Accepted Manuscript

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Elina Weiste, Anssi Peräkylä, Taina Valkeapää, Enikö Savander, Jukka Hintikka

PII: S0277-9536(18)30215-6

DOI: 10.1016/j.socscimed.2018.04.048

Reference: SSM 11728

To appear in: *Social Science & Medicine*

Received Date: 14 October 2017

Revised Date: 24 April 2018

Accepted Date: 26 April 2018

Please cite this article as: Weiste, E., Peräkylä, A., Valkeapää, T., Savander, Enikö., Hintikka, J., Institutionalised otherness: Patients references to psychiatric diagnostic categories, *Social Science & Medicine* (2018), doi: 10.1016/j.socscimed.2018.04.048.

Institutionalised otherness: Patients references to psychiatric diagnostic categories

Elina Weiste
University of Helsinki, Finnish Centre of Excellence in Research on Intersubjectivity in Interaction
P.O. Box 4, 00014 University of Helsinki, Finland
elina.weiste@ttl.fi

Anssi Peräkylä
University of Helsinki, Finnish Centre of Excellence in Research on Intersubjectivity in Interaction
P.O. Box 4, 00014 University of Helsinki, Finland
anssi.perakyla@helsinki.fi

Taina Valkeapää
University of Helsinki, Finnish Centre of Excellence in Research on Intersubjectivity in Interaction
P.O. Box 4, 00014 University of Helsinki, Finland
taina.valekapaa@helsinki.fi

Enikö Savander
Päijät-Häme Central Hospital
Keskussairaalankatu 7, 15850 Lahti, Finland
eniko.savander@phhyky.fi

Jukka Hintikka
Päijät-Häme Central Hospital, University of Tampere
Keskussairaalankatu 7, 15850 Lahti, Finland
jukka.hintikka@phhyky.fi

Corresponding author:
Elina Weiste
Finnish Centre of Excellence in Research on Intersubjectivity in Interaction
P.O. Box 4, 00014 University of Helsinki, Finland
+358503363727
elina.weiste@ttl.fi

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Abstract

Diagnosis is integral part of the way medicine organises illness: it is important for identifying treatment options, predicting outcomes and providing an explanatory framework for clinicians. Previous research has shown that during a medical visit not only the clinician but also patients provide explanations for the causes of their symptoms and health problems. Patients' lifeworld explanations are often differentiated from the diagnostic explanations provided by clinicians. However, while previous conversation analytic research has elaborated the ways in which diagnostic and lifeworld explanations are interactionally structured in somatic medicine, there is little research on how these explanations are organised in psychiatry.

Psychiatric diagnosis is particularly interesting because in mental disorders illness itself is not determined by any objective measurement. Understanding of the patient's problem is constructed in interaction between the patient and clinician. The focus of this research will be *patients'* references to diagnosis in psychiatry and the functions of these references.

The findings are based on conversation analysis of 29 audio-recorded diagnostic interviews in a psychiatric outpatient clinic. Our results demonstrate that patients can utilise diagnostic categories in several ways: disavowing a category to distance their symptoms from it, accounting for their life experiences being rooted in psychiatric illnesses and explaining their illnesses as being caused by certain life experiences. We argue that these explanations are important in patients' face-work – in constructing and maintaining a coherent and meaningful view of the patient's self.

Keywords: conversation analysis; diagnosis; explanation; lifeworld; psychiatry; self

Introduction

Diagnosis is integral part of medicine and the way in which it organises illness: a diagnosis is essential for providing an explanatory framework for clinicians, predicting outcomes and identifying treatment options (Jutel 2009). Diagnosis is also crucial for the patient, as it enables access to the "sick role" (Parsons 1951) that is needed to obtain medical services, insurance reimbursements, sick leave, disability payments and so on. Receiving a diagnosis may also be socially valuable to an individual who has become ill. It provides an explanation for why the person is different from other people and why s/he acts in ways which deviate from social norms (Jutel 2009). This may be important for the person's self-image (Goffman 1955), as well as for the management of that person's identity in encounters with others (Goffman 1963).

As receiving a diagnosis has several benefits for the patient, its absence may provoke an experience in which the patient's suffering is not institutionally recognised. This may cause confusion, stress and fear of the denial of essential services. This is particularly the case in illnesses that cannot be explained in terms of any organic pathology but are recognisable only on the basis of lists of symptoms (Jutel 2009). For instance, in psychiatry the "illness" itself is not determined by any objective measurement. The aetiology and the pathophysiology of psychiatric illnesses are mostly unidentified, and the diagnosis is determined by symptom categories provided in diagnostic manuals. Thus, in cases where the medical and individual symptom narratives fail to align, it is difficult for the patient to convince clinicians that s/he is really suffering from a certain disorder.

Mental illness can be understood as a *biographical disruption* (Bury 1982; 1991) in a person's life story, since the illness has consequences for the structures of everyday life, affects social relationships and can increase dependency on others, forcing sufferers to rethink their own expectations and plans. In many cases, the social consequences for those diagnosed as mentally ill are negative. Mental illness is considered one of the most stigmatising conditions in Western societies, and people with a psychiatric diagnosis are at severe risk of social exclusion and

significantly reduced life chances (Link & Phelan 2013). Receiving a diagnosis can be extremely stressful and socially problematic, especially if the person in question does not consider him/herself to be ill. It has been argued that medical discourse, especially in the case of psychiatric diagnosis, can determine the criteria for what is considered normal and thus function as a powerful tool of social control (e.g., Horwitz 2013). For instance, Avdi (2005) has suggested that patient participation is diminished in psychiatry, leaving patients few resources to affect the diagnostic process.

