Cover Sheet

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Bionote

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Abstract

National Health Service directives in the UK specify that, in any primary care consultation where a patient either demonstrably has – or is suspected to have – depression, a "direct question" should be asked regarding their thoughts or activities relating to self-harm or suicide. The evidence collected for this study, which takes the form of recorded interactions between doctors and patients in primary care settings, indicates that this is most commonly done post-diagnosis as an exercise in "risk assessment." Suicidal ideation is, however, not only classified as a possible outcome of depression but also a core *symptom* of the condition and, consequently, such a question is sometimes asked prior to the diagnostic phase of the consultation, as a key step in reaching a depression diagnosis. This specific activity presents a general practitioner with an inferably difficult communicative task: how to raise the matter of suicide/self-harm when the patient does not already have a depression diagnosis as an interactional resource with which to make sense of its local relevance. Herein, using a conversation analytic method, techniques employed by general practitioners and patients in negotiating three of these potentially sensitive moments are examined. Analytic observations are then used to highlight a range of issues pertinent to the formulation of normative frames of "good practice" in handling difficult clinical topics *in situ*.

Keywords: depression; suicide; interaction; primary care; stigma, conversation analysis.

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Depression, sense and sensitivity: On pre-diagnostic questioning about self-harm and suicidal inclination in the primary care consultation

Introduction

The link between depression and suicide is, in modern medical knowledge, a "given." The canons of contemporary psychiatry, without exception, specify that suicidal ideation, like the physical acts of self-harm and suicide, is a core symptom of the illness (American Psychiatric Association 2000; World Health Organization 2010). For example, the DSM-IV-TR, in its list of nine core symptoms of a "Major Depressive Episode," describes:

> "Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide." (American Psychiatric Association 2000: 356)

Moreover, suicide is also a characteristic (though far from inevitable) *outcome* of depression. Recent statistics from the UK indicate that:

> "Depression is the leading cause of suicide...Nearly two-thirds of deaths by suicide occur in people with depression (that is, about 2,600 suicides per year in England alone)." (National Institute for Clinical Excellence 2009: 594)

Consequently, a great deal of attention is accorded in clinical literature to methods for the early assessment of suicide/self-harm risk in cases of depression. UK National Health Service (henceforth NHS) primary care guidelines, for example, 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 with depression directly about suicidal ideation and intent." (National Institute for Clinical Excellence 2009: 120). This imperative, to ask direct questions, reflects an important property of "suicidal ideation" that is distinct from the other eight DSM-listed symptoms of depression.[1] Suicidal ideation, unless directly actually acted upon (and not even always then), is *exclusively* accessible through self-report by a patient.

Extant research indicates, however, that the communication of suicidal intent in just about *any* context is problematic – both at the levels of transmission and reception (Owens *et al.* 2009; Owens *et al.* 2011). For example, Owen *et al.* (2012) demonstrate that the "face-threatening" aspect of talking about suicide often results in disclosures that are ambiguous, indirect, euphemistic or even humorous in form; consequently, listeners frequently struggle to interpret the real intent underpinning such utterances. This can, in turn, result in the closing-down of channels of communication and stymieing of potential support-mechanisms. Horne and Wiggins (2009), meanwhile, intricately demonstrate the difficulties in getting such claims taken seriously in a culture where suicidal activity is often seen as a "cry for help." Exploring an internet forum for individuals with "suicidal thoughts," they note how

there is a social dilemma inherent when making any claim to be suicidal. To present oneself as:

> "…not suicidal enough and you may be treated as 'just' depressed; 'too' suicidal and it may be challenged if you do not carry through your actions." (Horne and Wiggins 2009: 170)

The *elicitation* of information regarding suicidal intent is similarly marked throughout clinical literature as a potentially problematic process specifically within medical interaction; suicidal ideation itself is taken to be universally "stigmatised" and, therefore, a difficult topic for patients to address in primary care scenarios, almost irrespective of the specific skills of the doctor (Vannoy *et al*. 2010).

As such, this paper reports findings from a conversation analytic (henceforth CA) study of the diagnosis of depression in primary care in the UK, with a view to contributing to the body of knowledge on the communication of suicidal thoughts and intent. Within the overall corpus of data collected, it was found that questioning about suicidal ideation was indeed a regular feature of the depression-related consultations. In the majority of cases the matter was raised after the delivery of the depression diagnosis. In three consultations, however, it was raised *before* diagnosis was reached, and it is upon these cases that the analytic focus of this paper falls. As a number of studies of medical interaction have demonstrated (Peräkylä 2006; Stivers 2006), the inferential properties of a diagnosis provide a rich range of interactional resources upon which healthcare professionals and clients can draw in post-diagnostic discussion. With respect to the elicitation of information about suicidal ideation, for example, a GP can reasonably infer that a patient would understand the links between depression and suicidal ideation and would therefore have some appreciation of the

relevance of the topic being raised. Questions can thus be framed (and ideally received) as, at least, a *logical outcome* (Jefferson and Lee 1981) of a depression diagnosis having being previously made. When raising suicide/self-harm as a part of the diagnostic process, however, the same resources are not necessarily available. Thus, as evidenced below, the GP can be faced with a very different set of interactional circumstances and concerns.

