

A Conversation Analysis approach to alternative medicine sessions

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Ethics statement

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Abstract

This dissertation presents a descriptive study of discourse practices used in the context of a doctor-patient interaction in alternative medicine sessions. Alternative medicine is oriented toward a mind-body integration in which the mental state of the patient is considered a significant contributor to the illness (Larson, 2007). Based on this philosophical background, I explore the communication in alternative medicine within the frame of patient-centred communication which informs the principles of modern healthcare.

I investigate the dimensions of elicitation and rapport, and their linguistic realizations in the form of speech acts, backchannels, joint productions, and repetitions. I examine the genre of the dialogues within the Systemic Functional Linguistics framework with a focus on stages and lexico-grammatical features related to discourse and semantics. I apply Conversation Analysis to a data comprised of nine recorded sessions between two alternative medicine doctors and their patients, native speakers of English. The corpus contains 5,378 turns and 3,139 units of analysis in total for all dyadic conversations.

The present study reveals that the alternative medicine speech event is an institutional genre with characteristics of patient-centred communication. The four linguistic features are used strategically — they contribute to conversational power-sharing and to collaborative creation of knowledge. Simultaneously with the conversational dominance (through questions), doctors accommodate and collaborate with patients (through backchannels, joint productions and repetitions). Reaching a diagnosis is often an incremental process in which doctors engage patients in an ongoing interactional meaning-making and shared knowledge. These practices advance the therapeutic alliance, rapport building, and shared responsibility — components that are at the core of patient-centred communication.

Seen in this perspective, the study findings can bring about insights into a linguistically underexplored area such as discourse in alternative medicine visits. It contributes to the body of research that applies Conversation Analysis techniques to study medical communication.

Keywords: medical discourse; alternative medicine; conversation analysis; elicitation; rapport; patient-centred, genre

Dedication

To my husband, Jordan

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List of acronyms

CA	Conversation Analysis
PCC	Patient-centred communication
SFL	Systemic Functional Linguistics

Chapter 1.

Introduction

Alternative medicine is simultaneously a new and old field of medical practice. New, because it has been institutionalized recently in the Western world; old, because its roots date back to ancient times. This emerging institutionalized type of medical discourse has not been sufficiently explored from a linguistic point of view. There is a growing body of research on medical discourse which uses Conversation Analysis (CA). The benefit of this framework is that it applies methods from studies of both “everyday conversations” and “institutional talk”. In this dissertation, I will approach the medical speech event by focusing on two dimensions that have been found essential (among others) in the models that inform doctor-patient communication in the last three decades: elicitation and rapport. I will show how devices available in everyday interactions are used strategically and systematically to fulfill institutional goals.

A key element of the philosophy of the alternative medicine is that is oriented toward a mind-body integration in which the mental state of the patients is considered a significant contributor to the illness (Larson, 2007). From a linguistic perspective, the implication of such a statement is that the talk in alternative medicine provides a linguistic event that is very likely to exhibit characteristics of patient-centred communication. An alternative medicine session unfolds in stages, similar to those found in general practice visits. Thus, the visit to an alternative medicine doctor (discussed in Chapter 3) becomes a meeting ground for different discursive practices taking place in the story telling, discussion, questioning, and negotiating. Those practices deserve special attention and further exploration.

1.1. Statement and rationale

In this dissertation, I investigate the nature of talk in alternative medicine sessions. More specifically, I examine two types of processes that are found to be quintessential in patient-centred communication. (de Haes & Bensing, 2009; Heritage, 2010; Pawelczyk, 2011; Pawelczyk & Erskine, 2008; Rogers, 1951; Stiles, 1992). These processes are *elicitation and rapport* (de Haes & Bensing, 2009; Roter, 2000). All stages of an alternative

medicine session are realized through language. Elicitation is defined here as the demand for information needed for an accurate diagnosis and best treatment for the patient. Throughout the study I will refer to “patient” as a person having a health problem for which they receive a medical care by a licensed practitioner in institutional context. From a genre perspective, elicitation is important because it is a part of the purpose of the genre: to obtain information about the patient’s needs. This, on the other hand, is necessary for achieving the ultimate goal of the session — to assist the patients with their health problems. In order for this to happen, the doctor tries to provide a safe and trusting environment, just like in psychotherapy, which predisposes the patients to unfold their narrative and bring further self-disclosure. In that context, building rapport becomes a foundational feature of a successful session that has the potential to contribute to a highly positive affective-relational communication between doctor and patients. Rapport is frequently a prerequisite for an effective outcome (Stone & Katz, 2005).

By taking the alternative medicine session as a type of consultation, I will examine how it reflects a patient-centred model of communication. Researchers in medical discourse tend to classify doctor-patient communication, specifically in the general practice, into two broad categories: interview (Heritage, 2010; Mischler, 1984) and consultation (Byrne & Long, 1976; ten Have, 1989). We will see in Chapter 5 that alternative medicine is best characterized as a form of consultation, because of the way power dynamics play out in the context of asking questions and providing information — two elements that are integral part of the medical encounter. In order to approach the sessions as a form of consultations, I first explore the linguistic strategies used to evoke *elicitation*. I investigate the functions and the mechanisms by which they express interactional behaviours in the doctor-patient context. Second, I examine how building *rapport* between doctor and patient is linguistically achieved. Rapport here is defined as mutual understanding that involves solidarity and empathy. All this is accomplished through analysis of four linguistic phenomena: demanding information speech acts (questions), backchannels, joint productions, and repetitions.

The motivation on which this work lies is personal experience from alternative medicine visits as well as academic curiosity about how doctors working in that field behave linguistically. As a patient, over the years I gradually became familiar with various modalities of alternative medicine. There was a point in my life when I had to cope with grief after a family member had passed away. In addition to the visits to my family doctor

and a psychologist, I visited an alternative medicine practitioner to seek help. During those visits, I became interested in how the practitioner performed the questioning and at the same time conveyed a sense of empathy and solidarity.

As a researcher, I am interested in interactional sociolinguistics. This is to say, I explore how participants in a real-life conversation understand each other's verbal actions. Such process is important because, by conversing, the members of the society co-construct meaning which is an essential part of human communication.

These two aspects, my personal background and research inclinations, helped me deepen my research interest further by investigating literature on medical communication. I found out that research on oral medical discourse offered an enormous variety of topics and various research methods. CA specifically, has been an established framework in health communication to investigate the interaction between doctors and patients by looking at sequential phases, moves and the social actions that they generate (Bowles, 2006). It has been applied in primary care, psychotherapy, and palliative care, to name a few. However, exploration of alternative medicine by applying CA as a qualitative methodological tool has not been, to my knowledge, performed yet. Existing studies on alternative medicine use multifaceted approaches involving disciplines such as sociology, gerontology, and psychology (Mackenzie, Taylor, Bloom, Hufford, & Johnson, 2003; O'Callaghan & Jordan, 2003; Simon, 2009; Tasaki, Maskarinec, Shumay, Tatsumura, & Kakai, 2002; Votova, 2003). For the most part, these studies focus on the use and attitudes to alternative medicine, but do not apply CA as a primary tool. My hope is that the present thesis will complement the body of linguistic research on CA in medical encounters by bringing more understanding of how talk is performed in the context of alternative medicine visits.

Qualitative research is grounded in the description of things, meanings and observations. Any researcher carrying out a qualitative study is at risk of experiencing a personal bias. In my case, the fact that I have been a patient of alternative medicine doctors is simultaneously an advantage and a disadvantage. The advantage is that I could observe the practices under investigation at first hand. This gave me insights into how doctors tried to accomplish their goals. The disadvantage is that my involvement might have resulted in unintentional bias in the interpretation of the conversations. Following the principles of CA, I did my best to detach from the data and describe meanings that are

observable and explained by the context. I tried to minimize any bias by re-evaluating the initial interpretations so to avoid pre-existing assumptions. I strongly believe they did not distort the reliability of the analysis and findings.

1.1.1. Research questions and objective of the dissertation

CA is a well-established methodological approach for analyzing medical discourse and in fact, can be exploited to investigate any medical encounter. The advantage of this framework is in its examination of how talk is managed locally. By applying CA to transcribed audio files from alternative medicine sessions, I will show how sequences of talk are locally managed. I will also show how the sessions present a blend of linguistic practices borrowed from everyday conversation and applied in institutional settings.

Previous studies in medical discourse have focused on elicitation techniques in which a great attention is given to speech acts. With the understanding that speaker's utterances represent various social actions, I am interested in how doctor and patient's utterances represent actions with regard to obtaining information. These considerations led to my first research question:

1. What are the mechanisms through which *elicitation* is performed?

This main question will be accompanied by several specific ones: What types of speech acts are performed and which ones are more prominent? How are they distributed between doctor and patient and across the stages of the visit? What is the distribution of backchannels and what interactive functions do they exhibit? How do they contribute to the collaborative nature of the talk?

The holistic approach of alternative medicine entails self-disclosure from the patient, for which rapport is an advantageous part that increases the effectiveness of the sessions' outcome. Previous literature has shown that several mechanisms are at the heart of building and maintaining rapport in conversation. From the extensive literature on CA and medical discourse, I have established that joint productions, in which a speaker initiates a turn and a listener completes it, and repetitions contribute to creating rapport. Thus, the main research question in this regard is:

2. What linguistic strategies are used to achieve *rapport* between doctor and patient?

Additional questions that guide the analysis are: Why do collaborations such as joint productions occur in the alternative medicine context and what are the motivations behind them? What social actions do they represent? What are the functions of repetitions and how is the social meaning they convey linguistically realized?

The four features (speech acts, backchannels, joint productions, and repetitions) carry certain interactional power and I want to investigate how this power reflects the role of the participants and how it assists in managing the relationship between doctors and patients in alternative medicine.

1.1.2. Outline of the dissertation

I have provided the objectives of the study within the context of institutional medical discourse. In the rest of this introductory chapter, I will describe how the remainder of the thesis is organized. In Chapter 2 I provide the theoretical framework for the study by reviewing medical discourse literature with a focus on patient-centred models of communication. Then, the concept of genre is briefly discussed in relation to medical contexts, followed by a description of the foundations of CA. In this chapter are also included some of the applications of CA in two medical fields — general medical practice and psychotherapy. The chapter ends with an explanation of the holistic aspect of alternative medicine and its characteristics as a type of institutional talk. In Chapter 3 I proceed with a description of the data for the study. I describe the participants and the settings, I explain the structural organization of the sessions and discuss the effects of the “observer’s paradox”. Then I outline the analytical techniques and transcription conventions, and list ethical considerations. At the end I provide the coding for the analysis that will be necessary for the linguistic examination of elicitation and rapport. Next, Chapter 4 provides the generic structure of the sessions from SFL point of view with a focus on staging and lexico-grammatical features. What actually is happening in the sessions I explore in Chapter 5 by presenting an analysis of speech acts, backchannels, joint productions, and repetitions along with a discussion of the results of each feature. The dissertation concludes with Chapter 6 which contains a summary of the overall findings of the study, discussion on the implications and limitations, and in the end, suggestions for future research.

Chapter 2.

Linguistic approaches to medical communication

In this chapter, I provide an orientation to the theoretical framework for the study. I begin with a review of medical discourse that includes patient-centred models of medical communication. I discuss the concept of genre in relation to medical contexts. Next, I provide a description of the basic premises of CA which inform the analysis in Chapter 5. I further present some of the applications of Discourse and Conversation Analysis methods in general medical practice and psychotherapy. I end the chapter with a description of alternative medicine as a healing modality and a type of institutional talk.

2.1. Medical discourse

2.1.1. Communication in different medical settings

Effective health communication is the basis for patient care and has been a vital component of quality health services leading to increased patient's satisfaction (Ekwall, 2013; McMillan et al., 2013), treatment adherence (Nitzan et al., 2012) and outcomes (de Haes, 2006; de Haes & Bensing, 2009; Sheeres, Slade, Manidis, McGregro, & Mathiessen, 2008; Sullivan, Ellison, Quaintance, Arnold, & Godrey, 2009; Thompson & Roger, 2014). Good medical communication is grounded in patient centredness and shared decision making. That line of thought has received great acceptance over the last few decades and has been supported by a growing body of research (de Haes, 2006; Eggins & Slade, 2015; McBrien, 2009; McMillan et al., 2013; Roter, 2000; Roter & Hall, 2004). The present study adds to this line of research by exploring the link between certain communication patterns and patient-centredness in alternative medicine. The analysis shows that talk in alternative medicine contains communicative features reflecting patient-centredness such as asking psychosocial questions, active enlistment, and emotionally-responsive talk (Roter, 2000). By investigating language within this particular framework, we gain insight into the nature of the talk in alternative medicine contexts.

The issue of effective communication is often explored within the frame of patient-centred care (discussed later), but nevertheless varies across different types of medical

service, for example, acute care, primary care, palliative care, rehabilitation care, or psychotherapeutic care, to name a few. Each domain brings a specific context with its own characteristics and challenges, and those contexts produce different forms of communication. I will review some of the above medical settings with regard to their communicative characteristics.

An area that has recently seen a considerable attention is that of communication practices in emergency departments (Eggin & Slade, 2015; Macqueen et al., 2016; Sheeres et al., 2008; Sullivan et al., 2009). Observational studies measuring the effects of poor communication suggest that it is “a likely cause of systematic error in the health system”. (Coiera, Jayasuriya, Hardy, Bannan, & Thorpe, 2002 p.415). The context of emergency hospital departments is unique because it involves a high-stress and time-pressure environment where patients arrive in acute pain and need urgent medical assistance. Accompanying factors such as anxiety, aggravated emotions or violence from patients make the communication challenging. These conditions create a series of co-occurrent events such as unpredictable workload, communication overload, interrupted interactions, multiple handoffs (i.e., transfer of professional responsibility of care for a patient to another healthcare professional) (Eggin & Slade, 2015), and multitasking (Coiera et al., 2002; Macqueen et al., 2016; Sheeres et al., 2008). The most comprehensive study of interactions in emergency units, to my knowledge, is the work of Eggin and Slade (2015). They found that the organizational structure of the medical consultation in emergency departments is similar to that of primary care consultations and, generally, includes the sequence of *greeting—exploration of condition—examination—diagnosis—treatment—disposition—goodbyes*. Where the emergency departments differ is in the non-linear fashion and repetitiveness of communication. The exploration of condition might be performed by several clinicians — junior first, senior later — in order to confirm a diagnosis. The study was also in alignment with previous studies on communication in emergency units in regards to the tendency of clinicians to maintain tight conversational control which turned out to be at the expense of building rapport (Sheeres et al., 2008). It appears that developing rapport as an essential element of patient-centred care is neglected due to the time-pressure constraints. However, Eggin and Slade point out that where patient-centred communicative styles were implemented by emergency departments, they did not cause longer consultations (see also McMillan et al., 2013; Rhodes et al., 2004).

While in acute care rapport building is often ignored due to time constraints or lack of previously established relationship with the patient, in palliative care it is a central component. In contrast to acute care, palliative care deals with chronic conditions and, in that respect, it is not restricted by time. This type of medical service is concerned with managing symptoms and improving quality of life for individuals with serious or terminal illnesses. Communication in this context is extended to a triadic configuration where decision making often involves the family members. Many times, they serve as proxy decision makers which is a unique characteristic of palliative care (Thompson & Roger, 2014). The seriousness and the stage of the illness have a significant influence on the communication. For instance, they have an impact on the delivery of bad news (Friedrichsen & Strang, 2003; Wittenberg-Lyles, Goldsmith, Sanchez-Reilly, & Ragan, 2008), on how much information to disclose, or on how to deal with “do-not-resuscitate” orders which also involve ethical concerns. That is why the investigation of rapport is an important aspect of the linguistic study of medical communication.

Rehabilitation care is another medical setting in which communication has been explored. Research on discourse patterns in rehabilitation context finds that communication in physiotherapy settings is informed on the whole by the biomechanical approach (Daykin & Richardson, 2004; Josephson, Woodward-Kron, Delany, & Hiller, 2015; Ostelo, Stomp-van den Berg, Vlaeyen, Wolters, & De Vet, 2003; Thornquist, 2001). Despite the fact that patient-centred principles are advocated in the practice guidelines, there is little evidence that they are realized in practice. Josephson, Woodward-Kron, Delany, and Hiller (2015) for example, explored how evaluative language in physiotherapy contributes to building a therapeutic relationship between a physiotherapist and a patient. They found that, while physiotherapists did acknowledge the patients’ emotions and opinions, they still preferred to stick to the biomechanical paradigm (see 2.4.1).

Yet another area of medical care which displays specific discourse practices is psychotherapy. Communication in this context is itself a unique topic due to the fact that the very nature of psychotherapy requires talk. Verbal patterns in the “talking cure” vary greatly depending on the psychotherapy “school” in which the therapists are trained — psychoanalytic therapies, client-centred therapies, cognitive-behavioral therapies, relational therapies, etc. Client-centred therapy is sometimes called “Rogerian”, after Carl Rogers who established it as a theoretical orientation (Rogers, 1951). It is a person-centred approach in which the therapist takes a non-authoritative stance, allows the clients

to unfold the narrative without judgment, and acknowledges their experience in a compassionate manner. Developing a therapeutic relationship is a crucial condition upon which the good outcome of the sessions depends. These and other approaches are implemented in the patient-centred models of health care that I will discuss below.

2.1.2. Approaches to doctor-patient communication

Communication is seen as a central component in the doctor-patient relationship (Bensing, Verhaak, van Dulmen, & Visser, 2000). In modern medical communication the principles of the patient-centred approach have been increasingly receiving priority over those of the doctor-based approach, also referred as biomechanical (de Haes, 2006; Matthiessen, 2013). The patient-centred approach adopts a biopsychosocial perspective (Engel, 1980) and exhibits influence of psychotherapeutic theories (Rogers, 1951) by putting focus on the patients' participation in decision making, and patients' perspectives and needs. The doctor-based approach provides a biomedical perspective by treating medicine as mostly a cognitive rational enterprise where the needs, preferences and emotional status of patients are considered irrelevant factors.

The patient-centred model informs the principles of the modern healthcare in the past several decades and is promoted in medical schools and practitioners' guidelines (Cole & Bird, 1991; Hebert, 2009; Silverman, D., 1987; Silverman, J., Kurtz, & Draper, 2005). Paradoxically, even though patient-centredness is recognizable in its overall meaning, it lacks a universal definition and operationalized tools of measurement (Bensing, 2000; Epstein et al., 2005; Ishikawa, Hashimoto, & Kiuchi, 2013). According to Bensing (2000), the central elements of the concept are evident to everyone. However, the marginal ones have insufficient clarity and the concept becomes "fuzzy". Bensing also holds that patient-centredness represents a container concept. It incorporates elements, which, although oriented to the same direction, refer to various processes in the medical visit. These processes can be adequately explained by different theories and operationalizations depending on which parts of the container the researcher had in mind. That makes the concept of patient-centred communication multidimensional (2000 p.21). There are numerous studies that attempt to provide a model of patient-centred communication. Among these are the studies of Roter (2000), Mead and Bower (2000), Epstein and Street (2007), and de Haes and Bensing (2009). Despite the disagreements among these studies in regard to the constituting elements of patient-centred care, all

models agree on the inclusion of patients' perspectives and the endorsement of the therapeutic physician-patient relationship.

Before I proceed with a discussion of a few of these patient-centred models, I would like to comment on the theoretical perspectives that construct them. Ishikawa, Hashimoto, and Kiuchi (2013) propose a framework for how patient-centred communication has been conceptualized in medical literature. The authors propose four different perspectives that shed light on various aspects of doctor-patient relationship: functionalism, conflict theory, utilitarian theory, and social constructivism. Two of these perspectives are pertinent to the analysis in the present study — conflict theory and social constructivism.

Conflict theory treats the physician-patient relationship as a power relationship. Physicians are in a superior position due to their academic training and possession of medical knowledge. As a result of that power, they also exert conversational power by using various ways to control the structure and content of the medical interview. The dyad here is seen as “professional — client” in which the physician uses information control as a means for professional superiority. A large number of studies explore this power relationship. Based on Emanuel and Emanuel's (1992) models of physician-patient relationships, Roter (2000) establishes four prototypes of this relationship. The first one is *mutuality*, characterized by balanced power. The goals, agenda, and decisions are negotiated, and patients' values are articulated and explored. The physician takes the role of a counselor or advisor. The second one is *paternalism*, in which physicians have more power. The goals, agenda, and decisions are set. The patients' voice is absent, biomedical terms dominate, and the physician takes the role of a guardian. The third type is the *consumerism* prototype. The patients are the ones who have the power. They demand information and technical services, and physicians accommodate the requests. Patients' values are fixed and unexamined by the physician who only has the role of a technical consultant. The last prototype is *dysfunctional*. There are unclear goals, obscured examination and the role of the physician is uncertain. According to Roter, the optimal model is that of *mutuality*, which reflects a patient-centred care.

A different interpretation of power dynamics is provided by Bensing (2000), who describes power by positioning the interactions between doctor and patient on X and Y axes governed by content and control (Figure 1). A doctor who controls the medical visit

with a biomedical agenda fills the upper-left quadrangle; the modern patient who controls the visit with a biopsychosocial agenda fills the lower-right quadrangle. The patterns in the other two quadrangles are also in opposition. The upper-right quadrangle is filled by an empathic doctor who lets the patient tell their story. Yet, the doctor is firm about the choice of medical plan. Finally, the lower-left quadrangle is filled by a patient who insists on a biomedical agenda while the doctor shows a biopsychosocial approach.

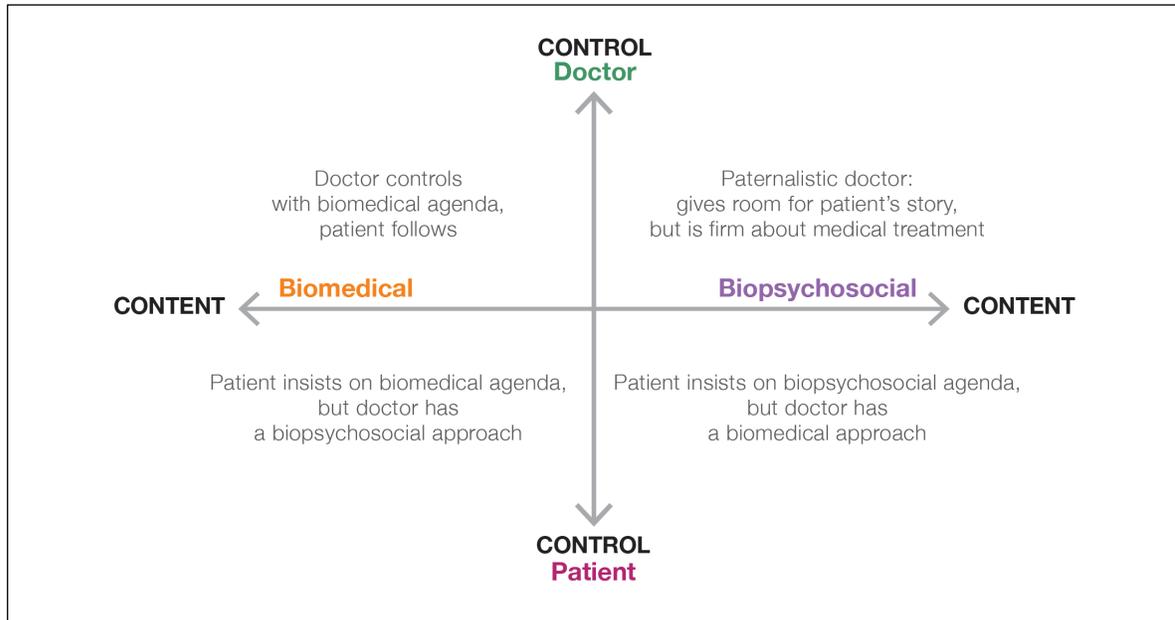


Figure 1 Power axes
Adapted from Bensing (2000 p.22)

Based on this visual representation of power dimensions, patient-centredness suggests a context where the doctor is sensitive to the patients' position on these axes and is capable of managing the different types of consultations that result (Bensing, 2000).

Social constructivists, on the other hand, see perceptions of individuals as building the social world. The discussion of health problems in medical encounters is built around physicians' and patients' different/similar views. "Illness" and "disease" are considered distinct concepts, with illness being socially and culturally constructed, and disease referring to abnormalities of body organs. Participants possess relational autonomy as opposed to individual autonomy (Epstein & Street, 2011) and their autonomies depend on trusting relationships. In that sense, agreement and decisions are mutual and achieved jointly in the medical consultation. Instead of being "reached", they are "constructed"

through interaction (Ishikawa et al., 2013 p.150). Lastly, the interpretation of communicative behavior in medical encounters relies on context. Studies following this conceptual framework explore the extent of common ground and the physician's responsiveness to the patients' concerns.

It is these two aspects, power relationship and common ground, that I will investigate in the present study. I will analyze conversational dominance by looking at the connection between elicitation and type of speech acts, mainly questions. Then, I will explore whether common ground is established by analyzing joint productions and repetitions.

2.1.3. Models of patient-centred communication

The contemporary view of doctor-patient communication is informed by the patient-centredness framework. However, patient-centred communication displays not a single construct (Michie, Miles, & Weinman, 2003), but rather a multifaceted one (Epstein et al., 2005). It is simultaneously connected to the physician's overall style of practice and to the behaviours of both physician and patient during the interaction (McWhinney, 1995; Roter et al., 1997). The design of the optimal model of patient-centredness is affected by various factors. According to Epstein et al. (2005), these include patient factors (severity of illness, personality, culture, values, socio-economic status, emotional distress), clinician factors (personality, risk aversion, knowledge of person-as-person, patient-centred orientation), relationship factors (race concordance, duration of relationship, trust, concordance of beliefs/values), and health system factors (access to care, choice of physicians, waiting times, visit length and frequency). Each of these groups affects the others so that in the end patient-centred communication is represented not only as a quality about physician, but about the health system as a whole as well as the relationship between physician and patient (Epstein et al., 2005). Furthermore, Mead and Bower (2002 p.1103) have identified three levels that have an impact on patient-centred behaviour. The remote level comprises the cultural norms, clinical experience, and socio-economic background of both physicians and patients. The second level is related to the influence of accreditation, professional norms, and government policy. The third level is linked to demographic or psychological characteristics that exercise the most immediate impact on the consultation. For example, ethnic differences may pose a challenge for effective communication.

Different models outline the goals of patient-centred communication (de Haes & Bensing, 2009). The research is mostly conducted in the domain of general practice, although it is emerging in other areas such as cancer care (Epstein & Street, 2007) and pediatrics. Table 1 below summarizes the functions of patient-centred communication of four models — those of Roter (2000), Mead and Bower (2002), Epstein and Street (2007), and de Haes and Bensing (2009) which, in turn, are based on earlier models (Cole & Bird, 1991; Lazare, Putnam, & Lipkin, 1995; Stewart et al., 1995). The choice of these four was based on the premise that they reflect a contemporary understanding of patient-centred communication. I have provided a brief discussion of the work of Epstein and colleagues (Epstein et al., 2005; Epstein & Street, 2007; Epstein & Street, 2011), and Mead and Bower (2002) in the previous paragraph, and I will discuss the others in more detail below.

Table 1 Model of patient-centred communication

Roter 2000	Mead & Bower 2000	Epstein & Street 2007	de Haes and Bensing 2009
Responsive (rapport building)	Therapeutic alliance	Fostering relationship	Fostering the relationship (respect, trust, rapport)
Facilitative (elicit information)	Patient-as-person (illness/disease)	Exchanging information	Gathering information
Informative (provide information)	Biopsychosocial perspective		Providing information
	Sharing power and responsibility	Making decisions	Decision making
Participatory (educate patients)		Self-management	Enabling disease and treatment related behavior
		Responding to emotions	Responding to emotions
Medically functional (use of time, performing technical tasks, etc.)	Doctor-as-person	Managing uncertainty	

It is apparent from the information in the table that the frameworks show overlaps in certain dimensions, but also some differences. For example, all frameworks include the dimension of *fostering therapeutic relationship* achieved by showing respect, trust, empathy, and rapport. Mead and Bower (2000) use the term “therapeutic alliance”, which they adopted from Rogers’ client-centred psychotherapy (Rogers, 1951). It relates to attitudes of empathy, congruence and positive regard — all necessary for the therapeutic

change in clients. De Haes and Bensing (2009) consider the quality of physician-patient relationship as an essential basis for the quality of health care. Epstein and Street (2007) developed their model as applied to cancer care. They see the building of rapport between doctor and patient as crucial for fostering the relationship — both verbal and non-verbal (Epstein & Street, 2007). They define rapport as “a perception of connection with another individual based on respect, acceptance, empathy and mutual commitment to the relationship” (p. 19). Verbal rapport is expressed by showing interest in the other’s views, by discussing shared goals and interests, and responding to emotions. Non-verbal rapport is displayed by facial expressions of attentiveness and tone of voice. Their model, as well as that of de Haes and Bensing (2009), includes *responding to emotions* as a separate component, while the others have included it in *therapeutic relationship*. This special attention seems motivated by the importance of addressing patients’ emotions, especially in cancer care. Terminally ill patients often experience vulnerability that elicits a wide range of emotions such as fear, sadness, or anger. If a physician addresses these emotional states properly, they can alleviate the discomfort in patients and bring more optimistic tone to the interaction. Some of the ways for achieving this are: making verbal expressions of understanding, showing acknowledgement, and showing empathy and support. A positive outcome of such behavior is nurturing a perception of being understood, which itself is a key element in psychotherapeutic talk.

The dimension of *exchange of information* is present in Roter (2000), Epstein and Street (2007), and de Haes and Bensing’s (2009) models, with Epstein and Street differentiating between *gathering* and *providing information*. Although differently named, I consider the *patient-as-person* component in Mead and Bower’s framework as belonging to that dimension too. The understanding of the patient as a person actually happens through elicitation of the patient’s story, which means that it is an act of gathering information. Mead and Bower (2002) also give a separate slot to the *biopsychosocial perspective* which the other three models incorporate in *exchange of information* as the biopsychosocial approach is an inherent part of the gathering information in patient-centred care and assists in integration of the patient’s perspective in the health care (Roter, 2000). On the patient’s end, Epstein and Street (2007) find that information provision by the physician yields knowledge of the illness and reduces uncertainty, contributes to a stronger connection, and assists in decision making.

In three out of the four models *sharing power and responsibility* is explicitly stated as essential. Mead and Bower (2002) define it as “a sensitivity to patients’ preferences for information and shared decision making” (p. 51). Apart from sensitivity, it entails a collaborative effort. The ideal symmetrical relationship in the medical encounters, however, is challenged by the existence of a “competence gap” between a health care professional and a lay person (Mead & Bower, 2000). While the patient-centred care clearly departs from the conventional paternalistic model of communication as described in Table 1 earlier, it certainly acknowledges the differences in medical knowledge between physician and patient. Yet, it stresses the importance of the patients’ knowledge of their illness and symptoms. By owning their personal story, patients become experts in knowing the illness and the significance it holds for them. Therefore, patients possess a different kind of knowledge equally necessary for the optimal treatment decision. To what degree a doctor-patient relationship can become authentically symmetrical is still unclear but nevertheless, what has been advocated in patient-centred care is the patients’ involvement, negotiation, and empowerment (Mead & Bower, 2000). Encouraging patients to voice their concerns and describe the “voice of the lifeworld” (Mischler, 1984) shows respect for their autonomy and simultaneously presents a way of sharing power over the emerging discourse. Seeing it from a practical point of view, without an informative patient, doctors cannot perform their professional duties (Bensing et al., 2000). This suggests a power shift in the exchange information stage of a medical visit. During the gathering information stage, the physician exerts more power by asking a high number of questions and thus dominates the conversational floor. In turn, once the patient is given the opportunity to report on symptoms and illness behaviour, they become the ones who hold the power. Further, this power becomes interactively shared in the decision-making stage. The patients have the opportunity to question diagnoses and negotiate treatments.

As might be expected, the components in any of the models are interrelated. It only makes sense to think that responding to emotions will enhance the therapeutic relationship or that a shared decision making will be facilitated by a patient who is well informed beforehand. Despite the differences, the models agree on the utmost importance of the following dimensions: fostering therapeutic relationship, biopsychosocial attitude to gathering information, and shared decision making. I will analyze these three components in Chapter 5. I will explore how rapport contributes to fostering the relationship by investigating functions of backchannels, joint productions, and repetitions. I will study the

process of elicitation in relation to the biopsychosocial perspective by looking at the type of questions. Finally, I will explore cases where shared decision making is performed.

Finding operational elements that can observe and measure patient-centred communication components from the models in Table 1 presents a methodological challenge (Roter, 2000). The problem partially arises from the fact that, as mentioned earlier, patient-centred communication is constructed of multiple components each one of which requiring different operationalization (Ishikawa et al., 2013). A substantial body of research has produced observational studies that measured elements of communication using quantitative methods, or so called “observational instruments” (Bales, 1950; Elliott, 1985; Elliott et al., 1982; Goodman & Dooley, 1976; Gottschalk, Lola, & Viney, 1986; Henbest & Stewart, 1990; Hill, 1986; Kinnersley, Scott, Peters, & Harvey, 1999; Rice & Greenberg, 1984; Roter, 1977; Stewart, 1984; Stiles, 1992; Stiles, Shapiro, & Firth-Cozens, 1988). The most frequently used techniques are coding systems, that is, determining frequencies of specific utterances (Hill, 1986; Roter, 1977; Stiles, 1992); interactional analyses (Mead, Bower, & Hann, 2002; Roter, 1977); checklists, that is, counting the presence or absence of specific skills (Kinnersley et al., 1999; Stewart et al., 2000); and rating scales, that is, measuring the quality or quantity of certain behaviours (Henbest & Stewart, 1990; Kinnersley et al., 1999; Winefield, Murrell, Clifford, & Farmer, 1996). The principle behind the verbal behaviour coding systems is grouping speech acts into mutually exclusive categories, for example “shows tension” vs. “asks for opinion” (Bales, 1950). The quantification of interaction is performed by first coding the verbal content (from audio or video recordings) and then counting the number of occurrences of categories pre-defined as “patient-centred”. The main focus in these studies is on quantification of task-instrumental versus socioemotional behaviors. One of the problems with this approach is that there is no universally accepted selection of which types of behaviours should (or should not) count as “patient-centred”. As with the rest of the techniques, there is no consensus as to whether patients’ behaviour should be included when measuring patient-centredness. Another issue is that the categories are simply imposed on the data and do not adequately account for what participants are actually doing in their interaction (Heritage & Clayman, 2010). Problematic is also the principle of mutually exclusive categories. For example, a patient’s question such as “If I have recurrent headaches, does that mean that I am going to be on pills all my life?” might fall simultaneously in two categories: “showing tension” and “asks for opinion”.