Studies exploring patients' expectations for the psychiatric encounter have found that patients would like to receive an explanation for their problems and symptoms (e.g., Bilderbeck et al. 2014). An explanation is an important resource for the *illness narrative*, which previous studies have shown to be one of the patient's methods of coping with altered circumstances and the disruption in biography caused by a severe illness (e.g., Bury 1991; 2001; Williams 1984). Patients use the illness narrative to create a link between the body, self and the society and reconstruct a meaningful and comprehensive picture of life in order to maintain a sense of personal integrity and reduce the threat to social status (Bury 1991; 2001). Attempts to find explanations for the illness and connect it to a wider perspective can be seen as essential for patients with a psychiatric diagnosis, as there is a risk that the illness is represented primarily as an individual matter.

While the studies presented above have increased our understanding of the importance to patients of explanations and illness narratives, they nevertheless fail to provide a detailed account of the communication between patients and clinicians in real-time medical encounters. Investigating somatic medicine, Mishler (1984) suggested that the communication between doctor and patient is organised around two competing yet interrelated "voices". In the voice of medicine, "the meaning of events is provided by abstract rules that serve to decontextualize events, to remove them for particular personal and social contexts" (p. 104). Conversely, the voice of the lifeworld "refers to the patient's contextually -grounded experiences of events and problems in her life" (p. 104).

While, according to Mishler, the two voices are in conflict in medical consultations, leading to the suppression of the patient's accounts, Barry et al. (2001) suggest a more varied picture. According to them, the patient and the doctor sometimes successfully align by exclusively using one or the other voice, while problems arise in cases where they misalign – with doctors ignoring or blocking the patient's appeals to the voice of the lifeworld. One concrete communicative practice for connecting these two voices, especially in the case of the diagnostic process, has proven to be metaphorical expressions (e.g. Hanne 2015; Mould et al. 2010).

Arguably, diagnosis is at the centre of the voice of medicine, as it involves a decontextualized label for the illness. However, conversation analysis (CA) studies on somatic medicine have shown that the two voices also interpenetrate each other in the context of diagnosis. Patients not only complain about their symptoms but also provide explanations for the cause of these symptoms, contributing to the diagnostic process (e.g., Gill 1998, Gill et al. 2001). In these explanations, patients most often connect their symptoms with their circumstances or life experiences (Gill 1998; Gill & Maynard 2005). Such explanations are inserted into the phase of the encounter where a clinician gathers information on the patient's medical situation, and they are designed in order to avoid compelling the clinician to provide an immediate assessment of the explanation. In addition, it has been claimed that patients avoid interfering in the collection of medical data, thus demonstrating a sensitive understanding of the pattern in which a medical interview typically occurs (Gill & Maynard 2005). Consequently, patients employ a range of communicative practices to express their experiences and the diagnostic significance they attribute to the symptoms, thereby demonstrating themselves to be fully competent participants in the diagnostic interview (Drew 2001).

The setting for our study is the psychiatric diagnostic interview. These interviews involve a particular type of institutional interaction in medical care. In the terminology of Drew and Heritage (1992; see also Heritage & Clayman 2010), interaction in diagnostic interviews involves a particular *goal orientation*, as well as *constraints on participants' contributions* and *inferential frameworks*.

As in many somatic medical consultations, the goal is to define the (possible) diagnosis and the appropriate treatment. However, these goals are more comprehensive than in most somatic medicine: the clinician often aims to learn about patients as human beings – their biographies and ways of managing their lives – rather than just defining a diagnostic category that fits the patient's symptoms. As in somatic medicine, patients' basic contribution is to describe their problem, and the clinician's task is to elicit these descriptions. Nevertheless, the psychiatric setting arguably allows for a broader set of themes for the patient's narration, as the problems manifest themselves in varied walks of life. Furthermore, in inferential frameworks, a psychiatric interview is more inclusive than a somatic medical consultation: the patients' problems are interpreted not only in terms of distinct pathological processes, but also more broadly in terms of stressful life circumstances and psycho-social strategies for coping with them. It is in this topically and inferentially inclusive conversational environment that our target phenomenon, the patient's talk about diagnosis, occurs. In Mishler's (1984) terminology, the voice of medicine and the voice of the lifeworld are intrinsically interwoven in these interviews. Furthermore, due to the relevance of the patient biography and other lifeworld matters, these interviews necessitate conversational face-work strategies (Goffman 1955) in order to construct a coherent and socially acceptable self for the patient.

In the present paper, we investigate patients' explanations of their situations by focusing on patients' use of diagnostic categories in their talk in psychiatric encounters. Thus, we explore how patients design their talk on diagnostic categories and the functions of these utterances.