1. Data and methods

Data were collected exclusively in UK primary care settings.[2] With full approval from the pertinent National Health Service ethics committee, participants were recruited at contributing surgeries in the course of regular/scheduled appointments. No patients were "pre-targeted," but rather informed consent to allow the audio-recording of consultations was collected from *all* patients over a series of weeks. In this way, new depression diagnoses could be collected, and recordings not relevant to the purposes of the project could be deleted securely at source. Recordings were collected by the GPs themselves, with no researchers present, to minimise disruption to the medical process.

Prior to their signing of the consent form, participants were assured of strong steps to preserve their anonymity (i.e. that all dates, places and names would be purged from transcripts, and that no details of the location or timing of the broader project would be made publicly available), and were also given a two-week "cooling off" period subsequent to their consultation, during which they could withdraw their contribution. All pertinent consultations were then transcribed using full Jeffersonian conventions (see appendix 1), and explored using conversation analysis (Sacks 1972; Sacks, Schegloff, and Jefferson 1974).

1.1. Interaction and "difficult" questions in sequence

It is axiomatic within CA that, in the flow of everyday conversation, participants orient to prior turns and previously disclosed information in the design of questions and answers (Sacks, Schegloff, and Jefferson 1974). As Suchman and Jordan (1990) and Antaki (2002) note, however, one of the key problems with asking "prescribed" questions (of any form) during an interaction is that the questions themselves may well violate this natural flow of talk. Putting aside, for a moment, the implications of asking prescribed questions specifically about self-harm or suicide, it is still important to note that there are practical problems with asking "set-sequence" questions of people in general, as one might in a fully structured interview. Not only is the contextually and sequentially sensitive nature of everyday questioning likely to be *noticeably* absent, but the possible types of answer that can be produced are also limited. The upshot of this type of questioning, as Hutchby and Wooffitt (2002: 176) argue, is that any particular element may "…become very irritating to the respondent…" in a range of ways:

1. It may appear to request information that the respondent has already provided (i.e. appear *irrelevant*);
2. It may constitute abrupt, and unaccounted-for, changes of subject (i.e. appear *out of place*);
3. It may prevent the respondent from disclosing information that has been made contextually relevant by prior utterances.

The primary care consultation is not, of course, subject to the same rigidity as a fully structured interview. While there is pertinent research on doctor-patient interaction that does analyse certain "rigidities" of turn-taking, and of "speaking rights" therein (Frankel 1984; Heath 1992), the simple point here is that the primary care consultation, unlike a structured interview, is not *pre-scripted*. The directives on risk assessment outlined above, however, present the GP with a particular kind of interactional problem pertinent to the second point on the list above. If the patient does not volunteer the explicitly relevant information or present an obviously appropriate opportunity to ask, how would one insert a "direct" question (National Institute for Clinical Excellence 2009: 120) about suicidal-thinking in such a way as to cause minimal disruptions or complications? Moreover, the GP must remain alert to the fact that what may, in medical terms, appear to constitute a straightforward thematic link between the patient's reported symptoms and potentially self-harming behaviour (via the lens of depression), may not constitute any such link *to a patient*. What might amount to "an appropriate opportunity to ask" is itself, therefore, not something which can be fully pre-specified, but rather an emergent phenomenon in situated cases of practical action. As such, in these terms, appropriateness (or relevance) is demonstrably a *members' concern* (Garfinkel 1967).

It is in this particular respect that the findings reported below diverge from much of the existing work on "delicate issues" in medical interaction, as typified in David Silverman's (1994, 1997) influential work on HIV counselling. A person attending an HIV counselling session following (or preceding) an HIV test, for example, could quite reasonably expect to be confronted with matters pertaining to HIV. As the data interrogated below will illustrate, an individual attending a standard consultation with their GP and presenting a set of largely "somatic" symptoms may be

rather less prepared to be asked about their thoughts on suicide, or their chances of self-harming. This is a contextual matter to which the GPs can be seen to pervasively attend in their activities.

2. Analysis

The analytic sections of this paper, thus, address the interactional activities of three GPs when addressing the particular business of pre-diagnostically assessing suicidal ideation. Descriptions are provided of the methods used by these GPs to "naturalise" the asking of such questions, i.e. to render them contextually appropriate, or at least to minimise the possible interactional damage that might occur.

2.1. Case 1

Consider the following extract, 1. Throughout the analysis, the GP is designated speaker "D" and the patient speaker "P." Up to this point in the consultation, P has complained of persistent exhaustion, lack of concentration and sleep perturbations.