Concurrently with the measurement systems, another stream of research concentrates on qualitative tools. It focuses on microanalysis of the discourse using different approaches, for instance, Conversation, Discourse and Narrative Analysis. Qualitative studies provide finer distinctions of certain phenomena such as turn-taking, questioning, evaluative language, communication of emotions, responsiveness and flow of conversation (Heritage & Clayman, 2010; Josephson et al., 2015; Muntigl & Hadic Zabala, 2008; Pawelczyk, 2011; Voutilainen, 2010). Another advantage of the qualitative approaches is that they account for context in order to interpret social actions and therefore provide a more nuanced dissection of the institutional encounter.

Similarly to such qualitative studies (Engeström, 1999; Heritage, 2013; Muntigl & Hadic Zabala, 2008; Pawelczyk, 2011; Pawelczyk & Erskine, 2008; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008b; Street, S., 1991; Voutilainen, 2010), my linguistic investigation will draw from CA to explore how participants deploy particular linguistic features from everyday conversation in order to perform institutional identities and achieve institutional tasks. At a local turn-by-turn level, the analysis will focus on question-response and other sequences with the purpose of showing the interactional resources participants use to elicit information and build common ground.

According to Epstein et al. (2005), the degree to which a physician adapts their conversational behavior to the needs of the different patients might be a key aspect of patient-centred communication. Communication behaviours in medical encounters, specifically, primary care visits, can be operationalized using different systems. Roter (2000) asserts that the existing systems share no common measurement ground. She offers an alternative, a building-block approach based on a comprehensive conceptual grouping of communication elements organized around five “building blocks”. Table 2 presents these building blocks, which Roter proposes as ways to integrate quantitative and qualitative approaches.



Figure 2 Communication “building blocks”
Adapted from Roter (2000)

The first of these elements is information giving. It is broken down to two subcategories, content and manner. The content distinguishes between topics related largely to the symptoms and history (biomedical) and topics related to the surrounding social, psychological or emotional context of the medical problem (psychosocial). The manner accounts for the information delivery. That is, using Labov and Fanshel’s terms (1977), an evaluation of “aggravated” (more direct) and “mitigated” (less direct) forms of conveying information. The division of biomedical/psychosocial is then applied to the second category, question asking. Question design considers the most frequently observed formats, closed and open questions. The third category, Partnership-building, relates to two kinds of behaviours — the one that facilitates the patients’ contributions and the other that decreases control over the encounter. The fourth category describes rapport-building behaviors. It is performed through verbal and non-verbal channels. Verbal rapport includes utterances expressing worries and anxiety, reassurance, empathy, validation and positive attitude. Non-verbal rapport, on the other hand, is created through body language, facial expression, and voice quality. The last category is concerned with

socioemotional behaviours associated with agreements, approvals, compliments, as well as non-medical exchanges, personal remarks, and casual conversation.

By applying CA methodology, the present study takes a qualitative approach to explore the relation between several of these communication elements and patient-centredness in alternative medicine sessions. Following the research questions posed in Chapter 1, I will investigate Information content, Question asking, and Rapport building directly. In the process, other communication elements, such as Partnership building and Socioemotional talk will be also touched upon. The results will be also presented in the form of descriptive statistics that will include counting occurrences of certain phenomena.

2.1.4. Genre

it is important to address the concept of genre when engaging in any form of discourse analysis. Genre here will be discussed in terms of structural characteristics, namely staging. Stages are considered the building blocks of any given genre and typically demonstrate a sequential order (Eggins, 1994; Eggins & Martin, 1997; Hasan, 1996). In that sense, the concept of genre becomes relevant because the labeling of speech acts, in particular, depends on the stages of the genre. A discussion on the generic structure of the visits follows in Chapter 4.

The term “genre” has its origin in literary studies but its application has broadened to other disciplines. Bakhtin (1986 [1952-53]) was among the first to discuss it from a linguistic point of view in his essay “The Problem of Speech Genres”, written originally in 1952-53. All areas of human activity, according to him, involve the use of language in the form of spoken and written utterances. The utterances are reflection of each individual domain in the sense that the context and the specific goals of the domain shape how the utterances are constructed. Each domain “develops its own *relatively stable types* of these utterances” which Bakhtin called *speech genres*. (Bakhtin, 1986 p.121). He also emphasized the dialogic nature of talk. In every conversation between two or more people, every utterance produced by a speaker is “other” oriented, that is, considers the world view of the other. The end of an utterance presupposes that the “other” will show a responsive understanding or a responsive action. These two dimensions of “addressivity” and “responsivity” carried by the utterances are interactionally motivated by the purpose of the specific domain in which the speakers communicate.

This connection between language and human activity that Bakhtin introduced is conceptualized and classified differently in the various approaches to genre analysis after his work (Bauman & Scherzer, 1975; Fairclough, 1992; Hymes, 1974; Preston, 1986). The two most influential, the systemic functional approach, or “Hallidayan” (Benson & Greaves, 1981; Eggins, 1994; Eggins & Martin, 1997; Eggins & Slade, 1997; Gregory & Carroll, 1978; Halliday & Hasan, 1985; Martin, 1985, 1992; Ventola, 1987) and the work of John Swales (Swales, 1990) view genre as purposeful. The main premise of both is that every genre is defined by the purpose that it has to fulfill in the domain in which operates. In that regard, genre is considered a social practice (Bax, 2011) realized through language. The way things get done linguistically in relation to a specific purpose produces different genres. Swales made the point that the purpose constitutes the rationale of the genre (Swales, 1990). To him genre is “a class of communicative events, the members of which share same set of communicative purposes” (1990 p.58). Relying on some shared knowledge, participants are supposed to achieve a consensus at least on the main communicative purpose (Askehave & Swales, 2001). The purpose of the genre defines largely its structure and the content. Still, genre is more of an ideal representation, a prototype, rather than a fixed set of characteristics (Paltridge, 1995). From this point of view, every actual realization of a genre might differ slightly from the prototype, and yet should be recognizable as belonging to a specific genre based on a sufficient similarity with the prototypical image.

The definition of genre that I will follow in this study is that of Martin who defines it as “a staged, goal-oriented, purposeful activity in which speakers engage as members of our culture” (Martin, 1984 p.25). A given speech event is recognized as belonging to a certain genre because of its constitutional elements, its stages. Stages are functionally motivated, that is, they accomplish communicative purposes and perform social functions. Stages are also related to each other and follow a particular order. The overall structure of each genre consists of a beginning, middle and closing part (Eggins, 1994; Stenström, 1994). The structural parts exhibit different patterns of meaning relatively consistent for each genre, which implies that stages are genre specific.

I started the chapter with a review of various medical settings: acute, palliative, rehabilitation, and psychotherapeutic contexts. It is apparent that what is considered as effective communication in these contexts depends very much on the purpose. It is only natural that the visits in these areas are structured differently from each other (cf. a visit

to the emergency department and a visit to the psychotherapist). Despite the overarching aim of improving health, there are purposes specific to each of the participants on a local level. According to ten Have (1989), the purposes of the patient and those of the physician are complementary. The patient acquires the local identity of an Advice-Seeker and the physician acquires that of an Advice-Giver. The medical session as a whole shows characteristics of a service encounter (ten Have, 1989) with discernable stages. It is this aspect of genre, the process of staging, that I will relate to in the discussion in Chapter 4 and in the analysis in Chapter 5.

2.2. Conversation Analysis

In order to situate the present study, I presented an overview of communication in medical settings and the two main approaches to doctor-patient communication — the biomedical and patient-centred paradigms. I discussed four of the proposed models of patient-centred communication which inform the current understanding of the concept. I dealt briefly with the concept of genre and discussed how it is relevant to the study. Now, I turn my attention to the basic principles of CA because this methodological framework guides the analysis in Chapter 5. CA is a suitable methodology for addressing the research questions in this study. It is able to adequately capture the complex connection between language and social action, context, and institution by looking at social actions expressed by linguistic forms in developing sequence (Bayley, Cameron, & Lucas, 2013).

CA is a method for studying the structure and processes occurring in social interaction between humans. It was developed by Harvey Sacks (Sacks, 1992 [1964-72]) in collaboration with Emanuel Schegloff, and Gail Jefferson (Sacks, 1992 [1964-72]; Sacks, Schegloff, & Gail, 1974). The framework was grounded in Goffman's idea that social interaction is a form of social organization (Goffman, 1955) and Garfinkel's notion that shared common sense knowledge is a fundamental feature of the social world (Garfinkel, 1967). The empirical bases of this qualitative approach are audio and/or video recordings of naturally occurring talk. Empirical data for CA represents all types of oral speech, including monologic (i.e., president's speech, professor's lecture) and dialogic (i.e., radio talk-show, interview, phone call). The primary domain for analysis is the ordinary conversation. CA began with the investigation of everyday conversations between friends (Sacks et al., 1974; Schegloff & Sacks, 1973), but grew to explore another domain — that of institutional talk (Arminen, 2005; Drew & Heritage, 1992; Heritage &

Greatbatch, 1991). The interactions in medical, legal, and educational settings found in institutions became part of its focus.

In order to explore how participants construct their orientation to institutional contexts and identities, CA differentiates two types of institutions — formal and non-formal (Heritage & Greatbatch, 1991, p.51). Formal types, such as talk in courts of law (Atkinson & Drew, 1979), broadcast interviews (Heritage, 1985), and job interviews (Button, 1987), are characterized by a strict order of turn-taking and a high level of formality, politeness and formal lexis. On the other hand, non-formal types, such as talk in family doctor visits (Frankel, 1990; Heritage & Greatbatch, 1991), counselling sessions (Peräkylä, 1998) and business meetings (Boden, 1994), are loosely structured, yet task-oriented. The turn-taking system here is more flexible, allowing for interruptions and overlap, attitudinal lexis and higher affective involvement (Eggin, 1994). The analysis revolves around specific types of actions that are put into work to achieve institutional goals (Heritage & Clayman, 2010). Figure 3 illustrates this division by presenting a formality continuum in which different forms of institutional talk are compared against everyday conversation (Sacks et al., 1974). The left end of the continuum depicts highly scripted interactions that exhibit a strict turn-taking organization with frequently predetermined turn content. This suggests a situational context that is imposed on the participants. The right end of the continuum lists unscripted interactions such as family dinner or chat with a friend. Turn-taking and turn content are flexible and participants in such events actively orient themselves to the relevant context (Hutchby & Wooffitt, 2008). Finally, forms of talk with a flexible degree of formality occupy the middle spot, where I have placed the alternative medicine session. It belongs to medical discourse practices which are already characterized as informal institutional talk (Heritage & Greatbatch, 1991) as they incorporate features of institutional formality and characteristics of everyday conversation.

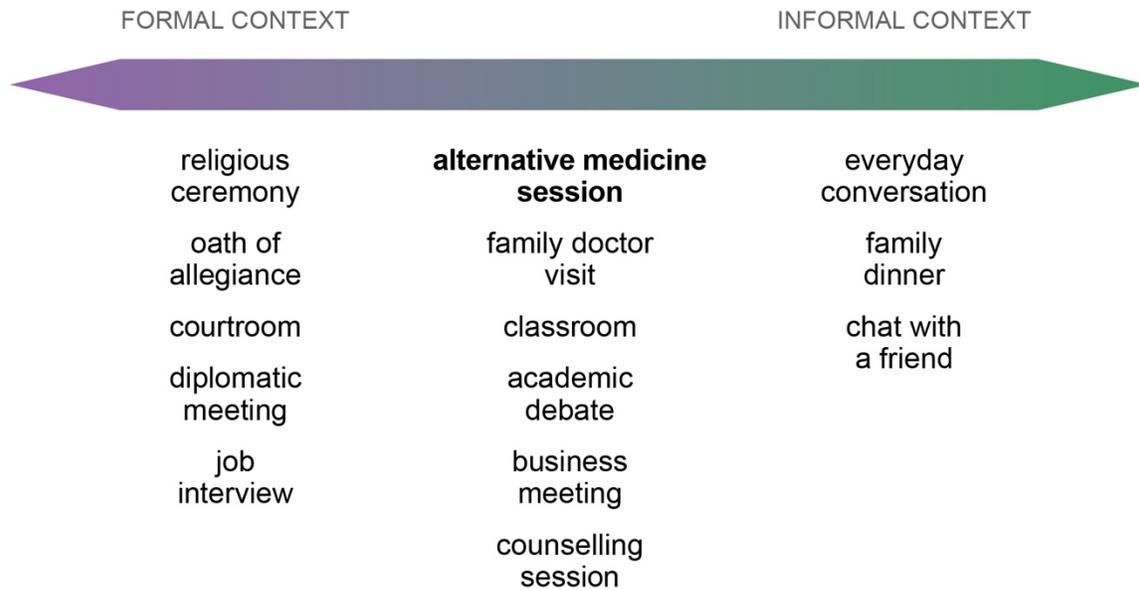


Figure 3 Formality continuum

The main analytical level on which CA operates is concerned with finding recognizable patterns in social interaction that form practices having a systematic nature. A practice is formed by particular elements which are: recurrent; found in the same specific contexts; and which attract distinct responses (Heritage & Clayman, 2010). The identification of practices is attainable by looking at the sequential organization of the talk-in-interaction. There are three foundational assumptions underlying this notion (cf. Heritage, 1984b Ch.8) — a) talk is action, b) talk is organized, and c) talk creates and maintains the intersubjective reality.

Talk is a fundamental activity in our life and the one that we experience the most as social beings (Peräkylä & Ruusuvuori, 2008). By talking to others, human beings communicate thoughts, exchange information, and present knowledge (Drew & Heritage, 2006). They perform identity work by creating identity roles — that of a mother, of a friend, of a colleague, of a doctor, of a teacher, etc. They also develop and maintain relationships with others. In doing so, people accomplish different actions — tell stories, defend a position, invite someone to an event, beg for help, describe problems, ask for directions, make compliments, apologize, and many more. All these are carried out using language. Schegloff points out that talk is the driving force of human action (Schegloff, 1991). Such and other actions have been topics of investigation in CA studies, for example, how interlocutors do self-corrections and repairs in ordinary talk (Schegloff, Jefferson, & Sacks,

1977), how they do openings and closings (Schegloff & Sacks, 1973), or how they display actions specific to some institutional settings — diagnosis (Heath, 1992; Peräkylä, 1998), delivering of bad news (Maynard, 2003), opening questions (Boyd & Heritage, 2006; Heritage, 2010).

The second assumption is that talk is structurally organized (discussed in Section 2.2.1). Sacks, Schegloff, and Gail (1974) proposed the idea that people talk in turns and these turns are ordered systematically. The systematic nature is defined by rules that govern different sets of practices to which the participants orient in performing social actions. The most important aspect is the interconnection between actions. That means that a given action has a connection to the preceding action as well as to the next one. Acts may be part of larger entities called “sequences”. A sequence could be described as a series of turns which are coherent and orderly connected. The transitions between turns are also signaled by transition points and reveal two things. In performing the ‘next’ turn, the speaker demonstrates understanding that the previous turn has possibly reached completion. Most importantly, it indicates that participants actively process the ongoing talk and respond to it in order to position themselves or to negotiate meanings in the conversation. The basic conversational sequence is called “adjacency pair” (cf. Schegloff, 1968). Examples of adjacency pairs include question-answer, invitation-acceptance, or greeting-greeting sequences (discussed in 2.2.1.). Sequential organization, in fact, is the main tool that participants deploy to create interactional roles in any given talk (Clayman, 1988).

The third assumption postulates that the talk creates and maintains intersubjectivity. This premise stems from the observation that talk is a not simply an exchange of information between a speaker and a hearer, but, rather, a process in which both sides mutually orient to and collaborate in order to establish a meaningful communication and common ground. Schegloff points out that “there is virtually nothing in talk-in-interaction which can get done unilaterally and virtually nothing is thoroughly prescribed” (Schegloff, 1986, p.22). The co-construction of meaning relies on the understanding of the previous turn performed by the current speaker. For example, when a speaker produces an utterance sounding as an answer, that means that the speaker perceived the previous utterance as a question. The interpretation of the previous turn is crucial for the process of interaction in cases where there exists a potential ambiguity between a statement and a complaint, a statement and a request (Peräkylä & Ruusuvuori,

2008). According to Sacks and Schegloff (Sacks, 1987; Schegloff, 1984), turns are both context-shaped and context-renewed. This means, that in producing a turn, participants orient themselves to the preceding talk (context-shaped), usually, the most immediate. At the same time, turns project the relevance of a particular action to be performed by a next speaker (context-renewing).

Another aspect of the intersubjectivity is the influence of the context on the talk. This is distinctly observable in institutional settings. The institution imposes institutional norms and tasks which shape the actions of the participants in the process of achieving their goals. The institutional context is reflected in turn-taking organization, overall structural organization, sequence organization, turn design, lexical choice, different forms of asymmetry (Drew & Heritage, 1992; Schegloff, 1992). CA research on institutional talk explores intersubjectivity by analyzing the sequential organization of talk, the management of turn-taking and the sequence design (Heritage, 2013; Heritage & Greatbatch, 1991; Maynard & Heritage, 2005). The most consistent findings across CA studies have been, indeed, on the collaborative and inter-subjective characteristics of conversation (Park, 2009).

In terms of methodology, CA undertakes a qualitatively, data-driven approach where statistical methods are peripheral. Empirical basis for the analysis is audio and/or video recorded spontaneous, real-life interactions. One advantage of this approach is that recordings make possible the check of the validity of the claims made in the analysis. This foundation is in contrast with the observational studies which use coding systems, and with experimental studies which rely on controlled situations. Schegloff finds that the experimental data disadvantages the applicability of findings (Schegloff, 1991). The implementation of role-plays in experiments, for example, causes lack of authenticity which negatively impacts the interpretation and the reliability of the results. Coding systems are widely used in psychotherapy research. Fitzgerald describes them as “blunt instruments insensitive to complexities of interaction” (2013 p.69).

The methodological procedures of CA provide researchers with tools to describe how participants create an orderly, rule-governed interaction where the sense-making devices are locally situated and motivated (ten Have, 1990). The focus in CA research is on the contextual and orderly particularities where no detail can be labeled as accidental. Interaction is organized everywhere, even at the level of detail. Zimmerman points out:

“No scale of detail, however fine, is exempt from interactional organization, and hence must be presumed to be orderly” (1988 p.415). This necessitates an analysis of not only what participants say, but also in silence, backchannels, sound stretches, discourse markers, and so on. Pawelczyk and Erskine (2008) showed how in therapy, specifically designed responses to the clients’ discourse marker *you know* are used by psychotherapists to resume the clients’ self-disclosure. Any findings require social, environmental, or cultural interpretation, taking into account the uniqueness of each individual case (Fitzgerald, 2013 p.70). For example, Cutrone (2014) found out that Japanese speakers learning English as a foreign language would successfully use backchannels as an indication of active listening, understanding or agreement when they talk to Americans. However, they will use the same tokens in situations where they do not want to openly disagree thus, exploiting them as a face-saving strategy.

In general, CA research is divided into single case studies and collection studies (Maynard & Heritage, 2005; Mazeland, 2006). The former analyzes the interaction between participants in a single episode, in relation to a certain feature. The latter does the same, but in a series of episodes. By accumulation of examples of a given practice, collection studies describe how the instances are the same, similar, or distinctive. Next step is to identify patterns from the “bunch of observations” which Sacks describes as an inductive process where researchers have to apply “unmotivated examination” (Sacks, 1984). The ultimate goal of collection studies is to arrive at reasonable generalization from the results (Mazeland, 2006). The present study is of the second type. By describing regularities associated with specific aspects (laid out in Section 1.1.1), the thesis gives an account of how participants orient to certain patterns using language. Despite the fact that it deals with a small data set which does not allow for substantial generalizations, the study makes effort to interpret the findings in a meaningful and purposeful way adequately representing the context. CA informs the analysis in this thesis mostly by drawing on CA approaches to conversation structure, which I discuss in the next section.

2.2.1. Conversation structure

Conversation structure describes the formal aspects of conversation, including the ways in which a conversation is open, closed and managed by turn-taking. The organization of turn-taking in ordinary conversation receives its technical description in Sacks, Schegloff, and Jefferson (1974). The underlying idea is that the distribution of turns

in conversation shows a systematic behavior. The authors list two sets of rules that apply to turn-taking: the turn-construction component and the turn-allocation component. The first component, turn-construction, deals with the linguistic forms of the units. For English, Sacks et al. included all syntactic levels: sentence, clause, phrase, and lexeme, and define a turn as built of units, or a “turn-constructive unit” (TCU). The boundaries of the turns are marked by “transition-relevance places” (TRP) that offer a potential place for another speaker to take the right to speak, or the floor. The transitional places are not salient, but rather unobtrusive in the course of a turn. The authors also discussed “possible completion points” (Sacks et al., 1974, p.721), which carry the possibility for another speaker to initiate the “next-turn starts”. The participants are capable of recognizing coming possible or actual transition-relevance places. That is, they can predict when the turn is likely going to end and could initiate a turn-transfer. This presents an opportunity for speakers to time their initiated turns.

According to Edelsky (1981), turns in the literature have been commonly defined on the basis of technicality (Duncan, 1973; Duncan & Fiske, 1985; Jaffe & Feldstein, 1970; Sacks et al., 1974; Schegloff, 1972b). Mechanical formulations include two main elements in determining a turn. The turn is either marked by the end of a unit type, or by initiation of talk by another speaker. The content has been ignored in favor of the organizational features. Contrary to this view are the definitions built on the basis of the participants’ intention, that is, on interactional grounds (Edelsky, 1981; Yngve, 1970). Building on Yngve’s (1970) understanding of a turn, Edelsky (1981) discussed turns on the basis of the completeness of the message being conveyed. To her, the speakers’ intentions to complete messages have consequences for social meaning. Both Yngve and Edelsky differentiate *turn* and *floor*. For Yngve, turn and floor are turn variables where someone can have several turns before having the floor (1970 p. 575). For Edelsky, the floor is basically what is going on in the conversation, be it a topic or a task. This study will take an interactional approach as it will consider the participants’ intentions to convey a complete message. As long as the speaker produces the main message or main “channel” (Yngve, 1970), it is their turn. The floor in the sense of “collaborative floor” will be discussed in Section 5.3.

The second component of the turn-taking model is the turn-allocation. Sacks et al. (1974) list the following set of rules that they think are applied in every conversation:

Rule 1

At initial TRP:

- (a). Current speaker selects next
- (b). If (a) does not apply, then self-selection may occur
- (c). If (a) does not apply, self-selection may occur unless another self-selects

Rule 2

Rule 1 applies to every next TRP

Although called rules, it is important to point out that they are not externally imposed on the participants. On the contrary, participants are intrinsically oriented to follow the rules or at least tacitly learn them. This point is demonstrated in early research (Jefferson, 1973; Schegloff, 1982; Schegloff et al., 1977; Schegloff & Sacks, 1973). Another major characteristic is that turn-transfer is not mandatory after a TCU. Rather, if turn-transfer is going to be initiated, this is the place where it is most likely to happen.

The distribution of turns involves the employment of allocation techniques oriented to “current select next” and “self-selection” procedures. There exist types of sequences that inevitably invoke the selection of the next speaker. Sacks (1992 [1964-72]) called them “paired action sequences” and developed “tying rules” that explain how actions are linked together and form a pair. Schegloff and Sacks (1973) defined this sequence as “adjacency pair”, having the following characteristics:

1. A sequence of two actions each produced by a different person.
2. The two actions typically occur adjacently.
3. The two actions occur in a specific order.
4. The first action in the sequence is doing different work than the second action.

As the term implies, they consist of two parts, each with their own function, called first part and second part. So, when a speaker asks a question, they select the next speaker by requiring the second part of the adjacency pair, the answer, to be filled in. Ideally, the two

parts are adjacent. However, there are often cases where insertion sequences intervene between the two parts as in the following example taken from the data:

Example 1

- 1 Franca: So tell me what's going through your mind?
- 2 Kate: **At night?**
- 3 Erika: Uh-huh.
- 4 Kate: Anything and everything.

It turns out that the second relevant part of the pair needs not be the next turn. The speaker Kate puts it on hold in order to receive the clarification she needs. Only after this clarification does she provide the expected second part of the pair.

Adjacency pairs also have preferred and dis-preferred responses. For example, an invitation might be followed by an acceptance (the preferred response), or a refusal (the dis-preferred response). It is expected that the next speaker will provide the second part of the required pair, and not of a different pair. A question is expected to be followed by an answer, not by a greeting. This property of adjacency pairs is called 'conditional relevance' (Schegloff, 1968). It defines the two pair parts as a sequence in contrast to just two utterances that happen to be adjacent. It implies that the production of a first pair part creates an expectation that a relevant second pair part will be the next action. The adjacency pair frequently functions as a central unit in larger structures that include other sequences. For example, a *pre-sequence* (line 3) may precede an adjacency pair (lines 10 and 11) in the form of a request in situations where the speaker needs a permission. This type of sequences can be explained with politeness theory (Brown, P. & Levinson, 1987), because this sequence involves saving face by not making a direct question.

Example 2

- 1 B: I've listen to all the things that you've said, an' I agree with you so much.
- 2 Now,
- 3 **I wanna ask you something,**
- 4 I wrote a letter.
- 5 A: Mh hm,
- 6 B: T'the governer.
- 7 A: Mh hm::,

- 8 B: -telling'im what I thought about i(hh)m!
9 A: Sh:::!
10 B: Will I get an answer d'you think,
11 A: Ye:s

(Schegloff, 1980 p.107)

There are also *insertion sequences* (Schegloff, 1972a). One example involves initiated repairs (self- or other-correction). In this case, Marge needs clarification for the name of the person she had been asked. Her lines (2 and 3) are embedded within the initial adjacency pair (lines 1 and 4).

Example 3

- 1 Bea: Was last night the first time you met Missiz Kelly?
2 Marge: **Met whom?**
3 Bea: **Missiz Kelly.**
4 Marge: Yes.

(Schegloff et al., 1977 p.368)

And finally, there are *post-expansions* (Schegloff, 1995) such as words of thanking or agreeing which are usually expressions of appreciation (Goffman, 1971).

Example 4

- 1 A: Have you got the time?
2 B: It's three o'clock.
3 A: **Thanks.**

(Coulthard & Brazil, 1981 p.95)

This section provided a brief description of the CA methodological framework. I expanded on CA analytical levels in terms of structural organization and intersubjectivity of talk. In order to address the research questions posed in this dissertation, I adopted the notion of adjacency pairs, insertion sequences, and elaborations. The chapter reflected on the systematic nature of conversation and presented the principles that build any conversational structure. For the purpose of the analysis, the position of alternative medicine on the continuum of formality was described. The following section reviews

applications of CA in two extensively researched medical fields, that of primary care and psychotherapy.

2.3. The discourse approach to medical encounters

In this section, I describe how discourse approach to analyzing oral medical encounters, such as primary care visits and psychotherapy practices, is used. I review CA studies that account for context in order to explain social actions by looking at three aspects: structure, sequentiality and construction of meaning. I discuss briefly two concepts related to the collaborative meaning-making process, that of politeness and that of linguistic convergence.

There is a well-established tradition in sociolinguistics and sociology of using discourse analysis to explore professional interaction (Sarangi & Roberts, 1999; Scambler & Britten, 2001). The research began in areas such as education (Erickson & Shultz, 1982; Mehan, 1979; Sinclair & Coulthard, 1975), courtroom (Atkinson & Drew, 1979; Bennett & Feldman, 1981; Cicourel, 1968; Linell, 1991; O'Barr, 1982), and healthcare (Ferrara, 1988; Fisher & Todd, 1983; Labov & Fanshel, 1977; Maynard & Heritage, 2005; Mischler, 1984; Peräkylä et al., 2008b; Silverman, D., 1987; West, 1984). It was in the last two decades of the 20th century that the question of effective communication in health care was realized to be crucial for understanding how participants involved in medical settings perform institutional talk and how their roles help them accomplish institutional goals (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Cicourel, 1975; Groves, 1978; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008a; Woodward-Kron, 2016). While there were studies that have been unilaterally oriented to and concerned mainly with the communicative acts of the physicians (Lipkin, Putnam, & Lazare, 1995; Platt & McMath, 1979), there existed another line of research which focused on the speech behaviour of both physician and patient (Frosh & Kaplan, 1999; Josephson et al., 2015; Roter et al., 1995). A great number of the first type of studies reported miscommunications in medical interviews and described an asymmetry between the doctor and the patient. One aspect of this asymmetry is reflected in the fact that doctors take the floor with higher frequency of requests for information than the patients (Coulthard & Ashby, 1975; Weijts, Widdershoven, Kok, & Tomlow, 1993; West, 1984b). Shuy (1983) showed that the use of jargon by doctors caused confusion for patients who did not know how much information was needed from them and how to introduce it in the medical consultation.

Advantages of improved communication were shown (ten Have, 1991) to be beneficial for both sides — quality of time spent during the visit, a better outcome for patients, and increased satisfaction for both patients and doctors (Roter & Hall, 2006; Silverman, D., 1987).

With the premise that language is the main source for the construction of experience and social relationships (Muntigl, 2010), discourse analysis offers a suitable framework for investigating social interactions in professional contexts such as healthcare. A number of studies have adopted one of the two main approaches to discourse analysis, CA (Atkinson & Heritage, 1984; Levinson, 1983; Madill, Widdicombe, & Barkham, 2001; Peräkylä, 2004; Voutilainen, 2010) emphasizing the sociological approach to the study of language (Heritage, 2003). The CA framework works toward gaining understanding of the communication in face-to-face interaction in medical encounters (Heritage & Maynard, 2006a; Waitzkin, 1991). CA analyzes the medical encounter in terms of its organization, sequentiality and construction of meaning (Wilce, 2009). The organizational structure of medical visits as comprised of stages — greetings, presenting the problem, history taking, physical examination, diagnostic announcement, treatment proposals and closings — is explored in a number of studies (Boyd & Heritage, 2006; Heritage & Clayman, 2010; "National Center for Complementary and Integrative Health," 2017; Roberts & Sarangi, 2005; Robinson, 2003; Stivers & Heritage, 2001; Tannen & Wallat, 1986). Roberts and Sarangi (2005) showed how the different stages were signaled by prosodic cues such as intonation, pausing, and rhythm together with non-verbal cues and other markers. Robinson (2006) explored the solicitation of patients' concerns during the *presenting the problem* stage by analysing the initial turns used by a doctor. The initial turns were found to be designed differently, depending on whether the visit is a first for the patient, a follow-up, or a routine one, and Robinson demonstrated how patients were sensitive to the design of the turns and reacted accordingly to "fix" the communication. Boyd and Heritage (2006) focused on the *taking history* stage by looking at the doctor's questioning. They found that two crucial principles were at play at this stage of the encounter. The principles were related to the design of questions aiming for "best case" responses and had relevance to the particular circumstances of the patient. The *diagnosis* stage has been investigated especially in regard to the delivery of bad news (Heath, 1992; Maynard, 2003; Maynard & Frankel, 2006; Peräkylä, 1998) in palliative care. Lutfey and Maynard (1998) discovered that doctors were discursively cautious in discussing death with the patient,

but through a progressive questioning strategy they could achieve a supportive and favourable environment before delivering the bad news.

The sequential organization of the encounters has been investigated both in primary care visits and psychotherapy sessions. The sequence of answer-question has received particular attention. The concept of 'adjacency pair' (Schegloff & Sacks, 1973) became central in analyzing questions and answers (Halonen, 2008; MacMartin, 2008), in discussing statements and (re)formulations (Antaki, 2008; Antaki, Barnes, & Leudar, 2005; Berceli, Rossano, & Viaro, 2008; Davis, 1986; Hutchby, 2005; Leudar et al., 2008), or investigating *expansions* (Schegloff, 2007), which present long and complex sequences built around a single adjacency pair (Berceli et al., 2008). Pawelczyk and Erskine (2008) investigated sequentially organized actions inspired by Schiffrin's sequential accountability (Schiffrin, 1987). Using a relational therapy database of 65 sessions (25 clients with the same therapist), Pawelczyk and Erskine focused on particular kinds of responses uttered by the client: *you know* and *I don't know*. They show how a therapist's response to a client's *you know*, *I don't know*, and the use of repetitions were tools to resume the discontinued process of self-disclosure. Furthermore, these strategies promoted a client's self-expression and demonstrate the therapeutic functions of language (Pawelczyk & Erskine, 2008, p.45).

