compared to routine care	No significant effects of the intervention on adherence
Loh (2007)	207 patients diagnosed with depression	Survey study and structural equation modelling	GP- and patient rated at 6-8 weeks post initial consultation for depression	Patient participation scale.	Patient participation was positively correlated with adherence measures (0.364) In the SEM - the latent variable adherence in the model was only explained by patient participation (explained variance = 0.15)
Loh (2007)	23 primary care physicians treating 405 patients with newly diagnosed depression	A cluster randomized control trial	Patient and provider report.	Intervention: physician training and a decision board for use during the consultation	No significant effects of the intervention on adherence
Ludmen et al (2003) Von Korff et al (2003)	386 primary care patients receiving antidepressant for depression (receiving a new antidepressant prescription)	Randomised trial	Patient self-report.	Intervention: education about depression, shared decision making regarding the use of maintenance pharmacotherapy, two visits and a telephone contact with a depression prevention specialist	Intervention patients were significantly more likely to refill antidepressant medication prescriptions than usual care patients during the 1 year follow up period (adjusted odds ration intervention: control= 1.91, 95% CI (1.37, 2.65) P<0.001) Intervention patients were also more likely to receive adequate dosage of antidepressant treatment compared to usual care patients during the 1-year follow-up period (adjusted odds ratio intervention: control = 2.08, 95% CI (1.14-3.06), P<0.001)
Sleath et. al (2003)	27 resident physicians with 6-21 patients with depression in general internal medicine and family practice	Not stated (prospective observational)	Pharmacy refill records used to calculate adherence for the 100 day period post consultation	Researchers coded for specific communication variables in audio-taped transcripts relating to discussions surrounding medication	Question asking about antidepressant adherence was related to adherence (p=0.03).

2.3.1 Clinician-patient alliance and treatment adherence

Alliance is consistently associated with better adherence in mental health. Of 10 studies (2 low quality, 7 moderate and 1 high), eight yielded significant associations to some aspect of the clinician-patient relationship. Table 4 outlines the characteristics and findings of all included papers. The clinician patient alliance was most frequently assessed via the Working

Alliance Inventory (WAI) (Hovarth et al 1989) (n=4). This instrument, used in patient/clinician self-report or observer rated versions, provides measures of three related components hypothesised to determine the degree and quality of clinician helping alliances: a) patient and therapist agreement on the goals of treatment, b) patient and therapist agreement on the tasks to achieve these goals and c) the development of a personal bond between patient and therapist. Whilst two studies found no association between alliance and adherence when analysing these factors globally (Lecomte et al 2008, Sajatovic et al 2006), one study combining cross sectional and longitudinal prospective analyses found adherence difficulties not only to be associated with weaker working alliance, but demonstrated its impact on the time-course of adherence maintenance in initially adherent patients and the development of adherence in initially nonadherent patients (Weiss et al 2002).

A particularly important aspect of the working alliance may be patient-clinician agreement on the tasks of treatment, found by two studies to be significantly associated with patient adherence in subscale analyses (Corriss et al 1999, Startup et al 2006). In a psychotherapy (Cognitive Behaviour Therapy) setting, therapist and patient agreement on the goals of treatment was also relevant to premature termination of therapy (Startup et al 2006). However, arguably this finding may be due to the formulaic nature of the therapy where clearly defined goals are inherent to the process. Mainstream psychiatric services differ from conventional psychotherapy in important respects including the commonly open-ended nature of treatment, actual or potential use of coercive treatment measures and higher variability of the frequency, length and goals of consultations (Priebe et al 2008). In attempt to address this issue, the same study used a dual measure of adherence, the Active Engagement Scale, a 15-item questionnaire, assessing primarily involvement in therapy and collaborative participation. Three studies (Startup et al 2006, Frank et al 1990, Olfson et al 2000) found significant associations with this definition of alliance. As prospectively observed over a two year period, the more actively engaged in therapy patients become the more likely they may be to take their medication as prescribed (Frank et al 1990). Moreover, particularly crucial dimensions of active engagement for adherence may be patient optimism about the usefulness of treatment, meaningful involvement in therapy, patient interest in understanding their illness and realistic perceptions of the therapist (Olfson et al 2000).

The 'alliance' has also been extended beyond the primary treating clinician and patient to encompass entire mental health teams. Two studies (Zeber et al 2008, Perron et al 2009) solicited perceptions of the therapeutic alliance using The Health Care Climate Questionnaire (HCCQ) (Ludmen et al 2002). This 10-item instrument, designed specifically for patients with bipolar disorder, elicits the degree of comfort a patient expresses with their treatment according to statements regarding their care environment as it has been developed by their mental health team. For example, 'I feel encouraged by my mental health team' and 'I am encouraged to ask questions about my treatment'. One study analysing the overall HCCQ rating found a significant association with baseline alliance but not with a follow up measure at 1 year (Perron et al 2009). This suggests that provider team support may contribute to client motivation and engagement, but the causal associations are unclear. In the second study, adherence outcome was differentiated by missed doses and interpersonal barriers to adherence. The Overall HCCQ score was significantly associated with interpersonal barriers to adherence, but not missed medication doses. Similarly, in individual item analyses, certain alliance variables were associated differentially to the two dimensions of adherence measured. Salient aspects of team alliance related to both measures were identified as conveying confidence in the patients ability to make changes, ensuring the patient and team stay in frequent contact and regularly reviewing the patient's progress in managing all aspects of their treatment plan. Finally, in a significantly larger sample than those studies reviewed, an internet-based survey among 1151 patients with major depressive disorder found low adherence was associated with, and predicted by, a neutral or negative doctor-patient relationship (Shigemura et al 2010) .

2.3.2 Communication styles and clinical messages

Other studies have employed greater specificity in capturing aspects of the clinician-patient interaction. This enables identification of candidate communication styles and clinical messages that may mobilise adherence. Of 12 studies (3 low quality, 4 moderate and 5 high), eight found at least one or more variable to be associated with adherence. So how should clinicians co-act with patients to optimise the therapeutic encounter? The extent to which patients perceive behavioural traits such as listening, empathy and respectfulness to manifest in the clinician's communication style relates to their following of medication directions (Yeh

et al 2008). However, the practitioner's ability to elicit a patient's perspective about treatment may be specifically important. Patients who identify a participatory decision making style in clinicians, their propensity to involve them in treatment decisions, have been found to be more adherent at 6 months follow up (Gonzalez et al 2005) and 6-8 weeks post initial consultation (Loh et al 2007). Imparting information within such an approach, including facts about the disease and treatment, may also be factorial in adherence behaviours (Loh et al 2007). Evidence for SDM is however inconsistent. In another sample, the degree to which outpatients viewed their prescribing doctor as exhibiting a collaborative style in relation to similar items was not associated with subsequent adherence at 3, 6, 9 or 12 weeks (Madsen et al 2008). Whilst an explanatory hypothesis for contradictory findings could be variation in patient preference for involvement in decisions, a further study found no association between perceived participation and adherence, even when the degree of patient involvement was aligned with their preference for SDM (Mahone 2008).

The SDM construct has also been explored experimentally with similarly inconsistent findings. Three trials explored the impact of a multi faceted intervention. The first applied a decision aid, a 16 page booklet addressing the pros and cons of alternative types of antipsychotic medication, and a planning talk between patient and physician to establish agreement on further treatment (Hamann et al 2007). In the second, physicians were trained in SDM and a decision board for use during encounters was distributed to the patients, in addition to printed information combining evidence-based knowledge about depression care and specific encouragement for patients to be active in the decision making process (Loh et al 2007). Though such tools are designed to enhance patient involvement, both studies found no effect on adherence compared to routine care. In the third sample however, clinicians were trained to provide a complex intervention involving an SDM element. Intervention patients received an educational book, videotape about effective management of chronic or recurrent depression, in-person visits and telephone monitoring and were significantly more likely to refill antidepressant medication prescriptions than usual care patients during the one year follow up period (Ludmen et al 2003).

If indeed collaborative communication stimulates adherence behaviours, its positive influence may be attributable to an intervening variable i.e. enhancing patient beliefs about the

medication prescribed (Bultman et al 2000). One unique study tested a theoretical model suggesting that physician (initial and follow up) collaboration style influences client medication beliefs and in turn medication-taking behaviour. Fundamental elements of physicians' initial communication style, derived from the Health Communication Model (Svarstad 1986) included the degree of friendliness during the visit, asking if the patient had questions or concerns, assisting with concerns relating to the use of medication, providing clear instructions on how to take medication, clearly explaining how the antidepressant would affect the patient and talking about things the patient can do to make them feel better. Key components of the follow up communication style were considered to be the extent to which the physician encourages expression of concerns or problems with taking medication, asking about and listening to concerns about medication and helping solve problems related to the patient's use of medication. This study highlights the importance of collaborative communication about treatment specifics more generally, rather than specifically treatment decisions. Consistent with this, two studies (Bull et al 2011, Lin et al 1995) identified distinct medication-related messages that may have a bearing on adherence behaviour. That is, the time period patients are instructed to take their medication and discussion regarding side effects may be instrumental in decreasing the odds of discontinuing antidepressant therapy. Patients told to take their medication for longer were found to be less likely to adhere to their medication. Furthermore, communication regarding adverse effects may significantly decrease the odds of discontinuing antidepressants (Bull et al 2011).

Potential medication-related motivators of adherence in the initial phase of antidepressant treatment have also been identified (Lin et al 1995). These include physician questions about prior use of antidepressants, instructions provided by the doctor i.e. to continue medication use even when symptoms have alleviated; check before discontinuing medication; take medication daily, and advising the patient what to do in case of concerns. General discussion of pleasant activities may also be important to initial motivation to adhere to regimens. In this study, no communication variables were found to be significant predictors of later stage adherence, suggesting important topics are dependent on the stage of treatment. Another study assessing the same communication messages did not find them to be related to adherence for patients prescribed antidepressants (Gonzalez et al 2005).

2.3.3 Objectively measured communication

Communication signifies an observable behavioural exchange between the patient and clinician and therefore has the potential to be captured in objective terms by an independent observer. Despite this, only one study (of moderate quality) examined the relationship to adherence via this method (Sleath et al 2003). Analysis was performed on a dataset including 27 resident physicians, each audio taped with 6 to 21 of their Spanish or English speaking patients, within general internal medicine or family practice. Researchers coded specific communication variables from transcripts including 1) discussion of antidepressants during the encounter 2) number of different types of information the doctor provided the patients about antidepressants 3) number of physician questions about antidepressants 4) number of different types of information the patient stated regarding antidepressants 5) number of questions the patient asked about antidepressants. Adherence was assessed for the 100-day period after the recorded consultation via pharmacy prescription refill records. Analyses determining how the communication variables were related to adherence, demonstrated that only patient question asking was significant. That is, patients who asked more questions about medication during the encounter were less adherent to their therapy during the 100-day period after their visit. However, the fact that medication-specific discussion was not found to be associated with adherence is in contrast to the previous research reviewed.

2.3.4 Variability in adherence measures

The variability in assessment and definition of adherence, as evident in Table 4, presents an important consideration as comparability between studies is affected. Most frequently, adherence was assessed via patient report (n=14), consistent with an identified preference for this method in extensive reviews of adherence assessment in mental health (Velligan et al 2006). Choice of measures and criteria for non adherence however were heterogeneous, ranging from patients being asked if they had stopped taking their medication for a period of one week or more during the intermittent follow up period (Olfson et al 2000), to patient's rating on a scale of 0-100 how often they forgot to take their medication, alter their dose, or miss a dose intentionally to suit their needs. The only measure to be duplicated between studies (Zeber et al 2008, Perron et al 2009) was the Morisky scale (Morisky et al 1986). Three studies used a combination of therapist and patient reports (Frank et al 1990, Hamann

et al 2007, Loh et al 2007) and two studies (Weiss et al 2002, Corriss et al 1999) used solely therapist report, both of which employed a 4-point likert scale with ratings from 1 'active compliance' to 5 'passive compliance' (McEvoy et al 1989). Direct i.e. objective, assessments were only used in four studies (Startup et al 2006, Gonzalez et al 2005, Hamann et al 2007, Sleath et al 2003) in the form of pharmacy refill records, premature termination of therapy and blood plasma levels. Subjective measures were therefore predominantly adopted which, particularly when used in isolation, can be susceptible to bias. For example, exaggerating the degree of adherence (patient self-report) and basing adherence judgements on deteriorating clinical state or inaccurate perception of agreement about treatment (Phillips et al 2011) (therapist-report). In line with existing literature (Velligan et al 2006), this review highlights the opportunity for advancement in adherence research. Most notably, in relation to consensus development, allowing for studies to be compared on a common variable. In turn, more valid conclusions could be drawn when assessing the effect of alliance or communication.

2.4 Discussion

2.4.1 Summary of main results

To the author's knowledge, this is the first review to examine alliance, communication and adherence in mental health. Twenty-three articles met the inclusion criteria. The methodological quality overall was moderate, reflecting the largely cross-sectional nature of the research in this field and limitations in comparability and identifying causality. Ten papers examined the relationship between adherence and the clinician-patient alliance, which emerged as a consistent predictor of adherence, though its components have differential significance. Twelve studies examined specific communicative styles or messages, only four of which employed intervention designs. Shared decision making yields inconsistent results in relation to patient engagement. However, collaborative features of communication more generally, such as imparting medication-related information and discussing the practicalities of treatment specifics, were associated with adherence, though less studied. Only one study explored the association between adherence and observer rated clinical communication, highlighting a gap in psychiatric literature for more objective methods of communication measurement. The specific communication mechanisms that may affect the alliance and patient adherence are discussed in more detail.

2.4.2 Specific communication mechanisms that result in patient engagement

It is commonplace to conceptualise the clinician-patient relationship as one depending on 'bond' and rapport (Leach et al 2005, Rogers 1957). This review shows that in relation to adherence, more task-oriented elements of the alliance may be instrumental. Agreement on the tasks of treatment, collaborative participation and regularity of contact with clinicians for example emerge as 'active' elements of the alliance. The treatment context may however influence the magnitude of benefit of these factors e.g. Goal elements in a psychotherapy setting (Frank et al 1990) may preside over such task-based features relative to an outpatients setting (Weiss et al 2002). It is unclear how a positive clinician-patient alliance translates to specific communication styles and messages that can be utilised to improve engagement. This is attributable to less consistent findings in the field of communication research and a lack of observed naturally occurring clinical communication. However, this review presents two main candidates for clinicians to consider. SDM provides a model of communication to enhance

patient involvement in the decision process of consultations, but is inconsistently associated with adherence in mental health. Whilst associated tools such as decision aids help patients make deliberative choices among treatment options and provide a platform from which they can assess the risks and benefits, non-significant associations with adherence outnumber positive. This uncertainty is further complicated by the difficulty of examining the effect of complex interventions with SDM elements. For example, arguably the positive outcomes described in Ludmen et al/Von Korff et al (2003) cannot be ascribed solely to the SDM element as it was part of a multi-faceted intervention. Sharing preferences about treatment may be particularly challenging in mental health care due to the nature of symptoms that make establishing a shared understanding about treatment problematic. Research must identify the complications of sharing decisions in these contexts to further understand its relationship with adherence behaviours.

Despite this, collaborative communication throughout the consultation more generally appears important to adherence. Clinicians who are friendly, explain medication, address questions and concerns and discuss treatment specifics e.g. medication instructions, may be more likely to have patients who adhere to regimens. Though further pathway research is necessary to reinforce findings (Street et al 2009), the mechanism by which this occurs may be enhancement of patient beliefs about medication. The emphasis on medication-specific discussion certainly aligns with the notion that knowledge maybe an important patient factor clinicians can influence in order to improve adherence in mental health. Patients need to be informed about and comprehend treatment. Coupled with the finding that clinician optimism is associated with adherence, perhaps provider attitudes towards treatment, manifest in communication, can influence patient's expectations of prescribed treatment. Indeed, when studied outside of the context of communication, clinician attitudes towards medications have been found to impact patient's medication adherence in mental health (Feros et al 2010).

Only one study was able to objectively identify a specific communication practice, patient question asking, as being related to adherence. Given the finding that communication may mediate beliefs and knowledge about medication (Bultman et al 2000), perhaps more question asking reflects less understanding on the part of the patient. Further studies of this nature may enable identification of specific communication practices that either indicate

patients are at risk of nonadherence, or are involved in mobilising self care behaviours in mental health. This review has demonstrated a clear paucity of research, in relation to objectively measured natural clinical communication.

2.4.3 Comparison to literature

The findings of this review are consistent with mental health research identifying the alliance to be associated with other treatment outcomes (Martin et al 2000). The emphasis on agreement about tasks of treatment is in line with perceived patient agreement being associated with adherence in general medicine (Phillips et al 2011). It has been suggested that discussing treatment specifics, highlighted in this review, enhances a clinician's ability to perceive such patient agreement (Phillips et al 2011). The potential for perceived collaboration in clinical encounters to encourage patient engagement aligns with findings in general medicine that collaboration is associated with improved adherence (Arthbutnott et al 2008). Inconclusive findings in relation to collaborative treatment decisions specifically i.e. SDM is inconsistent with more positive outcomes in general medicine (Joosten et al 2008), but consistent with reviews in mental health examining SDM and a range of patient outcomes (Duncan et al 2010). Interestingly, unlike general medicine where numerous empirical studies from various populations and settings link systematically coded clinician-patient communication to adherence (Zolnierek et al 2009), only one study objectively measured naturally occurring clinical communication, suggesting a deficit in research of this nature in psychiatry specifically.

2.4.4 Implications for future research

This review underlines numerous methodological weaknesses that may be useful to address in future research. Only six studies were deemed high quality according to QA criteria. Whilst practical constraints of cross-sectional studies in naturalistic settings are expected, general improvements to derive from these findings relate to: increasing implementation of validated measures and supplying adequate information on reliability and internal consistency; striving for larger sample sizes and performing formal sample size calculations to increase precision in extrapolating effects to the wider mental health care population; employing random sampling or recruiting consecutive patient admissions to optimise external validity and the potential inferences that can be made.

Beyond this, five specific areas may offer particularly salient improvements to research in this field; Firstly, whilst alliance was mostly assessed via validated instruments, the dimensions of this construct varied between measures. It may be important to distinguish between components in analyses and explore their differential associations with adherence, e.g. clinician-patient agreement about the tasks of treatment may be more important than bond, in order to enhance the potential application of findings in clinical practice and training. This may be possible by performing subscale analyses of measures in addition to global ratings.

Secondly, whilst alliance and communication are interrelated, they are analytically distinct concepts. It is therefore difficult to consider how specific communication practices are involved in the formation of a positive alliance. Furthermore, generalised communication coding categories such as 'discussions about medication' may fail to account for the wide range of behaviors and content these interactional events may incorporate. Investing more effort, and specificity, in studying clinical communication variables may provide a fruitful starting point from which we can look at how, and if, such practices are related to subjective perceptions of alliance and outcomes like adherence. More objective micro analytic methods such as conversation analysis that account for context, sense making and clinician-patient interactivity may be useful approaches in achieving this (Heritage & Maynard 2006).

Thirdly, whilst it is appealing to conclude that alliance and communication have an impact on patient cooperation with treatment regimens, it is important to contextualise any effect within the interplay of other possible adherence determinants e.g. illness related, demographic and psychosocial factors. These potential confounders should be sufficiently adjusted for in future research so valid inferences about the effect of the clinical interaction can be made.

Fourthly, longitudinal prospective studies that follow patients and clinical interactions over time are necessary to account for the potentially dynamic nature of adherence behavior and that the clinician-patient alliance may change or develop. To increase comparability between studies it may be useful for each investigation to report a mean percentage of medication consumed throughout the follow up period of such studies, even if the primary measure of adherence is operationalised otherwise (Velligan et al 2006).

Finally, due to the largely correlational nature of the research reviewed, the directionality of effect can only be speculated upon. The question of whether the predictive power of the alliance or communication derives from the effect of patient engagement itself on the interaction, or even patient characteristics present at the start of treatment, remains pertinent in further research. Further experimental studies or use of causal modelling techniques would allow researchers to elicit directions of causality and eliminate the alternative explanation that a strong alliance is not a pre-requisite for better adherence, but rather a consequence of positive clinical change.

2.4.5 Conclusions

Adherence to mental health treatment is frequently a challenge for practicing clinicians. Treatment and patient factors have attracted most attention in published research. However, this review shows clinicians play a role in mitigating nonadherence. A positive alliance is associated with more favorable adherence. How this translates into tangible communication practices, and the mechanisms by which these may influence treatment engagement are less conclusive and require more sophisticated studies and methodological techniques. Communication represents an observable exchange between patient and clinician that may be objectively described. However, adherence research relies mainly on subjective measures, making actual communication relatively under researched in mental health compared to medicine more widely. Addressing this deficit, and the considerable methodological limitations in this field, could facilitate better application of findings in clinical practice. Currently, literature implies providers should engage patients collaboratively in the consultation in order to establish agreement surrounding the tasks of treatment, an important aspect of alliance. Training clinicians to discuss treatment specifics, including patient concerns about treatment may improve their ability to perceive this agreement (Phillips et al 2011); improve patient's beliefs about and attitudes towards treatment; and gain insight into the idiosyncratic reasons outside of the clinical interaction also underling patient's nonadherence. As such, whilst time constraints on psychiatric encounters pose a challenge to clinicians in developing bonds with patients, more effective collaboration on practical aspects of treatment may be one way of compensating for this. Clinicians should also observe features of patient communication e.g. question asking that maybe indicative of engagement both

within, and external to, the consultation. SDM is outlined in policy as a preferred mode of communication that will improve patient adherence. However, further research is necessary to understand this relationship. Arguably, the implementation of such patient-centred principles may be particularly challenging in psychiatry (Priebe et al 2011). Despite methodological deficiencies in this field, engagement in the psychiatric consultation itself may impact patient engagement with treatment more globally: a finding that provides impetus for the following studies.

Having identified the validity of psychiatric encounters as a potential point of intervention, the following chapter selects the current methodological shortcomings that will be addressed in this thesis. The resulting guiding approach - conversation analysis - will then be detailed in terms of its theory and methods.

Chapter 3

Microanalysis of clinical communication

Conceptualising ‘good’ communication in the treatment of schizophrenia begins with identification of specific interactional variables - rather than abstract ideals - associated with positive outcomes (Chapter 1). Via a systematic review, the previous chapter determined a consistent association between adherence, the clinician-patient alliance and communication in psychiatry. However, a distinct paucity of observer-rated *naturally* occurring interaction was observed.

Three specific shortcomings identified in Chapter 2 will be addressed in this thesis, informing the selected methodology:

- 1) A reliance on correlational research in this field renders directionality of effect largely speculative. Causal modelling techniques could attempt to elicit the direction of causality statistically, but qualitative interactional studies are necessary to hypothesise the *explanatory* mechanisms underlying associations between alliance/communication and adherence.
- 2) Alliance (a subjectively rated psychological construct) and communication (subjectively or objectively rated components of the behavioural exchange) are interrelated, but analytically distinct concepts. Starting with the latter ‘micro-level’ - observer-rated naturalistic communication - would allow identification of tangible practices from which to explore their relationship with ‘higher-level’ subjective constructs i.e. the alliance or behavioural outcomes i.e. adherence.
- 3) To date however, observer-rated communication involves generalised and insensitive coding categories that may fail to account for the diverse behaviors and content that may occur *within* such categories. Methods such as conversation analysis (CA) that account for

context, sense making and clinician-patient interactivity may be useful approaches in addressing this shortcoming.

Accordingly, this chapter introduces a microanalytic approach to the study of psychiatrist-patient communication. It focuses on conversation analysis (CA) as a pragmatic methodology for this setting. The methodological history and context of CA will first be outlined, followed by its tools of analysis and applications in medicine and psychiatry. Four studies derived from this approach will then be introduced along with the data upon which they are based.

3.1 A brief history of medical communication research

In 1951 Parsons conceived the doctor-patient relationship a phenomenon of analytic concern (Parsons 1951). According to his functionalist viewpoint, medical encounters constitute a social system's mechanism for rehabilitation of the ill in order that they may return to fulfil their regular societal duties. However, the role-based model that Parsons constructed did not incur significant empirical exploration due to its abstract nature. Instead, analysis of doctor-patient interaction burgeoned in the 1960's when Interaction Process Analysis (Bales 1950) was applied to naturally occurring clinical encounters (e.g. Francis et al 1969). This allowed quantification of clinician-patient interactions by classifying role behaviour in relation to a contrast between socio-emotional and task-oriented aspects.

While showcasing the feasibility of systematically and objectively studying medical interaction, the method was originally developed for small groups and not adapted to the specificities of phases of medical consultations (Heritage & Maynard 2006). Subsequent coding schemes have been subject to refinement, becoming modified to the study of dyadic interaction and the content and stages of the clinical encounter. The most influential of these is the Roter Interaction Analysis system (RIAS) consisting of categories applicable to either the 'task-focused' or 'socioemotional' exchange. For example, the frequency that doctors make direct requests for questions, show approval and provide information (Roter et al 2002). Like the Bales system, RIAS uses these pre-defined codes to implement an exhaustive classification of the interaction, but with categories consistent with a three function model ('gathering data', 'developing rapport' and 'education and motivation') of the medical visit (Cohen-Cole and Bird 1991). Not only did this allow specification of the main

communicative patterns within consultations e.g. primary care visits (Roter et al 1997) but accommodated the exploration of links between communication variables and proximate (e.g. patient understanding) and distal outcomes (e.g. adherence to treatment) (See Brown (2003), Stewart (1995) for a review). As such, this approach has dominated the field of medical communication research: In 2002 almost 100 studies had been documented in multiple medical settings (Roter and Larson 2002).

While RIAS has facilitated applied and replicable findings in this context, it is prone to controversy. Critics argue that its categories are flawed due to their 'insensitivity' to the interactive nature of communication. Specifically, defining a series of codes *a priori* renders the capacity for one speaker to influence another or adjust behaviour in response to another invisible in the process of coding (Charon et al 1994). From this standpoint, explanatory processes underlying links between interactional variables and outcomes remain unclear or tenuous. Heritage & Maynard (2006) identify two particular coding deficiencies, the product of pitching categories at a generic level in order to generalise across medical contexts:

1) Content: In the process of coding the content of the medical encounter is diluted. The coded material effectively becomes 'the data', thus the specifics of the physician-patient discussion are lost.

2) Context: Coding expunges the context of utterances and the actions they perform. Their location in a specific sequence and phased activity within the consultation e.g. history-taking is effectively 'deleted'. It is such aspects of context, Heritage & Maynard posit, that ascribe 'meaning' to utterances and actions.

Alternatively, microanalysis of medical discourse exists at the polar end of the analytic spectrum in health communications, from which such criticisms have developed. These studies employ interpretive and ethnography derived methodologies to capture the understandings, background orientations, individual experiences, sensibilities and objectives within encounters (Heritage and Maynard 2006). Typically, such studies have focused on practitioner obstruction of patient subjectivity and experience, attributable to status and authority asymmetry. Whilst coding techniques like RIAS rate the presence of behaviours in interaction, microanalysis seeks to underscore what is notably absent assigning it a relatively

critical approach. Elliott Mishler's (1984) *The Discourse of Medicine* represents perhaps the most seminal implementation of this methodology. In the context of history-taking Mishler observed the often conflicting agendas that patients and doctors pursue in clinical encounters: biomedical assessment and treatment and the patient's 'lifeworld' agenda surrounding everyday experience and fears. He argued physicians recurrently curtail the expression of patient concerns via a three-step sequence of actions in which history taking is systematically performed (symptom question, patient response, evaluation/acknowledgement). Mishler argues this apparently simple mechanism allows doctors to control topic initiation, topic development and the extent to which patients can respond. Despite patient attempts to provide 'surplus' information relating to social, existential or moral issues (i.e. 'lifeworld' concerns) in response to medically-oriented questions, the clinician's questions that follow avoid taking up or developing such issues in favor of a strictly focused medical agenda (Misher 1984).

While such approaches retain aspects of interactivity, interpretation and sense-making that process coding negates, issues remain in producing non-interpretative evidential grounds for associations between communicative practices and medical outcomes (Heritage & Maynard 2006). Heritage & Maynard (2006) assert that in order to achieve robust outcome-based inferences about ideal communicative conduct for doctors, it is important to find a convergence between the two methodologies of microanalysis and coding. Conversation analysis, a specific microanalytic methodology offers a potential mode for accomplishing this. The background, principle, method and applications of this approach will hence be described.

3.2 Theoretical background

Developed in 1960s California by sociologists Harvey Sacks, Emanuel Schlegloff and Gail Jefferson, CA's inquiry centers largely on verbal communication and the recurrent practices people utilise in producing meaningful action and interpreting other speakers' meaning. This focus was inspired by the tenets of Erving Goffman's theory of an interactional order (Goffman 1983) and Harold Garfinkel's ethnomethodology. The former posits that conversation equates to its own social institution. In opposition to the Chomskian conception of talk as predominantly disordered and unsystematic (Drew & Heritage 1992), this alludes to a

structured and organised set of practices upon which speakers draw to accomplish social activities. As Goffman (1957) asserted 'We must see . . . that a conversation has a life of its own and makes demands on its own behalf. It is a little social system with its own boundary-maintaining tendencies' (Goffman 1957:47). Ethnomethodology is concerned with documenting the reasoning and methods people use in producing and maintaining recognisable social orders in everyday life (Garfinkel 2002).

3.2.1 Erving Goffman

Goffman's contribution to the development of CA emerged through his fascination in face-to-face interaction as a substantive domain available for analysis: through which 'most of the world's work gets done' (Goffman 1979:6). He described the behaviours that maintain order as often socially determined and abiding by them affords individuals 'appearing always in a steady moral light' (1956:251). Goffman therefore discerns a strong normative element in interaction: 'order' is omnipresent and, if broken, is quickly re-established. In an early publication, 'On face-work: An analysis of ritual elements in social interaction' (1955, 1969), Goffman details that social interaction is intrinsically tied to issues of 'face': 'the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact.' (1969:3). Through this concept, Goffman outlines the actions adopted by a person to 'make whatever he is doing consistent with face' (1969:9). Individuals systematically work to sustain face and 'save' it when it is in danger of being jeopardised e.g avoidance of situations or employment of corrective practices when a problem arises. This is particularly poignant in face-to-face interaction: concerns of social worth may be bound up in micro acts – words, tone of voice etc – to be judged by co-participants. Thus, activities accomplished in interaction – agreements, offers, rejections etc are performed using methods that support the maintenance of face: the conventions and practices of interaction have a prominent ritual and social element. Goffman later outlined more explicitly the ways in which interaction can be analysed as a substantive social domain. Meanwhile, Sacks and Schegloff had begun developing the conversation analytic approach influenced heavily by his theories.

3.2.2 Harold Garfinkel

Garfinkel aligns with Goffman, discerning daily taken-for-granted practices as fundamental to social order. However, while Goffman emphasises rules, 'the ritual element of interaction', Garfinkel assumes a more action-centred perspective: accommodating the role of practical reasoning (Garfinkel 1967). Opposing the prevailing quantitative approach to explaining variables of social life, Garfinkel championed detailed empirical description instead of a reliance on conceptual categories. While Parson's (Garfinkel's PhD supervisor) conception of social order was a factual order with objective and external rules constraining behaviours, Garfinkel perceives individuals as more active. Social actors use rules on an ad-hoc basis, rather than pre-determinedly complying with them. Thus, constraints on action do exist but they are not imposed from the external world.

Schutz (1962) and phenomenology were also a pivotal influence for Garfinkel. This ontological perspective is one grounded in perception: the world does not exist beyond our perceptions of it and, as humans, we do not have the capacity to experience or process it all. To deal with this level of complexity, we categorise phenomena in service of sense-making. Specifically, we accumulate 'typifications' – abstract models to constitute what is 'typical' of social phenomenon. These represent vital forms of taken-for-granted knowledge: through these devices we can act in, and understand, the world. Accordingly, Garfinkel did not identify order as external to action. Instead, order is a product of action – to which language is central.

While there are incompatibilities between Garfinkel and Goffman's thought, it is commonly asserted that CA emerged as the synthesis of these two approaches by devising an empirical method for the study of practical reasoning (Garfinkel) applied specifically to social interaction (Goffman) (Sidnell 2010).

3.3 Principles and methods

Studies in contemporary CA can be categorised as either 'pure' or 'applied'. Pure CA analyses 'ordinary' conversation in everyday settings e.g. telephone calls between friends, a family at the dinner table. However, CA also assumes that interaction is the basis for all other social institutions, therefore research is also concerned with how 'ordinary' conversation is

transformed in order to evoke and manage institutional realities, for example in medical settings (Drew & Heritage 1992). As such, this approach depends upon analysing naturally occurring interactions via audio/visual recordings. Transcripts are produced using standardised conventions documented by Gail Jefferson (Appendix 1) that include not only the content of utterances, but how they are spoken via features such as pauses, overlapping speech, intonation and volume. Non-verbal characteristics may also be transcribed such as eye gaze and gesture. The transcription system therefore captures the sequential characteristics of talk (Ten Have 1999).

CA's objective is to identify systematic patterns and interactional consequences in the organisation of talk therefore findings are often derived from the examination of large scale data corpora. Collecting data on this scale enables analysts to perform data-driven inductive analysis: uncovering recurring patterns of interaction upon which a model or rule explicating their occurrence can be developed. To elaborate, Drew et al (2001) delineated three particularly salient assumptions underpinning this analytic approach. Firstly, utterances are conceived as performing social actions. Talk is the vehicle through which we conduct the ordinary affairs of our lives: when studying conversation we are examining the practices by which these are accomplished. CA assumes that in interactions we don't just talk, but we are 'doing' things such as inviting, complaining, agreeing, disagreeing or greeting (Drew 2005).

Secondly, such utterances are connected in sequences of actions: what one speaker does is generated by and dependent upon what the prior speaker has said and done. CA attempts to elicit the dynamic processes via which connected sequences of actions are built up. Thirdly, such sequences appear to have stable patterns. How one participant speaks can be seen to have recurrent consequences for the responses of the recipient, thereby for the sequential shape and outcome of the interaction that ensues (Drew et al 2001). The assertion that patterns of talk are systematic, yet oriented to preceding talk leads us to another central tenet of CA: that the structure of conversation is simultaneously 'context free' and 'context sensitive' (Sacks et al 1974). While the resources we use to achieve something interactionally are context free: the set of techniques any conversationalist can use are not bound up in the circumstances of a specific occasion, at the same time the techniques which they *do* choose are dependent on what has occurred previously within that conversation, and possibly also their relationship

with that individual (Hutchby and Woofitt 2003). Talk is therefore designed in relation to such contextual specifics.

Based on these assumptions, the fundamental units of analysis are sequences and turns within sequences (Heritage 1984) and a number of conversational structures explicated in early CA research facilitate systematic analysis. The most fundamental form of organisation for conversation is that participants take turns to speak. According to CA, the turn-taking system incorporates turn constructional components, the basic units out of which turns are fashioned, and turn allocational units i.e. how speakers organise their interaction by 'selecting' speakers in a conversation (Sacks et al 1974). In a particular context, these turns accomplish recognisable social actions. The most basic way such actions are ordered in talk is described in CA through the adjacency pair sequence. That is, two utterances positioned adjacently (though the pair may be divided over a sequence of turns) and spoken by two different participants (Schegloff & Sacks 1973). These sequences are highly ordered comprising a first pair part and a second pair part which fit together e.g. an offer-acceptance/refusal, a greeting-greeting or a question- answer. If a first-pair part is asked by one speaker, a particular second pair-part is projected as 'conditionally relevant' (Schegloff 2007). In the instance of a response not being provided, this is an accountable matter that the initial speaker treats in terms of the recipient having some trouble in responding.

Other pivotal tools of analysis within CA include repair, preference organisation and turn design. Repair organisation delineates how parties in interaction deal with sources of trouble in relation to speaking, hearing or understanding (Schegloff et al 1977). All repairs are classified in terms of who initiates, self or other, and who

completes the repair, and how this unfolds within a sequence of turns. CA has also exposed structural preferences in conversation for particular types of actions within sequences over other actions. This is exemplified in the research of Pomerantz (1984), displaying that responsive actions that agree with, or accept, positions taken in a first action tend to be performed faster and more directly than those which decline or disagree. Finally, turn design refers to the (lexical) way in which utterances are formulated or constructed, as a meaningful choice given the set of alternatives available, for that recipient at that point in the

interactional exchange. Having established a phenomenon of interest, a CA researcher will collect all occurrences within a given dataset and compare their structure in relation to these analytical tools e.g. repair, turn design, sequence organisation etc. Deviant cases, which appear to depart from an emergent pattern, will be given close attention in order to test hypotheses which result from this examination (Perakyla 2004).

3.4 Strengths of CA

The identification of sequential patterns in talk and the practices through which they are generated distinguish CA as a unique approach to the study of social interaction. There are notable strengths to this. Principally, findings do not arise from or depend upon participants personalities, idiosyncratic styles or psychological dispositions (Drew et al 2001). CA's method is therefore an observational science that does not necessitate subjective interpretations about what speakers mean. Instead, it is based on tangible properties of talk e.g. turn design and how these impact the interactional uptake by the other speaker (Drew et al 2001). The rationale for claims made by analysts surrounding such elements of talk are made available through the highly detailed transcripts produced, providing people other than the researcher 'independent access' to the raw data (Ten Have 1999). As such, though CA's findings are descriptive in nature, the transparency of analytic claims afford the research 'apparent validity' (McCabe 2003). The researcher's claims are validated by ensuring that their interpretations are consistent with those of the speakers .

CA is the most sensitive and detailed method available to study social interaction: not only does it analyse the content of speakers' utterances, but how they co-occur to make them understood in one manner rather than another. As Heritage (1984) asserts, it is via this 'turn by turn' characteristic of talk that speakers display their understanding of the 'state of talk' for one another. Accordingly, CA highlights categories that speakers themselves use as opposed to those developed by analysts. As these are produced publicly, they are accessible as an analytical resource. This stands in contrast to the alternative approaches e.g. RIAS, that specify pre-determined codes or inventories to be applied to the talk under study. In analysing how both parties in a conversation continually construct an interaction as each utterance builds upon the previous turn of talk (Maynard & Heritage 2005), CA can account for how

the meaning and function of communication can alter over time and at particular critical junctures within the interaction.

3.5 Institutional talk

Many systematic practices, identified by CA, through which individuals conduct themselves in everyday conversation are embodied in institutional talk. However, institutional interaction is also distinct from ordinary conversation due to the tasks and identities that shape speaker's contributions. Heritage and Clayman (2010) identified the basic elements of institutional talk in terms of these constraints:

1. Participants are involved in specific goal orientations tied to their 'institutional-relevant identities' i.e. doctor and patient.
2. There are special constraints on the interaction in terms of what will be treated as 'allowable' contributions to the business at hand.
3. The interaction involves inferential frameworks and procedures specific to a medical context.

Such constraints may limit or transform the organisation of numerous dimensions of the interaction, including those addressed in the previous section. For example:

1. Turn-taking organisation.
2. Overall structural organisation of the interaction.
3. Sequence organisation.
4. Turn design
5. Lexical or word choice
6. Epistemological and other forms of asymmetry (Heritage & Clayman 2010)

3.6 Applications in medicine

The consequences of these communicative transformations for the ensuing success of the interaction are worth exploring, particularly in the current climate of ‘patient-centredness’ where clinicians are encouraged to facilitate patient involvement, experience and preference (See chapter 1). Drew et al (2001) outlines three applications that position CA as a pragmatic methodology in health settings. Specifically, its focus on sequential patterns and the practices via which these patterns are generated allow:

1. Identification of behaviours and their consequences that providers may more consciously consider in their interactions with patients and which, therefore might have training implications.
2. Identification of interactional strategies that create opportunities for patient participation in decisions and discussions about health-care.
3. Exploration of the association between certain interactional phenomena and outcomes such as adherence to prescribed treatment.

Indeed, Heritage (2011) exemplifies CA research displaying dysfunctional clinician communication processes relating to: problem presentation, clinician questioning that limits the expression of additional worries and the emergence of misalignment between doctor and patients in discussions of treatment recommendations. ‘Reduction of these dysfunctions is most likely to emerge when physicians recognise the nature of these dysfunctional practices.....’ (Heritage 2011:338). CA enables these characteristics to be described. Moreover, studies of paediatric interactions involving children with upper respiratory infections have subsequently led to quantitative studies showing how conversational actions are associated with medical outcomes: specifically, physician perception of demand for antibiotic medication and inappropriate prescription (Stivers et al 2003). These studies highlight alternative communicative practices clinicians could employ to prevent such negative outcomes (Mangione-Smith et al 2003). Understanding the intended and unintended consequences of specific actions provides a foundation via which we can link process and outcome, thus addressing the lack of explanatory power in cross sectional studies like those

reviewed in the prior chapter. Methodological challenges notwithstanding e.g. translating, in a valid manner, descriptively rich data into a form that can be quantified and integrated into statistical analyses to predict outcome from communicative processes (McCabe 2003), CA shows promise in this pursuit.

3.7 Applications in psychiatry

While CA research in general medicine has burgeoned and increasingly in psychotherapy (Perakyla et al 2011), there is a paucity of research in psychiatry. This is an important deficit to address, given the complex needs of conditions like schizophrenia. However, the few instances to date have shown the benefit of CA in establishing the interactional resources used by clinicians and their interactional consequences. Bergmann (1992) for example examined how psychiatrists conducting intake interviews formulate prior knowledge about the patient in order to elicit information. He observed how clinicians tell patients something they perceive about their situation or psychotic behaviour, using expressions denoting the second hand and derivative nature of their knowledge e.g. reporting what they had 'seen' in their notes or 'heard' from another doctor. In this way, they signal the uncertain character of their knowledge, indirectly inviting patients' to deliver a first-hand unmitigated account. Eliciting 'confession' of this nature, Bergmann posits, is a central objective of clinicians performing intake interviews: demonstrating the way psychiatrists design their utterances can be informed by their orientation to institutional tasks and roles.

In another example, Palmer (2000) employed conversation analytic methods to explicate the tacit skills via which delusional talk in schizophrenia is recognised by psychiatrists. Based on 3 recorded interviews, he showed turns were often designed to display insufficient grounding for patient's descriptions and elicit more evidence. Moreover the 'rationality' of that evidence was explored by orienting to a 'standard' that describing events with paranormal properties should be synonymous with evidence of a similar nature i.e. 'extraordinary'. Whilst patients recognised that the clinician required this type of evidence, unaccountably they did not provide it, displaying significant departure and disengagement from the realm of 'normal' social interaction.

In a larger corpus, McCabe et al (2002) showed how discussing the content of such experiences poses a challenge for psychiatrists. Examination of 32 outpatient consultations displayed patients actively attempted to initiate talk about the content of their psychotic symptoms via direct questions and repetition of questions and utterances. Patients' formulation of direct questions departs from the 'typical' 3 step sequence of actions (question (doctor), answer (patient), acknowledgement (doctor)) characteristic of doctor-patient communication. While patients' questions made relevant a fitting answer, instead they were the source of interactional tension: psychiatrist responses were not forthcoming, manifesting as response latency or responding with a question rather than an answer to avoid disagreeing with the patient about the origin of their beliefs. This indicated reluctance to engage with patient concerns about their psychotic symptoms, with each speaker attempting to realign the focus of the consultation in contrasting directions.

CA clearly has utility in exploring both the challenges of psychiatric communication and the resources clinicians use in attempting to overcome these challenges. However, in terms of identifying specific practices that lead to better adherence, only one study to date has attempted to use concepts derived from CA. McCabe et al (2013) used a standardised coding protocol to assess the frequency of 9 types of repair - as defined by Schegloff et al 1977 - for both patient and psychiatrist in audiovisually recorded outpatients consultations. The association between the repair categories with clinician-rated adherence was examined, adjusting for symptoms and length of the encounter. A specific repair factor; patient led clarification and psychiatrist response, comprising primarily of patients' other-initiation of repair (whereby patients flag something 'problematic' with the psychiatrists' prior turn) was associated with better patient adherence to treatment. The explanatory process for this association however remains unclear. Beginning to unpack such issues may create the possibility for new communication interventions to improve adherence.

This thesis continues to report three interlinked studies exploring the relevance of specific communication practices 1) patient other-initiated repair 2) psychiatrist questions 3) treatment decisions, for adherence in schizophrenia - the first building directly on McCabe et al (2013). We turn to describing the characteristics of the data used in these studies.

3.8 Data and approach

For the studies reported in Chapter 4 and 5, data was drawn from a study funded by the Medical Research Council (Grant ref: G0401323) examining clinical interaction in psychosis (McCabe et 2013), collected between 2006 and 2008. 36 psychiatrists from outpatient and assertive outreach clinics across 3 centres (one urban, one semi-urban and one rural) were randomly selected, 31 consented (86%). Patients assigned to clinicians who met Diagnostic and Statistical Manual – IV (APA) criteria for schizophrenia or schizoaffective disorder were also asked to participate. Of 579 eligible consecutive attenders, 188 did not attend their appointment, 42 were not approached (for symptomatic or logistical reasons e.g. overlapping appointments) and 211 declined participation. Written informed consent was obtained from 138 (40%) of those invited, following which their consultations were audio-visually recorded. 4 cases were excluded due to inadequate recording quality, leaving a total of 134 cases for analysis. Verbal dialogue was initially transcribed verbatim: the final set of **134** transcripts formed the dataset here. Table 5 depicts patients’ sociodemographic and clinical characteristics.