Extract 1: DP7 <depression>

1.	D:	ºri:ghtº (.) ahm (.) would you: say that (.) ºahmº (.) you are enjoying life (.) ah:: (.5) less?
2.		(.5)
3.	P:	less than:: (.) huh huh (.) who?=
4.	D:	=hah (.) less than usual (.) hhh.
5.		(.5)
6.	P:	we::ll (.) yeah (1.0) but >is: hard< teh enjoy much when ya ºfeelº like this:
7.		(1.5)
8.	D:	ºahmº (.) now (.) is there (.5) ahm (.) have you at any (.) er::: (.) ti::me? (.5) wo::ndered or (.) well:: (.) thought that it might not be (.) you know (.) ºwell:: º (.5) worth it?
9.		(2.0)
10.	D:	I (.) mean↓[um
11.	P:	[no (.5) I just feel ill
12.		(1.0)
13.	D:	okay then (.) ahh. *((continues))*

Note that the disclosure (turn 6) by P establishes a muted agreement with the material of D's question "are you enjoying life less?" (turn 1). From a third-party perspective, with knowledge of the diagnostic frames for depression (persistent exhaustion, lack of concentration and sleep perturbations all being characteristic symptoms), this disclosure could easily be interpreted as a logical step towards asking the question about suicidal ideation that follows. Indeed, D's decision to initiate this question in turn 8 indicates that he has most likely interpreted the interactional context in exactly this way. At the very beginning of turn 8, however, after the 1.5 second pause, D uses the utterance "ahm, now" as a disjunct marker (Jefferson 1978), indicating an inference that the question may still be heard *by P* as "out of place." Also noteworthy in this respect is the heavily perturbed flow of D's talk throughout. In turn 6 the question-proper begins with the dispreference marker "well," then "false starts" (the speaker self-repairing his first attempt), and further contains a series of pauses, hesitations and delays ("er," "you know").

Working from the NHS guidelines which emphasise the importance of "directness" in such questioning, it could well be asserted that the delivery of the question here is evidence of poor clinical practice. Silverman (1997), however, has demonstrated at length the manner in which such extensive perturbations are routinely utilised by speakers to explicitly display an orientation towards the embedded *material* of an utterance as "delicate." Indirectness here is, then, something actually *worked up* in the design of the question. The delicate material itself is formulated in the most everyday, ordinary terms available for this topic: "thinking it might not be worth it" as opposed to "thinking about committing suicide" or "having suicidal thoughts." Moreover, the specific information made conditionally relevant by the question pertains to occasional, formless and non-determinate thoughts about suicide

(via “at any time,” “wondered,” and “might not” respectively). The specific word-selections herein perform a range of important interactional functions. A more direct question such as “do you think about committing suicide?” could serve to implicitly categorise P as a potentially “suicidal person.” The design of the utterance neatly sidesteps any such implicit categorisation. Furthermore, by making relevant “occasional wonderings” about “possibilities,” D provides P with space to admit to having such thoughts while only aligning himself with this contextually problematic category in the weakest possible terms. Thus, more favourable conditions are generated for P to answer affirmatively should the conversational trajectory unfold in this way.

2.1.1. Interactional consequences

To summarise the above analysis, thus, D’s activity in early turns of this extract is characterised by heavily perturbed talk and distinctly indirect questioning. This could easily be read, in a decontextualised way, as evidence of lack of “confidence.” Such psychological attributions fall apart, however, when exploring the constructive functions of these features within the flow of the specific interaction. Herein, the question about suicidal ideation is asked in a position where it *could* be heard as a logical upshot of the immediate prior activity (i.e. P’s disclosure that he is enjoying life less). However, the perturbations of speech, augmenting the disjunct marker “ahm, now”, can be seen to work as a hearable pre-announcement (Terasaki 2004) of a sensitive and/or unexpected topic should the question *not* be heard in this way. Moreover, the “vague” and open-ended structure of the question itself functions as a means of facilitating any potential affirmative disclosure by P.

Following D's question, however, a disclosure is not immediately forthcoming. Instead, there is a two second silence at the transition-relevance point at turn 9. D then initiates a turn, explicitly marking it as a clarification: "I mean" (turn 10). This allocates the prior silence *to* P, but also retroactively characterises the prior question as potentially unclear for P's purposes. In these terms, P's non-answer is cast as resultant of him not fully understanding the question (rather than, say, a reluctance to answer). Accountability for the silence is diffused between both speakers but, centrally, the conditional relevance of an answer to that question (topical control) is maintained by D. In this sense, an interactional problem arising from the question is quickly dealt with. Interestingly, however, the actual clarification itself is not forthcoming because P initiates his turn almost as soon as D begins to speak (turn 11).

As a number of studies in studies in CA (e.g. Maynard 1991; ten Have 1991) have shown that patient-initiated overlap in medical interaction is relatively unusual when compared to everyday talk. Furthermore, the initiation of a turn when the previous turn does not appear complete cannot be treated as a simple and unproblematic case of "interruption" in *any* interaction (Jefferson 1984b; Schegloff 2000). Rather, an interruption is something oriented to by speakers *as* an interruption. P, in this case, proceeds with his turn as if D's utterance had not been inserted, thus re-characterising the insertion itself as little more than a token of encouragement. Moreover, D's subsequent activity clearly displays an orientation to P's turn as "legitimate." He makes no attempt to pursue the trajectory of conversation he opened up in turn 8 and, furthermore, explicitly acknowledges P's refusal of the topic (turn 11) as a satisfactory completion of the question-answer pair. This particular activity is in substantial part, of course, contingent *upon* the character of P's assertion that he "just feels ill." Firstly, by making available that no clarification is necessary, and by