The third focus of CA in medical settings, the construction of meaning, has become particularly essential in psychotherapeutic contexts (Buttny, 1993; Edwards, 1994; Gale, 1991; Kogan & Gale, 1997; Muntigl & Hadic Zabala, 2008; Muntigl & Horvath, 2005), (Arminen, 1998; Aronson & Cederborg, 1994; Ferrara, 1994; Fine, 2006; Grossen, 1996; Labov & Fanshel, 1977; Wodak, 1981). Psychotherapy is an intriguing subject for linguistic research as words are the main tool for diagnosis and treatment (Ferrara, 1991). At an individual level, psychotherapy is a therapeutic dyadic experience between a client and the psychotherapist. Many historiographies consider the beginning of psychotherapy to be the work of Freud and Breuer (1895) with a female patient called Anna O. She experienced repetitive anxious thoughts related to her experience of caring for her terminally ill father, and showed episodes of altered personality. Anna described the act of telling her worries and fantasies as 'a talking cure' because it was helping her to get relief from her symptoms (Peräkylä et al., 2008a). Freud discussed Anna's case as an illustration of psychoanalysis (Freud & Breuer, 1895). Psychoanalysis has since become the first form of psychotherapy. As mentioned earlier, approaches to the 'talking cure' differ greatly depending on the

psychotherapy school in which therapists were trained. Modern day psychotherapy is characterized by a great number of approaches which are often competing (Peräkylä et al., 2008a). For example, psychoanalysis and psychodynamic therapies deal primarily with the unconscious side of a person (Freud & Breuer, 1895) while cognitive-behavioural therapies emphasize the importance of people's perceptions of their experiences (Dryden, 2007). Relational therapies consider the need for relationship as the primary explanation of human behaviour (Pawelczyk & Erskine, 2008). Client-centred therapies (Rogers, 1951) focus on the client, providing an environment of empathy and non-judgment in order to help the person cope with the negative events in life, and to find positive solutions. The understanding of the interactive process and meaning-making were actively explored in all these fields, among others. Language as a cooperative enterprise has been investigated within interactional sociolinguistics, for example in the works of Buttny (1996), Wodak (1981), Ferrara (1994), and Pawelczyk and Erskine (2008), where the "what" and "how" of the therapist became equally important as the "what" and "how" of the client.

Linguistically cooperative strategies became a subject of analysis for researchers working with Communication Accommodation Theory (Giles, Coupland, & Coupland, 1991). Their studies showed how, in fact, interlocutors exhibit constant adjustments in conversational settings (Ferrara, 1991) at different levels of linguistic organization. An early attempt to analyze the nature of these adjustments was done by Lennard (1962) and Pepinsky and Karst (1964). The concept of *convergence* as an interactional change in psychotherapy was explored in Pepinsky and Karst's study (1964) inspired by Lennard's suggestion that "during the therapy there is growing similarity in verbal behaviour between therapist and patient" (Lennard, 1962). The authors suggested that the speech of the therapist can also exhibit accommodation. As a matter of fact, Ferrara (1991) showed evidence of bi-directional accommodated speech between a client who is a speaker of a highly stigmatized dialect, and a therapist whose dialect poses relatively high status. She concluded that the accommodation on phonological, morpho-syntactic, and discourse levels increased over time. Indeed, as she found out, the real amplitude of the accommodation may only become available with the amount of extended contact, as previous studies have shown (Bieber, Patton, & Fuhrman, 1977; Meara, Shannon, & Pepinsky, 1979). Accommodation Theory has been also extended to medical consultations (Hehl & MacDonald, 2012; Hewett, Watson, Gallois, Ward, & Leggett, 2009; Street, S., 1991). Street (1991) argued that the process of communicating in medical visits

is best explained within the accommodation framework. He discussed communicative processes and outcomes in the doctor-patient context in terms of convergence and divergence through verbal and non-verbal behaviour. He concluded that two patterns of accommodation were observed simultaneously. The first was convergence among behaviours (verbal responsiveness, agreements, gaze, body position, gestures, response latencies) and the second was convergence in communicative roles (topic initiation, extended floor holding durations, interruptions, pauses within speaking turns).

In addition to convergence practices, the notion of politeness became a relevant aspect of collaborative talk in the encounters. Robins and Wolf (1988) applied Brown and Levinson's (1987) theory of politeness to interpret and frame the communication that occurs between physician and patient. They showed how understanding of concepts such as 'face' and 'politeness' becomes a helpful tool in solving the problems inherent to the doctor-patient interaction, and allows physicians to achieve communicative competence. By performing an experiment with medical students in real-life medical encounters, the authors demonstrated that politeness strategies such as *asserting reciprocity* can be both face-saving and therapeutic, especially in communication with an angry patient. Irigiliati (2006) also demonstrated the importance of politeness strategies in medical discourse in Indonesia. She showed how positive and negative politeness strategies are closely related to the local values and have an influence on patients' recovery. She found out that Indonesian doctors achieved solidarity, liking, intimacy and affirmation by using intimate forms of address. To declare autonomy, however, they spoke to patients using impersonal forms of address.

One aspect that I take from this research and serves as a starting point in my analysis is the notion of conversational asymmetry. I use the speech act as a unit of analysis to explore how this asymmetry takes place in the real data. Given that a speech act constitutes a social action, I examine the construction of meaning in the dialogues by exploring the social actions of the participants. I take the concept of convergence and examine how the collaborative floor is achieved and face-saving strategies applied.

Discourse and conversation analyses are also involved in defining speech events in primary care and psychotherapy. There has been a widely accepted view that the primary care visit takes the form of an interview (Cole & Bird, 1991; Lipkin et al., 1995; Maynard & Heritage, 2005). The same claim is made for psychotherapy sessions by Labov

and Fanshel (1977), whereby a therapist tries to acquire information from a client. Labov and Fanshel were one of the first to explore psychotherapeutic talk from a linguistic point of view. They introduced a framework for discourse analysis appropriate for the specifics of psychotherapeutic talk and examined the first five minutes of a psychotherapy session with a client, who suffered from *anorexia nervosa*. Labov and Fanshel analyzed three fields of discourse: interview style, everyday style, and family style, and identified specific interactional phenomena, called A, B and AB speech events. They refer to certain state of affairs relating to the ownership of information, more specifically, whether something is known by one only or both speakers. In the case of A-events, a given bit of information is known to speaker A and not necessarily to speaker B, and vice versa. Speaker A may thus report information or express emotion so to make speaker B aware of the state of affairs. When both speakers are aware of what is being talked about, the event is called AB-event. Requests and responses fall into the category of AB-events. Ferrara (1994) argued that there is much more to a psychotherapeutic session than simply extracting information from the client. She suggested that a psychotherapy session is a type of *consultation* where “one person, A, approaches a specialist, B, to receive assistance in planning future behaviour or action, action that can be medical, legal, financial, or other” (Ferrara, 1994, p.37). An alternative definition is proposed by Gaik (1992), who argued that a psychotherapy session operates on two modes, therapeutic and counseling. The therapeutic mode is indirect and oriented to the discovery of the underlying causes of the client’s problem while the counseling mode is directive, performed by giving advice or solutions to the problem (Muntigl, 2010).

By taking the alternative medicine session as a speech event that combines elements from both formats, interview and consultation, I examine how it reflects a patient-centred approach through CA applied to speech acts, backchannels, joint productions and repetitions. I use the notion of “adjacency pair” to analyze how speech acts reflected in questions/answers and statements/repetitions, display the mechanisms of giving and providing information. I look into the sequential placement of backchannels in order to find out what work they perform and how they contribute to the patient self-disclosure. Lastly, I analyze how turn-taking is accomplished in jointly produced utterances and repetitions in order to see whether a collaborative floor is built.

Section 2.2 laid out the main principles of CA including conversational structure. It then outlined some of the practical aspects of CA in psychotherapy and general practice

by reviewing studies using applied CA, i.e., an analysis of interactions with institutional roles and purposes. This overview is relevant as the present study also investigates institutional settings involving CA practices and sociolinguistic considerations. The next, final section, describes alternative medicine as a healing modality as well as a type of institutional speech event.

2.4. What is alternative medicine?

In this last section of the chapter, I briefly present the philosophy behind alternative medicine as healing approach. Then, I discuss it as a type of institutional talk.

2.4.1. Alternative medicine as a healing modality

The philosophy of medicine is primarily concerned with concepts such as healing, illness, care, and “the moral claims of the sick on the well, on society, and on the health professions” (Pellegrino, 2008). The practice of medicine, however, is mainly concerned with restoring patient’s health (Pellegrino, 2008). It is commonly accepted that one of the main goals of medicine, if not the major one, is health (Nordenfelt, 2004). The question of “What is health?” has been discussed from various perspectives. The conceptualization of health naturally led to the emerging of distinct, often conflicting medical models such as the biomedical and the psychosocial models (Engel, 1977, 1980).

The focus on the body and the rapid advances in science both gave rise to modern medicine (Foucault, 1965). Advances in pharmacology and surgery during the 20th century significantly contributed to what we know today as the “biomedical model of medicine” in modern Western society. The biomedical model is a medical framework that considers only biological factors in order to understand a person’s “somatic” or “mental” illness (Rosen, 1972) and has molecular biology as its basic scientific discipline (Engel, 1977). It mainly focuses on the pathology, physiology, and biochemistry of the illness, and does not consider any social or psychological factors. Nevertheless, concepts and formulations, which provide a more holistic view of medical science started to emerge between 1940 and 1950 (Menninger, 1948; Romano, 1950). The culmination of this holistically oriented stream of propositions was the biopsychosocial model of medicine proposed and theorized by the American psychiatrist George Engel in the 1980s. In contrast with the

biomedical model, the biopsychosocial model takes into consideration social and psychological factors, as well as biological ones.

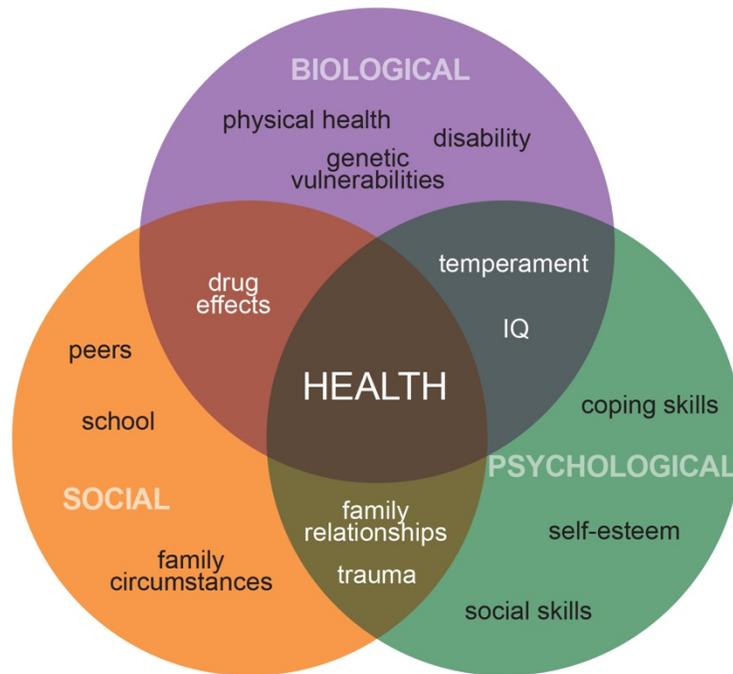


Figure 4 Biopsychosocial model of health

Adapted from: <https://www.open.edu/openlearn/science-maths-technology/exploring-the-relationship-between-anxiety-and-depression/content-section-2>

According to Engel, humans are simultaneously biological, psychological, and social beings. These three dimensions are incorporated into a hierarchically arranged continuum. The levels of the continuum do not present an assemblage of constituent parts (Engel, 1980) but are rather interconnected and mutually influenced. This naturally presupposes a patient-centred approach practiced by biopsychosocially-oriented physicians (Mead & Bower, 2000). In contrast, it has been reported in the medical literature that reductionist physicians are generally associated with practitioner-centred care (Byrne & Long, 1976; ten Have, 1991). The differences between visits to a biopsychosocially oriented physician and to a biomedically oriented physician are presented in Table 2:

Table 2 Comparison between visits to a biomedical and holistically oriented physician:

Reason for visit (chest pain)	Biomedically oriented physician	Biopsychosocially oriented physician
Presentation:	Primary focus on the causes Questions about pain history, symptoms, and diet	Finding out psychosocial and physical processes that may cause the complain Questions about recent life stressful events or behaviors
Diagnosis:	Check pulse, blood pressure, temperature Order lab tests	Lab tests and assessment of psychosocial factors
Therapy:	Medicinal plan based on biological etiology and pathogenesis	The physician discusses possible interventions taking into consideration lifestyles that could affect the pain or adherence to the treatment The patient is involved in the formulating and implementing the plan

Adapted from Engel (1980)

The holistically oriented approach to medicine is embodied in the so-called “alternative medicine” or “complementary and alternative medicine” practiced in the Western world today. The label “alternative” seeks to differentiate this approach from the mainstream approach. Since holism presupposes inclusivity, it follows that both the biological and the psychosocial aspect of the patient’s life are taken in account. From this point of view, talk will be an essential part of the process — the psychosocial and biological aspects are realized predominantly through dialogue and narratives encountered in the history taking, questioning, and discussion parts during a visit. Since the talk between a holistic physician and a patient takes place in institutional settings, much of the participants’ discourse identities are connected to the institutional aspect of their interaction.

2.4.2. Alternative medicine session as institutional talk

The purpose of the CA research initiated by Sacks and his colleagues was the exploration of the properties and structures underlying *any* social interaction (Peräkylä et al., 2008a). Most of the early CA studies were devoted to every day conversation. From the late 1970s onwards, there have been studies trying to explain specific types of interactions, different from ordinary conversations. One of the first institutional CA works

was Atkinson and Drew's *Order in Court* (1979), with focus on turn-taking organization. They analyzed lawyers' questions and their interpretations by witnesses, and connected this with the overall embodiment of institutional identities. Other studies explored classrooms (McHoul, 1978; Sinclair & Coulthard, 1975), doctor-patient communication (Heath, 1986; Peräkylä et al., 2008a; ten Have, 1991), courts (Heffer, 2007; Matoesian, 1993), news interviews (Clayman, 1988; Heritage & Greatbatch, 1991), or police stations (Fadden, 2008; Haworth, 2006), in which participants accomplish institutionally ascribed tasks. Each institutional context provides specific goal orientations and projects different identities: teacher and student, doctor and patient, interviewer and interviewee, lawyer/police investigator and suspect. Although the boundaries between ordinary conversation and institutional talk can be difficult to state precisely (Schegloff, 1999), the differences in the interaction between news interviews, medical visits and classroom lessons are clearly understood (Heritage & Clayman, 2010). Institutional CA has as its major focus the deployment of turn design and social actions to carry out institutional objectives.

There is no definitive explanation of "institutional talk" (Heritage & Clayman, 2010), but only a conceptualization of the term. It is evident that all parties in institutionalized context orient to particular tasks. Drew and Heritage (1992) suggest that there are three types of features influencing the participants' orientation. These include distinct goals and institutional identities, constraints on conduct, and specific procedures. Combined together, these features mark the uniqueness of every institutional interaction, or, as Heritage and Greatbatch (1991) name it, give it its "fingerprint". Empirically, one would investigate these at the level of turn-taking organization and design, overall structure, sequential order, lexical choice, and forms of asymmetry. All these levels are involved in the analysis to one degree or another, but I will address the overall structure specifically in Section 3.2.

Language and the professions, as a topic, is a relatively new subcomponent in linguistics that attempts to describe how language patterns and discourse practices are shaped by the specific professional context. By the same token, alternative medicine as an institutionalized practice is a relatively new phenomenon in the Western world. It refers to a set of medical practices, services and products, which are considered complementary to the mainstream medical care performed in hospitals. It can be conducted in a variety of settings including health clinics, counselling and community centres, and private practices.

The alternative medicine modalities that the doctors in this study practice require 4-6 years of intensive training and include more than 1,000 hours of clinical practicums and supervision.

In Section 2.3 I mentioned that CA is one of the frequently used qualitative methods to investigate interaction in clinical settings and psychotherapy. It is applied to analyze medical interviews as both social interaction and achievement of intersubjectivity. It is also used to describe sequential and coherent order, and to reveal meaning-making processes and negotiations in psychotherapy. A systematic account of the CA literature in the field of alternative medicine, however, does not exist yet. One reason might be that this line of research is in its embryonic state. The explorations of dialogue in this specific context are mainly investigated in terms of healing purposes, but not in terms of linguistic consequences and CA techniques, at least not to my knowledge. Another reason might be the fact that the alternative medicine encompasses varying subfields and modalities with their specific healing-tailored practices. A quick comparison of a homeopathic session with an aromatherapy session will reveal that in the former there is a lot of conversational behaviour, while little talk is required in the latter. The way the doctor engages the patient varies drastically between different modalities and no single overall structure will be applicable. Considering the broad spectrum of modalities that are included under the term "alternative medicine" (e.g., manipulative practices, creative therapies, Ayurveda, bioelectromagnetic therapies), my concentration is limited only to those modalities practiced in today's Western world that share organizational principles ("National Center for Complementary and Integrative Health," 2017). These are the modalities of homeopathy, naturopathy, and Chinese medicine.

The alternative medicine sessions constitute a format of a medical discourse. Here, I present Ferrara's (1994) table, which outlines seven dimensions of two types of medical discourse — medical visits and psychotherapy sessions.

Table 3 Dimensions

Dimension	Medical consultation	Psychotherapy session
Genre	Interview Unilateral questioning	Consultation Clients introduce topics and ask variety of questions
Reciprocity	Majority of the talk done by the doctor	Majority of the talk done by the client
Parity	Power/status relationship	Power/status relationship
Regulatory responsibility	Doctor initiates, regulates and ends the therapeutic discourse	Therapist initiates, regulates and ends the therapeutic discourse
Restricted topic	Physical health	Psychological health
Routine recurrence	Not necessarily	Fixed schedule of time and place
Bounded time	Max 15 min	Around 50 min
Remuneration	Remunerated	Remunerated

Based on Ferrara 1994

Ferrara proposed seven dimensions that differentiate therapy talk from medical visit, many of which constrain or modify the talk in a specific way. These are *parity*, *reciprocity*, *routine recurrence*, *bounded time*, *restricted topic*, *remuneration*, and *regulatory responsibility*. Ferrara claimed that *parity* was not observed in therapy. “By the virtue of the client’s need and the therapist’s training, they mutually accept premises that automatically assign roles to each other. One is the helper, the other will be helped” (Ferrara, 1994, p.39). In psychotherapy, the therapists are in charge of the situation. *Reciprocity* is reduced, which means that in therapy the question of who will speak and how will speak is predetermined, unlike in everyday conversation. *Routine recurrence* refers to a client’s fixed schedule and fixed time to have an appointment. *Bounded time* implies that sessions have the same duration. *Restricted topic* suggests that the talk will consider only the client’s feelings and attitudes. *Remuneration* means that the client pays for every visit, and, finally, the *regulatory responsibility* dictates that the therapist initiates, manages, and wraps up the therapeutic session.

I consider this a good starting point for comparison with alternative medicine. My analysis will draw on the first five dimensions in order to describe the alternative medicine sessions as a type of medical discourse, as we will see in Chapter 5.

In this chapter I have provided the theoretical background for the present study. I have presented an overview of communication practices in various medical settings and then compared four patient-centred models that reflect contemporary views on doctor-patient interaction. I have also briefly discussed the notion of genre as a staged activity because this is relevant to the analysis of speech acts. I have given a summary of the main principles of CA that will guide the linguistic investigation of elicitation and rapport. I have touched upon some of the applications of CA in primary care and psychotherapy. The chapter concluded with a description of alternative medicine as a healing modality and a type of institutional talk. I can now proceed with the methodological considerations and the analysis of the data.

Chapter 3.

Analyzing alternative medicine sessions: Data and methodology

After providing the theoretical background of the study, in this chapter, I give details about the data and propose a methodology for the analysis that follows in Chapter 5. I describe how I built the corpus, the analytical techniques that I used and which transcription conventions best served the goals that I set out for the study. I give a broad overview of the structural organization of the sessions. Since the corpus was based on real data, I introduce the persons who contributed to this research with their participation — the doctors and the patients. Recorded interviews are subject to the “observer’s paradox”, which is why I considered it necessary to discuss its effect on the participants. Finally, in the last section, I present an outline of the coding procedures for my main topics of interest in this study, namely, elicitation and rapport. In order to address the study’s research questions, I provide the units of my analysis and discuss specific concerns in terms of their classification. I propose categorization of speech acts, backchannels, joint productions, and repetitions.

Drew and Heritage (2006) describe CA as a “discovering science”, which explains why patterns of reasoning and standard of evidence vary among researchers. The CA methodology depends entirely on how the data is collected, what observations are performed, how recurrences of events are identified and systematically organized, and overall, how the analyses are built and performed. The first methodological aspect of CA is that its working data is audio and/or video recordings of naturally occurring interactions (Goodwin, 1993; ten Have, 1999). There are two reasons why only these sources of data are the most effective ones. One is that we can observe repeatedly interactional events in real time. The other is that audio/video recordings provide a chance to notice details that could otherwise be missed.

An illustration of how crucial the recordings and transcriptions are for finding patterns is the research that Ferrara (1994) performed on joint productions. She noticed instances when one speaker would finish the utterance of the other speaker and investigated when this was happening, as in the following example:

Example 5

- 1 Gerald: Boy, you sure talk about him in =
2 Wilma: = a negative way.

In order to prove that these were not simply interruptions, Ferrara measured the latched time marked by the equal sign (=) and found that it was 0.2 seconds. Existing research on the management of turns (Ford & Thompson, 1996) suggests that the minimal noticeable pause that indicates intonationally complete units is 0.3 seconds long. Thus, Gerald's utterance above could not be perceived as complete. On the other hand, it is not cut off because Wilma starts her utterance after the pause and aligns it syntactically with that of Gerald's. The convergent nature of the utterance extension "a negative way" and the immediate appearance of it suggest that it can be treated as a joint production, and not as an interruption, which is most likely to function as a tool to take the turn or redirect the topic (Ferrara, 1994, p.154).

Recordings are CA's primary data. They are transcribed following a transcription system initially developed by Jefferson (2004; 1974). A notation was given in order to capture all possible nuances of the spoken speech, from pauses to pitch contours. The details were represented, for example with symbols for silence, laughter, sighs, hesitations, coughs, overlapping talk, emphasis, intonation, timing, audible inhalation or exhalation, to name just a few. There are also symbols for body behaviour — gaze, gesture, and others.

Another aspect of CA methodology is its action-focused nature. The goal is to recognize practices or devices carrying meaning and indicating action (Drew & Heritage, 2006). Drew and Heritage (2006) list four basic characteristics of talk in interaction, which are essential in analyzing data. These are turn-taking, turn design or construction, sequence and sequence organization, and action. Regardless of the data, CA begins with observation on the construction of turns, as well as building bigger chunks and sequences. The relationship between turns and responsiveness is also analyzed. Finally, the actions that those turns exemplify are examined, that is, how the participants conduct social actions in a conversation.

The analysis in this study will concentrate on the linguistic realization of elicitation and rapport. Based on preliminary observations of the data, four features stood out as the

most salient linguistic tools for expressing the two phenomena. *Elicitation* is best characterized by questions, but also by backchannels, while *rapport* is created by the use of joint productions and repetitions. The exploration of *elicitation* and *rapport* through these features has the potential to reveal first, how and to what extent participants exert control over the emerging discourse and second, how they take part in the co-creation of knowledge.

3.1. Corpus

The data for the present study comprises nine recorded sessions between two alternative medicine doctors and their patients, all of whom are native speakers of English, born or raised in Vancouver (Table 4). I use pseudonyms for both doctors and patients in the present study.

Table 4 Data collection

Doctor	Women	Men	Total
Franca	1	2	3
Erika	5	1	6
			9

The sessions were recorded by each doctor and lasted between 25 and 60 minutes. That resulted in 4 hours and 38 minutes total recorded time. I, as a researcher, was not present at the sessions.

Since I was interested in understanding how participants use linguistic tools in the context of alternative medicine, I built a transcribed corpus of 5,378 turns and 3,139 units of analysis total, for all dyadic conversations. Once made, transcriptions provided a quick access to conversational episodes for examination. CA is a qualitative approach to language, which emphasizes the sequential features of talk. Thus, it became essential for me to represent an accurate sequential production of talk-in-interaction in my transcribed material as much as possible. My transcription included conventions that assisted in detecting interactional details related to overlaps, laughs, latching, intonation contours, emphasis, and repetition. The utterances were manually annotated in Microsoft Excel 2010. This was a fairly time-consuming process because, as ten Have points out, “what an utterance ‘means’ and what it ‘does’ is not fixed; ... but it is liable to be negotiated in utterances following it” (ten Have, 1999, p.4) That is why I had to frequently go back and

reassess certain utterances. My annotation system included a drop-down menu with 21 labels (see Appendix) which made the corpus searchable for counting occurrences and frequencies.

3.2. Structural organization

As mentioned in Section 2.4.2, Heritage and Claymann (2010) suggest several levels on which “institutionality” can be observed. One of them is the overall structural organization of the interaction. In order to understand how conversation is organized, I analyzed audio recorded sessions with patients. The medical visit is different from other institutional encounters in one respect, that there is no overhearing audience (as in court or a classroom). What is happening during a visit is that a layperson (patient) seeks help for health problems from a health care professional (alternative doctor). The visit exhibits a cultural “ideal sequence” which defines it as a particular genre, that of a medical interview (ten Have, 1989). The sequence of primary care visits described in Byrne and Long (1976) and ten Have (1989) consists of opening, problem presentation, data gathering (history taking and physical examination), diagnosis, treatment, and closing stages. Here, I give an overview of the stages found in a prototypical alternative medicine visit. I follow Martin’s definition (see 2.1.4) in its attempt to distinguish stages with corresponding purposes and functions oriented to the accomplishments of a particular task. Later in Chapter 4, I will describe stages from the Systemic Functional Linguistics (SFL) perspective in more detail.

The visit could be portrayed as a task-oriented dialogue where participants have specific goals and agendas requiring an exchange of information and a treatment (Eggins & Slade, 1997; Taboada, 2004a). The goal of the naturopathic doctor is to gather relevant information about the patients’ ailment, lifestyle habits, and patients’ personality in order to match it to a remedy (in the case of homeopathy); to alleviate discomfort; to provide a safe place to talk and eventually, to come up with an accurate diagnosis. Included in the naturopathic doctor’s agenda is to advise patients on how to make healthier choices and therefore, how to empower them. The goal of the patient, on the other hand, is to receive workable solutions for their health issues from an alternative medicine professional. Ideally, during each stage of the visit, these goals gets accomplished.

The content of the stages is influenced by the premises of holism. Holistic practices take the view that the body, mind and spirit of a whole person originate in a broader context — that of family, neighbourhood, community, culture, and society (Adams, 2010b; Stone & Katz, 2005). An example of a holistic approach is described by Adams (2010a). A patient with symptoms of depression will be asked about the circumstances in which they become stressed. They will be also invited to tell how these circumstances affect their family and work, and how they feel about managing the stress and preventing themselves from becoming depressed (Adams, 2010a, p.46). Adams goes on to comment that the doctor not only looks at the connectedness between the factors, but provides a simple cause and effect explanation. In doing that, they recognize the complexity of the relationship and take into account the personality of the patient (Adams, 2010a). Finally, the best treatment is discussed together with the likelihood of the patient to follow it.

During the *problem presentation* stage patients are given the opportunity to describe the physical symptoms and the emotional circumstances happening around the illness. An important aspect of alternative medicine is to provide a trustful environment in a fashion similar to psychotherapy. That includes ample time to predispose the patient to “openly tell their story without prejudice and judgement” (Adams, 2010a, p.223). During the *history taking* stage, the doctor gathers relevant information by asking questions so as to narrow down the possible directions for exploration of the problem and by providing careful and empathic listening. Allowing the patients to tell their narratives of illness and their meaning causes language to be not only a resource for interaction, but also the topic of conversation (Sarangi, 2001). In such a therapeutic setting, patient and doctor formulate through words the experience of pain (Sarangi, 2001). “Why me?”, “Why now?”, and “Why this particular illness?” are among the most universal questions that every individual probably asks themselves when suffering from illness. By going to see a medical doctor they want to find answers to these questions (Kelner, 2000). Good doctors recognize when it is hard for patients to communicate their problems. They would empathically use understanding remarks, emotionally supportive language, or other communicative strategies in order to elicit information and resume the narrative. Mitchell and Cormack call this stage “a first dimension of the healing act” (1998). It involves physical touch and intervention, but also mental treatment where “the patient and doctor communicate to alter the patients’ beliefs and ideas, as in various types of psychotherapy” (Buckman & Sabbagh, 1993, p.31). Next is the *diagnosis* stage. Particularly in homeopathy, the doctor

prescribes a remedy that corresponds closely to the patients' symptoms and personality. The closer the personality is to a remedy, the more profound the healing — the principle “like cures like” is the foundation of homeopathy (Stone & Katz, 2005). The *treatment* stage involves immediate therapeutic implementation and/or a discussion of future treatments. Depending on the healing modality, these may include acupuncture, prescribing homeopathic, naturopathic products, etc. It evolves as a collaborative process in which the doctor communicates their knowledge in a way that is meaningful to the patient. Together, they negotiate on the basis of wishes and expectations (Adams, 2010b, p.111). The key here is “negotiation”, which presupposes a partnership talk rather than a power talk. An important part of this stage is for the doctor to make sure that the patients are aware that they, too, are responsible for the successful outcome of the treatment. As alternative medicine sees the body-person as an active entity and capable of self-healing, the doctor therefore guides and facilitates the patient to discover the inner capacity of self-healing (Cassidy, 2006). After this point it is the patients' responsibility to undertake the necessary lifestyle changes (Stone & Katz, 2005).

The follow-up appointments are intended for review and evaluation of the symptoms. They might result in further intervention, refined assessment, or further review (Adams, 2010a). However, what is worth pointing out is the building of an ongoing dialogue between the two sides, based on consultation and sharing information (Kelner, 2000). Thus, the relationship often starts off as patient-oriented and gradually becomes relationship-oriented over time.

3.3. The doctors

An important goal of the present study is to obtain representative samples of naturally occurring speech in alternative medicine sessions a) with the maximum unobtrusiveness possible, b) without the presence of the researcher, and c) with high quality recordings. The phenomenon of the “observer's paradox” (Labov, 1972), where the observation of an event is influenced by the presence of the investigator, will be discussed in Section 3.6. The principle behind the selection of doctors was that they were experienced and had established reputations. My justification for this choice is that experienced alternative medicine doctors would demonstrate more stable language patterns built throughout the years, whereas novice doctors are more likely to be in a

process of establishing a communicative style and experimenting with various forms of language use.

The naturopathic doctors were recruited from my network of friends through the “friend of a friend” method (Milroy, 1987). I will use their pseudonyms to avoid confusion. The first whom I contacted, Franca, was a naturopathic doctor I visited twelve years ago. I briefly explained my goals to her. Franca has extensive experience of 27 years in acute care hospital settings working with terminally ill children, followed by over 12 years of experience in alternative medicine. Obtaining the participation of the second naturopathic doctor, Erika, was possible thanks to Franca. I went through the forms and reassured her that the confidentiality of the participants was strictly secured as described in the ethics approval for the study through Simon Fraser University’s Office of Research Ethics. Erika was an experienced homeopathic doctor with over 25 years of experience and successfully maintained her own private practice.

Developing communication skills was a professional requirement for both naturopathic doctors in their programs. I am not able to draw any conclusions on the degree of criteria standardization across the different schools, because communication curricula vary greatly in content, as well as in duration and objectives across medical schools (Roter & Hall, 2004). Boucher Institute of Naturopathic Medicine, the second medical school from which Franca graduated, offered courses such as Naturopathic counseling. The focus of this course was on relationship building and developing clinical rapport with patients applying the principles of patient-centredness paradigm. In our initial meetings she mentioned that communication skills were emphasized in every course, but most importantly during the hours of clinical practice. She was also exposed to motivational interviewing before she completed 1,200 hours of clinical training. The other physician, Erika, also received two degrees from two different schools — International College of Traditional Chinese Medicine and Vancouver Academy of Homeopathy. In the first one there was no course specifically designed for teaching communication skills. In the second, however, there was such a course, the focus of which was on communication skills for the health care professional. Some of the topics included verbal and non-verbal communication, therapeutic communication, listening skills and paraphrasing of patient’s words, providing empathy and how to understand the patient. Although I cannot confidently state that these courses influenced their approach, it is quite likely that the

structural organization and the characteristics that we see in the sessions arise from both direct instruction and their own experience as alternative medicine doctors.

3.4. The patients

The patients who agreed to participate had two things in common. First was the willingness and courage to share their problems with me as a researcher. Second was the fact that they have known their doctor for at least a year.

Recruitment was on a voluntary basis and performed by the doctors. Patients were informed that the researcher's study was about communication patterns in alternative medicine. Each patient was provided with a consent form to sign at the beginning of the session. The consent forms, including their wording, were approved by Simon Fraser University's Office of Research Ethics. The patients were given the chance to withdraw at any time during the recording. They could also withdraw after the session was over. The confidentiality of the data was guaranteed by substituting their names with pseudonyms. They were also given the Simon Fraser University Office of Research Ethics' contact information in case of any concerns or complaints. I did not provide any monetary incentive in return, but all participants have the option to obtain a copy of the results of the study.

The data is limited in size due to several reasons. First is the source of the data. It is not unusual practice for a doctoral student to be able to use corpora for their dissertation which is the intellectual property of another researcher at the same institution. A large sample, ideally, would have been a powerful tool to make substantiated claims about the observed interactions. That is why I approached a researcher at the Psychology department, who I knew had collected a big audio-recorded corpus of at least 240 audiotaped sessions. I sent a request and asked for a permission to use part the corpus for my thesis. I explained the purpose of my research and provided all necessary information. Disappointingly, I had no reply. As I could not find another researcher who had discourse data from medical encounters, I proceeded with collecting my own data. That happened in two ways. I had written an official a letter in which I explained my research and gave all the information needed for verifying the credibility of my request. Then, I personally went to the offices of the alternative medicine physicians that I found from BCNA (British Columbia Naturopathic Association), met personally with the doctors, or left the letter in case the doctors were with patients. A few agreed to participate in my

research, but then it was their patients who were not willing to share their sessions with a third party. The second way, as I mentioned earlier, was the sociolinguistic “friend of a friend” approach which, despite of all the benefits, could not provide such a large number of sessions. This is how I reached Erika and Franca.