Table 5. Patient Sociodemographic and Clinical Characteristics

Sociodemographic and clinical variable	N	%
Sex		
Male	87	63
Female	47	37
Ethnicity		
White	100	72.5
Employment		
unemployed	86	62.3
employed/student	30	21.7
voluntary	10	7.2
retired	8	5.8
Sociodemographic and clinical variable	Mean	SD
Age	42.2	11.5
Years in contact with psychiatric services	15.6	11.6
No. admissions	3.4	3.4
No. involuntary admissions	1.8	2.6
Symptoms		
Positive and Negative Symptom Scale (PANSS) total	54.4	18.6
positive	13.1	5.9
negative	12.5	5.8
general	28.8	9.6

For the study reported in Chapter 6, data from two studies was combined to maximise the screening corpus. 134 audio-visually recorded consultations were retrieved from the dataset

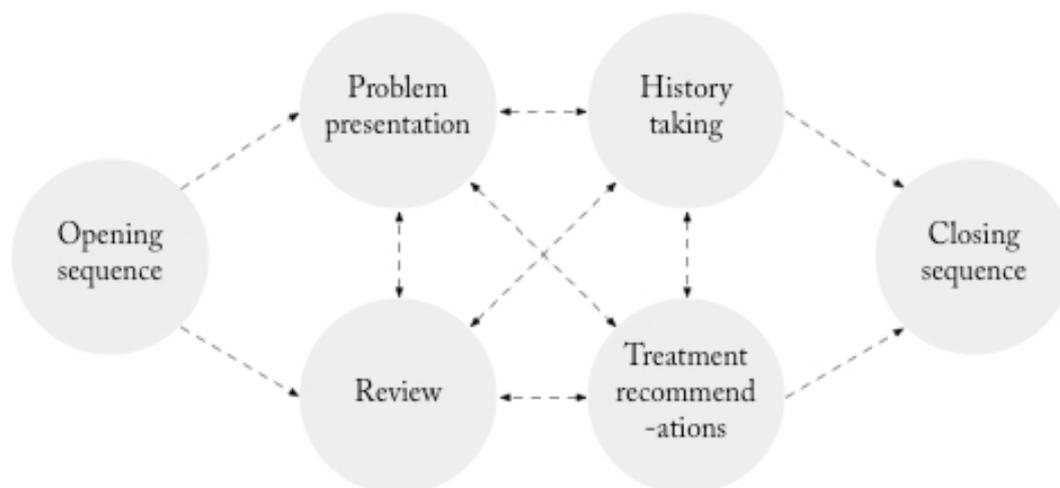
described above (McCabe et al 2013). 116 cases were also drawn for screening from a cluster randomised controlled trial - 'Developing and Piloting a New Intervention to Improve Psychiatrist-Patient Communication about Psychosis' (NIHR funded, Grant ref: PB-PG-0408-16279, PI: Professor Rose McCabe, Queen Mary University of London). The study assessed a communication skills training intervention for 22 psychiatrists and 50 patients with psychosis, collected - by a group of 3 research assistants and the author (who collected 10 cases) - between 2011 and 2013 from outpatients clinics in East London and North East London. Patients assigned to clinicians who met Diagnostic and Statistical Manual – IV (APA) criteria for schizophrenia or schizoaffective disorder were asked to participate. Written informed consent was obtained from those who accepted, following which their consultations were audio-visually recorded. The format of consultations between datasets was comparable. Dialogue was transcribed verbatim externally by professional transcribers: the final set of 250 transcripts formed the dataset for this study.

3.9 Structure of consultations

To contextualise the ensuing chapters, it is useful to outline the typical structure of consultations in these datasets. Before the recent advances in psychopharmacology and the introduction of managed care, the objective of psychiatric encounters was to create the necessary conditions to support the patient through a psychological journey of self discovery and transformation (Cruz & Pincus). Now, the goal of consultations is to assess symptom severity, educate the patient about the nature of their illness, negotiate a treatment plan, provide psychopharmacological treatment, and coordinate care provided by multiple caregivers (Cruz & Pincus). The psychiatrist attempts to balance data gathering functions with the development of a trusting and participatory relationship. Unlike many forms of interaction, doctor-patient communication has a discernible overall structure. The acute primary care encounter ordinarily manifests as an ordered structure of component activities: commencing with an opening sequence, progressing through problem presentation, history taking, physical examination, diagnosis, treatment recommendations and then onto a closing sequence (Byrne & Long 1976, Heritage & Maynard 2006, Robinson 2003). The structure of outpatient consultations in this corpus differed slightly: these were not first appointments. Psychiatrists and patients were engaged in ongoing relationships; therefore linear movement

through phases was not always evident. The primary objective was to review mental wellbeing and symptoms in order to make appropriate treatment decisions. While this process involved 'problem presentation' if new symptoms had appeared since the prior consultation (and a more proximate version of 'history-taking' from the psychiatrist accordingly), certain features e.g. presentation of diagnostic conclusion were absent and psychiatrists shifted backwards and forwards among topics in a central review phase with some issues being discussed recurrently. These topics typically involved psychotic symptoms, wellbeing, mood, daily activities, support from external services, medication or side effects. Treatment decisions were not always the concluding component and occurred at various points within the review phase. Consultations were therefore composed of 3 stages - the central of which was fairly fluid - as depicted in Figure 2.

Figure 2. Structure of psychiatric outpatient consultations



Motivated by the methodological shortcomings identified in a systematic review (Chapter 2), this chapter has introduced a guiding methodology for this thesis: conversation analysis. Its theoretical underpinnings, utility as an approach and applications in psychiatry have been described, before detailing the datasets under analysis and structure of consultations. Additional methodologies - explicated within each chapter - will accompany this approach, demonstrating the utility of combining methods in this field. Firstly, Chapter 5, builds on the statistical finding that patient other-initiated repair is related to better adherence in schizophrenia (McCabe 2013), to which we now turn.

Chapter 4

Patient adherence and other-initiation of repair in schizophrenia

Chapter abstract

Background

The prior chapters have identified a scarcity of research examining specific communication practices – from naturalistic encounters – in relation to adherence. However, by coding repair, McCabe et al (2013) found one promising candidate: patient other-initiated repair (Chapter 3). This chapter proceeds to build on these findings by taking a detailed and contextual examination of this practice.

Methods

Instances of patient next turn repair initiations (NTRIs) – as coded in McCabe et al (2013) – were extracted from consultation transcripts and transcribed in full Jeffersonian format. Descriptive and qualitative data were combined to yield an overview of this practice including frequencies and formats. Conversation analysis was used to conduct a transparent analysis of cases. Systematic patterns, in terms of repair management sequences and the sequential environment of psychiatrists' utterances targeted by NTRIS, were identified.

Findings

Other-initiated repair (NTRIs) mostly took the linguistic format of open-class repair initiators (OCRI) (Drew 1997): the least 'specific' format in terms of identifying the source of trouble in psychiatrists' prior turns. Patients invariably flagged issues with psychiatrists' questions – initiating an insertion sequence to resolve the trouble before answering. OCRI were most frequently deployed in a *pardon?* or *sorry?* format – that can be construed in terms of their relative politeness/formality compared to other forms e.g. *huh?*. Further evidence that these forms may be unequal alternatives included different orientations to the 'trouble' by the psychiatrist: *sorry?*/*pardon?* formats were frequently oriented to with verbatim repeats, while *huh?* was routinely responded to with a modified version of the original question: suggesting it may have been 'inappropriate' in its original form. While there can be no determinate relationship between a particular trouble-source and form of OCRI, there were some recurrent patterns in the sequential environment of the psychiatrists' questions targeted. Specifically: they were routinely hearable as topically or sequentially incoherent (Drew 1997) with the immediately prior talk. While sequential sources of trouble e.g. an abrupt unmarked topical shift, displayed overlap with those identified in ordinary conversation, they could often be explained by the institutional agenda. In a set of cases, the psychiatrist post-expanded a base question-answer sequence in order to pursue a more clinically-fitted, response. This action however may not have been immediately interpretable to the patient: the question was hearable as 'already answered' (thus sequentially incoherent), following which repair initiation occurred. The findings are discussed in relation to schizophrenia, adherence and implications for the remaining thesis.

4.1 Background

Psychiatrists, patients and *any* parties in conversation recurrently find themselves confronting troubles in speaking, hearing or understanding talk. These do not necessarily constitute 'objective' problems: 'while speakers may make grammatical or pronunciation 'errors' as measured against formal or informal normative standards, these are not always addressed or alternatively speakers may set out to resolve problems of talk that is seemingly flawless.' (Schegloff 2007:100). As such, any utterance is a candidate for being treated as troublesome and the practice by which speakers resolve such issues: 'repair' is crucial to maintaining mutually intelligible conversation (Schegloff 1992). Defined in the tradition of conversation analysis (CA), repair was introduced in the prior chapter. Here, the concept is elaborated, before explaining the relevance of a specific type: 'other-initiated' repair for patient adherence in schizophrenia and the resulting analysis.

4.1.1 Conversational repair: what is it?

While every turn-at-talk could be 'repairable', there are specific - and systematic - ways in which the activities of repair are composed. Schegloff et al (1977) identified three important features:

1. The initiator of the repair who identifies the turn as troublesome, marking a possible disjunction with the prior talk. This can be either the speaker of the problematic talk (referred to as the 'trouble-source' or 'repairable') or the recipient of the trouble-source (self-initiated or other-initiated repair respectively).
2. The repair outcome i.e. the person who completes the repair by clarifying the misunderstanding, accomplished by either the speaker of (self-repair), or the recipient of (other-repair), the trouble-source.
3. The position of the repair i.e. where in a sequence of turns the event occurs – either within the same turn of talk as the trouble-source (position 1) or subsequently: when the next person speaks (position 2) or when the speaker of the trouble-source speaks again (position 3).

Due to the rules of turn-taking in conversation (See Sacks, Schegloff, & Jefferson, 1974), e.g. when one person completes a turn of talk, it then becomes the other person's turn to talk, the first opportunity for repair is presented to the speaker of the utterance that embodies the trouble. As such, most trouble is resolved within the same turn of talk (Schegloff et al 1977). The next opportunity for repair is presented in the next turn of talk, to other speakers (Schegloff, 1992). Virtually all repair initiated by someone *other* than the speaker of the trouble-source – referred to as **other-initiated repair (OIR)** – is conducted in the next turn after the trouble-source turn; hence another term is 'next-turn repair initiations' or NTRIs as they will be referred to hereafter (for exceptions see Schegloff 1992). The following depicts an example:

Extract 1

- 01 DOC: What's your ↑sleep like at the moment Stephen.
- 02 PAT: **Sorry?**
- 03 DOC: Sleep how is your sleep.

Here, it is the patient (in line 02) not the speaker of the trouble-source (the psychiatrist) who identifies a problem with the previous turn. The patient retro-actively (Schegloff 2007) flags the psychiatrist's prior turn 'what's your sleep like at the moment Stephen' as, in some way, problematic. The question 'sorry?' is thus classed as a position 2 other-initiation of repair. The psychiatrist in line 03 attempts to repair the problem: reformulating his original question in the next-turn (position 3) in an attempt to re-establish the flow of the conversation. It is these patient NTRIs (and subsequent psychiatrist repairs) that are the concern of this chapter: this focus will next be justified in the context of treatment adherence in schizophrenia.

4.1.2 The relevance of repair for adherence in schizophrenia

The concern of this thesis has been demarcated as the mechanism by which specific – rather than abstract - communication practices are related to treatment adherence in schizophrenia

(Chapter 1). Having identified that research in this arena is sparse (Chapter 2), but that McCabe et al (2013) found NTRIs to be one candidate practice associated with *better* adherence (Chapter 3), this chapter proceeds to build on these findings.

Rather than defining 'good' communication in some abstract sense e.g. establishing 'shared understanding' in clinical encounters (e.g. Kurtz 1996), McCabe et al (2013) focused on the *details* of how psychiatrists' and patients' work to sustain mutual intelligibility in consultations. Specifically, by utilising the practice of repair: described as the primary site of inter-subjectivity in conversation (Schegloff 1992). A standardised protocol (Healey et al 2005) operationalising the system of repair classified by Schegloff et al. (1977) was applied to exhaustively code who initiates and completes repair and in which position the repair occurs (See appendix 4). 9 types of repair for both patient and psychiatrist were classified from transcripts of audio-visually recorded outpatient consultations. Consistent with a conversation analytic approach, the protocol did not rely on the analyst's decision as to whether a misunderstanding had occurred, but instead highlighted what participants treated as problematic. Each candidate repair/initiation was tested against a hierarchy of yes/no format questions e.g. 'is the contribution introduced to propose repetition or revision of another participants contribution?' (Healey et al 2005). A process of sequential elimination thereby identifies the repair type.

The association between the repair categories with clinician-rated adherence was examined by McCabe et al (2013), adjusting for symptoms (known to impact communication in schizophrenia (McCabe et al 2002)) and length of the encounter. A specific repair factor; 'patient led clarification and psychiatrist response', comprising primarily of patient position 2 Next Turn Repair Initiators (NTRIs) and psychiatrist position 3 other-initiated self repairs (as described above) was associated with clinician-rated patient adherence to treatment 6 months later (OR 5.82, 95% CI 1.31 to 25.82, p=0.02). Specifically, patients who initiated repair on psychiatrists' talk (subsequently repaired by the psychiatrist) had 5.82 times better odds of good adherence than those patients who did not.

4.1.3 The problem

The specificity of McCabe et al's (2013) approach allowed identification of a tangible communication practice - patient NTRIs - as being related to adherence. However, a reliance on coding and statistical methods alone limits the explanatory potential (Chapter 2, 3) that can be derived from this finding. The application of a standardised protocol does not entirely account for the local sequential context of patient NTRIs that – by a conversation analytic approach – may be inextricably linked to the action they might accomplish. An utterance may take the form of an NTRI, but in actual fact be 'doing' some other action. Schegloff (1992) for example showed that a practice ordinarily associated with initiating repair e.g. *huh?* can in fact achieve a markedly different action e.g. 'pursuing a response' (1992: 508). Moreover, there is a lack of previous inquiry on repair - and practices of communication more generally - in psychiatric communication. While repair is a generic order of organisation in talk-in-interaction: the 'self-righting mechanism for the organisation of language use in social interaction' (Schegloff, Jefferson & Sacks 1977: 381), as Kitzinger (2013) asserts 'there is still a great deal we do not know about.....the ways in which it may [or may not] be adapted for use in different institutional contexts' (Kitzinger 2013: 255). Studies on repair in schizophrenia specifically are also limited, having previously focused on self-repair (Leuder et al 1992, Caplan et al. 1996) or coded repair (Themistocleous et al 2009, Howes et al 2012). Against this background, patient other-initiation of repair is given analytic attention in the following study to further explore its link with adherence.

4.2 Aims

The overarching aim of this chapter is to achieve a better understanding of other-initiated repair in psychiatric outpatient consultations and generate explanatory hypotheses in relation to adherence. To achieve this aim, the following research questions will be addressed:

1. How often do patients initiate repair on psychiatrists' talk?
2. What are the form of the psychiatrists' utterances identified as trouble-sources?
3. What are the formats of patient NTRIs?
4. How do subsequent psychiatrist repairs orient to the 'trouble'?

5. What are the sequential environments of psychiatrists' utterances targeted by NTRIs?

4.3 Methods

All instances of patient NTRIs, as coded in McCabe et al (2013), were extracted from 134 transcripts of audio-visually recorded outpatients consultations (See chapter 3 for a description of the dataset). The research questions were explored by yielding a descriptive overview of relevant characteristics, accompanied by case-by-case presentations of individual NTRIs in context. Methodological techniques drawn from conversation analysis (Chapter 3) were used to conduct a comparison of various features of NTRIs e.g. repair management sequences and sequential environments, keeping in mind the ubiquitous issue for parties in talk-in-interaction (Schegloff and Sacks 1973: 299) - "why that now".

It is noted that Schegloff (2000) identified that other-initiated repair can occur in other turns than merely the next turn, but due to application of a coding protocol in the original study (See McCabe et al 2013, Healey et al 2005) the phenomena examined here (and were found to be linked to adherence) were all in the next turn (NTRIs).

4.4 Results

4.4.1 How often did patients initiate repair on psychiatrists' talk?

134 consultation transcripts were screened by the author for NTRIs - as handcoded in McCabe et al (2013). This search yielded a total of 103 patient NTRIs and enabled preliminary observations of frequency and context. NTRIs occurred across 46 of the 134 encounters - lasting a mean length of 17.2 (SD 9.1) minutes - and ranged from 1-13 instances per interaction. Based on initial examination, NTRIs were not notably topic-specific, spanning a range of conversational contexts, consistent with the structure of a typical outpatient consultation (Chapter 3).

4.4.2 Alternative NTRI formats

There are a range of alternative formats for OIR. Schegloff et al (1977) characterised these as varying along a continuum in terms of their capacity to locate and identify the ostensible problem in the prior turn of talk. This varies from 'weaker'; i.e. showing the least grasp of the trouble-source turn to 'stronger' e.g. claiming a version of understanding, subject to

confirmation (Schegloff, Jefferson, Sacks, 1977). By situating the data in this typology of OIR formats, we can see this range is reflected in the corpus. Table 6 displays NTRI extracts from the dataset, as classified along this continuum (starting from the ‘weaker’ end). More precise definitions are outlined below.

Table 6. Range of patient specificity in locating the trouble-source

1) Open class	2) Category-specific	3) Repeats	4) Candidate understandings
DOC: So it helps you unwind does it?	DOC: Do you go to a day centre?	DOC: That is a possible side effect.	DOC: W:f do you f- do you really ↑fee:l i:t or is it just a sensation?
PAT: Pardon?	PAT: Where?	PAT: Side effect?	PAT: Is it what I'm thinking is that what you mean?

1. **Open class** repair initiation forms (Drew 1997) e.g. sorry?, pardon?, huh?, excuse me?, what? ostensibly display the least grasp of the prior talk in that they do not locate the specific source of the trouble in the prior turn: they leave ‘open’ the nature of the difficulty by treating the whole utterance as somehow problematic. (However, the notion of ‘whole’ utterance has been questioned in recent research (Robinson 2013 ICA))
2. **Category-specific** forms are interrogatives that claim a grasp of the trouble source as relating to either a time formulation (when?) person (who?), place (where?), or object (what?). These can be stand alone NTRIs or - in a ‘stronger’ version- be framed by a repeat of all or some of the trouble-source turn (Kitzinger 2013:249) (e.g. John did what?)
3. **Repeats** (either partial or full) of the trouble-source turn claim the capability to (partially) recreate it, but not necessarily to understand its import (For a consideration of the alternative actions accomplished by full and partial responses after questions see Robinson and Kevoe-Feldman (2010))
4. **Candidate understandings** are formulations of the trouble-source turn in different words, often framed by 'you mean' (e.g. you mean reduce the dose of my

tablet?). These forms claim to hear and have a possible grasp on what was meant, subject to clarifying this with the psychiatrist: the speaker of the repairable turn.

These formats have been identified across numerous languages (for some examples see Kitzinger 2013:250, Enfield et al 2013), pointing to the existence of a generic organisation of practice, albeit one adapted to various linguistic and social factors across languages and cultures (Schegloff 2007): further supported here in a psychiatric context.

4.4.3 What format of patient repair initiation was most frequent?

Table 7 displays the distribution of patient OIR formats. As is shown, by far the most frequent (49) were the least ‘specific’ method of flagging the psychiatrists’ prior turn as a trouble-source: open-class repair initiators (OCRIs).

Table 7. Distribution of patient repair initiation formats

1) Open class	2) Category-specific	3) Repeats	4) Candidate understandings
49	12	25	17

As the largest collective group (found to be analytically salient in other contexts (e.g Drew 1997, Robinson 2006), the remaining analysis focuses on OCRIs.

4.4.4 The form of the trouble-source: psychiatrists’ questions

When patients initiate repair on psychiatrists’ prior turns with OCRIs, they perform a ‘backwards’ operation: retroactively flagging trouble with the prior turn - albeit in a non-specific way. Schegloff (2007) termed this as initiating a ‘retro-sequence’ (2007:218): while flagging trouble the patients’ OCRI also launches a ‘proactive sequence, projecting the relevance of a 2nd pair part addressed to repairing the trouble whose existence has been brought to attention’ (2007:218) So what types of psychiatrists’ utterances did patients’ flag as trouble-sources? OIRs - as described- can occur after *any* turn at talk. Accordingly, they may be employed after a sequence-initiating action i.e. a first pair-part like a question. As has been observed previously with other formats of OIR (e.g. Hayashi & Hayano 2013), the most common position OCRIs were employed was indeed following a first- pair part: psychiatrist questions.

The patient recipient of this action is normatively expected to produce a relevant answer in the next turn. Under this sequential mandate to produce a response, ‘the recipient is systematically motivated to inspect the adequacy of the prior turn and assess whether there is any need for clarification of the prior turn in order to formulate an appropriate response’ (Hayashi & Mayano 2013: 301). 40 out of 49 instances (82%) of OCRI were used in this post-first position to seek such clarification. By initiating repair in this position, the patient indicates they are not ready to provide a sequentially relevant answer yet, but the prior turn must first be confirmed, thus creating a ‘post-first’ insertion sequence (Schegloff 2007: 100). Extract 2, in which the psychiatrist asks the patient whether smoking cannabis helps him ‘unwind’, represents one example.

Extract 2

01 DOC: So it helps you unwi:nd does it?
02 (0.2)
03 PAT: Pardon?
04 DOC: It helps you (.) unwi:nd.

(DOC = psychiatrist PAT= patient)

Here, when the patient initiates repair on the psychiatrist’s question in line 03, he displaces the second pair-part, an answer (e.g yes or no), that would normatively be relevant in response to a tag question that invites (dis)confirmation (the interrogative fragment ‘does it?’ in line 01). His OCRI ‘*pardon?*’ represents another first-pair part: the first pair part of a post-first insert-expansion sequence (Schegloff 2007), devoted to resolving the trouble that suspends the course of action in which the speakers are otherwise engaged. The psychiatrist in line 04 delivers the 2nd pair part of the insert sequence by partially repeating his question verbatim: ‘it helps you unwind’. This renews the relevance of the base 2nd pair part as done by his original question. As such, the OCRI here interrupts ‘progressivity’ (Schegloff et al 1977) of the question-answer sequence. Note the questioning intonation of the patient’s repair initiation in line 3 (represented by ‘?’). Indeed, 96% (47) of the OCRI in this corpus were

completed with such rising intonation. This may be notable: Schegloff (1997) for example examined OIR devices such as what, when, and where and found that when they are spoken with rising intonation, they delay progressivity and initiate repair, whereas when deployed with falling intonation, they progress talk by inquiring into the nature of the referent (see also Drew, 1997).

4.4.5 The form of patient open-class repair initiations: flagging trouble ‘politely’?

While OCRI can be collectively identified in terms of their lack of specificity in locating the repairable aspect of the prior turn (in this corpus, mostly psychiatrists’ questions), different linguistic formats can function as open-class other repair initiators. Enfield et al (2013) described three basic strategies for open-class repair initiation.

1) *Hub?*

One form of OCRI are primary interjections. ‘Defined broadly, an interjection is a word unit or equivalent unit that can stand as a complete utterance in itself e.g. *hub?*’ (Enfield et al 2013:349) and does not retain potential to combine with other syntactic constructions. Alternative forms constituting interjections in English are *mm?* or *hm?*

2) *What?*

The second basic form of OCRI is to deploy a question word form like *what?* ‘By definition, these kinds of structures are distinct from the primary interjection-type’ (Enfield et al 2013: 350) as unlike *hub?*, *what?* has the syntactic potential to be combined with other units. This form can also be used with some syntactic elaboration e.g. *what’s that?*

3) *Sorry?*

Beyond primary interjection and question-word strategies, there are further ways of doing open-class other-initiation of repair, including *Pardon (me)?*, *Excuse me?*, and *Sorry?*. Robinson (2006) described the latter as ‘apology-based’ formats.

These strategies are ‘non-identical alternatives’ (Enfield et al 2013:350) i.e. a set of alternatives that can each relevantly appear in the same slot: following any turn of conversation that a patient wishes to flag as a trouble-source. One way the differences

between formats can be construed is in relation to perceived formality or politeness (See Brown & Levinson 1987, Sidnell 2008:483, Kim 1993) e.g. Huh? vs Pardon?, (Enfield et al 2013:350), the former being 'less' polite/formal. Relatedly, Robinson (2006) argues that apology-based OCRI's e.g. sorry? are a practice for communicating (at least ostensibly) repair initiators' stance that the responsibility for the trouble lies with themselves (e.g. the patients' 'fault' for not hearing rather than the psychiatrists' for producing – in some way – a problematic prior turn), even when interactional evidence suggests to the contrary. The following extract 3, excerpted from Robinson (2006:152), shows this in play:

Extract 3

Extract 13: MUMMY (Field:X.2.1.9)

```

01 LES: Hello:~
02         (0.4)
03 1→ MAR: Hallo. is Mummy there,
04         (0.8)
05 2→ LES: Sorry:~
06         (0.4)
07 3→ MAR: Oh who is it speaking.
08         (0.7)
09 LES: [(Oh) ]
10 MAR: [Is it] Les.
11 LES: Re: ya::s. (h)i[t (is) Mummy- It's [Mu:mmy. ]
12 MAR: [ Le::s↓ [you s:gu]nd (ih)- is
13 <mummy there> ee: GQ:ds

```

Here, while Leslie initiates repair with 'sorry?' in line 05, her subsequent 'It's Mu:mmy' in line 11 is 'post-hoc evidence' that she did, in fact, hear the trouble source 'Hallo. Is Mummy there,' in line 03 (See Robinson 2006:152 for the full analysis). She has thus used the OCRI as a social practice: claiming responsibility for a trouble created by the other speaker i.e. incorrectly addressing her as a child.

Table 8 displays the distribution of individual OCRI formats used when flagging trouble with the psychiatrists' talk. As is evident, patients most frequently selected 'polite'/'formal' formats e.g. *pardon?* or *sorry?* (27/49, 55%) followed by the interjection strategies *huh?* (20%), *mm?*, *Eh?*, with the questioning word *what?/what's that?* used rarely.

Table 8. Distribution of different linguistic formats of OCRI and OISR

Form of OCRI	Frequency
<i>Hub?</i>	10
<i>Mm?</i>	7
<i>Eb?</i>	3
<i>Pardon?</i>	14
<i>Sorry?</i>	13
<i>What/What's that?</i>	2

4.4.6 How did psychiatrists repair the trouble?

While it is possible one format of OCRI may be more polite relative to another, it remains an open question as to whether there is a functional distinction between them e.g ‘one form might be used when you didn't hear something and the other for when you didn't understand something’ (Enfield 2013: 350). While this does not appear to be supported in English data: for example Drew (1997) treated OCRI as equivalent on the basis ‘there does not appear to be any differentiation between them in terms of their sequential distribution, the circumstances in which they are characteristically selected, their interactional use or function, or their consequences for the emergent repair sequence’ (1997:73). It has been argued that further research is necessary before ruling out this possibility (Enfield et al 2013:350, Robinson 2006:142). Nonetheless, psychiatrists’ repair of the trouble in the turn following the patient OCRI may display something meaningful about how they choose to *display* their orientation to the trouble-source turn. For example, if the repair constitutes a verbatim repeat of the trouble-source: Robinson (2006) argued ‘by redoing the same action in the same way, repeating the trouble source claims that it was both understandable and “appropriate” in its original form, and thereby strongly delimits the trouble type to that of the repair-initiator’s hearing’ (2006:146).

Psychiatrist repairs following OCRI were examined by format and coded as ‘verbatim repeats’ or ‘alterations’. The former included reproductions of the trouble-source in whole or in part and, within that repeated segment, reformulation, addition or reordering of words had

not occurred (Robinson 2006:149). The second category, alterations, included other ways psychiatrists responded to OCRI, such as revising or replacing the trouble-source, reformulating its words, specifying or elaborating references or downgrading or upgrading it epistemically (Schegloff 2004) - thereby conceivably orienting to the trouble as something other than hearing e.g. understanding or acceptability etc. Table 8 displays the distribution of types of psychiatrist repairs.

Table 9. Type of psychiatrist repairs

Form of OCRI	Total	Verbatim response	Alteration	Ratio of verbatim responses
<i>Hub?</i>	10	2	8	1:5
<i>Mm?</i>	7	6	1	1:1.2
<i>Eh?</i>	3	2	1	1:1.5
<i>Pardon?</i>	14	9	5	1:1.5
<i>Sorry?</i>	13	8	5	1:1.6
<i>What/What's that?</i>	2	0	2	*
	49	27	22	

*(0 cannot be represented as a ratio)

As is evident, verbatim repeats (27) of the trouble-source were slightly more frequent than those containing alterations (22). For ease of presentation, verbatim responses were also represented as a ratio. The most marked distinction is that *hub?* relative to the other OCRI formats was rarely repaired with a verbatim repeat (2/10 times; 1:5). Remaining formats were more regularly responded to with repeats (*mm?* 1:1.2, *Pardon?* 1:1.5, *Sorry?* 1:1.6). Such ratios should be noted tentatively due to small numbers per class of OCRI format (particularly *eh?*). However, consistent with the 9/14 verbatim repeats that followed OCRI in the form of *sorry?*, Robinson (2006) found that 50/81 instances of *sorry?* - approximately the same ratio - also incurred verbatim repeats. Next, some cases-by-case examples of OCRI and psychiatrist repairs are analysed to contextualise these findings. Given that they were most frequent, *Hub?*, *pardon?* and *sorry?* OCRI formats are focused on.

4.4.6.1 Psychiatrists orienting to patients misunderstanding their question

Patient OCRI in the form of *hub?* were recurrently oriented to by the psychiatrist in a manner suggestive of problems *beyond* that of the patients' hearing of the repairable. Specifically, the evidence presented here suggests, in each case, psychiatrists use the relevant

slot created by the OCRI to amend, in some way, their original question. As Robinson (2006) asserts of alternative (non-verbatim) responses to 'apology-based' OCRI's:

'All of these types of responses - which are being produced by speakers of the trouble source - differ from verbatim repeats because, in containing some revision of the trouble-source unit and/or its action, they stand as possible (but not definitive) evidence that trouble-source speakers understood...OIRs as communicating the need for some type of revision; that is, as communicating repair-initiators' stance that trouble responsibility belongs to trouble-source speakers (vs. OIR producers)' (2006: 150)

We see consistent evidence of such revision of the trouble-source turn in the following extracts, highlighted in bold text.

Extract 4

01 DOC: Do you think it's about you?

02 (0.4)

03 PAT: Huh?

04 DOC: Do you think its **something to do with** you?

In extract 4, following the patient's OCRI 'huh?' in line 02, the psychiatrist repairs the trouble-source question in the third position through a partial revision: replacing 'about' (you) with 'something to do with' (you). This highlights the possibility that the action was not 'appropriate' in its initial form and needed specification in order to make it so. A similar pattern is observable in extract 5:

Extract 5

01 DOC: Presumably the ice has gone?

02 (0.4)

03 PAT: Huh?

04 DOC: Presumably the ice has gone **it was quite icy this**

05 **morning.**

Here, the psychiatrists' verbatim repetition of his original question in line 04 (the slight stress of 'ice' highlighting the particular word containing the probable trouble) is immediately augmented with the incremental 'it was quite icy this morning'. This expansion appears to explain the relevance of this referent: locating it within a specific frame of (time) reference – earlier that morning – that may not have been deducible from the initial question. Extract 6, depicts a similar alteration:

Extract 6

01 DOC: Are you sleeping on (.) the higher dose?

02 (0.8)

03 PAT: Huh?

04 DOC: **Were** you sleeping **when you were taking twenty**?

Again, the psychiatrist reproduces his questioning action in line 01 with some marked changes in line 04. He repairs the turn-initial auxiliary verb 'are' to 'were', correcting his reference to tense, and specifies 'on the higher dose' by personalising the formulation with the additional pronoun 'you' and locating it within a particular point in time: 'when' the patient was 'taking twenty' [mg] of medication.

These extracts support the notion that even unspecific formats of OIR like 'huh?' have the potential to raise the relevance of a lapse in communicative success (i.e. failure to self-repair the problem in the initial question rather than in the third position): showing an orientation to revision of the original question being appropriate. In relation to Brown & Levinson's (1987) aforementioned politeness theory and Goffman's concept of 'face', OIRs may thus be (structurally) susceptible to threatening the trouble-source speakers' positive face by communicating that they are responsible for repair related trouble (cf Robinson 2006).

But what else could the psychiatrist have done in these slots following patient OCRIs? We turn to compare such alterations with an alternative way in which the psychiatrist *could* have repaired the trouble-source: with verbatim repeats.

4.4.6.2 Psychiatrists orienting to patients not hearing their question

In order to appreciate an alteration of the trouble-source as ostensibly displaying a particular construal of the problem flagged by the OCRI, it is necessary to contrast it with alternative responses that may represent different orientations. Most frequently patient OCRIs in the form of *pardon?/sorry/mm?* occasioned *verbatim* repeats from the psychiatrist.

Unlike the prior extracts, in each example that follows, the psychiatrist displays a possible orientation to the OCRI practice as claiming a hearing trouble by responding with a (near) word for word repeat of the trouble-source question. As in the psychiatrists' declarative question in extract 7, line 03:

Extract 7

01 DOC: Sometimes very busy?

02 Pat: Pardon?

03 DOC: **Sometimes very busy?**

Here, the psychiatrist redoes the questioning action 'sometimes very busy' in line 01, uniformly in line 03, displaying an orientation to no correction being relevant. Extracts 8 displays a similar orientation.

Extract 8

01 DOC: So: what's happening with your family at the moment?

02 (0.4)

03 PAT: mm?

04 DOC: **What's (.) happening with your family?**

In line 04 the psychiatrist produces a partial verbatim repeat of the trouble source question in line 01, rather than an alteration. His only modifications are the removal of the adjunct 'at the moment', leaving the essence of the question intact 'what's (.) happening with your family', and the removal of a turn-initial 'so'. Trouble-source turns are often repaired with such a 'near

repeat' because components may be dispensed with on resaying (Schegloff 2004). The removal of 'so' for example can be explained by the question's shift from 1st to 3rd position. This discourse marker can be used to signal a relationship between immediately adjacent units of talk (Schiffren 1987) (here this was a prior patient comment regarding a family member), but the question in line 04 no longer needs to mark connectivity to the same prior turn. The remaining question - echoing the former - further displays the psychiatrist's orientation to the trouble as one of hearing. A similar verbatim repeat can be seen in extract 9:

Extract 9

01 DOC: Are you saying you think its just the antidepressant?

02 (0.2)

03 PAT: Sorry?

04 DOC: **Are you saying you think its just the antidepressant?**

05 PAT: ↑I don't know if it's the tablets or the anti-depressants

I don't know.

In this fragment, the only alteration in the psychiatrists' repeated question is the emphasis on 'saying' and 'antidepressant' in line 04. As Curl (2005) found, repeats can also be phonetically differentiated from the trouble source turn. Such enunciation relative to the trouble-source turn may be further evidence that the psychiatrist is orienting to the trouble as one of hearing. However, by also examining the patient's subsequent response in line 14 – the base 2nd pair part displaced by the inserted repair sequence - a caveat is highlighted i.e. that as analysts we cannot definitively determine the nature of the trouble-source, only possible evidence of participants' orientations to it. While the psychiatrists' question invites confirmation of a candidate formulation of the patients' prior talk, the patient responds with a dispreferred 2nd pair part: an extended narrative (Raymond 2003), claiming insufficient knowledge to confirm. This retrospectively raises the possibility of an alternative explanation for the repair initiation, in contrast to how both patient and psychiatrist have claimed to orient to it.

As Schegloff (2007) asserts, an important interactional use of other-initiated repair is to signal an upcoming dispreferred response or other form of nonalignment: 'other-initiated repair sequences often serve as vehicles for the expression of disagreement or for introducing its relevance' (Schegloff 2007: 151). Such repair sequences break contiguity between the first pair part and 2nd pair part of the base adjacency pair; thus like gaps, turn-initial delays, accounts etc 'other-initiated repair sequences can operate as pre-rejections and pre-disagreements - as harbingers of dispreferred base second-pair parts.' (Schegloff 2007: 102)

Alternative explanations for the operation of OIR underlines that OCRI can be a 'social practice' (Robinson 2006:152) and so neither the OCRI format, nor the psychiatrists' orientation to it (repair), are necessarily sufficient to identify the 'true' source of the trouble: only how it is displayed by participants. However, another observable feature of OIR available to the analyst in this respect are the environments in which OCRI are deployed, to which we now turn.

4.4.7 The sequential environment of psychiatrists' questions targeted by patient OCRI

In this section, the sequential environments (Drew 1997) of the psychiatrists' questions targeted by patient OCRI are described. It is not the purpose here to propose a determinate relationship between OCRI and a specific source of trouble i.e. cause and effect. OCRI were mostly in response to questions, but it is problematic to identify these as the 'start' of the repair sequence itself. As Schegloff (2007) asserts:

'It is tempting to think of the repair sequence beginning with the repairable or trouble-source, which engenders the repair initiation, which makes the repair operation relevant next. But this conflates 2 quite different types of sequential operations, each of which is grounded in the repair initiator. One of these serves to locate the source of the trouble; the other to engender dealing with it. The trouble source itself, however, is not sequentially implicative for the repair initiation; the trouble source itself does not make anything relevant next, even though the repair initiation locates it as its source. It is this 'backward' operation of locating the source of some outcome that the term 'retro-sequence' is meant to capture' (2007: 218)

However, by exploring the environments in which OCRI are deployed, it may be possible to begin to identify 'some of those troubles in comprehension' (Drew 1997:72) to which patients may attend (rather than claim to attend, or are oriented to by the psychiatrist) and to observe

if they are similar to those reported in ordinary (non-institutional) conversation (e.g Drew 1997, Curl 2005).

The following analysis sketches evidence for one recurrent feature of these trouble-source questions - described in each case - that they are topically or sequentially incoherent with prior talk (Drew 1997, Robinson et al 2010). To the patient therefore, the questions may be hearably unforeseen or 'inappropriate' in relation to the talk that preceded. In the first set of examples, this constitutes an abrupt topical shift. A number of studies have recorded regular occurrences of other-initiated repair in topic-initial positions (e.g. Schegloff 1979, Drew 1997, Kim 2001) such that 'the opaqueness in the current turn's relationship to the prior introduced by a disjunctive topic shift may result in a puzzle on the part of its recipient, for which the repair may be initiated.' (Hayashi and Hayano 2013:306). One potential factor contributing to the psychiatrists' questions as disjunctive or 'unexpected' was an absence of lexical markers that can display positive evidence of understanding (See Clark & Schaefer 1989) of the patient's prior turn or mark a change of topic/activity as upcoming.

In the second set of examples, the psychiatrist questions are also hearably incoherent with the patients' prior talk, but not due to topic-initial positioning: rather in the sense they have been 'already answered', thus are 'inappropriate' as a response to the patients' prior turn. Conversation operates on the general premise that, unless otherwise indicated, a turn deployed after some prior is to be understood as produced in response to or in relation to that prior (Schegloff and Sacks 1973, Heritage, 1984, Schegloff 2007). Based on this assumption, a psychiatrist's question that follows a patient response (to another question) should account for that prior response.

A collection of cases emerged in which the psychiatrist appears to solicit information that, in its essence, has already been provided by the patient in the prior turn. While its sequential connection may not therefore be immediately obvious to the patient (as has been observed previously e.g Drew 1997), there is evidence in each case that the question is not merely a 'mistake' e.g. the product of not hearing the patients' prior turn. Rather, it is produced in service of pursuing a more specific or elaborated response from the patient in relation to some clinically-relevant detail i.e. a 'first pair part reworking' (Schegloff 2007:162) to clarify the

particulars of the patients' answer. As such, the psychiatrist and patient may have misaligned orientations to what the psychiatrists' turn is doing i.e. the action. By showing how the psychiatrists' turns preceding NTRIs are designed in this way, this chapter adds another dimension to previous studies of OCRI that have focused on ordinary conversation rather than institutional settings (e.g. Drew 1997, Curl 2005).

4.4.7.1 The regularity of patterns

This pattern of topical or sequential incoherence was observed in 29/49 (60% or 1:1.7) cases. Specifically, 19 of the psychiatrists' questions appeared in topical-initial positions and 10 appeared in service of pursuing a more specific response. The patterns were present across the four most frequent OCRI formats: *hub?*, *pardon?*, *sorry?* and *mm?*, presenting possible (though not definitive) evidence that these formats may represent alternative social strategies for the same – sequential – source of trouble. Of course, there were 20 cases in which the psychiatrists' questions were not topically/sequentially incoherent in this way. In the scope of this chapter, these are not explored here, but it is noted that some of these were produced following overlapping talk, or turns that were sequentially 'fitted' rather than 'incoherent' e.g. continuing a sequence in progress (see Curl 2005). It has been argued that other initiation of repair deployed in overlap may be a very different practice from that produced on talk produced 'in the clear' e.g. a resource for regaining the floor (see Curl 2005 Schegloff, 2000b).

The following section presents some examples of these potentially 'incoherent' questions on a case-by-case basis, culminating with a discussion of the chapter findings overall in relation to adherence (McCabe et al 2013).

4.4.7.2 Psychiatrist questions in topic-initial positions

In 19 instances, psychiatrists' questions were observed in a topic-initial position: defined as the question relative to the preceding turn introducing a new topic (or new topical focus within the same overarching topic). Extract 10, line 07, is an example:

Extract 10

01 DOC: Sort of (.) u::m (.) does it feel as if (0.4)

02 you've been hea:rd today >cos I know< (.) it's a short
03 appointment and (.) ((patient nods)) yeah good okay.
04 PAT: Alright?
05 DOC: Yeah.
06 (2.8)
07 DOC: Presumably the ice has gone?
08 (0.4)
09 PAT: Huh?

At the end of a consultation, the psychiatrist enquires if the patient feels they have 'been heard today' (Line 01) to which the patient affirmatively nods and responds with 'alright' (Line 04): the rising intonation coincides with the patient rising from his chair. Whilst this talk is closure implicative, after a pause (Line 06) (in which the psychiatrist gathers his papers) the psychiatrist delivers a declarative question 'presumably the ice has gone?' (Line 07). Though relating to the adverse weather experienced at that time and signalling completion of medical 'business', this has no referential link to the preceding talk and thus represents a sudden topical departure. The introduction of new topics are usually prefaced with lexical markers of discontinuity e.g. 'anyway' and/or relevant prosodic changes (Levinson 1983). The absence of any lexical marker here may render this shift unmarked and thus unexpected. This occasions the patient's open-class initiation of repair, 'Huh?' (Line 09): initiating an insert expansion sequence (Schegloff 2007) to resolve this putative trouble.

In 15 cases, psychiatrists' topic-initial questions were introduced in some 'unmarked' way such as here i.e. without an explicit marker of topical continuity (e.g. lexical repetition) or discontinuity (e.g. anyway, by the way etc) or, perhaps more common in doctor-patient communication (though not necessarily applicable to the prior extract), lexical markers of receipt of the patients' prior turn e.g. 'okay' 'I see' and 'Mm hm' 'which doctors use frequently'

(Heritage & Clayman 2010:31) and may display positive evidence of understanding (See Clark & Schaefer 1989). These units can be used to ‘soften’ shifts of activity by signalling a change as upcoming (e.g Gardner 2001).

Extract 11 displays another example. The psychiatrist engages in an extended sequence of questioning about voice hearing experiences – of an instructional nature - starting in line 01 ‘do you ever hear voices telling you to do things), a typical method of assessing risk of harm to self and others in schizophrenia (Singh et al 2011). However, at line 17, the psychiatrist appears to discontinue the topic of talk and introduce a sudden shift – in response to which the patient initiates repair. As Drew (1997) shows the repairable turn occurs at what appears to be a ‘topical juncture’ (1997:75). Note here, while a similar disjunctive shift is apparent, the patient’s selected repair initiation format is not *huh?*, as in extract 10, but the apology-based (Robinson 2006) *sorry?*.

Extract 11

01 DOC:.hh ↑do you ever hear ↑voice:s (.)

02 telling you to do things.

03 (2.0)

04 PAT: No.

05 DOC: No.

06 PAT: °No.°

07 (0.6)

08 PAT: One thing I know I am not violent.

09 (0.4)

10 DOC: °Hm° I’m just wondering (.) if whether you hear a voice

11 saying Stephen you must do this you must do that do this

12 do that telling you to

13 (0.2)

14 PAT: No.

15 DOC: °No:°

16 PAT: that will not doesn't happen to me=

17 DOC: =What's your ↑sleep like at the moment Stephen.

18 PAT: Sorry?

We can see that this shift follows emerging misalignment between the speakers. The patient's response to the psychiatrist's initial question in line 02 is not immediately forthcoming. After a significant silence in line 03, the patient answers 'no' in line 04, which he repeats (line 06) following the psychiatrist's receipt (line 05). However, while this represents a possibly complete turn (i.e. a type-conforming answer with period intonation), when questioning does not immediately proceed (line 07) the patient adds another TCU 'one thing I know I am not violent' (line 08).