Materials and Method

The data for this study consist of 29 audio-recorded diagnostic interviews collected between 2015 and 2016 in the psychiatric outpatient clinic of a Finnish central hospital. These recordings are of

the first visits of an assessment procedure where the clinical team meet the patient from four to eight times. Each session includes three participants: the patient, a psychiatrist, and a psychiatric nurse or psychologist. The lengths of the encounters vary from one hour to 90 minutes and comprise approximately 39 hours of interaction. The patients typically have a referral from primary care, a private sector clinic or an occupational health unit. While the diagnostic interviews always involve the beginning of a new contact between the patient and the clinic, most of the patients in our data have been treated in the same or other psychiatric clinics at some earlier point in their lives; however, there are also a few first-timers. Of the 29 patients in our data, 25 have previous experience of psychiatric health care, two have had previous appointments in non-psychiatric institutions (such as primary care or maternity unit) to treat their psychiatric problems prior to referral and two have no previous psychiatric treatment history. The patients, men and women aged 26 to 58, have a variety of psychiatric symptoms, most commonly depression, anxiety or panic attacks.

Permission to collect the data was obtained from the Ethics Committee of Tampere University Hospital. Informed consent was obtained from all patients and clinicians. The researchers were not present in the encounters. The clinicians participating in the study recruited patients whose treatment would not be disrupted by their diagnostic interviews being recorded. All names and other details which would enable identification of the participants have been altered in the text and data excerpts.

The data were analysed by means of conversation analysis (CA). Conversation analysis is a method of qualitative data analysis used for studying video or audio recordings of naturally occurring interactions. In CA, every turn of talk is seen as performing social actions (such as asking, suggesting, accounting or agreeing) (Sacks et al. 1974). A turn contains the main content of the utterance and is built from various unit types involving the point where the turn may end and a new speaker may begin (Clayman 2013). The main idea is to investigate the function of a particular turn

of talk a given moment of social interaction (Schegloff 2007). A central feature of CA is its examination of the organisation of different social actions into *sequences*. Sequentiality means that a single turn is intrinsically related to the turns-of-talk that precede and succeed it. Thus, the "next turns are understood by co-participants to display their speaker's understanding of the just-prior turn and to embody an action responsive to the just-prior turn so understood" (Schegloff 2007, p.15).

In our analytic procedure, the recordings were first transcribed according to CA conventions (Appendix). Next, the recordings were listened to several times and turns-of talk in which the patients explicitly used a diagnostic category (such as schizophrenia, depression or alcoholism) were identified. These turns were qualitatively analysed case by case to specify the nature and variation of the phenomenon in question. The turns were then categorised into three thematic collections based on their primary interactional function, i.e. what the patient accomplished by using them (Maynard & Peräkylä 2003). At this point in the analysis, the clinicians' orientation to the patients' use of diagnostic categories was also explored. This was achieved by focusing on the clinician's question that invited the patient's turn involving a diagnostic category, as well as the clinician's turn which immediately succeeded it.

Results

In the dataset, 23 sequences were identified in which the patient used a diagnostic category (from 21 different patients). These were of three distinct types: first, those in which a diagnostic category was used to distance the patient's symptoms from a particular diagnostic category, second, those in which a diagnostic category was used to account for a patient's life experiences as being rooted in psychiatric illnesses, and third, those using life experience to explain the patient's diagnosis. In this section, each of these three sequence types is described through data examples. The four examples that follow were chosen to illustrate the phenomena in the data in a clear and accessible way.

Disavowing a diagnostic category

The cases in which patients disavowed a diagnostic category occurred in response to psychiatrists' symptom-related questions. In such cases, patients referred to a diagnostic category in order to challenge its applicability to their symptoms. Our data contained five such cases, and all were found in the recordings of patients with previous psychiatric treatment histories. Moreover, each case involved some sort of rupture in mutual understanding: either the quality of the patient's experience was unclear or the intensity of the experience caused a problem of understanding.

Data extract 1 provides a case in point. The extract is taken from the very beginning of an encounter in which the clinicians are exploring the reasons for patient seeking for help. The patient, a young man in his twenties, has a previous history of substance abuse and panic attacks. In the first line, the psychiatrist (D) asks the patient (P) to describe how the panic attacks feel in his body

Extract 1

01 D: mut miten kuvailisit [miltä se tuntuu kropassa?
how would you describe it [how does it feel in your body?

02 P: [no siihen no siihen mm se pulssi nousee ja
[**well there well there mm the pulse goes up**

03 en[meinaa happea saa[ha
and I'm almost un[able to get enough [air

04 D: [joo. [joo.
[yes. [yes.

05 P: ja sit (0.4) jon- joskus tulee semmossia vähän niinko .hh luuppaava
and then (0.4) som- sometimes I get that kind of erm .hh like looping

06 (.) ns huutava ajatus (.) lause tai lause niinku [päähä.
(.) so called shouting thought (.) sentence or sentence [in my head.

07 D: [↑luuppaava ajatus.
[↑looping thought.

08 P: no siis e- siis et siis niinko päässä luuppaa tietty ajatus.
well erm like a certain thought looping in my head.

09 (0.2)

10 D: luuppa.
looping.

11 P: ää sii[s niinko toistuu,
erm li[ke is repeated,

12 D: [njoo?
[yeah?

13 N: kier[tää kehää?
circ[les?

14 P: [tai (.) nii tois[tuu nii kiertää.
[or (.) yes is re[peated yeah circles.

15 D: [kier°tää°
[cir°cles°

16 N: jo-o joo.
yeah yes.

17 D: o[kei kerro joku esimerkki mikä se ajatus vois olla?
o[kay could you describe an example of what that thought could be?

