Managing the Challenge

'CONFLICT' AND RESOLUTION IN THE DIAGNOSIS OF DEPRESSION

PAUL K. MILLER, LANCASTER UNIVERSITY

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Background

From a broader project examining problems with diagnosis of depression in Primary Care.

Conversation Analysis & Membership Categorisation Analysis. Single case analysis here.

Diagnoses of depression unusual in that they are virtually always, to some extent, 'resisted'.

- Wide range of reviewed studies in health sciences make same point.
- Common employment of 'Conduit' model – social cognition.

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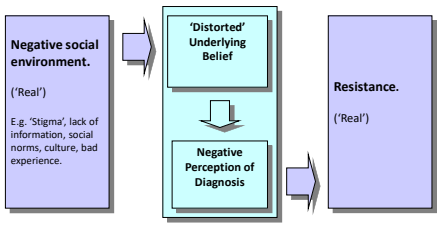
'Conduit' Model (Simplified)



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Literature

Matter of emphasis:

- Medical/Psychological – Beliefs/Cognitions.
- Sociological – Stigma, Norms, Cultures.

Universal solution: *Educate the patient!*

- Reflected in policy and practice literature.

'Confusion and embarrassment often surround a diagnosis of depression. Therefore, it is essential to try to dispel negative perceptions of the disorder with an explanation of the causes, mechanisms and impact of the illness..'

(*American Family Physician*)

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Not 'As-It-Occurs'

Character of core phenomenon presumed to be known already; cognitive-environmental matter.

- Search for *causal* account, beliefs as active agents.
- Explanations pre-set: resistance through 'ignorance' or 'stigma'.
- Limited concept of medical professionals.
- Cultural 'doping'.

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Data

Chunk of interest is on page 2 of data sheet (Lines 47-76).

Superficially seems to support 'conduit' model.

- Diagnosis of depression (47-53).
- Patient raises problems with the diagnosis (56-63).
- GP explains the 'true' nature of the condition (65-74).
- Patient concedes the validity of the diagnosis (76).

Left at that level, however, we run into major contradictions.

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Resistance?

'snot like ahm (.5) ºlikeº suicidal or anythin like ah said (1.0) jus: a bit (.) ya know (.) run down'

'Silent belief'?

- Depressed people are suicidal people.
- I am not suicidal.
- Therefore I am not depressed.

Shortfall in knowledge, obstructing diagnosis?

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Education?

Lines 64-70, GP releases 'new information'.

Information released not to any extent 'new' unless we are to attribute a very short memory to the patient.

All information readily available from local context.

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Conversation Analysis

Regular, oriented-to 'asymmetrical' sequencing in consultations:

- GP asks questions, sets topics.
- Patient follows lead.

Challenges and questions by patient unusual.

- Done in indirect manner.
- Preserves 'expert' role of GP.

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Local Interactional Context

Lines 1-46, normal 'asymmetry':

- Symptoms explicitly constructed *as* unclear (7-10).
- Symptoms low-level, undramatic, but *enduring* (28).
- Delimits inference that symptoms are *product* of 'mental state' (24 & 37).
- Aggressive denial of 'suicidal thoughts' – *just* 'ill' (44).

'Ordinary' person doing the 'rational' thing in consulting a GP.

- Before any suggestion of depression is made.

Identity construction - 'Reasonable Witness' (Zimmerman, 1992) to his own state of health.

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Diagnosis in Sequence

Diagnosis:

- Pre-announced as 'nothing serious' (49).
- Co-implicates the patient - 'looking at what you've said' (51).
- Minimal form - 'a *little* depression' (53).

Done *as dispreferred* (Sacks).

- Formulation anticipates unfavourable reception.

Sensitive to *stance* taken by patient.

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Category Ascription

Diagnosis = offer of admittance to relevant social category.

In situ acceptance of category = simultaneous acceptance *of all (potential) inferential properties of that category.* (Sacks)

Practical problem for patient here:

- Outright *acceptance* of a diagnosis 'depression' potentially challenges prior interactional work .
- Outright *refusal* of diagnosis runs same risk.

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Resolving the Practical Problem

Initial 'objection' itself done in dispreferred form – 'yes-but' structure.

- Mitigated agreement - 'suppose it might' (59).
- Question - 'ya ºumº sure?' (60).

Formulation dually:

- (a) avoids any direct assertion at the outset that the GP is simply 'wrong' or 'mistaken'.
  - Upholds the GP's role as 'expert', avoids inferential 'belligerence'.
- (b) creates *conversational space* for the patient to override normal turn-taking pattern, and do more talking.
  - Defers his admittance to the diagnostic category.

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Construction of 'Resistance'

Talk reasserts key features of 'ordinary' identity.

Contrast structure: I'm not X…I'm Y.

snot like ahm (.5) ºlikeº suicidal or anythin like ah said (1.0)
jus: a bit (.) ya know (.) run down

- Binary opposition *emphasises* ordinariness of' 'just run down'.
- Account also *embeds* clear memory of prior events in the consultation.

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Therefore…

Mitigated resistance *in the patient's first turn* after diagnosis.

- Avoids denying potential categorical relevance outright.
- Provides space to reassert 'ordinary' / 'reasonable' identity.

Thereby mitigates inferences available from category 'depression' that could challenge status as reasonable witness in local context.

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The GP, Meanwhile…

…collaborates in the construction of this identity in his 'explanation'.

Constructs a 'commonly held' conception of depression (64-65).

This knowledge then ascribed a 'partial' character;

- True a 'lot of the time', but, 'not always' (65-66).
- Delimits inference that Patient is just 'wrong' or 'misguided'.
- Aligns patient with 'most people' – 'ordinary'.

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'Public Knowledge'

GP builds a 'minority' understanding of depression (69-70).

- Different, but *'equally' correct*.
- Avoids implying that the patient is 'ignorant' of easily-available facts.

This construction gists Y component of the patient's challenge (62).

- Co-implication.
- Explicit direction ('like you said').
- Echoes 'ordinariness' of that utterance ('you might **just** feel…').

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Thus:

Patient's challenge cast as being grounded in knowledge that is:

- Well known;
- Correct;
- Applicable in *many circumstances*.

Thereby patient's activity itself is accorded the status of:

- Reasonable.
- Legitimate.

Patient's own identity as 'rational agent' underscored.

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Turn-Taking

Normal question-answer sequence of the consultation suspended.

GP relinquishes topical control to the patient and makes no attempt to reassert it until an accordance is reached.

- Asymmetrical 'rights' reversed.
- Patient allocated the status of a 'knowledgeable agent'.

Facilitates and reinforces the construction of a 'competent' identity for the patient.

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Summary

The construction of the diagnosis is sensitive to the stance adopted by the patient with regard to his own symptoms throughout the consultation.

The patient's 'resistance' is sensitive both to inferential business generated by the diagnosis with respect to this stance, and to the design of the diagnosis itself.

The 'resistance' itself reasserts the patient's 'ordinary' identity, delimiting potentially damaging inferences while also avoiding compromising the local interactional context.

The GP collaborates with the construction of this ordinary identity, temporarily relinquishing control of task and topic, to achieve a mutually acceptable 'result'.

Accordance as result of category consensus.

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