Second, securing permission from patients is what took most of my time and energy in the data gathering process. I had to take into consideration the fact that many patients felt sensitive about the issues discussed during the visits. It is the confidential nature of health and emotional concerns that made them reluctant to give permission. There were also a few patients who withdrew their signed consent form after the visit took place. And third, I aimed for native or near-native speakers of English. Different levels of mastering English could have led to misunderstandings, let alone cultural differences in communication. All these obstacles prevented me from acquiring more audio-recorded sessions.

Still, it was a rewarding process and I am grateful to all participants who decided to share their personal health and emotional problems for the cause of this thesis. The doctors used their own judgment in deciding which patients to approach because some patients were shyer than others and felt vulnerable being recorded. While this study cannot provide a larger sample and make robust generalizations, it nevertheless offers a glimpse at the ways of speaking in a context, that has not been linguistically explored before.

3.5. Time and setting for the data collection

3.5.1. Time

I collected the nine sessions over a period of one year. One disadvantage was that both doctors were in-high-demand specialists and had contracts, workshops, and presentations in other parts of the country, which required them to travel a lot. The other obstacle was the permission of the patients, and a third challenge was that there were quite a few cases of cancelled recordings due to uncharged batteries.

3.5.2. Setting

Labov (1972) observed that setting is a significant factor that affects speech, and this is especially true in the context of a medical visit. The types of the locations used in the data collection are similar and I provide a description of them below.

Since both doctors maintain their own private practices, the sessions took place at their offices. They were both located in professional buildings in Vancouver. The offices were furnished with leather couches and examining bed-tables with accompanying medical equipment and blankets. Both places had doctors' diplomas on the walls. The offices were small and sound-proof rooms with solid doors, the concern being to keep the privacy of the sessions from the outside reception area and the neighbouring offices. This allowed for a very high quality of recordings and minimum ambient noise. Occasionally, there was quiet, mellow music in the background. During the sessions, doctors took notes on paper that were later added to the patients' personal files. They were in binders placed on bookshelves. In Franca's case these were in her office and in Erica's case they were in a bigger office next to hers which was occupied by a colleague with whom she shared the location. In both offices there was a free space of approximately one meter between the doctor and the patient.

Franca's office was windowless yet cozy. There was a bookshelf with supplements and medical supplies. Next to one of the walls there was a table with an equipment for laser therapy. There was a little space on the table where Franca could write and keep her personal belongings such as phone and keys. This is where she normally placed the recorder. The walls in her office were coloured in light beige. Hung on the wall across from the bed/examining table there was an Impressionist painting in warm colors. Franca sat on a saddle type dark brown leather chair.

Erica's office was also small but unlike Franca's, had a big floor-to-ceiling window. Next to it there was a white bookshelf with medical supplies. An educational poster of the human body acupuncture points hung on the wall beside it. Since the office was on the 6th floor of a professional building, one could see the back yard with tall colorful trees. Erica kept her tablet on the sofa and played chillout music from it during treatments. The walls were painted in light brown. Above the sofa hung a large Chinese Buddhist painting in earthy colors. There was no computer in the office. Like Franca, Erica took notes on paper

while seated on a similar chair. When she had to record a session, she would pull out a small movable table and put the recorder.

At the time of the data collection I used high-quality recording equipment such as the Edirol/Roland R-09HR WAVE/MP3 recorder. It is portable, relatively small in size, easy to operate, and makes exceptional quality recordings. The doctors were given thorough instructions on how to use it with the settings I had previously set. To ensure that the doctors were comfortable with the recorder and would know what to do if something went wrong, I asked them to practice with one or two short recordings.

3.6. The “observer’s paradox”

The term “observer’s paradox” refers to the problem of observing “how people talk when they are not being systematically observed” (Labov, 1972 p.209).

In this sense, the presence of a recording device theoretically increased the risk of gathering less natural data from participants. I discussed with each doctor the best place in the room to put the recorder so that it would be less conspicuous. Because of the small size, the recorder was relatively unobtrusive and was usually placed on a table between the doctor and the patient. Thus, even when not in full view, it was able to record both voices well. In both offices the tables were between the doctor and the patient but not centrally positioned. They were on one side, yet close to the interlocutors, and they did not obstruct the view between the doctors and their patients.

It is widely accepted that the “observer’s paradox” can never be fully overcome, but its effects can be drastically minimized (Ferrara, 1994; Labov, 1972, 1984; Schiffrin, 1985; Tannen, 1984). There were three ways related to the present research that had the opportunity to contribute to the reduction of the “observer’s paradox”. First, the collection of natural speech is most likely to occur when the researcher is not the main addressee (Labov, 1978). “Researcher as audience” (Wilson, 1987) brings the risk of leading the communicative process in unwanted directions just by the virtue of being present where speakers feel judged and assessed. In consideration of this, I, as a researcher, was not present at the sessions with the patients. The benefits of this decision were twofold. One it allowed for objectivity, and second, it allowed for a greater replicability. Analyzing interactions of people who are not known to the researcher triggers different types of

interactions. The fact that I, as a researcher, am not part of the participants' social networks, promotes an analysis that is not affected by ongoing social relationships. Thus, recording interactions in which I have a non-participant status increases the chances for objectivity. As to the replicability aspect, I believe that two or more researchers might reach very similar conclusions looking at the same data to which they were not parties.

Second, Labov (1972) and Tannen (1984) noticed that conversationalists who were highly involved in a discourse tended to be less aware of the recorder. Stories that involve strong emotions such as those experienced in danger situations, illnesses, or painful memories, brought a lesser degree of self-consciousness about the speech allowing a more casual style to occur. Third, Milroy (1987) made the suggestion that the conscious behaviour about being recorded had been strong at the beginning of the recording. My speculation was that the longer the recording, the greater the chance that speakers would "forget" about the recorder and would use more natural speech. The alternative medicine sessions last between 25 and 60 minutes, rarely longer. Because of these lengths of time it was plausible then that speakers would become less conscious of being recorded.

3.7. Analytical techniques

In analyzing discourse in spoken language, researchers often return many times to data recording, to make corrections or to find something that was overlooked. It is a continuous process of discovery because our attention is selective about different features or patterns at different times (Ferrara, 1988). Usually, audio recordings are transformed into transcripts that become the main basis for analysis. Upon receiving recordings from a doctor, I would first start to listen to them one by one, from beginning to end. This helped me to get an idea of how the sessions were overall structured in terms of stages and whether the structure was different for each or some of the patients. I observed how the method of treatment and the specific health complaint shaped the way the session would unfold. As I listened, I made rough transcriptions that were reworked many times for correctness. Then I would start marking pauses, laughs, and overlaps. At the beginning I was not able to tell what exactly to explore, what was so prominent and unique for this type of situated language use. As I listened to the conversations more and more, however, I became aware of the recurring patterns and the features that could be worth exploring.

3.8. Transcription conventions

For the present study I use a version of the transcription conventions originally developed by Sacks, et al. (1974) and slightly modified by Ferrara (1994). The conventions can be found in the beginning of this dissertation (p. xiii).

3.9. Ethical considerations

This research was conducted under the permission of the Simon Fraser Research Ethics Board. Participants (both patients and doctors) are free to obtain any information on this study or address any issues regarding it by contacting the director of the Ethics Board. Protection of anonymity was secured by using pseudonyms and archiving the data in a secure location. As a researcher, I will provide the results of the study to any of the participants upon their request. Five of them have expressed interest in the results of the work.

3.10. Coding

As it was seen from my research questions, I am interested in how speech acts and backchannels invoke elicitation and how joint productions and repetitions assist in building rapport. In order to investigate this, I categorized the phenomena of interest according to the following coding scheme.

3.10.1. Elicitation

The demand for information during *problem presentation*, *medical history taking*, and *physical examination* mainly happens through elicitation. *Elicitation* is one of the core discourse events observed in a medical session — both in mainstream and alternative medicine. The aim is to gather information that will help to identify an accurate diagnosis and best treatment for the patient.

Based on the existing literature (Maynard & Heritage, 2005; Peräkylä et al., 2008a; Silverman, D., 1987; Tannen & Wallat, 1986) I propose that *elicitation* is happening through:

1. performance of certain speech acts
2. backchannels

1. Performance of speech acts

For the selection of speech acts appropriate for the information gathering process in the area of an alternative medicine session, I took into consideration a few classifications. It took into account the illocutionary force and the linguistic form of the utterance (Searle, 1969), based on which direct and indirect speech acts were differentiated. Felicity conditions and type of rules applied to question and request (Searle, 1969) underlie the composition of the demanding information component in the local structure. More specifically, based on the similarity of preparatory, sincerity, and essential conditions in the two rules, I decided to include both “question” and “request” as instances of demanding information. An additional source of help as to how to classify speech acts and design the local structure, was Martin and Rose’s outline of speech functions (Martin & Rose, 2003).

Speech acts in the *problem presentation, history taking, and physical examination* stages in the alternative medicine session that reflect elicitation are the following. Demanding information is performed by both doctors and patients, and it is usually followed by providing the required information. It takes various forms, the most frequent of which is a *question*. Questions are classified according to syntactic (word order) and prosodic features (intonation) as well as a projected response. The following main groups are identified and analyzed in Chapter 5:

1. Open questions or Wh-Questions: What happened?
2. Closed questions:
 - a. polar: Do you have the food combining sheet?
 - b. close-ended: When was your last visit?
 - c. alternative: Do you want first this or do you want me to tone you up?
 - d. tag: It’s nice, isn’t it?
 - e. declarative: You get any time off for the holidays. (rising intonation)
 - f. elliptical: Anything else?

The grouping of questions took into consideration the classifications found in Tsui (1992) and Quirk et al. (1985). Particularly, Quirk et al. defined questions as a semantic

class that look for information and receive three types of answers: affirmation/negation, wh-questions or alternative questions. However, Tsui also took into consideration their grammatical form, therefore, this characteristic will also inform the analysis.

2. Backchannels

The analysis is concerned with non-lexical verbal backchannels and their uses in eliciting information. This does not exclude some other functions that they possibly demonstrate simultaneously, such as agreement or acknowledgement. I will provide evidence of how they function as an elicitation device. Following Yngve's (1970) and Eldesky's (1981) notions of a turn, the backchannels that I will analyze would not be treated as instances of turns and would not be considered as an initiation of taking the floor.

There is abundance of backchannels performed in the data set demonstrating various discourse functions. The focus of my analysis is on the backchannel tokens with the highest number — *mm-hm* and *yeah*. Other types of backchannels also found in the data and were lexical items such as *Great! Wonderful! I hear ya*, but they are beyond the scope of this research and will require a different study.

3.10.2. Rapport

Joint productions

Joint productions are jointly constructed utterances where one speaker initiates a proposition and another completes it semantically and syntactically. Instances that were coded as joint productions are exemplified in lines 2 and 3:

Example 6

- | | | |
|---|----------|---|
| 1 | Shelley: | And I was noticing it here. I still feel it there. My elbows, my... OK, |
| 2 | | alright, yeah... Did a great job but... = |
| 3 | Erika: | = you feel it. |
| 4 | Shelley: | Yeah. With that I noticed I know why that happened. |

In the following analysis joint productions will be treated differently from interruptions, which occur independently and have no syntactic or semantic alignment with the first speaker's proposition.

Repetitions

Repetitions were coded following Ferrara's (1994) terms: *echoing and mirroring*. *Echoing* type of repetitions are repetitions of doctor's utterances *by the patient*. These types of rejoinders are clausal rather than phrasal and repeat immediate discourse. They are pronounced with downward intonation and serve as an emphatic agreement. An example of how I coded an *echoing* repetition is in lines 3 and 4:

Example 7

- 1 Erika: You are all set for the holidays? Set as you can be?
- 2 Ingrid: Very.
- 3 Erika: **You lay low.**
- 4 Ingrid: Yeah, I **lay low**.
- 5 Erika: OK
- 6 Ingrid: Very low key and... in some ways I don't know if that's really because
- 7 In... in a way like no effort.

I ignored cases where the repetition was part of an answer to an alternative question. That is why cases like Example 8 were excluded.

Example 8

- 1 Erika: Is it the legs too or just the arms?
- 2 Tom: Just the arms. Sometimes the feet.
- 3 Erika: Yes, that's classical stuff. Sometimes feet get cold.

However, I included uses of repetitions when they were repetitive of a question:

Example 9

- 1 Erika: So, if you can change anything in your life right now, instead of the
- 2 pain, that's the obvious, what [would you do?]
- 3 Shelley: [what would I] do?
- 4 Erika: Yeah.
- 5 Shelley: Change July nineteenth when this happened.

Mirroring type of repetitions — partial repetitions of patient's statement by the *doctor* are demonstrated below:

Example 10

- 1 Erika: And are you feeling like crap or are you've been feeling well? Tell me
- 2 about it.
- 3 Christie: **I'm really good but really *dry*.**
- 4 Erika: **You feel *dry*.** Ok.

In this chapter I laid out my methodological approach. That included description of the corpus, participants, and settings as well as the coding procedure for the linguistic features that realize elicitation and rapport. Now I will proceed with the generic analysis and show what stages and lexico-grammatical features characterize the sessions in the data set.

Chapter 4.

Generic structure

By now, I have provided the theoretical foundation of the study and have described the methodological tools for carrying out the CA analysis that follows in Chapter 5. In Chapter 2 I briefly introduced the concept of genre. I consider a genre analysis of the dialogues to be instrumental for broadening the scope of the thesis. Therefore, I now present a generic analysis of the sessions which is informed by SFL framework.

I mentioned in 2.1.4 that the working definition of genre in this thesis is based on Martin's definition who defines genre as a purposive activity organized in stages. The genre analysis here reveals how doctor and patient achieve their goals across stages and how each of the stages exhibits distinct language patterns that are connected to the function of the stage. I show how this is achieved by providing an overview of the functions and the linguistic features of each stage of the visits from an SFL perspective. I discuss the structural characteristics and the ways through which the participants achieve their goals during the institutional interaction. The genre analysis follows the steps outlined by Eggins and Slade (1997). A general discussion of the findings is provided in reference to the generic staging where I also reflect on two aspects of the *diagnosis* stage: optionality and embedding.

As mentioned in 3.3, both doctors have received training in communication for medical purposes. The feedback that I received from both of them via personal communication revealed that during these courses, there was an emphasis on developing clinical rapport with the patients, as well as on applying the principles of patient-centredness. The structural organization, that is, the stages of the visits, is influenced by both the communication frameworks in which the doctors were trained, and their own experience as alternative medicine practitioners.

I take an SFL approach to genre to investigate the sessions. The analysis will be concerned with the purpose and the task of a face-to-face interaction, together with the linguistic features that realize them. The approach has been useful in studies of other institutional contexts. In the field of education, genre has been examined as a purposive and staged activity that has been influenced by culture (Christie & Martin, 1997; Christie

& Unsworth, 2005; Hasan & Martin, 1989). Christie (1997), for example, examined how pedagogic subject positions are expressed through curriculum genres in school. In the area of technology and manufacture, Rose (1997) demonstrated the effective application of text staging in technological explanations in science disciplines. A genre approach has been successfully applied in business and commerce, specifically, in analyzing service encounters (Taboada, 2004b; Ventola, 1987). Another institutional area is that of law where different types of discourse have been shown to exhibit particular and well-defined stages (Chik, 2018; Moore & Tuckwell, 2006). Medical encounters, in particular, are object of interest for researchers applying the SFL genre approach. Halliday (1978) was one of the first to describe the generic structure of the medical consultation. His analysis is based on a single text in which he defines the following stages: “opening”, “investigation”, “examination”, “diagnosis”, and “suggested treatment” (comprising “negotiation” and “reassurance”). (Tebble, 1999, 2014) examines the dynamics in healthcare interpreting. Tebble draws attention to the importance of interpersonal elements in the interpretation (Tebble, 1999). She identifies 11 generic stages of interpreted consultations where the exposition stage is the culmination. This is the stage where the physician provides diagnostic findings and sets up future action. She concludes that the manifestation of this stage depends on contextual features and it is crucial how accurately interpreters “read” the physician’s consulting style. Another study in the area of clinical settings is that by Asp and de Villiers (2010). The authors integrate the SFL approach with other theoretical frameworks in order to explore language and context in clinics. A detailed generic analysis in the area of medical education and training is presented in Pryor and Woodward-Kron’s (2014). The researchers have examined the generic structure and language features of intra-professional telephone calls of junior doctors who seek assistance from senior doctors. They have found that not all calls were effective and that the success or failure of accomplishing a successful call depends on variables that are institutional, professional, and situational in nature.

The SFL framework seems suitable for the analysis that follows as it links special-purpose discourse with language in context. It examines linguistic systems as influenced by culture and situation of use (Eggins & Slade, 1997; Halliday & Hasan, 1976), which is relevant in the present data set. In my analysis, I draw on the notion of Generic Structure Potential (GSP) developed by Hasan (Hasan, 1978, 1996) which refers to an abstract representation of the elements of a genre. Hasan maintains that GSP varies according to

social contexts which determine the range of structural configurations of elements. The GSP also accounts for the presence and absence of optional stages, and for the sequential order of both optional and obligatory stages. The other research that informs the present analysis is that of Martin (1984) and Eggins and Slade (1997). In developing the structural formula of the visits, I followed the 6 steps outlined by Eggins and Slade (1997:230-235) in their algorithm for doing generic structure analysis. These are (1) recognition of a chunk of talk that appears to move through predictable stages; (2) identification of the social purpose of the chunk and labeling the genre; (3) differentiation of the genre stages; (4) identification of obligatory and optional stages; (5) generation of a structural formula; and (6) an analysis of semantic and lexico-grammatical features of each stage (1997 p.230-235). Eggins and Slade's genre analysis is relevant to the present data because the interaction between the alternative medicine doctors and their patients seems to unfold in predictable stages dictated by the global purpose of the institutional interaction.

Stages are delineated along the general division of *beginning*, *middle*, and *end* components. These have been found to constitute the majority of casual conversations (Eggins, 1994; Stenström, 1994, 1999) and task-oriented conversations (Ventola, 1987), among others. The identification of the boundaries between stages is also helped by certain grammatical structures that, on analysis, turn out to be representative for each stage. In my exploration, I will point out lexico-grammatical features pertaining to interpersonal meaning (Ventola, 1987), that is, related to discourse and semantics. In the process, I will follow Eggins and Slade's analysis of appraisal who defined it as "attitudinal colouring of talk along the range of dimensions including certainty, emotional response, social evaluation, and intensity" (Eggins & Slade, 1997 p. 124). I will focus on the two dimensions that I consider well presented in the data – appraisal and involvement. I will make a reference to the linguistic realizations of their subtypes, namely, appreciation and affect for appraisal, and naming and technicality for involvement.

In doing the generic analysis, I followed the procedures described below. The first task was to arrive at a structural formula that best represents instances of the genre (Taboada, 2004b p.33). In order to do that, I defined the overall social function of the genre. In the present case, the social function that the texts fulfill is that of assisting a lay person with a health problem. Next, I assigned the functional label – a medical visit. This was based on the observation of the social activities took place during the speech event: complaining

about health, inquiring about the history of the problem, reporting on symptoms, performing physical examination, recommending action or remedy, etc. After identifying the social purpose and labeling the genre, I proceeded with dividing each session into three main parts – beginning, middle, and end. Then, I broke down the middle part into its constituent stages by looking at what each stage was doing in relation to the whole. I took into consideration the interactional nature of the dialogues by looking at how the doctor and the patient achieve their goals collaboratively. This resulted in defining the functional label of each stage: *problem presentation*, *history taking*, *diagnosis*, and *treatment*. The next step was to identify obligatory and optional stages within the genre. According to Hasan (Hasan, 1978, 1996) obligatory stages are the ones that make the genre recognizable, while optional stages can occur across genres and respectively, are not genre defining. I analyzed all texts in terms of these two types and observed the sequential order and recurrence of the stages. After those initial steps, I was ready to design the structural formula that describes the genre. By using notation developed by Halliday and Hasan (1980), Ventola (1987), and Taboada (2004b), I placed the stages in the order in which they occurred, and accounted for repetitive and embedded elements.

The second task was to analyze the semantic and lexico-grammatical features for each stage. As Eggins and Slade (1997 p.235) point out in regard to this last step of the generic analysis, the process does not imply that each stage has unique lexico-grammatical structures. Rather, each stage employs different configurations of lexis and grammar corresponding to the task.

Figure 5 shows the global structure of the stages. Dotted lines indicate that the diagnosis, *physical examination* and *treatment* might be optional, particularly in the case of a follow-up visit when the patient presents a recurrent problem. I will refer to this representation in the analysis that follows.

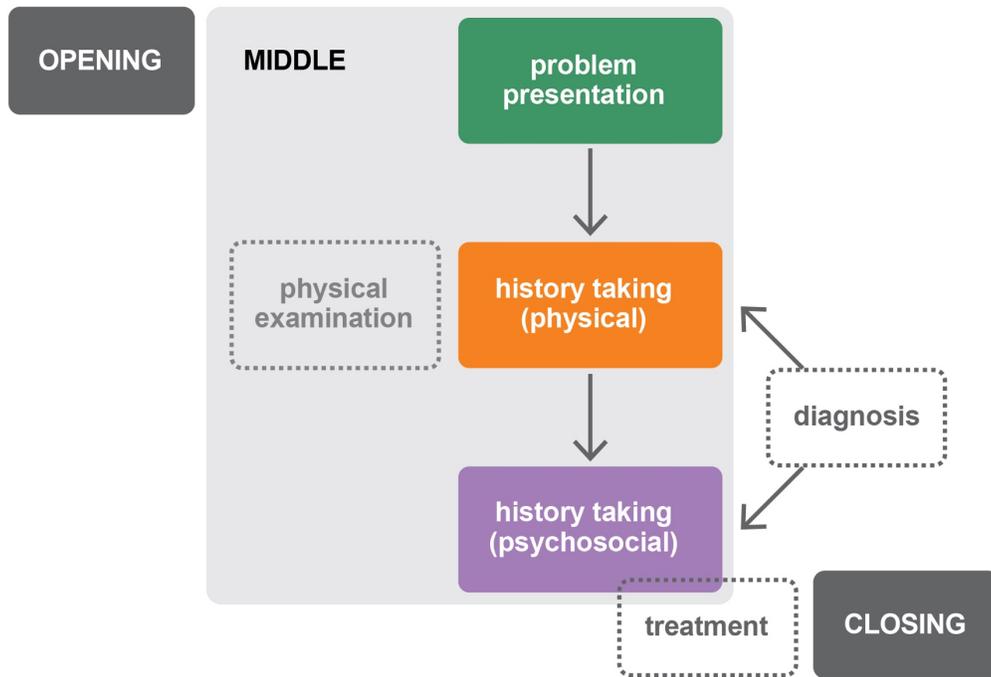


Figure 5 Global structure

Having described the methodological steps in my analysis, I now provide a short overview of the main lexico-grammatical features characterizing each stage of a session that exhibits the “ideal” sequence (ten Have, 1989). The session reveals the presence of all stages, realized in a linear order. In doing this, I share observations on these features across the rest of the conversations in the data set.

This is the session between Franca and her patient Kate, a breastfeeding mother suffering from insomnia. It is one of the cases where patients were asked to participate just before the session begins. They were first introduced to the purpose of the study and were asked whether they would participate. If they agree, the doctor would give the consent form to be signed. After this procedure the recording begins and the *opening* stage usually starts with organizational remarks: “Testing, one, two, three...”, “It’s testing”, “And now we are recording”, etc. In this case the conversation starts with Franca’s remark: “So... this is going to be a recording on you, Kate, so I hope it’s recording.” That explains the lack of greetings as they were performed prior to the recording.

There are other cases where patients had previously agreed to participate, signed the consent form and had been informed that the session would be recorded. So the recording started the moment they entered the room at the day of their visit. The *opening* stage of

those sessions consists of formulaic expressions such as greetings: “How have you been?”, “How are you?”, or “How are you doing?”. It varies in length. It can include only greetings or organizational remarks, but also casual, friendly remarks such as terms of endearment and pleasantries. It can therefore span more than 10 turns. Examples of terms of endearment and pleasantries include: “OK, lovely Shelley”, “We’ve got a 29-year old guapa here”, “Your birthday is coming, Ides of March boy”, “Oh, I like the booties, they look solid”. A subcategory of the dimension involvement, the vocatives, suggest positive affect on the addressee. The compliment on the booties is a form of appreciation, realized with the verbal construction “I like” and then the adjective “solid”. Both vocatives and the compliment perform positive politeness strategies which, according to Brown and Levinson (1987), are solidarity oriented. In general, deciding what is considered polite entails that the speakers assess the social distance between them. In the case of the terms of endearment, the doctor uses good-humored references in a playful manner. She calls the patient “guapa” (“beauty” in Spanish), referring to her Latin-American origin, and the other patient “Ides of March boy”, knowing that his birthday is on March 15th. Such instances assert not only shared knowledge, but also a certain degree of solidarity and decreased social distance. Based on these assets, the doctor allows herself to tease the patients when addressing them. The *opening* stage fulfills a social purpose — to initiate a connection with the interlocutor, as well as a practical purpose — to set forth the session. I consider the *opening* stage to be from the beginning of the session till any remark initiated by the doctor that directs the conversation to the patient’s problem. Such redirection indicates that a new stage has begun, that of the *problem presentation*.

The *closing* stage begins with the doctor announcing the end of the session. Typically, the end of the session is when the treatment is over and when the doctor turns the recorder off. Franca announces it to Kate with: “Now I’m gonna actually stop this”. In five of the sessions, the end of the stage was the moment at which the patient was left to relax alone in the room with acupuncture treatment: “I’m going to let you relax”. Lastly, there were two sessions lacking the closing part due to the battery dying. Having said that, *closing* is an optional element of the session in this particular data set. It includes only a couple of utterances that fulfill a practical purpose, that is, to announce the end of the service, both as a consultation and a treatment. Except for one session, there are no recorded farewells as the doctor had stopped the recording. I suppose that the social exchanges took place

after the recorder was off and when the patients proceeded to the front desk to make payments for the service.

Now I will turn to the *middle* stage which contains several substages: *problem presentation*, *data gathering (history taking and physical examination)*, *diagnosis*, and *treatment*. As mentioned above, the *problem presentation* is initiated by the doctor. Stenström (1994 p.22) suggests that a dialogue can be initiated through three main channels: by proposing an action, by submitting an observation, or by asking for information. I observed all three initiation channels in the data. For example, Franca opens up the stage by proposing an action using imperative mood: "Tell me a little bit what's been going on with you." Examples from other sessions include: "Talk to me", "So, now tell me what's happening", "You can tell me what is happening". West (1990) assigns the last one the status of "imbedded" imperative as it embeds the modal "can" in otherwise explicit command. This embedding somehow downgrades the explicit command to a request. (p. 97). The onset of the stage can also be performed by submitting an observation in the form of a statement with the illocutionary force of a question: "So, you are walking a bit better, but you are still limping." Finally, the onset can be realized by asking for information in the form of a question: "How is your hip?" I further elaborate on this opening question later in the chapter.

In 8 out of 9 sessions the *problem presentation* stage is initiated by the doctor. Only in one session, that with Martin, is it introduced by the patient. Franca greets Martin with: "How have you been?" which is part of the *opening* stage. To this greeting Martin replies with two utterances that represent two distinct speech acts: "Good. I just came back from the oncologist". I consider the first utterance as a second-pair part of a greeting-greeting adjacency pair. However, I find the proposition "I just came back from the oncologist" to be initiating the *problem presentation* stage because what follows is a discussion about how the patient felt and what he experienced.

The problem presentation of an old problem results in a short complaint part that spans one or two utterances only: "I still have, I still have my pain in it"; "Yeah, it's still, it's still in there"; "I've still got that pain. When I get up after [...] seems down for a while and I'm limping around. It's kind of strange." The problem presentation of a new problem, however, unfolds over a longer narrative. It is recognized with the help of the following indicators. First, one of the speakers, in this case the patient, dominates the conversational floor and

is allowed to do so (Eggins & Slade, 1997 p.231). Second, the narrative consists of a detailed description of symptoms. Kate describes hers as: “I have difficulty falling back asleep after I fed [the baby]”; “there were a couple of nights where just created a little bit more anxiety.” These symptoms are accompanied by circumstantial information that includes action verbs in the past tense: *I had, I went, I took, I found, I was able, I started*. In providing the time sequence (Eggins & Slade, 1997), Kate also used highly affective language: “I was a bit **weepy** and I was **emotional**, just **overwhelmed, I think**”; “I started **feeling jealousy**”; “**I felt bad**”; “**I’m feeling** a little bit **more comfortable**.” In 7 of the sessions the patients expressed concerns about one major problem and only in two visits they expressed three.

The next stage, the *history taking*, starts when the patient has completed the narrative of the complaint. The completion point of their turn is signaled by a pause or a filler such as “yeah” with falling intonation. This creates a TRP where the other participant, the doctor, takes the floor by asking a question. This stage, in all sessions, is initiated by the doctor performing a request for information. The body of the stage is characterized by a question-answers series aiming to gather relevant information and is highly loaded with evaluation lexis (in bold below), uttered from both doctors and patients. Franca starts with asking how old Kate’s baby is now: “So, the baby is now two and a half months old?”. Other instances of questions include: “**Better** than before [the pain] or **just as bad**?”; “And for how long has this been going on?”; “So they [the hands] were **painful** too?”; “Did you do anything with the Arnica?”; “Is the **feeling heavy**? Or **just a real fatigue, just a real weakness**?”; “Is it your left side?”. The different types of questions and their answers can be found in the Appendix of the thesis and are further discussed in 5.1.2. Observations from the rest of the data showed that the evaluation language is expressed along the axis of affect where the linguistic realizations are adjectival (heavy, bad, better, real, painful, good, amazing, yummy), but also nouns (fatigue, weakness) and verbs forms (*boiling your blood, I didn’t like, bothered me, I feel, I’m stoked*). This stage is also heavily taxed with appreciation type lexis, especially when patients evaluate their experiences or make assessment of a state: “I’m not too concerned”; “I was really disappointed”; “It looks great”; “I don’t know”; “I initially thought”; “It’s neat”, It’s spectacular!”

The stage also includes repetitions performed both by doctors (Example 11) and patients (Example 12):

Example 11

- 1 Kate: Oh my god, never have had an IV before. Oh, yeah, in the hospital,
2 of course. *I had a C-section*, so...
3 Franca: ***You had a C-section?***
4 Kate: Uh-huh

Example 12

- 1 Franca: **So, it's actually interrupted.** (the sleep)
2 Kate: ***It's tOally interrupted***, yeah

Occasionally, the doctor would interpret a symptom by giving an explanation in lay medical language: "So, basically what is happening is your skin tries to get rid of stuff. One way of doing it is via the bowel movements or the urination way. Another is maybe detoxification via the skin." Instances of joint productions (discussed in detail in 5.3) are also performed here.

The *history taking* stage includes physical examination, if the case requires. Kate's health problem did not require Franca to check on anything, except her veins in order to apply an intravenous infusion of vitamins and minerals. In other sessions, the doctor checks the pulse and examines the tongue, or has a look at the extremities or the skin for problematic spots.

The next stage, that of providing a diagnosis, is naturally performed by the doctor. When it is a discernable stage, as in the session between Franca and Kate, it is realized as a statement presenting the main hypothesis and accompanied by some clinical reasoning, avoiding technical language. Based on the information provided by Kate, Franca hypothesizes that Kate's problem has to do with the depletion of vitamin Bs that supply the nervous system with the necessary elements to function properly. Similarly, in some of the other sessions, I observed diagnostic hypotheses such as: "It is a sign of liver congestion. I'm wondering in your case if there is, if the cystic ovary has anything to do with it [dry skin]". The technical language, or the degree of specialization with which conversational objects are talked about (Eggins & Slade, 1997 p.148), is restricted to commonsense medical lexis which is understandable without any special background on the subject. Eggins and Slade claim that the degree of technicality is indicative of the distribution of power in the situation. By restricting the medical jargon, doctors present

themselves as willing to involve the patient in the dialogue. The “expert” status is demonstrated in a less authoritative stance.

Next comes the *treatment* stage. It is announced by the doctors and often is followed by directives. Franca announces it by making suggestion: “So... why don’t we at least get going the IV and if we can squeeze...”. Other treatment initiation utterances include: “I’ll just get the needles ready and we shall begin”; “I’m gonna get you everything out and what I’m getting you to do is the usual ... so we will needle you up and kind of settle you down a bit”; “What I will get you to do... I’ll cover you with the blanket and then I will probably inject you”; “Alright, let’s get you to.... I wonder if I want you on your side or if I want you on your front”. While the patients lie down for the treatment, the doctors often continue the talk by discussing management plans and give rationale for the advice. Franca gives an advice that strongly implies an imperative tone: “I don’t want you to be reading them [social media web sites] at night...Because what you are doing now is you are reinforcing all those thoughts when you are going to sleep. Because whatever you do at night is going into your mind and it’s marinating your mind all night long”. The second advice that requires a future action from Kate is for her to take certain minerals. Lastly, Franca finishes her management plan suggestions with “And the other thing that I would definitely recommend for you to take is, probably the most important one, just for your overall mental health and just ... you feeling like, you know, you can cope with, is a B vitamin”. This stage contains the issuing of directives, mitigated and aggravated: “If you are going to do an iron supplement, do it before going to bed”; “Remember that there is a balance that you have to create. You have to be a little bit mindful of that.” The observations on the use of directives and technical language led me to conclude that the structural realization of the imperative mood is a strategy of linguistic construction of authority (Iedema, 1997), while avoiding technical language is considered an act of involvement.