18 P: [se on niinku ( ) laatua
[it is like ( ) quality

19 P: e::mmä ny tässä ku ne ei oo sellaittas kovinka rationaalisia vaa ne
I can't because they're not very rational but

20 on (0.2) hyvinki sellasia niin[ko,
they're (0.2) very [erm,

21 D: [onks se joku moittiva ta:i,
be-Q it some criticizing or
[is it like criticising o:r,

22 P: e:::i [ei se sellane ei se niinkä sem- no et se ois (.)
NEG NEG it kind+of NEG it PRT PRT PRT it be-COND
no::: [it's not like that that it would be (.)

23 D: [ei mitään.
[nothing.

24 P: jotenki ulkoapäi skitsofreniaa [tai mitää.
somehow from+outside schizophrenia-PAR or anything
somehow from the outside like schizophrenia [or anything.

25 D: [joo ee- en en en sitä
[yeah no no no I didn't

26 tarkota mut ihmisil nyt jää jää joku ajatus päähän.
mean that but sometimes people get get some thought in their head.

The psychiatrist invites the patient to describe his symptoms. He begins by describing his bodily experience, heightened pulse and difficulty in breathing (lines 2–3), both commonly experienced symptoms during panic attacks. The psychiatrist acknowledges the patient's description with minimal responses (line 4). The patient then adds a metaphorical expression, "a looping thought", to the description of his panic attacks (lines 5–6). The patient's description involves many markers of

hesitation, such as pauses and interrupted and self-corrected words. He begins by describing his experience as a “looping thought”, then he changes it to a “shouting thought” and finally changes “thought” to “sentence”. In line 7, overlapping with the patient’s talk, the psychiatrist repeats the words “looping thought” with high pitch and strong emphasis, initiating a repair sequence that invites the patient to clarify his description. In response, the patient again describes his experience as “a certain thought looping in my head” (line 8) and the psychiatrist repeats the word “looping”, thereby conveying that it is still unclear to her what the patient means (line 10).

Next, the patient describes his experience in other words, “like is repeated” (line 11), and the psychiatric nurse (N) offers a candidate understanding, “circles”, which is accepted by the patient in line 14. This brings the repair sequence to a close, but the quality of the patient’s experience remains unclear. This is seen in the psychiatrist next turn, in which she asks the patient for an example of such a thought (line 17). The patient struggles to provide such an example, and the psychiatrist suggests another expression “criticising thoughts” to speculate the alternative ways of viewing a puzzling set of symptoms. As criticising thoughts are a common symptom of schizophrenia, the psychiatrist’s question can be understood as invoking such a condition.

The patient first rejects the suggestion (lengthened *no*, line 22) and then describes his experience as different. His description, again, involves markers of hesitation and interrupted words. The patient explains that his thoughts are not heard “outside of his mind”, as in schizophrenia (lines 22, 24). By introducing a diagnostic category, *schizophrenia,* the patient challenges its applicability to his symptoms. By challenging the psychiatrist suggestion, the patient attempts to display himself as knowledgeable about symptoms related to psychiatric conditions and capable of evaluating the kind of conditions his symptoms are (or are not) related to (line 24). This challenge may also function as a face-saving strategy to demonstrate that he is not suffering from such a stigmatising illness as schizophrenia. The psychiatrist also seems to orient to the patient’s face-work turn and rejects

schizophrenia as the meaning of her previous turn. Moreover, she normalises the patient's experience by suggesting that people commonly experience such thoughts (line 26).

As the extract demonstrates, patients can use a diagnostic category to challenge its fit to their symptoms. By disavowing a particular category, patients accomplish to present themselves as persons without discrediting attributes the category might involve. By challenging the clinicians' suggestions, the patients were also able to display themselves as knowledgeable about psychiatric terminology and capable of participating in the evaluation of their situation.

Using a psychiatric diagnosis to account for life experiences

The cases in which the patients used a diagnostic label to account for their life experiences being rooted in psychiatric illnesses occurred in response to psychiatrist's requests for a description of the patient's life situation. There were eight such cases, and all were found from patients with previous experience of psychiatric treatment. In such cases, use of a diagnostic category connects the patient's experience with a diagnosis so as to provide an explicit account of the patient's problem being rooted in psychiatric illness. In this way, the patient distances him/herself from the troublesome life experience and presents the diagnosis as "another" actor with independent agency in the patient's life. In these cases, the clinicians did not typically validate the patient's use of a diagnostic category but suggested an altered explanation.

Extract 2 is an example of such a case. The patient, a man in his late thirties, has been describing his recent divorce and a previous episode of depression. In line 1 the psychiatrist asks if the patient knew his wife when he was previously receiving psychiatric treatment for depression.

Extract 2

01 D: tunsitko sillon jo (0.8) puolisosi?
did you know your (0.8) wife already back then?

02 (0.2)

03 P: en:
no:

04 D: et.
you didn't.

05 P: elik[kä tämä tapahtu jo ennen sitä [että,
so this happened already before that [so,

06 D: [joo joo okei.
[yes yes okay.

07 (1.0)

08 P: tavallaan mul on jopa sellanen ajatus pyöriny päässä että
in+a+way SG1-ADE be even that+kind+of thought roll-PPC head-INE that
in a way I've had even that kind of thought in my head that

09 (3.0) että onko m-mulla niinku tää masennus periaatteessa
that is-Q SG1-ADE PRT DEM1 depression principle-INE
(3.0) that have I had this depression basically

10 (0.8) koko ajan oll:ut täällä taustalla hhh mutta nyt ku mä
whole time-GEN is-PPC here-ADE background-ADE but now when SG1
(0.8) all the time in the background hhh but then when I