answering the question directly, P provides for the inference that he did, in fact, understand the question in the first place. Thus, the silence following the question is reconstituted as a "delay" or a reluctance to answer, and D's interjection as the out-of-place action. Secondly, *all* inferences regarding P that the question itself has opened up related to suicidal ideation and its implications, are systematically closed down. An alternative framework for making sense of the previously described symptoms is then provided: "I just feel ill." In this way, P firmly distances himself from the potential category-ascription "people who think about suicide" and firmly locates himself in a far more everyday category (a relative downgrading further emphasised by the comparison marker "just"). By closing down the topic in this way, and re-setting the agenda for discussion, P actively establishes unfavourable conditions for any further questions pertaining directly to suicidal ideation. Such questions would have to be introduced *as* contextually out-of-place (i.e. the topic is now dead) and, more damagingly, would be potentially implicative of P "not telling the truth." D's acknowledgement token ("okay, then") in turn13 reflexively characterises this as a legitimate end to the topic, and a new phase of questioning begins.

2.1.2. Doing "logical" progression

As first noted by Jefferson and Lee (1981: 408), medical *advice* is most likely to be well received where it is in some way requested by the patient/client and, as such, emerges:

> "…as the logical outcome of a diagnosis offered by the troubles-recipient and concurred in by the troubles-teller; i.e. the advice is sequentially appropriate and the talk is interactionally "synchronous.""

This suggests that, where these features are absent, i.e. where a "trouble" is not first presented by the client, we are more likely to find the advice in some way rejected. Heritage and Sefi's (1992) account of interactions between health visitors and mothers further elaborates this analysis of advice rejections. They observe that the mothers, in their collected data, usually resist any advice which is not recipient-designed to a specifically elicited problem. They show that a more favourable environment for the giving of advice can be created by the establishment of an agreed "problem" that is being experienced by the potential advice-recipient. Advice is, in these terms, much more likely to be well received when it is addressed to a client problem elicited by a series of questions and requests for specification. In the extract above, only a mitigated agreement on the nature of a problem advanced by D (turns 3 to 4) is established. Consequently, even though the *question* about suicidal ideation was marked as potentially "out of place" and treated as a distinctly delicate object, the flow of the interaction was briefly compromised, with P abruptly closing down the topic.

2.2. Case 2

The analysis of extract 1, above, revealed some complex strategies in the management of issues surrounding a question marked as delicate. It was possible to observe how even apparently dysfunctional or "troubled"' talk serves constructive functions within the local context of the consultation. Also highlighted, however, with relevance to Heritage and Sefi's (1992) study, are the interactional consequences of not establishing a direct and mutual consensus on the character of a problem in advance of the asking of a question about suicidal ideation. In extract 2, below, a different approach is taken by D to establishing "agreement" on the nature of a problem.

In turn 3, P (who has hitherto complained of feeling consistently fatigued and over-emotional) constructs an ongoing and "embarrassing" state of affairs. Fundamental to the interactional sense of this state-of-affairs formulation is the manner in which P self-repairs "stupid" with "embarrassing," two terms with markedly different inferential properties as descriptors of her own behaviour.

Extract 2: DP27 <depression>

1.	D:	are you finding the symptoms disru:ptive (.) um: (.) in >your routine<?
2.		(.5)
3.	P:	yes (.) very much (.) I keep crying at work and thats really (.) well (.5) stup↑ ahm: (.) emba:rrassing↓ (.) but I just can't help it
4.		(1.0)
5.	D:	I s:ee: .hhh (.5) so:: (.5) you (.) um: (.) dont know how to co:pe with all this?
6.		(.5)
7.	P:	ºwell:º[
8.	D:	[do you (.) ºsorryº (.) ever think that its just all too (.5) much or that (.) you can't carry on:? um=
9.	P:	=no: (.) ive (.) ive never felt that bad (.5) no (.) just very (.) you: know (.) do:wn
10.		(.)
11.	D:	goo:d ((continues))

To characterise this behaviour as "stupid" would permit for a wide range of inferences to be drawn; for example, that it is inherently unnecessary or unwarranted. The re-selection of "embarrassing" delimits such inferential possibilities, however. It instead furnishes D with resources from which to infer that this is merely normal behaviour taking place in an inappropriate context. Any potentially awkward inferences arising from this formulation are then themselves mitigated through the assertion that the behaviour is involuntary ("I just can't help it").

It is important to note, however, that P does not simply construct an embarrassing state of affairs, but a state of affairs *as embarrassing*. This formulation attends to some key inferential issues relating to her character as author of the account. As Palmer (2000) describes, hallucinations or delusions are generally recognised in

psychiatry not through the particular content of an account, but from a marked lack of orientation on the part of a speaker to the unlikely or contentious character of a claimed experience. In framing her behaviour in this particular way, P orients a listener to its inferentially unusual character, but also makes available the *normality* of her own reaction to it. As such, in Sacks' (1984) terms, she does "being ordinary." This is to say that she frames her activity as being something that is recognisably the kind of thing that "normal" people might do; one could reasonably assume, for example, that many people would indeed be embarrassed by recurrent crying at work. As such, she builds an identity for herself as a "normal" person experiencing "unusual" circumstances rather than, say, as an "unusual" person. In doing so, she further underscores the veracity of the account itself; i.e. it is one provided by "a reasonable witness" (Zimmerman 1992). The character of this account forms a major resource in D's subsequent activity.