This preempts a negative inference (See Stivers and Heritage 2001) of the psychiatrist's question: treating it as implicitly inferring that 'things' refer to violent acts, embodying an 'institutional' understanding of the question's relevance (i.e. an assessment of risk to others). The patient thus conveys a defensive stance by rejecting an unstated implication that he may be potentially dangerous. The psychiatrists' turn-initial 'Hm' in line 10, as well as doing receipt of the prior turn, appears to prepare the ground to disalign (See Gardner 2001 on turn-initial 'hm' followed by substantial same-speaker talk) from the patient's statement. Her ensuing turn is prefaced with "I'm just wondering if", thereby framing it as an account for the initial question (in line 01) and conceivably correcting or downgrading the patients' understanding displayed in line 08 e.g. the 'everyday' premise of the voices telling him to 'do this do that' relative to something 'violent'.

Again, the patient responds ‘no’ (line 02), but following receipt from the psychiatrist in line 15, he expands his answer again with the increment (Ford et al 2002) ‘that will not doesn’t happen to me’ (line 16). By re-completing his turn, the patient creates another possible slot for the psychiatrist to respond. However, unlike the patient’s addition in line 08, this is not receipted. The psychiatrist instead rushes through (symbolised in the transcript by the equals sign) to initiate a new course of action: inquiring as to the patient’s state of sleep (line 17 – highlighted). While this rush-through may be in service of ‘managing or avoiding the incipient trouble’ (Clayman 2013), the patient’s understanding of the question is possibly problematised by this sudden shift and an entirely new topic. Again, this shift is performed without an initial lexical marker of receipt or discontinuity.

In order to appreciate how an ‘unmarked’ questioning action may appear disjunct, it is useful to contrast it with an alternative ‘marked’ psychiatrist question. In extract (12), whilst topic change occurs, moving from social networks and therapy to mood, unlike the prior cases presented, it is ‘marked’ in a turn-initial position. In line 05, the preceding extended patient narrative is responded to with a turn initial- ‘excellent’, positively assessing the patient’s experience of therapy, before marking the topic shift to mood with an ‘and’ preface used to link this subsequent question and answer-sequence as an element of the common activity (Heritage & Sorjonen 1994).

Extract 12

01 PAT: yeah I’m able to::: make friends easily yeah I have lot
02 of friends now but a uni u:::m yeah u:::m yeah
03 it’s ↑been a: (.) it’s been a big change actually: u:::m
04 since I e:::r started seeing um (0.6) the therapist yeah
05 DOC: ↑Excellent a:::nd, (1.0) how’s your ↑moo:d been.
06 PAT: Yeah <mood has bee:n very good.>

In another contrast, the psychiatrist questions in the following section, like extract 10 and 11, are hearably incoherent with the patients' prior turn, but, *unlike* 10 and 11, are not in topic-initial positions. Specifically, in each fragment, the psychiatrists' question preceding the OCRI is perceptibly 'already answered' by the patient in the prior turn, thus its sequential connection may not be immediately apparent.

4.4.7.3 Sequentially incoherent questions: pursuing a clinically specified patient response

As Bolden et al (2012: 45) state 'Faced with a second pair-part turn by another, the recipient of that turn can assess it for its adequacy as a response to the initiating action. When the recipient of a second pair-part finds it to be in some way inadequate, there is a range of ways in which a "better" (i.e., more fitted or more elaborated) response can be pursued in the third position.' (For examples see Bolden et al 2012, Schegloff 1997, 1992). A collection of cases in the present corpus emerged in which, following a question-answer sequence, the psychiatrist oriented to the patient's answer as 'inadequate' in so far as being in need of specification in relation to some clinically-relevant detail. By post-expanding (see Schegloff 2007 non-minimal post-expansion) the sequence: asking a similar, but specified, question that follows a 2nd position patient response, the psychiatrist narrowed the scope of the terms on which the patient should (re)answer in relation to some medically-salient detail e.g. medication dosage (extract 13), stress (extract 14), medication frequency (extract 15) , metric of alcohol consumption (extract 16) etc. Such 'first pair part reworkings' (Schegloff 2007:162) display how sequences can be expanded not only by 'elaboration or multiplication of second pair parts, but also through renewals, rewordings, repetitions, modifications, enhancements etc of the first pair part, by reference to the second pair part which was its response' (Schegloff 2007: 162)

The action of these questions however - pursuit of a more clinically-fitted response - was possibly obscured to the patient recipients. The question's similarity to the trouble-source rendered it hearably 'already answered', thus sequentially confusing - not appearing to take account of the patients' previous answer and in each case occasioning an OCRI. By examining

the similarities and differences of extracts 13-16 exhibiting this pattern, four separate types of evidence are presented for these misaligned orientations to the questions' action preceding the OCRI being in play i.e. the question is 'doing' something other than merely duplicating its prior.

1. An additional question element (e.g. adjective/noun or lexical replacement) that indicates the psychiatrist requires further specification of the patients' prior responses (extracts 13-16).
2. The psychiatrist accounting for the (re)question in 'psychiatric terms' (extract 14), orienting to its clinical significance and the terms on which it should be (re)answered.
3. The psychiatrist's receipt of the patient's prior answer (presenting positive evidence (Clark & Schaefer 1989) of hearing: suggesting the subsequent question is doing something other than duplicating the original). Additionally, the patient's orientation to having 'already answered'. (extract 15)
4. A similar example extracted from a *different* clinical setting (Stivers & Heritage 2001) (extract 16) serving to support the findings (Perakyla 2004).

4.4.7.4 An additional question element

Extract 13 displays an example of an NTRI within the environment described. This sequence occurs in the context of a discussion regarding the appropriateness of an antidepressant dosage change (self imposed by the patient). The psychiatrist inquires as to the patient's state of sleep in line 1. The subsequent confirmation that he is 'sleeping good' (line 2) completes the base question-answer sequence, creating an opportunity for numerous actions from the psychiatrist, including those that are closure implicative and associated with progression to the next activity e.g. the 'shift-implicative' receipt '*okay*' (Beach 1995) or simple receipt with a 'sequence-closing third' (Schegloff 2007) e.g. the assessment *good* etc. The selection of such resources in this position would orient to the patient's answer as both understood and as having produced a relevant response. The psychiatrist however chooses to post-expand (Schegloff 2007) past the minimal question-answer sequence in line 3.

Extract 13

- 01 DOC: Are you sleeping?
- 02 PAT: I'm sleeping good.
- 03 DOC: Are you sleeping on (.) the higher dose?
- 04 (0.8)
- 05 PAT: Huh?

Here the psychiatrist's interrogative in line 03, deals with the 2nd position response (Schegloff 2007) by projecting further topical talk about the patient's state of sleep. The psychiatrist repeats the question, but with an additional element 'on (.) the higher dose'. This displays an orientation to soliciting a more specified response on more constrained terms: seeking confirmation that the patient is sleeping on the higher dose rather than sleeping 'good' more generally. Accordingly, it seems useful to draw upon literature relating to 'third turn repair' (Schegloff 1997, 1992) in this analysis.

Schegloff (1997: 31) asserts when 'some party to the conversation has produced an utterance, the response to which...reveals an apparently problematic understanding, the 'misunderstood' speaker may then undertake to set the matter straight, and does so in the turn following the one which displayed the problematic understanding'. Such 'third position repairs' (termed so because they show themselves to be prompted by the response (position 2) to an earlier utterance (position 1)) regularly take the form 'No, I don't mean X, I mean Y' (Schegloff 1997:31)

While the response here clearly does not take the form of a third position repair, there are interactional similarities. By reworking and specifying his original first pair part, the psychiatrist orients to the patient's answer as 'problematic' in so far as not having satisfied his need to understand the role of *medication* on the patients' sleep (information that would allow the psychiatrist to fully assess the appropriateness of the medication change). The additional question component 'on (.) the higher dose' functions to retrieve a more specific answer based on additional terms: creating a new slot for the patient. As Schegloff (1997:31) states:

'the major job that is served at third and fourth position is the retrieval of "next turn position" so as to allow another, better "fitted" next turn to be done. Third position repairs accomplish this by the speaker redoing his or her own prior (trouble-source) turn, after which its next turn position is again to be redone.'

Meanwhile, from the patient's perspective, the repairable question may appear to not properly take into account - or be appropriate next to - the prior turn (Drew 1997). In its essence, this question was 'already answered' in line 02. Following some silence (line 04), this occasions the patients' repair initiation in line 05. Schegloff et al. (1977: 373) noted that other-initiated repair is regularly "withheld a bit past the possible completion of [the] trouble-source turn" in order to allow trouble-source speakers a chance to correct themselves. Note here, that the patient's chosen repair initiation strategy is the interjection *hub?*. The following example displays a similar sequential environment preceding the OCRI, where the selected format is however *pardon?*.

4.4.7.5 Justifying the (re)question in 'psychiatric' terms

In line 01, the clinician delivers an interrogative to solicit the patient's willingness to go on an imminent family holiday. The patient produces a type-conforming 'yes' response (line 03). However, instead of receipting the patient response, denoting a transition from 'unknowing' to 'knowing' and conveying acceptance of, and belief in, what the patient has said (Heritage and Clayman 2010), the psychiatrist, like extract 13, post-expands (Schegloff 2007) the sequence: reworking his prior question in service of a more psychiatrically-fitted response.

Extract 14

01 DOC: Are you willing to go:?

02 (.)

03 PAT: Yes.

04 (1.8)

05 DOC: Are you prepa:red to go because er (.) we were

06 discussi:ng (.) e:r about the stress that you

07 [could] ha:ve over there.

08 PAT: [Ye::s.]

09 (0.4)

10 DOC: Are you prepared?

11 (0.5)

12 PAT: Pardon?

Firstly, the psychiatrist replaces ‘willing’ - implying a personal preference or inclination - with the more practically oriented ‘prepared’. As we see in his subsequent elaboration (an account for the question), this lexical reformulation may relate to psychiatric concerns: in this case potential ‘stress’, a candidate reason for the patient being ‘unprepared’ for the holiday. Secondly, the psychiatrist does not leave space for the patient to respond following the first TCU (are you prepared to go), continuing the turn with the subordinating conjunction ‘because’ to introduce ‘we were discussing about the stress that you could have over there’ as a dependent clause. This serves to *account* for his post-expansion i.e. the question is being deployed ‘in view of the fact’ the psychiatrist and patient have engaged in this discussion: the patient’s subsequent (re)answer is hence made relevant on these (new) terms.

Thus, while the patient has produced a type-conforming response (line 03) abiding with the constraints of the original yes/no interrogative (line 01), the psychiatrist’s reworking + account in the third position (05-07) orients to the contingency that his original question may have been ‘accessible to alternative interpretation’ (Schegloff 1992:1300) or misunderstood in terms of ‘the upshot of what ...[he] is doing with a turn’s talk’ (Schegloff 1992:1300). It is ambiguous whether the patient’s ‘yes’ in line 08 constitutes a receipt or answer to this, occurring in interjacent overlap (Jefferson 1986). However the psychiatrist, having specified the grounds for the question and thus terms for a relevant answer, repeats ‘are you prepared?’ creating a slot for the patient to confirm. Like the prior extract, from the patient’s perspective, it is possible this turn appears not to properly take account of his original answer (in line 03 and possibly line 08) and occasions an OCRI *pardon?*

4.4.7.6 'Hearing' the patient's previous answer and the patient's orientation to 'already answering'

Extract 15 displays another example of potentially misaligned orientations to the psychiatrist's question that precedes the patient OCRI.

Extract 15

01 DOC: Would would you like to ↑a:sk your doctor to give
02 you something to help with that?
03 PAT: O:h they tr- **I've trie:d** [bu:t] he 'as given me he's
04 given=
05 DOC: [Mm::]
06 PAT: =me like the: (.) wh- lactulose [I've tried] the
07 senecot
08 DOC: [Yea:h yeah]
09 PAT: lactulose **I've tried them a:ll** it doesn't[(work)
10 DOC: [You can
11 **try them on a** ↑regular **basis if you li:ke?**
12 (0.4)
13 PAT: Sorry?
14 DOC: >You can try them on a regular< basis.
15 PAT: Er I ↑ha:ve tried them on a regular basis but there's
16 no: it doesn't change it.

Prior to this extract the psychiatrist enquires if the patient is happy on his current medication in response to which he voices discontent around physical side effects of constipation. This occasions the psychiatrist's yes/no question in line 01 'would you like to ask your doctor [GP] to give you something to help with that?'. This question appears to be functioning as an offer in so far as the turn 'proposes to satisfy another's want or need, or to assist in resolving a difficulty experienced by another' (Curl 2006: 1256). However, the psychiatrist frames the *patient* rather than *himself* as the agent in realising this i.e. by asking his GP.

Note here, the patient's response to this inquiry is rejection-implicative. He prefaces his turn with 'oh': potentially signaling that 'the question to which it responds is innapposite in some way' (Heritage 1998:296). Indeed, he delivers an extended narrative (lines 03-09) informing the psychiatrist of the futility of this action: that he has 'tried' (line 03) and in relation to medications for the problem: he has 'tried them all' (line 09). We see positive evidence that the psychiatrist has heard and understood (Clark & Schaefer 1989) this answer by the receipt tokens – highlighted in green – he deploys in lines 05 and 08 (Mm and yeah yeah, respectively). This presents possible prospective evidence that his subsequent question (preceding the OCRI) 'you can try them on a regular basis if you like' is doing some *other* action than merely requesting information he 'missed' in the patient's response.

Indeed, the psychiatrist deploys a more overt offer based upon more specified terms: his addition of, and stress on, 'regular' in line 11 (symbolised by underlining) pursues and answer based on medication *frequency*. This was something left unspecified in the patient's prior answer i.e. 'trying' them all does not necessarily equate to trying on a 'regular basis'. As Davidson (1984) asserts 'given rejection, an...offerer may then display that he is attempting to deal with whatever inadequacy in the initial version led to the rejection, where this attempt is displayed through...offerers' doing a subsequent version' (Davidson 1984: 107). While the questioning action may therefore be pursuing a response based on the new 'conditions' for the offer, it may be hearable to the patient as soliciting information already provided (re that he has 'tried' medications before): so simultaneously 'inappropriate' as a next action. As with the prior extracts, the patient initiates repair in line 13: this time with an 'apology-based' format (Robinson 2006) *sorry?*, flagging this turn as troublesome.

The psychiatrist's repair, a partial verbatim repeat that orients to the action as indeed appropriate in its original form (Robinson 2006), renews the relevance of a patient answer (line 15). This transpires to also be salient: the 'have' in his response: 'Er I have tried them' is deployed with considerable stress and pitch change: constituting possible post-hoc evidence that his orientation to the question is one of having 'already answered' the trouble-source question— as opposed to simply mishearing.

4.4.7.7 A similar case, a different clinical setting

Each of the extracts presented are drawn from separate consultations with different psychiatrists. However, if questioning actions preceding OCRI's were often in service of pursuing a more clinically-fitted patient response, one might expect to find a similar pattern in a different clinical context – providing further support for the findings. As Perakyla (2004:296) asserts in relation to reliability of CA research: 'does everything that is said on case studies in institutional interaction apply exclusively to the particular site that was observed, or do the results have some wider relevance?'. The final extract 16, is excerpted from Stivers and Heritage (2001: 60) and appears to display a patient OCRI following a questioning action with similar potential to attract misaligned orientations: in a primary care setting. Like prior extracts, this question appears 'aimed at the particulars of a prior second pair part' (Schegloff 2007:163).

Extract 16

(8)
 1 DOC: Alcohol use?
 2 (1.0)
 3 PAT: Mm:: moderate I'd say.
 4 (0.2)
 5 DOC: Can you define that, hhhehh ((laughing outbreath))
 6 PAT: Uh huh hah .hh I don't get off my – (0.2) outa
 7 thuh restaurant very much but [(awh:)
 8 DOC: [Daily do you use
 9 alcohol or: = h
 10 PAT: Pardon?
 11 DOC: Daily? or[:
 12 PAT: [Oh: huh uh. .hh No: uhm (3.0) probably ::
 13 I usually go out like once uh week.
 14 (1.0)
 15 DOC: °Kay.°

Following a declarative inquiry regarding the patient's 'alcohol use' in line 01 and an answer in line 03, Stivers and Heritage (2001) show, as in extracts 13-16, how the doctor 'pursues expansion of the patient's answer – in this case, an estimate of her alcohol consumption' (2001:160). They describe the clinician's orientation to seeking a more specific response: 'As it stands, the patient's judgment lacks an underlying measurement framework that would make it interpretable, and it is just this issue that the doctor's question at line 5 pursues' (2001:160) i.e. 'can you define that...'. The patients' subsequent elaboration however is not treated as adequate. As Stivers & Heritage (2001) assert 'the doctor's next question, 'Daily do you use alcohol or' does not treat this as sufficient: it pursues a measurement framework in terms of a periodic metric (e.g., daily, weekly) that is exemplified by the selection of 'Daily'. It is this pursuit of a more clinically specified response that, as with the prior extracts, occasions an OCRI. While Stivers and Heritage (2001) do not deal specifically with the repair sequence, other than noting its occurrence; 'After a repair sequence (lines 10 to 12) the patient arrives at a specification of her alcohol use in terms of such a metric 'once uh week' (2001:160), it appears possible – particularly due to 'daily' being obscured in interjacent overlap (Jefferson 1986) – that this question, while pursuing a specific response, is simultaneously hearable to the patient as 'already answered', supporting the analysis here.

In the following section these results are synthesised and discussed in relation to the concern of this thesis - treatment adherence in schizophrenia. Specific consideration is given to how this series of qualitative findings – including the formats of NTRIs and the sequential environment of utterances they target - might be used to contextualise the quantitative study upon which they build (McCabe et al 2013, see also 4.1.2 here). By using a standardised protocol to code various types of repair (Appendix 4), McCabe et al (2013) identified the relative odds of good adherence to poor adherence as significantly higher in patients who initiated repair on psychiatrists' talk, even when accounting for potential moderating variables. By reconsidering this statistical association in light of the insights that have emerged from a contextual examination of NTRIs (within the same corpus), several possible - empirically grounded - interpretations of this link are presented.

4.5 Discussion

4.5.1 Summary of main results

Other-initiated repair in psychiatric consultations has not previously been systematically studied. Classifying repair in these encounters, McCabe et al (2013) identified patient NTRIs and subsequent psychiatrist repairs to be associated with better adherence in schizophrenia. By providing a detailed overview and analysis of the corpus used in the study, this chapter has described NTRIs in context. There are six key findings that serve to answer the initial research questions.

Firstly, other-initiated repair was relatively infrequent, occurring in less than half of the consultations, aligning with findings that there is a preference for self-initiated relative to other-initiated repair (Schegloff et al 1977). Secondly, the format of patient repair initiations spanned a range of specificity in terms of identifying the troublesome aspect of the psychiatrists' prior talk, consistent with the typology identified by Schegloff et al (1977). By far the most frequent type of NTRI employed by patients was the least 'specific' method: OCRI (Drew 1997). Thirdly, the most common position they were deployed was following a psychiatrists' question, displacing an answer and initiating a post-first insert expansion sequence (Schegloff 2007) to resolve the trouble: suspending the ongoing course of action. Fourthly, while a number of strategies for OCRI exist, including interjections and question words, patients most frequently selected *pardon?* and *sorry?* formats that can be conceptualised in terms of their relative politeness, formality and (in relation to *sorry?*) ability to present the responsibility of the problem with the patient rather than the psychiatrist (Robinson 2006). Fifth, psychiatrists displayed different orientations to the trouble flagged by the patient OCRI in their repair of the problem in the third turn. If the assumption holds that clinicians' verbatim repeat repairs treat their original questioning action as appropriate in its original form, while modified versions present evidence the OCRI communicated the need for some type of revision (Robinson 2006), the format *huh?* was more likely to be oriented to by psychiatrists as the latter. *Pardon/sorry?* NTRIs more regularly incurred verbatim responses, supporting the notion that OCRI formats may be unequal social practices for the same slot. Further underlining this, *huh?*, *sorry?* and *pardon?* were deployed within similar sequential environments: the final finding being that trouble-source questions were routinely hearably

incoherent with the patient's prior talk. While this often manifested as an 'unmarked' topical shift, in a distinct set of cases the questions' incoherence stemmed from misaligned orientations to the questions' function. In post-expansion of a question-answer sequence, the psychiatrist refined and specified the original question in service of acquiring a more clinically fitted response. This action may not however have been immediately interpretable to the patient, hearably soliciting information already provided in the prior turn and displaying a sequential disconnect. These findings underline previous studies, identifying potential sequential sources of trouble where NTRIs are deployed (e.g. Drew 1997, Curl 2005, Robinson et al 2010), but add an extra dimension to this work by displaying how those troubles may relate to the clinical tasks in which the psychiatrist is engaged.

4.5.2 The relevance for schizophrenia and patient adherence

The findings here highlight potential proximate – *sequential* - sources of troubles in psychiatric communication, similar to those that have been documented in ordinary conversation (Drew 1997, Curl 2005, Robinson et al 2010). Conversely, literature on repair in schizophrenia previously, albeit sparse, has focused on *cognitive* processes posited as preceding the use of repair (e.g. psychotic symptoms) instead of interactional analyses, and only focused on self-repair (See Leudar et al (1992) and Caplan et al 1996). This may be problematic, as Heritage (2005) asserts: conversational markers may indicate that a mental process has occurred but we are unable to determine this conclusively so should attend to only that which can be evidenced. Moreover, cognitive assumptions locate problems within *individuals* so are at odds with a basic premise of repair as inter-subjective (Schegloff 1992) by focusing on just one speaker.

While the sequential environments of OCRIs overlapped with those observed in ordinary conversation, there is evidence to suggest the frequency and format of patient other-initiated repair is different relative to other studies/contexts. For example, OCRIs were predominantly deployed here, but in a corpus of both informal conversation and institutional interaction between social workers and their clients, Svennevig (2008) identified that predominantly more specific forms e.g. category-specific and candidate understandings (both conceptualised as 'candidate solutions' (2008:338)) were used. Moreover, Howes et al (2012) found fewer patient other-initiated repairs in this same psychiatric outpatient setting, compared to a

corpus of ordinary conversation from the British National Corpus. Whether this is related to formality of the context relative to everyday conversation or the patients' condition itself, remains an open question.

There are several possible interpretations of this study's findings in the context of their association with adherence (McCabe et al 2013) and how one might explain such a link. It is important to consider that patients' initiation of repair on psychiatrists' talk could reflect them being more engaged with the communication and treatment already, i.e. they are adherent independent of the communication. Other-initiated repair highlights errors in others' talk and people generally seek to avoid this in attempt to 'save face' (Brown and Levinson 1978). This may be particularly pertinent in a doctor-patient interaction, where to flag trouble with psychiatrists' talk could be hearable as questioning their expert status: some patients may not feel empowered enough to initiate repair. The association with adherence could reflect more empowered patients, investing more effort in maintaining mutually intelligible conversation, when sequential (or otherwise) circumstances may disrupt the understandability of the interaction or alignment between speakers. Patients making more bids to maintain intersubjectivity (Schegloff 1992) may be more likely to keep abreast of discussions around treatment and as such achieve a better degree of understanding more globally.

Moreover, while we have found that psychiatrist orientations to the trouble appeared different between *huh?* and other OCRI formats e.g. *pardon?* or *sorry?*, they were deployed in similar environments, suggestive of unequal social practices for the same ostensible sequential trouble. A key finding was that patients most frequently selected *pardon?* or *sorry?*: interpretable as 'polite' methods of addressing troubles-in-talk. Arguably, this could reflect a greater level of rapport or cooperation in saving face, thereby, on some level, a better clinical relationship. As Robinson (2006) has suggested OIR may be 'a rich region of interaction in which to study the constitution of relationships and intersubjectivity' (2006: 156) and as we identified in Chapter 2, a good clinical alliance has been consistently found to be related to adherence.

One alternative interpretation could be to conceive the sequential troubles as indexing a particular clinician communicative approach, present in those consultations in which NTRIs

occurred. Such a hypothesis is made tentatively given that any utterance is a candidate repairable (Schegloff 2007): there may be numerous cases in which sequentially ‘troublesome’ questions were not repaired. Nonetheless, some questions preceding OCRIIs appeared highly task-oriented: shifting topics in ways that could display close adherence to the medical agenda or pursuing a clinically-relevant response to distil diagnostically relevant information. As Drew & Heritage (1992) note in relation to asymmetry in institutional discourse: the question-answer sequences that characterise doctor-patient communication allow clinicians to gather information from patients, but can sometimes result in them directing and controlling talk: introducing, dissolving and changing topics and selectively formulating the terms in which patient’s answers are expressed. Furthermore, this organisation provides less opportunity for the answerer (typically a lay person) to initiate talk, thereby allowing the institutional representative to gain a measure of control over the introduction of topics and hence of the ‘agenda’ of the consultation (Drew & Heritage 1992). Given that NTRIIIs recurrently occurred in such contexts, perhaps they index the psychiatrist orienting more closely to the medical agenda, thus rendering sequential sources of trouble relating to abrupt shifts and pursuit of clinically specific responses more likely. Though this would contradict the assumption that more open non-directive interactions, associated with the principles of patient-centredness (See Chapter 1), are beneficial for patient engagement with treatment, it would align with the counter argument: that many patients in fact want to retain the asymmetry of the clinician-patient relationship (Silverman 1987). The expertise implied through a more directive approach may be reassuring, inspiring clinician trust and confidence in prescribed treatment, albeit at the expense of patient’s experiential contributions on a micro-level. Trust is accordingly associated with better adherence in general medicine (Lee & Line 2009) and research in psychiatric samples finds a high level of trust in doctors expecting them to lead on taking treatment decisions (Laugherne & Priebe 2006).

More evidence would be required to confirm these speculative hypotheses, but an important collective upshot can be inferred from them. While it is tempting to construe ‘misunderstandings’ and misalignment (e.g. the sequential troubles identified here) in interaction as inherently ‘bad’ (thereby their *absence* to be preferable) – their potential import in terms of how such troubles are addressed by participants and what they may reflect about

patient's themselves, the clinical relationship or the psychiatrist's approach to questioning (and not least their statistical association with adherence itself McCabe et al (2013), suggests that, in fact, the *presence* of misalignment and the 'self-righting mechanism' (Schegloff et al 1977) (repair) to address such issues may be notable in clinical talk as indicating something 'good' about, or consequential for, patient engagement. NTRIs and psychiatrist repairs may therefore be important *specific* practices (rather than abstract ideals) for clinicians to be aware of.

4.5.3 Limitations

Before proceeding to the next study, this chapter should however be considered in the context of its limitations. Firstly, whilst the findings display interesting overlaps with CA research on NTRIs in ordinary conversation, this study focused specifically on patients with a diagnosis of schizophrenia and did not perform a comparative analysis. The nature of associated symptoms can bring major disruption to interactions. For example, disorganized speech (APA 2000) or poverty of speech from negative affect (Cretchley et al 2010). Further research is necessary to fully understand if and how levels of patient repair may be impacted by symptomatology. Extrapolating findings to health interactions in the treatment of other disorders is therefore cautioned. Secondly, though noted at points, this study did not systematically examine non-verbal behaviour that can be important in the meaning of OIR sequences e.g. phonetic features of OIR and responses (See Curl 2005). Thirdly, while other types of OIR were identified such as repeats, category-specific repair initiations and candidate understandings, these were not examined in detail here. The present arguments are only supported for OCRI.

Fourthly, when examining OCRI by format, some individual categories were small, therefore the ratios presented may be misleading. Moreover, while a marked distinction between psychiatrist responses to *huh?* relative to other OCRI formats (i.e. they were routinely revised) was observed, one could argue these should have been grouped with other types of OCRI interjection strategies e.g. *mm*. For example, Schegloff (1992) did not see it fit to distinguish between Huh? and Hm: 'I have not been able to establish any interactionally relevant differences between the open and closed realisations' (1992:108). A larger corpus of examples would be preferable for less tentative findings.

4.5.4 Thesis implications

Patient NTRIs mostly occurred in response to psychiatrists' questions and this study highlights their sequential implicativeness as having interactional import. However, little is known about the nature of questioning in psychiatry which remains understudied relative to medical communication more generally. NTRIs are infrequent compared to the amount of questions in any given consultation. The latter could therefore represent an additional – and more prevalent - practice that may be related to adherence, or further our understanding of the link between NTRIs and adherence. As Heritage (2009) asserts: medical questioning plays a fundamental role in the management of the social relationship between the doctor and the patient, thus demands analytic attention. The following chapter will examine psychiatrists' questions, and their relationship with adherence and alliance, in more detail.

Chapter 5

Psychiatrists' questions, the therapeutic relationship and patient adherence

Chapter abstract

Background

In Chapter 4, patients were observed using open OCRI on psychiatrists' questions that were hearably disjunctive. However, further research is needed to understand the nature of questions in psychiatric encounters more generally: they remain understudied relative to medical communication and are commonly defined in generalised terms e.g. 'open' and 'closed' that may have limited usefulness in practice.

The aims of this chapter are to; undertake a detailed examination of the types of questions asked by psychiatrists: explore their association with patient adherence and the therapeutic relationship; and further examine the utility of applying conversation analysis to contextualise statistical findings.

Method

A coding protocol was developed to exhaustively classify psychiatrists' questions in 134 psychiatric outpatients consultations, predominantly by form i.e. syntactic structure. Bivariate correlations between frequently asked categories and measures of patient adherence and the therapeutic relationship were examined. Question types significantly associated with these outcomes were subjected to more detailed qualitative exploration using conversation analysis.

Findings

A small subset of question types were regularly used by psychiatrists: 1) Yes/no questions 2) Wh questions 3) Declarative questions 4) Tag questions. Only psychiatrists' declarative questions were correlated with better patient adherence and better psychiatrist perceptions of the therapeutic relationship. When examined using CA, these questions were recurrently so-prefaced formulations of patients' prior talk that displayed sensitivity towards the psychological aspects of patients' accounts or troubles tellings e.g. so you feel a bit anxious? While exhibiting understanding of patients' contributions (and allowing psychiatrists to distil summaries within a psychiatric frame of relevance) they simultaneously limited them. Declarative questions were associated with sequence constraint (in 3 ways; minimal patient responses, absence of third position post-expansion, subsequent topic change by the psychiatrist) and ultimately correlated with less patient talk overall within consultations.

Collectively, these findings help validate a more granular analysis of clinicians' question types to understand questioning practices in psychiatry. Declarative questions may provide a candidate index of psychiatric practice in action and how adherence, relationships and intersubjectivity may be constituted in, or improved by, clinical interaction.

5.1 Background and rationale

Psychiatry is not conceivable without clinician questions. They are the mechanism for achieving clinical objectives: history taking, reviewing symptoms and deducing diagnostic hypotheses. As such, questioning manages the formation of a therapeutic alliance, the benefits of which include patient adherence (Chapter 2). It is crucial that psychiatrists know how to question effectively in routine consultations. A conceptual issue, sketched in the introduction, however hinders this in practice: there is no definitive model of 'good communication' (Priebe et al 2011). Instead, it is viewed more generically through the ideology of 'patient-centredness' i.e. accounting for patients' psychosocial context: preference and experience. While questions are the mode for eliciting this experience, advice in psychiatry textbooks is limited and generalised e.g. 'in general try to use open questions rather than leading questions or closed questions' (Burton 2010: 14). In fact, 'open' and 'closed' categories encompass numerous linguistic question types, each of which may have different interactional consequences (Heritage 2010). No research to date has examined the actual questions (by a more sensitive, utilitarian classification) that psychiatrists' deploy in clinical encounters and how they are linked to the therapeutic relationship and treatment adherence. In order to specify training and improve these outcomes, we must first explore three research questions, the aim of this chapter:

1. What types of questions do psychiatrists ask in routine consultations?
2. Are particular question types associated with better therapeutic relationships and treatment adherence?
3. What are question types associated with the therapeutic relationship or adherence 'doing' interactionally?

To answer these questions, this study is formed of two parts:

Part 1 – Quantitative analysis: Questions 1) and 2) will be explored by coding psychiatrists' question types in order to yield descriptive statistics and correlations with measures of patient

adherence and the therapeutic relationship. Correlations with symptoms will also be assessed as a potential confounding variable.

Part 2 - Qualitative analysis: Question 3) will be explored in a study applying conversation analytic principles. Significant question types in relation to these outcomes, identified in part 1, will be examined in more detail to contextualise the findings.

5.2 Part 1 methods

5.2.1 Data

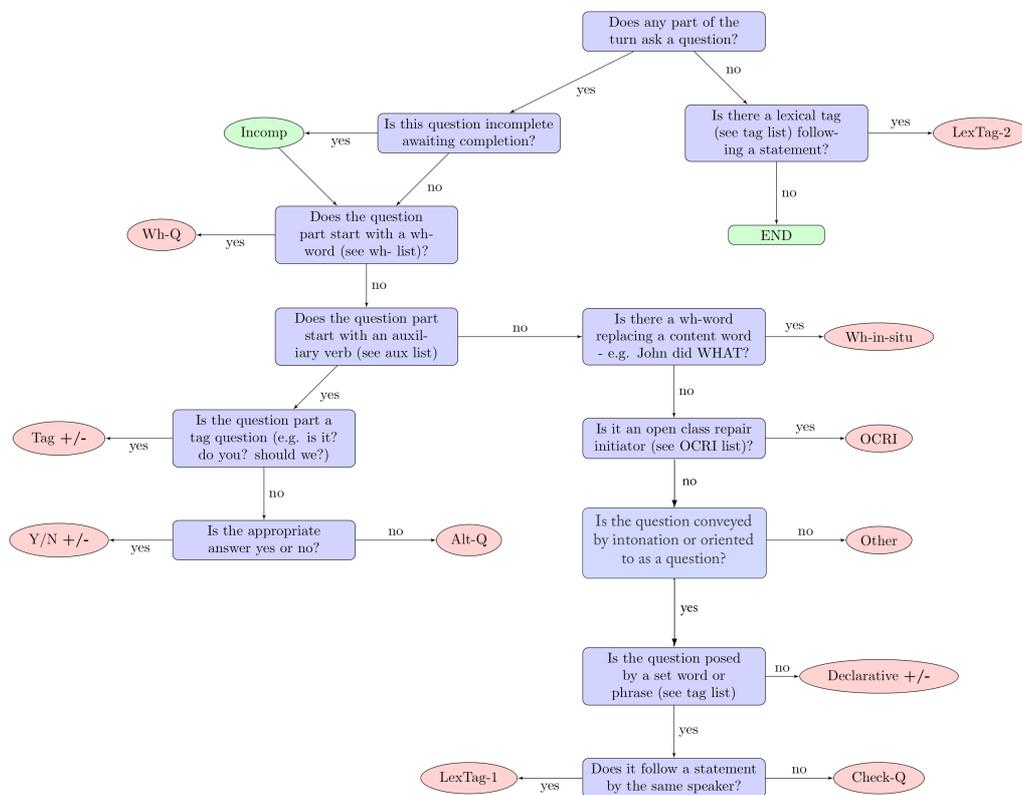
As with chapter 4, data were drawn from an MRC study examining clinical interaction in psychosis (McCabe et al. 2013), collected between 2006 and 2008. A full description of the dataset was provided in Chapter 3. Verbal dialogue was transcribed verbatim: the final set of 134 transcripts formed the dataset here.

5.2.2 Question coding

A standardised protocol (Figure 3 and appendix 2) was developed and piloted collaboratively by the author and a team with experience in linguistics and psychiatric communication (For description of team, see appendix 2). Regular meetings facilitated the refinement of the protocol: applied by the all team members to transcripts of video-recorded consultations in an iterative piloting process. The resulting coding scheme allowed an exhaustive classification of questions within each transcript. Question taxonomies (that move beyond an ‘open’ vs ‘closed’ conceptualisation) vary according to the accepted meaning of a question itself i.e. whether constituting a type of sentence (interrogative), the speech act of requesting information (interrogative act) or ‘the ‘thing’ which is being asked, and which, as a consequence, may be (partially) answered’ (Groenendijk and Stokhof, 1997). These definitions result in contrasting approaches to question classification, broadly (but not exhaustively) speaking; syntactically (by form), semantically (by meaning), pragmatically (by function). Based on an examination of the transcripts, the approach taken here uses a combination of these classifications, in order to identify and distinguish all of the items of interest. Where possible, questions are identified by their syntactic form. However, although there are two types of sentence forms that constitute syntactic questions in English (see Ginzburg & Sag 2001) – starting the sentence with a wh-word (see section 5.2.3 below), and swapping the order of the sentence’s subject

and auxiliary verb, so that the latter is the first word (so called subject-auxiliary inversion; see section 1) below), these are by no means the only ways that questions may be asked. For example, specific lexical items may be commonly used as and taken to be questions (e.g. pardon?, see sections 8) and 10), also Drew 1997 and chapter 4 here) and sentences that are syntactically identical in form to non-interrogatives may be used and identified as questions e.g by their rising (questioning) intonation (see section 3) below). The classification here seeks to identify all of these question types. The resulting categories will next be described.

Figure 3. Questions coding protocol (larger version: appendix 2)



5.2.3 Question categories

The complete coding protocol (Figure 3) was constructed to be usable without specific knowledge of linguistics. Each candidate utterance is tested against a hierarchy of yes/no format questions, formulated to be as simple as possible. A process of sequential elimination thereby identifies the linguistic type of any question, and this process is repeated on the

utterance until no further questions are identified. There are 10 possible categories, shown in Table 10, with an example from the data. More precise definitions are outlined below.

Table 10. Question types resulting from coding

Question type	Example from data
1) Yes/no questions	Do you ever feel someone is controlling your mind?
2) Wh questions	Where was that done?
3) Declarative questions	So you feel anxious about that?
4) Tag questions	You're on 10mg of olanzapine, aren't you?
5) Lexical tags	I'll write a letter to your GP, okay?
6) Incomplete questions	Your keyworker is?
7) Alternative questions	Do you feel better having stopped it or worse?
8) Check questions	Yeah?
9) Wh-in-situ	He did what?
10) Open class repair initiators	Pardon?

1) Yes/no questions (Y/N Qs)

Y/N Qs are a syntactically identifiable question category with an auxiliary verb in the first position of the sentence, followed by the subject. Only auxiliary verbs can undergo this subject-auxiliary inversion, as can be seen in examples 1, 2 and 3.

1. You would like tea → Would you like tea.
2. You like tea → *Like you tea.
3. You do like tea → Do you like tea.

* the preceding asterisk denotes ungrammaticality

Auxiliary verbs often express distinctions of tense, aspect or mood and include *do*, *can*, *will*, *have*. Y/N Qs are one of the class of 'closed' questions because they can be answered with a yes or no – i.e. they project yes or no as the type-conforming answer (Heritage & Clayman 2010) from the patient.

2) Wh-questions (Wh Qs)

Wh-questions have a question word in the first position e.g. who, what, when, why or how. Accordingly, they elicit information on a state of affairs or the property of an event, highlighting a category e.g. agent, cause, time, place that needs to be instantiated by the

patient. Wh-questions are considered to be ‘open’ questions because they do not project a specific response or set of responses.

3) Declarative questions

Declarative questions are not marked via an auxiliary or questioning word, rather they have the syntax of a declarative sentence (Heritage & Clayman 2010). Understanding declarative sentences as questions (i.e. requiring confirmation/disconfirmation by the patient) depends on sequential, prosodic, pragmatic and epistemic features, not syntax alone (Stivers & Rossano 2010). A rising intonational contour in particular is likely to index recognition of declaratives as questions (Safarova & Swerts 2004). Questioning intonation was annotated in transcripts, thus declarative sentences designed as questions denoted by a ‘?’ in the transcript were included. Alternatively, where a candidate declarative (e.g. appearing as ‘b event’ statements (see Labov & Fanshell 1977): information only known to the patient thereby inviting (dis)confirmation) coders looked to the next turn (the patient response) to see if it had indeed been understood as question. Declarative questions are accordingly considered one class of ‘closed’ question because they invite yes/no type responses (Raymond 2010).

4) Tag questions

A tag question transforms a declarative statement or imperative into a question by adding an interrogative fragment (the ‘tag’) i.e. an auxiliary verb followed by a pronoun e.g. “isn’t it?”, “would he?”, “do you?”. Like Y/N Qs and declaratives, tag questions can be seen as inviting confirmation/disconfirmation from the patient, thus are another class of ‘closed’ question.

5) Lexical tags

Lexical tags also invite confirmation/disconfirmation by adding an interrogative fragment to a statement, but using specific words, rather than an auxiliary verb and pronoun. A list of words that could act as lexical tags, e.g. “right?”, “okay?”, “yeah?”, “you know?” was provided to coders. Lexical tags marked on the transcripts as conveyed by a questioning intonation (‘?’) were included.

6) Incomplete questions

Grammatically incomplete sentences that invited a candidate completion by the patient were coded as incomplete questions. They may be initially formulated as another syntactic structure e.g. declarative or alternative question, but invite (usually through questioning intonation) the patient to complete the missing component. Questions coded as incomplete were also coded for the type of question being formulated.

7) Alternative questions

Like Y/N Q's, alternative questions have an auxiliary verb in the first position, but present two or more possible answers that the patient may choose.

8) Check Q's

Check questions are synonymous in form with lexical tags, but follow a statement by another conversational participant, rather than being appended to one's own declarative statement.

9) Wh-in-Situ

Wh-in-situ are questions formed by using wh-words, but as a replacement for content words, instead of at the beginning of the sentence (e.g. 1).

1. John went to the zoo → John went where? (cf. Where did John go?)

10) Open Class Repair Initiators

Psychiatrists may draw attention to a problem of hearing or understanding the patients' prior turn using questions that are 'open' class repair initiators (OCRIs) (see Drew 1997 and chapter 4) e.g. pardon?, sorry?, what?, huh?.

5.2.4 Application of the protocol

A software suite designed to facilitate the annotation of language data (Dexter Coder (dextercoder.org 2011)) was used to apply the protocol. The author and two other raters performed coding independently. Transcripts consisted of verbal dialogue therefore assigned question codes were based only on surface syntax. However, where questions were not linguistically marked as such by auxiliary verbs or questioning words i.e. declaratives, lexical

tags and check questions, intonational cues (or patient responses – 3)) denoted in the transcript by question marks were used to determine that the question had been conveyed by intonation (an item in the protocol). Inter-rater reliability was found to be good for all question types using Cohen's kappa ranging from $k = 0.76 - 0.89$.

5.3 Outcome measures

Three outcomes were examined, as measured by researchers (excluding the author) independent of patients' treatment (McCabe et al 2013). While not the primary focus of the study, symptoms - measured in post-consultation interviews - were explored as a potential confounding factor. Additionally, psychiatrist evaluations of their experience of the therapeutic relationship (as measured by baseline questionnaires) and impression of patient adherence (as measured in a follow up interview, 6 months after the consultation) were also examined. Descriptions of the scales used in McCabe et al (2013) are provided below.

5.3.1 Symptoms

Patient symptoms were measured on the Positive and Negative Syndrome Scale (PANSS, Kay et al., 1987). 30 items, rated 1-7, assess positive, negative and general symptoms, where higher scores denote greater severity. Positive symptoms indicate a change in the patients' behaviour or thoughts e.g. delusions or sensory hallucinations. Negative symptoms represent a reduction in functioning, including blunted affect, emotional withdrawal and alogia. Subscale scores for positive and negative symptoms ranged from 7 (absent) - 49 (extreme), general symptoms e.g anxiety scores ranged from 16 (absent) - 112 (extreme). Inter-rater reliability using audio-visually recorded interviews was good (Cohen's kappa=0.75).

5.3.2 Therapeutic relationship

Perceptions of the therapeutic relationship were assessed post-consultation using the Helping Alliance Scale (HAS, Priebe and Gruyters, 1993), capturing doctors' experience. 5 Items were rated 1-10 on various interpersonal variables including mutual understanding about providing necessary treatment. Ratings for individual items were combined to create a single value, where a lower score represented a poorer therapeutic relationship.

5.3.3 Adherence to treatment

Patient adherence to treatment was rated by the clinicians on two three point-scales (1 = good, 2= average, or 3 = poor) six months after the consultation. The first related to prescribed medication and the second, general treatment. Psychiatrists assessed according to their impression of adherence within the last three months. Both scores were combined to provide a single score (/6), where a lower value indicates better adherence.

5.4 Analyses

Statistical analyses were conducted using SPSS 18.0 (SPSS 2009). Coded questions were added to a database containing the outcome measure scores; symptoms, the therapeutic relationship and adherence. Descriptive data, including frequencies and means, on questions types were retrieved to answer research question 1. To explore research question 2, bivariate correlations between each question type and the primary outcomes (the therapeutic relationship and adherence) were performed, establishing significant associations to motivate further analysis. Initially, correlations with symptoms, a potential confounder, were explored. Subsequently, coefficients were obtained for adherence and the therapeutic relationship.

5.5 Results

5.5.1 Sample

Coded questions were obtained from 134 consultations involving 31 psychiatrists. 63% of clinicians were male and 72% were of white ethnic origin. Consultations lasted a mean length of 17.2 (SD 9.1) minutes. A full description of the sample, setting and patients' sociodemographic and clinical characteristics are reported in Chapter 3.