Having recognized the chunks, identified and labeled the different stages, I will now turn my attention to the elements participating in the structural formula. On the basis of the 9 transcripts, I identified obligatory and optional stages. Following Eggins and Slade’s (1997 p.243) way of summarizing genre, purpose and stages for a given text, I present these as they apply to my data:

Genre: Medical (alternative medicine) visit
Purpose: Doctor: to assist with a health problem
Patient: to get assistance with a health problem

Stages: $Opening \wedge Problem\ presentation^n \wedge History\ taking \wedge (Diagnosis) \wedge Treatment \wedge (Closing)$.

As discussed in 3.2, the structural organization of a medical visit follows an ideal sequence of *opening*, *problem presentation*, *history taking*, *diagnosis*, *treatment*, *closing* (ten Have, 1989). As defined above, the formula reflects the dimensions of sequential order, optionality, reiteration, and embedding. The caret sign (^) marks sequence, parenthesis () indicate optional stages, reiteration is marked by a superscript *n* referring to any number of repetitions, and the arc arrow indicates embedding of an element (Halliday & Hasan, 1980; Taboada, 2004b; Ventola, 1987). The formula reads as follows: In the data set of alternative medicine sessions, the stages that have been identified are *opening*, *problem presentation*, *history taking*, *diagnosis*, *treatment* and *closing*. They are realized in linear order where *diagnosis* and *closing* exhibit optional status. The *problem presentation* can be reiterated and *diagnosis* stage can be embedded into *history taking* stage. *Physical examination* has been left out from the formula.

I want to discuss two aspects related to the *diagnosis* stage – optionality and embedding. In regards to optionality, the status of the *diagnosis* stage is a bit problematic. The formula defines it as an optional element. Indeed, the provision of diagnosis was not always present across the sessions. The *diagnosis* stage is considered an obligatory element of medical visits and Hasan(1996) maintains that obligatory elements are genre-defining. However, although this particular stage has not been observed in all sessions, the genre is similar to other medical genres and the conversation is fully functional. The analysis reveals that the nature of the complaint (i.e., the problem) determines the presence or absence of the *diagnosis* stage. If the patient presents a first-time problem, then the middle portion of the sessions unfolds in the following sequence: first-time problem – history taking – diagnosis – treatment. If the patient presents an old problem for which the diagnosis is already known to the doctor, then the sequence skips the *diagnosis* stage: old problem – history taking – treatment. It seems that the type of the problem (old vs. new) cannot be captured by the GSP. According to Ventola, a flow chart reflects better the dynamics of the sessions (Ventola, 1987). In our case, it also accounts for the variation between visits that deal with a new problem and visits that address an old problem. Figure 6 depicts a simplified flow of the middle section of the visits.

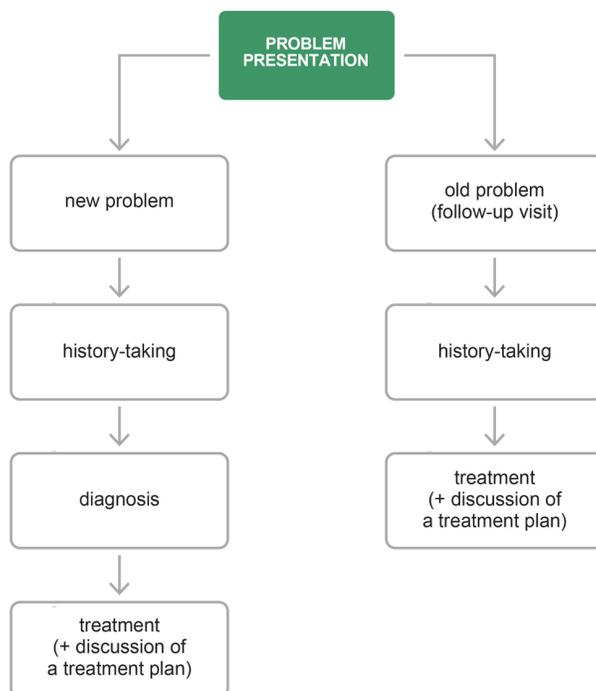


Figure 6 Sequence of stages defined by problem presentation

The problem type reflects a slight change in the context. Hasan defines context as a combination of different factors: the object of interaction or what is being discussed, the participants, and the medium of communication (audio or video). Following her approach, any change in the contextual configuration would result in distinct GSPs, in our case, one with *diagnosis* stage present and another with the stage absent. As a consequence, there are two different types of discourse, respectively, two different types of genres. Similarly to what Ventola found for her data from service encounters, I consider this not to be the case here because, first, the overall function of all sessions in the data sets is the same, and second, the linguistic realizations of the stages are similar to each other (Ventola, 1987).

The second aspect, the embedding, is related to the placement of the *diagnosis* stage in several of the sessions. The analysis showed that if the stage is not delineated, but not absent either, then it is embedded in *history taking* stage. Hasan (1978) states that the degree of mobility varies across sets of elements. In the present situation, the *diagnosis* stage mobility is “partial”, meaning that the stage is not a stand-alone unit moved in between elements, but rather, found within the boundaries of another element and realized in incremental fashion. I will now illustrate how this is happening by analyzing the session

between Franca and Richard, a professional athlete, who comes with a complaint of a painful hip after a treatment he received by Franca the previous week.

In regards to sequencing, the *opening* and *closing* stages are fixed. *Problem presentation* is immediately located after the *opening*, followed by the *history taking* stage. However, the latter contains elements of diagnostic hypothesis as well as treatment suggestions (Figure 5). In the session with Richard those stages unfold in the following way. After the realization of *opening* and *problem presentation* stages, Franca initiates the *history taking* stage with the question “How did you respond to the treatment?” and then the imperative “Tell me what happened in the first two days of the treatment.” Richard describes the physical pain as going into phases: “I initially thought it was good and then I thought it wasn’t good and now, when I am at the end of the week, I think it probably gets some good.” To this statement Franca responds with a lengthy explanation of how “controlled inflammation” works, which is the goal of the treatment she applies on Richard. Franca continues with further gathering of information: “So describe me the pain. Did it feel like bruising, sharp?” and Richard responds. Then Franca asks about Richard’s activity levels during the previous week and asks him to assess the pain level during those activities. Further, they discuss body biomechanics during cycling and which body parts carry more weight. Richard takes the initiative to describe some of his habits related to body postures without being asked. After this information, Franca gives her first treatment suggestion: “In terms of your running, I want to put you on hold for six weeks”, followed by a rationale for it. Then she proceeds with the second piece of advice which suggests that Richard simulate the cardio rate as if he is on an endurance training (a training program that includes high oxygen-demanding exercises such as swimming, running and biking). Next, Franca makes a detailed plan of the training activity. She complements her narrative with reasoning at each step of the plan and puts focus on how an injury would affect the body. At this point of the interaction, Richard provides his main concern in the form of a statement question (see Appendix for the types of questions): “Actually, one of the questions I had is if there is a frozen or nerve damage or something with me”. To this, Franca quickly replies that it is in fact a joint, not a nerve. This is the first time in the interaction when the doctor provides a diagnostic statement. Richard is not entirely convinced and continues to question the diagnosis. Franca demonstrates a collaborative behaviour by showing willingness to hear Richard’s arguments. She is interested in where his reasoning stems from: “What kind of pain you were getting that made you think that

maybe it was the nerve?" This inquiry is, in general, a part of the *history taking* stage which indicates that both the treatment advices and the diagnosis are occurring within this stage. Franca takes time to explain her reasoning and she even takes a medical plastic model to show the movements of the hips in the affected area. She uses lay medical language so that the patient can understand the clinical reasoning and participate in the ongoing discussion. Finally, after these lengthy exchanges, Franca proceeds with gathering the last piece of information about Richard's condition and this time it is related to a problem in his left foot. She performs a physical examination and gives a diagnosis that it is a tendonitis. However, the cause of the problem is discussed in length after that.

Some observations in terms of the realization of the stages include the brevity or extensive length of some stages. For example, the problem presentation given by the patient was comprised of only two statements: "I've still got that pain. When I get up after [...] seem down for a while and I am limping around." However, the adverb "still" signals that this is an old problem of which Franca is aware. In that sense, the brevity of this stage is justified. In contrast, the *history taking* is extensively long. It contains argumentative language and it takes up close to two thirds of the session.

In the session between Franca and Richard, I observed and analyzed repeatable elements that operate on grammatical (clause) and discourse levels. In terms of language structures, I found the following patterns. The *opening* and *closing* stages are characterized by conventionalized expressions. In the case of *opening*, these are greetings such as "Hi, how are you doing?". For the *closing* stage there are statements that directly point to the end of a session as in "I'm going actually to finish with you now" or "That's all for today". Particularly in the session with Richard, the question that follows the greetings "How is your hip?" is also considered part of the *opening* stage. According to Heritage and Robson's (2006) classification of opening *problem presentation* questions by physicians, the goal of such inquiries is not to solicit problem presentation. They simply display overt knowledge of the patient's problem (compare with "What I can do for you today?" which displays a more agnostic stance). The actual *problem presentation* is initiated by a more specific inquiry: "What is happening with your hip?". The floor is explicitly given to Richard to present his concern. On a discourse level, this stage is recognized by the narrative of the patient, containing speech acts such as complaints.

After a brief outline of the problem, the session proceeds to the next stage, the *history taking*. It is initiated by the question “How did you respond to the treatment?” and opens up a long chain of exchanges between the participants. This stage is characterized first by interrogative grammatical structures. There are wh- and polar interrogatives performed by Franca: “Was there a day in the last seven days that you did not exercise? Were you in any pain on this long ride? Do you feel you are working at the same cardio level when you are riding? Did you make any changes in shoes?”. Their use is justified by the purpose of this stage of the visit, that is, to gather information – missing and circumstantial. More on questions and their functions is presented in 5.1.2 – 5.1.3.

Imperative structures are another type of a grammatical feature present in this stage. Franca uses the canonical way of issuing a command, a proposition in imperative form: “Tell me a little bit about when...”; “Tell me what happened during the course of the week”; “Describe me the pain.” This canonical way of expressing a command is contrasted with another, where a declarative form is used to realize the meaning of a command. Examples include: “I want you to still stay off your feet for six weeks; Ideally, I would like you to do seven but... I want you to be at least 85% into your zone”. The intention is to get the patient to do something, to follow certain instructions. While the canonical imperatives are observed in *history taking*, the declarative forms that carry illocutionary force of a command are found only in the *treatment* stage, specifically in treatment recommendations. Eiggins and Slade (1997) note that employment of the preferences for different structures to express the meaning of a command is easily affected by the context, the purpose of the stage, and the roles of the participants. For example, in the *history taking* stage canonical imperatives, with its strong force of imposition, are preferred grammatical choice because the doctor requires immediate action, i.e., providing information. Eiggins and Slade also claim that the choice of an imperative mood is a way to build status differences.

According to West (1990), both types of performing directives described above, the imperative forms and the declarative forms carrying illocutionary force of a command, are among the most “aggravated” forms of issuing a directive by physicians. For a comparison, a mitigated form would involve, among others, proposals for joint action: “Let’s stick to our plan”. West (1990) labeled directives that use verb forms “I want/would like you to” *want statements*. *Want statements* boldly require an action from the addressee. Here, the

doctor requires adherence to instructions from the patient which she considers crucial for treating the problem.

Soon after the history taking has started, the doctor decides to proceed with giving a treatment, in that case laser and prolotherapy, an injection-based remedy. She makes the patient aware of her decision by announcing it directly: "So, I am actually having you lay down on the side... We want the affected side up and we are going to start with the laser while we are still speaking." This time Franca uses a collaborative expression "we want" instead of "I want you to".

Elements of the diagnostic hypothesis are recognized by the medical statement about the patient's condition which is followed by clinical reasoning presented in lay medical language. Explanations such as the following prove to be frequent and aim to educate the patient about his condition: "The muscles are in control here. The muscles are starting everything. They are the ones that pulled and got tight because you didn't stretch enough or you pushed yourself too much some days and you are just overtraining. Overuse. 90% of all injuries are from overuse." The stage of the *diagnosis* is not solely comprised of the doctor's statement; it is actually negotiated. The patient challenges the doctor's opinion, demands more information, and even contradicts. I further comment on this particular excerpt in the discussion following Example 22, but for the present exploration I would like to point out that these speech behaviours by Richard fulfill interactional work of negotiating a diagnosis across turns and sequences.

As I analyzed the excerpt, I noticed the degree to which the patient allowed himself to contradict the doctor's diagnostic hypothesis. Further in the audio recording, there was an evidence that Franca and Richard had known each other for many years, with Richard being a long-time patient of Franca. That explained the level of familiarity of their personal relationship. It also confirmed Eggins and Slade's observation that very often, close relations entail participants confronting each other rather than supporting (Eggins & Slade, 1997 p.55). In the negotiation of the diagnosis I encountered frequent use of subordinate clauses in the speech of Franca introduced by the conjunctions "so" and "because". Typically, these connective elements are used to link cause or reason with results, or to give reasons. This feature of Franca's speech is necessitated by her willingness to provide arguments to Richard in favour of her diagnostic hypothesis. It should be mentioned that clauses with these connectives are used by Franca earlier in the session when she justifies

her choice of treatment. Utterances such as “But why I am getting so much pain?” challenge Franca’s diagnosis. Richard also contradicts Franca’s hypothesis by saying: “I thought maybe it’s a nerve. That’s the other aspect we should look at. Maybe we are treating the muscles, but not the nerve.” This is an open contradiction to the diagnosis that Franca has given a few turns earlier when she says that Richard’s problem has to do with joints, not with nerves. Further in the discussion, Franca supports her clinical reasoning by describing basic anatomy and biomechanical aspects of the human body. In doing so, she frequently creates educational narrative by explaining medical issues in lay medical language. The narrative contains statements and supporting arguments: “... the nerves come out there **so** this is why this gets tight, it starts to get pinching of the nerves which goes all the way down to your toes.”; “That’s one of the issues **because** the problem is that the muscles are imbalanced but the muscles, as the chain goes on, are connected to the joints”. In my opinion, all questions issued by Richard after hearing the diagnosis, together with Franca’s explanations, belong to the stage of *diagnosis*. Because only after this discussion is the patient convinced that this is a correct diagnosis and is open to adhere to the proposed treatment plan. This discussion is an important aspect of creating rapport with the patient and reaching a common ground by participating in a collaborative floor. Such negotiations not only contribute to building trust, but also educate the patient and empower him/her to make healthier choices.

The initial history taking was followed by a diagnosis which was then deconstructed for the patient. Next, further data gathering was performed and another diagnostic piece of information provided. It is important to notice that this second chunk of information is not related to a separate health problem but an elaboration of the first diagnosis. The sequence of events within the boundaries of the *history taking* stage can be presented as history taking – diagnosis (deconstructed) – history taking – diagnosis (elaboration). The presence of such sequence reflects, first, the dynamic nature of the interaction and second, the doctor’s attitude of accommodation and collaboration. It also suggests that the stage of the *diagnosis* can be performed earlier and into chunks. Therefore, the *diagnosis* stage is not strictly fixed in reference to the predicted generic staging. In their study investigating telephone calls between junior and more senior doctors, Pryor and Woodward-Kron (2014) have found that the *diagnostic hypothesis* stage was the least constrained of all stages in relation to the ideal for their data (2014 p.50). Regardless of the different contexts — interaction between professionals (Pryor & Woodward-Kron,

2014) versus interaction between a professional and a lay person (present study) — the main purpose in both situations is to seek clinical advice in which identifying the correct diagnosis is crucial. From the perspective of a genre analysis, the flexible position of this stage would influence the arrangement of the other elements in the schematic structure. Whether it has to do with the specific relationship between participants is worth further investigation.

An interesting feature of this session is the “deconstruction” of the diagnosis in the sense that medical reasoning follows the diagnostic hypothesis. The medical reasoning has a dual function. First, it provides evidence for the credibility of the diagnosis. Second, the doctor educates the patient by giving explanations and supporting arguments. Such educational occurrences are found both in the *history taking* and *diagnosis* stages. Seen through the philosophy of alternative medicine, this is a form of empowering the patient by giving knowledge and encouraging him to make healthier and educated choices. Another characteristic of this session is the balanced power exercised by the doctor. Franca took on a more directive role when issuing aggravated directives during *history taking* and *treatment* stages. This dominant behavior is grounded in the purpose of the stages. For example, her role in *history taking* was in contrast with the role of a collaborator when Franca gave space to Richard to challenge her knowledge. The alternation of these states contributed to the realization of two stages simultaneously.

Based on what I have presented so far, I provide an overview of the stages, their function and content examples (Table 5), and an overview of the lexico-grammatical features related to interpersonal meaning (Table 6). The stage analysis also informed the discussion of speech acts in the next chapter.

Table 5 Generic stages of a typical session

Stage	Function	Examples
Opening	Doctor and patient acknowledge the presence of each other	<i>How have you been?</i>
Problem presentation	Patient presents the problem	<i>I just had insomnia. I got a rash that's been developing in various, well, not a rash, rashes or spots, like itchy spots.</i>
History taking	Doctor gathers relevant information in order to make a correct diagnosis. Patient provides the required information	<i>Q: How's the urination? A: Still pretty good. Still waking up once a night.</i>
Diagnosis	Doctor issues a diagnostic hypothesis (and provides reasoning)	<i>It's a sign of liver congestion.</i>
Treatment	Doctor applies treatment on the spot; Doctor discusses treatment plan for patient to follow	<i>I would definitely recommend ... B vitamins.</i>
Closing	Doctor initiates the end of the session	<i>I'm gonna actually finish with you now.</i>

Table 6 Language features

Stage	Language features	
	Discourse/semantics features	Lexico-grammatical features
Opening	greetings, organizational remarks vocation naming	terms of address
Problem presentation	<i>description of symptoms</i> <i>circumstantial information</i> <i>patient dominates the floor</i> <i>affect</i> <i>engagement</i>	interrogative structures verbs in past tense evaluative lexis
History taking	lay medical language circumstantial information joint productions affect engagement	interrogative structures (open, close-ended, polar questions) “aggravated” directives (imperatives) evaluative lexis repetitions
Diagnosis	lay medical language clinical reasoning	indicative mood subordinate clauses introduced by <i>so</i> , <i>because</i>
Treatment	proposals for future action rationale for advices	“aggravated” directives (“want statements”)
Closing	social exchanges	

To summarize, in this chapter I have shown how I arrived at the structural formula that captures the unfolding of the stages. I discussed a particular case, that of an embedded and deconstructed diagnosis. I showed some of the lexico-grammatical features of the stages. In the next chapter, I will turn my attention to analyzing the sessions from CA perspective while referring to the staging of the visits.

Chapter 5.

Analysis of alternative medicine sessions

As mentioned in Chapter 1, I consider elicitation and rapport to be an important part of the talk in alternative medicine sessions. In this chapter, I present the examination of the features that work towards the linguistic realization of these two phenomena. More specifically, I explore how elicitation is performed through the use of certain speech acts and backchannels, and how rapport is built through the employment of joint productions and repetitions. Each linguistic feature is situated in the relevant literature on mainstream medicine and psychotherapy. Then, I provide the results and discuss each feature in an attempt to address the proposed research questions in the introductory chapter. I offer concluding remarks on the findings at the end of each section.

5.1. Speech acts

This section considers the speech acts associated with the process of elicitation. More specifically, it places emphasis on questions, as they present a major component of medical encounters and an overt strategy to exert power over the discourse. The present section provides an overview of the relevant literature on speech acts.

I classify speech acts based on surface features, context, and illocutionary force. For example, an utterance such as “You had a C-section” can have a range of illocutionary forces such as prompt for elaboration, uncertainty, request for confirmation, providing information, or surprise. The utterance yields its specific force when the context is known and surface features are taken into consideration.

- 1 Franca: You had a C-section? ↑
- 2 Patient: Uh-huh

The declarative form of the sentence is accompanied by a rising intonation, when considered with the patient’s positive reply “Uh-huh”, suggesting that the speech act performed by the doctor is a request for confirmation. The intention is to verify the truthfulness of a fact.

5.1.1. Background on Speech Act Theory

How people use language to convey meaning and the ways meaning is successfully recognized by the interlocutors in a conversation are issues that different models of talk try to explain. One such model is Speech Act theory (Searle, 1969). The concept of how people act using words was introduced by Austin (1962) in a series of lectures. He drew attention to the pragmatic side of language use and focused on two main questions: What activities do people accomplish by using words, and how do they do it? He claimed that these actions are context dependent. Initially, he distinguished two types of utterances — constatives, which are utterances that say something about the world, as in “I am hungry”, and performatives, which are utterances that carry out an action: “I lend you my book”. However, he realized that this division is insufficient to describe what we are doing with words, and he proposed the idea of *locutionary*, *illocutionary*, and *perlocutionary* acts, which accompany every utterance we produce. A *locutionary* act is the act of speaking itself — uttering sounds and words. *Illocutionary* acts are acts such as stating something, asserting, greeting, disagreeing, etc., which Austin further categorizes as verdictives, exercitives, commissives, behavities, and expositives acts. Finally, *perlocutionary* acts express respectively the (un)intended effects of the illocutionary acts on the addressee (e.g., surprise, disappointment, pleasure), or their effects on the world.

Searle (1969) expanded on Austin’s concept of talk and set out specific claims about how the accomplishment of acts is done through the use of language. Searle’s model is known as Speech Act Theory. Based on the premise that an illocutionary force is comprised of the force and the proposition, he proposes an alternative taxonomy of illocutionary acts: assertives, directives, commissives, expressives, and declaratives. As per Searle’s definitions, assertives are statements that can be verified as true or false; directives are statements that require the listener to do something; commissives are statements that commit to a course of action; expressives are statements that express a psychological position; and, finally, declaratives are statements that, through their utterance, perform an act.

Searle also made a connection between the action and its linguistic form. The acts of making statements, questions, or commands correlate to declarative, interrogative, or imperative sentence forms. A match in the mapping of form onto function defines direct

speech acts. An instance of such mapping is a command, which takes the form of an imperative sentence: *Give me that book!* That means that the literal meaning of the sentence matches the utterance meaning (the participants' meaning) in a specific context. For the cases where there is a mismatch between form and function, Speech Act Theory uses the term indirect speech acts. An example of an indirect speech act is the following exchange:

A: Do you want to go for a walk?

B: I have to pick up my car.

The utterance "I have to pick up my car" does not entail any act of rejection as it would in "No, I don't want to", which indicates a clear rejection. Thus, speaker B uses an indirect speech act to politely reject the proposal.

Quite often, speakers do not produce complete sentences in spoken language but rather utter only a phrase or a word. That characteristic calls for a differentiation between a sentence and an utterance. A sentence is defined as consisting of a set of words with a certain structure, while an utterance is the production of a sentence, a phrase, or a word (Turnbull, 2003, p.49).

Speech act taxonomies

Speech act taxonomies represent models of talk that try to capture interpersonal relationships. According to Stiles (1992), most of them tend to be redundant and competing, instead of complementary. Those that are created based on real data show a tendency to be domain specific. Particularly important categories, such as question, edification, reflection, interpretation, disclosure, advisement, and acknowledgment, receive prominence, while those that are not important are omitted or collapsed. The classifications also differ in terms of types of units and use of observational strategy (audio, video, transcripts).

The taxonomies that have high frequency of use are those of Austin (Austin, 1962), Searle (1969), Bach and Harnish (1979). These have been widely used in a variety of domains such as task-oriented dialogues, classroom settings, human-computer interaction (email threads, message board posts, distant education), and multi-agent systems (Herring, Das, & Penumarthy, 2005; Nastri, Peña, & Hancock, 2006; Sinclair &

Coulthard, 1975; Traum & Hinkelman, 1992). In the remainder of the section, I discuss taxonomies generated for particular medical genres — medical visits and psychotherapy sessions. Some of the speech acts found in these classifications are relevant to the present analysis.

Speech act systems applied in medical visits are typically employed in order to gain insights about cognitive (knowledge), behavioral (compliance), and attitudinal (satisfaction with care) outcomes from doctor-patient encounters (Bales, 1950; Inui, Carter, Kukull, & Haigh, 1982). A few of the oldest, but widely applied taxonomies in clinical settings are those of Bales (1950), Roter (1977), and Stiles (1992).

Bales’s (1950) classification differentiates acts in terms of three types of affect — interpersonal and “neutral” (task-oriented statements or questions). He identified 12 mutually exclusive categories (Table 7). Verbal behaviors in 1–3 mark positive exchanges, in 4–9 present informational exchanges, and in 10–12 present negative exchanges.

Table 7 Verbal categories

Categories	Affect
1. Shows solidarity (raises other’s status, help, reward)	positive
2. Shows tension release (jokes, laughs, shows satisfaction)	positive
3. Agrees (passive acceptance, understands, concurs, complies)	positive
4. Gives suggestion (direction, implies autonomy for other)	neutral
5. Gives opinion (evaluation, analysis, feelings, wish)	neutral
6. Gives orientation (information, repeats, clarifies, confirms)	neutral
7. Asks for orientation (information, repetition, confirmation)	neutral
8. Asks for opinion (evaluation, analysis, feelings)	neutral
9. Asks for suggestion (direction, possible ways of action)	neutral
10. Disagrees (passive rejection, formality, withholds help)	negative
11. Shows tension (asks for help, withdraws)	negative
12. Shows antagonism (deflates other’s status, defends self)	negative

Bales, 1950

Roter’s system (1977) is a modification of Bales’. It is patient-oriented in the sense that it was created to investigate patient’s interrogative behavior. Roter explored affective behavior using four dimensions: anger-irritation, sympathy-kindness, anxiety-nervousness, matter-of-factness-professionalism. Unlike Bales’ taxonomy, these dimensions are not ascribed to any discourse units, but rather are assessed based on the overall affective impact of the encounter.

A more recent classification used in medical settings is that of Heszen-Klemens and Lapinska (1984), which explores only intent without considering form and content. The verbal categories are derived from two main principles: (1) object of interaction (speaker or the partner) and (2) the sphere of intended influence (cognitive, emotion, or behavior). The authors identify 22 categories. A few of the most used ones include: to gain/give emotionally neutral information; to improve the partner's emotional state by reassurance, emotional support, etc.; to give information that will improve the partner's emotional state; to influence the partner's behaviour by giving advice, instructions, etc.; to influence the partner's behaviour by giving instructions on what to do and how to do it. They found that, while doctors used all of these intents in at least 50% of the cases, patients used only the first four categories in at least 50% of the cases.

Most taxonomies empirically derived from counselling and psychotherapy have categorized speech events on the basis of the participants' actions or intentions (Elliott et al., 1982). Others have based their taxonomies on the immediate therapeutic impact (Elliott, 1985) or sub-outcome (Rice & Greenberg, 1984). Stiles (1992) finds Reflection and Interpretation to be prominent categories in psychotherapy and counselling. This finding naturally reflects the therapist's main task, namely, to better understand the clients' experience and help them to reframe it in a productive way that will eventually lead to a positive life change. Hill (1986) identified 14 categories, 10 of which include the other's experience (Minimal encourager, Silence, Interpretation, Confrontation, Approval—reassurance, Reflection, Restatement, Non-verbal referent, Open question, Closed question) and only three that are related to speaker's experience (Self-disclosure, Information, Direct guidance).

Expanding on Goodman and Dooley's (1976) framework, Stiles (1992) developed an 8-item general-purpose classification of speech acts (Verbal Response Mode system) that differentiates acts by form and intent. The Verbal Response Mode categories include: Disclosure, Edification, Advisement, Confirmation, Question, Acknowledgment, Interpretation, and Reflection. Each of them corresponds to one of eight grammatical forms (Table 8), which comprises 64 form-intent possible combinations.

Table 8 Summary of verbal response modes and forms

	Verbal response	Form
1	Disclosure	Declarative; first person (“I”) or first-person plural (“we”)
2	Edification	Declarative; third person (“she”, “he”, “it”, “they” or a noun)
3	Advisement	Imperative
4	Confirmation	First person plural (“we”) where referent includes other
5	Question	Interrogative, with inverted subject-verb order or interrogative words
6	Acknowledgment	Non-lexical utterances
7	Interpretation	Second person (“you”), verb implies an attribute or ability of the other
8	Reflection	Second person (“you”), verbs implies internal experience or volitional action

Stiles, 1992

In addition to context, three main binary principles govern the determination of the intent of any given utterance: source of experience, presumptions about experience, and frame of reference.

Stiles provides an overview of how intents differ among therapies and forms between individual therapists. The most frequent intents reflect the premise of the therapy and the therapist’s role. For example, client-centred therapies (Rogers, 1951) are based on the assumption that change in the client is achieved by exploring their own frame of reference. Therefore, in order to express empathy, the therapist uses mainly the client’s frame of reference. That is reflected in the high frequency of categories such as Reflection, Acknowledgment, Confirmation, and Edification. On the other hand, classical psychoanalysis (Freud & Breuer, 1895) postulates that change comes from making the unconscious experience conscious. To achieve this, the therapist alters the client’s perception using interpretations. The therapist is focused only on the client’s experience. The most used speech acts in this modality are Question, Acknowledgment, Reflection, and Interpretation.

Forms, however, differ across therapists that work with the same modality. They can be used as a strategy or can simply reflect personal style. The strategic use of the form is a result of the therapist’s intention to soften certain statements. For example, the following utterances demonstrate the same intent, that of Interpretation, but are realized in different forms — Interpretation, Edification, Question, and Disclosure forms:

1	You are being too critical of yourself.	Interpretation
2	It could be that you are being too critical of yourself.	Edification
3	Don't you think you are being too critical of yourself?	Question
4	I wonder if you are not being too critical of yourself.	Disclosure

In summary, the reviewed classifications build on the opposition objective (information) versus subjective (affect). For the purposes of the analysis of both elicitation and rapport, I consider some of the categories to be of a particular importance. These include Bales' categories *Gives orientation (information, repeats, clarifies, confirms)* and *Asks for orientation (information, repetition, confirmation)*. They seem to be relevant to my study as they examine affective behaviour and eliciting information. In exploring rapport, the categories of *Shows solidarity (raises other's status, help, reward)* from Bales' taxonomy, and *Disclosure and Acknowledgment* from Stiles' taxonomy become applicable as they work simultaneously towards providing information and creating an affective-relational communication. I expand on these categories in the next sections.

5.1.2. Types of speech acts in the data

The alternative medicine session is a type of task-oriented dialogue and this naturally projects two fundamental types of speech roles adopted by speakers — giving and demanding. Speakers can give/demand information or goods-and-services (Halliday, 1994). Muntigl (2004), however, claims that exchanges also include appraisal, normative frameworks, accountability and identity. For the purpose of this study, I will focus on how participants give and demand information.

The present taxonomy is based on theoretical considerations but also on my own interpretation. I was interested, first, in seeing whether providing information in such a context is performed in a directive or in a non-directive, simply guiding, style of medical discourse. Second, as a person who uses the medical services provided by alternative medicine doctors, I find my attention was drawn to the type of questions that the doctors asked. I noticed that they seemed to move in a circular way — the visit will start with questions related to physical problems, will continue with psychosocial ones and in the end will go back to physically-related inquiries.

The identification of speech acts draws on Austin and Searle's frameworks and takes into consideration both the propositional content and the illocutionary force. It is

consistent with sociolinguistic research (Labov & Fanshel, 1977) in that it allows for more than one action to be identified in a given utterance (e.g., statement and question). An additional source of help for designing the local structure was Martin and Rose's outline of speech functions (Martin & Rose, 2003). Mapping acts to utterances (Turnbull, 2003) in the cases of indirect acts is guided by surface-based cues. For example, the token "yeah" is coded as an affirmation after a question, but as a backchannel after a statement. A statement pronounced with a rising intonation is defined as a question. Where the surface cues are not compelling, the coding relies on inferential interpretations of the context.

As a stepping-stone for my classification, I took into consideration the three fundamental types of propositions: statements, questions, and commands. I also relied on the context, as will be seen in the analysis that follows. Context helped me to differentiate between types of acts, as sometimes a proposition will have different labels depending on context. For example, context was crucial to making a difference between a backchannel and an answer when they appear in the form of "yeah". The coding is based on the division between acts that belong to *demanding information* and acts that belong to *providing information*. Under the label *demanding information* I include open, closed, declarative, elliptical, and tag questions, and under *providing information* I consider answer, affirmation, negation, and statement as relevant categories. The utterances are coded according to one of the main speech functions: question, statement, or command (Halliday, 1994). The notion of an adjacency pair (Schegloff & Sacks, 1973) is what I further based my classification on. As we saw in Section 2.2, an adjacency pair requires two utterances, which are produced by two different speakers successively. It also has to be conditionally relevant so that the first utterance is a first pair part and the second utterance is a second pair part (Tsui, 1989). Following this definition, the utterances are further paired with a relevant response such as answer/affirmation/negation, acknowledgment/disclaimer, or compliance/non-compliance (Table 9). For a full description see the table in the Appendix.

Table 9 **Speech acts pairs**

1. question	How are the bowels?
answer	They've been OK, I think.
2. statement	You are enforcing all these thoughts.
acknowledgement	Yes.
3. command	Now, talk to me about the back pain.
compliance	I took the drops and Sonja was like: "If these drops help you I want some..."

Another consideration in the taxonomy presented is that of insertion sequences (Schegloff, 1972a). Example 13 shows such an embedded sequence in a question-answer pair:

Example 13

- 1 Franca: So, tell me what's going through your mind.
- 2 Kate: **At night?**
- 3 Franca: **Uhum**
- 4 Kate: Anything and everything.

The embedded sequences can be viewed as an outcome of participants following Grice's cooperative principle. In order to provide truthful, informative, relevant, or unambiguous answers, they insert an additional sequence before providing the second part of the adjacency pair with which they clarify missing information.

