

Miller, Paul K. (2016) Brief encounters with qualitative methods in health research: conversation analysis. *Cumbria Partnership Journal of Research, Practice and Learning*, 5 (1). pp. 19-22.

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Brief encounters with qualitative methods in health research: Conversation analysis

Paul K. Miller

Abstract

This paper provides a brief introductory outline of the conversation analytic method, and some of its applications in health research. Drawing on extant literature and an illustrative original case study of suicide risk-assessment in primary care, the core tenets and techniques of the approach are described.

Keywords

conversation analysis; health research; interaction; language; talk

Introduction

Conversation analysis (henceforth CA) is, in the grand scheme of things, a relatively recent development in the systematic investigation of the social world, pioneered as a coherent set of analytic principles chiefly by Harvey Sacks in a pathbreaking series of lectures in the 1960s and early 1970s¹. These lectures outlined an original field of study that was, certainly initially, concerned almost exclusively with the organised properties of 'ordinary' everyday conversation which, crucially, Sacks considered to be the form of talk from which all other forms either derive or deviate (Sacks, Schegloff & Jefferson, 1974). It is the first kind of talk that everyone learns to 'do', and it is done largely *ad-hoc*. Sacks' project was, then, grounded in an empirical study of huge bodies of such naturally occurring talk, with a view to elucidating the systematic properties of what was 'going on' between speakers. In his own words (Sacks, 1984):

The idea is to take singular sequences of conversation and tear them apart in such a way as to find rules, techniques, procedures and maxims... that can be used to generate the orderly features we find in the conversations we examine...

He continues:

So what we are dealing with is the technology of conversation. We are trying to find this technology out of actual fragments of conversation, so that we can impose as a constraint that the technology actually deals with singular events and singular sequences of events – a reasonably strong constraint on some sets of rules (p.414-415).

This paper provides a very brief introductory outline of the conversation analytic method, and some of its applications in health research. Drawing on extant literature and an illustrative original case-study of suicide risk-assessment in primary care, the core tenets and techniques of the approach are described.

Key tenets of the method

The core focus of all studies in CA is upon the way that interaction unfolds turn-by-turn. It focuses upon how speakers use what others have said previously during an interaction as a *resource* when forming their own utterances, and how these utterances themselves inform the range of possible future turns. Simply put, within an interaction, what we say is influenced by how we have interpreted what others have said, and what others subsequently say is then grounded in how they have interpreted us. Levinson (1983) explains this 'proof procedure' principle thusly:

Conversation, as opposed to monologue, offers the analyst an invaluable analytical resource: as each turn is responded to by a second, we find displayed in that second an analysis of the first by its recipient. Such an analysis is thus provided by participants not only for each other but for analysts too (p.321).

From this point of view (and this is the principle that gives CA its analytic distinctiveness), it is not the task of the researcher to impute layers of significance to the words of the people we study, or to fit them into *a priori* analytic categories. Rather, the job here is to track, describe and elucidate how people make sense to each other in the to-and-fro of interaction. In doing so, we can explain, for example, how apparently

¹ His collaborators Gail Jefferson and Emmanuel Schegloff were instrumental in popularising these lectures. They also made their own contributions to the field both before and after Sacks' premature death in 1975.

highly sensitive topics can be successfully raised and discussed without offence being caused; how major breakdowns of understanding can occur when they theoretically should not (or vice-versa); how one individual can 'guide' another into giving particular kinds of answers; or how phenomena such as 'authority' or 'respectfulness' are produced in face-to-face scenarios. More importantly, perhaps, and as Grimwood and Miller (2014) illustrate, its focus upon how interaction actually (rather than ideally) unfolds allows us to observe how even such apparent 'nothings' as silences operate in interaction. Compare, for example, two different ways (below) of *representing* a GP delivering a diagnosis of depression in primary care². Firstly, we might consider what was ultimately *said*, as is typically done in qualitative health research:

Extract 1

Doctor: Yes, well [Patient's name], it strikes me that you have depression. Not severe, but it's just as well you came in. I know there are some misperceptions about depression, it's not an uncommon illness though and we can sort out treatment now. And in a minor case like this, there should be no problem. It's not a big deal at all.

Herein, we treat the GP's talk as, ostensibly, a monologue. If, however, we consider, the way the interaction unfolded, turn-by-turn³, with the inherent silences mapped in seconds (and parts thereof)⁴:

Extract 2

1. D: ye:s (.5) well [Patient's Name] it strikes me that you (.) have depression (.) not severe but it's just as well you came in
2. P: (1.0)
3. D: I know there are some (.) misperceptions about depression
4. P: (.5)
5. D: it's not an uncommon illness though (.) and we can sort out treatment now
6. P: (1.5)
7. D: and in a minor case like this (.) there should be no problem
8. P: (1.0)
9. D: it's not a big deal at all