5.5.2 Types of questions asked by psychiatrists

Psychiatrists asked patients a total of 7570 questions across 134 consultations (M= 51.7 SD= 32.1). Table 11 depicts specific linguistic question types and their mean frequencies in descending order. As length and density of doctor utterances varied between consultations, means were also normalised by acquiring values relative to a common variable i.e. per 1000 words. This controlled for the possibility that higher question frequencies were due to

particular psychiatrists talking more. A corresponding order resulted from this, as further displayed in Table 11.

Most frequently, psychiatrists asked patients yes/no auxiliary verb questions (M=16.5), followed by wh- questions (M=12.7), declarative questions (M=11) and tag questions (M=3.9). Given the relatively low frequency of remaining linguistic types, these 4 categories were deemed frequent enough for inclusion in statistical analyses exploring associations with the therapeutic relationship and adherence.

Table 11. Distribution of psychiatrist question types

Question type	Total	Mean (SD)	Range	Mean per 1000 words	Range
All Q's	7570	51.7 (32.1)	165	35 (16)	93
YNQ's	2362	16.5 (12.2)	57	12 (6)	30
Wh Q's	1700	12.7 (10.4)	63	8.5 (4.8)	23
Declarative	1648	11 (8.3)	47	9 (8)	40
Tag Q's	842	3.9 (4.5)	25	2.3 (2.1)	11
LexTag	496	3.7 (5.2)	29	2 (2.2)	11
Incomp Q's	196	1.5 (1.7)	8	1.1 (1.8)	12
Alt Q's	159	1.2 (1.5)	10	0.8 (1.2)	9
Check Q	85	0.6 (1.4)	7	0.4 (1.2)	6
What-in-situ	47	0.35 (1)	10	0.2 (0.6)	5
OCRI	35	0.3 (0.7)	4	0.2 (0.6)	4

5.5.3 Correlations with outcomes

Bivariate associations between outcomes and selected question formats; yes/no auxiliary verb, wh, declarative and tag were examined using Pearson/Spearman correlations. Correlation coefficients and values of significance for each measure; symptoms, adherence and the therapeutic relationship are reported independently in the following subsections. Statistically significant findings (at the $p < .05$ level) are described.

5.5.3.1 Symptoms

Symptom severity in schizophrenia can impact communication, therefore correlations between each question type and the three PANSS symptom scales (positive, negative, general) were explored. As displayed in Table 12, yes/no auxiliary verb questions were positively correlated with negative symptoms and wh- questions were positively correlated with positive symptoms. Neither psychiatrists' declarative or tag questions were associated with any symptom subtype.

Table 12. Correlations with patient symptoms

PANSS Subscale	YN Q's		Wh Q's		Declaratives		Tag Qs	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>P</i>	<i>r</i>	<i>p</i>
SYMPTOM TYPE								
General	.130	.138	.152	.082	.133	.131	.126	.152
Positive	.054	.052	.182*	.037	.028	.747	.143	.103
Negative	.182*	.036	-.008	.927	-.010	.911	-.027	.760

* Correlation is significant at the $p < .05$ level

5.5.3.2 Therapeutic relationship

Clinician ratings of the HAS scale were examined both globally and by individual subscales to increase specificity and explanatory potential. Bivariate correlations for each question type are outlined in Table 13. Statically significant correlations are highlighted in bold.

The deployment of declarative questions was associated with better clinician perceptions of the therapeutic relationship. Psychiatrists' HAS global ratings were highly significantly correlated with their use of this question type i.e. psychiatrists who used more declarative questions, rated the therapeutic relationship with their patients more favourably. When examined by subscale, all individual items were also positively correlated: more declarative questions related to more affirmative ratings of *getting along with the patient, understanding their problems, looking forward to meeting them, feeling actively involved and feeling able to help*. Remaining question types were not associated with the therapeutic relationship.

Table 13. Correlations with the therapeutic relationship

Measure of relationship/rater	YN Q's		Wh Q's		Declaratives		Tag Qs	
HAS Total Psychiatrist	.030	.732	.099	.259	.282**	.001	.036	.681
Do you get along with the patient?	-.016	.854	-.052	.551	.190*	.029	.151	.085
Do you understand the patient and his/her views?	.056	.525	-.080	.363	.205*	.018	-.012	.894
Do you look forward to meeting the patient?	.029	.743	-.013	.879	.213*	.014	.089	.310
Do you feel you are actively involved in the patient's treatment?	-.043	.626	-.106	.228	.242**	.005	-.049	.573
Do you feel you can help the patient and treat him/her effectively?	.103	.241	-.081	.357	.284**	.001	-.009	.919

* Correlation is significant at the $p < .05$ level

**Correlation is significant at the $p < .01$ level

5.5.3.3 Adherence

Only one question type was significantly associated with better patient adherence as displayed in Table 14 (in bold). Psychiatrists use of declarative questions was negatively correlated with the adherence scale, where a lower score represents a positive assessment of adherence. This

means greater use of declarative questions from the psychiatrist was associated with more adherent subsequent behaviour from the patient.

Table 14. Correlations with patient adherence

	YN Q's		Wh Q's		Declaratives		Tag Qs	
	<i>r</i>	<i>P</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Adherence	.043	.636	.033	.718	-.204*	.022	.137	.126

* Correlation is significant at the $p < .05$ level

5.6 Part 2 Qualitative analysis

5.6.1 Summary of findings from part 1 and analytical focus of part 2

Psychiatrists can use a range of questions to solicit information from patients by varying the structure of their utterances. In the first part of this study, these alternatives were captured in a coding protocol. Despite the different possibilities of question form, constructible by variations in syntactic structure, lexical items and intonation, it was found only a relatively small subset are regularly used by psychiatrists: 1) Yes/no auxiliary questions 2) Wh questions 3) Declarative questions 4) Tag questions. While this pattern is of interest in its own right, it further appears choice of question type could be consequential for the therapeutic relationship and adherence in schizophrenia. Psychiatrists' use of declarative questions; statements that invite confirmation/disconfirmation from the patient (and would typically be considered 'closed questions' in psychiatry textbooks) were associated with *better* adherence and better psychiatrist perceptions of the therapeutic relationship (on all items of the HAS scale)¹, but not patient symptoms: a potential confounding variable.

Motivated by these findings, we turn to exploring this phenomenon qualitatively in part 2. The methodology of conversation analysis – outlined in Chapter 3 – will be employed in an exploratory study to examine declarative questions interactionally. The aims are to contextualise the findings retrieved in part 1 (reversing some of the limitations of applying pre-defined codes also described in Chapter 3), generate explanatory hypotheses, and explore the utility of combining these methodological approaches to psychiatric communication.

¹ A subsequent study (Thompson et al 2013 in preparation) assessing the relationship further (using generalised estimating equations) found a main effect of declarative questions on adherence/psychiatrist perceptions of the therapeutic relationship, even when adjusting for symptoms and psychiatrist ID.

5.6.2 The corpus

Given the labour intensive nature of this methodology, the corpus size (134) was reduced by selecting a random subset of 30 consultations. Transcripts with mean frequencies below 3 declarative questions per 1000 (31 consultations) were excluded in order ensure selected cases contained a sufficient density of questions. Approximately 7 declarative questions from each consultation were extracted, providing a total of 210 for initial analysis.

5.7 Part 2 methods

The extracted questions and surrounding talk were transcribed using Jeffersonian orthography capturing micro-level features of interaction (Chapter 3). Although non-verbal data was not included in the transcription, pauses due to the psychiatrist note-writing were included to prevent misinterpretation of inter-turn delays. In accordance with CA methodology, question extracts were analysed inductively and on the understanding that to talk is always to 'do' something (Schegloff 1996).

As per the strategy for data elaboration described by Paul Ten Have (2007), on the basis of analytic descriptions from a turn-by-turn consideration of a single case, some more general observations were gradually formulated as additional cases were examined - continually revising the summary of an apparent pattern to accommodate these instances (2007:165). The results that follow are presented in the context of CA literature that emerged as relevant as the analysis developed. However, in line with an increasing body of CA research (e.g. West 1984, Sennedvig 2008, Frankel 1984) and the approach taken in Chapter 4, there is reference to counts and distributions that were derived from, and used to complement, the qualitative data - providing wider relevance within the dataset.

5.8 Results

5.8.1 What are declarative questions?

DOC: So you feel a bit anxious?

In part 1 of this chapter, psychiatrists' questions were classified by linguistic type. Here, one category, correlated with adherence and the therapeutic relationship, is examined exclusively: declarative questions. Schegloff (1984) claims that what unites questions is their placement in conversational sequences:

“Even where an utterance is in the linguistic form of a question, and seems to be doing questioning, the latter will not be adequately accounted for by the former. For if the question form can be used for actions other than questioning, and questioning can be accomplished by linguistic forms other than questions, then a relevant problem can be posed not only about how a question does something other than questioning, but about how it does questioning; not only about how questioning is done by non-question.” (1984)

From this standpoint, declarative questions, as coded here, may be accomplishing more/other actions than questioning itself. Before exploring this further, the definition of declaratives is expanded upon, beyond the brief properties provided earlier.

From a CA perspective, declarative questions constitute a 'yes/no type initiating action' (Raymond 2010). That is, the first part of an adjacency pair sequence that make relevant a response: the second pair part. The question thus projects the relevance of a next action to be done by a subsequent speaker (See Schegloff 1972). While declarative questions retain the syntax of a declarative sentence and are not grammatically 'marked' as questions, lacking the subject/verb (auxiliary or modal) inversion usually associated with interrogatives (see section 5.2.3), they typically invite confirmation/disconfirmation as they contain 'B event information' (Labov and Fanshell 1977:73) – social facts known to B (the addressee) (in the example above: whether the patient feels anxious) but not to A (the speaker). Declaratives are thus 'B-event statements'. Like all questions, declarative questions set agendas by identifying a specific topical domain as the appropriate domain of response, achieving this by making non-responses (e.g. silence) or failures to address the question's topical agenda noticeable and accountable (Schegloff 1972).

Despite the range of possible yes/no type initiating actions, constructible by variations in grammar and polarity (in this study's protocol; declarative questions, yes/no interrogatives, tag questions, lexical tags and check questions), the correlation between declaratives specifically and adherence/the therapeutic relationship implies that a binary 'open' vs 'closed' categorisation is not sufficiently nuanced to capture the interactional (and potentially

behavioural) consequences of the different questioning resources psychiatrists can select. Indeed, existing CA literature has identified tangible differences in declaratives compared to other yes-no type initiating actions to this effect. The proceeding section illustrates this with an example from the present corpus.

5.8.2 Psychiatrists' declarative questions – displays of a shallow epistemic gradient between psychiatrist and patient

A declarative question not only projects the relevance of a yes/no type action, but can be differentiated from other 'closed' questions in important respects. Epistemic stance is one example i.e. the degree to which the psychiatrist conveys access to (i.e. is 'knowing' of) the information the question aims to solicit. By applying principles described in Heritage (2010) to adaptations of an example in the current dataset: the declarative 'so you feel a bit anxious?', we can see there are various ways the same question could have been designed as a yes/no type initiating action: each to elicit the same information, yet establishing a different 'epistemic gradient' (2010:8) between the psychiatrist and the patient:

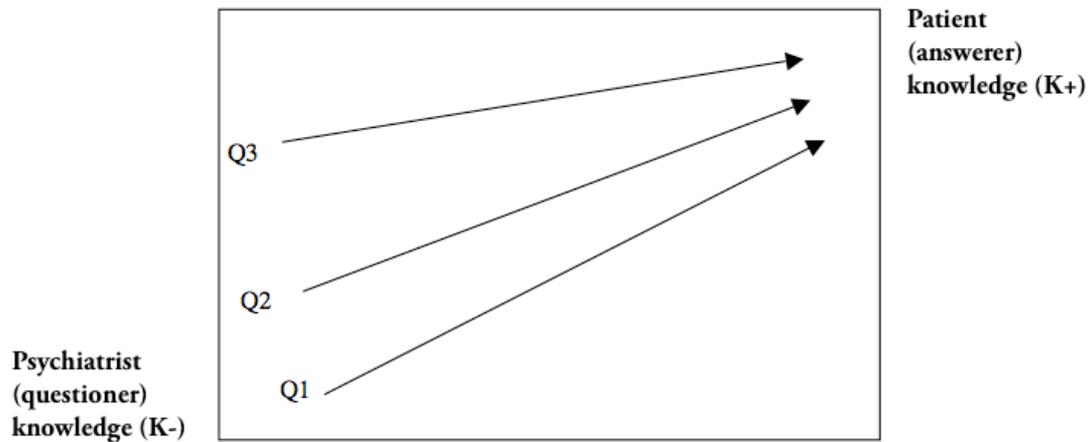
Q1) So do you feel a bit anxious? (Y/N interrogative)

Q2) So you feel a bit anxious, don't you? (tag question)

Q3) So you feel a bit anxious? (declarative question)

Each of these questions refers to whether the recipient 'feels a bit anxious': 'B event information' (Labov & Fanshell 1977), only properly known by the patient. That is, the patient has primary epistemic rights to the information (Heritage & Raymond 2005). However, each question represents distinct stances towards it, as displayed in Fig 4, adapted from Heritage (2010).

Figure 4. Psychiatrist question designs and epistemic gradients



Q 1 indicates that the psychiatrist has no certain knowledge of the patient feeling anxious, indexing a steep ‘epistemic gradient’ between the knowledgeable (K+) patient and a relatively ‘unknowing’ (K-) psychiatrist. Contrastingly, Q2 indicates a shallower gradient by displaying an inclination towards the likelihood that the patient does feel a bit anxious. While the psychiatrist formulates the utterances initially as a declarative statement ‘so you feel a bit anxious’, his epistemic entitlement is ‘downgraded with a tag question’ (Heritage 2012:14): ‘don’t you?’, seeking confirmation of the assertion made in the declarative component (for alternative uses of tag questions see Stivers & Rossano 2010).

Finally Q3, a declarative question, without an interrogative fragment (Q2) or auxiliary-subject preface (Q1), proposes a strong allegiance to the idea that the patient does indeed feel anxious. As Heritage (2010) posits, the latter declarative form ‘merely seeks to reconfirm or alternatively convey inferences, assumptions or other kinds of ‘best guesses’ (2010:9) Accordingly, Raymond (2010) argues, ‘speakers assert the matters formulated in their initiating action and thereby claim to know about them (or assume them or treat them as established) as a basis for making confirmation of them relevant’ (Raymond 2010:92).

While Q 1, 2 and 3 are all versions of ‘closed’ questions that aim to solicit the same information from the patient i.e. whether he feels a ‘bit anxious’, the selection of one form over another can have significant consequences for the ensuing interaction with the patient. As Heritage (2010) argues ‘taking the ‘unknowing’ stance of a y/n interrogative can invite

elaboration and sequence expansion, while the 'knowing' y/n declarative form merely invites confirmation of known information by the recipient, who is projected as an authoritative source' (Heritage 2010:10). Raymond (2010) compared y/n interrogative questions and declarative questions and found this to play out in interactions between health visitor nurses and new parents. The use of these different grammatical forms invoked contrastive social relations between the HV and mother, thus making different kinds of responses relevant. For declarative questions this was mere confirmation whereas y/n interrogatives treated the matters formulated as 'in question' thereby making relevant 'an answer': inviting elaboration and further topical talk (Raymond 2010). Raymond (2010) therefore concludes that the use of declaratives underscores the institutional, impersonal nature of the interaction more than y/n interrogatives (Raymond 2010). Having identified that declarative questions retain interactional distinctions relative to other 'closed' questions, some further core observations from the corpus are next outlined. These relate primarily to turn design, lexical choice and sequence expansion.

5.8.3 Psychiatrists' declarative questions: recurrently so-prefaced

A fundamental assumption in CA is that, in constructing a turn at talk, speakers usually address themselves to preceding talk and, most commonly, the immediately preceding talk (Sacks 1987, 1992; Schegloff and Sacks 1973). On initial examination of the 210 declarative questions, two distinctions were observable in this respect. A small proportion (23) incorporated patients' immediately prior talk, often repeating lexical elements verbatim (See Robinson 2013b, Robinson et al 2010). The remaining questions however, as per Heritage's (2009) earlier assertion, conveyed 'inferences or assumptions' about the patients' prior talk (187). On further examination of the latter, a somewhat homogeneous subgroup became apparent - that of 'so-prefaced' inferences (90). As the largest collective group, these phenomena form our focus here. Similar practices have been shown to have analytical salience in contexts outside of psychiatry (See Johnson (1998) and Beach & Dixon (2001)), further justifying this focus. As per the aforementioned methodology, the preceding observations were started, and expanded from, a single in depth analysis of one case.

Extract 1 displays a collection of 19 questions (21%) from the dataset. Three basic observations will be drawn from these examples and their sequential environments, features

analysed in more depth as the analysis proceeds. The cases shown here were selected as particularly clear examples of the phenomenon and the systematic properties observed.

Extract 1 A collection of so-prefaced declarative questions

a) DOC: .hhh so you are feeling, (0.4) not so well?

b) DOC: so you are quite happy [to] continue with the

Risperidone?

c) DOC: So the:: the the the things that you fi:nd difficult

no:w are your self confi↑dence.

d) DOC: So you feel okay about it?

e) DOC: So: you're quite happy being on your o:::wn?

f) DOC: So ↑that's something that you want to switch off from?

g) DOC: So you got a little bit depressed.

h) DOC: So you're under a lot of pressure at the moment.

i) DOC: So you feel a bit anxious?

j) DOC: So on the whole from a psychiatric point of view (.)

you're very stable,

k) DOC: So I think in terms of ↑what we're doing at the moment

you are quite satisfied?

l) DOC: So but overa::ll (.) you feel better, (.) in yourself.

m) DOC: SO YOU'RE FEELING better in any case.

n) DOC: So you you think you're better off.

- o) DOC: So:: you're not feeling we:ll?
- p) DOC: So ↑these have been helpful?
- q) So you have ↑episo:des when >you feel< really ba::d
- r) So you feel anxious about the amount you're eating
- s) So:::, (.) you're lethargic you're (0.4) just couldn't be
 ↑bothered then to ↑go::: an- (.) ↑do these things?

1) As mentioned, the collection of questions presented in extract 1 are all prefaced by 'so'. This discourse marker constitutes one way of indexing 'inferential or causal connections' (Bolden 2009:974) with prior talk (For alternative pragmatic functions of so, see Bolden 2009). As such, in each case, the psychiatrist frames the ensuing declarative question as closely resulting from, thereby contingent upon, the patients' prior talk (See Bolden 2009, Schiffren 1987). Indeed, what invariably followed was not only a declarative, but a display of understanding of that talk: each of the declaratives in extract 1 constitutes a 'formulation' (Heritage & Watson 1979). As will be shown in subsequent extracts including the patients' prior turns, the psychiatrist appeared to present a summary of these utterances, replacing the patients' wording with their own formulation that captures the 'gist' (See Heritage and Watson 1979, 1980, Antaki 2008, Drew 2003) of the patients' turns. This formulation was typically within a psychiatric frame of relevance (cf Depperman & Fogasy 2011, Beach & Dixon 2001). As evident in extract 1, 8 of the questions refer to the how the patients' 'feels' and all 19 contain reference to some kind of emotional state. In the following section, the psychiatrist will be observed producing a psychological upshot of events that the patient describes (an account or troubles telling), but while presented as something implicit within the patients' prior talk, this process involves editing, deleting and, to some extent transforming (Heritage and Watson 1979) the patient's contribution, consistent with current results of research on formulations in psychotherapy - to which reference will be made as the analysis develops.

2) While formulations may be a generic conversational device, by editing the patients' talk to highlight its psychological implications, they are one resource that psychiatrists can use in their primary task of routinely reviewing the patients' wellbeing and mental state. Distilling (and inviting confirmation of) diagnostically-relevant information from patients' reports, can be one tool for producing intermittent (and sequentially consequential – see point 3) 'psychiatric summaries' - such to the extent that, on occasions, this function i.e. the question being deployed in service of an overall 'psychiatric point of view' was explicitly formulated in the declarative itself (see j, k and l in extract 1).

3) Psychiatrists' use of declarative questions in this corpus had significant impact on the ensuing interaction. As each of the examples in extract 1 contain 'b event information' (the patients' psychological state), that is only properly known by the patient, the psychiatrist creates a slot for the patient to (dis)confirm. The (dis)confirming action made relevant is minimal relative to other yes/no type initiating actions with less shallow epistemic gradients – as described in section 4.3.2. Moreover, by providing a resource to ostensibly display a summary of understanding, declaratives may be one tool psychiatrists can use in sensitively closing down particular trajectories of talk and managing topic transition. The constraining effect on sequence expansion in relation to the patients' prior talk was evident in 4 ways; 1) Patient responses were largely confirming/disconfirming tokens rather than narratives 2) Psychiatrists' rarely expanded beyond the base declarative – answer sequence: third position talk was typically absent or merely a 'sequence- closing third' (Schegloff 2007) e.g. an assessment like 'good' 3) This was followed by a topic or activity shift. 4) Greater use of declarative questions was associated with less patient talk overall in consultations. As such, psychiatrists' so-prefaced declaratives appeared one resource for closing down patients' narratives/troubles tellings - in a manner that simultaneously displays intersubjectivity - and managing the interactional progress of the interaction.

These three features are evident in Extract 2:

Extract 2

01 PAT: >I ↑mean< ↑it's (.) it's ↑↑eight months on and I can still

02 remember it.

03 DOC: °Mm::°

04 PAT: The ↑last thing I wa:nt is for somebody to keep re↑minding

05 me.

06 DOC: °Oka::y° so ↑you you think you're better off.

07 PAT: Yes.

08 DOC: Just looking forward.

09 PAT: Yes.

10 DOC: °°Okay.°°

11 (5.6) ((Doctor writes in notes)

12 DOC: .hhh did you get the ↑job you've ↑bin (.) applying ↑for?

13 PAT: Yes I got the job.

In line 06, the psychiatrist formulates what the patient has said regarding his reluctance to receive counselling for distressing (past) psychotic experiences across lines. He replaces the patient's description with his own psychological summary 'so you you think your better off', bringing the discussion to a close. The question appears to merely recapitulate and display understanding of the patient's words: the 'so' preface indicates the patient should understand the upcoming action as a natural upshot. As Fraser (1999: 50) suggests discourse markers (such as so in question prefaces) can 'signal a relationship between the segment they introduce...and the prior segment'. However, the brevity of this turn relative to the patient's (spanning lines 01-05) indicates that, in the process of formulating, the psychiatrist has deleted parts of his account i.e eight months on/his disinclination to be reminded etc. Moreover, given the patient's prior action was hearable as a complaint - recalling the enduring and undesirable nature of his memories - through editing of its design and terminology an

element of transformation has occurred (Heritage & Watson 1979). The psychiatrist recasts the patient's answer to accord with a more positively framed outlook i.e. that he thinks he is 'better off' (without counselling). This pattern of declarative formulations will be explored further in sections 5.8.4 and 5.8.5 below.

Turning to the sequential aspects of the question: the patient's thoughts constitute 'B event information' (Labov & Fanshell 1977) therefore a relevant slot is created for the patient to confirm/disconfirm. While he provides this in line 07, the psychiatrist increments his question: 'just looking forward' in line 08, specifying his reference. By recompleting his question, he sequentially deletes (Ford et al 2002) the patient's answer: renewing its relevance in line 09, where the patient again responds 'yes'. Notice that the declarative question was originally produced with a turn-initial 'okay'. These actions can be used as 'pre-closing' devices (Schegloff and Sacks 1973, Beach 1993, 1995) deployed to acknowledge, yet enforce closure on patients' immediately prior elaborations (Beach & Dixon 2001). Indeed, following this confirmation in line 09, produced with terminal intonation, the psychiatrist hearably orients to topical closure. He does not expand the sequence in the third position (Schegloff 2007) by projecting further related talk, rather deploys the receipt token 'okay' – which can be used to mark an upcoming change of activity (Gardner 2001). Accordingly, a change is forthcoming: following a pause in which the psychiatrist writes in his notes (presumably a 'summary' of their discussion), we see a marked shift in topic in line 12: the psychiatrist inquires about the patient's prospective job application. This pattern of sequence closure i.e. so-prefaced declaratives occurring at topical junctures, is explored further in section 5.8.6.

5.8.4 Making psychological inferences: So- prefaced declaratives as formulations of patients' talk

In extract 2, the psychiatrist produced a formulation of the patient's prior turns at talk. Garfinkel and Sacks (1970) first identified this interactional phenomena:

'a member may treat some part of the conversation as an occasion to describe that conversation, to explain it, or characterise it or explicate, or translate, or summarise or furnish the gist of it.....that is to say, a member may use some part of the conversation as an occasion to **formulate** the conversation'. (1970:350)

Formulations have been a prominent theme in recent conversation analytic research on psychotherapy. Typically, through this resource, speakers can offer their interpretations (Drew 2003), candidate understandings (Schegloff 1996) or candidate representations (Hutchby 2005) of that which can be taken as having been inferred in previous talk by their interlocuter. This line of inquiry was initially developed in two seminal papers by Heritage and Watson (1979, 1980), in which they characterised some systematic properties of formulations. Here, the focus is on a central aspect, readily detectable in the present dataset;

'Displays of understanding can be achieved by producing a transformation or paraphrase of some prior utterance. Such paraphrases preserve relevant features of a prior utterance while also recasting them. They thus manifest three central properties: preservation, deletion and transformation' (Heritage and Watson 1979:129).

Extracts 3, 4 and 5 demonstrate how such a pattern was indeed manifest in this corpus of so-prefaced declarative questions. In each extract, the psychiatrist formulates the patients' account, replacing it with their own version of the patients' words. Specifically, a summary that displays sensitivity to the psychological implications of the events described (see also Depperman & Fogasy 2011, Beach & Dixon 2001). In doing so, the psychiatrist edits and deletes parts of the patients' prior utterances, transforming the report within a 'psychiatric' frame of relevance. These declaratives thereby repeatedly display the 'fitting of differently focused, but related talk to some last utterance in the topic's development' (Schegloff & Sacks 1973: 305). Extract 3 below displays this in relation to how the patient feels about spending time by himself.

Extract 3

01 PAT: ↑Yeah I like to chill out in the 'ou::se doctor [you]
02 know=
03 DOC: [°Mm°]
04 PAT: =I watch telly::: and (.) cook something and (0.4) then
05 m- washing and (0.4) tidy the 'ouse up you know.
06 DOC: ↑Yeah.

07 (3.4) ((Doctor writes in notes))

08 DOC: So: you're quite happy being on your o:::wn?

09 PAT: I'm quite happy doctor yea:h yea:h.

In line 08 the psychiatrist deploys a so-prefaced declarative to condense a larger stretch of the topical talk in which the patient describes his daily homelife: activities engaged in when not spending time with his friends. After receipting the description in line 06 and subsequently engaging in notewriting (line 07), the psychiatrist offers a formulation of the patient's experience 'so you're quite happy being on your own'. This provides the opportunity to intersubjectively ground (Clark & Schaefer 1989) the doctor's conclusion (presumably a version of which is being written in the notes, preceding its deployment) by establishing the conditional relevance (Schegloff 1972) for a confirmation from the patient – which he provides (I'm quite happy doctor yeah yeah).

The psychiatrist's formulation is presented as a mere summary: 'you're quite happy being on your own' being 'something implicitly meant by the client' (Bercelli 2008). However, in the process of its production, the psychiatrist has the opportunity to discard irrelevant material: here the information of mundane activities (watching television, cooking and tidying etc) and shape that which remains in a more 'overall' emotional framework that the patient is 'happy being on his own'. Antaki (2008) asserts such displays of understanding in psychotherapy show 'ostensible cooperation': they appear to be replaying a summarised version of the patient's prior utterances, but in doing so have 'deleted some material, selected what suits the interests at hand, and edited its design and terminology' (2008:30). This is also observable in extract 4 below.

Extract 4

01 PAT: Yeah quite bad yeah.

02 (.)

03 PAT: I don't like going anywhere on my own really and that now

04 .hhh my mum's been taking me a lot of places and that.
05 (0.6)
06 PAT: In the car.
07 (0.4)
08 PAT: cos I get paranoid when I'm on the bus and everything and
09 I think other people are after me an' that.
10 (0.6)
11 DOC: .hhh so you are feeling (0.4) not so well?
12 PAT: No:::

Unlike extract 3, the patient's narrative that precedes the psychiatrist's question (line 09) is hearable as a troubles telling (Jefferson 1988). The patient claims his paranoid thoughts of late (the topic of a prior line of questioning) have been 'quite bad', proceeding to provide evidential grounds for this assessment in lines 01-09 - a reliance on his mum to take him places and feeling paranoid when on the bus. The psychiatrist passes up the opportunity to receipt or respond in lines 02, 05 and 07: the latter silence follows an increment 'in the car' (Ford et al 2002) that Schegloff (2000) noted - when initiated post-gap - can be seen to address 'the absence so far of ensuing talk' in pursuit of a response. This occasions the patient's continuation in line 08 'cos I get paranoid....' that serves to *account* for his disinclination to go out and his dependence on his mother by reference to a delusion. He designs this account with generalised tense 'I get' and 'I think' rather than, for example, using a modal formulation 'I *can* get/think' or quantifying the occurrence '*sometimes* I get/think' thereby projecting his certainty over these feelings (He, 1993, Pomerantz 1986).

Like the prior examples, in line 11 the psychiatrist formulates what the patient has said. While he displays a candidate understanding and evaluation 'so you are feeling not so well', he simultaneously distils, and thereby deletes, the relatively extensive material provided by the patient into an overall general sense or 'gist' (Heritage and Watson 1979) of the patient's

wellbeing. By summarising the patient's description in a *general* framework, this enables the psychiatrist to 'label' (Johnson 2002:105) the patient's narrative - in so far as how the patient is 'feeling' overall - and reduces the *individual* significance (thereby need to address) of specific elements of the patient's account. This may be particularly pertinent when discussing delusions, like those the patient concedes to in lines 08 and 09. By displaying, and inviting confirmation of, how the patient may 'feel' on account his description, it may allow the psychiatrist to be sensitive to the implications of the experience, while maintaining a clinically desirable attitude of non-collusion (Turkington et al 1998) with aspects of its *content* - e.g. here that 'people are after' the patient. Moreover, this arguably makes transition onto the next activity (including possible resolution of the problem), an easier subsequent interactional move. A similar orientation is evident in extract 5.

Extract 5

01 PAT: E:::::r, ↑i:t's just that (0.4) someti:me in the afternoon I
02 get (0.6) like, (.) you know I get the feeling that (.) i:t's
03 (0.6) going to happen to me:::
04 (.)
05 PAT: I will end up in the hospital.
06 (0.2)
07 DOC: Okay.
08 PAT: A::::nd er
09 DOC: So you feel a bit anxious?
10 PAT: Um yea:::h

Here, the patient's narrative, also hearable as a troubles telling, asserts concern regarding his recent mood, concern of relapse and associated return to hospital. The psychiatrist receipts

the account in line 07 'okay' and, while the patient produces an incomplete TCU in line 08 'and er', the psychiatrist takes the next turn as an opportunity to formulate the talk so far. Indexing the inferential connection between the prior talk and his upcoming action with a recognisable 'so' preface, he invites confirmation of his understanding of the emotional upshot of the patient's account 'you feel a bit anxious'. In doing so, he preserves the 'feeling' the patient describes in line 2, whilst simultaneously deleting the finer details of the account surrounding its circumstance e.g. that the patient will end up in hospital, the feeling occurs in the afternoon.

At the same time, an element of transformation occurs: the psychiatrist specifies the 'feeling that it is going to happen to me (.) I will end up in hospital' as feeling a 'bit anxious' (line 8), thereby recasting the information in more recognisably 'psychiatric' terminology. In this way the psychiatrist, like extract 4, is able to evaluate, summarise and label (Johnson 2002) the patient's more extensive talk. This provides the opportunity to intersubjectively ground (Clark & Schaefer 1989) the psychiatrist's understanding of patient's topical talk, but may also assist in transforming the account 'according to institutional relevancies' (Depperman & Fogasy 2011:117). The psychiatrist's (institutional) tasks may be supported by a device that allows for selective formulation of the relevant outcomes of patient's answers. This notion is hence considered further.

5.8.5 What can so-prefaced declarative questions do institutionally?

Psychiatrists' declarative questions have been observed as recurrently constituting so-prefaced formulations of the patients' prior talk, highlighting its relevance from a psychological perspective. In each of these cases, declarative formulations were used to make emotional/psychological states of the patient explicit (being happy/not feeling well/being anxious). In doing so they may function, and be hearable as, displays of understanding (Depperman & Fogasy 2011) empathy (Ruusuvuori 2005, 2007) and active listening (Hutchby 2005). In this - and the subsequent - section however, an emergent theme in extracts 1-5 is expanded upon: how they may simultaneously promote psychiatric interests.

In Chapter 3, institutional interaction was described as distinct from ordinary conversation due to the tasks, constraints and goal orientations tied to 'institutional- relevant' (psychiatrist-

patient) identities that have implications for various features of interaction. Formulations present an interesting phenomenon to consider in this respect. While, as Heritage and Watson (1979) assert 'the uses of formulations are multiplex...they may be used to address an immense variety of matters, these matters being, in their most specific terms, heavily embedded in the specific stretches of talk in which they occur' (1979: 128), there may be particulars to formulations that make them a conducive resource for institutional settings, such as a psychiatry.

Indeed, examples of formulations appear most likely to be found in institutional settings. In Heritage and Watson's papers (1979, 1980) none came from ordinary conversation, rather from crisis intervention calls, a medical social worker consultations and broadcast news interviews, such that they note 'formulating is relatively rare in conversation' (Heritage 1985:100). Furthermore, Drew (2003) reports that formulations are relatively infrequent in mundane conversation, indicative of them doing some institutional job. In a comparative analysis of formulations in institutional settings, Drew (2003) found the same phenomena to be associated with different core activities in each setting. For example, in a radio-talk show, a formulation may be used by the host to propose a tendentious reading of what the caller has said, prompting them to argue or assert their case. Conversely, when used by news interviewers, it may be a neutral alternative to an 'oh' news receipt, thus serving the need to project impartiality while clarifying issues for the viewing audience. In industrial negotiations however, though ostensibly reporting the other's position, a formulation might also manipulate it to one side's own advantage. As such, Drew (2003) concludes: 'if formulating is a generic practice, the devices or objects through which it is realised are shaped by the activities and thus the settings in which they are employed' (2003:261). Antaki (2008) asserts that the common thread tying these together is that the institutional agent's formulation plucks out something in the other's words and, while presenting it as a mere neutral summary or implication, uses the opportunity to edit it in ways that will help the speaker's own institutional interests.

As addressed in Chapter 3, a typical outpatient encounter involves the psychiatrist reviewing the patient's mental state, drugs and associated side effects, daytime activities (for example, attendance at a day facility, work, training), social activities, living arrangements, finances,

and contact with other mental health professionals. This information is diagnostically-relevant in relation to assessment of symptom severity (a diagnosis of schizophrenia/schizoaffective disorder has already been ascribed) and resulting decisions regarding appropriate medication e.g. dosage changes of antipsychotics. The interval between consultations varies, though in this data was on average 3 months. The psychiatrist must therefore gain an overall impression of the patients' current and retrospective health status during the intermittent period, in order to assess wellbeing and tailor care. The psychiatrist must solicit and record a summary of this information in the form of handwritten or electronic notes. It is proposed here that so- prefaced declaratives may be one interactional resource 1) that can be used in service of this 'psychiatric summarising' and 2) that can manage sequence closure, thereby the agenda and progress of the interaction.

As observed in fragments 2-5, formulating the patients' talk involved deleting and editing its design and terminology to distil its central 'theme', frequently in terms of its psychiatric implications e.g. emotional state, overall wellbeing. In extracts 2 and 3, this was closely situated to moments in which the psychiatrist engaged in note writing – a pattern which occurred in 30 cases. While such non-verbal features have not been examined in depth here (though we note doing so may have analytically salient implications in medical interaction – See Heath 1986), this provides an indicator of psychiatrists' communication being shaped by such tasks. However, clues of 'psychiatric summarising' were also present in the design of so-prefaced declaratives themselves, such that, as in examples 6 and 7 below, this function could be explicitly formulated in the question itself.

Extract 6

- 01 DOC: So on the whole from a psychiatric point of view (.)
- 02 you're very stable,
- 03 PAT: Yes for the mome::nt.

Extract 7

- 01 DOC: So I think in terms of ↑what we're doing at the moment you
02 are quite satisfied?
03 PAT: ↑Yes ↑yes.

In the declarative questions highlighted, the psychiatrist produces, and attempts to solicit agreement, of an upshot by first qualifying that the formulations, in which the patient is the central figure (you're/you), are not verbatim, but a consequence of the sense the psychiatrist has made of the patients' prior talk. Specifically, 'in terms of what we're doing at the moment' (extract 7 line 1) i.e. 'from a psychiatric point of view' (extract 6 line 1). As such, the psychiatrist narrows the frame of relevance for the formulation that follows: extract: 6 'you're very stable' and extract 7: 'you're quite satisfied' are presented as contingent on these terms of reference, the emphasis being psychiatric interpretation - a summary of wellbeing using the medical terminology ('stable') and overall patient satisfaction with treatment. In doing so, the psychiatrist asserts justification for the editing and deleting of the patients' prior talk by explicitly formulating that the communication and its frame of relevance is being shaped by the activities and setting (See Drew 2003) in which they are engaged. As one resource psychiatrists can use to produce 'psychiatric summaries' of preceding talk, declarative questions may further be suited to the closing down and managing of topical trajectories. As such, the sequential aspects of this corpus and the impact on the ensuing interaction are next examined.

5.8.6 Psychiatrists' declarative questions, patient responses and sequence constraint

Having identified distinctive elements of turn design and lexical choice, it seems appropriate to return to an issue addressed earlier regarding the sequential aspects of declaratives: 'the 'knowing' Y/N declarative form merely invites confirmation of known information by the recipient, who is projected as an authoritative source' (Heritage 2009:10). Though formulations in this corpus appear contingent on client's prior turns, they are also questions: first pair parts (yes/no initiating actions (Raymond 2010)) of a specific sequence. In, relation

to formulations specifically Heritage and Watson (1979) termed this the formulation-decision sequence. The clinician formulates some aspects of the clients previous answer/s and the client confirms, disconfirms or corrects the formulation – regularly attaching yes/no or equivalent responses such as uh-huh or nu –huh (Schegloff 2007).

A consistent theme in CA research on both declarative questions and formulations in medical/psychotherapy communication is that of sequence constraint. This refers to both expanse of the 2nd pair part (dis)confirmation and third position post-expansion by clinicians (i.e. talk by a first speaker that deals with a second position response (Schegloff 2007: 115-62)). In a study including formulations in psychotherapy setting, Bercelli (2008) noted clients' confirming decisions generally consist of a minimal confirming token (such as yes or hm, with falling intonation) and are not post-expanded, or only minimally post-expanded by therapists. In a similar vein, Beach & Dixon (2001) examined how formulations were used to organise patients' talk by closing down narratives/troubles tellings – the formulations (declaratives) initiated a three-part cycle 1) interviewers' formulated understandings 2) patients' confirmations 3) topic shift by the interviewer – accordant with extract 2. Similarly, the aforementioned study by Raymond (2010), compared the sequence constraining effect of declaratives, compared to that of yes/no interrogatives: 'The different actions made relevant by yes/no declaratives and yes/no interrogatives are reflected in the forms that responses to them typically take and in the ways that sequences initiated by them come to be expanded or not' Raymond (2010:95). In his corpus, sequences initiated by yes/no interrogatives (treating the matter as 'in question' – see Figure 4) were regularly expanded past the minimal base sequence, coming to involve talk in the third position. Such expansions can be minimal e.g. a 'sequence-closing third' (Schegloff 2007) or they can project additional talk e.g. a follow up question. By contrast, yes/no declaratives effectively constrain sequence expansion: the constraints set in motion by this question type (that assert the matter as 'known') can be satisfied by mere confirmation, typically involving no third position expansions, or minimal sequence-closing thirds e.g. assessments.

Against this background, the effects of declarative questions on sequential expansion in the current dataset are examined here. Table 15 displays the distribution of patient responses and

third position talk (beyond that of a ‘sequence-closing third’ (Schegloff 2007)) from the psychiatrist. We can see that declarative formulations were designed largely with positive polarity, preferring ‘confirming responses’, consistent with Heritage and Watson’s observation of the ‘sequential power’ of formulations– their projection of agreement (Heritage & Watson 1979) - that patients have to actively provide, as in extract 7, or combat in the next turn as in extract 8.

Extract 8

01 DOC: SO YOU'RE FEELING better in any case.

02 PAT: Well I feel a lot better than I did two weeks ago two or

03 three weeks ago ↑e::r

Here, we see the patient commence his response with a turn- initial ‘well’. This can act as a marker for a forthcoming non ‘straight forward’ response (Schegloff & Lerner 2009). Indeed, instead of delivering the simple confirmation/disconfirmation that is projected as relevant, the patient resists the terms of the question (See Stivers 2010), specifying that he feels better than he did ‘two weeks ago’, thus narrowing the scope of *what* he is confirming with additional elaboration. ‘Nonconforming’ i.e. narrative responses, like we see here, are the most frequent sequence-specific method for managing misalignment between speakers regarding the particular choice posed by a y/n question (Raymond 2006).

Table 15. Responses to so-prefaced declaratives and 3rd position psychiatrist expansion

	Confirming/disconfirming response	Narrative	Third position expansion by psychiatrist
All questions	49	19	11
Positive questions	41	14	9
Negative questions	8	5	2

As can be seen in Table 15, only 19 patients within the corpus resisted the constraints of the question by producing a nonconforming narrative response (See Raymond 2006). The majority produced confirming responses (e.g yeah, mm) consistent with the identified

preference for type-conformity (Raymond 2003). In terms of psychiatrist expansion past the minimal base declarative–confirmation sequence, only in 11 instances did psychiatrists produce a turn in the third position that projected additional talk. As we see in extract 9:

Extract 9

01 DOC: So yo- you're feeling a bit low at the moment?

02 PAT: Yeah.

03 DOC: Can you explain ho::w,

Here, the psychiatrist’s interrogative in line 3 deals with a second position response (Schegloff 2007) in line 02: the patient’s confirmation of feeling low. As such, the psychiatrist projects further elaboration (an account to ‘how’ the patient feels low) as relevant by shifting to display a less ‘knowing’ (K-) stance. In the remaining cases, psychiatrists followed patient answers with a shift in activity, sometimes prefaced by the token ‘okay’ signalling this as upcoming, or brief assessments i.e. sequence – closing thirds (Schegloff 2007).

5.8.7 Is sequence constraint associated with amount of patient talk?

While psychiatrists’ declarative questions in this corpus were responsive to patients’ prior utterances and displayed sensitivity to the psychological aspects of their accounts, they were simultaneously sequence constraining as opposed to expansive. This prompted the hypothesis that, using more ‘sequence closing’ devices in consultations to manage the interactional progress of the session may have a bearing on patients’ contributions overall. Using Pearson’s correlation to preliminarily explore this conjecture, the bivariate association between psychiatrists’ declarative questions and amount of patient talk (words per consultation from verbatim transcripts) within each encounter was examined.

Table 16. Correlation with amount of patient talk

	Psychiatrists’ declarative questions	
	<i>R</i>	<i>P</i>
Patient words	-.219*	.013

* Correlation is significant at the p <.05 level

Indeed, as we can see in Table 16, a statistically significant negative correlation is evident: the more declarative questions psychiatrists asked, the less words patients said in consultations. Having outlined some core observations of psychiatrists' questions in this corpus, we turn to discussing the findings from part 1 and 2 collectively.

5.9 Discussion

5.9.1 Summary of findings

By developing a standardised protocol to classify questions in outpatient consultations, a small subset were identified as frequently deployed by psychiatrists: 1) Yes/no questions (the prevalence of which is consistent with findings in general medicine e.g Roter and Hall (1991)) 2) Wh questions 3) Declarative questions 4) Tag questions. Moreover, psychiatrists' selection between these alternatives could be related to patient outcomes. Greater use of declarative questions by psychiatrists (one class of 'closed question' in more generalised terms) was associated with better patient adherence and more favourable clinician perceptions of the therapeutic relationship.

Examining these phenomena qualitatively revealed declaratives were recurrently so-prefaced formulations of patients' prior talk. Through the shallow epistemic gradient they created between clinician and patient and features of turn design, declaratives could be used to convey a distinct relationship to patients' prior utterances. Not least, so-prefacing framed the question as contingent on (and inferentially connected to) patients' prior talk (narratives or troubles tellings) and psychiatrists' lexical choices displayed sensitivity to its emotional implications by making implicit psychological meanings explicit: often specifying how the patient must 'feel' on account of the events they described. While displaying a degree of understanding and the opportunity for the patient to confirm (thereby intersubjectively ground) the psychiatrists' summaries, the process of their production involved simultaneously deleting and editing the patients' contribution, so as to recast it in a more psychiatric frame of relevance. For example, 'thematizing' the patient's answers within a general framework in relation to an 'overall' emotional state, condition or sense of wellbeing. By providing a resource to ostensibly display a summary of understanding, declaratives also constitute one

tool psychiatrists can use in sensitively closing down particular trajectories of talk and managing topic transition. The constraining effect on sequence expansion in relation to the patients' prior talk was evident in 4 ways; the minimal responses made relevant by declaratives; absence of third position post-expansion from psychiatrists; subsequent topic/activity shift; and correlation between more declaratives and less patient talk overall. As such, so-prefaced declaratives may retain an important narrative sequencing function (see also Johnson 2002) and be useful to the psychiatrist in maintaining control of topic movement and ensuring the relevance of psychiatric goals e.g. producing reports of the patient's overall mental state and wellbeing – such that this function was sometimes explicitly formulated in the question. As outlined throughout part 2, the analysis here is largely in accordance with research on declarative questions and formulation sequences (e.g. Heritage & Watson 1979, Drew 2003, Antaki 2008, Depperman & Fogasy 2011, Beach & Dixon 2001).