Demanding information acts

In classifying questions I took into consideration Tsui's (1992) typology in which yes/no and alternative questions project restricted answers. I also took into an account both the grammatical form and received answers. Thus, questions in the present study are classified into two main categories: **open** (wh-Q) and **closed** (polar, close-ended, alternative, tag, declarative, elliptical). **Open** questions invite an unrestricted set of answers, while **closed** ones constrain the range of provided answers. Rhetorical questions are excluded, as their illocutionary force is not a request for information. They aim at making a point, not at eliciting an answer. Similarly, exclamatory questions such as "Isn't that great!" are also eliminated. They are simply evaluative comments and expect no answer, functioning more as backchannels rather than as elicitation tools.

Questions

Open questions contain a wh-word and may receive either short or lengthy answers. **Closed** questions come in six types. *Polar* questions are yes/no questions with a modification of *any-polar* questions such as “Did you have any problems before the baby was born?” *Close-ended* questions are those containing words such as *how much, how long, where, which, when, who* that ask for specific information. *Alternative* questions provide options or require clarification: “Are they on the extremities or on the gut?” *Tag* questions are presented by the classical form (aux (neg) + Sub: “You feel tired, **don’t you?**”) and by tag elements, or pseudo-tags (Stenström, 1994) such as *ok, right, eh, yeah*. *Declarative* questions present statements with rising intonation. *Elliptical* questions are elliptical structures without a complete interrogative form. A sub-type of elliptical questions is the group of the *incomplete* questions, which show the syntactic form of a question, but are unfinished. All types are presented in Table 10:

Table 10 **Types of questions**

Open questions	Closed questions
What’s been going on with you?	polar: Would this help me with insomnia?
	close-ended: How much sleep are you getting?
	alternative: Do you want first needles or do you want first this?
	tag: It’s all I am asking for, ok?
	declarative: You just want treatments?
	elliptical: Anything else?

Commands

Commands are identified based on the verb form, but also on the illocutionary force of the utterance. Thus, commands are utterances such as “Let me see your tongue”, as well as “I just don’t want you to move”, which implies the imperative mood. The first example fulfills the requirement for a direct speech act in a way that its illocutionary force is the canonical illocutionary force of a command, where the verb is in imperative form. The second example, though, does not show a direct mapping of illocutionary force onto form. The form is declarative, which usually is associated with performing a statement. From that point of view, the doctor who produces that utterance indeed makes a statement about what she wants. The illocutionary force, however, is that of a command — “don’t

move”. This is a case of an indirect speech act, a command in the form of a declarative sentence and therefore considered for the analysis.

Providing information acts

In this group we find a great variety of speech acts: answers to questions, affirmations, negations, statements, acknowledgments, disclaimers, compliances, non-compliances.

Answers

Answers are classified as those statements that follow questions and provide information (Example 14) Those that follow a yes/no question are labeled affirmations (Example 15) or negations (

Example 16).

Example 14

- 1 Franca: So, what's your routine after that?
- 2 Kate: **Oh, we go for a walk.**

Example 15

- 1 Franca: So, you are making enough milk?
- 2 Kate: **Yes.**

Example 16

- 1 Erika: Any itchiness?
- 2 Christie: **No, no itchiness, just pain.**

Statements

Statements are utterances that assert a proposition and usually are followed by acknowledgments. Some of them carry a question force, but are different from declarative questions in a way that they do not end with a rising intonation: “I am wondering if this is shifting things around for you↓”. They may be as short as one sentence or as long as one paragraph:

Example 17

- 1 Franca: **You buy neutral shoes and when you put your correction and**
- 2 **it makes it compensate for you**
- 3 Richard: Ahem, yeah.
- 4 Franca: **and what adjustment he has been made.**

Acknowledgments

Acknowledgments follow statements or a disclaimer, and show acceptance as in Example 18. They are full-fledged sentences, not just contentless words or expressions that can be perceived as backchannels. Such utterances express recognition of the truthfulness of what has just been said by the other speaker and often, in order to stress the importance of it, are accompanied by an elaboration in the form of a fact or a revelation as in line 3.

Example 18

- 1 Erika: That's excellent! Because sometimes it's just your body's way of
- 2 saying: "You need it, you needed that".
- 3 Christie: **I know. I realize I do.**

Disclaimers

Disclaimers follow requests for information presented in the form of a statement and deny their truthfulness. Negative forms such as "no", "not", "nobody", "nowhere" are used as in line 2 of Example 19:

Example 19

- 1 Christie: But I have to be dying or something.
- 2 Erika: **Not quite that.**

Compliances and non-compliances

Compliances (Example 20) and non-compliances follow commands. They respectively carry out the proposition expressed in the command or not. In Example 20 the command performed by the doctor requires a verbal compliance and the patient provides it in lines 2, 4, 6, and 7.

Example 20

- 1 Erika: Tell me, tell me.
- 2 Christie: **It was weird too and nice**
- 3 Erika: I'll take that coat.
- 4 Christie: **when I saw the doctor about getting the blood test and stuff**
- 5 Erika: Yeah
- 6 Christie: **and she was saying that I am not the typical person to have the**
- 7 **cystic or whatever.**

The Demanding information process triggers a variety of *providing information* responses, as shown in the local structure in Figure 7. A discussion on how these are distributed across stages of the session is included in the next section.

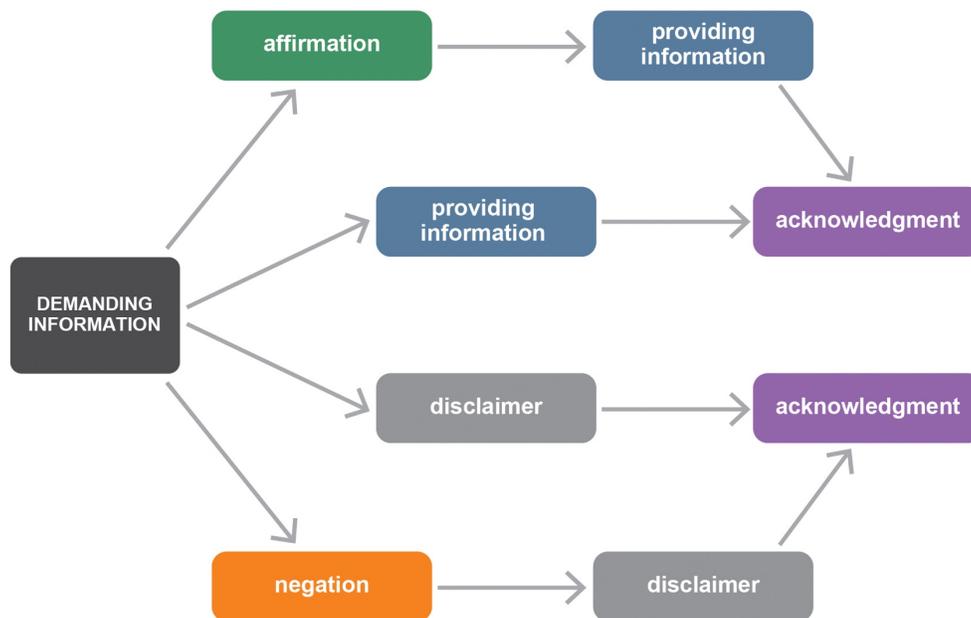


Figure 7 Local structure of the demanding information stage

5.1.3. Results and discussion

Distribution and frequency

The distribution of questions in terms of asymmetry will be discussed at the end of Section 5.1.3. What follows is a description of the distribution of the speech functions.

Speech functions

The distribution of instances of *demanding* and *providing information* is presented in Table 11. As I have an uneven number of sessions — three from Franca and six from Erika — in order to present more comparable data, I show the percentage and a further break down per patient in Table 12 and Table 13. Both doctors and their patients produced statements the most, followed by questions and commands: statements > questions > commands. In that respect the sessions in the data depart from medical interviews in which questions tend to outnumber the statements.

Table 11 **Distribution of speech functions**

Speech functions	Franca	Franca's patients	Erika	Erika's patients
Questions	115	65	317	39
Commands	57	2	65	1
Statements	264	194	407	495
Total	436	261	789	535

Questions

Doctors

Table 12 and Table 13 reveal a striking difference in the total amount of produced questions. Of all questions that were performed during the sessions with the patients, Franca performed 64%. For Erica and her sessions this number is even higher — she performed 89% of the total amount of questions. On average, Franca produced 38 questions per session and her patients produced 22. Erika produced 52 questions per session, but her patients only six. That means that Franca asked nearly two times more questions than her patients, while Erika asked nearly eight times more questions than her patients. A comparison with mainstream medical doctors will reveal similar results. West (1984b) analyzed questions in 21 medical visits and found that out of 773, 91% were asked by the doctors and 9% by the patients. Todd's study (1984) on women's contraception examined 20 medical interviews and found that doctors asked 5.6 times more questions than patients. One conclusion that can be drawn from this comparison is that both Erica and Franca align more (Erica) or less (Franca) the volume of the questioning to that performed by mainstream medicine doctors in medical visits.

Table 12 **Distribution of questions in sessions with Franca**

	Kate	Martin	Richard	Total	%
Franca	53	23	39	115	64%
Patient	14	14	37	65	36%
Total Qs	67	37	76	180	100%

Table 13 **Amount of questions in sessions with Erika**

	Ingrid	Tom	Maria	Thea	Shelley	Christie	Total	%
	24	38	74	74	66	41	317	89%
Patient	6	12	3	4	7	7	39	11%
Total Qs	30	50	77	78	75	48	358	100%

Patients

Franca’s patients contribute extensively to questions, with the percentage ranging from 21% to 49%, while Erika’s patients were allowed to produce questions only in the range of 4% to 24%. In fact, the higher percentage (24%) of Erika’s patients is actually close to the lower end of Franca’s patients’ range (21%). The sessions for both doctors that received the highest number of questions asked by patients were with male patients — Richard and Tom, both 55. In personal communication with the doctors, independently of each other, they both shared the observation that there is a tendency for older patients to have more questions during visits. Another factor contributing to Richard and Tom’s asking multiple questions might be their health literacy. Health literacy is a much discussed topic in healthcare and refers to the degree to which individuals can obtain and process basic health information that is needed to make adequate healthcare decisions (Wolf & Serper, 2014). However, since I did not interview the patients myself, nor did I perform any questionnaires related to health literacy as a part of my study, I could not tell convincingly that this particular factor accounts for their high demand for information.

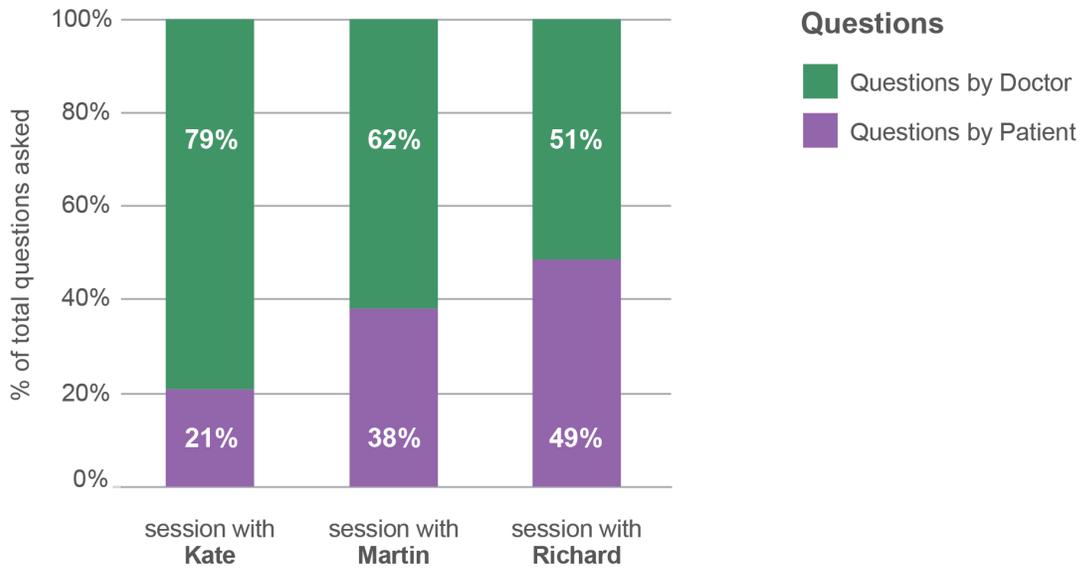


Figure 8 Percentage of questions in sessions with Franca

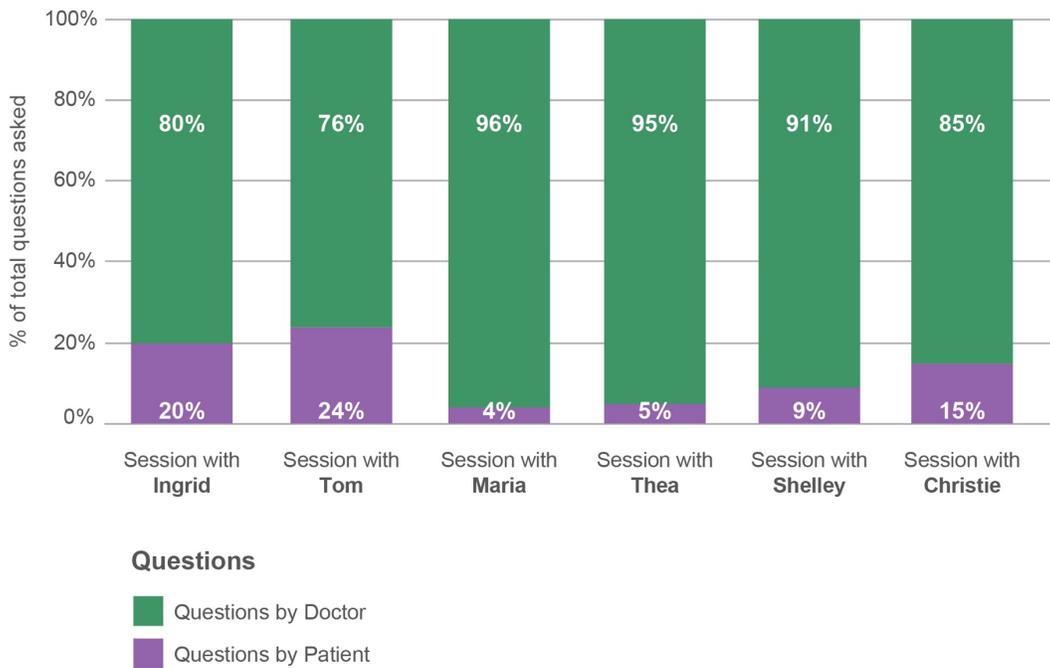


Figure 9 Percentage of questions in sessions with Erika

Commands

One third of commands performed by the doctors have a form different from the imperative. Examples of these include: “What I want you to do...”, “I need to keep your arm straight”, “I would definitely recommend you to take something”. They demand the proposition to be carried out in a non-directive way and bear implications, which are successfully recognized by the patients. This is proved by their compliances. Commands can demand a physical action: “Squeeze!”, “Deep breath in” but also a verbal action: “Tell me what’s going on with you”, “Describe me your typical day”. The commands produced by the patients are context-relevant such as “Look at this”.

Statements

It is interesting to notice that doctors and patients almost equally contributed to the production of statements. Franca produced 58% of statements versus 42% for her patients, and Erika produced 45% versus 55% for her patients. Although Erika had a very dominant interrogative behaviour (89%), she gave patients space in order to provide elaborate statements and did not dominate in that respect. Actually, in five out of six sessions, the patients performed more statements than Erica. That was not the case with Franca, in whose sessions all patients performed less than the doctor. The range of statements performed by the patients varies between 41% and 45% for Franca and between 36% and 67% for Erika.

Speech acts across stages

Here I discuss how stages of the session affect the distribution of speech acts. As it was discussed in Chapter 4, stages of the alternative medicine sessions are defined in terms of what particular task is being accomplished. The task is accomplished gradually and the sessions unfold in stages, each of which fulfills a smaller purpose that contributes to the realization of the global task. As mentioned earlier, the overall three-fold segmentation of alternative medicine sessions includes opening, middle, and closing stages (Eggins, 1994) and the middle portion is broken down to *problem presentation*, *history taking*, (involves also a review of the patient’s file), *physical examination*, *diagnosis*, and *treatment* (Heritage & Maynard, 2006b).

Regardless of the individual doctor’s approach, an interesting feature of the sessions in the present study is that, on several occasions, the middle part involves a

blend of two stages (*history taking* and *diagnosis*) as depicted in Figure 5. This means that, while investigating a patients' history, doctors make patients aware of elements of the diagnosis. This act demonstrates a very collaborative approach in which patients are provided with clinical reasoning. The structure is in contrast with typical medical visits, where, usually, each stage is distinguished in a straightforward and consecutive fashion (ten Have, 1989).

Each stage reveals dominance of certain types of speech acts. The *problem presentation* stage is always initiated by the doctor. Depending on the opening questions (Heritage & Robinson, 2006; Robinson & Heritage, 2006), patients display orientations to longer or shorter problem presentations. There are two types of openings that physicians exploit. The first type is comprised of a) more general, open-ended questions such as "How have you been?"; b) commands that have the illocutionary force of a question such as "You can tell me whatever is going on"; or c) a clear a command — "Tell me what is going on with you". These openings usually initiate longer multiunit responses from the patients, sometimes interrupted by doctors asking non-medically related questions ("You get any time off for the holidays?"). The second type of opening that physicians use is comprised of a) close-ended questions such as "Did you do the liver cleanse?"; b) a command: "Tell me what happened during the first two days of the treatment"; or c) a statement that evaluates the patient: "OK, so, you are walking, but you are still limping". These speech acts set different agendas for the patients as they constrain the content in a particular direction. The two type of openings solicit different types of narratives — on the one hand, longer, broad, often psychosocially oriented, and on the other hand, shorter and restricted to a particular topic. In both scenarios however, while patients are offered the conversational floor, physicians intervene with only brief clarification questions and backchannels. Physicians signal the end of the presentation problem stage with statements such as "OK, that tells me that there is still stuff going on internally", or "Let me write this down" and then proceed with information gathering questions such as "When did it all start?" (Robinson, 2003). *Problem presentation* is followed by the *history taking* stage, which is characterized by intensive questioning using predominantly wh-Q, polar, and close-ended questions.

Some of these questions become part of sequences with a formulation at the end. Formulations present follow-up moves, which Antaki (2008) defines as:

Formulation = you-are-saying-that-X.

The function of formulations is usually to rephrase inferentially what the other has just said. In that sense, they communicate the same thing but “the content is remarkably altered” (Vehvilainen, 2003, p.584). In Example 21, Erika asks Maria what else she wants to share. Maria talks at length about having problems with sleep and dry skin.

Example 21

- | | | | |
|---|--------|--|--------------------|
| 1 | Maria: | I think I've been getting up. Seven hours of sleep. One night I didn't | |
| 2 | | sleep very good. | answer |
| 3 | Erika: | And it ruins it, doesn't it? | formulation |
| 4 | Maria: | Yeah, but then before I was having... | |

Erika makes attempt to formulate the psychological effect that Maria's sleeplessness has on her. The tag question signals an effort to establish common ground and to receive a confirmation. Maria validates the inference, although she goes on to provide some arguments. In psychotherapy, arguments are often used to bring attention to specific points, which is similar to what we see here in this example. Formulations of this type demonstrate high attentiveness toward a client's or patient's problems, which is itself a highly accommodating feature. *Diagnosis* stage is mainly characterized by PROVIDING-INFO on the doctor's end and acknowledgment on the patient's end. Yet, the overall diagnosis in some cases is not a discernible stage. The arrows pointing at the *history taking* stage in Figure 5 depict the fact that the elements of the diagnosis are often given throughout the *history taking* stage. This does not mean that a full account of the patient's problem is not given, but just that this process is often happening incrementally. Example 22 illustrates the case in point. The doctor actively performs questions in order to properly address the problem and offer an accurate diagnosis. Instead of making a conclusive statement about the diagnosis after the medical history is taken, she gradually provides bits of information throughout the *history taking* stage. This is visible in lines 13 and 34, and the elaboration in line 36.

Example 22

- 1 Erika: How you've been?
- 2 Maria: OK, I had my period last week
- 3 Erika: OK.
- 4 Maria: and I think it was this one 'cause I didn't have any back pain
- 5 Erika: OK
- 6 Maria: but it was all brown.
- 7 Erika: Was it thick congealed blood or was it almost like a discharge?
- 8 Maria: Yeah, I think it was almost like a discharge
- 9 Erika: OK
- 10 Maria: like brown seeming.
- 11 Erika: OK
- 12 Maria: Yeah, no blood at all, not red.
- 13 Erika: **No, that's right. That's the stasis.**
- 14 Maria: That was... yeah. Let's see what else.
- 15 Erika: Was there pain?
- 16 Maria: Nope. No pain.
- 17 Erika: No pain.
- 18 Maria: No pain.
- 19 Erika: OK. And How long did it last?
- 20 Maria: Probably, I don't know, you can't call it "heavy".
- 21 Erika: Yeah, exactly.
- 22 Maria: Three days, two days
- 23 Erika: OK.
- 24 Maria: And then spotting for maybe four or five.
- 25 Erika: OK. And it was all brown?
- 26 Maria: Mm hm.
- 27 Erika: OK
- 28 Maria: Yeap. What else? My neck. Every once in a while, it gives me issues.
- 29 Still.
- 30 Erika: Mm hm.
- 31 Maria: I've been really tired. I don't know since when but like today
- 32 Erika: Me too.
- 33 Maria: I've been like my eyes, like kinda burning sensation. I don't know...
- 34 Erika: **Yeah, that's the liver.**
- 35 Maria: That's the liver?
- 36 Erika: Yeah. The dryness kind of thing and burning thing going on.

As mentioned above, during the *diagnosis* stage providing information is performed by the doctor and an acknowledgment by the patient. There is one session, however, where the patient disagrees with the suggested diagnosis and initiates an argumentative discourse (Example 23). The doctor gives the diagnosis in line 3. This is actually an answer to Richard's indirect request in lines 1-2 where he uses a statement to ask about nerve damage. Richard disagrees with the doctor's diagnosis and makes attempt at directing her at what she should look (lines 6-7). He seems quite confident about his opinion, but does not show confrontation in a blunt way. He uses hedging ("I thought", "maybe"), which softens the force of the criticism. The doctor does not behave authoritatively nor does she openly contradict Richard's view. Instead, she opens up a new line of narrative with the open-ended questions in lines 9-10 and gives the floor to Richard to elaborate on his experience. Richard provides information in a detailed manner. This segment illustrates how the providing information part is performed by the patient in the *diagnosis* stage. This case presents another reason why in the *diagnosis* stage has two arrows pointing at *history taking* in Figure 5. During Richard's turns, Franca continuously provides clues that she has been listening attentively by producing backchannels (lines 17, 20, 24, 27). When Richard finishes his explanation, Franca takes the floor and gives her account of the facts incorporating in her turn Richard's experience (line 29 — 41). She is responsive to Richard's concern. There are subtle ways through which Franca could have exercised power over the patient by using technical expertise to argue with the patient, because knowledge is always an exercise of power and power is always a function of knowledge (Foucault, 2001 [1991]). Instead of providing technical information, she provides information that is understandable and useful. By doing so, she also educates the patient (Roter, 2000). This particular episode is an illustration of what Roter (2000) calls the "mutuality prototype" in her description of the physician-patient relationship, as we saw in Chapter 2. It is defined by balanced power that is reflected in the negotiation of decisions and the acknowledgment of patients' values and concerns. Franca becomes more of an advisor than an authoritative figure. This model, according to Roter, represents patient-centred care which is the most advantageous for both sides.

Example 23

- 1 Richard: Actually, one of the questions I had is if there is a frozen or nerve
- 2 Damage, or something with me. Is it -
- 3 Franca: It's actually a joint, not a nerve. But the nerve runs
- 4 Richard: [Yeah, but why am] I getting that pain?

5 Franca: [in this joint].

6 Richard: I thought maybe it is a nerve. That's the other aspect we should

7 maybe look at. But maybe we are treating the muscles but not the nerve.

8 Erika: The muscles need to be treated more than the nerves but tell me a bit

9 about your pain that you are getting. What kind of pain? What kind of pain

10 were you getting that made you think that maybe it was the nerves?

11 Richard: Well, it just, it did feel more than muscular, it felt different than muscular.

12 And this, you know, a reminder when I am doing that reading and getting

13 up and down, I am crouching. And then I am going, you know, meet her,

14 and then I am going down again and I am getting up and your legs, you

15 know, are in a different position every time depending on, you know,

16 'cause sometime it's a foot, sometimes is five feet

17 Franca: **Uh-huh**

18 Richard: And you are up and down over and around, lots of crouching and bending

19 over.

20 Franca: **Yeah, so...**

21 Richard: So, you are not doing the full extent of your legs. Your legs are getting,

22 you know, half use, just sort of, just like that but are not really... went

23 through a whole process like you are when you are walking where

24 Franca: **Uh-huh**

25 Richard: every muscle is sort of doing something in the nature of making a

26 regular pattern.

27 Franca: **Uh-huh**

28 Richard: My pattern is robotic.

29 Franca: So most of the time, Richard, when you start having pain, it is the joint.

30 Somebody that is chronic like you, that has the pain for the last three

31 months, we are looking at joints. And we are also looking at, as I was

32 saying earlier to you, at threatening the tendons, basically, that's joining the

33 muscle to the bone. Muscle is just something that want to heal, it is more

34 like a bruise type of pain and you are very aware of how the muscle pain

35 feel like.

36 Richard: Uh-huh

37 Franca: But when we look at people going up and down and crouching in a

38 certain position and then getting up or sitting, is one of the first things you

39 said: "If I sit down when I get up, I have pain".

40 Richard: Uh-huh

41 Franca: And that's all joints.

Both doctors engage the patients in a collaborative meaning. Sharing power (conversational or knowledge-based) is an essential element of the patient-centred models of communication that was discussed in 2.1.3 (de Haes & Bensing, 2009; Epstein & Street, 2007; Mead & Bower, 2000). One aspect of it consists of having sensitivity to the patients' preferences for information (Mead & Bower, 2002) and one way of doing is for doctors to open up a space for the patients to feel that their personal illness narratives are being accounted for and accommodated in a collaborative fashion.

Lastly, the *treatment* stage provides further space for both parties to elaborate on their narratives. Patients request details about the diagnosis and doctors respond positively to such behaviour. Doctors perform requests for physical actions ("Lie down", "Show me your tongue"), but also use this space to get to know patients better by showing interest in the "lifeworld" of the patient (Mischler, 1984), in other words, their everyday life events. During this stage, patients receive another opportunity to set agendas. Sometimes they do that by initiating questions about the doctor's lifestyles: "You just get vitamins?", "You've got new tenants?", "Do you gather people around you?" Displaying interest in the doctor's personal matters implies that patients feel comfortable enough to do it.

A summary of the types of speech acts found in the middle section of alternative medicine visits are presented in Table 14:

Table 14 Stages and speech acts

Stage	Speech Acts
problem presentation	demanding information, providing information, acknowledge
history taking	demanding information, providing information, acknowledge, affirmation, negation, compliance
diagnosis	providing information, acknowledge
treatment	demanding information, providing information, acknowledge, affirmation, negation, compliance

As mentioned in Section 2.1.4, the labeling of the speech acts relies on the stages of the genre. Certain speech acts gain prominence depending on the purpose of each stage. Although demanding and providing information are shown in most of the stages in Table 13, they have dominance in the *history taking* stage because the goal is to gather all relevant knowledge. By the same token, the act of compliance is a characteristic of *history*

taking (physical examination) and treatment, because one of the goals of these particular stages is to make patients comply with physicians' directions.

Elicitation through questions

Demanding information is mainly represented by the use of questions. Questions constitute a big part of the medical visits and are regarded as the backbone of the medical interaction. In identifying their function, I took into consideration the type of the reply and its location. That is to say, I looked at questions as presenting the first part in adjacency pairs (Schegloff & Sacks, 1973) and replies as presenting the functionally related second part.

The questions in this data set perform the following main functions:

Table 15 Functions of questions

Function	Type of question
To elicit information (facts)	wh-questions close-ended questions alternative questions polar questions
To elicit confirmation	declarative questions elliptical questions tag questions
To elicit clarification	elliptical questions
To elicit agreement	tag questions
To request non-verbal action	polar questions

The two main groups of questions — open and closed — differ in propositional nature. Open questions introduce incomplete propositions (Carlson, 1988), while closed questions present propositions that need polarity or specifying identification (Stenström, 1994). In that sense, open questions show lack of knowledge and closed ones presuppose certain or prior knowledge. Table 16 presents the distribution of the two types for doctors and patients. It is apparent that the percentage of closed questions is higher than the one for open-ended for both doctors. The high number can be explained with the nature of the visits. The problem presentation is prompted mainly by open-ended questions. Once this stage is over, the doctors begin to employ closed questions in order to rule out different hypotheses and reach a diagnosis. Such a progression from open to closed questions is not uncommon and has been found in other studies (Meyercough, 1991) In general, close-ended questions (and commands) are not considered to be patient-centred due their goal

to restrict and control in some way the patient (Roter & Hall, 2004). However, no data-gathering can be accomplished without them (Lazare et al., 1995). A detailed breakdown of all closed questions is given in Table 17:

Table 16 Distribution of open and closed questions

	Questions				
	Open questions	%	Closed questions	%	Total
D1	25	28	90	72	115
D2	45	15	272	85	317
Ps 1	8	12	57	88	65
Ps 2	9	23	30	77	39

Table 17 Closed questions

	Closed Questions												
	Polar	%	Closed	%	Alt	%	Tag	%	Decl	%	Ellipt	%	Total
D1	29	32	14	15	1	1	15	17	15	17	10	18	90
Ps1	13	23	6	11	1	1	14	24	14	25	9	16	57
D2	82	30	27	10	20	7	39	14	38	14	66	24	272
Ps2	9	30	1	3	0	0	5	17	6	20	9	30	30

Note: D1 = Franca; D2 = Erika; Ps1 = Franca's patients; Ps2 = Erika's patients

One observation that can be made from Table 17 is that the doctors have similar percentages for polar (32% vs. 30%), tag (17% vs. 14%) and declarative questions (17% vs. 14%). If these three types of questions are analyzed using the Labov and Fanshel's (1977) terms, then they all present "B-events" information. That is, they present information which is known to speaker B, but not to speaker A. Heritage (2010) proposed that the degree of knowing increases from polar to declarative questions. Seen from this perspective, polar questions suggest speaker A's little knowing on the subject, tag questions suggest a higher degree of knowing, and declarative questions suggest the highest degree of knowing. The examples below support this pattern. The patient represents speaker A, the one who possesses knowledge on the subject, and the doctor, speaker B, who has varying degrees of knowing. In Example 24, the doctor has no prior knowledge on whether the patient lives with her parents at the moment. The polar question awaits a yes/no answer or elaboration. In Example 25, the doctor is likely to know how the patient feels and offers a tag question. In Example 26, it looks like the doctor is showing a strong epistemic stance and simply expects a confirmation.

Example 24

- 1 Erika: Now, are you at home with mom and dad? **Polar Q**
2 Thea: Just mom.

Example 25

- 27 Erika: And on top of that you got all the emotional stuff going on, right? **Tag Q**
28 Christie: Yeah

Example 26

- 1 Erika: You got itchy ears. **Declarative Q**
2 Thea: Yeah, I just got an itchy ear.

The choice of question design shows the doctor's orientation toward possible answers. For example, the use of tag and declarative questions is able to evoke agreement and acknowledgement in the case of the former and confirmation in the case of the latter. Taken together, these functions suggest that doctors make certain assumptions about patients' knowledge and try to establish a common ground. This is an important aspect of the communication, because a shared common ground presupposes a greater mutual understanding. Viewed from a socio-interactional point of view, this is a highly convergent practice.

At the same time, the eliciting force of tag and declarative questions may differ. Declarative questions elicit a reply to a greater degree than tag questions. In Example 27 Richard's declarative question receives more than a simple confirmation, while in Example 28 the doctor's tag question receives only a backchannel as an acceptance.

Example 27

- 1 Richard: So, you wouldn't recommend though that I cycle over to Grouse
2 Mountain and go up the Grind ↑
3 Franca: **You know, actually the Grind will be OK with you. Because the**
4 **Grind is actually a really good work-out....**

Example 28

- 1 Erika: And the key, the key is to clear the heat and itch, alright?
- 2 Christie: **Right.**
- 3 Erika: So that's the main thing.

Questions and asymmetry

In this last section I discuss how questions and asymmetry are related in an alternative medicine context. It is widely observed that questions are a way for doctors to exert power (Boyd & Heritage, 2006; Mischler, 1984). The idea that the institutional interaction between doctor and patient is characterized as “asymmetrical” is not new in the literature, as was discussed in Chapter 2. Based on other researchers’ data and his own, ten Have (1991) describes seven aspects of asymmetry observed in questioning in medical visits, which are mainly described as doctor-centred. I will discuss the ones that are relevant to the present study and will also discuss how they show a reverse pattern — one that works toward a more symmetrical relationship.

First, ten Have discusses how speech functions requiring actions such as questions, orders, and proposals, are mostly performed by doctors, but are “dispreferred” when performed by patients. The distribution of questions in my data showed a remarkable difference between the two doctors, with Erika having a dominant interrogative behaviour by performing 89% of all questions.