11 tapasin vaimoni (.) .hhhh [se jotenki niinkun (1.2)
meet-PST-1 wife-POSS-1 it somehow PRT
met my wife (.) .hhhh [it somehow (1.2)

12 D: [mmm

13 P: jäi vähäoireisemmaksi [(0.5) sinne taustalle ja nyt sitten kun
become-PST less+symptoms-COMP-TRA there+in background-ALL and now PRT when
became milder [(0.5) there in the background (1.8) and now when

14 D: [mm.

15 P: mä taas (1.0)[jäin yksin niin se tulee sieltä (2.0) [jyräten päälle hh
SG1 again left-PST alone PRT it come there+from rolling over
I'm again (1.0) [all alone it comes (0.2) [rolling over me hh

16 D: [nii [joo::?
[yes [yes::?

17 D: joo:: joo joo
yeah:: yes yes

18 (0.5)

19 P: et mä aloin niinku miettimää että moni näistä meidän (2.0)
so SG1 start-PST PRT thinking-ILL PRT many dem-PL1-ELA PL1-GEN
so I started to think that many of these reasons for our (2.0)

20 erimielisyyksien syistä ehkä on juuriki ollu tästä mun
disagreement-PL-GEN reason-PL-ELA maybe be just be-PPC DEM1-ELA SG1-GEN
disagreements have been about this my

21 mahdollisesti että ku mulla oli jo masennus sillon
possibly PRT PRT SG1-ADE be-PST already depression then

possibly because I already had depression back then

22 meiän suhteen aikanakin pääl[lä että kun ei ollu (0.5) halua
PL1-GEN relationship-GEN during-CLI over PRT PRT NEG be-PPC urge-PAR
during our relationship [cuz I didn't have (0.5) any urge

23 D: **[mmm mmm**

24 P: lähtee mihinkään tehdä mitään ja (0.2) [.hhhhhh (1.2) olla vaan
go-INF anywhere-CLI do-INF anything and be-INF PRT
to go anywhere or do anything and (0.2) [.hhhhhh (1.2) just be

25 D: **[hmm-mm**

26 P: ja kö̲köttää ja hhhhh
and stay+put-INF and
and st̲ay put and hhhhh

27 D: **mm-mm**

28 S: toisaalta toi sun (0.5) halu läh- öö olla läh- tapaamatta ihmisiä
on the other hand your (0.5) urge to erm not to g- meet people

29 vaikuttaa myöskin semmoselta tavalta suojautua rasitukselta
seems to be also a way to protect yourself from stress

30 jos sä koet joutuvasi toistuvasti (.) terapeutiksi ja,
if you feel that you must constantly (.) act as a therapist and,

The patient responds to the psychiatrist's history-eliciting question by stating that his previous treatment episode had occurred before he met his wife (lines 3, 5). The patient then expands this theme by suggesting that he might have been depressed "all the time" rather than episodically (lines 8–13). Thus, in this case, the category "depression" was first used by the psychiatrist and the patient now reuses it. Rather than describing his experience in everyday words as "being depressed", the patient refers to a diagnostic label: "having depression" (lines 9 and 21). He also uses a demonstrative pronoun, "this depression" (line 9), to refer to a specific condition which he considers has independent agency in his life. Depression is described as another actor which remains in the background (lines 10, 13) and then rolls over the patient (line 15). The psychiatrist responds with minimal acknowledgements (lines 12, 14, 16, 17), aligning herself as a recipient of the patient's description. Next, the patient suggests that depression could actually be the reason for his divorce (lines 19–36). This account is grounded in the patient's prior description with the turn initial conjunction "et", that could be translated as "so" or "that" (line 19). The patient marks his suggestion as something based on his own reasoning (line 19), and he characterises his own

behaviour during the marriage (lines 22, 24, 26) as evidence of depression having been there all along. The account is presented as tentative, with the use of the epistemic adverb “possibly” (line 21), which downgrades the knowledgeability of the patient.

The patient’s account is received by the psychiatrist with only minimal acknowledgements (lines 23, 25, 27), but the psychologist (S) takes a different perspective (line 28) and suggests that the patient’s lack of urge to go anywhere could also be seen as a way to protect himself from burdensome social relationships (lines 28–30), something the patient has previously complained about. Thus, the psychologist seems to bypass the patient’s account of depression having caused his divorce. In the psychologist’s explanation, the depressive symptoms the patient has previously described, are seen as meaningful and competent behaviour. In this way, compared to the patient’s own formulation, the psychologist posits the patient as a more active agent.

Hence, while a diagnosis may offer an exonerating account of behaviour or circumstances that could otherwise be seen as the patient’s fault, thus diminishing the patient’s agency and responsibility for the situation, the reception of such an account can be problematic. In their responses, the clinicians seemed to disregard the patients’ accounts and reformulated them to present the patients as active agents in their lives whose participation was needed in treating mental illness. The clinicians also seemed to orient to the primary task of psychiatry: to find an explanation for the patient’s psychological symptoms (such as depression) rather to use psychiatric conditions to account for relationship (or other lifeworld) problems. As the next section demonstrates, the patients also provided such explanations for their symptoms and causes of their illnesses.