Note how in the first transcript, the talk comes off as totally unproblematic. In the second, however, we get a

sense of a rather more difficult interaction. The silence of a single second after the diagnosis (in Turn 2) is demonstrably interpreted by the GP (a) as the *patient's* silence and (b) as a noticeable absence of agreement, because he begins to work on 'downgrading' the hearable import of that diagnosis. In short, his post-hoc activity indicates that *he has taken that silence as indicative of a negative reaction* (either as a result of his general experience with diagnosing depression, or anticipation of this particular patient's likely reaction). Had he not, he would likely have moved the consultation on to a discussion of treatment options as is typically done at this stage (Frankel, 1984). With each silence thereafter, however, he moves to explain ever more explicitly how depression is not a 'problem' diagnosis and, thus, to placate or reassure the patient, even though no active objection has been made. In short, the GP uses the *absence* of replies as a resource through which to infer ongoing negativity from the patient regarding the diagnosis he has made. This enables us to interpret the GP's practical reasoning regarding what is actually 'causing' this silence. If he had inferred that the silence was a result of the patient having not heard, or not understood, the diagnosis, then his verbal activity here would likely have been very different. The fact that he works to underscore just how 'everyday' and 'real' the condition is indicates that he has taken the silence to be indicative of *resistance*.

CA and medical interaction

Arguably the most practical and user-friendly guide to the actual doing of CA remains *Conversation Analysis* by Ian Hutchby and Robin Wooffitt, (2008), now in its second edition⁵. To date, the method also has produced a rich body of work in the study of interaction in the medical and broader healthcare fields. Instructive, book-length accounts therein include David Silverman's (1997) remarkable investigation of the interpersonal dynamics of HIV counselling, and Christian Heath's (1986) classic study of body movement and talk in medical interaction. Antaki and colleagues (2007; 2007; 2008), meanwhile, have produced a rich body of work exploring talk in the psychotherapeutic domain, while activity in Primary Care has been a major concern for other conversation analysts (Heritage & Robinson, 2006; Maynard, 1992; Maynard, 1997; Peräkylä, 1998)⁶.

For those familiar with social scientific studies of medical interaction, it is important to emphasise that work in CA often provides a very different picture of

2 Full ethical clearance for the research was received from the pertinent NHS committee.

3 Note that, herein, D=Doctor and P=Patient.

4 (.) indicates a micropause of less than half a second.

5 There are several other excellent introductory texts on the method available, for example Ten Have (2007), while David Silverman (1998) provides an insightful overview of Harvey Sacks' broader programme of investigation.

6 An excellent starter volume for those interested in CA's general approach to medical interaction is Heritage and Maynard's (2006) edited collection of papers on the topic.

medical discourse to that evident in more 'critical' accounts (see, for example, Wodak, 1996). The latter often seek to expose power relations in talk between healthcare professionals and their clients, often (necessarily) beginning from the proposition that GPs, psychiatrists and so forth effectively 'subjugate' their patients with complex jargon and institutional totems. In CA, however, specific interactions are monitored *as they unfold* without such presumption. This facilitates intricate tracking of how conflicts occur when they occur, for sure, but also how apparently tricky topics can be discussed without hiccup, or how resolutions and compromises are found by speakers working together (in this respect, see also Rowe, this issue). As an example, section 4 briefly outlines some findings first reported in Miller's (2013) study of suicide risk assessment in primary care, with a view to illustrating the dynamics of the conversation analytic method in terms of its applicability to a practical interactional issue in that domain.

Case study: Suicide-risk assessment in primary care

Depression and suicidal ideation are, in the vast majority of medical texts, taken to be universally stigmatised phenomena, and therefore inherently difficult things to discuss. As such, clinical dictats, such as those in Tylee, Priest & Roberts' (1996) often-cited guidebook, provide a normatively oriented set of recommendations for conduct in the primary care consultation when addressing these difficult matters. On the surface, the general recommendations are highly logical: Using 'open' questions; asking about feelings; not hurrying the consultation; employing a friendly and empathic style; asking for clarification of verbal cues; asking direct questions about depression and never interrupting a patient. Tylee, Priest & Roberts (1996) do acknowledge that 'unquantifiable' factors such as culture, use of language, social skills and so forth play roles in the consultation. These matters are not really addressed in the guidelines, however, which are instead based upon common-sense 'universals' for what is understood to be good clinical practice (Silverman, 1997).

Exploring specific primary care consultations in which the topic of suicidal ideation is raised, however, Miller (2013) highlights how GPs often use tacit *social skills* – which can superficially look very much like 'poor practice' in the light of the guidelines outlined above – to highly constructive, context-sensitive ends. Consider, for example, extract 3⁷.

Extract 3

1. D: Are you finding the symptoms disruptive (.) um (.) in your routine?

2. (.5)
3. P: Yes (.) very much (.) I keep crying at work and that's really (.) well (.5) stup. ahm (.) embarrassing (.) but I just can't help it
4. (1.0)
5. D: I see [intake of breath] (.5) so (.5) you (.) um (.) don't know how to cope with all this?
6. (.5)
7. P: Well..
8. D: ...do you (.) sorry (.) ever think that it's just all too (.5) much or that (.) you can't carry on? Um..
9. P: No: (.) I've (.) I've never felt that bad (.5) no (.) just very (.) you know (.) down (.)
10. D: Good ((continues))

From the point of view of a normative framework in which the characters of, for example, 'open style' and 'interruption' had been pre-assumed, it could be argued that even during this very short period of interaction the GP is guilty of:

- Asking leading questions, rather than open ones (turn 5), and/or:
- 'Telling the patient what she meant' (turn 5), and therefore not employing a sufficiently open style, or even lacking contextual empathy, and:
- Actively interrupting the patient (turn 8) and also, thereby, not fully listening to what the patient was attempting to tell him, or hurrying through the consultation.