2.2.1. Prefacing the question

In turn 5 of extract 2, D issues "I see" as an assessment token (Jefferson 1984a), which serves a number of purposes at this stage:

1. To mark the previous utterance as a satisfactory completion of a question-answer pair.
2. To mark the information provided as "new" and/or significant. As such, P is equipped to expect a potentially unforeseen trajectory of talk.
3. To make visible his "correct" understanding of the significance the utterance. This insulates future utterances by D against the accusation that they are based on a misunderstanding of the circumstances.

The forthcoming activity is thus marked as potentially awkward, but also relevant, using what is essentially a "hear me out" device.

D then proceeds to reformulate P's prior talk in terms of a *gist* (Antaki, Barnes and Leudar 2005): "so you don't know how to cope with all this." While condensing all detail thus far disclosed by P into the generalised summary-token "all this," the gist itself preserves the sense of one essential element of the immediately-prior utterance: the admission by P that she cannot help her behaviour. Interestingly, despite P's endeavours to align herself with an "ordinary" identity, D's utterance aligns her with an altogether more delicate one, marked with a series of pauses and hesitations; "people who don't know how to cope." This announcement is, superficially, rather combative. It appears to undermine some of the interactional work done by P through offering an alternative version of what she is *actually* saying. In this consultation, however, when P takes up the subsequent potential transition-relevance position (turn 7), D almost immediately closes down the turn. While D himself orients to the overlap as interpretably an interruption (note the apology in turn 8) he carries on nevertheless. In this sense he retroactively characterises the pause that P treated as a transition point (turn 6) as, in fact, *merely* a pause in his turn. This has the effect of allowing him to continue talking without violating P's rights to take her turn. The significance of this activity becomes more apparent, however, when the character of P's abortive turn in taken into account. "Well" (turn 7) is probably *the* classic dispreference marker in the English language (Schegloff and Lerner 2009) and hearably so. D's closing down of the turn, thus, prevents the production of what began as *a likely challenge to his summary*.

2.2.2. On the preservation of relevance

The "interruption" itself (turn 8) ultimately transpires to take the form of a question relating to suicidal ideation and, as in extract 1, the word-selection utilised in the question itself omits any direct reference to suicide or self-harm. Moreover, the design of the utterance closely mirrors the design of his previous turn (itself retrospectively characterised as a factual statement/analysis of P's talk). Indeed, "thinking it's just all too much" is formulated as an ongoing upshot of "not knowing how to cope with all this."

A. so:: (.5) you (.) um: (.) dont know how to co:pe with all this?

B. do you (.) °sorry° (.) ever think that its just all too (.5) much or that (.) you cant carry on:?

It is also interesting to note that the question itself is not characterised by the same turbulence or delays as were observed in extract 1, but is delivered rather more directly. The point is that the details of utterance A render the content of utterance B explicitly and hearably relevant, so utterance B does not *need* to be marked as potentially unexpected and/or out-of-place. A specific problem is formulated, and an identity is ascribed to P; "someone who is not coping." The follow-up question itself is hearable as a "logical outcome" of this identity-ascription, a reasonable question *to* ask somebody who is not coping. In short, D generates relevance by adapting the local interaction context to create conditions suitable for the asking of the question. It can now be observed that an explicit challenge to the formulation of statement A, before the question was asked, would have undermined this conversational relevance (as occurred in extract 1). By closing down this potential challenge, however, D risks seeming transiently "impolite," but also maintains the relevance of the question he

subsequently asks. Thus, the contextual sensitivity of that question (the extent to which it is hearable as sequentially appropriate) is enhanced.

It is of further note that the act of asking of the question reflexively delimits P's opportunity to challenge the preceding statement, by moving on her current conversational obligation to one *of* answering the current question. As Sacks (1972) notes in his earliest work, there is a normatively appropriate sequence for doing things in interaction, contingent on the character of the particular conversation. To step outside of the relevant sequence can disrupt the flow of talk and make available a range of inferences about the speaker. In this case, for P to return to her challenge subsequent to the asking of the question would have been hearable as evading the question itself, or even rudeness. This would have violated the ongoing question-answer sequence that has hitherto characterised this interaction as one between a GP and a patient. Whatever she may "wish" to do, there is now a normative pressure to attend to the task at hand. As such, D places P in a position where the easiest way of maintaining the local social solidarity is simply to answer the question, and thus the conversational risks of interruption (turn 8) as a "displacement" strategy are minimised.

Finally, as a logical upshot of a state of affairs, the question itself embeds the expectation of an affirmative answer. As in extract 1, this demonstrates some key inferential business being done by D: an affirmative answer is more potentially awkward or embarrassing to give, and a negative answer would be less troublesome for P. Thus, by embedding the expectation of an affirmative answer, D creates conditions whereby P can admit to suicidal ideation *with minimal need to account for it*. P is, consequently, afforded a "best of both worlds" context for answering a potentially awkward question. The success of this strategy is emphasised by P's

completion of the pair as a straightforward question-answer, explicitly acknowledging the relevance of the question (turn 9). While this answer refuses the detail of the question, it also characterises those details as a logical extension of the way P actually does feel ("never that bad"), and thus the contextual legitimacy of the question itself is endorsed.