Attributing a diagnosis to life experiences

The patients also used diagnostic categories in sequences where they explained their illness as being caused by certain event(s) in their lives. These explanations occurred in response to a question from

the psychiatrist inviting a description of the patient's life situation. In these cases, the patients' explanations were, however, quite implicit: the patients presented a correspondence, such as a temporal connection, between a life experience and a diagnosis that provided an implicit explanation for why the patient had become ill. In our data, such explanations were often validated by the clinicians. We found nine such cases in our data, three of which came from patients with either no previous psychiatric treatment experience or experience of treatment for psychiatric symptoms outside a psychiatric institution.

The following extract is from a woman in her thirties with a long history of panic attacks. At the beginning of the consultation, the psychiatrist has surmised from the referral that the patient is suffering from a panic disorder. Prior to the extract, the patient has extensively described the symptoms during her panic attacks, and the psychiatrist has asked when she experienced her first attack. In response, the patient has described her failed studies and a burdensome relationship. In the first line, the psychologist (S) presents the next history-enquiring question, eliciting more information on the patient's relationship.

Extract 3

01 S: mites sen suhteen sitten on käyny,
how did it go with that relationship then,

02 (2.5)

03 P: ee: siis se ihmine on tällä hetkel jossai varmaa vankimielisairaalassa tai
e:rm that person is probably in some prison for the criminally insane at

04 jossai siis mun käsittääksei jossain siis .hhhhhh suljetulla hh
the moment or as far as I know in some .hhhhhh closed ward hh

05 (1.0)

06 P: et sehän tota (1.4) hetkinen no se oli (0.5) niin sillo
PRT it-CLI PRT moment PRT it be-PST PRT then
it was erm (1.4) just a moment it was (0.5) yes

07 kakstuhattayheksän joo samana vuonna kun mul puhkes toi .hhhhh
two+thousand+nine PRT sama-ESS year-ESS PRT SG1-ADE pop-PST DEM2
two thousand and nine yes the same year I got that .hhhh

08 ↑paniikkihäiriö niin totah (2.0) se päätty se suhde sitte et se
panic+disorder PRT PRT it end-PST it relationship PRT PRT it
↑panic disorder so erm (2.0) that relationship ended then when he abused

09 viimesen kerran pahoinpiteli mut että jakoavaimella tai jollain
last-GEN time-GEN abuse-PST SG1-ACC PRT wrench-ADE or with+some
me for the last time or hit me in the head with a wrench or

10 astalollal löi mua päähän ja sitten vetäs vielä .hh turpaan siinä
blunt+object-ADE hit-PST SG1-PAR head-ILL and then draw-PST PRT muzzle-ILL there
some blunt object and then even .hh beat me up there

11 ja huh huh [.hhse oli sit sen suhteen [loppu ja,
and it be-PST then it-GEN relationship-GEN end and
and huh huh [.hhit was the end of that relationship [then and,

12 S: **[◦mmm◦.** **[◦m-mm◦.**

The patient responds to the psychologist's question by providing a description of being seriously abused by her boyfriend, which caused the termination of the relationship (lines 3–11). Being abused is temporally connected to developing a panic disorder, thus providing an implicit explanation for the patient's diagnosis (lines 6–8). Similar to Extract 2, the patient reuses a diagnostic label (in this case referring to an explicit "disorder", line 8) that the psychiatrist has introduced at the beginning of the consultation. The explanation is sequentially located in the middle of the patient's description, which makes it difficult for the clinicians to confirm/disconfirm. At the end of the patient's description (line 12), the psychologist responds with minimal, quietly produced acknowledgement tokens that emphatically support the progress of the patient's narrative.

In extract 4, the patient uses a diagnostic category in a similar type of environment. This patient, however, has come to seek help for his problems from a psychiatric clinic for the first time. Thus, in contrast to the previous examples, it is less clear what the patient's diagnosis might be. In response to a question from the psychiatrist, the patient has described the situations he has encountered when drinking alcohol. In lines 1–14 the patient comes to the end of this long description.

Extract 4

01 P: oikeestaa se prenkun ottaminen jäi vähän enemmän päälles sillon ku .hhh
actually that boozing continued somewhat more when .hhh

02 oltii viel naimisissa ja oli sitähhh niist oikeudenkäynneist
we were still married and there was stress about thosehh trials and

03 sun muust sitä stressii ni se oli helppo tapa nollata .[hhh
and stuff and that was an easy way to reset to zero .[hhh

04 D: **[mm.**

05 P: sit se oli (0.5) oli (0.2) aivan uskomattoman raskas se ero
then it be-PST be-PST just unbelievably heavy it divorce
then it was (0.5) was (0.2) just unbelievably burdensome that divorce

06 ja (1.2) mä tota menetim myös luottotiedot tän mun eksvaimon takii
and SG1 PRT loose-PST-1 also credit+rating DEM1-GEN sg1-GEN ex-wife-GEN due
and (1.2) I erm also lost my credit rating because of my

07 sitte ja (1.5) .hhh näin vierest ku hän alko vetää huumeit
PRT and see-PST-1 next-ELA when she start-PST take-INF drugs-PAR
ex-wife and (1.5).hh I was just looking when she started to take drugs

08 sun muita siitä nii (0.7) e::i vittu se oli kyl hhh (0.5) .hhm oli aika
other+stuff-PAR PRT PRT NEG fuck it be-PST PRT be-PST PRT
and other stuff (0.7) fuck no:: it was hhh (0.5) .hhm was really

09 paska homma silloin et tai (0.5) niinku (1.0) irti arjesta
shit thing then PRT OR PRT detached everyday+life-ELA
shitty back then so (0.5) erm (1.0) detached from everyday life it was