5.9.2 Clinical implications – explaining the relationship between declaratives, the therapeutic relationship and adherence

There are a number of clinical implications and possibilities for how one might at least speculate on the statistical relationship between declarative questions, the therapeutic relationship and adherence. Collectively, the findings strongly suggest a more granular classification than 'closed' vs 'open' questions is necessary to inform understanding of best questioning practices in psychiatry. Firstly, declaratives were the *only* class of closed question to be associated with better adherence. Secondly, when examined qualitatively, they are more complex interactional objects than the conventional binary definition (open = good, closed=bad) implies due to their relationship with the patients' prior turns and the projected relevance of next actions. Psychiatry and medical textbooks discourage declaratives, classifying them as 'leading' closed questions (Burton 2010) with inherently negative connotations. Conversely, this research lays out the prospect that training clinicians to in fact ask more declarative questions, like so-prefaced formulations of patients' talk, may be one method of displaying understanding and *improving* the therapeutic relationship and subsequent adherence. This hypothesis aligns with the findings and conceptual framework outlined in the systematic review (and by the various included studies) that perceptions of the therapeutic relationship, mediated through talk, are linked to adherence.

Alternatively, given this particular pathway of causality cannot be confirmed within the scope of a correlational study, an equally interesting alternative is the polar directionality. Through this lens, declarative questions, like NTRIs in Chapter 4, represent one possible communicative index for how positive alliances and/or adherence are *manifest* in interaction i.e. ‘a rich region of interaction in which to study the constitution of relationships and intersubjectivity’ (Robinson 2006: 156). It may be easier for psychiatrists to achieve, display and invite confirmation of their ‘understandings’ (through declarative questions) with patients who are more adherent and engaged with treatment in the first place (and more likely to make bids to maintain intersubjectivity in the interaction i.e initiate repair – see the prior chapter). Recognising candidate interactional ‘markers’ of good relationships, like NTRIs and declarative questions, within naturally occurring communication may be one of the first steps for developing interventions to promote adherence.

Declaratives may also be one useful tool for clinicians on a more practical level: aiding in distilling and recording psychiatric summaries and managing the interactional progress of the session. The corpus examined here display formulations as a means to transform patients’, often detailed and multifaceted, accounts according to psychiatric relevancies. In particular, sensitivity to the main emotional theme underpinning their descriptions was observed, thus conceptualising the situation talked about in a ‘certain way’ (cf. Heritage and Watson 1979; Drew 2003; Antaki 2008). The capacity of formulations to achieve this may offer pragmatic applications in the treatment of schizophrenia. Discussion of psychotic symptoms for example – like those described by the patient in extract 3 - are often the source of interactional tension in psychiatric outpatient consultations (McCabe et al 2002): it can be problematic to establish a shared understanding of two differing versions of ‘reality’. The clinician must walk a ‘tightrope’: ‘asking questions of an appropriate depth and pace while maintaining an attitude of non-confrontation and non-collusion’ (Turkington et al 1998:237). Declarative formulations, when used to display candidate understandings of how the patient may ‘feel’ on account of these experiences, could be one resource to display sensitivity to, and establish a shared understanding of, the emotional implications while avoiding collusion or direct confrontation with the *content* of particulars of that account.

However, while on the one hand these questions are responsive, displaying the psychiatrist as working closely with the patients' talk in the ways outlined, they simultaneously edit and delete patients' contributions and can ultimately confine their topical development. So-prefaced declaratives were often in response to narratives/troubles tellings and by displaying a 'knowing stance' made relevant minimal responses, to which psychiatrists rarely expanded by projecting additional talk as relevant in the third position. Thus, like other devices identified in CA (See Drew & Holt 1998) they often occurred in topic transition sequences, in a turn where a topic is summarised thereby initiating the closing of that topic (Drew & Holt 1998). In doing so, they created relevant junctures at which psychiatrists could shift to the next topic of the next pending agenda item. As they can do this in 'responsive' and psychologically sensitive way, perhaps such actions 'detoxify' topic shift, therefore minimizing the likelihood that movement forward in the interview can be framed as a doctor's heavy-handed pursuit of a medical 'agenda' removed from the patient's concerns' (Beach & Dixon 2001: 29) Nonetheless, they appeared to represent close control of that agenda - and indeed appeared to limit patient involvement (in terms amount of actual talk) overall. As Raymond (2010) asserts declaratives may index a more institutional approach to communication than other forms of questions (Raymond 2010). Thus, while on the one hand the declaratives examined here displayed understanding and assimilation of patients' accounts, sequentially they can be conceived as departing, in some respects, from the open and non-directive ideal (Lawn 2007) of 'patient-centred' interaction. As was concluded in Chapter 4 in relation to NTRIs, this suggests widely endorsed conceptions of 'good' communication in relation to adherence (outlined in Chapter 1) may be too abstract to map directly onto actual interaction that is more nuanced when examined on a micro-level.

5.9.3 Limitations

While this exploratory research presents some interesting possibilities, the findings should be considered within the context of the study's limitations. Firstly, two contrasting approaches to question classification were combined in the same study: part 1 coded questions by form (largely syntax) and part 2 analysed declaratives from a conversation analytic perspective. As earlier addressed, from the standpoint of CA, what linguistically defines questions as questions, does not define them as interactional objects: a question without the linguistic

form of a question may still accomplish questioning and the form of a question can be used for actions other than questioning (Schegloff 1984). If there is no exact one-to-one correspondence between form and action, to define an analytic focus (declarative questions) by one definition and proceed to analyse that group by another could appear somewhat incompatible and insensitive. Utterances doing the same actions (though in linguistically different forms) as those identified in part 2 of the study may have been excluded. However, given that a statistical link with adherence was identified in addition to systematic patterns among a large proportion of this grouping, suggests there may indeed be some meaningful value in initially grouping questions by linguistic type. Moreover, triangulating findings in a qualitative analysis, serves to retrospectively counteract some of the limitations of applying pre-defined codes outlined in chapter 3.

Secondly, there are various issues around what constitutes a declarative question specifically. For consistency, declaratives understood as questions or designed as such: denoted by a '?' in the transcript, were coded. However, Crystal (1969:283) for example claimed that it could be misleading to think in terms of typical interrogative intonation patterns when classifying questions (cf. Halliday 1970: 22-23), rather each sentence has instead a 'most likely' intonation. Declaratives by other definitions may have been omitted that could have impacted our analysis and findings. Relatedly, the qualitative analysis consisted only of 'so-prefaced' declaratives, the largest collective group within those identified. Alternative categories of declarative questions (e.g. psychiatrist other initiation of repair) were not examined. While arguably a sufficient focus for the purposes of an exploratory study, these types may also have been contributing to the correlation with adherence, therefore the explanatory potential is only partial.

Thirdly, the inferences that can be made regarding the effect of psychiatrists' use of declarative questions on adherence/therapeutic relationship are constrained by the statistical methods used here: correlation cannot determine directional causality. While in a follow up study (Thompson et 2013 in preparation) a main effect of declarative questions on adherence/psychiatrist perceptions of the therapeutic relationship - even when adjusting for symptoms and psychiatrist ID - was found, the possibility remains that patients were more adherent independent of the communication. Thus, the communication itself (and displays of

intersubjectivity like declarative formulations) may reflect an already engaged patient and existing positive therapeutic relationship (from the clinicians' perspective at least). Furthermore, patient-ratings of the relationship are not available to help contextualise the findings further.

Fourthly, while psychiatrists so-prefaced declaratives have been given significant attention in terms of their interactional function e.g. displaying understanding and sequence constraint, less emphasis has been placed on examining the actions that patients were engaged in prior to their deployment. To systematically focus on this in future research may prove valuable.

5.9.4 Thesis implications

In accordance with the thesis aims, this Chapter has identified a specific communication practice, declarative questioning, as associated with better patient adherence and the therapeutic relationship. Analysing this practice on micro-level, combined with findings in Chapter 4, has further enabled observation of psychiatric practice 'in action': from psychiatrists' pursuing a response on clinically specified terms (Chapter 4) or systematically editing and recasting patients' talk to confirm an underpinning psychiatrically relevant theme.

Declarative questions and NTRIs, while associated with adherence, can be construed, in certain respects, as departing from what might normally be associated with 'ideal' communication, at least in policy terms (Burton 2010, NICE 2009). The former constitutes a type of 'closed' question that may constrain the degree to which patients' topical talk comes to be expanded and NTRI sequences represent practices used to address misunderstanding: here often found to flag sequential sources of trouble and misalignment between speakers. The implications in relation to common held, abstract, assumptions about 'good' communication will hence be a core theme in the overarching discussion of this thesis. Not least, linguistically grouping questions as 'closed' (and accordingly discouraging their use in practice), may not fully capture their potential.

Indeed, the uses of declaratives are 'multiplex' (Heritage & Watson 1979: 128) and these questions may be employed to address a large variety of matters. Similarly for NTRIs, *any* utterance can be targeted as a candidate repairable (Schegloff 2007). In this respect they are generic practices, albeit, in the case of declaratives, with important institutional functions. In

the following chapter therefore, it is appropriate to shift to a more specific site of interaction that is central to the remit thesis. Clinician-patient agreement about treatment is often cited as the precursor to adherence (Martin et 2005). To acquire a fuller picture of communication and adherence in schizophrenia, the following chapter examines treatment decisions themselves - without which 'adherent' behaviour is not applicable in the first place.

Chapter 6

Formulating treatment decisions in schizophrenia

Chapter abstract

Background

In Chapters 4 and 5 two practices associated with better treatment adherence were analysed: other-initiated repair and declarative questions. However, adherence cannot be considered without exploring its necessary pre-condition: the formation of a treatment decision itself. Consultations for patients with chronic mental health conditions are increasingly conceived as ‘meetings of experts’: medical and experiential, respectively. Treatment decisions, in these terms, become a joint responsibility rather than handed down *ex-cathedra*. One resource for constituting decisions as ‘shared’ is the treatment recommendation itself: decisional authority can be invoked to various extents through its design. Historically defined as ‘unilateral directives’ (Byrne & Long 1976), under the ideals of ‘Shared Decision Making’, recommendations should account for patients’ decisional responsibility, afforded through shared expertise. The methods psychiatrists *actually* use in practice, and their interactional consequences, remain undefined.

Aims & method

A coding protocol was developed to classify alternative action formulations (pronouncements, suggestions, proposals and offers) and patient responses from 250 outpatient consultations. In Part 1, descriptive and qualitative data was combined to yield an overview of decision-making practices and patient responses. In Part 2, conversation analysis was used to contextualise the findings. Through an analysis of 96 alternative action formulations this chapter maps 1) the range of practices psychiatrists use to initiate decisions about treatment (new and dosage change) 2) the systematic resources through which decisional responsibility is projected 3) the consequentiality of alternative formulations for patient uptake in the next turn, with a focus on overt resistance

Findings

Psychiatrists predominantly oriented to decisions as optional: frequently designing their recommendations as proposals and suggestions. Alternative action formulations could be conceptualised in terms of decisional accountability: accomplished, in part, by the deployment of personal pronouns. First person (I and we) and 2nd person (you) pronouns were routinely used between formulation classes to foreground patient preference (offers – ‘you’ formulations), psychiatrist endorsement (suggestions – ‘I’ formulations) or the clinician-patient partnership (proposals – ‘we’ formulations). Patients’ overt resistance was more frequent in response to formulations characterised by *less* psychiatrist responsibility: proposals and offers. Examining the nature this resistance, patients not only opposed proposed/offered treatment, but decisional responsibility itself. Two practices were detected indexing alternate orientations to the constitution of ‘expertise’ in the encounter. Most frequently patients oriented to their *own* expertise: resisting proposed treatment (often ‘directly’) with accounts of side effects. By formulating internal sensory experiences within their epistemic domain (often in ‘extreme’ constructions (cf Pomerantz 1986) induced by *external* stimuli, patients invoked an *inability*, rather than unwillingness, to comply. Where this type of resistance was present, medication frequently remained un-prescribed. In a smaller set of cases, patients oriented to the *psychiatrists’* expertise: postponing acceptance in service of *countering* decisional responsibility. This occasioned psychiatrist reformulation to instead *recommend* treatment, in accord with the patient’s preference – subsequently receiving acceptance. Where this type of resistance was observed, medications were prescribed. Expanding research beyond ‘recommending’ per se reveals the nuances and contingencies involved with psychiatric treatment: these are collectively discussed in relation to patient adherence.

6.1 Background and rationale

6.1.2 The ideal of shared decision making

Two resources in clinical encounters were described in Chapters 4 and 5: patient other-initiated repair and psychiatrists' declarative questions. These represent generic practices of talk-in-interaction that, by some mechanism – speculated upon – are associated with better patient adherence in schizophrenia. However, consideration of such interactional factors is fragmentary without also addressing the pre-requisite for relevant adherence behaviour – the formation of a treatment decision itself. Enhanced involvement of patients in decision-making is increasingly advocated in mental health, a benefit of which is postulated as improved treatment adherence (Duncan et al 2010). Addressed in Chapter 1, this practice has become labelled 'Shared Decision Making' (SDM), a process in which patient and clinician share information, preferences and build a treatment consensus (Charles et al 1997). It is considered integral to a model of wholly patient-centred (PC) medicine/communication, aligning with the earlier provided definition – 'helping patients to share power and responsibility' (Epstein et al 2005: 1517). While borne out of general medicine, the trend has been paralleled in mental health treatment and schizophrenia specifically, reflected in the latest guidelines:

'For people with newly diagnosed schizophrenia, offer oral antipsychotic medication. Provide information and discuss the benefits and side-effect profile of each drug with the service user. **The choice of drug should be made by the service user and the healthcare professional together**, considering [factors such as] the relative potential of individual antipsychotic drugs to cause....side effects (NICE 2009: 17)

6.1.2 Choice & responsibility for the expert patient

The recommendation of a partnership approach to decision-making accommodates patient choice and decisional responsibility. Indeed, particulars to antipsychotic medications e.g. evidence regarding overestimation of efficacy, underestimation of toxicity and alternative treatment options (Morrison et al 2012) suggest that regimens should be conceived via preference-sensitive decisions. An SDM model recognises that patients with schizophrenia have a relevant contribution garnered from first-hand experience of their illness and the subjective effects of, sometimes multiple, treatments. The NHS 'expert initiative' (DOH 2001) is premised on this notion – patients living with chronic conditions are often best

equipped to know their management needs and expectedly 'are willing to share responsibility on treatment' (ibid). In these terms, the consultation is framed as a meeting of experts, a conceptual departure from the expert doctor - passive patient characteristic of traditional paternalism (Chapter 1). So what does this mean for psychiatric practice?

Psychiatry developed somewhat separately to general medicine (Ramon 1985) and, through prolific use of psychopharmacology, has struggled to detach its image from one of an agent of social control (Rogers et al 1998). SDM can thus be construed as a marker for psychiatrists concerned to present their profession as a legitimate speciality, aligned with its medical counterparts (Quirk et al 2012:2). While patients with severe mental illness generally express a desire for more participation in decisions about psychiatric care (Jared et al 2007), there may be circumstances, exclusive to this setting, that problematise the realisation of this ideal. Concerns about SDM's feasibility for schizophrenia specifically have been raised. For example, in relation to patients' ability to rationally evaluate treatment options, distrust in people when they are experiencing paranoia, possible attention deficits (Hamaan et al 2006), or how a participatory approach can be adopted with an inpatient treated against their will. Moreover, Chapter 2 (a systematic review) displayed that current evidence on SDM and adherence is sparse and inconsistent in mental health, limiting the scope for conclusions on its benefit. A further obstruction is the immediate methodological challenge of describing what SDM actually *looks* like in naturalistic communication. While scales have been developed to capture the degree to which clinicians facilitate patient involvement e.g. the Option scale (Elwyn et al 2005), they rely on pre-defined criteria and focus solely on the clinicians' behaviour: not how patients respond e.g. accept/resist, or how treatment decisions are co-constructed.

6.1.3 The treatment recommendation: an opportunity to invoke patient choice?

One site for examining how, and if, psychiatrists invoke patient choice is the formulation of treatment recommendations: decisional 'authority' can be implied to various extents through their design. In a seminal study, Byrne and Long (1976) defined a treatment recommendation as a 'clear directive to undertake some course of action' (1976:93). This characterisation implies a paternalistic relationship and unilateral authority of the clinician. Conversely, under

the ideals of SDM, recommendations should account for patients' decisional responsibility, afforded through shared expertise: retaining a *collaborative* character.

6.1.4 Aims and research questions

The following chapter examines alternative action formulations for psychiatrists' recommendations (expanding beyond 'recommending' per se) in the treatment of schizophrenia. It aims to map 1) a range of practices clinicians use to initiate decisions about treatment 2) the consequentiality of alternative formulations for patient uptake, with a focus on overt resistance. To achieve these aims, the following research questions will be addressed.

1. How do psychiatrists initiate decisions about treatment for patients with schizophrenia?
2. To what extent do psychiatrists invoke patient responsibility in their formulations?
3. How do patients respond?
4. What resources do patients draw upon to overtly resist treatment decisions?

For utility, treatment 'formulations' are used as an umbrella term throughout the ensuing analysis. As will become evident, certain practices are not synonymous with 'recommending' per se (and the degree of psychiatrist endorsement this implies). 'Treatment formulations' describe a more diverse phenomenon: spanning actual 'recommendations' to actions that enable patients to specify their desired course of treatment.

As with Chapter 5, to answer these research questions this study forms 2 parts.

Part 1: A descriptive study

Questions 1), 2) and 3) will be explored by coding alternative action formulations and patient responses in outpatient consultations. Synthesising the descriptive data, a general overview of psychiatrist formulation categories will be presented and elaborated in terms of lexical distinctions. Patient responses to alternative formulations will also be presented descriptively.

Part 2: A Conversation analytic study

The descriptive findings will hone the focus of part 2. Conversation analytic techniques will be applied to explore question 4). The nature of patients' overt resistance to psychiatrists' treatment formulations, and the resources through which they enact it, will be described.

Part 1: How do psychiatrists initiate treatment decisions in Schizophrenia? A descriptive study

6.2 Methods

6.2.1 Data

Data from two studies were combined to maximise the screening corpus (described in chapter 3). Verbal dialogue of audio-visually recorded outpatient consultations was initially transcribed verbatim: the final set of 250 transcripts consultations formed the dataset here. Based on examination of the transcripts and video observation, inclusion criteria were developed for screening purposes.

6.2.2 Screening

250 transcripts were screened for psychiatrists' treatment formulations and patient responses. To be included for subsequent coding and analysis, cases were required to meet pre-defined criteria. Specifically, formulations were included that:

- were made and initiated by the psychiatrist. If the patient initiated discussion of the treatment (for or against), the recommendation was excluded.
- made relevant a decision about a new medication or existing medication (dosage change).
- could relevantly be oriented to as a recommendation by the patient in the next turn e.g. accepted or refused.
- pertained to new or existing patient symptoms.
- were not prospective i.e. 'future' or contingent recommendations. (However, 'as needed' recommendations were included)
- presented a prospective treatment either by drug name or drug class. Alternatively, a general recommendation such as 'I'll prescribe something' or 'some medicine' would be included, if by context it was clear what symptom the treatment would be treating.

- constituted the first utterance that could be oriented to as a recommendation i.e. if a suggestion was later upgraded to a pronouncement, the former would be coded.

6.2.3 Coding

A coding protocol (appendix 3) was developed collaboratively by a team of CA researchers, including the author - see appendix 3 for full team description and affiliated universities. Devised for a larger project examining new treatment recommendations across various medical specialities (primary and secondary care) in the UK and US (Title: ‘A cross-national study of physician-initiated medical treatment recommendations in patients’ visits to primary and secondary care’ (no current funding source)), the codes were adapted and implemented for the purposes of this study. Regular team meetings facilitated the development of the coding scheme, drawing on preliminary analyses of screened cases and iteratively revising the specifications. The protocol aimed to exhaustively classify formulations complying with the above inclusion criteria.

The central objects of interest were the alternative action formulations that can be selected by psychiatrists and the implicit claims instantiated in their design relating to their collaborative character. Codes were developed by the author based on further piloting within outpatient consultations: considering their relevance for a psychiatric (relative to a primary care/neurology) context. The resulting version of the protocol allowed for classification of all treatment formulations (Table 17a below) and patient responses (Table 17b below).

Table 17a. Psychiatrist treatment formulation codes

Formulation	E.g.	Definition
Pronouncement	“I’m going to start you on...”	Pronouncements assert what treatment will be in a way that the patient is given no choice (even if they, in fact, resist)
Suggestion	“I suggest you try...”	Suggestions imply that ultimately the patient can decide whether he/she wants to use the medication, but as a recommendation there is typically some indication of psychiatrist endorsement (to varying degrees)
Proposal	“Shall we start...”, “how about trying”	The patient is, to some degree, invited to weigh in or endorse the psychiatrists’ idea: projecting a joint decision.
Offer	“Do you want me to give you...”	The psychiatrist orients to a willingness to do something for the patient, thus implying full patient choice and not displaying active support of the medication.

Table 17b. Patient uptake response codes

Patient uptake	E.g.
Accepts	'okay', 'that's fine' etc
Acknowledges	'uh huh', 'yeah', 'mm hm', nods etc
Resists	Questions or rejects treatment
No uptake	Says nothing in response

Additional categories (from the original protocol) included: recommended medication, strength of clinician endorsement (in terms of framing and/or lexical items), formulations used for naming treatments e.g. a specific drug or class of drug. Features coded (added to the original protocol) included; the type of treatment decision e.g. a new medication or dosage change, and whether the latter pertained to an increase or decrease. One formulation category, 'assertions', was removed from the protocol for its ambiguity in whether acceptance could relevantly be provided by patients in the next turn. An accompanying codebook, providing detailed guidance for the application of each criterion, was used. All cases screened for inclusion were transcribed according to Jeffersonian conventions as described in Chapter 3.

6.3 Results

6.3.1 Types of treatments decisions for patients with schizophrenia

250 consultations were screened of which 135 contained psychiatrist treatment formulations. 40 of these pertained to the introduction of new treatments. More frequently, dosage alterations of existing medications were formulated (56), reflecting the often long-term usage characteristic of this patient group. Within this subset, dosage increases and decreases were equally occurring (29:29). Alternative treatments, including psychological therapies and support groups, were formulated in 39 cases, consistent with the notion that pharmacology remains the mainstay of psychiatric treatment for schizophrenia. The focus here is decisions about medication: 96 new and dosage change formulations formed the corpus for further analysis.

6.3.2 How did psychiatrists' formulate these decisions?

Table 18 depicts frequencies of each formulation type. Most frequently – approximately a third of cases - psychiatrist formulations were designed as proposals (30), followed by suggestions (29), pronouncements (24) and offers (13). Thus, while decision formulations can

constitute clear directives (Byrne & Long 1976) e.g. pronouncements, 72/96 psychiatrist formulations in fact embodied a degree of patient choice. Differentiating findings by treatment type, new treatment formulations were most frequently designed as suggestions 15/40 (37.5 %), while dosage change formulations (relating medications that patients were currently taking – thereby retained experience of) were recurrently formulated as proposals 22/56 (39%).

Table 18. Distribution of treatment formulations

Formulation	New	Dosage change	Total
Pronouncement	8	16	24
Suggestion	15	14	29
Proposal	8	22	30
Offer	9	4	13
Total	40	56	96

6.3.3 Who is accountable? Personal pronouns and decisional responsibility in psychiatrist formulations

'Do **you** want to increase your medication?'
 vs 'I think you should increase your
 medication'

Four alternative treatment formulations have been mapped. However, variability between *and* within formulation categories can exist through the selection of alternative constructions. The focus here is on 3 psychological constructs that psychiatrists can foreground to lesser or greater extents in the design of their formulations - implicative for who is constituted 'responsible' for the decision - patient *preference*, psychiatrist *endorsement* and clinician-patient *partnership*. Examination of the coded formulations, revealed a key linguistic resource in the projection of these constructs was the provision of personal pronouns i.e. first person (I and we) and second person (you): the 'central forms of referring to speaker and recipient' (Sacks 1992: 1349).

For example, a psychiatrist could deploy one of two formulations, both interpretable as suggestions: ‘**I** recommend that you increase the dose’ or ‘you could try increasing the dose’. The former construction contains the pronoun *I* in combinative construction with a *recommend* verb. This personalises and endorses the prospective dosage change, relative to the latter design that only casts the patient as the agent of the activity. Alternatively, a psychiatrist could lexically invoke the doctor-patient partnership by employing the first person plural pronoun: ‘we’ e.g. ‘**we** could increase the dose’.

A third pertinent design choice is the foregrounding of the wants or desires of the patient. For example, the psychiatrist could deploy one of two formulations, both hearable as offers e.g. ‘Do **you** want to increase your dose?’ or ‘I can increase your dose?’. While both actions ‘propose to satisfy recipients needs’ (Curl 2006:1258) characteristic of offers, the syntactic design of the former foregrounds the preferences of patient, while the second only denotes the psychiatrist as the agent of the offered treatment activity: this preference-implicative pronoun is notably absent.

Table 19 displays the distribution of personal pronouns between and within alternative treatment formulation categories associated with such foregrounding of psychiatrist endorsement (e.g. **I** think/recommend/advise etc), decisional partnership (e.g. **we/us**) or patient preference (do **you** want/feel etc).

Table 19. Distribution of personal pronouns

	I (endorsement)	We (partnership)	You (preference)	Total formulations
Offers	0	0	10	13
Proposals	2	22	0	30
Suggestions	19	2	0	29
Pronouncements	13*	8	0	24
Pronoun total	34	32	10	

* endorsement is implicitly embodied in the design rather than explicitly formulated – see later examples

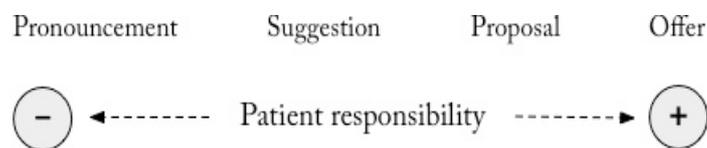
Despite relevant alternatives, pronoun use was relatively systematic. Offers were typically formulated with ‘you’ (10/13): explicitly displaying dependency on patient preferences, proposals were most frequently ‘we’ formulations (22/30): lexically invoking the psychiatrist-patient alliance and suggestions were recurrently ‘I’ formulations (19/29): personally endorsed by psychiatrists. For pronouncements, endorsement was implicitly embodied in the design ‘I

am going to give you...' (orienting to the decision as 'complete'), but also frequently in a manner that lexically invoked the clinician-patient partnership e.g 'we are going to...' 13/24 and 8/24, respectively.

6.3.3.1 The accomplishment of decisional responsibility

These lexical choices are significant: the linguistic embodiment of a treatment formulation may impact who (patient or psychiatrist), at least overtly, is displayed as responsible for that decision on acceptance i.e. upon whose preferences or endorsement it is based. The formulation 'I recommend that you increase your dose' for example, explicitly displays one of the epistemic resources – the psychiatrist's professional opinion – that forms its basis. He thus treats himself as, to a degree, accountable to the patient (See also Costello & Roberts 2001). Conversely, the formulation 'do you want to increase your dose' foregrounds the patient by making him the subject - 'you': casting him 'as the agent of 'want' (Curl 2006: 1269), thereby accountable for the decision. Alternative formulations (pronouncements, suggestions, proposals, offers) in this corpus can therefore be usefully conceptualised in terms of patient decisional responsibility (accomplished and indexed, in part, by the deployment of personal pronouns). This is graphically represented from low to high in Figure 5 and is next elaborated with data examples.

Figure 5.



In the scope of this descriptive chapter, the following fragments are presented in isolation and not as part of a *situated* analysis, unlike Part 2. Given that actions accomplished by a practice are not determined solely by form, but inextricably tied to the local sequential position in which they are used (Schegloff 1984), the findings here should be considered an overview.

Table 20. Examples of treatment offers

'You' formulations – foregrounding patient preference

1) DOC: .tch .hhhhhh (.) ↑if the voices are really bothering you: >I can< in↑crea::se
your injection >a little bit< **if you wa::nt.**

2) DOC: E::r and ↑also (.) ↑**do you want** to make any changes to you::r (.)
olanzapine at all.

3) DOC: .hh >I mean< **do you feel you'd like** to try: a:n antidepressant a↑gain see if
it makes you feel any different?

In 10 coded treatment offers the patient was invoked as the central figure: containing a preference - implicative pronoun, 'you'. The patient's role in the decision is thereby demarcated in the psychiatrists' formulation. Indeed, according to Sacks (1992:1:163-8 and 568-77) one of the characteristics of 'you' is that the listener is always included. As Goodwin (1996) asserts, 'you' is the pronoun that encodes the role of 'recipient'. Table 20 displays 3 examples from the corpus. The patient's 'role' in each fragment relates to the expression of treatment choices. While the psychiatrist retains the agency to act in realising the offer (i.e. prescribe), the decision itself is explicitly marked as *contingent* on patients' preferences e.g. if you want (1), do you want (2), do you feel you'd like to try (3).

Offers were typically formatted as questions (See also Curl 2006) (e.g. 2,3) and invited the patient to engage in decision-making. As Heritage (2013) asserts, offers operate as requests concerning others' preparedness for future activities and involvements that as such 'frame the speaker as in a K- position' (2013: 388). Indeed, while in each case the psychiatrist marks available option(s); 'increase your injection' (1), make 'changes to your olanzapine' (2), 'try an antidepressant' (3), the patient is invited to identify his preparedness to take it. The epistemic

gradient then (in terms of knowing/asserting what the patient *should* do) is tempered by the fact that the psychiatrist does not claim to have the right to advise the patient (cf Heritage & Sefi 1992) or perform explicit endorsement of the treatment. The decisional responsibility in the following formulations is lexically invoked as more shared. Table 21 depicts 3 examples of formulations coded as proposals.

Table 21. Examples of treatment proposals

'We' formulations: foregrounding the clinician-patient partnership

1) **DOC:** .hh I suppose the question is whether **we** should reduce the olanzapine a
bit mo:::::re?

2) **DOC:** **We** might need to think about changing the olanzapine to another
medication.

3) **DOC:** .hhh (.) How about **we** try another antidepressant a different
kind of antidepressant?

22/30 proposals were designed to invoke the dr-patient partnership, containing the first person plural pronoun, 'we'. As Sacks (1992) asserts, 'we' entails collective involvement and group membership (Sacks 1992:1:333-40 and Sacks 1992:2:391-5). In this way the 'self' is minimised as it becomes part of a collective. The psychiatrist in examples 1, 2 and 3 constructs the decision as a joint responsibility by projecting himself and the patient as mutually implicated in its realisation.

Additionally, while each formulation contains a clear prospective course of action i.e. 'reducing the olanzapine' (1), 'changing the olanzapine' (2) or trying a 'different kind of antidepressant', it is hedged or treated as in question; 'the question is whether' (1) ; 'might need to think about' ; 'how about we try' (3). In this way, the psychiatrist avoids asserting a

firm K+ position (marking the appropriate course of action as ‘known’) or signalling overt endorsement. A role for patient choice is thus accommodated, while not, unlike the prior offers, presenting it as an exclusive condition. Conversely, in the following ‘suggestion’ formulations, the psychiatrist claims an explicit view on treatment, establishing a greater degree of decisional accountability.

Table 22. Examples of treatment suggestions

‘I’ formulations – foregrounding psychiatrist endorsement

1) DOC: e:::r e:::r **I would really recommend** you to decrea::se to go down with
the medication.

2) DOC: .hh ↑what **I’m going to suggest** (.) <is tha::t> (.) you: (0.4) u:::m, (0.8)
tail off (.) the aripiprazole.

3) DOC: um ↑**I would suggest** that I give you a prescription for procyclidine

19/29 suggestions contained ‘I’ pronoun formulations combined with reporting verbs e.g ‘I would really recommend’ (1), ‘I’m going to suggest’ (2) and ‘I would suggest’ (3). According to Sacks (1992), ‘I’ links the talk to other parts of the talk and indexes the speaker to the here and now (1992:1:32). Elaborating on this, Malone (1997) regards ‘I’ to state the speaker’s position and provide subjectivity. ‘I’ can also be used as a means of showing a degree of personal commitment and involvement: encoding a ‘personal voice’ (Wilson 1990). Indeed, the fragments in Table 22 display the psychiatrist using I/I’m to convey ownership of the suggestion, marking the ensuing treatment action: ‘go down with the medication’ (1), ‘tail off the aripiprazole’ (2), ‘give you a prescription for procyclidine’ (3) as contingent on his endorsement. By displaying the epistemic grounds – his clinical opinion – that form its basis, he treats himself as partly liable to the patient (See also Costello & Roberts 2001). However,

while the psychiatrist formulates a view on what *should* be done thus, relative to an offer or proposal, the suggestions here are epistemically ‘upgraded’, he does not choose to formulate what *will* be done. An orientation to patient choice is still accommodated. The following ‘pronouncement’ formulations however, depicted in Table 23, show an even greater commitment to the course of action: endorsement is implicitly embodied within their design. The pronouns ‘I’ and ‘we’ are used in formulations constructed as informings or directives.

Table 23. Examples of treatment pronouncements

‘Informing’ or ‘directing’ – endorsement embodied within the formulation

1) DOC: .hh so what we are going to do is (.) increase the olanzapi::ne.

2) DOC: . e::rm, (4.4) I’m ↑going to increase a ↑little bit one of the medica:tion

3) DOC: So take more of the olan::zapine in the morning.

Psychiatrists’ pronouncements projected the treatment decision as ‘complete’. Example 1, 2 and 3, show that the doctor does not give an opinion but *announces* a course of action that the patient (or himself) will take. Decisional endorsement and responsibility are implicitly embodied in the design of the recommendation: the unmitigated declarative form of (1) and (2) contributes to a resulting action that is ‘unambiguously an ‘informing’ (Heritage 2012:8). Similarly, (3) acts as a clear directive through the use of the imperative verb (*‘take 5 mg of olanzapine’*). By declaring a course of action, the psychiatrist claims both to know what *can* be done and what the patient *should* do (increase the olanzapine (1), increase...one of the medication (2) take more of the olanzapine (3)), independent of patients’ preferences. He thus strongly evokes a right to advise the patient (cf Heritage & Sefi 1992), establishing a K+ position. As Potter & Hepburn (2010) assert in relation to directives, building on the work of Curl & Drew (2006): ‘they show high entitlement to direct the other speaker and little or no

orientation to the contingencies on which compliance with the directive may rest' (2010: 426). The abilities or desires of the patient, at least in the formulation itself, are precluded.

Patients do however have a relevant slot in the turn following a treatment formulation in which they can implement a variety of resources (as coded) to align or disalign with the psychiatrists' action. Patient responses to each formulation class are reported next.

6.3.4 How did patients' respond to these formulations?

Previous studies (e.g. Stivers 2007, 2005b, Koenig 2011) indicate that patients and clinicians orient to treatment recommendations as normatively requiring acceptance, relevant on completion, before progressing onto the next phase of the consultation. Stivers (2005b) identified routine acceptance of recommendations with terminally intoned objects such as 'okay', 'alright', 'lets do that', 'that's fine' or assessments e.g. 'good'. Thus, while psychiatrists may formulate decisions as pronouncements or suggestions that do not, at least in this dataset, recurrently foreground patient preference (like offers) or the clinical partnership (like proposals), patients can still orient to such formulations as something to be accepted or rejected (See Stivers 2005a, 2005b, 2006, 2007). Extract 1 shows this stance in play within the current corpus:

Extract 1

```
01 DOC: .hh so what we are going to do is increase the  
02         olanzapi::ne.  
03 PAT: Yeah okay.
```

The psychiatrist formulates a pronouncement for an increase of antipsychotic medication in line 01. It is designed as an unmitigated informing that implies no explicit role for patient choice. However, immediately on completion of the turn constructional unit (TCU), the patient responds with 'yeah okay' in line 02. This token- particularly with final intonation- accepts the doctors' recommendation, treating it as a proposal that makes relevant acceptance, and not as an informing (Stivers 2006). This suggests an orientation to the treatment

formulation as a 'bilateral process' (Heritage & Clayman 2010:64): interactively rather than unilaterally (i.e. constituting the recommendation turn only) constructed.

If acceptance is normatively oriented to, some *alternative* behaviour, where acceptance is expected, may constitute 'passive resistance' (Heritage and Sefi 1992). Thus, allowing a gap of silence, a stand alone head nod or producing a minimal acknowledgement token (Stivers 2005b, Heritage & Sefi 1992) may be resources for implicitly resisting recommendations: they withhold acceptance and do not 'constitute an undertaking to follow the advice offered' (1992:395). Extract 2 depicts this orientation in play with another example from the present corpus. Here, the psychiatrist indicates that acceptance of his formulation is necessary: actively pursuing it. Following discussion of the patient's complaint of tremor: a typical side effect of antipsychotic medication, the psychiatrist deploys a suggestion for a prescription of Procyclidine, a drug designed to diminish such effects. Having offered his formulation, the psychiatrist waits for uptake (line 03) and, when none is forthcoming, he continues to adjoin additional statements, supporting his original suggestion (lines 04, 06, 08, 12).

Extract 2

01 DOC: Um ↑I would suggest that I give you a prescription for
02 procyclidine.
03 (0.4)
04 DOC: That you can take once or twice a da::y ↑if you need them.
05 (0.4)
06 DOC: ↑A::nd (.) it may benefit the shake.
07 (0.2)
08 DOC: M- most people they find most of their shaking goes away.
09 PAT: Right.

10 DOC: ↑Would that be o↑kay with you::

By withholding explicit acceptance i.e. passing on the opportunity to respond (lines 03, 05 and 07) and providing a minimal acknowledgement token (line 09), the patient has resources to orient to the psychiatrist’s recommendation as ‘incomplete’. Here, this passive resistance leads the psychiatrist to *pursue* patient endorsement by elaborating on the medication’s benefit and effects (line 06 & 08). When acceptance is still not forthcoming in line 09 following the addition of this supporting information, the psychiatrist proceeds to *explicitly* pursue acceptance in line 10 ‘would that be okay with you....’.

While the alternative action formulations coded in this study do not all constitute ‘advice’ or ‘recommendations’ per se, these findings provide a useful context within which to examine patient responses. Table 24 displays the frequency of each category, differentiated by formulation class.

Table 24. Distribution of patient responses

Formulation	Patient uptake				Total
	Accepts	Acknowledges	Resists	No uptake	
Pronouncement	8	13	2	1	24
Suggestion	6	17	1	5	29
Proposal	6	9	13	2	30
Offer	3	0	8	2	13
Total	23	39	24	10	96

Patients did not routinely accept formulations in the next turn. Of the 96 treatment recommendations deployed by psychiatrists, over a third were acknowledged (39/96). Resistance, in terms of rejecting or questioning treatment was next frequent, occurring in 24/96 cases. Remaining recommendations received acceptance (23/96) or no uptake (10/96). Grounding these frequencies in the finding that where acceptance is normatively expected, alternative behaviours may constitute passive resistance (Heritage & Sefi 1992) - resistance (passive and active) was conceivable in 81/96 cases, forming the dominant patient uptake. Differentiating the findings by formulation, it is apparent that acknowledgements (possible passive resistance) were more likely to occur in response to ‘endorsed’ formulations: pronouncements and suggestions (13/24, 17/29 respectively), than proposals and offers that

more frequently attracted direct resistance (13/30, 8/13 respectively), followed by acceptance (6/30, 3/13 respectively).

While 34 formulations received resistance or no uptake in the next turn (and 39 were potentially passively resisted), the majority of recommendations were ultimately prescribed. 52/57 recommendations for an increase or decrease of an existing regimen were effectuated. Less frequently, 29/47 recommendations for new treatments were prescribed by the end of the consultation.

The high rate of resistance identified here provides impetus to further unpack this finding - the focus of proceeding sections.

6.3.5 What types of treatment recommendations are patients most likely to overtly resist?

If acceptance is normatively oriented to, recommendations resisted in the next turn display patients enacting 'rights to choose how and when they endorse the recommendation' (Koenig 2011: 1106). *Success* in forming a treatment decision and subsequent adherence relies on cooperation between the psychiatrist and patient: the first step is to get the patient on board with the proposed treatment. Having identified the prevalence of resistance to formulations, we turn to examining, with more granularity, for which categories this was especially problematic.

Stivers (2005a), defines active resistance as an action that implicitly or explicitly 'questions or challenges' the treatment recommendation (coded in this study's protocol as questioning or rejecting treatment). While acknowledgement responses can constitute passive resistance e.g. treating the clinician as 'not yet done' (Stivers 2006: 285) or, withholding acceptance as 'a way to ensure general understanding by preventing premature closure of the recommendation' (Koenig 2011: 1109), their deployment can also be more innocuous. For example, 'to ensure the recommendation has come to full completion' if physicians simply ambiguously design the recommending turn (Koenig 2011:1109). Accordingly, 'passive resistance is more difficult to quantify' (Monzoni et al 2011). Cases of active resistance, representing a 'stronger type of resistance' (Stivers 2005c), combined with passive resistance i.e. no uptake that subsequently 'surfaced in more overt signs of resistance' (Heritage & Clayman 2010) (identified by close

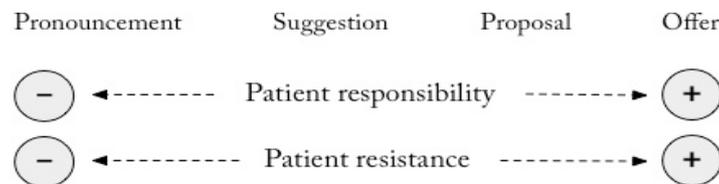
examination of all the transcripts) is thus used here as a more reliable proxy. Table 25 depicts the distribution of overt patient resistance. For ease of presentation and interpretation, instances of are displayed as raw proportion and a ratio. As depicted, formulations designed as pronouncements received the least resistance (1:12), followed by suggestions (1:5). Formulations designed as proposals and offers received proportionately the most resistance (1:2 and 1:1.3 respectively)

Table 25. Distribution of patient resistance and recommendation type

Formulation	Proportion	Ratio
Pronouncement	2/24	1:12
Suggestion	5/29	1:5
Proposal	15/30	1:2
Offer	10/13	1: 1.3
Total	35/96	

Mapping these findings onto the earlier representation of formulation - decisional responsibility, the frequency of resistance increases in the same direction, sketched in Figure 6.

Figure 6.



6.3.6 Summary of findings from part 1 and analytical focus of part 2

When psychiatrists initiate medication decisions, they have an opportunity to formulate various degrees of patient choice by varying the design of their utterances. In part 1, a range of alternatives action formulations; pronouncements, suggestions, proposals and offers were captured in a coding protocol. While treatment recommendations are historically defined as ‘unilateral directives’ (Byrne & Long 1976), expanding this definition has allowed a range of practices psychiatrists use to be mapped. Most frequently, psychiatrist formulations retained a degree of patient choice and a collaborative character (72/96).

Alternative action formulations could be usefully conceptualised in terms of decisional responsibility: accomplished, in part, by the deployment of personal pronouns. Despite relevant alternatives, first and second person pronouns (I, we, you) were routinely used between formulation classes: foregrounding patient preference (offers: 'you' formulations), psychiatrist endorsement (suggestions: 'I' formulations) or the clinician-patient partnership (proposals: 'we' formulations). Paradoxically however, formulations characterised by *less* psychiatrist responsibility, were more frequently overtly resisted by patients.

Motivated by these findings, this phenomenon is explored qualitatively in Part 2. Methodological techniques of conversation analysis will be employed in an exploratory study examining the nature of patient resistance to treatment proposals and offers. The aims, like Chapter 5, are to contextualise these findings and generate explanatory hypotheses.

6.4 Part 2: Patients' overt resistance to treatment proposals and offers: accounts of side effects

'No::: >because it makes me tired.<'

Treatment proposals and offers frequently received resistance from patients. A total of 25 instances of overt resistance was observed out of 43 of these action formulations (See Table 24). To further understanding of these findings, CA will be employed as a companion approach, aligning with the methodologies of Chapters 4 and 5. The nature of this resistance, and the systematic resources through which patients enacted it, will be examined across the 25 cases identified in part 1. The findings will be collectively discussed in relation to treatment adherence to conclude the study. Some precursory contextual literature on patient resistance is next briefly described.