2.3. Case 3

The two extracts analysed thus far reveal two different methods for addressing the potentially difficult task of asking a patient about suicidal thoughts before diagnosis is delivered. The first, in extract 1, faced with only a tentative consensus on the nature of a problem, employs a number of resources to mark the question *as* potentially delicate and/or unexpected. The second, in extract 2, manufactures a consensus via the closing of a challenge such that the question *becomes* sequentially relevant. Despite these differences, the extracts are demonstrative of an orientation by both GPs to two interactional requirements:

1. Making the question relevant to the local interactional context, and thus minimising the likelihood of "troubled" reception of the question itself.
2. Creating appropriate conditions for the disclosure of potentially delicate information in the patient's answer.

The GPs work to avoid disruptions to the flow of interaction that the question itself may cause. This is done while also rendering a potentially difficult disclosure as easy for the patient to make as possible, should the interaction unfold in this way. This is in no way to suggest that the GPs are "trying" to elicit affirmative answers; in both cases,

the negative answer subsequently provided is treated unproblematically. In extract 3, meanwhile, an affirmative answer *is* elicited.

Extract 3: DP63 <depression>

1.	D:	has it been ahm. (.) worse since you stopped working at [location confidential]?
2.		(.5)
3.	P:	yeah (.) definitely (.) I mean (.) losing ma job↓ meant tha (.) um: (.) I just dun know what to do with mahself all day an:
4.		(.5)
5.	D:	yes?=
6.	P:	=um (.5) I jus dun know wha ta do (.) I jus feel (.) ya know useless:? (.) all I wanna do is (.) well (.) sleep all day an (.) huh huh (.5) i: don have any trouble sleepin though so at leas thas not a problem↑
7.		(.5)
8.	D:	so it's just (.5) well (.) all too much at the moment?
9.		(1.0)
10.	P:	yeah tis (.5) ºtoo muchº yeah
11.		(1.5)
12.	D:	under these kinds of circumstances (.) a lot of people (.) quite understandably (.) start to think they don't want to carry on with (.) li:fe (.) an:d have you ever (.) had any worries or (.) thoughts like that?
13.		(1.0)
14.	P:	well (.) um:: (.5) sorta (.) yeah
15.		(1.0)
16.	D:	yes?
17.		(.5)
18.	P:	i mean (.) some days i wake up (.) huh huh (.) in the afternoon[(.) like ah said (.)
19.	D:	[ºheheº
20.	P:	and ah:: jus think ahd be better off if (.5) if I werent here at all but (.5) ahd never do anythin stupid (.) ya know
21.		(.5)
22.	D:	just the occasional thought (.) then?=
23.	P:	=yeah (.) they jus kind ah (.) pop in there huhh huh=
24.	D:	=huh (.) okay (.) that's ºgoodº

In turn 8, and as has been previously observed, D formulates an upshot gist of P's talk in turns 3 and 6. In this case, the upshot is accepted unproblematically by P who completes the pair as a straightforward question-answer in turn 10, the repetition of part of the question itself marking the agreement as a particularly strong one. D then

proceeds to ask a question about suicidal ideation, turn 12, the detail of which is noteworthy in a number of ways.

Firstly, a factual state of affairs is constructed. The detail of the previously-agreed problem (regarding the situation being "too much") is truncated to a set of circumstances, which externalises the problem to P himself and downgrades his personal accountability for the way he feels. Also "these *kinds* of circumstances" makes available that P's position is in no way unique but there are many similar circumstances, an inferential property of the utterance that is further worked-up by adding a quantity marker; "a lot" of people encounter these circumstances. Moreover, an activity is then formulated which these (numerous, generic) people "quite understandably" tend to do (suicidal ideation itself). Indirectness is, again, worked up in the design of the question. By using third-person pronouns and quantified generic populations, D actively "creates distance" (Harris 2001) between P and the specific act of suicidal ideation. This act itself is, meanwhile, formulated as an upshot of circumstances, rather than made accountable to the people themselves. It is also presented in a weak form (they *start* to think). This circumscribes any inference that such thoughts are a "total" or enduring experience. Finally, P is asked if he has "ever" had comparable thoughts himself, similarly minimising the implication that he may think this way all the time. In this way D furnishes P with information about a general category of ordinary people sharing common (if undesirable) circumstances, and a specific activity as common or "normal" upshot of those circumstances. P is then invited to align himself *with* these people via a disclosure of the relevant activity.

The point here is that should P respond in the affirmative, a range of inferential work has now been done to mitigate the implications of such a disclosure. Firstly, suicidal ideation is inferentially rendered an *outcome of circumstances*. It is,

therefore, not hearable as P's "fault," and should be more easily admissible. Secondly, it is a *group phenomenon*. Because suicidal ideation is not uncommon among people in these circumstances, it is less delicate an issue. Finally, it is an *occasional phenomenon*. Therefore, P's affiliation to the relevant identity is temporary and, by extension, less "serious." In turn 14, P does indeed issue a (mutedly) affirmative answer. Despite the question embedding a preference for such an answer, however, the answer itself is done *as* dispreferred. It is prefaced with "well," delayed, and also accomplished in weak form ("sorta") to minimise the strength of the agreement. By formulating his initial answer *as* "incomplete," thus, P makes relevant a call for clarification from P, which is issued in turn 16. In this way, P elicits a request for a piece of self-accounting *that was not made germane by the original question*.