Second, ten Have discusses how questions by physicians come mostly in series, so that patients’ answers become enclosed. That means that the conversation is shaped by sequences of question-answer-acknowledgment (optional) that come one after another without leaving the patients to contribute more except the answers. The same process is also observed by Mischler (1984) and Dillon (1990). This is definitely noticeable in the history taking stage of the Erika sessions. The intensive questioning is motivated by the doctor looking for “differential diagnosis”. However, there are cases where in the middle of such restrictive interrogation, the doctor manages to provide simultaneously empathetic remarks (line 9) and space for other exchanges (lines: 10-11):

Example 29

- 1 Erika: Any lower back pain?
2 Maria: Not recently, no.
3 Erika: OK.
4 Maria: No. But yeah, very tired.
5 Erika: Sleeping seven hours.
6 Maria: Yeah, I think so, yeah.
7 Erika: Do you wake up rested in the morning?
8 Maria: Not always. Like today I was like: "Ok, four more hours".
9 Erika: **Yeah, I feel that today, too.**
10 Maria: **I don't know if it's the weather or something else.**
11 Erika: **It does play a role. Yeah. I know. I was thinking too. Ok...How**
12 are the bowels?
13 Maria: They've been OK, I think.

Such verbal response illustrates responsiveness on the end of the physician by showing empathy and legitimation of patient's concerns. These, as Roter (2000) comments, are important elements of building rapport and crucial for a patient to feel understood (Cole & Bird, 1991; Kurtz, Silverman, & Draper, 1998; Lazare et al., 1995). Such remarks on the end of the physicians also present them as real people or, in Mead and Bower's definition, "doctor-as-a-person" (Mead & Bower, 2000). This aspect of patient-centredness is described as the attention to various cues of an affective relationship and awareness of emotional responses.

Third, ten Have (1991, p.139) made the observation that motivation for physicians' questions is not provided: "Patient is not informed on the reasoning process that supposedly guides the doctor's actions". The exact opposite conclusion can be made from alternative medicine sessions in the data. Doctors not only share their reasoning, but also elaborate on patients' questions in detail. In the session between Franca and Richard, there is a large portion of the interaction where the doctor explains at length how she reached a particular diagnosis and her motivations for a particular treatment. Erika also tends to reveal elements of diagnosis as she asks questions during the history taking stage. In Example 30 she provides insight in line 13 into why she asked the question in line 7:

Example 30

- 1 Erika: How you've been?
2 Maria: OK, I had my period last week
3 Erika: OK.
4 Maria: and I think it was this one 'cause I didn't have any back pain
5 Erika: OK
6 Maria: but it was all brown.
7 Erika: Was it thick, congealed blood or was it almost like a discharge?
8 Maria: Yeah, I think it was almost like a discharge
9 Erika: OK
10 Maria: like brown seeing.
11 Erika: OK
12 Maria: Yeah, no blood at all, not red.
13 Erika: **No, that's right. That's the stasis.**

Lastly, ten Have concludes that physicians tend to ignore patients' subjective experience, personal circumstances and social conditions. Josephson et al. (2015) made a similar assessment in their work on evaluative language in physiotherapy practice. They found that patients' affective evaluations related to emotions were in most cases recognized by the physiotherapists, but not followed up. They concluded that, while the patients get involved in the conversation from both a clinical and interpersonal perspective, physiotherapists are engaged mainly with the clinical aspect of the session.

Again, this is one of the essential characteristics of the communication in the alternative medicine sessions in this data. Doctors do not only acknowledge patients' experience, but they further ask a significant amount of questions related to social circumstances, life experiences and subjective views. Based on these observations, we can differentiate between three major groups of questions — medical, psychosocial, and conversational. Medical questions pertain to the patient's illness and epistemological knowledge. Psychosocial questions ask about emotions and feelings, patients' identity, etc. Conversational questions correspond to what Roter and Stewart call "social" (cf. Roter & Stewart, 1989). They help with finding out how illness is situated in a patient's life.

Table 18 displays the number of questions and percentages of medical, psychological, and conversational questions in my data. It is clear that psychological and conversational questions have a noticeable presence in the questioning. This reflects the

holistic approach of the alternative medicine, which looks at the person as an organic entity of body, mind and emotions, and considers the three aspects to be interrelated (Heller, 2005). The majority of the questions are medical such as: “Are you hydrated?” “How are the bowels?” “Is there any pain there or is it just the bloating?” Conversational questions are related to the patient’s current life, relationships, work: “So for how long have mom and dad been split?”, “Are you having a job interview today?”, “How long have you been with him?”. Psychological questions are the least represented. Still, they provoke reflection, which is typical and essential for psychotherapy sessions: “If you can change anything in your life right now, instead of the pain, that’s the obvious, what would you do?” “Is that part of the anxiety too, you think?” (talking about debt), “Did they feel hostile to you?” (talking about relatives).

Table 18 Percentage of medical, psychological, and conversational questions performed by doctors

Doctor	medical		psychological		conversational		Total
Franca	50	63%	2	3%	27	44%	79
Erika	125	62%	29	14%	50	24%	204

With both doctors, the numbers of questions decrease in the following order: medical–conversational–psychological questions. Both doctors also have almost an equal percentage of medical questioning. However, they differ in the other two types of questions, with Franca having more conversational questions and Erika more psychological. It was shown in Figure 9 that Erika has a more dominant interrogative behaviour. However, the quality of the questions suggests that, while she gathers medical information in 62% of her questions, she also strategically uses the questioning to establish social relationships through the use of psychosocial questions. These findings embody elements of the patient-centred models discussed earlier. Particularly, the aspect of “patient-as-a-person” in Mead and Bower’s model (Mead & Bower, 2000) and the biopsychosocial perspective characterizing most of the accounts of patient-centredness. This is also an illustration of one of the major communication building blocks that Roter (2000) describes as crucial.

Another interesting observation is that patients also use conversational questions as part of their verbal repertoire. This usually happens during the *treatment* stage, and it can be seen as an attempt to build rapport. Doctors show a positive stance: they answer patients’ questions and even share personal stories relevant to the topic.

5.1.4. Conclusion

The speech act analysis of the sessions was oriented toward the notion of elicitation. It showed how certain categories acquire prominence: demanding information, providing information, acknowledge, affirmation, negation, disclaimer, compliance. Clearly, these are domain-specific categories and reflect the conversational dynamics between physician and patient in alternative medicine, as well as the purpose of each stage of the visit.

As with mainstream medical consultations, questions compose the essential part of the visit. Both doctors were very active in questioning. Franca asked two times as many questions as the patients and Erica asked significantly more than Franca — eight times. In that respect, Erica gravitates toward the dominant interrogative behaviour of doctors who have a doctor-centred approach to medical communication (Todd, 1984; West, 1984). Simultaneously with their active interrogation, however, both Erica and Franca offered topics conducive to personal psychological narratives. They granted patients time to unfold them, acknowledged these subjective experiences, and, on many occasions, followed them up. This act contributed to the enhancement of the therapeutic alliance (de Haes & Bensing, 2009; Mead & Bower, 2000; Stewart et al., 2000), which is a key element in the patient-centred models of medical communication. At the same time, these speech activities become building blocks of an affective-relational communication (Robinson & Heritage, 2006) between doctor and patient.

5.2. Backchannels

This section deals with the production of backchannels in order to find out how they work toward elicitation. It begins with a short overview of backchanneling in medical discourse (5.2.1), and then proceeds with describing the distribution of backchannels in the data (5.2.2). The two types *Mm hm* and *Yeah* are investigated in relation to the prosody and sequential placement in Section 5.2.3. A brief conclusion is provided in 5.2.4.

“Backchannel” is an umbrella term for the listeners’ minimal response tokens in a conversation. Typical examples include non-words such as *uh-huh*, *mm*, *yeah*, *mm hm* as illustrated in the following example:

Example 31

- 1 Franca: Tell me a bit what is going on with you.
2 Kate: Aaa, I just had, aa... insomnia.
3 Franca: **Mm hm**
4 Kate: I just couldn't fall asleep at night. Also, I have difficulty going back to
5 sleep after I fed her
6 Franca: **Mm hm**
7 Kate: and so, I went to the doctor, and I was, I think I was a bit weepy and I
8 was emotional, just
9 Erika: **Mm hm**
10 Kate: overwhelmed, I think...
11 Erika: OK

The term “backchannel” was coined by Yngve (1970), who describes it as a process in which the person who performs the turn receives short messages from the addressee such as *uh-huh* or *yes*. The speaker controls the “main” channel (White, 1989) and conveys the main message, while the addressee provides information through the short messages without claiming the floor. In addition, Yngve argues that there are two levels of turn variables — “having the turn” and “having the floor”. He illustrates this with an example in which participants take “several turns before someone is giving the floor” (Yngve, 1970, p.575).

The discourse literature labels these utterances differently. They are known as acknowledgment tokens (Drummond & Hopper, 1993; Jefferson, 1984), continuers (Schegloff, 1982; Zimmerman, 1993), minimal responses (Fellegy, 1995), response tokens (Czyzewski, 1995; Gardner, 2001), and reactive tokens (Young & Lee, 2004). The majority of the authors researching the topic of backchannels describe the tokens as a homogenous set. This implies that tokens such as *uh-huh*, *mhm*, *yeah*, *mm* are lumped together (Bublitz, 1988; Dittmann & Llewellyn, 1968; Holmes, 1997; Yngve, 1970). Other researchers, mostly from the CA tradition, have been differentiating backchannels according to the function they serve in a given context. Sacks (1992 [1964-72]) coined the term “continuer” in reference to *uh-huh* and *mm-hm*. Gardner (2001) differentiated between *yeah* as an acknowledgment token, and *uh-huh* as a continuer. One more distinction was established between bodily backchannels such as gaze, nodding the head, and gesture, and vocal backchannels such as *uh-huh*, *mhm* (Yngve, 1970). This study

focuses on tokens similar to the latter and uses the term “backchannel” to refer to the short utterances produced by one of the speakers, who does not take the conversational floor.

The investigation of non-lexical utterances that have no referential meaning is challenging in the sense that absolute claims about their functions cannot always be made. Traditionally, backchannels are perceived as signals of attention, interest, and understanding (Czyzewski, 1995; Roger & Nesshoever, 1987; Yngve, 1970; Zimmerman & West, 1975). They are also found to reflect empathy and enthusiasm, but paradoxically, they can indicate lack of interest or indifference at other times. Lambertz (2011) looked at *yeah* and *mm*, and found that they fall into three categories — continuers, alignment and agreement tokens. Gardner (2001) suggested that their functions depend on sound shape and context — more specifically, the timing and the placement (within a sequence of talk or a single turn). In many cases, tokens serve a dual function. For example, *yeah* could function as a continuer in one context, but as an acknowledgment token in another.

5.2.1. Backchannels in medical discourse

Research on backchannels in medical discourse views these items mainly as a minimal “third turn” expansion in question series (Fitzgerald & Leudar, 2010; Heritage, 1984a; Schegloff, 1995; ten Have, 1991). For the most part, when uttered by the doctors, they are used as a signaling device indicating that information is received and that the patient can go on. Nevertheless, some systematic distinctions between different continuers have been established. Jefferson (1984) analyzed *mm hm* and *yeah* in excerpts from American and British medical interactions and suggests that they perform distinct work. *Mm hm* indicates “passive reciprocity”, while *yeah* initiates speakership. Mazeland (1990) also found that the use of *mhm* signals passive reciprocity in his investigation of doctor-patient communication. Finally, ten Have (1991) reached the conclusion that continuers do not reveal the doctor’s opinion of the patient’s answer. Their job is simply to invite the patient to provide more information on the topic and to advance the conversation.

However, research in psychotherapy found backchannels to be able to carry emotional load and affective stance. In addition, these minimal tokens are extremely frequent in psychotherapeutic discourse. Most therapies, especially client-centred ones, require the therapist to be a non-intrusive and non-judgmental listener. The status of a

listener, however, offers the therapist a limited set of activities in the conversation. One way to participate in the ongoing talk is through the production of backchannels. Gerhardt and Beyerle (1997) claimed that the use of response tokens is largely responsible for the success of the therapeutic work. They propose a “scale of speaker 2 alignment with speaker 1” in which there is progression of affirmative intensity. On that scale, acknowledgment tokens as *mm-hm* and *uh-huh* have positive valence followed by *yeah*, *yes*, which expresses agreement; *sure*, which signals certainty; *right*, which is equivalent to “exactly”; and at the end of the set is *I bet*, which conveys the meaning of “to stake a bet that something is so”. Fitzgerald and Leudar (2010) demonstrated that the use of continuers by therapists can support the facilitative climate necessary for successful therapy. They analyzed the use of the continuer *mm* as a therapeutic device and found that, depending on the prosody, it can carry the therapist’s stance on the client’s narrative. In their data, *mm* shows three distinctive functions. *Mm* functions as a classical continuer when produced with mid volume and no emotional content. In this form, *mm* simply indicates that the therapist is present and listening. *Mm* is an empathic continuer when the volume is low and the content emotional — that is, when the client is revealing feelings or working on a problem. And, lastly, *mm* functions as a channeling continuer when the volume is high and accompanies the client’s positive expectations. Buttny (1996), on the other hand, investigated the use of continuers by clients and found that in specific contexts they express “I do not wish to elaborate on this”. Finally, Muntigl and Zabala (2008) demonstrated that continuers produced by the therapist such as *mm hm* functions as “expansion elicitors” when they are preceded by pauses.

The analysis of backchannels will be concerned with the functions of *mm hm* and *yeah*. The reasons behind this decision are as follows: first, these are the most frequently used backchannels in the data; second, they are the most studied in medical discourse; and third, I want to see whether their uses relate solely to the process of elicitation or to the process of rapport as well.

The analysis will be guided by the following research questions:

1. What is the distribution of *mm hm* and *yeah*?
2. How are prosody and sequential placement related to the interactive functions of the backchannels?

3. How do *mm hm* and *yeah* contribute to the elicitation and the collaborative nature of the discourse in alternative medicine sessions?

5.2.2. Distribution

Since the two backchannels differ in that *mm hm* stands for a non-lexical item only, while *yeah* can have semantic content, for the purpose of the analysis, instances where *yeah* functioned as the part of a question-answer sequence are eliminated. In these cases, *yeah* stands for an affirmative answer, not for a backchannel.

Table 19 Distribution of *mm hm* and *yeah* across sessions

Speaker	<i>mm hm</i>		<i>yeah</i>		Total per participant	Total per dyad
Franca	1.24	(65)	0.05	(3)	1.29 (68)	
Kate	0	0	0.84	(44)	0.84 (44)	2.13 (112)
Franca	0.63	(66)	0.24	(26)	0.87 (92)	
Richard	0.30	(32)	0.17	(18)	0.47 (50)	1.34 (142)
Franca	0.66	(25)	0.55	(21)	1.22 (46)	
Martin	1.49	(56)	1.25	(47)	2.74 (103)	3.96 (149)
Erika	0.60	(20)	2.02	(67)	2.62 (87)	
Ingrid	0.15	(5)	0.99	(33)	1.14 (38)	3.76 (125)
Erika	0.12	(6)	1.48	(70)	1.60 (76)	
Tom	0	(0)	0.29	(14)	0.29 (14)	1.89 (90)
Erika	0.21	(9)	0.94	(40)	1.16 (49)	
Maria	0.14	(6)	0.78	(33)	0.94 (40)	2.1 (89)
Erika	0.21	(10)	0.64	(30)	0.86 (40)	
Thea	0.23	(11)	0.66	(31)	0.90 (42)	1.76 (82)
Erika	0.17	(6)	0.62	(21)	0.80 (27)	
Shelley	0.17	(6)	1.55	(52)	1.49 (50)	2.29 (77)
Erika	0.44	(20)	0.91	(41)	1.36 (61)	
Christie	0	(0)	1.54	(69)	1.54 (69)	1.36 (130)

Note: Raw counts are in parenthesis

In order to accurately compare the distribution of backchannels across sessions with different duration and number of words produced, I present in Table 19 the frequency of *mm hm* and *yeah* normalized to 100 words. It can be seen that Franca has a stronger tendency to produce more *mm hm* (65) than *yeah* (3) in the sessions with Kate and Richard, while the number of occurrences of the two backchannels in the session with Martin is almost equal (25 vs. 21). In general, Franca produces *mm hm* three times more often than *yeah*. The patients also have a preference toward *mm hm* compared to *yeah*, with the exception of Kate, who produced zero *mm hms*. Overall, Franca produced more

backchannels than the patients, with the exception of the session with Martin, where the patient produced two times more backchannels than the doctor.

In contrast to Franca, Erika shows a strong preference toward *yeah* in all of her sessions. She produces *yeah* three times more than *mm hm*. The same is also true for her patients — they produce *yeah* three to eight times more than *mm hm*, with two patients producing zero *mm hms*. Unlike Franca's patients, Erika's patients show a strong preference toward *yeah*. One explanation for this contrast is that there possibly exists some sort of alignment between participants, which leads to linguistic convergence at the level of backchannels. Linguistic convergence and divergence comprise the fundamentals of Accommodation Theory (Giles et al., 1991), which exist on many linguistic levels. In our case, *yeah* can be interpreted as a convergent feature whereby, based on interpersonal influence, the patients align their speech to the high frequency of *yeah* used by the doctor.

5.2.3. Prosody and sequential placement

Mm hm

The instances of *mm hm* are stand-alone items, with a few exceptions where they are accompanied by the token *OK*. The majority of these are found during extended turns by the other speaker. The extended turns usually perform a story telling or a long explanation. *Mm hms* mainly appear at turn-constructural units or at “opportunity space” where there is a partial grammatical completion (Lerner, 1996). The analysis that follows is concerned only with a simple distinction between rise and fall contours, which are impressionistically perceived.

Mm hm with rising intonation

These are mostly found with narratives by another revealing factual information. The largest number of *mm hms* in the data is observed in the *history taking* stage. The functions of the doctors' *mm hms* are differentiated based on the intonation contour. Example 32 is an illustration of the therapist's use of *mm hm* as a continuer.

Example 32

- 1 Franca: Tell me a bit what is going on with you.
2 Kate: ... As the doctor prescribes the medication I told you on the phone...
3 and said to take half of the pill,
4 Franca: **Mm hm** ↑
5 Kate: which was 7.5 mg, I think.
6 Franca: **Mm hm** ↑
7 Kate: Half is 7.5.
8 Franca: **Mm hm** ↑
9 Kate; The whole pill is 15
10 Franca: OK
11 so something like that
12 Franca: **Mm hm** ↑
13 Kate: and I found for the first couple of nights just... how my mind stop
14 bouncing around
15 Franca: **Mm hm** ↑
16 Kate: and I was able to fall asleep.

All of the *mm hms* above occur at TRP, which indicates that the doctor is actively listening. Fitzgerald (2013) described such instances in short-term therapy as “channeling continuers” which signal heightened involvement. The work that *mm hm* is performing here is very similar to what Fitzgerald reported and in contrast to Bublitz (1988), who claims that backchannels were used to simulate listenership. If that was the case, the occurrences of *mm hm* should have been expected to be scattered and random, not systematic by being placed exclusively at TRPs. Moreover, the backchannels in lines 4, 6, 8, 12, 14, and 15 come at the end of TCUs. At these points the doctor has the opportunity to self-select and take the conversational floor, but instead she decides to pass up this possibility. She continuously performs *mm hms* over the patient’s extended turn and, in doing so, she prompts Kate to say more on the topic. This successfully results in Kate providing additional bits of information after each *mm hm*.

Erika also uses *mm hm* with rising intonation in order to secure listenership, elicit information and move the conversation. She shows different choices of backchanneling (Example 33, line 2, 4, 6, 8, 10), all occurring at TRP or opportunity spaces. Ingrid begins to describe how her cat helped her reduce anxiety. The doctor has all *mm hms* repeated in her turns, which indicates curiosity, invitation for Ingrid to go on, and attention to what

is being said. There is a minimal time juncture between Ingrid's utterances and the doctor's *mm hms*, which also contributes to the doctor being intrigued by the story. This is a typical illustration of a continuer token that recognizes "that the story is yet going on" (Sacks, 1992 [1964-72]).

Example 33

- 1 Ingrid: And Zuy is like... still. He is really amazing. When David can't sleep
- 2 Erika: Yeah
- 3 Ingrid: and David had a really rough night, I change beds
- 4 Erika: **Mm hm, mm hm** ↑
- 5 Kate: to sleep and animals aren't allowed in our room
- 6 Erika: **Mm hm, mm hm** ↑
- 7 Ingrid: but they can come in this other room where
- 8 Erika: **Mm hm, mm hm** ↑
- 9 Ingrid: It's like where I do yoga
- 10 Erika: Right
- 11 Ingrid: and so he just lies on me
- 12 Erika: Yeah
- 13 Kate: It's amazing how that ... like the weight
- 14 Erika: [Oh, yeah!]
- 15 Ingrid: [of him], he is like seventeen pounds
- 15 Erika: Oh, so he is a big boy!
- 16 Ingrid: Big boy ... just really puts me under
- 17 Erika: Yeah
- 18 Ingrid: Like, he can calm me down from a disruptive feeling.
- 19 Erika: They know! I believe they know.

Mm hm by patients is exclusively used as a continuer with rising intonation (Example 34). Their function is to express an interest as the doctor reveals useful information for them with no emotional content. This can be perceived as an illustration of partnership building communication in which participants use interest cues to show active enlistment (Roter & Hall, 2004).

Example 34

- 1 Maria: ... right now, I am not eating any yogurt.
2 Erika: OK
3 Maria: I don't know if it's a good thing.
4 Erika: Well, yeah, OK, that's fine.
5 Maria: Yeah
6 Erika: If I push a dairy product, I don't mind yogurt.
7 Maria: **Mm hm** ↑
8 Erika: 'cause some fermented foods are good for you. In this case it can be
9 One of them but it is still a mucosi type of food
10 Maria: **Mm hm** ↑
11 Erika: so you wanna be careful with that. And that would add to the
12 dampness in the body which adds to cysts and kind of stuff.
13 Maria: **Mm hm** ↑
14 Erika: Alright? So, I am giving you the whole season.

Here, the patient wonders whether excluding dairy from her diet is a good thing. Erika explains the effects that dairy has on the body, and as Maria listens to this she produces backchannel tokens at TRP places. After each turn-constructural unit performed by the doctor, Maria does not grab the floor as she might have done. Instead, she utters *mm hms*, which here functions like the statements “I am listening, I am present, I want to know more”. The *mm hms* are delicate interventions aiming to show interest in what the doctor is saying and present a “passive reciprocity” stance at the same time. Jefferson (1984) shows how the realization of “passive reciprocity” can elicit further talk, and she claims that this is a technique typical for interviewers. Here, the same strategy is used by the patient, who by producing *mm hms* evokes and projects further talk, and, eventually, receives the information she needs. This occurs when the doctor elaborates on the topic of whether yogurt is good or not and why.

***Mm hm* with falling intonation**

Unlike the *mm hm* with rising intonation, the *mm hms* with falling contour accompany mostly narratives of a sensitive emotional nature and are only produced by the doctors. The following example illustrates nicely the contrast in the use of the two *mm hms*.

Example 35

- 1 Franca: So, tell me what's going through your mind.
2 Kate: At night?
3 Franca: Mm hm ↑
4 Kate: Anything and everything.
5 Franca: Yeah?
6 Kate: Any- nothing that I am worried. Like some things I'm worried about
7 my son starting kindergarten so a little bit...
8 Franca: Mm hm ↑
9 Kate: Lots of changes.
10 Franca: Mm hm ↑
11 Kate: I think in the beginning when I first had my son I was guilty a lot, you
12 know, mother's guilt.
13 Franca: **Mm hm** ↓
14 Kate: Aaam, but no, the thoughts were just bouncing from one person, not
15 even about myself, thinking about other people,
16 Erika: **Mm hm** ↓
17 Kate: the things that are going on
18 Erika: **Mm hm** ↓
19 Kate: Eeem.... (1.5)
20 Erika: Do you watch TV at night?

The doctor sets up the topic of the conversation with the command in line 1. Kate provides an account of her experiences starting with a vague statement in line 4, which further gets unfolded into more specific descriptions. Kate begins her answer by talking about her son starting kindergarten. She receives encouragement to go on by the doctor through *mm hms* produced with a rising intonation. The moment Kate mentions her feelings of guilt as a mother, the doctor's *mm hms* change their contour (line 13, 16, 18) and are now produced with a falling intonation. These *mm hms* have a supporting role, trying to secure an atmosphere of trust where the patient can safely share vulnerable experiences. They express understanding, and in this sense present an engagement with the patient's feelings. Such supportive tokens become natural features of alternative medicine sessions, where one of the principles is to provide a safe environment for the patients regardless of the school in which the doctor was trained. This type of continuer is very similar to the empathic continuers that Fitzgerald and Leudar (2010) found in center-focused psychotherapy. They carry an empathic component that is unobtrusively

expressed through the intonation contour. In that setting, the *mm hm* with falling contour exhibits the function of a continuer, but there is more to it. It expresses “I see” or “I empathize”, which adds another layer of support and understanding. Nevertheless, the *mm hm* in line 18 is at the end of a turn-constructural unit where Kate has finished a complete grammatical and pragmatic segment. She has provided the doctor with an answer, but hesitantly continues with “eem” to probably reveal more on her thought patterns. This “eem” is followed by a pause of 1.5 sec. However, the doctor takes the opportunity to fill that pause by self-selection and shifting the topic by asking the question in line 20. It seems that she has received sufficient information from Kate and decided to gather further details on another matter in order to fully understand the patient’s situation.

Yeah

A differentiation between rising and falling intonation is observed with the backchannel *yeah* as well and its variants *yes* and *yep*. In contrast to *mm hm*, *yeah* occurs not only in isolation, but also with additional talk.

Yeah with falling intonation

Yeah with falling intonation is claimed to be the canonical use of this token marking acknowledgment (Gardner, 2001). This is overwhelmingly confirmed by the present data. Doctors use *yeah* ↓ when they listen to a personal narrative, often on a sensitive topic. In Example 36 Thea shares her concerns about her boyfriend, to which the doctor responds with *yeah* ↓ in line 4. The backchannel is at an opportunity space, that is, after a subordinate clause (line 3), but before a subsequent main clause (line 5). It marks an agreement with the statement that Thea provides in line 3. Moreover, it is pronounced with very low volume, which is in alignment with Thea’s feelings on the subject. The empathic component that *yeah* ↓ carries here is similar to the emotional load of *mm hm* ↓, which is used by the doctors in similar contexts discussed below:

Example 36

- 1 Thea: ... Like sometimes puts his guard up and then
- 2 Erika: Sure, something is triggering him, yeah.
- 3 Thea: yeah and then like maybe if he is stressed up in his own life
- 4 Franca: **Yeah** ↓
- 5 Thea: takes it al. I don’t know...

Patients mainly use *yeah* with falling intonation, both in isolation (lines 2, 7, 14) and together with further talk (line 16), as in Example 37:

Example 37

- 1 Franca: So, again — the higher the fat level
2 Kate: **Yeah** ↓
3 Franca: the more satisfied... they will be (the babies).
4 Kate: OK
5 Franca: But usually, you know, three hours is what I look at to make sure they
6 are starting to twitch a bit and starting to wake up
7 Kate: **Yeah** ↓
8 Franca: and that is usually a healthy design. Hm, so... for the last two and a
9 half months you haven't been taking your minerals. Usually, what we
10 recommend when you are still breastfeeding, is exactly the same
11 amount because you need extra calcium and extra vitamins and
12 minerals because you are actually helping someone to grow right
13 now
14 Kate: **Yeah, yeah** ↓
15 Franca: and so you are actually the factory.
16 Kate: **Yeah** ↓ like... and he is taking everything, right?

The *yeah* here functions as a token of acknowledgment. After each piece of information from the doctor, Kate performs *yeah* ↓ and so signals adequate receipt of the doctor's turn. Unlike *mm hm*, *yeah* is oriented to the prior talk (Gardner, 2001) and not toward the projection of further talk. Its job is to assert to the speaker that the message is received and acknowledged. The fact that the listener decides to provide the speaker with such a cooperative strategy contributes to the establishment of a common ground. In other words, Kate makes the doctor aware that they are “on the same page” or at least she understands what the doctor is talking about. This status is kept till line 15, where Kate changes her role from listener to speaker and after *yeah*, she asks a question. This transition is observed nowhere with the production of *mm hms*, which does not lead to speakership initiation.

Yeah with rising intonation

Although the core function of *yeah* is that of an acknowledgment, there are instances where *yeah* is accompanied by a rising intonation contour. These are performed

by the doctors. In these cases, *yeah* functions as a continuer. In the following example, the doctor pronounces *yes* repeatedly with rising intonation and with the second time overlaps with the patient's speech. This cooperative overlap is indicative of increased involvement and positive affect.

Example 38

- 1 Shelley: I've been using the roller
- 2 Kate: **Yes, ↑ yes ↑**
- 3 Franca: To [loosen this] out
- 4 Kate: **[Yes, ↑ yes ↑]**
- 5 Franca: but it's very painful.

5.2.4. Conclusion

The use of backchannels in the present data shows that they serve many interactional functions. Similar to their use in medical visits, they signal that information is received and that the speaker can continue. At the same time, they function as a non-directional, non-obtrusive strategy to elicit information, which is a regular practice in psychotherapy.

There were individual preferences among the doctors. *Yeah* shows higher frequency than *mm hm* with Erika and her patients as compared to Franca and her patients. Furthermore, *yeah* is found in isolation, but also together with further talk, whereas *mm hm* is never found with further talk. The core function of *mm hm* is that of a continuer realized in two functionally distinct contexts — with rising intonation when the information is neutral, and with falling intonation, when the talk is emotionally loaded. As such, *mm hm* exhibits cooperative use — it functions as an active listening device, it asserts understanding, and it encourages speakers to reveal useful information. *Yeah*, on the other hand, also exhibits rising and falling contours. When accompanied by the canonical falling contour, *yeah* functions as an acknowledgment token, asserting alignment or agreement. When the contour is falling, then *yeah* works as a continuer (Table 20):

Table 20 Summary of the functions of backchannels

Mm hm		Yeah	
Mm hm ↑	elicitation, active listening, understanding	Yeah ↑	alignment, agreement
Mm hm ↓	support, empathy	Yeah ↓	active listening

Another result from the analysis is that *yeah* shows speakership incipency (Gardner, 2001), while *mm hm* shows zero speakership incipency. That is, in many cases *yeah* is followed by same-speaker further talk, unlike *mm hm*, which comprises the only utterance in the turn. Finally, the analysis of *mm hm* and *yeah* illustrates an important dimension of the talk-in-interaction — that the listener is not a passive actor, but also a co-structor of interactive talk. Both backchannels index “attuned discourse management” (Giles et al., 1991), whereby doctor and patient show each other supportive reciprocity.

These observations on the functions of backchannels are consistent with some crucial dimensions that are at the core of patient-centred models. For example, fostering the relationship in the de Haes and Bensing’s model (2009) is viewed as crucial for the quality of health care. This includes building rapport by virtue of being empathic and respectful. The functions summarized in the table above illustrate mutual attentiveness and response to emotions. According to Roter and Hall (2004), backchannels are elements of the partnership building. Their research also found out that it is female physicians who used them more frequently.

5.3. Joint productions

Rapport is the second phenomenon of interest in this study that I consider an essential part of alternative medicine sessions. In this section, I turn my attention to the mechanisms that work toward building rapport. I start with joint productions. I provide a review of how these jointly produced utterances are seen and examined in the literature (5.3.1). Then I move on to discuss what I found (5.3.2) and end with concluding remarks 5.3.3.

Research on discourse strategies used in psychotherapy sessions (Ferrara, 1994) has shown a frequently-used sequence where a speaker initiates a turn and the listener completes it. According to Ferrara (1994), such completions of a turn demonstrate a

strategic use of cohesion. They present interlocked utterances when speaker A initiates a proposition and speaker B completes it or extends it in a syntactically and semantically aligned fashion.

An instance of a joint production is the following example where the doctor asks the patient to describe the sciatic pain that she experiences. The time junction between the two utterances — the patient's utterance and the doctor's joint production — is indicated in brackets, which are respectively five and three tenths of a second.

Example 39

- 1 Shelley: I feel it like elastic, just =
- 2 Erika: (0.5) = springs back
- 3 Shelley: Yeah.
- 4 Erika: (0.3) = or won't move back
- 5 Shelley: Yeah, yeah.

The completions are performed in the speaker A's turn-in-progress, in this case the patient's turn. They usually appear at an opportunity space, that is, at a possible Transition Relevant Place, and bring the current turn-unit-in-progress to a completion (Lerner, 2004). Such instances of collaborative meaning making are not isolated cases in the data from alternative medicine sessions. The analysis that follows aims to provide answers to the following questions: Why do these collaborations occur in this particular context? What are the motivations behind the joint productions and what facilitates them? What social actions do they represent?

5.3.1. Previous work on joint productions

The discourse phenomenon of utterances that are jointly constructed is well known in the literature (Duncan, 1974; Goodwin, 1979; Goodwin, Goodwin, & Yaeger-Dror, 2002; Jacoby & Ochs, 1995; Lerner, 1991; Sacks, 1992 [1964-72]). As with backchannels, these jointly produced utterances are labeled differently across researchers. Sacks (1992 [1964-72]) and Schegloff (1984) used the term "collaboratives", but elsewhere Sacks (Ms, Ch.3) referred to them as "joint productions". Sacks examined two types of joint productions: "sentence extensions" and "helpful completions". In the context of psychotherapy Ferrara (1994) investigated these and identifies three more — "predictable utterance completions", "invited utterance completions", and "delayed utterance completions". She argued that the

motivations for their existence range from seeking truthfulness to eliciting information. Examining how the affiliating utterances are created and used in women's friendly conversations, Coates (1987) labeled them "jointly constructed utterances". Lastly, Lerner names the sequences "compound turn construction units", but later refers to them as "pre-emptive completions" (Lerner, 2004). The labels reflect similar theoretical conceptualizations of the phenomenon. For this study, I will use the term "joint production" to refer to these types of turn completions.