6.4.1 Patient resistance and treatment decisions

The critical account of medical authority, characteristic of early approaches to the microanalysis of medical discourse, was described in Chapter 3. Within this paradigm, doctors may curtail patient choice and expression of 'lifeworld' concerns and largely dictate the agenda (e.g Mischler 1984). In relation to treatment recommendations specifically, prior studies have displayed ways in which patients can be swayed by doctors' paternalistic approaches. Jansen et al (2004) proposed that patients might perceive they have no choice when recommendations are authoritative. Gurmankin et al (2002) found patients were willing to follow doctors' recommendations, even if this defied their own preferences. Indeed, in part 1, pronouncements – often designed as informings - were most frequently accepted of all categories (to a ratio of 1:3). However, by focussing on how practices are co-constructed, CA has exposed the systematic, often discreet, strategies that patients use to assert their preferences and how doctors may relinquish this authority (Toerien et al 2013). During the 'restrictive' primary care environment of history taking, patients can expand their answers, 'volunteering more information than was asked for' (Stivers & Heritage 2001:151). Patients may respond to treatment decisions in ways that elicit 'reformulation of the recommendation' (Costello & Roberts 2001:250) and, in neurology settings, encounters are described as 'characterised by patient resistance' (Monzoni et al 2011: 199). However research in

psychiatry is sparse. Only one study to the author's knowledge has used CA to explore decision-making in schizophrenia, theorising a spectrum from pressured decisions to open decisions (Quirk et al 2012). The findings in part 1 sit within this tempered version of medical authority. Psychiatrist formulations predominantly accommodated a degree of patient choice and patients frequently resisted formulations, often overtly: the focus here.

Resistance has been examined in a minority of CA studies. Of these studies, even fewer have examined how more overt forms are accomplished. This gap is perhaps attributable to explicit resistance being relatively rare in other corpora (e.g., Heritage & Sefi, 1992; Silverman, 1997). Considerably more attention has been allotted to 'passive' (Heritage & Sefi, 1992) forms of resistance e.g. acknowledgement tokens. The application of this inquiry to treatment decisions was initiated in Stivers (2005a, b, 2007) seminal work – that grounded the analysis in part 1 - between doctors and parents of children with upper respiratory infections. When parents responded to recommendations with straight acceptance (e.g. okay), doctors generally advanced towards closure of the consultation. Conversely, when responses consisted of minimal receipts (e.g. mm) or silence, doctors sustained talk about treatment, often revising or accounting for their recommendation. As such, they invested further effort in order to gain full acceptance before moving to a close, orienting to these responses as passive resistance. Where this was not achieved, antibiotics were often prescribed inappropriately. In this vein Koenig (2011), argues that patient resistance to treatment recommendations is one interactional resource to assert agency; through resistance patients' create an opportunity to collaboratively co-construct and participate in 'how a treatment recommendation ultimately emerges as acceptable' (Koenig 2011:1112).

By focussing on what *actually* happens in clinical encounters, such findings sketch subtler shades of medical authority. Notably, it can be moderated by patient actions, even when the doctor does not explicitly create an opportunity for patient participation. Largely unexplored however, in CA literature and psychiatry specifically, is patients' more overt resistance when participatory opportunities *are* created. This may be salient in chronic conditions like schizophrenia: the direction of policy directives (NICE 2009) and the experiential expertise patients acquired through long-term pharmacology use may render these opportunities increasingly more frequent. Understanding the interactional resources through which patients

enact resistance to treatment offers and proposals could supply insight into how successful treatment decisions, the pre-requisite for adherent behaviour, might be formed.

6.4.2 The framework for patient resistance

In part 1, patient responses that involved questioning or rejecting treatment were coded as 'resistance'. To illuminate analysis of the following data, this definition is elaborated in relation to preference structure. As introduced in Chapter 3, the minimal, and most fundamental, sequence within conversation consists of an adjacency pair (Schegloff, 2007). This comprises of two turns by different speakers that are adjacently positioned: a first pair part (FPP) and a second pair part (SPP). The former constrains the latter, making a limited set of possible SPPs relevant, organised by a preference structure. These alternative responses for the same slot represent different alignments to the action embodied in the FPP. The response that furthers the course of action, a proposal or offer, is referred to as the *preferred* SPP. An alternative method that embodies a problem in the realisation of the proposal or offer is the *dispreferred* SPP. This preference structure does not relate to psychological preference, but the structure established by the prior turn. When psychiatrists deploy a formulation, the alternative responses made relevant to the patient involve acceptance - the preferred response - and rejection of, or resistance to, the FPP - the dispreferred response. Generalising preferences across action categories can, in some cases, be problematic (See Pomerantz & Heritage 2012): participants themselves may make distinctions within categories of action. Schegloff (2007) provides the following example of how accepting an offer may, on occasion, be a dispreferred action:

'although generally it appears that accepting is the preferred response to offersthis may be contingent on the item being offered and the context. Some offers ("would you like the last piece of pie?") may more cogently be understood as preferring rejections' (2007:60)

Alternatively, proposals or offers may carry 'cross-cutting preferences' (Schegloff, 2007) e.g. grammatically designed as an interrogative preferring a "no" response, even though the action of the turn prefers a "yes". However, broadly speaking, the preference structure of the sequences under investigation here can be schematised as follows:

Psychiatrist FPP Offer/Proposal



Patient SPP Acceptance of offer/proposal (preferred)

Resistance/rejection of offer/proposal (dispreferred)

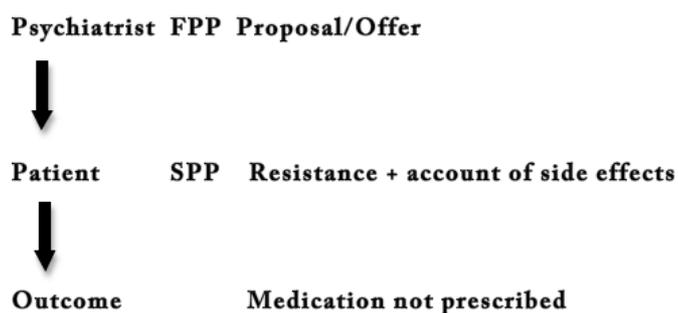
6.5 Part 2 aim and methods

When patients produce dispreferred responses, they are displaying resistance observable to the psychiatrist and the analyst. By scrutinising the nature of these turns, the primary aim of this study, it is demonstrable how resistance, as a dispreferred action that problematises the course of action underway, is enacted and managed. As with prior chapters, this study is informed by the methodology of CA (Chapter 3): resistance sequences are analysed for recurrent systematic linguistic and sequential features. For context, the excerpts are presented in terms of the consultations' proximal outcome: whether or not the proposed/offered treatment was ultimately prescribed. While this is a qualitative study, relative frequencies of observations are provided to aid interpretation of the claims.

6.6 Results

25 cases of resistance were analysed: identified in the former descriptive study. Two distinct practices by which patients resisted proposals and offers were discernable, reported next. Like prior studies, these underlined the premise that 'patient agency is both active and operative' (Costello & Roberts 2001:243) in terms of asserting preferences. However, unexplored previously (attributable perhaps to a focus on 'recommendations' per se), resistance wasn't exclusive to treatment itself - extending, in a minority of cases, to the acceptance of decisional responsibility. The two practices thus index alternate patient orientations to the constitution of 'expertise': patients' own and the psychiatrists'. These orientations appeared a relatively discriminating factor in terms of whether the proposed medication came to ultimately be prescribed.

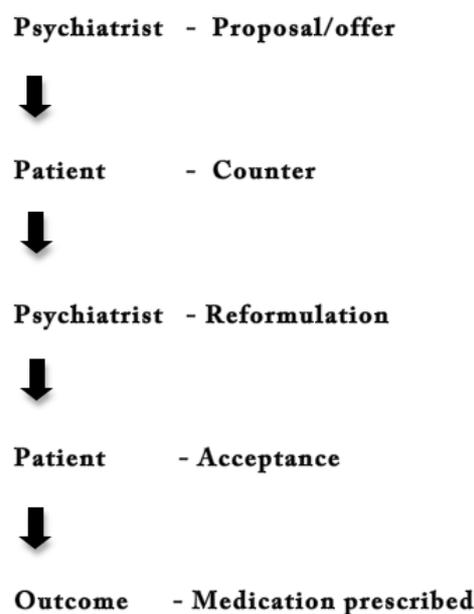
Firstly, the systematic resources through which patients most frequently accomplished resistance will be described. In the cases presented, patients display an orientation to their *own* expertise: asserting the right to decline treatment (either ‘indirectly’ or ‘directly’ – described with reference to preference organisation) by accounting for their dispreferred action with ‘inability to comply’ accounts (Heritage 1984, Drew 1984). These invariably relate to acquired experience of side effects thereby foregrounding contingency: the granting of the proposal/offer is dependent on factors outside of both the psychiatrists’ and patients’ direct control. The described experiences are internal to the patient e.g. tiredness and lethargy, but framed as induced by an external stimuli, the proposed/offered medication. Their subjective quality locates the matters at hand firmly within the patient’s ‘epistemic domain’ (Stivers and Rossano 2010) - the psychiatrist can have only have second hand access to these particulars of medication. Accordingly, in line with current policy terminology (DOH 2001, see also 6.1.2 here), the term patient ‘expertise’ as opposed to merely ‘experience’ is adopted here. Indeed, patients reports were often heightened by the use of ‘extreme case formulations’ (Pomerantz 1986) invoking ‘certainty’ and reducing the accounts’ disputability. Where this type of resistance was observed, proposed/offered treatment was often not ultimately prescribed. These resistance sequences occurred in 17/25 (14 of which were not prescribed) and could typically be represented schematically as follows:



Patient expertise and contingency was also oriented to in the proposals/offers themselves. While the primary focus is patient resistance, the design of psychiatrists’ FPPs was notable and is touched upon throughout the analysis: building on earlier ‘non-situ’ observations of proposals and offers in section 6.3.3. In a study of requests, Curl & Drew (2008) found selected forms reflected speakers’ orientations to their entitlement to make the request and

the contingencies that may be associated with it. Indeed, formulations were designed in ways suggestive of contingencies being involved with the granting of the treatment decision. Frequently, psychiatrists foregrounded the capacities of the patient (e.g. 'could we'), wants of the patient (want forms) and oriented to the action as not entirely 'straight forward'. Hedges (e.g. 'whether'), turn-initial delays (Schegloff 2007) and 'I mean' prefaces (Fox Tree et al 2002) were often deployed, displaying the action of proposing/offering medication, at that point in the interaction, as a 'delicate' one.

Secondly, an alternative resource by which resistance was enacted will be described. Patients could instead orient to the *psychiatrists'* expertise by asserting the right to resist the form of the proposal/offer itself: specifically, the decisional responsibility it projects (a pattern exhibited in 3/25 cases - 2 offers and one proposal - in this corpus). In one extended fragment, the patient will be observed exploiting the normative sequential structure (Stivers 2005, Koenig 2011) of an offer sequence by postponing acceptance to counter decisional responsibility. This ultimately occasioned psychiatrist reformulation of the action i.e. a 'subsequent version' (Davidson 1984) that aligned with the patient's preference for *psychiatrist* expertise (codable in part one of the study as a pronouncement) - subsequently receiving acceptance. Unlike cases of resistance that constituted accounts of side effects, all 3 cases exhibiting this pattern were ultimately prescribed and could be represented schematically as follows:



Following presentation of cases, the chapter will culminate with a discussion of findings in relation to decision-making and adherence in schizophrenia.

6.6.1 Patients' orientation to their own expertise - appealing to negative experience of side effects

In fragments 1-5 an account is offered that expresses the patient's difficulty in adhering to the prospective treatment change in the proposal/offer. These are hence accounts for doing a dispreferred action that invoke an 'inability to comply', carrying a 'no fault' quality (Heritage, 1984). Specifically, the accounts all draw upon the physical effects of medication, enabling patients to assert their *inability* to accept the proposal or offer rather than, for example, showing an 'unwillingness or decision not to' (Drew 1984:129). Such reportings display an attempt to manage the potential problems created by the dispreferred action underway. In appealing to this physical contingency as the reason for their resistance, patients provide descriptions of internal subjective experiences - their own epistemic domain - thus 'expertise'. Take for example extract 1: the patient resists a proposal for antidepressants, with reference to the 'awful feeling' that medication induces in her stomach.

Extract 1 (Outcome - not prescribed)

01 DOC: And ↑what a↑bou:t (.) y- abou:t ↑trying a bit of
02 antidepressant to see if that would boost your mood a bit.
03 PAT: ↑U::m (0.4) you see::: (.) the Kemadrin (.) is about all I
04 can cope with because (.) I get an awful feeling in my tummy.
05 (0.2)
06 PAT: Even when I take Kemadrin I: (.) it affects my ↑tummy.
07 (.)
08 DOC: .tch (.) so you'd be worried about the antidepressant

09 PAT: Ye:::s.

10 DOC: Affecting your tummy would ↑↑you:?

11 PAT: Ye:::s.

Following an agreement that a dosage reduction of antipsychotic medication would be appropriate, the psychiatrist in line 01 proposes that the patient also tries ‘a bit of antidepressant’ to see if that would ‘boost’ her mood. The ‘and’ preface, links this action as an element of common activity (Heritage & Sorojoren 1994) in which the speakers have been aligned, while ‘a bit of’ ‘minimises’ the proposed regimen addition, synonymous with a small dose. However, the patient’s response in line 03 displays a shift in alignment, hearably resisting the proposal. The hesitant start of the patient’s turn signals a dispreferred action as upcoming (Pomerantz 1984). Indeed, she formulates an inability to ‘cope’ with an additional medication to Kemadrin (a drug that targets side effects), but does not project completion at the first TRP: she holds the turn in order to deploy a conjunctive account. Specifically, she appeals to a negative physical state, ‘because I get an awful feeling in my tummy’, information only accessible to the patient.

Accordingly, the patient designs her turn in a way that projects certainty over her account. The absence of modal verbs and the use of present tense (e.g. “I get” as opposed to ‘I *could* get’) can project an utterance as true and verifiable, and the speaker as having a higher epistemic status relative their interlocuter (He, 1993). When the psychiatrist does not immediately respond in line 05, the patient further expands, ‘even when I take Kemadrin I it affects my tummy’. This works to upgrade her prior account: the Kemadrin alone ‘affects her tummy’, implicitly highlighting the contingency that an additional medication would exacerbate the problem. Thus, while the patient has not, across lines 03-06, explicitly stated the upshot (Drew 1984:131) of these reported circumstances i.e. that this would problematise adhering to the proposed treatment, she has created sufficient conditions for the psychiatrist to judge and address these implications for the original proposal (Drew 1984:130).

Indeed, in line 08 the psychiatrist displays understanding of the patient’s concerns by formulating (Heritage 1984) the patient’s account in emotional terms: extrapolating its

impact for the prospective treatment decision i.e. the patient would be 'worried about the antidepressant'. While the patient confirms this formulation in line 09, the psychiatrist's increment and interrogative tag in line 10, 'affecting your tummy, would you?', re-completes and specifies (Schegloff 1996, Ford et al 2002) the prior turn, explicitly formulating the 'worry' as a consequence of the negative physical state described by the patient. This sequentially deletes her confirmation (Lerner, 1989): occasioning a second 'yes' response in line 11.

Here, the patient has resisted the psychiatrist's proposal with a sensory experience that is, in this respect, indisputable by the psychiatrist, and neither the patient's or the psychiatrist's 'fault' per se. As Heritage (1984) explains:

'accounts are commonly required as design features of disaffiliative (dispreferred) second actions to invitations, requests and the like because these first actions inherently project affiliative second actions and invoke a variety of assumptions about the desirability etc. of the relevant second actions which, in turn, implicate the 'face' of, and the relationship between, each participant. The latter are threatened by disaffiliative second actions. Accounts resolve these threats by focussing on 'no fault' considerations. Such matters, in drawing upon matters properly known to the account giver, tend to short-circuit any potential for further conflict or disagreement' (1984: 272)

The method of resistance is similar in extract 2. The patient's account contains reference to another unpleasant physical state: experiencing a 'dry mouth'. Moreover, design features of the psychiatrist's proposal itself render the action hearably 'delicate', associated with possible contingencies.

Extract 2 (Outcome – not prescribed)

01 PAT: But (.) I don't get as much done in my flat as I'd like to.

02 DOC: No:

03 (0.2)

04 PAT: So (.) it's not sulphiri:de.

05 DOC: I mean could we have an ex[↑]periment that you take more

06 sulphride and we measure how much you do:: and less sulphride,

07 (0.4) you know we can (0.4) try and get a: (.) you know
08 some kind of measure of this.
09 PAT: Well there's no way I'm taking more sulpiride at night
10 because I have fa:r too much of a dry mouth.
11 (.)
12 PAT: .hh on medicines a:nd sleep apnea causes excessive dry mouth.
13 DOC: Hm mm okay.

This extract follows a discussion regarding the role of Sulpiride, an atypical antipsychotic medication, on the patient's increased levels of activity. The patient asserts that the medication organises his thoughts 'but I don't get as much done in my flat as I'd like to' (line 01). Following psychiatrist receipt in line 02, the patient concludes his complaint – prefaced by the upshot marker 'so' (Schiffrin 1987) - inferring 'its not sulpiride' that is responsible (line 04). In line 05 the psychiatrist makes a proposal for the patient to 'experiment' with dosages to gain a 'measure' of 'this': representing the degree to which the Sulpiride impedes or increases the patients' activity levels. To deploy this proposal following the patient's conclusion that Sulpiride does *not* affect his activity levels is a sensitive, hearably inapposite, action. Indeed, there are design features of the psychiatrist's turn that may be selected in service of doing the proposal 'cautiously'.

He prefaces his action with the discourse marker 'I mean'. This marks his upcoming proposal as tied to the 'naturalistic, unplanned, unrehearsed, collaborative nature of spontaneous talk' (Fox Tree et al 2002:745). In doing so, the psychiatrist, in part, distances himself from a potentially face-threatening action (Fox Tree et al 2002:733) that, in essence, presupposes the that Sulpiride could, in fact, have a positive effect on activity, contrary to the patient's assertion in line 04. As Fox Tree et al (2002) assert:

'I mean may be linked with positive politeness because using it reminds conversational participants of more casual talk. At the same time it may be linked to negative politeness by decreasing face treat; saying I mean may be like sating 'I'm not committed to what I just said and will adjust if you are offended' (2002:741)

Moreover, the psychiatrist lexically invokes the clinician-patient partnership ‘could we’ rather than personally endorsing the treatment e.g. ‘I think you should’ and formulates his proposal with ‘you know’. This can be used to indicate a shared understanding of a situation (Schiffirin 1987) and, as such, ‘may blunt the blow of face threatening talk that...follows [‘I mean’]’(Erman & Kotsinas 1993:83).

When the patient takes his turn in line 09 he begins with “well” which may be indicative of a forthcoming complex response or dispreferred response (Schegloff & Lerner, 2009) Indeed, the patient employs resources, comparable to extract 1, to resist the proposal. Asserting ‘there’s no way I’m taking more sulpiride at night’, he continues the turn beyond a TRP in order to account for this resistance with the dependent clause ‘I have far too much of a dry mouth. He thus expresses a direct relationship between his refusal to take more Sulpiride (at least at night) with a physical condition. Like extract 1, the patient’s response is designed with present tense ‘I have...’, rather than the modal construction ‘I *could* get’/‘I *might* get’. This formulates his reason for resisting as something that is *generally* the case: projecting certainty and epistemic authority over his account. As Pomerantz (1986) asserts, this is an example of an ‘extreme case formulation’ used to legitimise claims. ‘I have’ (or ‘I get’ extract 1) imply this is a regularly occurring event rather than an isolated/occasional occurrence. ‘The import of the status of ‘regularly occurring’ versus ‘odd’ cases is that the former kind of case should be taken into consideration, whereas the later kind of cases may or ought to be dismissed.’ (1986:223).

The patient further increments his turn in line 12: the micropause in line 11 is retrospectively hearable as ‘belonging’ to patient, it becomes an intra-turn pause located within this turn at talk (Ford et al 2002). He uses this opportunity to continue building his account in these ‘general’ terms i.e. ‘on medicines’ (rather than on Sulpiride) and implicates another condition: ‘sleep apnea *causes* excessive dry mouth’. This intensifies the indisputability of his report: not only does he recount an internal experience within his epistemic domain, but attributes it to medication (i.e. a side effect) that precipitates a *pre-existing* – recognisable – medical condition. The psychiatrist receipts this in line 13 ‘hm mm okay’.

6.6.1.1 Direct Resistance

Certain design features of the resisting turns in extracts 1 and 2 are structurally typical of dispreferred actions. Seminal research by Pomertantz (1984) on assessments and Davidson (1984) on invitations, offers and requests display a tendency to minimise stated disagreement/rejection and maximise stated agreement/acceptance (Pomerantz 1984). Co-participants avoid stated disagreements by providing instead tacit *signals* of disagreement. Such signals take numerous shapes, including ‘well’ prefaces, ‘hesitations, questioning repeats, requests for clarification (See chapter 4), weakly stated disagreements’ (Pomerantz 1984: 77) and, notably here, accounts (Heritage 1984b).

As Pomerantz and Heritage (2012) assert ‘disagreements, disconfirmations and rejections that are performed with delays, prefaces, mitigation and accounts are interpretable as ‘reluctantly’ preformed instances of the action’ (2012:215). In the present corpus however it became apparent that patients, in a turn-initial position, often enacted more ‘direct’ forms. In the following fragments, systematic accounts of side effects are prefaced with more overt rejection of the psychiatrists’ proposal/offer. The declinations of treatment are not mitigated or delayed, but are structurally typical of an agreement: placed directly after the proposal/offer without hesitation. Extract 3 displays an example.

Extract 3 (Outcome - Not prescribed)

```
01 DOC:.tch .hhhhhh (.) ↑if the voices are really bothering you: >I  
02     can< in↑crea::se your injection >a little bit< if you wa::nt.  
03 PAT: No::: if, (.) if you increase it then I might get side  
04     effects you know like
```

By designing his turn in line 01 with a conditional + main clause syntax (Curl 2006), the psychiatrist offers an increase of antipsychotic injection in attempt to suppress the patient’s voice-hearing. The patient deploys a flat ‘no’ response that is significantly elongated in line 03. He not only refuses, but designs his turn in a way that is *structurally* aligned with an

agreeing response. As Pomerantz (1984) notes 'in general agreements are performed with minimisation of gap between the prior turns' completion and the agreement turns initiation' (1984:65). His response thus manifests as markedly more direct than characteristic shapes of dispreferred responses e.g extract 1. This acts to assert the patient's epistemic rights in the matter at hand: he claims his right to reject the offer. However, as with the prior extracts – structurally *typical* of dispreferred responses - this immediate refusal is qualified. The patient produces an account, formulating a causal link between a medication increase and the prospective physical contingency of 'side effects'. The patient's resistance to treatment is similar in extract 4.

Extract 4 (Outcome – not prescribed)

01 DOC: a::nd u::m (0.8) I was thinking Claire that we would be
02 able to::: (.) increase your risperidone a little bit.
03 (.)
04 i::f you >would agree?<
05 PAT: No::: >because it makes me tired.<
06 (.)
07 PAT: The more medication I take the more tired I become.

The psychiatrist delivers a proposal to increase the patients' antipsychotic medication (Risperidone) across lines 01-04. Again, the patient asserts the right to decline: delivering an immediate elongated 'no' response. Like earlier fragments, she formulates an account with present tense 'it *makes* me tired', framing this side effect as something that is *generally* the case when taking Risperidone, rather than one *possible* contingency or based on a quantifiable incident(s). When the psychiatrist does not take a turn at line 06, the patient upgrades her account, like extract 3, expressing a causative relationship between taking 'more medication' and becoming 'more tired'.

By directly declining *and* accounting, she does leave it to the psychiatrist to detect the upshot (cf Drew 1984) of these physical circumstances i.e. that she will not accept an increase of medication. However, the account accomplishes a consistent function: ascribing a ‘no fault’ quality to her report – her declination is premised on her (physical) inability, rather than a more indiscriminate unwillingness.

Note again, in extracts 3 and 4, features of the psychiatrist’s offer and proposal are expressed tentatively with optionality on behalf of the patient. Both are commenced with turn initial delaying devices (Pomerantz 1984, Schegloff 2007) and explicitly marked as contingent on the patients’ preferences (if you want – extract 3), (if you would agree extract 4). Moreover, in extract 4, the psychiatrist uses the hypothetical modal ‘would’ that can be seen as a hedge: used as ‘part of a tentativeness strategy’ Preisler (1986:92). By attending to the capacities and desires of the patients, such formulations may therefore embody ‘orientations to known or anticipated contingencies’ (Curl & Drew 2008:129), subsequently realised in patients’ resistive accounts.

Extract 5 shows a similar orientation. Here, the patient directly refuses a hedged proposal to increase her antipsychotic medication with reference to a physical contingency: it would make her ‘too lethargic’.

Extract 5 (Outcome – not prescribed)

01 DOC: Do you ever hear or see anything when you’re on your own

02 in the [house.

03 PAT: [No::: no=

04 DOC: =You ↑never hear voices talking to you about ↑this?

05 (0.6) ((Patient shakes head))

06 DOC: No?

07 PAT: Nothing at all no.

08 DOC: And you never see giant moths o:r [anything like that.

09 PAT: [No::::: I never see giant

10 moths °°no.°°

11 DOC: .hhhh (0.6) I mean one thought I did ↑ha:::ve (.) was (0.4)

12 ↑whether (0.4) it'd be worth increasing your depo slightly.

13 PAT: ↑No[::::::::::

14 DOC: [Just to see if it would reduce it.

15 PAT: No::::: it would make me too leth:::rgic and I wouldn't be

16 able to cope with Cli:ve.

This proposal-resistance fragment follows an extended discussion regarding the patient's psychotic experiences. The psychiatrist inquires if these feelings are worse towards the latter part of the interval between her antipsychotic depot injections - which the patient confirms. Key here, is that the patient does not acknowledge these feelings may be related to her illness i.e. 'delusions'. She claims to be worried and puzzled by people in her village who perceive her to be 'special' and wish to sacrifice her to a 'giant moth' – something she believes to constitute 'reality'. Otherwise, she expresses contentment with her life.

Following this, the doctor deploys a string of interrogatives across lines 01 - 08 to solicit (dis)confirmation that the patient hears voices or 'sees' things, a typical method of assessing psychotic symptom severity. The patient discounts these possibilities with some certainty: she provides a series (lines 03, 07, 09) of 'no- problem' (Heritage & Sorjonen 1994:8) responses that, at lines 03 and 09, are delivered before the psychiatrist has come to completion of his question: in interjacent overlap (Jefferson 1986). To deploy a proposal for increasing treatment at this point - an intervention specifically designed to deal with the *presence* of these symptoms - would be at odds with the patient's responses, thus a delicate action (see also extract 2).

Accordingly, across lines 11 and 12 the psychiatrist makes a proposal that, in several ways, is constructed tentatively: embodying an orientation to contingencies being associated with its acceptance. He deploys a turn initial delaying device (Pomerantz 1984, Schegloff 2007): a long inbreath followed by an intra-turn pause before beginning to speak. Additionally, like extract 02, his turn is prefaced with 'I mean', hearably displaying *spontaneous* reasoning that 'distances' him from this potentially face threatening action (Fox Tree et al 2002:745). Indeed, the psychiatrist continues his turn with 'one thought I did have', framing the proposal as somewhat transient: 'one thought' relative to firmer epistemic commitment e.g. 'I think'. The remaining TCU ('was whether it would be worth increasing your depot slightly') is further hedged: the use of the conjunction 'whether' expresses a degree of doubt or choice between alternatives i.e. to increase/not to increase the patient's depot.

Like extract 3 and 4, the patient provides an instant rejection of the proposal in line 13. Immediately, the psychiatrist recompletes his proposal with an account: 'just to see if it would reduce it' in terminal overlap (Jefferson 1986). This turn is 'parsable as not a TCU, but as an increment to the prior talk by same or other speaker, at least in part because it does not start with a recognisable beginning' (Schegloff 1996b:74). Specifically, he commences this increment with 'just'. This device hearably minimises the onus of the proposal: it distils the *essence* of its purpose as a mere experiment: 'to see if it would reduce it' (the pronoun 'it' here substitutes reference to the patient's 'delusion'). This suggests an orientation by the psychiatrist to the potential trouble a depot increase could cause to the interaction, and an attempt to manage that trouble. In making the proposal sound simple and 'impermanent', acceptance is arguably made easier. As Davidson (1984) asserts, given rejection a speaker 'may then display that he is attempting to deal with whatever inadequacy in the initial version led to the rejection, where this attempt is displayed through the inviters' or offerers' doing a subsequent version (1984:107).

By recompleting his proposal, the psychiatrist reinvokes the relevance of a new response: 'the doing of some subsequent version provides a place for another response, presumably an acceptance, but of course possibly a rejection or rejection-implicative object' (1984:108) Indeed, the patient overtly rejects: deploying a second elongated 'no', without hesitation. She continues her turn to deploy a characteristic account, explicating a negative side effect

contingency: 'it would make me too lethargic'. She further augments this account – increasing its incontestability - by adding a consequence: a restrictive responsibility in her life involving a third party: her son Clive.

Extracts 01 – 05 display the systematic resources through which patients' enacted resistance to proposals and offers in this corpus. The routine procedure identified was the production of accounts relating to side effects: the area of treatment over which they retain primary epistemic rights. This resistance was often direct - structurally untypical of dispreferred responses - and frequently resulted in the proposed/offered medication remaining unprescribed. Indeed, psychiatrists' oriented to anticipated contingencies in their formulation of proposals/offers: foregrounding the capacities of the patient or constituting the action 'delicate'. As such, unlike alternative action formulation coded in part 1 e.g. suggestions and pronouncements, the psychiatrist does not claim an explicit clinical perspective on what the patient *should* do. In 3 cases that deviated from this pattern of accounting however, it appeared to be precisely this lack of claimed epistemic entitlement that underpinned patients' subsequent resistance. This is demonstrable in the following example.

6.6.2 Patient orientation to the psychiatrist's expertise – postponing acceptance

Resistance also occurred in relation to decisional responsibility itself. In such cases, patients exploited the normative sequential structure (Stivers 2005, Koenig 2011) of the recommendation sequence by postponing acceptance to counter decisional responsibility. Ultimately, this occasioned reformulation that aligned with the patient's preference for psychiatrist expertise - which subsequently received acceptance. This series of events is analysed in extract 6 in which the patient orients to the psychiatrist as accountable for employing his *own* knowledge in the decision making process.

Extract 6 (Outcome – prescribed)

01 DOC: .hh ↑no::w, (.) shall I increase your medication a little
02 bit.
03 PAT: It's entirely up to you::: [you] know I don't know what

25 DOC: I'll write (to you about that) as we:ll but of course y- y-

26 you show him this piece of ↑pape::r.

Following a series of optimised declarative questions regarding the patient's drug and alcohol use (to which he claims there is problem), the psychiatrist shifts activity in line 01, offering an increase of medication. Using the auxiliary verb *shall* and first person pronoun *I*, he foregrounds himself as the agent (Curl 2006) of the increase and frames the offer as a yes/no interrogative. By soliciting the patient's preparedness and preference, the psychiatrist positions himself in a K- position (Heritage 2013: 388), making relevant an acceptance or refusal. The patient opts for neither of these 'relevant' responses, instead providing a 'nonanswer response' (Stivers 2010) in line 03. This constitutes an immediate and explicit reversal of the decisional responsibility invoked in the offer; 'It's entirely up to you::', receipted by the psychiatrist in transition space overlap (Jefferson 1986). However, the patient uses a medial 'turn-holding' (Fox Tree et al 2002) 'you know' to continue: attempting to account for his failure to produce an answer 'I don't know what you::'; claiming insufficient knowledge to accept or decline. This functions to counter (cf Schegloff 2007:109) the offer by framing the psychiatrist as accountable in the decision-making process.

While this response does not rule out the possibility of accepting, it 'impedes the progress of the sequence at hand' and is thus 'disaligned' (Hayano 2013:213) with the psychiatrist's action – acceptance is tabled as conditional on the psychiatrist's decision. The patient's nonanswer therefore orients to the action as insufficient in its original form, suspending the relevance of acceptance/refusal in favour of further treatment-relevant talk. Making relevant a next action by the psychiatrist i.e. opinion-giving, this turn is characteristic of Stivers (2006) definition of 'active resistance': 'both a responsive and initiating action' that makes it 'a stronger type of resistance' (2006: 288). Until the patient clearly accepts (or declines) the offer, the sequence here cannot come to a closure. The treatment formulation 'must be extended to obtain patient acceptance.' (Koenig 2011:1107), allowing advancement to the next activity. As such, the patient has manipulated the normative sequential structure, creating an opportunity for the psychiatrist to make his formulation more acceptable.

Notice the psychiatrist does not immediately respond with the opinion requested. In fact, he does not do so until line 17. In the intervening period – lines 06-12 - the doctor elicits a series of agreements as to the nature of the patient's existing treatment. That this may be done in service of pursuing realignment *and* defending his offer is tenable. Firstly he commences 'spontaneous' (Fox Tree et al 2002) reasoning with the declaration 'I mean you are on se-quetiapine'. The turn-initial "I mean" in line 06, like earlier fragments, appears important. It has been argued that I mean can be used to introduce commentary and justification (Fox Tree et al 2002, Schiffren, 1987). Furthermore, Maynard (2013) describes I mean prefaced utterances (IMPUs) in contexts of misalignment (complaint sequences). Specifically how, if the recipient shows resistance through silence or lack of aligning responses, IMPUs can operate as 'defense mechanisms', functioning to defuse the speakers' own action in order pursue aligning uptake and 'defend the stance previously exhibited' (2013:206).

Secondly, following receipt from the patient in line 07, the psychiatrist continues to assert the details of the patient's treatment, but designs his talk in a manner that discreetly highlights the different epistemic positions they occupy i.e. psychiatrist-prescriber, patient medication-taker. In the middle of formulating a declarative statement in line 08 'you're taking.....220mg twice a day', he retreats from completion with a self-repair to insert 'according to my report'. Given that such repairs reveal the design choices made by a speaker, they show which alternatives matter to participants (Drew et al 2013). Here, the insertion of evidential grounds was important enough for the psychiatrist to prioritise the repair over more immediate completion of the turn. His addition displays to the patient the second hand/indirect source of his information (Pomerantz 1984, Bergmann 1992), thus projecting the patient as authoritative.

While the patient confirms his regimen in Line 10: 'yeah', the doctor pursues further confirmation in 3rd position with a y/n interrogative 'is that right?', 'downgrading' his epistemic status further and reinvoking the relevance of (dis)confirmation from the patient. Despite a more hedged response 'I *think* that *sounds* right' that he accounts for in *inability* terms (Heritage 1984b) 'I haven't bought it with me so I don't know what's on the box', the psychiatrist appears ready to deliver the opinion made relevant back in line 5. Having established common ground on treatment, he hastily receipts the patients' turn in line 16 in

interjacent overlap (Jefferson 1986) and proceeds to deliver an alternative action formulation in line 17: the pronouncement 'I'd like you to increase it.' He both projects himself in a more K+ position in terms of appropriate treatment and personalises his formulation 'I'd like', positioning himself as accountable for the decision. Following specification of this increase in line 19, patient accepts the 'upgraded' formulation in line 20 'right, alright'. By postponing acceptance until his preference for medical authority has been satisfied, the patient has actively participated in how the ultimate decision emerges as acceptable (Koenig 2011). Both speakers then orient to movement onto the next phase of activity, prescribing, as being allowed. The psychiatrist offers to write 'it' (their decision) down (line 21) and the patient informs the psychiatrist he is also due a 'prescription' from his GP (line 22), advancing progressivity into a new phase of their encounter (Stivers 2006).

The resources through which the patient has realised resistance contrast markedly to the prior extracts. He has not drawn on his own epistemic resources to assert an inability to grant the offer. Conversely, this inability is conveyed as a *lack* of epistemic resources - delaying acceptance until this epistemic misalignment has been reconciled. This case thus displays an alternative orientation to the constitution of 'expertise' in the encounter. We turn to discussing these findings, and those from Part 1, including their relevance for adherence.

6.7 Discussion

6.7.1 Summary of main findings

A range of practices that psychiatrists deploy to initiate treatment decisions in schizophrenia – an area underexplored in psychiatry - have been mapped in this chapter. By developing a protocol and classifying treatment formulations in 4 categories 1)pronouncements 2)suggestions 3) proposals 4)offers, distinguishable by their collaborative character, an overview of some of the methods available to clinicians has been provided. While psychiatrists have resources to assume a paternalistic stance i.e 'pronounce' a treatment decision, the findings broadly suggest that work is done to pull back from an authoritarian position. Most frequently, formulations were designed as proposals: projecting the decision as a *joint* responsibility. A lexical practice implicating the magnitude of decisional accountability (patient or psychiatrist) was observed as personal pronouns (I, we, you). Despite relevant

alternatives for the same action, pronouns were routinely used to foreground patient preference (offers - you formulations), psychiatrist endorsement (suggestions - I formulations) or the clinician-patient partnership (proposals - we formulations). Formulations could thus be usefully conceptualised along a continuum (from pronouncements to offers) in terms of decisional responsibility. Patients frequently overtly resisted those characterised by *less* psychiatrist responsibility – proposals and offers.

By employing conversation analytic techniques to augment these findings, two systematic resources by which patients accomplished resistance to proposals and offers were detected. Indexing alternate orientations to the constitution of 'expertise' in the encounter, these appeared discriminatory in terms of prescription status. Most frequently patients oriented to their own expertise - resisting proposed treatment (often structurally 'directly') by appealing to the physical contingency of side effects. Such accounts displayed an attempt to manage the dispreferred action underway. By formulating internal sensory experiences within their epistemic domain (often in 'extreme' constructions (cf Pomertanz 1986)), induced by *external* factors i.e. the medication, patients invoked an *inability*, rather than unwillingness, to comply. Indeed, psychiatrist's proposals and offers were often constituted 'delicately', embodying anticipative orientation to such contingencies. Where this type of resistance was present, medication frequently remained un-prescribed.

Conversely, in a smaller set of cases, patients oriented to the *psychiatrists'* expertise by resisting decisional responsibility itself. In analysis of a contrasting case, the patient postponed acceptance of the treatment offer in service of *countering* decisional responsibility. This ultimately occasioned psychiatrist reformulation of his offer to instead *recommend* a treatment, in accord with the patient's preference – subsequently receiving acceptance. Where this type of resistance was observed, medications were prescribed. The implications of these findings for decision-making and adherence in schizophrenia are next discussed.

6.7.2 Implications for decision-making and adherence in schizophrenia

The application of partnership approaches to decision-making are hindered by a lack of clarity in terms of what *actually* happens in psychiatric encounters and the interactional consequences of alternative approaches. Descriptive findings are necessary before

understanding how, and if, patients' adherence can be improved through shared decision-making practices, underscored by the inconsistent research base, identified in chapter 2. While characteristics of schizophrenia e.g. positive symptoms (Hamaan et al 2006) may problematise the realisation of the SDM ideal, the data yielded in this study indicates, at least in terms treatment formulations themselves, the asymmetry that can manifest in doctor-patient communication (Heritage & Clayman 2010) e.g. through unilateral directives (Byrne & Long 1976) is predominantly diffused, yet susceptible to resistance.

Expanding research beyond treatment 'recommendations' per se reveals the more explicit ways psychiatrists and patients orient to the validity of *experiential* expertise and the contingencies associated with psychiatric treatment. Consultations are premised on an expert view being necessary to resolve patients' problems. Relative to patients, doctors are typically conferred greater epistemic rights due to their significant access to resources regarding medical and diagnostic decisions (See Heritage 2005b). The treatment decision itself is one point where epistemic asymmetry *can* be particularly exposed. Arguably, regardless of the action formulation the psychiatrist deploys; pronouncement, suggestion, proposal offer, he is still in a K+ position relative to the patient (Heritage 2012) e.g. via specialist knowledge acquired in medical training. However, treatment of chronic conditions like schizophrenia presents a unique context: 'expertise' may be more fluid with regard to certain domains. The frequently enduring nature of anti-psychotic treatment, vulnerable to intolerable side effects, inefficacy (Lieberman et al 2005) and divergent evaluations by patients (Hellewell 2002) creates a domain in which they may retain the 'specialist' knowledge. Given that psychiatrists' informedness of such effects can only be derivative i.e. '2nd hand', recognising patients' epistemic primacy may be mutually beneficial in terms of achieving appropriate treatment decisions. Indeed, when examined in more detail proposals were routinely designed in 'hedged' ways that appeared sensitive to possible contingencies - matters in patients' epistemic domain - involved in their granting. Their assembly may therefore relate to considerations of recipient design: the 'multitude of respects in which the talk by a party in a conversation is constructed or designed in ways which display an orientation and sensitivity to the particular other(s) who are co-participants' (Sacks & Schegloff 1974). As Hudak et al (2011) argue while appearing to be the doctor's proposal alone - recommendations may *reflect* a patient's

treatment preference. This offers explanatory potential in terms of why resistance was more frequent for proposals and offers, relative to suggestions or pronouncements. In neurology settings Monzoni (2011) found patients' resistance was maximal when topics were within their own 'epistemic remit' (2011:196). Relatedly, patients explicitly used physical contingencies, adverse side effects over which they hold epistemic rights, to account for the dispreferred action underway. Facilitating the assertion of such experiences may be constructive for clinicians in finding/modifying appropriate treatment, with minimal side effects, that attracts adherence long term. Thus (as posited in Chapter 4), the *presence* of misalignment: here resistance that problematises the preferred course of action, may through this lens be interpretable as a positive. Like NTRIs (Chapter 4) and declarative questions (Chapter 5), this in certain respects departs from what might be typically glossed as 'positive' communication on a more global level. Construing 'agreement' about treatment as the prerequisite for adherence (Martin et al 2005), arguably neglects such nuances. Resistance to treatment proposals and offers, at least on a micro-level, may index patients (and psychiatrists) orienting to the, often distressing, physical contingencies associated with anti-psychotic treatment, leading to medication changes – appropriately – remaining *un*-prescribed.

Alternative formulations e.g. suggestions and pronouncements may be more 'difficult' to resist, at least overtly. On epistemic grounds, it would position the patient in opposition with an 'expert' opinion (Toerien et al 2013), often one that was personally endorsed e.g. constructed in 'I' (think/suggest/advise) formulations. Thus, although patients have ways of passively asserting agency and preferences following treatment formulations (Koenig 2011, Stivers 2005), a *recommending* turn itself is not designed to *invite* them to do so: contingencies, or the possibility of non adherence, are not as strongly oriented to as an option. Resistance here would contradict the doctors' opinion: an interactionally delicate action with potential 'face' consequences for the psychiatrists. Conversely, when formulations are designed as proposals and offers, the patient does not need to work in epistemic opposition to an explicit expert view. They are *invited* to engage in decision-making, based on their preferences. However, a lack of claiming medical authority may cause interactional difficulty in itself. A second nuance of resistance in decision-making was identified in this study – that

of patient resistance to decisional responsibility itself. Thus, this chapter adds to an emergent theme in this thesis: the question of whether the softening of paternalism is in fact a preferable outcome (Pilnick & Dingwall 2011). Specifically, do patients always *want* greater choice? As evident in this analysis, patients with schizophrenia sometimes actively *seek* a formulation that contains an expert opinion: delaying acceptance until this has been forthcoming.

6.7.3 Limitations

This chapter should be considered within the context of its limitations. While the final sample size was larger than many studies examining treatment recommendations, the extent of individual formulation categories was relatively narrower. Certain results may thus warrant caution. Patient resistance to formulation classes were presented in a ratio format - and analysed further in Part 2 - on the assumption these relative frequencies may have broadly held in a larger corpus. This may be sufficient for an exploratory study, but given that some formulation categories were small (e.g offers 13), one would hope to replicate these findings in a larger dataset – and explore statistically - for greater confidence. Secondly, while sequential analysis was performed to examine the nature of patients' overt resistance, the focus was exclusively proposals and offers. Further research might take a situated analysis of *all* practices in order to fully map the ways in which decision-making-in-action (Rapley 2008) is accomplished and its consequences for patient uptake.

Thirdly, aspects of the analysis were grounded in assumptions that have emerged out of CA research on treatment recommendations (e.g. Stivers 2007, 2005b). However, the focus here expands beyond 'recommendations' per se. As Toerien et al (2013) asserts:

‘the standard conversation analytic account of the treatment phase will need revision. This currently takes the recommendation sequence as a given. For example, key texts discussing the application of CA to clinical encounters carry summaries of Stivers (2007) work as the sole discussion of how treatment decisions are reached.....despite published evidence that clinicians may...actively pursue patients' contributions' (Toerien 2013: 26).

Such texts have focused largely on actual recommending rather than those practices e.g. proposals and offers that may, epistemically, be more relevantly resisted. While, attempts were made to circumvent such limitations – for example focussing on overt rather than passive resistance - evidence regarding normative acceptance/passive resistance has not been

substantiated with the full array of decision-making practices (e.g. those designed to *invite* patients to participate) or contexts e.g. psychiatry.

This fourth and final study, raises several issues of collective significance for this thesis. We turn to a more detailed overarching discussion, consolidating the findings in relation to patient adherence.

Chapter 7

Thesis discussion

7.1 Summary of findings

Clinician-patient dialogue forms the basis of psychiatric treatment, yet remains understudied observationally. Three core communicative practices have been described in this thesis: patient other-initiated repair, psychiatrist questions and alternative action formulations for treatment recommendations. Concurrently, the utility of a mixed methods approach, i.e. synthesising quantitative/coded and interactional data, has been established. The resulting series of findings have been discussed in terms of their applied relevance for treatment adherence. In this culminating chapter, these conclusions are collectively expanded to assess overarching methodological, clinical and theoretical contributions. In doing so, the original aims (to examine: 1. what actually happens in naturally-occurring psychiatric encounters 2. the specific communicative practices related to patient adherence 3. the explanatory mechanism of such a relationship) are consolidated within the scope of all three practices. Opportunities for further research, deduced from these findings, are also highlighted.