The detail of the account provided (turns 18 and 20) is formulated explicitly around a "yes-but" device (Sacks 1987). By way of a "yes" component, P initially reasserts that he does indeed have thoughts such as those occasioned in the question he has been asked. Notably, he formulates these ideas within a milieu of extremely ordinary activity and, moreover, uses laughter (a token returned by D in turn 19) as a means of directing D to hear the overall account as, while not an actual joke, "not too serious" (Jefferson 1979). The "but" component (turn 20), however, is key: P makes the claim that he would not do anything "stupid" as a consequence of these thoughts. Orienting to an awareness of the causal connection between suicidal thoughts and suicidal actions, the inferential link between suicidal activity and his *own* activity is firmly closed down using the extreme case formulation (Edwards 2000; Pomerantz 1986) "never." The opportunity for D to ask any further questions on the topic is, consequently, also delimited. In conjunction, by characterising any activity resultant of suicidal thoughts as "stupid," he also attends to his own identity as author of the

account. The act of admitting suicidal thoughts has very powerful inferential properties, not least relating to "psychological unreliability." By explicitly characterising actions resultant of such thoughts as non-rational, he makes available his own rationality in relation to the topic and, thus, underscores the veracity of the account itself.

3. Reflections on guidelines for "good practice"

One area in which the observations made above have a particularly applied relevance is the manner in which they reflect on general guidelines for personal and professional conduct in the consultation provided for General Practitioners. With a view to improving rates of detection of depression in UK primary care, the frequently-cited guidebook *"Depression in General Practice"* (Tylee, Priest and Roberts 1996), for example, proposes entire normative frameworks of "good practice" for doctors when confronted with suspected cases of the condition. The key suggested features of such good practice include:

- 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;
- Never interrupting a patient.

The authors, following Paykel and Priest (1992), do acknowledge that unquantifiable factors such as variability in tacit knowledges, culture, use of language, ad hoc skills, attitudes and social understandings play roles in the diagnostic process and the structure of the consultation itself. Little is done, however, to really address these matters in any specific advice, which is instead grounded in largely common sense "universals" for what is understood to be good clinical practice (McLeod 1994; Silverman 1997), such as those listed above. This model of grounding encourages an analytic oversight of the practical good sense of the things both GPs and patients do and say in real consultations; i.e. the functionality of even apparently dysfunctional action (Garfinkel 1967). The central problem with the use of normative frameworks for the interpretation of empirical action, however, is that they are dependent on pre-established definitions of the phenomena being explored. Moreover, these definitions are usually little more than categorised extrapolations of commonsense understandings of what certain interactional phenomena "look like." As Sacks (1963) articulates at length, such abstracted categorisation blinds the analyst to the complex and local assembly of the phenomena being investigated; it obscures what those phenomena are *to the people involved in social interaction itself*. Reflect again, for example, on this passage of talk from extract 2:

3.	P:	yes (.) very <u>mu</u>ch (.) I keep crying at work and thats really (.) well (.5) stup↑ ahm: (.) em<u>ba:</u>rrassing↓ (.) but I just cant h<u>e</u>lp it
4.		(1.0)
5.	D:	I s:ee: .hhh (.5) s<u>o::</u> (.5) you (.) um: (.) dont know how to co:pe with <u>all</u> this?
6.		(.5)
7.	P:	°well:°[
8.	D:	[<u>do</u> you (.) °sorry° (.) ever think that its just all too (.5) much or that (.) you can't carry on:? um=

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 during this interaction the GP is guilty of:

- Asking leading, rather than open, questions (turn 5), and/or:
- “Telling the patient what she meant” (turn 5), thereby not employing a sufficiently open style, or even lacking empathy, and:
- Interrupting the patient (turn 8) and also, thereby, not listening to what the patient was trying to tell him, or hurrying the consultation.

As demonstrated in the analysis presented above, however, an exploration of the local organisation and subsequent trajectory of the interaction reveals much more subtle, intricate and *constructive* functions for these activities. Apparent interruptions can function to preserve the relevance of a topic; indirect questioning can facilitate easier disclosure of awkward information.

4. Discussion and Conclusions

Two central themes have emerged from the analytic work presented in this paper. The first, and most fundamental, of these is that what constitutes an awkward or embarrassing issue is clearly a matter arising within, and attended to, in local interactional contexts. The second is that professional knowledge and lay knowledge are by no means mutually exclusive. In all cases above, both GP and patient could be seen to collaboratively orient to inferential possibilities arising from their own actions, and from those of each other. There are a range of more subtle issues, however, that are evident in the finer detail of the analyses.