A more careful analysis of the way that the talk is used here, however, reveals something rather more productive at work. UK National Health Service (henceforth NHS) primary care guidelines clearly stipulate that a general practitioner (henceforth GP) should explore the danger that any patient with suspected depression represents to themselves at the first available opportunity: "*Always ask people... directly about suicidal ideation and intent.*" (National Institute for Clinical Excellence, 2009, p. 120). One of the key problems that faces a GP when asking a question about suicidal ideation at a point like this (where depression is clearly suspected) is that it may 'surprise' the patient, seeming out-of-place in the consultation, and induce a strong negative reaction. So this presents a very real practical problem for a GP. How does one directly broach the matter of suicidal ideation when the patient may not be expecting it?

One key way in which this is done is by *pre-establishing* a sense of relevance (Miller, 2013) for the issue itself. So, in Turn 5, D summarises P's previous

⁷ This uses a simplified version of the original transcription notation.

words in a way that can be hearably connected to an actively depressed state by the patient. It might well seem a lot more logical to ask someone who 'doesn't know how to cope' about suicidal ideation than someone who is just 'embarrassed about crying at work.' In Turn 7, P begins with a 'Well' which, as noted by a number of analysts, often indicates forthcoming disagreement (Schegloff & Lerner, 2009). By cutting off the patient at this point, D thereby *sustains* the relevance of the question that he has to ask when the patient may have diminished that by contesting his summary. Consequently, when it is finally asked in Turn 8, P answers in the negative, but unproblematically so. There is no 'recoil' from it because it is hearably a logical upshot of what was already being said.

The study from which these findings are taken further illustrates a range of ways in which GPs and patients work together to negotiate potentially difficult situations in consultations to positive ends, not all of which, normatively speaking, would appear to be 'good practice'. For example, the GPs often used rather "vague" questioning about suicidal ideation which, although lacking institutionally recommended "directness" (National Institute for Clinical Excellence, 2009), demonstrably served to "soften the blow" of the question itself (Miller, 2013) where a full sense of its relevance could not be generated. In sum, GPs consistently used a range of apparently "dysfunctional" but highly skilled, interpersonal activities to make potentially difficult questions easier for patients to hear, and to sustain "local social solidarity" (Silverman, 1997) within the consultation itself.

Conclusion

The short discussion of CA above barely scratches the surface of the method itself, but is manifestly intended to illustrate a few small ways in which the broad approach has had, and can have, great facility in health research. Perhaps its most potent quality in this sense is in its capacity to illuminate the tacit skills of healthcare professionals and their clients without recourse to pre-judgements about power or over-simplified notions of 'good practice'. In this respect alone, qualitative health researchers may find the extant corpus well worth investigating.

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Brief Encounters with Qualitative Methods in Health Research: Narrative Analysis.

Louise Rowe

Abstract

Narrative research is a recently developed approach to qualitative investigation in health settings which is growing in popularity. The methods and analytic procedures used, however, are diverse, have developed in very different disciplines and are often not well prescribed in the literature. This can make it difficult for those new to this approach to assess what narrative research actually *is*. The aim of this article, therefore, is to introduce the process of narrative research and open a discussion on what constitutes a 'narrative', and the defining features of narrative analysis. Some examples of narrative research in health will then be presented.

Keywords:

health; narrative analysis; participant-centred analysis; qualitative research

Introduction

Narrative research "...refers to any study that uses or analyses narrative materials" (Lieblich, Tuval-Mashiach & Zilber, 1998, p.2). Put simply it is the study of a story. The approach evolved from the study of literary works and folklore, but has since been adopted by a wide range of disciplines. It is a more recent qualitative method to emerge, with a rapid increase in popularity in the last few decades (Murray, 2000).

Although many other qualitative methods use some form of narrative as their object of study, narrative research is characterised by the use of methods and analytic procedures that examine the way that the story is told, and preserve the voice of the participant. These elements are often lost in other qualitative research procedures. For example, Overcash (2003) notes that ethnographic accounts of experience (see Benkwitz, this issue), despite putting

the participant at the centre of the research, are often over-reliant on the voice of the researcher to describe the phenomena under investigation. Narrative researchers also criticise standard thematic analysis, and grounded theory (see Earnshaw, this issue), for mechanistically dissecting text into disjointed segments which are then rebuilt into themes. This can break the narrator's intended connection between sequence and consequence, and also disrupt or obscure meaningful narratives. This cause-effect in personal meaning-making is an essential feature of narrative data.

Personal narratives can take many forms, such as research interviews, observations of conversations, journals, written accounts or even reports or discussion documents. Online stories in the form of blogs, or YouTube videos, have also been used (Wen-Ying, Hunt, Folkers & Augustson 2011). A unifying