Five contributions will be discussed that collectively extend existing knowledge on medical interaction: offering explanatory potential or demonstrating the utility of the methodology used. These are thematised as follows:

1. The consequentiality of psychiatrists' communicative choices
2. The manifestation of alliance and adherence in clinical talk
3. A democratic decision making forum: orientation to experiential expertise and the contingencies of antipsychotic medication adherence

4. Reconceptualising ‘good’ communication: misalignment as key to clinical success and adherence
5. Evidence of the interaction order in schizophrenia
6. A mixed methods approach: reconciling the nuances of naturalistic interaction and clinical outcomes

Before elaborating on each theme, the main analytic findings are first re-iterated and some overarching limitations addressed.

In Chapter 1, the therapeutic alliance was conceived as a candidate intervention point for supporting adherence, aiding prevention of relapse. Mediated through talk itself, identification of best practice is hindered by a lack of conceptual clarity around the constituents of ‘good’ communication. Typically construed via abstract models of ‘patient-centredness’ and ‘shared decision-making’, the chapter questioned whether these ideals pragmatically translate into employable techniques for clinicians. Despite the appeal of a single unified set of principles guiding communication, the conclusion was drawn that examination of *actual* practices used by psychiatrists and patients is an essential and logical precursor to evaluating how the values of patients may, or may not, be advanced. To accomplish this in schizophrenia is particularly important: its complex psychopathology may present additional challenges in the implementation of ‘patient-centred’ ideals.

To establish the validity of clinical encounters as an intervention point, a systematic review (Thompson & McCabe 2012) was reported in chapter 2: discerning the existence and extent of the connection between communication/alliance and adherence, and methodological shortcomings in the field. A consistent association was identified for both phenomena, but further research of naturalistic/observer-rated communication was advocated to facilitate application in practice. While the findings indicated that agreement on the tasks of treatment and collaborative communication may be instrumental to adherence, the generality of these constructs is problematic. Moreover, the preponderance of research relied on cross-sectional methodologies that limited the explanatory potential of findings. Applying qualitative methods that account for more *proximate* context and the *co*-construction of meaning in

interaction was concluded as offering benefits in both respects. Starting with this ‘micro-level’ could allow identification of tangible practices from which to explore the relationship with ‘higher-level’ constructs i.e. the alliance or behavioural outcomes i.e. adherence.

Chapter 3 established conversation analysis (CA) as an appropriate combinative means to address such shortcomings and generate explanatory hypotheses regarding the link between *observable* practices and better adherence. How CA systematically analyses talk as action was described, in addition to its medical and, to date minimal, psychiatric applications. However, one relevant application in psychiatry was identified. Rather than defining ‘good’ communication in some abstract sense, McCabe et al (2013) focused on the *details* of how psychiatrists’ and patients’ work to sustain mutual intelligibility in consultations. Specifically, by utilising the practice of repair within CA. Using a standardised protocol, McCabe et al (2013) identified that a specific type of repair, NTRIs and subsequent psychiatrist repairs, was associated with better treatment adherence: forming the basis for the 2nd study in this thesis.

Building on McCabe et al (2013), patient other-initiated repair was analysed and described in situ in Chapter 4. The concept of repair was elaborated and exemplified with data before describing observable patterns in the corpus: repair management sequences and the sequential environment of psychiatrists’ utterances targeted by NTRIS. The findings showed that open-class repair initiations (OCRI) were most frequent and typically occurred in response to questions, initiating an insert expansion sequence to address the ostensible trouble. OCRI were most frequently deployed in a *pardon?* or *sorry?* format – construable in terms of their relative politeness compared to other forms e.g. *huh?*. Further evidence that these forms may be unequal alternatives included different orientations to the ‘trouble’ by the psychiatrist: *sorry?*/*pardon?* formats were frequently oriented to with verbatim repeats, while *‘huh?’* was routinely responded to with a modified version of the original question, suggesting it may have been ‘innappropriate’ in its original form. There were further recurrent patterns in the sequential environment of the psychiatrists’ questions targeted by OCRI. Specifically: they were routinely hearable as topically or sequentially incoherent (Drew 1997) with the immediately prior talk. While sequential sources of trouble e.g. an abrupt unmarked topical shift, displayed overlap with those identified in ordinary conversation, they could often be explained by the institutional agenda. In a set of cases, the psychiatrist post-expanded a base

question-answer sequence in order to pursue a more clinically-specified, response. This action however may not have been interpretable to the patient: the question was hearable as 'already answered' (thus sequentially incoherent), following which repair initiation occurred. The findings were discussed for their relevance in terms of the constitution of relationships, intersubjectivity and adherence in talk and how the *presence* of misalignment and misunderstanding might be (mis)construed.

The sequential implicativeness of psychiatrists' questions, identified in Chapter 4, prompted examination of their nature more widely in Chapter 5. The development of a standardised protocol, classifying questions according to their linguistic structure, was described in addition to correlational analyses between alternative question types and measures of adherence and the therapeutic relationship. A small subset of question types were established as regularly used by psychiatrists: 1) Yes/no auxiliary questions 2) Wh questions 3) Declarative questions 4) Tag questions. Only questions in declarative form were correlated with better patient adherence and psychiatrist perceptions of the therapeutic relationship. On further examination using CA, these questions were recurrently demonstrable as so-prefaced formulations of patients' prior talk that displayed sensitivity towards the emotional aspects of accounts or troubles tellings e.g. so you feel a bit anxious? While exhibiting understanding of patients' contributions (and allowing psychiatrists to distil summaries within a psychiatric frame of relevance), they simultaneously limited them: declarative questions were associated with sequence constraint (in 3 ways; minimal patient responses; absence of third position post-expansion; subsequent topic change by the psychiatrist) and statistically correlated with less patient talk overall within consultations. These findings were discussed as supporting a more granular analysis of question types: declarative formulations provide a candidate intimation of psychiatric practice-in-action and how adherence, relationships and intersubjectivity may be constituted in, or improved by, clinical interaction.

While Chapters 4 and 5 addressed generic practices of talk-in-interaction, Chapter 6 described a more specific site: the formulation of treatment decisions, the necessary precondition for adherence behaviour. The development of a standardised coding protocol was described: classifying alternative action formulations for treatment recommendations. It was found that psychiatrists predominantly oriented to decisions as optional: designing their

formulations as proposals and suggestions. Alternative action formulations could be usefully conceptualised in terms of decisional accountability, accomplished, in part, by the deployment of personal pronouns. First person (I and we) and 2nd person (you) pronouns were routinely used between formulation classes to foreground patient preference (offers – ‘you’ formulations), psychiatrist endorsement (suggestions – ‘I’ formulations) or the clinician-patient partnership (proposals – ‘we’ formulations). Patients’ overt resistance was more frequent in response to formulations characterised by *less* psychiatrist responsibility – proposals and offers. Examining the nature of this resistance, patients not only opposed proposed/offered treatment, but decisional responsibility itself. Two practices were detected indexing alternate orientations to the constitution of ‘expertise’ in the encounter. Most frequently patients oriented to their own expertise, resisting proposed treatment with accounts of side effects (often ‘directly’ – described with reference to preference organisation). By formulating internal sensory experiences within their epistemic domain (often in ‘extreme’ constructions (cf Pomertanz 1986)) induced by external stimuli, patients invoked an inability, rather than unwillingness, to comply. Where this type of resistance was present, medication frequently remained un-prescribed. In a smaller set of cases, patients oriented to the psychiatrists’ expertise: postponing acceptance in service of countering decisional responsibility. This occasioned psychiatrist reformulation to instead *recommend* treatment – in accord with the patient’s preference – receiving acceptance. Where this type of resistance was observed, medications were prescribed. The findings were discussed in terms of the contingencies involved in psychiatric treatment and how misalignment, in terms of resisting the ‘preferred’ course of action, may counter-intuitively be a desirable feature of some treatment decisions

Discussed in individual chapters, these findings can now be considered in terms of their collective contributions. Before detailing these, in both clinical and methodological respects, some overarching thesis limitations are next addressed.

7.2 Limitations

This thesis should be considered within the context of its limitations. Study-specific issues have been addressed in each chapter. Here, more general contentions are detailed. Firstly,

while analysing naturalistic consultations retains significant methodological benefits, potential confounding variables should be reflected upon. In the datasets analysed, both psychiatrist and patient were asked to give consent; those who consented may differ from those who declined participation. As such, patients may not be randomly distributed among clinicians. For example, those who mistrust their physician might have terminated the relationship (Safran et al 2001), while others may have been attracted by particular unmeasured psychiatrist characteristics. Both participants may also modify their behaviour through knowledge of being observed (Coleman 2000).

The most notable concern is in relation to the construct validity of adherence: measured in the study upon which Chapter 4 builds (McCabe et al 2013) and in Chapter 5. Ratings were recorded by clinicians on two three point-scales (1 = good, 2= average, or 3 = poor) six months after the consultation, according to their assessment of adherence within the last three months. However, such subjective/indirect measures of adherence - heavily relied on in this field (See Chapter 2) – are problematic. As Velligan et al (2006) asserts ‘provider report may be based on the report of the patient or on a worsening clinical condition, which may be related either to poor adherence or to a failure of the chosen medication to control symptoms (Velligan et al 2006:735). Phillips et al (2011) also noted that doctors’ ratings of adherence are frequently related to their perception of clinician-patient agreement.

The studies reported in Chapter 4, 5 and 6 all emerged from coding protocols. This process of coding treats these phenomena as technical categories on the basis of pre-defined criteria - albeit developed from conversation analytic concepts (McCabe et al 2013, Chapter 6) or related disciplines such as linguistics (Chapter 5). However subsequent analysis was undertaken by a methodology - CA - that treats utterances as common-sense categories that are interactionally generated (e.g see Schegloff 1984) and not based on form alone. Something may take the form of a technically imposed category e.g. a question, but its action may be quite different e.g. complaining, disagreeing, displaying understanding. Combining these approaches may be of some utility, allowing consistent coding of a large corpus of data and statistical justification, but arguably combining them raises philosophical concerns.

Despite these limitations that warrant caution when interpreting the findings, there are some notable contributions of this thesis.

7.3 Clinical, theoretical and methodological contributions

7.3.1 The consequentiality of psychiatrists' communicative choices

While causality cannot be definitively determined, the findings contribute to a growing body of research that indicates clinicians' 'specific interactional choices can have surprisingly large effects on both the interaction itself and its outcomes' (Heritage & Maynard 2006b: 365). This potential was shown distally via statistical associations between declarative questions, the therapeutic relationship and adherence (Chapter 5), but also on a more proximate level: treatment proposals and offers of treatment were more frequently overtly resisted by patients than alternative action formulations (Chapter 6) and declarative questions were sequence constraining rather than expansive: associated with less patient talk overall.

Such resources thereby represent '*unequal alternatives*' (Enfield et al 2013), inextricably linked to patients' contributions. Such links have been observed elsewhere. Responses to the doctors' questions like 'what can I do for you today?' are on average four times as long as responses to the question 'sore throat and runny nose for two days, huh?' (Heritage & Robinson 2006) and the choice has a significant influence on patients' satisfaction, regardless of how long they actually spend presenting a medical problem (Robinson & Heritage 2006). Indeed, like other devices identified in CA, declarative questions are 'epistemically designed' to add little 'new to the sequence and thereby to effectuate a move toward closing the topic' (Heritage 2012:48). While indexing social relations aligned with a more institutional approach (Raymond 2010), counter to principles of patient-centredness that deem 'mutual participation' (Toop 1998) as core, the observed action nuances and association with the therapeutic relationship/adherence, suggest declarative questions offer a promising avenue for research in schizophrenia. Formal guidelines for questioning practices remain unspecified, beyond general advice discouraging overuse of 'closed questions' (Burton 2010). Conversely, declarative formulations - one subtype of 'closed' question - offer a sensitive device for intersubjectively grounding and displaying understanding of patient's contributions while capturing psychiatrically relevant upshots - crucial for appropriate treatment decisions, conducive to adherence. Moreover,

what would clinical interaction look like *without* these displays of understanding? Questions are also raised here about the potential role of formulations in the discussion of psychotic symptoms e.g. delusions. The psychiatrist must balance information gathering with sensitivity to patient experience, all the while maintaining an attitude of non-confrontation and non-collusion (Turkington et al 1998:237). Declarative questions, at least when so prefaced formulations, may be a device for *reconciling* these diametrical requirements. These findings open promising avenues for applied research.

Clinicians should be aware of the potential influence of their communicative choices, both despite, and in light of, adherence being a multi-factorially determined variable. Correlates of poor adherence include patient beliefs about their illness and the benefits of treatment (e.g. insight into illness, belief that medication can ameliorate symptoms), perceived costs of treatment (e.g. medication side-effects) (Perkins 2002) - all conceivably mediated by communication. Chapter 5 successfully assessed one of these correlates - the therapeutic alliance - and a practice of naturalistic communication (psychiatrists' questions), paving the way for further pathway analysis: identified as necessary in adherence research (Chapter 2).

7.3.2 The manifestation of alliance and adherence in clinical talk

A counter interpretation of directionality is that alliance and adherence *manifest* in communication itself. Statistical associations may be discernable as they reflect already engaged patients and positive therapeutic relations. Declarative questions - often formulations of patients' talk - may reflect psychiatrists' increased propensity to display empathic responses with engaged, adherent patients. Chapter 4 also highlighted the potential in recognising *patients'* communicative moves i.e. other-initiated repair. Initiating the resolution of disalignment, flagging sequentially 'problematic' questions, may represent more empowered and engaged patients. Moreover, patients' selection between unequal social practices for accomplishing this initiation may represent something telling about the clinical relationship. Most frequently patients selected *pardon?* or *sorry?*: interpretable as 'polite' (Brown & Levinson 1978) methods of addressing troubles-in-talk. Arguably, this could reflect a greater level of cooperation in saving face, thereby, on some level, better rapport or alliance. However, the relationship between CA and psychological constructs like relationships is a complex one. Conversation analysis is congruent with work on the

constitutive view of relationships. Rather than treating facets of social relationships as ‘independent variables with discursive consequences’ (Hopper & Chen, 1996:310), the constitutive view construes them as constituted and reconstituted, on a turn by turn basis, by practices of social action that are co-constructed by speakers (Mandelbaum, 2003). To assume the relationship is stable, independent and systematically reflected by specific practices of talk may be problematic. However, a fair conclusion seems that the phenomena examined in this thesis are not ‘inherently neutral in terms of their implications for social and personal relationships’ (Robinson 2006). The capacity to link communication practices to global measures of the relationship (Chapter 5) is certainly of both clinical and theoretical interest.

The findings also add to accumulative descriptions of psychiatric practice ‘in action’ (e.g. Bergmann 1992). This can be illuminated by returning to Heritage & Clayman’s (2010) definition of the fundamental elements of institutional talk provided in Chapter 3:

1. Participants are involved in specific goal orientations tied to their ‘institutional-relevant identities’ i.e. doctor and patient
2. There are special constraints on the interaction in terms of what will be treated as ‘allowable’ contributions to the business at hand
3. The interaction involves inferential frameworks and procedures specific to a medical context

Indeed, psychiatrists’ declarative formulations and questions targeted by patients’ other-initiated repair were comparable: their functions embodied these institutional drivers e.g. shifting rapidly between medically relevant topics, pursuing clinically specified responses and – through editing and transformation – filtering psychiatrically relevant upshots from patients accounts via formulations that functioned as sequence closing devices. This adds to how generic resources may be ‘shaped by the activities and thus the settings in which they are employed’ (Drew 2003).

Relatedly, an emerging consideration has been how such actions, while related to adherence, are interpretable as innaposite to principles of patient centredness that advocate instead *non-directive* interaction (Lawn 2007), increased patient participation and involvement in the agenda. Combined with the finding that some patients enact resistance to bilateral, in favour

of unilateral, decisions (Chapter 6), the prospect that many patients would *prefer* an asymmetrical doctor-patient relationship - and their adherence may benefit as a result - cannot be eliminated. Indeed, in the systematic review (Chapter 2), it was identified that shared decision making - to date at least - is inconsistently associated with adherence. This area warrants further attention: highlighting preference-sensitivity towards both antipsychotic medication *and* decisional responsibility itself as necessarily exercised by clinicians.

7.3.3 A democratic decision making forum: orientation to experiential expertise and the contingencies of antipsychotic medication adherence

While there is a concern that people diagnosed with schizophrenia are infrequently involved in treatment decisions and sometimes not even told their diagnosis (Bayle et al, 1999), the analyses in chapter 6 indicate that outpatient consultations are surprisingly 'democratic' decision-making forums. Treatment formulations were frequently designed to accommodate patient responsibility, often explicitly denoted by personal pronouns, marking the decision as 'shared'. In the 18-month Clinical Antipsychotic Trials for Intervention Effectiveness (CATIE) study (Lieberman et al, 2005) a remarkable 74% of patients discontinued medication prematurely and the most common reasons for discontinuation were patient choice, lack of effect or intolerability of side-effects. Indeed, the nature of patients' frequent resistance to treatment proposals and offers displayed both patients and psychiatrists orienting to the *validity* of such choice and experiential aspects of treatment. Patients' resistive accounts invariably referred to adverse side effects - their own epistemic domain - while the design of proposals and offers indicated there may be contingencies associated with their granting: perhaps communicating 'information to patients about physicians' expectations' Heritage (2011:340) or their 'entitlement' (cf Curl & Drew 2006) to make such decisions, given such contingencies associated with adherence.

A great deal of attention has focused on methods to *persuade* patients to adhere to treatment decisions, without sufficient acknowledgement that avoidance of sometimes complex, costly and unpleasant regimens may be entirely rational (Mitchell, 2007). By providing a more holistic picture - mapping a *range* of practices psychiatrists use to initiate decisions in naturally-occurring consultations - support for this perspective is offered here. Patients' resistive accounts were systematically derived from direct, indisputable, experience of

intolerable side effects, and hence were often not prescribed. Thus, achieving appropriate, *tolerable*, treatment may be contingent on this experiential expertise and the *presence* of resistance may index something clinically pragmatic and indeed something co-constructed.

7.3.4 Reconceptualising ‘good’ communication: ‘misalignment’ as key to clinical success and adherence

Agreement about treatment is often assumed, and cited (e.g. Martin et al 2005), as intrinsic to adherence. This has connotations of psychiatrists and patients being mutually aligned in discussions about treatment. The findings here suggest perfect alignment will not always be reached, and in fact may not be desirable. Some degree of misalignment or conflict between the views or actions of psychiatrists and patients may be necessary if true collaboration is to occur and a variety of treatment options, ways to adhere to them and associated contingencies are to be jointly considered (Katz 1984). In the case of antipsychotic medication, ‘expertise’ may be somewhat subverted: the assumption that ‘doctor knows best’ is tempered by the subjectivity of side effects over which psychiatrists cannot hold true epistemic authority: patients may need to disalign from particular courses of action accordingly.

A key contribution of this thesis therefore is in relation to how ‘good’ communication should usefully be conceptualised. The *presence* of misalignment: referring to the ways in which ‘participants to an interaction in a given moment steer their interaction in diverging directions’ (Voutilainen et al 2011), whether resisting the preferred course of action in treatment recommendation sequences (Chapter 6) or patients flagging sequential sources of trouble e.g. misaligned orientations to a questions’ action (Chapter 4) may, counter-intuitively, denote something clinically helpful. The findings underscore that there are constant matches and mismatches between the actions and the project they embody (Perakyla et al 2008) of the psychiatrist and patient, but while this is a central aspect of what in psychotherapeutic literature is called ‘ruptures of the therapeutic alliance’ (Safran & Muran 2006), such ‘ruptures’ and their repair (e.g Chapter 4) or the treatment decisions that emerge following them (e.g. Chapter 6 - not to increase or decrease a medication dose) may be crucial to adherence.

As Safran et al. (2001) suggest ‘the process of recognizing and addressing weakness or ruptures in the therapeutic alliance may play an important role in successful therapy.’ In this outpatient context, it may represent patients being open e.g. feeling empowered to address misunderstandings rather than glossing over them (Chapter 4) or directly declining a treatment that they know will induce intolerable effects (Chapter 6). Misalignment and misunderstanding on a micro-level may therefore ensure better ‘understanding’ more globally. As earlier alluded to abstract notions of ‘good’ communication, including agreement, (Chapter 1, 2) may need refining. As Healey (2008) asserts (in the case of language co-ordination), misalignment may be key to communicative success, contrary to common perceptions.

‘This emphasis on misalignment may seem counterintuitive. It contrasts with what many people ordinarily regard as the goal of successful communication. It also contrasts with the focus on communicative success that is characteristic of contemporary psycholinguistic models of dialogue. Although some models provide accounts of what happens when communication fails, these are treated as secondary or auxiliary processes....we argue instead that this priority should be reversed with misalignment treated as the primary focus for explanations of how sub-language coordination emerges and is sustained.’ (Healey 2008: 2)

The acknowledgment of differences and the manner in which they are dealt with may be important part of building respectful and trusting relationships between psychiatrists and their patients. This thesis provides empirical support for the claims that misalignment may be both a normal and significant part of psychiatric interaction. More global notions of patient centredness and SDM therefore – while ethically laudable concepts - may not be entirely pragmatic for improving outcomes when considering what communication *actually* looks like on a turn-by-turn level.

7.3.5 Evidence of the interaction order in schizophrenia

By employing conversation analytic techniques, each chapter has presented a series of recurrent patterns in terms of how particular actions are accomplished in outpatient encounters. The ability to identify systematicity validates CA as a useful method to examine psychiatrist-patient communication in schizophrenia and holds theoretical relevance more widely. For example, while previous literature in schizophrenia has focused on *cognitive* processes posited as preceding repair (e.g. psychotic symptoms) (Leuder et al 1992), Chapter 4 instead highlighted potential proximate – *sequential* – sources of troubles in psychiatric communication, similar to those that have been documented in ordinary (non-institutional)

conversation (Drew 1997, Curl 2005, Robinson et al 2010). By identifying generic practices, from those repair-related to the resources through which patients manage dispreferred actions e.g. deploying accounts (Chapter 6), the significance of Goffman's interaction order for clinical interactions is reinforced. Even here, where patients are experiencing the complex symptomatology of schizophrenia, often involving the *impairment* of 'order' in many cognitive respects (Van Os et al 2009). Thus, while institutional objectives and roles may disrupt or constrain aspects of interaction (Chapters 4 and 5) and certain generic practices are used to accomplish important institutional functions e.g. declarative formulations to distil psychiatric summaries (Chapter 5), evidence of the deeply engrained structures of interaction are here reinforced. As Heritage (2011) asserts, these structures far outdate the conception of medical communication itself:

'It is the notion that there is an interaction order – an institutional framework of norms, principles and associated inferential practices – that undergirds the structure and sense-making involved in human social interaction. This order has evolved and become sedimented into the habitus of human societies as a method of regulating social relationships of all kinds 'in the wild'....It is very stable and ontogenetically 'early' in the life of society, and of the individual persons who live therein. It is a resource through which all social institutions are sustained and, beyond and within them, identity, personhood and agency are renewed. The interaction order was not designed for the practice of medicine, the objectives and constraints of which are of very recent origin.' (Heritage 2011: 342)

By combining an approach that accounts for structural organisation with those approaches more characteristic to medicine e.g. coding and psychological measures of adherence/alliance, this thesis has articulated a possible methodology to counterbalance the need to identify actual practices of talk-in-interaction in psychiatry, with the applied interest of linking such practices to clinical outcomes.

7.3.6 A mixed methods approach: Reconciling the nuances of naturalistic medical interaction and clinical outcomes

This thesis has attempted to address the significant gap in research on naturally-occurring psychiatric communication. The central methodological contribution is a demonstration of how to produce a unified research account derived from different methods of inquiry. Despite the potential for philosophical inconsistency - outlined in the limitations - this thesis has greater value as a result of combining methods and comparing and contrasting findings from three studies. It also has more impact as an applied project in a field of research motivated by statistical associations with outcomes. Correlational inquiry and coding was used to inductively motivate in depth qualitative analyses and the utility of conversation analysis to

achieve this has been established. Analysing participants' orientations and the sequential characteristics of talk allows the troubles (Chapter 4) and consequences (Chapter 5 and 6) of clinicians' communication practices to be identified and shows 'how closely interdependent patient participation is with how doctors design their interactional moves (turns at talk) (Drew 2001: 64). Some of the choices psychiatrists make in their turns at talk and the sequential trajectories which result from these selections have been identified here.

While the issue of quantification has been somewhat controversial in CA (e.g. Schegloff 1993), these findings show promise in the pursuit of establishing which communication practices may be meaningful to outcomes like adherence. Combining qualitative and quantitative methods 'allows for the synergistic interaction between the two' (Epstein et al 2005:1522). After inductive quantitative/coding analyses yields a phenomenon of interest, CA provides a contextualised case-by-case analysis to generate explanatory hypotheses, in a detailed and transparent manner that is not possible with quantitative analyses alone.

7.3.7 Future research and concluding remark

The contributions of this work could be optimised through further research. During the course of this PhD, a series of decisions had to be taken regarding which of the many analytic themes that emerged from the data to pursue, leaving some unaddressed. For example, research might also be fruitfully invested in studying linguistic question types associated with symptoms (wh questions and YN interrogatives). Additionally, other formats of repair e.g. questioning repeats would be interesting analytic objects, given findings derived in other studies/setting to date (e.g. Robinson et al 2010).

In terms of the mechanisms underlying patient adherence, numerous hypotheses have been generated regarding the link between communication and adherence that could be further explored in mixed methods studies. This thesis could motivate theoretically grounded research to examine hypothesised pathways and mediators between communication practices and adherence. The rationale for studying these links requires two conditions: a plausible mechanism by which a specific communication practice influences adherence, and an instrument to measure that mechanism (Epstein et al 2005). Proximal outcomes of interaction that could be candidate mediators include those related to the therapeutic alliance

e.g. patient understanding and trust. For example, it has been shown that psychiatrists' declarative formulations show a simultaneous orientation to displaying (emotional) understanding while constraining sequence expansion. Future research might explore whether patients' feeling 'understood' in a more global sense is associated with both declarative questions and adherence in a path analysis. Such hypotheses are theoretically strengthened as they are grounded in empirical observations. Specifically, conversation analytic results, that 'are descriptions of the organisation of conduct that investigators validate qualitatively by reference to the participants' own actions in situ' (Heritage & Maynard 2006b: 365) Another hypothesis may relate to declarative questions and the questions targeted by patients' other-initiated repair indexing an institutional task-oriented approach to communication (Chapter 4 & 5). Coupled with the finding that sometimes patients orient to psychiatrists' expertise as preferable (Chapter 6), one might also wish to test 'trust' as a candidate mediator. Trust may be inspired in doctors who communicate paternalistically: implying expertise and more confidence in treatment. Such findings would pave the way for training interventions to optimise the therapeutic effects of communication by explicitly orienting communication to accomplish these intermediate outcomes (trust/understanding), in service of improving adherence.

Another analytic step would be to collect similar data in a different mental health setting to determine whether the findings are replicable across conditions. This would enable comparison and could take numerous analytic directions. For example, exploring other chronic conditions where patients' 'experiential expertise' (Chapter 6) might be evident and validly oriented to. Alternatively, it may be interesting to examine how the relationship between communication practices and adherence in schizophrenia may differ in an inpatient setting i.e. assess whether the various practices described here: e.g declarative formulations, patient other-initiated repair and the range of practices psychiatrists use in initiating decisions about treatment, can also be observed.

Observational studies offer a rare opportunity to micro-analyse clinicians' communication, while emphasising the importance of the patients' contribution. Psychiatrists seldom get to see how their colleagues attempt to question or recommend treatment and the interactional consequences of alternative communicative selections. In providing this opportunity

'providers may more consciously consider their interactions with patients' (Drew 2001). Such findings could be fed into training for psychiatrists and encourage reflective practice when addressing the ubiquitous problem of adherence in schizophrenia. This thesis has demonstrated the pursuit of exploring what *actually* happens in psychiatric encounters as one of theoretical, methodological and applied interest.

References

- Adam, S.G., Howe, J.T. (1993) Predicting Medication Compliance in a Psychotic Population. *Journal of Nervous Mental Disorders*, 181:558–560.
- Allardyce, J., Os, J. (2010) The natural history of the course and outcome of schizophrenia. *Advances in schizophrenia research*, 51- 65
- American Psychiatric Association (APA): Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC; 2000
- Andrew, A., Knapp, M., McCrone, P., Parsonage, M., Trachtenberd, M. (2012) Effective interventions in schizophrenia: The economic case. A report prepared for the Schizophrenia Commission. London: PSSRU at London School of Economics
- Antaki, C. (2008) Formulations in psychotherapy. In A. Peräkylä, C. Antaki, S Vehviläinen and I Leudar (eds.) *Conversation Analysis of Psychotherapy*, Cambridge. England; CUP.
- Artaloytia, J.F., Arango, C., Lahti, A., et al (2006) Negatives signs and symptoms to secondary to antipsychotics: a double-blind, randomized trial of a single dose of placebo, haloperidol and risperidone in healthy volunteers. *American Journal of Psychiatry*, 163: 488-93
- Arthbutnott, A., Sharpe, D. (2008) The Effect of Physician-Patient Collaboration on Patient Adherence in Non-Psychiatric Medicine. *Patient Education and Counselling*, 1: 60-67
- Bales, R.F. (1950) *Interaction Process Analysis: A Method for the Study of Small Groups*. Reading, MA: Addison- Wesley
- Battaglia, J. (2001) Compliance with Treatment in Schizophrenia. <http://www.medscape.com/viewarticle/418612> [01 July 2013]
- Bayle, F. J., Chauchot, F., Maurel, M., et al (1999) Survey on the announcement of schizophrenia diagnosis in France. *L'Encephale*, 25: 603–611

- Beach, W.A., (1993) Transitional regularities for ‘casual’ ‘okay’ usages. *Journal of Pragmatics*, 19, 325-352
- Beach, W.A. (1995) Conversation analysis: “Okay” as a clue for understanding consequentiality. In S.J.Sigman (Ed.), *The consequentiality of communication* (pp. 121–161). Hillsdale: Erlbaum
- Beach, W. A., Dixon, C.N. (2001) Revealing moments: Formulating understandings of adverse experiences in a health appraisal interview. *Social Science and Medicine*, 52, 25 – 44
- Bercelli, F. et al (2008) Clients’ responses to therapists’ reinterpretations. In A. Peräkylä, C. Antaki, S Vehviläinen and I Leudar (eds.) *Conversation Analysis of Psychotherapy*, Cambridge. England; CUP.
- Bergmann, J.R. (1992) Veiled Morality: Notes on Discretion in Psychiatry. In P. Drew and J. Heritage (eds) *Talk at Work* pp. 137-162. Cambridge: Cambridge University Press
- Bolden, G., (2009) Implementing incipient actions: the discourse marker ‘so’ in English conversation. *Journal of Pragmatics*, 45, 974-998
- Bolden, G., Mandelbaum, J., Wilkinson, S (2012) Pursuing a Response by Repairing an Indexical Reference. *Research on Language and Social Interaction*, 45: 137- 155
- Brown, P., & Levinson, S. C. (1987). *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press
- Brown J.B., Stewart, M., Ryan, B.L. (2003) Outcomes of patient-provider interaction. In T. Thompson, A. Dorsey, K. Mille, R. Parrott (eds) *Handbook of Health Communication*. Mahwah, NJ: Lawrence Erlbaum
- Bull, S.A., Hu, H., Hunkeler, E.M., Lee, J.Y., Ming, E.E., Markson, L.E., Fireman, B. (2011) Discontinuation of Use and Switching of Antidepressants. *JAMA*, 288:1403–1409
- Bultman, D.C., Svarstad, B.L. (2000) Effect of Physician Communication Style on Client Medication Beliefs and Adherence with Antidepressant Treatment. *Patient Education and Counselling*, 40:173–185.

- Burton, N., (2010) *Psychiatry*. Oxford: Wiley Blackwell
- Byrne, P.S., Long, B.E. (1976) *Doctors talking to patients: A Study of the Verbal Behaviours of Doctors in the Consultation*. London: HMSO
- Catty, J. (2004) 'The vehicle of success' Theoretical and empirical perspectives on the therapeutic alliance in psychotherapy and psychiatry. *Psychology and Psychotherapy: Theory Research and Practice*, 77:255–272.
- Caplan, R., Guthrie, D., Komo, S. (1996). Conversational repair in schizophrenic and normal children. *Journal of the American Academy of Child and Adolescent Psychiatry* 35 (7): 950–958.
- Charles, C., Gafni, A., Whelan, T. (1997) Shared decision-making in the medical encounter: what does it mean? *Social Science and Medicine*, 44, 7, 681- 92
- Charon, R., Greene, M.J., Adelman, R.D. (1994) Multi-Dimensional Interaction Analysis: A Collaborative Approach to the Study of Medical Discourse. *Social Science and Medicine*. 39: 955-65
- Clark, H. H., Shaefer, E.F. (1989) Contributing to discourse. *Cognitive Science*, 13, 259-294
- Cohen-Cole, S.A., Bird, J. (1991) Function 3: education, negotiation and motivation. In Steven A. Cohen-Cole, *The Medical Interview: The Three Function Approach*. St Louis, MO: Mosby Year Book, Chapter 5
- Coleman, T. (2000). Using video-recorded consultations for research in primary care: Advantages and limitations. *Family Practice*, 17, 422–427.
- Conley, R., Kelly, D. (2001) Management of treatment resistance in schizophrenia. *Biological Psychiatry*, 50, 898 -911
- Corriss, D.J., Smith, T.E., Hull, J.W., Lim, R.W., Pratt, S.I., Romanelli, S. (1999) Interactive Risk Factors for Treatment Adherence in a Chronic Psychotic Disorders Population. *Psychiatry Research*, 89:269–274

- Costello, B.A., Roberts, F. (2001) Medical recommendations as joint social practice. *Health Communication*, 13, 3, 241 - 260
- Coulehan J.L., Block M.R. (1997) *The Medical Interview: Mastering Skills for Clinical Practice*. Philadelphia: FA Davis Co Publishers
- Cretchley, J., Gallois, C., Chenery, H., Smith, A. (2010) Conversations between Carers and People with Schizophrenia: A Qualitative Analysis Using Leximancer. *Qualitative Health Research*, 20, 1611
- Cruz, M., Pincus, H.A. (2002) Research on the influence that communication in psychiatric encounters has on treatment. *Psychiatric Services*, 53, 1253- 1265
- Crystal, D. (1969) *Prosodic Systems and Intonation in English*. Cambridge: Cambridge University Press
- Curl, T. (2005) Practices in other-initiated repair resolution: the phonetic differentiation of 'repetitions'. *Discourse Processes* 39, 1-44.
- Curl, T.S. (2006) Offers of assistance: Constraints on syntactic design. *Journal of Pragmatics*, 38, 1257-1280
- Curl, T., Drew, P. (2008) Contingency and Action: A Comparison of Two Forms of Requesting. *Research on Language and Social Interaction* 41: 129- 53.
- Curtis, L. (2011) *Unit costs of health and social care*. Kent: PSSRU at University of Kent
- Davidon, J. (1984) Subsequent Versions of Invitations, Offers, Requests and Proposals Dealing with Actual or Potential Rejection. In J.M. Atkinson & J. Heritage (Eds) *Structures of Social Action*. Cambridge: Cambridge University Press. 102-128
- Day, J.C., Bentall, R.P., Roberts, C., Randall, F., Rogers, A., Cattell, D., Healy, D., Rae, P., Power, C., (2005) Attitudes Towards Antipsychotic Medication: The Impact of Clinical Variables and Relationships with Health Professionals. *Archives of General Psychiatry*, 62, 717-22

Deeks, J.J., Dinnes, J., D'Amico, R., Sowden, A.J., Sakarovitch, C., Song, F., Petticrew, M., Altman, D.G. (2003) Evaluating Non-Randomised Intervention Studies. *Health Technology Assessment*, 7:1–173.

Department of Health (2001) The expert patient: a new approach to chronic disease management in the 21st century. London: HMSO. PDF available online at <http://www.dh.gov.uk> [November 2010]

Depperman, A., Fogasy, S. (2011) Doctors' questions as displays of understanding. *Communication and Medicine*, 8, 111-122

Dexter Coder (2011) Dexter: Tools for Analysing Language Data (<http://www.dextercoder.org>) [06 January 2011]

Downs, S.H., Black, N. (1998) The Feasibility of Creating a Checklist for the Assessment of the Methodological Quality both of Randomised and Non-Randomised Studies of Health Care Interventions. *Journal of Epidemiology and Community Health*, 52:377–384.

Drew, P. (1984) Speakers' Reportings in Invitation Sequences. In J. Maxwell Atkinson and John Heritage (eds) *Structures of Social Action*. Cambridge: Cambridge University Press, 28-53

Drew, P., Heritage, J. (1992) *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press

Drew, P., (1997) 'Open' Class Repair Initiators in Response to Sequential Sources of Trouble in Conversation. *Language and Cognitive Processes*, 2, 19-41

Drew, P., Holt, E. (1998) Figures of speech: Figurative expressions and the management of topic transition in conversation. *Language in Society*, 27:495-522.

Drew, P., Chatwin, J., Collins, S., (2001) Conversation Analysis: A Method for Research into Interaction Between Patients and Health-care Professional. *Health Expectations*, 4, 58-70

Drew, P. (2003) Comparative analysis of Talk in Interaction in Different Institutional Settings: A sketch. In Phillip Glenn, Curtis D. LeBaron and Jenny Mandelbaum. *Studies in Language and Social Interaction: In Honor of Robert Hopper*. Mahwah, New Jersey: Lawrence Erlbaum Associates Publishers

Drew, P., (2005) *Conversation Analysis*. In, *Handbook of Language and Social Interaction*. New Jersey: Lawrence Erlbaum Associates

Drew, P., Walker, T. and Ogden, R. (2013) Self-repair and action construction. In Hayashi, M., Raymond, G. and Sidnell, J. eds. *Conversational Repair and Human Understanding*. Cambridge University Press:113-147

Duncan, E., Best, C., Hagen, S. (2010) Shared Decision Making Interventions for People with Mental Health Conditions. *The Cochrane Collaboration*, 1: 1-29

Elywn, G., Hutchings, H., Edwards, A., Rapport, F., Wensing, M., Cheung, W.Y., Grol, R. (2005) The Option Scale: measuring the extent that physicians involve patients in decision-making tasks. *Health Expectations*, 8, 34-42

Enfield, N.J., Dingemanse, M., Baranova, J., Blythe, J., Brown, P., Dirksmeyer, T., Drew, P., Floyd, S., Gipper, S., Gisladdottir, R.S., Hoyman, G., Kendrick, K.H., Levinson, S.C., Magyari, L., Manrique, E., Rossi, G., San Roque, L., Torreira, F. (2013) Huh? What? A First Survey in Twenty One Languages. In M. Hayasho, G. Raymond and J. Sidnell (Eds) *Conversational Repair and Human Understanding*. Cambridge: Cambridge University Press

Epstein, R.M., Franks, P., Fiscella, K., Cleveland, G.S., Meldrum, S.C., Kravitz, R.L., Duberstein, P.R. (2005) Measuring patient-centred communication in Patient-Physician consultations: Theoretical and practical issues. *Social Science and Medicine*, 61: 1516 - 1528

Ermanm B., Kotsinas, U.B. (1993) Pragmaticalisation: The Case of ba' and You Know. In: . Falk, K. Jonasson et al (Eds). *Stockholm Studies in Modern Philology* (Vol. 10: 76-93). Stockholm: Almqvist & Wiksell International, Stockholm, Sweden

- Feros, D.L., Byrne, M.K., Deane, F.P., Meadows, G., Favilla, A., Gray, J. (2010) Allied health clinicians' beliefs and attitudes about medication adherence in depressive disorders. *Journal of Evaluation in Clinical Practice*, 16: 1361-1363
- Ford, C.E., Fox, B.A., Thompson, S.A. (2001) *The Language of Turn and Sequence*. New York: Oxford University Press.
- Fox Tree, J.E., Schrock, J.C. (2002) Basic Meanings of You Know and I Mean. *Journal of Pragmatics*. 34: 727:747
- Francis, V., Korsch, B.M., Morris, M.J. (1969) Gaps in doctor-patient communication. Patients' response to medical advice. *New England Journal of Medicine*, 10, 535-540
- Frank, A.F., Gunderson, J.G. (1990) The Role of the Therapeutic Alliance in the Treatment of Schizophrenia. *Archives General Psychiatry*, 47:228-236.
- Frankel, R.M. (1984) 'From sentence to sequence: Understanding the medical encounter through micro-interactional analysis', *Discourse Processes* 7: 135-70
- Fraser, B. (1999) 'What are Discourse Markers?' *Journal of Pragmatics*, 31: 931-52.
- Frese, F.J., Knight, E.L., Saks, E. (2009) Recovery from schizophrenia: with views of psychiatrists, psychologists and others diagnosed with this disorder. *Schizophrenia Bulletin*, 35: 370-380
- Gardner, R. (2001) *When Listeners Talk: Response Tokens and Listener Stance*. J Benjamins Publishers
- Garfinkel, H. (1967) *Studies in Ethnomethodology*. Englewood Cliffs, N.J.: Prentice Hall
- Garfinkel, S., Sacks, H. (1970) On formal structures of practical actions. In J. C. McKinney and E.A. Tiryakian (eds) *Theoretical Sociology*. New York: Appleton-Century-Crofts
- Garfinkel, H., (2002) *Ethnomethodology's Program*. New York: Rowman and Littlefield
- Ginzburg, J., Sag, I.A., (2001) *Interrogative Investigations*. CA: CLSI publications
- Goffman, E. (1956) *The presentation of self in everyday life*. Doubleday: Anchor Books

- Goffman, E., (1957) Alienation from Interaction, *Human Relations*, 10, 113-136
- Goffman, E. (1969) *Where the action is: Three essays*. London: Allen Lane The Penguin Press
- Goffman, E. (1979) *Gender advertisements*. New York: Harper and Row
- Goffman, Erving (1983) The Interaction Order. *American Sociological Review*, 48, 1-17
- Gonzalez, J., Williams, J.W., Hitchcock, N.P., Lee, S. (2005) Adherence to Mental Health Treatment in a Primary Care Clinic. *JABFP*, 18:87-96
- Goodwin, C. (1996) Transparent Vision. In Ochs, E., Schegloff, E.A. and S.A. Thompson (eds.) *Interaction and Grammar*. Cambridge: Cambridge University Press, 370-404.
- Groenendijk, J., Stokhof, M. (1997) Questions. In van Benthem, J. and ter Meulen, A., (eds) *Handbook of Logic and Language*. Cambridge, MA: MIT Press: 1055-124
- Gurmankin, A.D., Baron, J., Hershey, J.C., Ubel, P.A. (2002) The role of physicians' recommendation in medical treatment decisions. *Medical Decision Making*, 22, 262-271
- Halliday, M.A.K. (1970) *A Course in Spoken English: Intonation*. Oxford: Oxford University Press
- Hamann, J., Leucht, S., Kissling, W., (2003) Shared Decision Making in Psychiatry. *Acta Psychiatrica Scandinavica*, 107:403-409.
- Hamann, J., Langer, B., Winkler, V., et al (2006) Shared decision making for in-patients with schizophrenia. *Acta Psychiatrica Scandinavica*, 114, 265 -273
- Hamann, J., Cohen, R., Leucht, S., Busch, R., Kissling, W. (2007) Shared Decision Making and Long-term Outcome in Schizophrenia Treatment. *Journal Clinical Psychiatry*, 68:992-997
- Hayano, K. (2013) Question design in Conversation. In J. Sidnell and T. Stivers (eds) *The handbook of conversation analysis*. Chichester: Wiley-Blackwell

- Hayashi, M., Hayano, K. (2013) Proffering Insertable Elements: a Study of Other-Initiated Repair in Japanese. In M. Hayasho, G. Raymond and J. Sidnell (Eds) *Conversational Repair and Human Understanding*. Cambridge: Cambridge University Press
- Healey, P.G.T., Colman, M., Thirlwell, M. (2005) Analysing Multi-Modal Communication. Repair Based Measures of Human Communicative Co-ordination. *Current and New Directions in Discourse and Dialogue*. Kluwer Academic
- Healey, P.G.T. (2008) Interactive misalignment. *Language in flux: dialogue coordination, language variation, change and evolution*. London: College Publications
- Heath, C. (1986) *Body Movement and Speech in Medical Interaction*. Cambridge: Cambridge University Press
- Hellewell, J.S. (2002) Patients' subjective experience of antipsychotics: clinical relevance. *CNS Drugs*, 14, 457-471
- Heritage, J., Watson, R., (1979) Formulations as Conversational Objects in George Psathas (ed), *Everyday Language*, New York, Irvington Press: 123-162.
- Heritage, J., Watson, R. (1980) Aspects of the Properties of Formulations. *Semiotica* 30: 245-262.
- Heritage, J. (1984) *Garfinkel and Ethnomethodology*. Cambridge: Polity Press.
- Heritage, J., Sefi, S. (1992) Dilemmas of advice: aspects of the delivery and reception of advice in interactions between health visitors and first time mothers. In P. Drew and J. Heritage (Eds) *Talk at Work*. Cambridge: Cambridge University Press
- He, A. (1993) Exploring modality in institutional interactions: Cases from academic counselling encounters. *Text*, 13: 503-528.
- Heritage, J., Sorjonen, M.L. (1994) Constituting and Maintaining Activities across Sequences: And-Prefacing as a Feature of Question Design. *Language in Society*, 23:1-29.
- Heritage, J. (1998) Oh-prefaced Responses to Inquiry. *Language in Society*, 27, 291-334

Heritage, J. (2005a). Cognition in discourse. In H. te Molder and J. Potter (eds) *Conversation and Cognition* 184–202. Cambridge: Cambridge University Press.