10 varmaa siihe ahdistukseenki jonkullaine (0.2) jonkullaine lääkes
probably that+in anxiety-ILL-CLI some+kind+of some+kind+of medicine
probably for that anxiety some sort of (0.2) sort of medication

11 sitte (0.5) e- no (0.5) .mhhhhhh olluhh että mhhhh hmm en tiiä (0.5)
then PRT be-PPC PRT NEG-1 know
then (0.5) e- well (0.5) .hhhhhh that mhhh hmm I don't know (0.5)

12 kuinka riippuvai- no valitettavasti tietenki (0.2) no on riippuvuutta
how addict PRT unfortunately of+course PRT be addiction-PAR
how addict- well unfortunately of course (0.2) well it is addiction

13 joo et kyl mä oon itestän alkoholismi .hhhhh piirteitä löytäny hhh
yes PRT PRT SG1 be-1 myself+from alcoholism-GEN features-PL-PAR find-PPC
so I've found features of .hhhh alcoholism hhh in me

14 ja mm nyt tosiaan niist sitte vähä pyrkiny eroon mutta,
and now PRT dem-PL-ELA PRT little try-PPC rid+off-ILL but
and now I'm trying to get rid of them but,

15 (3.8)

16 P: **.hhhh [mm.**

15 D: [tarvitset siin apua.
[you need help in that.

The patient describes how he began drinking regularly because of the burdensome situation in his life. He produces an emotionally loaded description of his difficult divorce and other challenging situations he encountered because of his ex-wife's drug use by using a high, tense voice, extreme case formulation ("unbelievably burdensome", line 5) and swear words ("fuck no", "really shitty", lines 8–9). These stressful events are connected in order to explain the patient's alcohol use: it

functioned as an escape from everyday life and medicine for the anxiety-inducing situation (lines 9–10). Next, the patient hesitates and mitigates his knowledgeability (line 11), before introducing the categories “addiction” (line 12) and “alcoholism” (line 13) to describe his behaviour. Although the patient seems to mitigate the severity of his problems by presenting them as only *features* of alcoholism (line 13) and as something he has already tried to eradicate (line 14), the patient nevertheless describes himself as having a condition serious enough to be labelled in diagnostic terms. By introducing diagnostic categories, the patient is able to display himself as knowledgeable about psychiatric terminology and capable of participating in the evaluation of his situation.

While the patient in the previous example (Extract 3) presented “panic disorder” (line 8) as something unquestionably established, the patient here (Extract 4, lines 11–14) reports a reasoning process where he has considered whether his condition represents “alcoholism”. In this way, the patient also constructs himself as a “first-timer” in a psychiatric clinic and therefore someone whose diagnosis has yet to be established. The patient’s emotionally intense description of his alcohol use as medication for his stressful and burdensome life-situation provides an implicit explanation for this suggested diagnosis. The psychiatrist, in her following turn (line 15), validates the patient’s explanation by treating the patient’s problem as something for which he needs help, without confirming or disconfirming the reasons for the patient’s condition.

In sum, the cause of the psychiatric diagnosis in both cases was presented as the patients’ relationship situation. Thus, life experiences provided an explanation for receiving a diagnosis – or for having symptoms serious enough for them to be considered a certain type of psychiatric disorder. In this way, the patients justified their reasons for visiting the clinic and their need for psychiatric treatment. The patients also diminished their own responsibility for becoming ill by allocated agency to other people who were significant in the events that led to the diagnosis. In their responses, the clinicians validated the patients’ explanations, treating them as being entitled to use psychiatric vocabulary in this way.

Discussion

This paper has demonstrated that patients in psychiatric encounters are active agents who can utilise diagnostic categories in their own talk in several ways. The patients accounted for their problems – for instance, divorce – as being rooted in a psychiatric diagnosis, thus providing them with a rational explanation for such socially problematic experiences. In a similar vein, explaining the diagnosis with a life experience provides a socially acceptable explanation for why the patient became ill and is acting in ways which deviate from social norms (Jutel 2009).

We argue that these explanations are important in the context of the overall goal of the psychiatric interview, which is to understand the patient's problem in a comprehensive way. These explanations may be seen as part of the patient's illness narrative, which helps to correct the biographical disruption in his/her life story (Bury 1982; 1991). They are also one key facet in the patients' "face-work" – in constructing and maintaining a coherent and meaningful view of the patient's self (Goffman 1955; 1959). In our society, psychiatric problems are perceived as discrediting attributes (Goffman 1963) – some of them more so than others, with schizophrenia being the extreme example (e.g., Rose et al. 2007). Disowning a diagnostic category (Extract 1) can be a straightforward case of face-work where the patient claims to lack a particularly discrediting attribute. However, our results suggest that in the context of the psychiatric interview, a diagnosis is not exclusively treated as a discrediting attribute that threatens loss of face. References to a diagnosis can also be a resource in face-work. Attesting to or claiming a diagnosis (as in Extracts 2, 3 and 4) can be part of patients' presentation of self, through which they can perhaps demonstrate their knowledgeability and responsibility for themselves. Metaphorical expressions (like those in Extract 1) seem also to be one way of claiming a diagnosis and speculating about alternative ways of viewing the patient's symptoms (see Hanne 2015).