Throughout, GPs and patients monitor the unfolding of the consultations, and the inferential properties of the categories deployed therein, to produce, manage and ultimately mitigate sets of issues as *contextually* problematic. Within these activities resonate Bergmann's (1992) assertion that, sociologically speaking, "stigma" is not an intrinsic property of an object or issue but is something realised in the construction *of* that object or issue. For example, the question "Are you enjoying life less?" is not inherently awkward or difficult to ask, neither is an answer inherently difficult to provide. To paraphrase Silverman (1997), "stigma" itself arises within, and is dealt with through, *the machinery of the interaction itself*. It is fair to assert, meanwhile, that most people would reasonably regard directly asking someone if they think about self-harming, or even suicide, as delicate in some way. Again, however, the manner in which particular activities and issues are situationally treated as "awkward" by the participants in the consultations analysed is demonstrably accountable to local interactional concerns, while any grand social meta-stigmas, directing the behaviour of social actors from afar, remain staunchly invisible.

One particular area in which this matter is evident is the way that the GP speaking in extract 1 produces his question "Have you ever thought it might not be worth it?" highly cautiously where, centrally, it was potentially *sequentially inappropriate*; a full prior consensus on the nature of a relevant problem had not been established. Where such consensus had been established (or in the case of extract 2, "manufactured"), the question was delivered much more directly (and received much more favourably). As such, the degree to which the topic was approached by the GPs *as* delicate was contingent upon prior activity in the consultation itself, rather than some general social rule of thumb regarding what is a "delicate" issue. Moreover, whether admitting or denying suicidal thoughts, the patients speaking in all three

cases were oriented to the inferential issues arising from being categorised as "troubled" *for the received veracity of their accounts*. Even in the final extract, where the patient did indeed disclose affirmatively relating to such thoughts, he did so in such a way as to emphasise the rationality of his own position regarding the disclosure and its implications. This also, in itself, does much to undermine any simple association that might be drawn between suicidal ideation and "irrationality." While making a disclosure that could potentially render doubtful the reliability of his general reasoning process, the patient shows the skills to simultaneously rework the categories and mitigate such inferences. Equally, the design of the GP's questions demonstrated similar orientations, collaboratively allowing for the patient *to* answer affirmatively with minimal damaging interactional consequences incurred.

Also fundamental to the analyses herein have been illustrations of the constructive functionality of apparently dysfunctional talk by the GPs. For example, it has been shown how both highly perturbed, or even vague, questioning and apparent "interruption" of the patient cannot be treated as simple evidence of insufficient directness or "not listening" respectively. Rather, both were observably designed to create more comfortable conditions for the delivery and reception of a potentially awkward question. These observations find kinship with the work of Jefferson and Lee (1981) and Heritage and Sefi (1992). Although those particular studies related to the delivery of medical *advice*, their findings on acceptance/rejection are pertinent here. Both maintain that advice is best received where it can be heard as the "logical outcome" of a problem which is identified by the practitioner and agreed upon by the client. Observed herein were, then, practical and skilled efforts by the GPs striving to create such interactional relevance for the asking of a question, such that the material of the question would be received *as* a relevant question within the sequence. In these

terms, it can be argued that not only is the design of a question itself key to the way it is received (as acknowledged in the bulk of the medical literature), but also, and possibly more so, is its positioning within the interactional sequence.

Appendix: standard Jeffersonian transcription symbols

(.5)	The number in brackets indicates a time gap in seconds (i.e. in this instance, five tenths).
(.)	A dot enclosed in brackets indicates a pause in the talk of less than two tenths of a second.
·hh	A dot before an 'h' indicates an in-breath by the speaker. More h's indicate a longer breath.
hh	An 'h' indicates an out-breath. More h's indicate a longer breath.
(( ))	A description enclosed in double brackets indicates a non-verbal activity.
-	A dash indicates a sharp cut off of the prior word or sound.
:	Colons indicate that the speaker has drawn out the preceding sound or letter. More colons indicate a greater degree of 'stretching' of the sound.
( )	Empty brackets indicate the presence of an unclear fragment in the recording.
(guess)	The words within a single bracket indicate the transcriber's best guess at an unclear fragment.
.	A full stop indicates a stopping fall in tone, not necessarily the end of a sentence.
,	A comma indicates a continuing intonation.
?	A question mark indicates a rising inflection, not necessarily a question.

*****	An asterisk indicates a ‘croaky’ pronunciation of the immediately following section.
↑↓	‘Up’ and ‘Down’ arrows represent a rising or falling intonation, respectively.
CAPITALS	With the exception of proper nouns, capital letters indicate a section of speech louder than that surrounding it.
º º	Degree markers indicate that the talk they encompass was noticeably quieter than that surrounding it.
underline	Indicates speaker emphasis
Thaght	A ‘gh’ indicates a guttural pronunciation in the word.
> <	‘More than’ and ‘less than’ signs indicate that the section of talk they encompass was noticeably quicker than surrounding talk.
=	‘Equals’ indicates contiguous utterances.
[	Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.

Notes

[1] These being: weight loss or gain; psychomotor retardation or agitation; depressed mood; diminished interest or pleasure in activities; insomnia or hypersomnia; fatigue or loss of energy; feelings of worthlessness, or excessive or inappropriate guilt; and diminished ability to think, concentrate or make decisions.

[2] Conditions of ethical approval preclude disclosure of collection times/dates, or locations more specific than the national.

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