Heritage, J., Raymond, G. (2005) The Terms of Agreement: Indexing Epistemic Authority and Subordination in Talk-in-Interaction. *Social Psychology Quarterly*, 68, 15-38

Heritage, J. (2005b) Revisiting authority in physician–patient interaction. In Duchan, J.F. and Kovarsky, D. (eds) *Diagnosis as Cultural Practice*. Berlin: Mouton de Gruyter. pp.83-102.

Heritage, J., Maynard, D. (2006) *Communication in Medical Care: Interactions between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press

Heritage, J., Maynard, D.(2006b) Problems and prospects in the study of doctor-patient interaction: 30 years of research in primary care.' *Annual Review of Sociology*. 32: 351-374

Heritage J, Robinson J. (2006) The structure of patients' presenting concerns. 1: Physicians' opening questions. *Health Communication*. 19:89– 102

Heritage, J., (2009, 2010) *Questioning in Medicine*. In Freed, A.F., Ehrlich, S., (eds.) *Why Do You Ask?: The Function of Questions in Institutional Discourse*. Oxford: University Press

Heritage, J., Clayman, S (2010) *Talk in Action: Interactions, Identities and Institutions*. Chichester: Wiley Blackwell

Heritage, J. (2011) The Interaction Order and Clinical Practice: Some Observations on Dysfunctions and Action Steps. *Patient Education and Counseling*. 84:338-343

Heritage, J. (2012) Epistemics in action: action formation and territories of knowledge. *Research on Language and Social Interaction*, 45, 1-29

Heritage, J. (2013) Epistemics in Conversation. In Jack Sidnell and Tanya Stivers (eds), *Handbook of Conversation Analysis*. Boston: Wiley-Blackwell: 370-394.

HESonline (2011) Primary Diagnosis: 3 character table. <http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?sideID=1937&categoryID=203> [3 September 2011]

- Hopper, R., & Chen, C. H. (1996). Languages, cultures, relationships: Telephone openings in Taiwan. *Research on Language and Social Interaction*, 29, 291-313
- Hovarth, A.O., Greenburg, J.S. (1989) Development and Validation of the Working Alliance Inventory. *Journal of Counselling Psychology*, 36:223–233.
- Howes,C., Purver,M., McCabe,R., Healey, P., Lavelle, M. (2012) Helping the Medicine Go Down: Repair and Adherence in Patient–Clinician Dialogues. In SemDial 2012 (SeineDial), Paris, September 2012.
- Hudak, P.L., Clark, S.J. and Raymond, G. (2011) How surgeons design treatment recommendations in orthopaedic surgery. *Social Science & Medicine*, 73, 1028-36
- Hutchby, I. and Wooffitt, R. (2003) *Conversation analysis*. Cambridge: Polity Press.
- Hutchby, I., (2005) Active Listening: Formulations and the elicitation of feeling-talk in child counseling. *Research on Language and Social Interaction*, 38, 303-329
- IOM (2006) *Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Substance-Use Conditions: Quality Chasm Series*. Board on Health Care Services, Institute of Medicine: National Academies Press
- Jansen, S.J.T., Otten, W., Van de Velde, C.J.H., Nortier, J.W.R., Stiggelbout, A.M. (2004) The impact of the perception of treatment choice on satisfaction with treatment, experienced chemotherapy burden and current quality of life. *British Journal of Cancer*, 91, 56-61
- Jefferson, G. (1986) Notes on 'latency' in overlap onset. *Human Studies*, 9: 153-183
- Johnson, A.J., Cotterill, J. (2002) So...? Pragmatic implications of so-prefaced questions in formal police interviews. In Janet Cotterill (ed) *Language in the Legal Process*. Palgrave: Basingstoke
- Joosten, E.A.G., Defuentes-Merillas, L., Weert, G.H., Sensky, T., Van Der Staak, C.P.F., De Jong, C.A.J. (2008) Systematic Review of the Effects of Shared Decision-Making on Patient Satisfaction, Treatment Adherence and Health Status. *Psychotherapy and Psychosomatics*, 77: 219-226

- Katz, J. (1984) *The Silent World of Doctor and Patient*. Maryland: John Hopkins University Press
- Kay, S., A, Fiszbein., Opfer, L., (1987) The Positive and Negative Syndrome Scale (PANSS) for Schizophrenia. *Schizophrenia Bulletin*, 13, 261
- Kemp, R., Hayward, P., Applewhaite, G. (1996) Compliance Therapy in Psychotic Patients: Randomised Controlled Trial. *BMJ*, 312: 345-349
- Kemp, R., Kirov, G., Everitt, B., Hayward, P., David, A. (1998) Randomised Controlled Trial of Compliance Therapy. 18-Month Follow-up. *The British Journal of Psychiatry*. 172:413-419
- Kendler, K.S., McGuire, M., Gruenberg, A.M., Spellman, M., O'Hare, A., Walsh, D. (1993) The Roscommon Family Study. II. The risk of nonschizophrenic nonaffective psychoses in relatives. *Archives of General Psychiatry*, 50, 645-652
- Kim, K.-H. (1999) Other-initiated repair sequences in Korean conversation: types and functions. *Discourse and Cognition* 6: 141-168.
- Kim, K. (2001) Confirming Intersubjectivity through Retroactive Elaboration: organization of phrasal units in other-initiated repair sequences in Korean conversation. In M. Selting and E. Couper-Kuhlen (eds) *Studies in Interactional Linguistics*. Amsterdam; Philadelphia: Benjamins.
- Kitzinger, C. (2013). Repair. In J. Sidnell & T. Stivers (Eds.), *The handbook of Conversation Analysis* (pp. 229-256). Oxford: Blackwell.
- Koenig, C. (2011) Patient resistance as agency in treatment decisions. *Social Science & Medicine*, 72, 1105 -1114
- Labov, W., Fanshel, D. (1977) *Therapeutic discourse: psychotherapy as conversation*. Academic Press. Orlando: Academic Press
- Laugharne, R., Priebe, S. (2006) Trust, Choice and Power in Mental Health: a Literature Review. *Social Psychiatry and Psychiatric Epidemiology*, 41, 843-52.

- Lawn, S. (2007) The Mental Health Expert Patient: Findings from Pilot Study of a Generic Chronic Condition Self-Management Programme for People with Mental Illness. *International Journal of Social Psychiatry*, 53, 63-74
- Lazarus, J.A., Sharfsteub, S.S. (1998) New Roles for Psychiatrists in Organized Systems of Care. Washington DC: American Psychiatric Press
- Leach, M. (2005) Rapport: A Key to Treatment Success. *Complementary Therapies in Clinical Practice*, 4: 262-265
- Lerner, G. (1989). Notes on overlap management in conversation: The case of delayed completion. *Western Journal of Speech Communication*. 53: 167-177
- Leudar, I., Thomas, P., Johnston, M. (1992) Self-repair in Dialogues of Schizophrenics: Effects of Hallucinations and Negative Symptoms. *Brain and Language* ;43:487– 511.
- Lecomte, T., Spidel, A., Leclere, C., MacEwan, G.W., Greaves, C., Benthall, R.P. (2008) Predictors and Profiles of Treatment Non-adherence and Engagement in Services Problems in Early Psychosis. *Schizophrenia Research*, 102:295–302.
- Lee, Y.Y., Lin, J.L. (2009) The Effects of Trust in Physician on Self-Efficacy, Adherence and Diabetes Outcomes. *Social Science & Medicine*, 68, 1060-1068
- Leucht, S., Corves, C., Arbter, D., Engel R.R., Li, C., Davis, J.M. (2009) Second generation versus first generation antipsychotic drugs for schizophrenia: a meta analysis. *Lancet*, 373: 31-41
- Leudar, I., Thomas, P., Johnston, M. (1992) Self-repair in Dialogues of Schizophrenics: Effects of Hallucinations and Negative Symptoms. *Brain and Language*, 43:487– 511.
- Levinson, S.C. (1983) Pragmatics. Cambridge: Cambridge University Press
- Lichenstein, P., Yip, B.H., Bjork, C. et al (2009) Common genetic determinants of schizophrenia and bipolar disorder in Swedish families: a population-based study. *Lancet*, 373, 234-39

- Lieberman, J.A., Scott Stroup, T., McEvoy, J.P., Swartz M.S., et al (2005) Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia. *New England Journal of Medicine*, 353:1209–1223.
- Lin, E., Von Korff, M., Katon, W., Bush, T., Simon, G.E., Walker, E., Robinson, P. (1995) The Role of the Primary Care Physician in Patients' Adherence to Antidepressant Therapy. *Medical Care*, 33:67–74
- Loh A, Leonhart R, Wills CE, Simon D, Harter M (2007) The Impact of Patient Participation on Adherence in Primary Care of Depression. *Patient Education and Counselling*, 65:69–78.
- Loh, A., Simon, D., Wills, C.E., Kriston, L., Niebling, W., Harter, M. (2007) The Effects of a Shared Decision Making Intervention in Primary Care of Depression: A Cluster-Randomized Controlled Trial. *Patient Education and Counselling*, 67:324–332.
- Ludmen, E.J., Simon, G.E., Rutter, C.M., Bauer, M.S., Unutzer, J. (2002) A Measure of Assessing Patient Perception of Provider Support for Self-Management of Bipolar Disorder. *Bipolar Disorder*, 4:249–253
- Madsen, J.W., McQuaid, J.R., Craighead, W.E. (2008) Working with Reactant Patients: Are we Prescribing Nonadherence? *Depression and Anxiety*, 26:129–134
- Mahone, I.H. (2008) Shared Decision Making and Serious Mental Illness. *Archives Psychiatric Nursing*, 0:1–10
- Malone, M.J. (1997) *Worlds of Talk: The presentation of self in everyday conversation*. Oxford: Polity Press.
- Mandelbaum, J. (2003) Interactive methods for constructing relationships. In P. Glenn, C. D. LeBaron, & J. Mandelbaum (Eds.), *Studies in language and social interaction: In honor of Robert Hopper* (pp. 207-219). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Mangalore, R., Knapp, M. (2007) Cost of schizophrenia In England. *Journal of Mental Health Policy and Economics*, 10, 23-41

- Mangione-Smith, R., Stivers, T., Elliott, E., McDonald, L and Heritage, J. (2003). Online commentary on physical exam findings: a communication tool for avoiding inappropriate antibiotic prescribing? *Social Science and Medicine* 56(2):313-320
- Martin, D.J., Garske, J.P., Davis, M.K. (2000) Relation of the Therapeutic Alliance with Outcome and other Variables: A Meta- Analytic Review. *J Consult Clin Psychol*, 68: 438-50
- Martin, L.R., Williams, S.L., Haskard, K.B., Dimatteo, M.R. (2005) The Challenge of Patient Adherence. *Therapeutics and Clinical Risk Management*, 1: 189-199
- Matson, J.L., Gonzalez, M.L., Smith, K.R., Terlonge, C., Thorston, R.T., Dixon, D.R. (2006) Assessing Side Effects of Pharmacology Treatment of Bipolar Disorder: A 20-year Review of the Literature. *Research on Developmental Disabilities*, 27:467-500
- Maynard, D.W., Heritage, J., (2005) Making Sense of Qualitative Research: Conversation Analysis Doctor-Patient Interaction and Medical Communication. *Medical Education*, 39, 428-435
- Maynard, D. (2013) Defense Mechanisms: I-mean Prefaced Utterances In Complaint and Other Conversational Sequences. In M. Hayashi, G. Raymond & J. Sidnell (Eds.), *Conversational repair and human understanding*. Cambridge: Cambridge University Press.
- McCabe, R., Heath, C., Burns, T., Priebe, S., (2002) Engagement of Patients with Psychosis in the Consultation: A Conversation Analytic Study. *British Medical Journal*, 325, 1148-1151
- McCabe, R., (2003) Conversation Analysis. In, Priebe, S. & Slade, M. *Choosing Methods in Mental Health Research*. Brunner- Routledge
- McCabe, R., Healey, P., Priebe, S., Bremner, S., Lavelle, M, Dodwell, D., Laugharne, R., , Snell, A., (2013) Shared Understanding in Psychiatrist-Patient Communication: Association with Treatment Adherence in Schizophrenia. *Patient Education and Counseling*, <http://dx.doi.org/10.1016/j.pec.2013.05.015>

- McEvoy, J.P., Apperson, L.J., Appellbaum, P.S., Ortlip, P., Brecosky, J., Hammill, K., Geller, J.L., Roth, L. (1989) Insight in Schizophrenia. It's Relationship to Acute Psychopathology. *Journal Ver. Mental Disorders*, 1: 43-7)
- Mishler, E. (1984) *The Discourse of Medicine : Dialectics of Medical Interviews*. Norwood, NJ: Ablex
- Mitchell, A. J. (2007) Adherence Behaviour and Psychotropic Medication: Is it a form of Self-Medication? *Medical Hypotheses*, 68:12-21
- Moher, D., Cook, D.J., Eastwood, S., Olkin, I., Rennie, D., Stroup, D.F. (1999) Improving the Quality of Reports of Meta-analyses of Randomised Controlled Trials: the QUOROM Statement. *Lancet*, 354:1896-1900.
- Monzoni, C., Duncan, R., Grunewald, R., Reuber, M. (2011) Are there interactional reasons why doctors may find it hard to tell patients that their physical symptoms may have emotional causes? A conversation analytic study in neurology outpatients. *Patient Education & Counselling*, 85, 189-200
- Morisky, D.E., Green, L.W., Levine, D.M. (1986) Concurrent and Predictive Validity of a Self-Reported Measure of Medication Adherence. *Medical Care*, 24: 67-74
- Morrison, A.P., Hutton, P., Shiers, D., Turkington, D. (2012) Antipsychotics: is it time to introduce patient choice? *The British Journal of Psychiatry*, 201: 83-84
- National Institute for Health and Clinical Evidence (NICE) (2009) *Schizophrenia: Core Interventions in the Treatment and Management of of Schizophrenia in Primary and Secondary Care*. Guideline 82. London: NICE
- Nose, M., Barbui, C., Gray, R., Tansella, M. (2003) Clinical interventions for the treatment of nonadherence in psychosis: a meta- analysis. *British Journal of Psychiatry*, 183: 197-206
- O' Donnell, C., Donohoe, G., Sharkey, L., Owens, N., Migone, M., Harries, R., Kinsella, A., Larkin, C., O'Callaghan, E (2002) Compliance Therapy: A Randomised Control in Schizophrenia. *BMJ*, 327: 834-836

- O'Donovan, A. (2007) Patient-Centred Care in Acute Psychiatric Admission Units: Reality or Rhetoric? *Journal of Psychiatric and Mental Health Nursing*, 14, 542-548
- Olfson, M., Mechanic, D., Hansell, S., Boyer, C.A., Walkup, J., Weiden, P.J. (2000) Predicting Medication Noncompliance after Hospital Discharge Among Patients with Schizophrenia. *Psychiatric Services*, 51:216–222
- Palmer, D. (2000) Identifying delusional discourse: Issues of rationality, reality and power. *Sociology of Health & Illness*, 22: 661-678.
- Parsons, T. (1951) *The Social System*. New York: McGraw-Hill
- Peräkylä, A. (2004) Reliability and validity in research based on naturally occurring social interaction. In D. Silverman (ed.) *Qualitative Research: Theory, Method and Practice*, London: Sage
- Peräkylä, A., Antaki, C., Vehviläinen, S., Leudar, I. (2008) (eds.) *Conversation Analysis of Psychotherapy*, Cambridge, England; CUP.
- Perkins, D. O. (2002) Predictors of noncompliance in patients with schizophrenia. *Journal of Clinical Psychiatry*, 63, 1121–1128
- Perron, B.E., Zeber, J.E., Kilbourne, A.M., Bauer, M.S. (2009) A Brief Measure of Perceived Clinician Support by Patients with Bipolar Spectrum Disorders. *Journal Nervous Mental Disorders*, 8:574–579
- Phillips, L.A., Leventhal, E.A., Leventhal, H. (2011) Factors Associated with the Accuracy of Physicians' Predictions of Patient Adherence. *Patient Education and Counselling*, 85: 461-7
- Pilnick, A., Dingwall, R., (2011) On the remarkable persistence of asymmetry in doctor/patient interaction: a critical review. *Social Science & Medicine*, 72, 1374- 1382
- Pinikahana, J., Happell, B., Taylor, M., Keks, N., (2002) Exploring the Complexity of Compliance in Schizophrenia. *Issues in Mental Health Nursing*, 23: 513-528

- Pomerantz, A., (1984) Agreeing and Disagreeing with Assessments: Some Features of Preferred/Dispreferred Turn Shapes. In Atkinson, P., Heritage, J., (eds) *Structures of Social Action: Studies in Conversation Analysis*. Cambridge University Press
- Pomerantz, A. (1986) Extreme Case Formulations: A Way of Legitimizing Claims. *Human Studies*, 9: 219-229
- Pomerantz, A., Heritage, J. (2013) Preference. In Jack Sidnell and Tanya Stivers (eds), *Handbook of Conversation Analysis*. Boston: Wiley-Blackwell: 210-228.
- Potter, J., Hepburn, A. (2010) Directives: Contingency and entitlement in action. *Discourse Studies*, 12: 1-24.
- Preisler, B. (1986) Linguistic sex roles in conversation: Social variation in the expression of tentativeness in English. Berlin: Mouton de Gruyter
- Priebe, S., Gruyters, T., (1993) The Role of the Helping Alliance in Psychiatric Community Care: A Prospective Study. *Journal of Nervous and Mental Disease*. 181, 552-557
- Priebe S, McCabe R (2008) Therapeutic Relationships in Psychiatry: The Basis of Therapy or Therapy in Itself? *International Review of Psychiatry*, 20:521-526.
- Priebe, S., Dimic, S., Wildgrube, C., Jankovic, J., Cushing, A., McCabe, R. (2011) Good Communication in Psychiatry: A Conceptual Review. *European Psychiatry*, 7: 403-7
- Quirk, A., Chaplin, R., Lelliott, P., Seale, C. (2012) How pressure is applied in decisions about antipsychotic medication: a conversation analytic study of psychiatric outpatients consultations. *Sociology of Health and Illness*, 34, 95-114
- Ramon, S. (1985) *Psychiatry in Britain: Meaning and Policy*. Dover: Croom-Helm
- Rapley, T. (2008) Distributed decision-making: the anatomy of decisions-in-action. *Sociology of Health & Illness*, 30:429-44
- Raymond, G. (2003) Grammar and Social Organization: Yes/No Interrogatives and the Structure of Responding. *American Sociological Review*, 68: 939-67

Rogers, A. Day, J.C., Williams, B., Randall, F., Wood, P., Healy, D., et al (1998) The meaning and management of neuroleptic medication: a study of patients with a diagnosis of schizophrenia. *Social Science and Medicine*, 47, 1313-1323

Raymond, G. (2006) Questions at Work: Yes/No Type Interrogatives in Institutional Contexts. In Paul Drew, Geoffrey Raymond, Darin Weinberg (eds.), *Talk and Interaction in Social Research Methods*. London: Sage.

Raymond, G. (2010). Grammar and social relations: Alternative forms of Yes/No type initiating actions in health visitor interaction. In Alice F. Freed and Susan Ehrlich (eds.), "Why Do You Ask?": The Function of Questions in Institutional Discourse New York: Oxford University Press: 87-107.

Robinson, D., Woerner, M.G., Alvir, J.M. et al (1999) Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives General Psychiatry*, 56: 241- 247

Robinson, J. D. (2003). An interactional structure of medical activities during acute visits and its implications for patients' participation. *Health Communication*, 15, 27-59.

Robinson, J. (2006) Managing Trouble Responsibility and Relationships During Conversational Repair." *Communication Monographs* 73, 137-161.

Robinson, J.D., Heritage, J. (2006) Physicians' opening questions and patients' satisfaction. *Patient Education and Counselling*, 60:279-85

Robinson, J. D., & Kevoe-Feldman, H. (2010) Using full repeats to initiate repair on others' questions. *Research on Language and Social Interaction*, 43, 232-259.

Robinson, J. (2013) Using Open-Class Repair Initiation to Comment on the Generic Organization of Conversational Repair. In *International Communication Association Conference*, London, June 2013

- Robinson, J. D. (2013b). Epistemics, action formation, and other-initiation of repair: The case of partial questioning repeats. In M. Hayashi, G. Raymond & J. Sidnell (Eds.), *Conversational repair and human understanding*. Cambridge: Cambridge University Press.
- Rogers, C. (1957) The Necessary and Sufficient Conditions of Therapeutic Change. *Journal of Consulting Psychology*, 21: 95-105
- Roter, D.L., Hall, J.A. (1991) Health education theory: an application to the process of patient-provider communication. *Health Education Research*, 6:185-93.
- Roter, D., Stewart, M., Putman, S., Lipkin, M., Stiles, W., Inui, T.S. (1997) The Patient-Physician Relationship: Communication Patterns of Primary Care Physicians. *Journal of the American Medical Association*. 227, 350-356
- Roter, D., Larson, S. (2002) The Roter Interaction Analysis System (RIAS): Utility and Flexibility for Analysis of Medical Interactions. *Patient Education and Counselling*, 43, 243-251
- Ruusuvuori, J. (2005) Empathy and sympathy in action: attending to patients' troubles in Finnish homeopathic and general practice consultations. *Social Psychology Quarterly*, 68, 204-22
- Ruusuvuori, J. (2007) Managing affect: integrating empathy and problem solving in two types of healthcare consultations. *Discourse studies*, 9, 597-622
- Sacks, H. (1987). On the Preferences for Agreement and Contiguity in Sequences in Conversation, In G. Button and J. R. E. Lee (eds.), *Talk and Social Organisation*. Clevedon, UK: Multilingual Matters
- Sacks, H., Schegloff, E.A. and Jefferson, G. (1974) A Simplest Systematics for the Organization of Turn-Taking for Conversation. *Language*, 50: 696-735
- Sacks, H. (1992 [1964—72]). *Lectures on Conversation*, 2 vols. Oxford: Blackwell.
- Safarova, M., Swerts, M. (2004) On recognition of Declarative Questions in English. In proceedings of Speech prosody. Nara, Japan

- Safran, D. G., Montgomery, J. E., Chang, H., Murphy, J., & Rogers, W. H. (2001) Switching doctors: Predictors of voluntary disenrollment from a primary physician's practice. *Journal of Family Practice*, 50:130–136
- Sajatovic, M., Bauer, M.S., Kilbourne, A.M., Vertrees, J.E., Williford, W. (2006) Self-Reported Medication Adherence Among Veterans with Bipolar Disorder. *Psychiatric Services*, 57:56–62.
- Schegloff, E.A. (1972) Notes on a conversational practice: Formulating place. IN D. Sudnow (ed) *Studies in Social Interaction*. New York: Free press. 75, 289-237
- Schegloff, E.A., Sacks, H., (1973) Open up Closings. *Semiotica*, 8, 289-327
- Schegloff, E.A., Jefferson, G., Sacks, H., (1977) The Preference for Self-Correction in the Organisation of Repair in Conversation. *Language*, 53, 361-382
- Schegloff, E.A. (1979) The Relevance of Repair to Syntax-for-Conversation, In T. Givon (ed.), *Syntax and Semantics, Volume 12: Discourse and Syntax*, New York: Academic Press, 261-286.
- Schegloff, E.A., (1984) On some questions and ambiguities in conversation. In J. Maxwell Atkinson and John Heritage (eds) *Structures of Social Action*. Cambridge: Cambridge University Press, 28-53
- Schegloff, E. A. (1992). Repair after next turn: The last structurally provided defense of intersubjectivity in conversation. *American Journal of Sociology*, 97, 1295-1345.
- Schegloff, E.A. (1993) Reflections on Quantification in the Study of Conversation. *Research on Language and Social Interaction*, 26:99-128.
- Schegloff, E.A. (1996) Confirming Allusions: towards an empirical account of action. *American Journal of Sociology*, 104, 161-216
- Schegloff, E.A. (1996b) Turn Organization: One Intersection of Grammar and Interaction, In E. Ochs, E. A. Schegloff and S. Thompson (eds.), *Interaction and Grammar*. Cambridge: Cambridge University Press, 52-133.

- Schegloff, E. A. (1997). Practices and actions: Boundary cases of other-initiated repair. *Discourse Processes*, 23, 499-545.
- Schegloff, E.A. (2000) When 'others' Initiate Repair. *Applied Linguistics*, 21, 205-243
- Schegloff, E. A. (2000b). Overlapping talk and the organization of turn-taking for conversation. *Language in Society*, 29, 1-63.
- Schegloff, E. A. (2004). On dispensability. *Research on Language and Social Interaction*, 37, 95-149.
- Schegloff, E.A., (2007) *Sequence Organization in Interaction: A Primer in Conversation Analysis*, Volume 1, Cambridge: Cambridge University Press
- Schegloff, E., & Lerner, G. (2009) Beginning to respond: Well-prefaced responses to wh-questions. *Research on Language & Social Interaction*, 42: 91-115.
- Schiffrin, D. (1987) *Discourse Markers*. New York: Cambridge University Press.
- Schutz, A. (1962) *Collected papers, volume 1: The problem of social reality*. The Hague: Martinus Nijhoff
- Shigemura, J., Ogawa, T., Yoshino, A., Sato, Y., Nomura, S. (2010) Predictors of Antidepressant Adherence: Results of a Japanese Internet-based Survey. *Psychiatry and Clinical Neuroscience*, 64:179-186.
- Sidnell, J. (2008) Alternate and complementary perspectives on language and social life: The organization of repair in two Caribbean communities. *Journal of Sociolinguistics*, 12, 477-503
- Sidnell, J. (2010) *Conversation Analysis: An Introduction*. Chichester: Wiley-Blackwell
- Silverman, D. (1987) *Communication and Medical Practice: Social Relations in the Clinic*. London: Sage
- Silverman, D. (1997). *Discourses of Counselling: HIV Counselling as Social Interaction*. London: Sage.

Singh, J.P., Serper, M., Reinharth, J., Fazel, S. (2011) Structured Assessment of Violence Risk in Schizophrenia and Other Psychiatrist Disorders: A Systematic Review of the Validity, Reliability and Item Content of 10 Available Instruments. *Schizophrenia Bulletin*, 37, 399-912

Sleath, B., Rubin, R.H., Huston, S.A. (2003) Hispanic Ethnicity, Physician-Patient Communication and Antidepressant Adherence. *Comprehensive Psychiatry*, 44:198-204

SPSS I. (2009) PASW Statistics 18. 0. Chicago: SPSS Inc.

Startup, M., Wilding, N., Startup, S. (2006) Patient Treatment Adherence in Cognitive Behaviour Therapy for Acute Psychosis: The Role of Recovery Style and Working Alliance. *Behavioural Cognitive Psychotherapy*, 34:191-199

Stewart, M. (1995) Effective Physician-Patient Communication and Health Outcomes: A Review. *Canadian Medical Association Journal*, 152, 1423-1433

Stivers, T., Heritage, J. (2001) Breaking the sequential mould: answering "more than the question" during comprehensive history taking. *Text*, 21: 151-185.

Stivers, T., (2003) Why do Physicians think Parents Expect Antibiotics? What Parents Report Vs What Physicians believe. *The Journal of Family Practice*, 2, 140-148

Stivers, T. (2005a) Non-antibiotic treatment recommendations: delivery formats and implications for parent resistance. *Social Science & Medicine*, 60, 949-964

Stivers, T. (2005b) Parent resistance to physicians' treatment recommendations: one resource for initiating a negotiation of the treatment decision. *Health Communication*, 18, 14-47

Stivers, T. (2006) The interactional process of reaching a treatment decision in acute medical encounters. In J. Heritage & D. Maynard (Eds.) *Communication in Medical Care: Interactions between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press, pp 279-312.

Stivers, T. (2007) *Prescribing under pressure: Parent – physician conversations and antibiotics*. Oxford: Oxford University Press

- Stivers, T. (2010) An overview of the question response system in American English conversation. *Journal of Pragmatics*, 42, 2772-2781
- Stivers, T., Rossano, R.F., (2010) Mobilising response. *Research on Language and Social Interaction*, 43, 1, 3-31
- Street, R.L., Makoul, G., Arora, N.K., Epstein, R.M. (2009) How Does Communication Heal? Pathways Linking Clinician- Patient Communication to Health Outcomes. *Patient Education and Counselling*, 74: 295-301
- Svarstad, B.L. (1986) Patient-Practitioner Relationships and Compliance with Prescribed Medical Regimens. In Applications of Social Science to Clinical Medicine and Health Policy. Edited by Aiken LH, Mechnic D. New Brunswick: Rutgers University Press
- Svennevig, J. (2008) Trying the Easiest Solution First in Other-Initiation of Repair. *Journal of Pragmatics*, 40, 333-348
- Ten Have, P. (1999/2007) Doing conversation analysis: A practical guide. London: Sage.
- The Schizophrenia Commission (2012). The Abandoned Illness: A Report by the Schizophrenia Commission, Available from <http://www.schizophreniacommission.org.uk/the-report/> [14 February 2013]
- Themistocleous, M., McCabe.R., Rees, N., Hassan. I., Healey, P.G.T., Priebe. S. (2009) Establishing Mutual Understanding in Interaction: an Analysis of Conversational Repair in Psychiatric Consultations. *Communication and Medicine*; 6:165-76.
- Thornicroft, G., Brohanm E., Rose, D., Sartorius, N., Leese, M. (2009) Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross sectional survey. *Lancet*, 373: 408 - 15
- Thompson, L., McCabe, R. (2012) The Effect of Clinician-Patient Communication on Treatment Adherence in Mental Health Care: A Systematic Review. *BMC Psychiatry*, 12, 87
- Thompson, L., Howes, C., McCabe, R., Lavelle, M., Strapelli, N. (2013 In preperation) The Effect of Psychiatrists' Questions on the Therapeutic Alliance and Adherence.

- Toerien, M., Shaw, R., Reuber, M. (2013) Initiating decision-making in neurology consultations: 'recommending' versus 'option-listing' and the implications for medical authority. *Sociology of Health and Illness*, 35, 873-90
- Toop, L. (1998) Primary Care: core values patient centred primary care. *British Medical Journal*, 316: 1882
- Turkington, D., Siddle, R. (1998) Cognitive Therapy for the Treatment of Delusions. *Advances in Psychiatric Treatment*, 4: 235-242
- Van Os, J., Kapur, S. (2009) Schizophrenia. *Lancet*, 374: 635-645
- Velligan, D.I., Lam, Y.W.F., Glahn D.C., Barrett, J.A., Maples, N.J., Ereshefsky, L., Miller, A.L. (2006) Defining and Assessing Adherence to Oral Anti-Psychotics: A Review of the Literature. *Schizophrenia Bulletin*, 32: 724-42
- Von Korff, M., Katon, W., Rutter, C., Ludmen, E., Simon, G., Lin, E., Bush, T. (2003) Effect on Disability Outcomes of a Depression Relapse Prevention Program. *Psychosomatic Medicine*, 65:938-943
- Weiden, P., Olfson, M. (1995) Cost of relapse in schizophrenia. *Schizophrenia Bulletin*, 21, 419 -429
- Weiss, K.A., Smith, T.E., Hull, J.W., Piper, C.A., Huppert, J.D. (2002) Predictors of Risk in Nonadherence in Outpatients with Schizophrenia and Other Psychotic Disorders. *Schizophrenia Bulletin*, 28:341-349.
- West, C. (1984) *Routine Complications: Trouble with Talk between Doctors and Patients*. Bloomington: Indiana University Press
- West, C., Frankel, R.M. (1991) *Miscommunication and Medicine*. In *Miscommunication and problematic talk*. Nikolas Coupland, Howard Giles, John M. Wiemann (Eds). California: Sage Publications
- Williams, S., Weinman, J., Dale, J (1998) Doctor-patient Communication and Patient Satisfaction: a Review. *Family Practice*. 15:480-492.

Wilson, J. (1990) *Politically Speaking: The pragmatic analysis of political language*. Oxford: Blackwell.

World Health Organisation (WHO) (2003) *Adherence to long-term therapies: evidence for action*. Geneva: World Health Organisation

World Health Organisation (WHO), (2013)
http://www.who.int/mental_health/management/schizophrenia/en/ [02 June 2011]

Wykes, T., Steel, C., Everitt, B., Tarrrier, N. (2008) Cognitive behaviour therapy for schizophrenia: effect sizes, clinical models and methodological rigor. *Schizophrenia Bulletin*, 34: 523 - 37

Zeber, J.E., Copeland, L.A., Good, C.B., Fine, M.J., Bauer, M.S., Kilbourne, A.M. (2008) Therapeutic Alliance Perceptions and Medication Adherence in Patients with Bipolar Disorder. *Journal Affective Disorders*, 107:53–62

Yeh, M.Y., Sung, S.C. (2008) Predictors of Adherence to an Antidepressant Medication Regimen among Patients Diagnosed with Depression in Taiwan. *Mental Health Nursing*, 29:701–717

Zolnierok, K.B., Dimatteo, M.R., (2009) Physician communication and patient adherence to Treatment: A meta-analysis. *Medical Care*, 47:826–834.

Appendices

Appendix 1: Jeffersonian transcription conventions

Left-justified numbers: Line numbers referred to in text.

Abbreviated name with colon: Speaker identification (e.g., DOC /Doctot, PAT/Patient).

Period: Falling intonation.

Comma: Slightly rising intonation.

Question mark: Strongly rising intonation.

Underlining: Increased volume/amplitude relative to surrounding talk.

Brackets: Onset and offset of overlapping talk.

Parentheses with a period: A pause of less than 0.2 seconds.

Parentheses with numbers: Silence measured in seconds and tenths of seconds.

Colon(s): Preceding sound is extended or stretched; the more the longer.

Period preceding h's: Inbreaths; the more the longer.

H's: Outbreaths (sometimes indicating laughter); the more the longer.

Greater-than/less-than signs: Talk with increased pace relative to surrounding talk.

Less-than/greater-than signs: Talk with decreased pace relative to surrounding talk.

Word/sound followed by hyphen: Preceding sound is cut off/self-interrupted.

Equals sign: Words/sounds are latched or ran together with no silence.

Number sign: Words/sounds are produced with vocal fry (i.e., frog voice).

Degree signs: Talk with decreased volume relative to surrounding talk.

Up arrow: Talk with increased pitch relative to surrounding talk.

Down arrow: Talk with decreased pitch relative to surrounding talk.

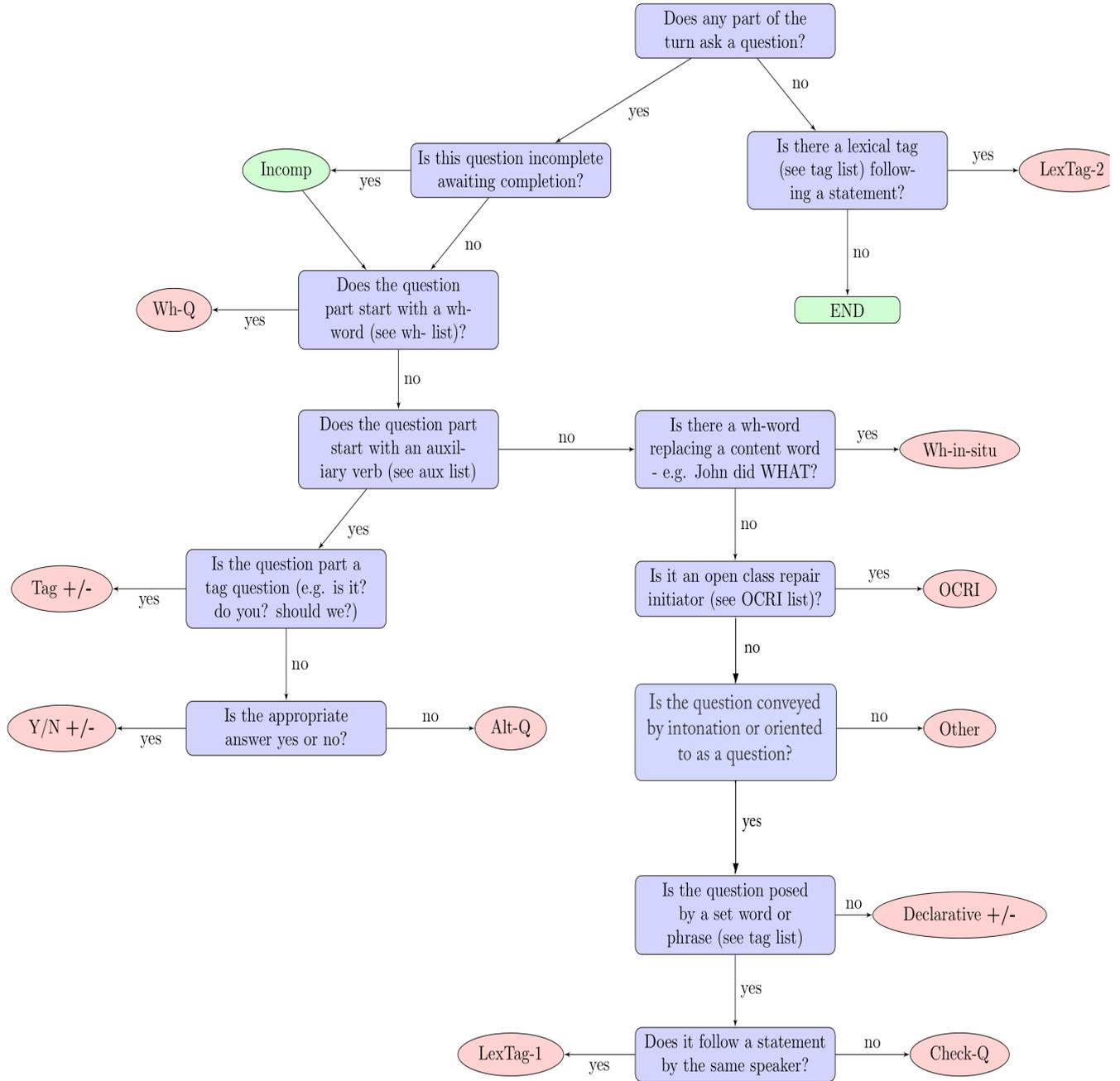
Filled single parentheses: Transcriptionist doubt about talk.

Filled double parentheses: Scenic or non-verbal detail

Empty parentheses containing a question mark: Words/sounds that are not hearable/understandable

A fuller glossary can be found in Atkinson, J. M. and Heritage, J. (ed.) (1984). *Structures of Social Action*, Cambridge University Press, pp.ix-xvi.

Appendix 2: Questions coding protocol



This protocol was developed and piloted collaboratively. The team comprised the author and a group of researchers with experience in linguistics and psychiatric communication:

Dr Christine Howes (Interaction, Media & Cognitive Science, Queen Mary University of London)

Dr Mary Lavelle (Queen Mary University of London)

Dr Rose McCabe (Queen Mary University of London)

Appendix 3: Treatment formulations coding template

Database	list which database this comes from
Case ID	2 letter country code; 2 digit data base code; 2 digit MD code; 3 digit patient code; 2 digit treatment rec.e.g. US011200401 (American data from database1, Doctor #12, patient #4; recommendation #1)
Patient Type	List the primary diagnosis and/or whether patient is being seen for an acute condition, chronic etc.
Physician Type	list specialty of physician
Patient Demographics	list sex, age, anything else relevant
MD Demographics	list MD sex, age
MEDICATION	list the medication being recommended in this recommendation
Prescription	list whether medication is prescription or OTC
Condition	list the condition being treated with this medication
Status of condition	list whether this is newly diagnosed vs. existing condition
Associated risks	list any risk issues that could affect recommendation format
TREATMENT REC ACTION	list Pronouncement, Suggestion, Proposal, General Assertion or Offer
STRENGTH OF ENDORSEMENT	Strength of recommendation (Strong, Moderate, Weak)
MULTIPLE RECOMMENDATIONS	Are 2 or more different treatments presented. If so, list whether CHOICE or BUCKET recommendation
MEDICATION FORMULATION	Generic, Class, Drug or Pronoun named in recommendation
IF PRONOUN	Was most specific prior treatment reference as generic, class, or drug?
US-NESS RECOMMENDATION IN	list whether or not Let's, We, Us is used in rec.
UPTAKE/RESPONSE	list type of patient uptake: ready acceptance, acknowledgement; resistance, nod, nothing
OPPORTUNITY SPACE	indicate whether patient has an opportunity to respond (e.g., there is a clear TRP after the first recommendation TCU or they simply begin). If they respond, indicate NA

TREATMENT OUTCOME	list whether this medication was ultimately recommended
-------------------	---------------------------------------------------------

The treatment formulations protocol was developed and piloted by a team of 6 researchers including the author:

Professor Tanya Stivers (University of California Los Angeles)

Professor John Heritage (University of California Los Angeles)

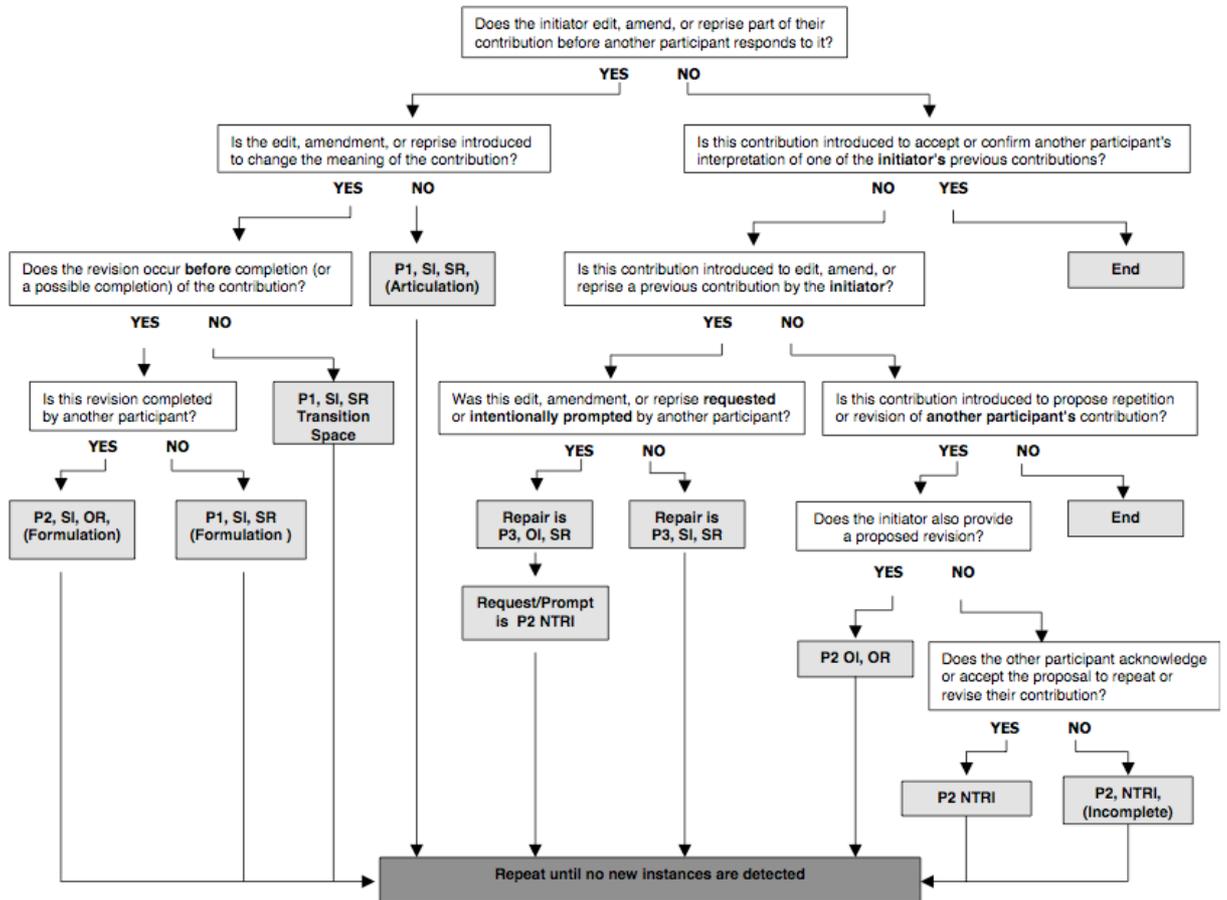
Dr Merran Torrien (University of York)

Dr Rebecca Barnes (University of Bristol)

Dr Rose McCabe (Queen Mary University of London)

Piloting was performed in datasets recorded in the US and the UK across primary care, neurology and psychiatry settings.

Appendix 4: Repair coding protocol



As originally produced in Healey et al (2005 pg 9)