A diagnosed mental condition is not the only relevant discrediting attribute in the psychiatric interview: misfortunes and adversities in the patient's personal life, such divorce or violent partnerships, can also serve a similar function. The different ways patients use diagnostic categories seem to involve different choices of face-work in situations where their self-presentation strikes a balance between a discrediting diagnosis and discrediting personal life circumstances. Indeed, this appeared to be the case in Extract 2, where the patient suggested that his incipient depression (in this encounter, perhaps the less discrediting attribute) might be the reason for his divorce (perhaps the more discrediting attribute), and in Extract 4, where a difficult divorce and his ex-wife's behaviour (perhaps the less discrediting attribute in that case) explained the patient's alcoholism (perhaps the more discrediting attribute).

Yet another line of face-work concerns agency and responsibility. As mentioned earlier, patients can reduce their own responsibility for socially problematic situations by allocating agency to the illness/diagnosis (Extract 2) or other people who played a significant role in the events that precipitated the diagnosis (Extracts 3 and 4). Diminishing one's own or another's agency has been shown to be a face-saving strategy in socially delicate situations, such as discussing one's problematic alcohol use (Kurri & Wahlström 2007). Here, paradoxically, it appears that relinquishing one aspect of the self (i.e. agency) helps preserve other aspects.

Previous CA research has demonstrated how patients in somatic-medicine encounters place their explanations in the information-gathering phase of the medical encounter (Gill & Maynard 2005). In our data, the patients also used diagnostic categories as a response to the clinicians' history-taking or symptom-related questions. Moreover, prior research has demonstrated that clinicians often leave patients' explanations unassessed, as those explanations are designed in ways which avoid interfering in the collection of medical data (Gill & Maynard 2005). In our data, the patients' explanations also seemed to be designed in ways which diminished the expectation of a clinician response. For instance, patient explanations for receiving a diagnosis because of certain life events

were sequentially placed in the middle of the patient's talk (Extract 3). In comparison, the patients' accounts for their problems of life as being rooted in psychiatric illnesses provided a slot for responding to the patient's account. In their immediate responses, the clinicians reformulated the account in ways which focused on a symptom behaviour or psychological processes that could be treated in psychiatric care. The role of different psychiatric professionals (e.g., psychiatrists and psychologists) in these reformulations remains an intriguing topic for further research.

By using a diagnostic category, patients inevitably display their knowledge of psychiatric terminology. In Extracts 2 and 3, the patients referred to a diagnosis that they had already received, but in Extracts 1 and 4, the patients first introduced diagnostic labels. In Extract 1, this was done to challenge the suitability of the label for the patient's symptoms and in Extract 4 to self-diagnose. In both cases, the patients presented themselves as knowledgeable about psychiatric terminology and capable of evaluating the kind of conditions they were or were not suffering from.

Today, patients are much more knowledgeable about psychiatric vocabulary, which, so it is claimed, has encroached on every area of life (Furedi 2004). Indeed, psychiatric terms such as stress, anxiety, trauma and addiction have become common ways to describe the experiences of daily life. In this paper, we have focused on the ways these words are used as diagnostic labels. An interesting theme for further research would be to compare how these same words are used as descriptions of life experiences.

Our findings also raise the question of the possible difference between first-timers and more experienced patients in their use of diagnostic categories. The few patients in our data with very limited previous experience of psychiatry only used diagnostic categories when explaining the diagnosis with a life experience. In Extract 4, the patient presented himself as a "first-timer" by self-diagnosing and showing that his diagnosis has not yet been established. It should be borne in mind, however, that our dataset only included a small number of first-timers, and thus the question of the

differences between first-timers and more experienced patients in their use of diagnostic categories remains for further research.

The patients in our data primarily seemed to use diagnostic categories when referring to their life experiences. Thus, although the patients displayed their knowledge of psychiatric terminology and actively participated in the diagnostic interview, their participation appeared to be restricted to displays of "folk" understanding of their psychiatric problems. In our cases, the clinicians seemed to follow the patients' "voice of the lifeworld" by recognising the patient's psychological problems (Barry et al. 2001). This may help them acknowledge the patients as unique human beings and protect their vulnerable sense of self and agency.

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Appendix

Transcription symbols

[	overlapping talk
(.)	micropause
(0.0)	pause (length in tenths of a second)
.hh	audible in-breath
hh	audible out-breath
w<u>o</u>rd	emphasis
-	truncation
°	whisper
:	lengthening of a sound
↑	rise in pitch
,	level pitch
.	pitch fall

Glossing abbreviations

1, 2	person
PL	plural
DEM	demonstrative pronoun
GEN	genetive
PAR	partitive
ESS	essive
TRA	translative
INE	inessive
ELA	elative
ILL	illative
ADE	adessive
ALL	allative
ACC	accusative
COMP	comparative
INF	infinitive
COND	conditional
CLI	clitic
Q	question clitic

NEG	negation
PST	past tense
PPC	past participle
POSS	possessive
PRT	particle

Singular, nominative, active, present tense, and third person are forms that have been considered unmarked. These have not been glossed.

Acknowledgments

This study was financially supported by Finnish Centre of Excellence in Research on Intersubjectivity in Interaction, University of Helsinki, and the Competitive State Research Financing of the Expert Responsibility area of Tampere University Hospital.

Highlights:

- Patients' use of diagnostic categories was studied.
- The data were obtained from audio-recordings of psychiatric interviews.
- Patients accounted for their lifeworld problems as being rooted in a diagnosis.
- Patients explained their illnesses as being caused by a certain lifeworld events.
- Both are important in constructing a coherent view of the patient's self.