Completing the sentence of the other is a discourse strategy used in a variety of situations. Utterance completions are widely observed in day-to-day conversations of ordinary people (Coates, 1987; Ferrara, 1992; Goodwin, 1987; Jefferson, 1973; Lerner, 1991; Sacks, 1992 [1964-72]; Schegloff, 1994). Ochs, Schieffelin and Platt (1979) explored them in the speech between caretaker and child. Sacks (Ms, Ch.3) observed joint productions in group therapy, while Duncan (1974) investigated them in individual therapy. In the context of patients with aphasia, Oeschlaeger and Damico (1998) identified word search, turn completion, and "appendor" production as types of joint productions.

All patients who participated in this research have frequent contact with the two doctors. It has been found that frequent contact may help to create a growing degree of familiarity and facilitate the use of more informal talk, which with time could promote the existence of jointly produced utterances (Coates, 1987; Ferrara, 1994). Coates (1987) noted that in talk between equals, speakers will often build a collaborative floor, and what is being talked about will be jointly accomplished (Coates, 1987, p.70). It is a fact that doctor and patient in alternative medicine sessions are not equals, but the data reveals that both patients and doctors demonstrate recurrent interactional practices like joint productions and repetitions that express collaboration and rapport typical for less formal styles of speech and symmetrical talk. These highly accommodating practices indicate the existence of a mutual understanding and common ground upon which participants build and co-construct meaning in conversation.

An important data-based consideration is the question of how joint productions are different from interruptions. In the following analysis, joint productions will be treated differently from interruptions for the following reasons. As Ferrara (1994) suggests, joint productions are syntactically and semantically a continuation of speaker A's utterance. Interruptions, however, occur independently and have no syntactic or semantic

considerations related to speaker A's utterance. Second, they do not aim to shift the topic, whereas interruptions do. On the contrary, they complete the meaning of speaker A's input without changing the topic. Third, they do not aim at seizing the turn and cutting off speaker A. In all but one case in the data, speaker B, who completes the turn, does not attempt to continue talking or redirect the topic. She doesn't offer elaborations, but instead steps back and speaker A "regains" the floor. As will be discussed with one of the types of joint productions, the "invited joint productions", the floor is not actually taken by speaker B, but speaker A "invites" speaker B to participate in a jointly created utterance. Ferrara makes the point that joint productions are convergent and interruptions are divergent practices. They represent attuned talk, while interruptions disrupt the talk of the other. In some cases, they can function as a face-saving strategy. Example 40 exemplifies all three differences. Richard's completion "it's stepping" is a subordinate clause that is syntactically and semantically aligned with the doctor's proposition in lines (3-5); it does not change the topic, and does not seize the turn.

Example 40

- | | | |
|----|----------|---|
| 1 | Richard: | So, you wouldn't recommend though that I cycle over Grouse |
| 2 | | mountain and go up the Grind? |
| 3 | Franca: | Actually, the Grind will be OK with you. Because the Grind is |
| 4 | | actually a really good work-out, because we know [that] |
| 5 | Richard: | [it's stepping] |
| 6 | Franca: | and it is also going against gravity, right? |
| 7 | Richard: | Ahem. |
| 8 | Franca: | So, it's already a hill work out. So yes, I highly recommend that to you. |
| 9 | | But to do both together at the same time — I am not sure if I'll do it the |
| 10 | | first time. I think the first time what I'll do is test it out but just doing |
| 11 | | the Grind. |

5.3.2. Results and discussion

The basis for the present analysis is a set of 48 instances of joint productions extracted from four hours and 38 minutes of speech from alternative medicine session dyads with nine different patients and two doctors. The classification (Ferrara, 1994) takes into consideration syntactic form, prosodic signals, and received response. The following four types will be discussed below:

1. Utterance extensions (Extensions)
2. Predictable utterance completions (Predictable)
3. Helpful utterance completions (Helpful)
4. Invited utterance completions (Invited)

Table 21 Distribution of joint productions

Patient	Exten D	Exten P	Predict D	Predict P	Helpful D	Helpful P	Invited D	Invited P	Total Session
Franca									
Kate	1	1		1			2		7
Martin							1		1
Richard	2		1	2	1				6
Erika									
Ingrid			3	1	1				5
Tom			10		1				9
Maria		1	1						2
Thea		2	4				1		7
Shelley		1	6		1				8
Christie	1		1	1					3
Total Type	4	5	26	5	4	0	4	0	48

Note: D: Doctor; P: Patient

The data showed that both doctors and patients participate in the creation of joint productions. The most frequent type of joint production is the Predictable utterance completion, with 26 instances performed by the doctors, from which 25 are produced by Erika. Utterance extensions by doctor and patient, as well as Predictable utterances by patient and Helpful utterances by doctor, range from four to five instances. Helpful and Invited utterances by patient are not performed at all.

Utterance extensions

The first class of joint productions is that of Utterance extensions. They present an expansion of an already syntactically complete proposition. In the following example the doctor questions Kate about her evening habits and what she usually does before she goes to bed.

Example 41

- 1 Franca: What kind of activities do you do?
- 2 Kate: I'm nursing=
- 3 Franca: = (0.7) OK and then he falls asleep=
- 4 Kate: =(0.1) and then
- 5 I can maybe look up at the computer

Kate's reply "I'm nursing" is a syntactically complete utterance S (NP +VP) which gets extended with the doctor's backchannel "OK" and then a jointed VP "and then he falls asleep" with only seven tenths of a second latching time. With this extension the doctor participates in the creation of a collaborative narrative but at the same time, probes the accuracy of the facts and looks for a confirmation. This confirmation is given in line 5, where Kate contributes with another utterance to the narrative. This way she extends the doctor's proposition in line 4, but also validates the doctor's extension and accepts it. The sequential organization of this multi-turn utterance takes the form of:

Proposition

Extension 1/Proposition 2

Extension 2/Proposition 3

where extensions build on one another like brick layers in a collaborative fashion. The original speaker of the TCU, Kate, regains her speakership and attempts to bring the turn to completion in line 5. As Lerner (2004) suggests, affiliated utterances are candidate completions, not just guesses, and in this example the candidate in line 4 is accepted as the right one. It looks like the motive for Utterance extensions here is an interest in the truthfulness and accuracy of the facts. It looks also like the speakers are tacitly following Grice's (1975, p.45) Cooperative principle and its third conversational maxim (Quality), which governs truthfulness: "Do not say what you believe to be false and do not say that for which you lack adequate evidence" that is, and look for truthful propositions. When in doubt, speakers offer "a truth-insuring extension" (Ferrara, 1994), which in this case is line 5.

Let us consider another example of an extension. In the following extract, Thea throws in a conjoint VP to make more complete and more accurate the doctor's statement.

In this particular episode of the session they are discussing Thea's temperament and what an impact this has on different areas of her life.

Example 42

- 1 Erika: But then it depends on what your life experiences bring to you and
2 and how you react to that. **So that be to trigger things or down, or**
3 **whatever, [but]**
4 Thea: **[or] high them up**
5 Erika: (0.1) or high them up is right

As with the previous extract, the extension in line 5 serves as a check for truthfulness. The overlapped speech suggests Thea's impatience to complete the doctor's proposition and to offer a candidate that will best clarify the meaning of the proposition. The doctor can be seen as acknowledging and accepting the extension by incorporating it in her own turn in line 5.

Although Utterance extensions are defined in our discussion as extensions of already complete propositions, there exist cases, like the following one, where features of two types of joint productions can be said to take place. In the segment from which this example is taken, the doctor and Shelley have been reflecting on the meaning of physical pain and what it tries to tell us about our bodies and lifestyle changes that need to be taken. Shelley comes to the session with severe back pain. She expresses her frustration at not being able to understand why this happened and feels helpless in finding a solution:

Example 43

- 1 Erika: **Alright, so now it's talking about getting a wake-up call**
2 Shelley: Yeah
3 Erika: **of a worse kind [but]**
4 Shelley: **[but] it's not getting you back to the gym. Takes**
5 **a lo:ng time.**
6 Erika: Yeah. You can feel? Sorry honey, but I got to stimulate.

The doctor expresses the opinion that the pain is a wake-up call of a worse kind, which presents a complete utterance. At this possible completion of the propositional unit, the doctor continues with "but" (line 3), which gets overlapped with Shelley's "but" (line 4) and followed by a conjoined VP (line 4). This single instance of a joint production, itself an Utterance extension, also entails the use of a Predictable utterance completion. Here, the

completion “but it’s not getting you back to the gym” brings forward another possible motivation for this type of joint production — that of clarity. While Shelley could have agreed with the proposition made by the doctor, she, however, has the urge to clarify that although she should follow the implied advice to take it easy in order to feel better, she will not feel great until she starts going to the gym again.

The data suggests that this type of joint productions demands completeness, correctness, and clarification in terms of the truthfulness of the information. Utterance extensions are performed both by the doctors and patients and present 18% of all joint productions. Half of them are introduced by overlapped speech instead of a pause between the utterances, and all of them were confirmed except one, which was not confirmed, but not rejected either.

Predictable utterance completions

The Predictable utterance completion is the most frequent type in the data and accounts for 54% of all joint productions. Unlike *Utterance extensions*, Predictable utterance completions offer a completion to an unfinished proposition. Ferrara (1994) suggests that “speakers project their intended utterances well before their point of completion” (1994, p.159). How exactly is this done during talk? What clues does the addressee receive in order to start initiating a joint production? Are these clues always clear, or do speakers undertake this collaborative activity regardless of how clear the clues are? Do their completions get rejected and, if so, in what context and who does it the most — the doctor or the patient? These are the questions that will lead the following discussion.

Mechanisms and forms

The process by which these types of completions take place involves overlapped speech and different kinds of cues. The latter function as signaling devices for an upcoming completion and for a type of collaborative turn sequences. A decision to contribute collaboratively to the ongoing turn-in-progress occasionally results in overlapped speech. The overlapped speech can be a total match of utterances:

Example 44

- 1 Erika: What dosage you take?
2 Ingrid: 1M
3 Erika: 1M, OK
4 Thea: And I took it... The day before I've got the cold, I got it. Last time I
5 was here... **It was... [three weeks ago]**
6 Erika: **[three weeks ago]**
7 Ingrid: That's when I started the Amica.

The two speakers say exactly the same thing and thus, signal synchronicity and attuned talk. Alternatively, the overlapped portion can result in two different word choices. The example below shows that the word choices have actually closely related contextual meaning and both take the form of a PP:

Example 45

- 1 Erika: So, let's see what the results tell us.
2 Christie: Yeah. Well, it was interesting it wasn't flagged.
3 Erika: Right
4 Christie: **Like I've had two [last year]**
5 Erika: **[from before]**
6 Christie: and I was like: "Hugh".

The average length of these completions is two to four words with the exception of one case in the data where the length was seven words presented by two conjoined VPs. In terms of their syntactic representation, Predictable utterance completions take the form of a NP (Predicative nouns and complements (Adj + N)), a VP in present tense, or an AdvP for time or manner.

Jaffe and Feldstein (1970), among others, suggest that speakers can often project what the other would say. If joint productions are a universal strategy, then why do speakers decide to engage in such an activity and what do they gain from it? How do speakers make the projectability available? First, it seems that speakers orient their predictable completions to an opportunity space in the turn-in-progress of the other speaker (Lerner, 2004). Second, these opportunity spaces are signaled by certain cues. Ferrara suggests four cues to the juncture that facilitate Predictable utterance completions. These are word stretches, conjunctions, brief pauses and laughter. In the

present data, pauses were the most used signal for a speaker to take on a guess and complete an utterance-in-progress. The pauses are measured at less than half of a second. In Example 46 Ingrid was asked about her complaints; she talks about her sleepless nights, recent cold, and then she shares a concern about her liver. Here, we actually have two cues that provide a potential space for a sentence completion work: the pause after Ingrid's "giving me a bit of", which is extremely short (0.1 sec), but also the repetition of "bit", which suggests hesitation on her end.

Example 46

- 1 Ingrid: My liver is a little bit... giving me a bit of ...=
- 2 Erika: (0.1) = hard time
- 3 Erika: Mine does too.

The doctor not only completes the initiated utterance by Ingrid, but also takes the opportunity to retain the floor for a little while and adds another statement, "Mine does too", in order to validate the patient's experience and show understanding of the situation. In that sense, the collaborative completion becomes a facilitator of empathy (Roter, 2000) and works toward partnership building.

Providing a completion also prompts a collaborative turn sequence (Lerner, 2004):

Speaker A: Proposition (beginning of a TCU)

Speaker B: Completion (completion of the TCU)

Speaker A: Assessment of the completion (confirm/reject/other of the TCU)

The proposition could be performed by either party. The propositions in line 4 (Example 45) and in line 1 (Example 46) in are proposed by the patients, while that in line 1 (Example 43) is performed by the doctor. The second speaker provides a completion of the turn and thus, finishes the TCU in process. What differentiates this type of completion from the other three is the emergence of the assessment slot in which speaker A resumes speakership.

The existence of the assessment slot offers a few important things to consider. First, it shows that, although speaker B violates the rule "one speaker at a time" (Sacks et

al., 1974), in the cases of overlap he/she does step back after the completion and the initial speaker regains the right to talk. The stepping back proves that speaker is aware of this rule. In other words, while violating it momentarily, speakers do not do it bluntly. They only “bend” it (Ferrara, 1994) in order to perform interactional work. Second, the fact that speaker A regains speakership contributes to the argument that completions are not interruptions. Regardless of the assessment, positive or negative, they evaluate speaker B’s completion as a continuation of their own turn-in-progress. They possess the authority over the turn (Lerner, 2004).

And lastly, both the completion and the assessment slot construct the intersubjectivity of the talk. They are interactional, a response to what the other has just said. Engaging in a completion and its assessment, demonstrates that speakers participate in a meaning-making process. They negotiate it in order to achieve a common background and mutual understanding (Epstein et al., 2005).

The assessment slot provides three options. It can confirm the offered completion, reject, or provide an alternative.

a) Confirmations

Confirmations are abundant in the data. They are expressed in three ways: only with “Yeah”; with “Yeah” “I know!” “Absolutely” followed by an elaboration in the same turn, or with a build-up joint production.

b) Rejections

From all 26 examples, only one instance of an utter rejection and another one with a mild rejection made the completions unsuccessful. Both instances were performed by the patients. In Example 47 the doctor gives a homeopathic product to Tom in the form of drops sprinkled in his mouth followed by a small injection. He tries to assess the taste and to compare it with what he had last time. His utterances overlap with “higher”, but then the doctor completes with a “kick”, which Tom doesn’t seem to accept. He does it not with an outright rejection, but with the “not a kick so much”, which has a function of a hedge in this context.

By providing a mild rejection, Tom expresses his willingness to negotiate a meaning. As a reaction, the doctor probes again (after the unsuccessful completion) with the following question in line 8 in order to achieve common ground. Finally, Tom gave up, but the doctor reassures him that it is ok not to be able to explain. With her reassurance, she performs a face-saving strategy, which is another form of cooperative behavior.

Example 47

- 1 Erika: And now we are doing the three drops for the candida. Here we go.
2 Tom: Tastes almost the same.
3 Erika: Oh, well, you know....
4 Tom: **This has more of a lower ... the other a bit more of a**
5 **[higher]...**
6 Erika: **[higher] (0.8) kick**
7 Tom: Not kick so much but a...
8 Erika: The flavor was more peppery or?
9 Tom: Yeah. It was a bit more of a... It's hard to explain.
10 Erika: I understand. I get what you are saying because I used to be a music
11 teacher so when someone tells me "higher" I get it. So it's alright.

c) Alternatives

These are cases where either confirmation or rejection is provided.

Example 48

- 1 Franca: **So, needling is=.**
2 Richard: **(0.1) = like a porcupine.**
3 Franca: So, needling is a painful procedure. So you don't want to be giving
4 the patient a laser, prolotherapy, and more acupuncture because I
5 may have to live in the room for the night [laughter]

It could be argued that the doctor agrees with the completion, as she defines the acupuncture as a painful procedure, but that statement is not very convincing, because we do not know what Richard implies with the metaphor "like a porcupine". He might have in mind the visual image of a person with needles in their body imitating the needles of a porcupine. But alternatively, he might have in mind what it is to step on a porcupine and feel the pain from the needles.

And lastly, there is one case where the assessment slot was provided but not occupied. This is Example 46 repeated here in an expanded form:

Example 49

- 1 Ingrid: My liver is a little bit... giving me a bit of ...=
- 2 Erika: **(0.1) = hard time.**
- 3 Mine does too. (2 sec). All right. Hop on. You know the deal. Take care of the thing
- 4 because we are going to do that.

After the added nominal “hard time” and the elaboration “Mine does too” which serves as validation of the patient’s experience, there is a pause of two whole seconds, which is a relatively long pause in a conversation, that provides opportunity for a turn-allocation. However, Ingrid, who is the initial speaker in the collaborative sequence, does not take advantage of it. The doctor then self-selects with “Alright” and continues with instructions related to the health procedure that follows.

The data reveals that Predictable utterance completions demonstrate synchrony and focused talk. Two-thirds of them are performed by the doctor, mainly in the *history-taking* stage. Their motivation is to show understanding of what the other was about to say. They modify the topic in a certain direction, which most of the time is accepted by the interlocutors. This contributes to the establishment of a common ground.

Helpful utterance completions

The third type of utterance completion is a joint production that provides lexical help. According to Sacks (1992 [1964-72]), these are short additions made by speaker B upon detecting some hesitation on the part of speaker A. These joint productions are signaled by a pause or “uh” by speaker A, and are followed by one, maximum two words uttered by speaker B. There are only four cases of Helpful utterances. In Example 50 Tom is trying to recall what type of ointment he used. The doctor offers a guess and the rising intonation suggests that she is not sure whether this is the word Tom was trying to access in his mental lexicon. Tom confirms that the guess is right with the repetition “**The cream** that Michela had” in line 7.

Example 50

- 1 Tom: I've found I got some issues. I got a rash that's been developing. Well,
2 not a rash. Rashes.
3 Erika: Right, right.
4 Tom: or spots, like itchy spots
5 Erika: Right
6 Tom: **and I am trying the, some of that... =**
7 Erika: **(0.2) = the cream?**
8 Tom: The cream that Michela had.

The four Helpful utterances in the collected data are contributions from the doctor. There were cases where the distinction between Predictable and Helpful utterances was questionable, especially in cases where the signaling element was just a pause. The following excerpt illustrates this.

Example 51

- 1 Ingrid: yesterday was the first day I woke up and ha:d =
2 Erika: (0.7) = **a sleep.**
3 Ingrid: **A sleep!** Like... I've slept the night.
4 Erika: Yeah.
5 Ingrid: So I'm OK, I'm on the other side of this thing.

I had initially counted this as a Predictable utterance completion because of the slight word stretch in “ha:d” and the pause that followed. However, I noticed that the pause was longer and the assessment slot was taken by a repetition, which is never the case with Predictable completions. In the latter, the confirmation assessment slot is normally taken by “Yeah”, “Yeah, I know!”, “Absolutely”, and pauses are shorter. Furthermore, while analyzing carefully the audio files, I found that Helpful utterances always expressed considerable hesitation on the part of the speaker demonstrated by a longer pause and the intonation contour. The other difference was that they lack the projectability aspect of the Predictable utterances. Listeners provide just guesses as to what the missing lexical item could be. In all four cases of Helpful utterance completions found in the data, speakers signaled acceptance by repetition of the completion. In Example 50 this is illustrated by the repeated noun phrase “the cream” as incorporated in a new utterance, and in Example 51 by the noun phrase “a sleep”.

Invited utterance completions

The fourth type of joint productions that is observed is Invited utterance completions. These are similar to the previous type of utterance in that, they are all performed by the doctor. These utterances are quite interesting in a few aspects. In Example 52, the doctor is preparing Kate for an IV treatment. As Kate is anxious about it due to her fear of needles, the doctor tries to provide information that will convince her that the IV is necessary and beneficial for her.

Example 52

- 1 Franca: OK, so why don't we at least get going the IV?
- 2 ...
- 3 Kate: **So, this is gonna make me fee:l=**
- 4 Franca: (0.7) = relaxed.
- 5 Kate: A little bit more relaxed.
- 6 Franca: Absolutely.

Ferrara calls these “invited” because they are actually “questions masquerading as statements with the addressee intended to supply the missing Wh-information” (Ferrara, 1988, p.202). The turn-initial “so”, the elongation of the syllable in *fee:l*, and the pause of 0.7 sec, all suggest that Kate expects the doctor to answer a question that is not explicitly stated. In that sense, the patient successfully uses an elicitation strategy because the doctor provides the missing information.

Furthermore, the elongation of the syllable followed by a pause (0.7 sec) also contributes to the expectation for providing missing information. In that sense, Invited completions have the function of an elicitation tool. However, it is not clear whether speaker A knows the information and waits for confirmation, or simply does not know and looks for an answer. If it is the latter, the doctor’s completion can be seen as a face-saving strategy (Brown, P. & Levinson, 1987). An IV is a standard procedure for naturopathy, and a lot of doctors emphasize its benefits for the nervous system.

With this strategy the speaker does not use any syntactic form or intonation that indicates a question, yet an answer is still required. That is why such utterances are disguised questions that invite the interlocutor to provide the information. It could be argued that with the word stretch and the pause, speaker A gives speaker B the opportunity to take the floor and perform a turn. However, this is not the grabbing-the-floor

action performed by speaker B, as she intervenes only to provide information and then steps back. Speaker A then continues with further utterances. That indicates that the speakers are tacitly aware of the rules of turn-taking in a conversation.

Unlike the other type of joint productions, Invited utterances are not voluntary but requested. “In order to remain cooperative, interlocutors are forced into syntactically completing a sentence” (Ferrara, 1994, p.163). The doctors have other options to react to such masked questions — to change the topic or to ignore them. Instead, they provide the missing information, which shows attuned and attentive listening, as well as willingness for cooperation. (Goodwin et al., 2002)

5.3.3. Conclusion

The analysis of the joint productions suggests that such a demonstration of attuned talk arises from various motivations: to look for completeness and correctness of information; to show understanding; to assist in word search; and to elicit information without directly asking about it. As it was mentioned at the beginning of the chapter, joint productions are not isolated cases, but are observed in many other social contexts that involve close or longstanding relationships. The fact that such types of talk synchronicity are found in alternative medicine sessions suggests that they have to do with the relationship between interlocutors. Indeed, all patients in the present data have at least a one-year relationship with the doctors. There is a high probability of developing closer social relations and allowing participants to take an active stance to build on each other's utterances, to create collaborative meaning based on established common ground and achieve a higher level of convergence. All these speech activities assist in building trust and providing a safe environment. These findings demonstrate a stimulated and fostered relationship, which is a key communication aspect in patient-centred communication (Brown, J., Stewart, & Ryan, 2001; de Haes & Bensing, 2009). As a linguistic strategy, joint productions express overall speakers' responsiveness and this is particularly true for the doctors. Mead and Bower (2000) considered such responsive behavior as an element of patient-centred interaction.

Strictly speaking, joint productions perform a violation of the turn-taking rules (Sacks et al., 1974). The rule “one speaker at a time” is openly violated in order to produce a jointly constructed turn. This way, however, the conversational space becomes “a

collaborative floor” to which both the speaker and the listener contribute concurrently (Edelsky, 1981). This stands in contrast with the “single floor”, where the “one speaker at a time” rule is applied. According to Edelsky, the single floor is successfully claimed in asymmetrical relationships such as doctor-patient, teacher-student, or adult-child, where participants are not equal in terms of power. The presence of a collaborative floor in alternative medicine sessions suggests that the differences in power are decreased in comparison to what is observed in mainstream medical sessions. The doctor has the authority, which, however, is not imposed. The formality of a mainstream medical visit here is substituted with a mix of formal and informal styles of conversation, and joint productions tend to appear in order to build good social relations and to work toward better understanding and creating rapport.

Lastly, joint productions exhibit cohesive functions and, as a result, advance the flow of the conversation. They are possible when speakers pay very close attention to each other at all linguistic levels (Coates, 1987).

5.4. Repetitions

In the previous section I explored joint productions as the first mechanism that assists in building rapport between doctors and patients in alternative medicine. Here, I discuss the second mechanism, that of repetitions, with which I end the chapter of analysis. I summarize previous work on repetitions (5.4) and then provide results and discussion of the two types of repetitions found in the corpus: mirroring and echoing (5.4.2). I also offer a conclusion at the end (5.4.3).

In examining lexical cohesion in English, Halliday and Hasan (1976) define two major subcategories: *reiteration* and *collocation*. According to Halliday and Hassan, reiteration covers repetition, that is, the lexical recurrence of a lexical item and the use of synonymy. The authors demonstrate that reiteration can range from repetition of exact words to the use of anaphoric pronouns. According to them, reiteration serves as a lexically cohesive tie (Halliday & Hasan, 1976, p.278). Synonymy is not employed by the participants in my data, but repetitions of exact words do occur and are, in fact, the building blocks of full and partial repetitions that I analyze in the next sections. I consider repetition here as contributing to the cohesiveness of the talk from dialogic point of view as opposed to single speaker self-repetition. Based on this frame of reference, reiterated utterances

can either keep the focus on important topics or smoothly redirect the topic, the latter practiced especially by the doctors.

Repetition is often considered to be a form of communicative redundancy (Brody, 1986). However, if it represents the action of saying the same thing again, why do speakers choose it over other resources that language provides, such as substitution, paraphrase, and ellipsis? Ferrara discusses this question, giving as an example the statement “Your uncle is very good with kids”, to which the following possible rejoinders are available:

ELLIPSIS: Yes, he is.

PARAPHRASE: My uncle is very patient with children.

SUBSTITUTION: He’s very patient with them.

REPETITION: My uncle is very good with kids.

(Ferrara, 1994, p.111)

According to Ferrara, if speakers bypass the first three options and have preference for the repetition as an immediate rejoinder, it is very likely that the repetition functions as a discourse strategy. The preference also indicates that it is a conscious choice by the speaker and that some social meaning has been conveyed. This concurs with Cook (2000) who argues that every time an utterance is repeated, its meaning is changed: “Even where repetition is exact, the self-same sequences of words take on new meaning in new circumstances, or in the light of what has been done or said before” (Cook, 2000, p.29). This is also in alignment with Bazzanella’s view: “From the very moment something is repeated, it ceases to be the same, not only on a semantic level, but also on a pragmatic one” (Bazzanella, 2011, p.248).

The focus in this section is on two types of next-turn syntactic repetition — partial and phrasal, which are called *mirroring* and *echoing* (Ferrara, 1994). By looking at these as defined by Ferrara I will be able to investigate iteration performed by both sides. These were found to be the most salient types of repetition in the data. Their strong presence is worth analyzing in order to see whether they are accidentally performed or are used to contribute to the intersubjectivity of the discourse and thus, have interactional functions.

Mirroring marks a repetition by the doctor of a patient's statement, like in the example below:

Example 53

- 1 Erika: Do it for a period of about five to seven times so the whole thing
- 2 it will take you 15 minutes
- 3 Tom: OK
- 4 Erika: so to speak
- 5 Tom: Oh, so *it's a repeated thing...*
- 6 Erika: ***It's a repeated thing***
- 7 Tom: OK

Echoing represents a repetition by the patient of a doctor's statement:

Example 54

- 1 Kate: He is waking once or twice a night so I go to bed, I wake for about...
- 2 I don't know. I would say six or seven hours but divided up...
- 3 Franca: Uhum
- 4 ...
- 5 Franca: **OK, so it's actually interrupted**
- 6 Kate: ***It's totally interrupted, yeah.***

The present analysis is concerned with repetition as a type of rejoinder to a statement. Therefore, the analysis situates repetition in the adjacency pair statement-repetition and considers the sequential environment immediately before and after the pair. According to Halliday and Hasan (1976) the term "rejoinder" is distinct from "response" in the sense that it may serve as a second adjacency pair part after a command or a statement. The purpose of analysis is to answer the second part of research question 2, namely, "What are the functions of repetitions and how is the social meaning they convey linguistically realized?" Therefore, I will discuss functions of repetitions and will provide a discussion on the social actions performed through repetitions in a sequential context.

Repetition is pervasive in our everyday communication and is commonly used in a variety of human interactions — everyday conversation, business meetings, instructions, care-taker-child communication, language learning, and computer-mediated communication. The description and analysis of repetition have been extensive in the study of language. Researchers from various disciplines such as rhetoric, phonology,

philosophy, psycholinguistics, discourse analysis and CA (Bazzanella, 2011; Heritage, 1984a, 1984b; Schegloff, 1987, 1997; Sorjonen, 1997; Tovaes, 2005; Wang, 2005) identify a variety of functions and motivations (Sergio, 2012). At the same time, what it is true for the function of repetition in one context may be different in another context.

5.4.1. Discourse functions

Any given repetition may have one of many functions. (Bada, 2010; Bazzanella, 2011; Brody, 1986; Bublitz, 1989; Fung, 2007; Hsieh, 2009, p.163; Johnstone, 1994; Norrick, 1987; Tyler, 1994). Brody lists seven main functions of repetition: facilitating information, emphasis, imitation, keeping track, cohesion, stylistics, and solidarity. Repetition facilitates the process of information in persuasive or instructional discourse. It is also used to stress the most important message in a discourse. It is employed in imitations performed by children and thus functions as a strategy in language acquisition. Reiterated units help participants to keep track of what is being said. They are also cohesive devices that assist in holding the utterances together as text. In addition, repetition is used as a rhetorical device. Lastly, according to Brody, repetition can be “conceived as social in nature” (1986, p.258); it can reinforce social solidarity by repeating formulaic material expressing social beliefs carried on over generalizations.

Emphasis, which is the most examined function of repetition (Ferrara, 1992; Longacre, 1983; Schiffrin, 1982) is often analyzed together with intensity (Bazzanella, Caffi, & Sbisà, 1991; Schiffrin, 1982). Exploring the emphatic aspect of repetitions, Hsieh makes the following point: “Pragmatically speaking, repetition, both self-repeats and other-repeats, can be used to double up the illocutionary force, i.e., to do emphasis or to do persuasion, by means of repeating the linguistic form” (Hsieh, 2009, p.163). Another function is that of cohesion. Broadly defined, cohesion is the process of grammatical and lexical linking within a discourse that holds the text together in a meaningful way (Halliday & Hasan, 1976). In that sense, repetition presents one aspect of cohesion and serves as a discourse-cohesive device. It ensures that the content of an utterance is linked to that of a preceding utterance.

Functions of repetition from an interactional perspective are discussed by Tannen (1987a, 1987b, 2007). In her book “Talking Voices”, Tannen (2007, p.68-78), offers a detailed classification of functions of dialogic repetitions, clustering them into four groups:

production, comprehension, connection, and interaction. According to Tannen (2007, p.68-78), the first three are associated with the meaning in the conversation. The fourth one, the interaction function, is further broken down into:

- repetition as “participatory” listenership
- ratifying listenership
- humour
- savouring
- stalling
- expanding
- repetition as participation
- evaluation through patterned rhythm
- bounding episodes

In general, studies have found that repetition takes on a different task in informative discourse than when it is in conversational settings. Johnstone (1994) holds the view that in the former the main functions are primarily related to the cohesive aspect of the text, whereas in the latter more interactional and collaborative functions take place.

Self-repetition and other-repetition

An important distinction in the research on repetition is made between *self-repetition* and *other-repetition*. Schegloff (1997) considers self-repetition to be a strategy of repair as well as a registering receipt. Norrick (1987) discusses self-repetition from an interactional point of view and identifies four functions — semantically-based, production-based, comprehension-based and interaction-based.

Other-repetition has been investigated by Weiner and Goodenough (1977). Framing their study into the sequential organization of a dialogue, the authors analyzed why speakers do “repetition passing turns” in a conversation. They look into three types of situations — peer interaction, teacher-student, and doctor-patient contexts — and conclude that speakers repeat lexical or syntactic units to gain time (stalling) in order to hold the floor, which allows them to plan another move before giving it up. Another study on other-repetition is done by Bazzanella (1993), who investigates what interactional functions are carried out by dialogic repetition. Positioned on an agreement-disagreement

scale, the functions range from a complete agreement (positive polarity) to a disagreement/opposition (negative polarity). Between these two points, however, exist different intermediate levels such as a request for clarification.

Repetition in medical discourse

Repetition has not received much attention in institutional settings (Park, 2009). In the area of law, Heffer (2007) referred to it as an intensifying device used in courtrooms. Matoesian (1993) analyzed it as managing the topic by defence cross-examiners. In research on air-ground communication between pilots and controllers, Cushing (1994) demonstrates how the recognition of repetition is crucial for preventing miscommunication that could lead to accidents. In medical visits, Park (2009) reports that repetition is mainly considered as a facilitative tool (Cox, Hopkinson, & Rutter, 1981; Ley, 1988) but no typology and meanings have been investigated in detail. Koch et al. (2009) analyze medical word use in clinical encounters. They found that patients were exposed to a variety of medical terms used by the doctors throughout the visit, but did not ask for any explanation of these terms. They estimated that 79% of the medical terminology was not explained by the doctors, and concluded that doctors were not willing to give clarifications. Lastly, they found out that the patients repeated doctors' medical words two times less than the doctors. In order to avoid uncertainty about whether patients understand medical terminology, the authors suggest that doctors ask patients to repeat what they were told, a strategy called "teach back". This is one way to prevent misunderstanding, along with other communicative strategies that they propose. Yan (2013) explores repetition in medical discourse from a discourse comprehension and processing perspective. He also found that doctors use repetitions in order to seek agreement, confirmation and to invite elaboration, whereas patients repeat utterances to attract the doctor's attention, to invite elaboration, and to seek assurance. Barton (2006), explores repetition as signaling an agreement. The data focused on end-of-life conversations between physicians and families in American medicine. These extremely emotional communicative events involve discussions with a primary agenda to reach a consensus on changing the treatment from therapeutic to palliative. Physicians perform verbal decision-making in an aligned progression with the family members through the discourse strategies of repetition and accounts of understanding. Repetitions are central in establishing an agreement, which is considered as the basis of the consensus of all parties.

In psychotherapy repetition plays a crucial role. Some of the main functions include invoking further self-expression, creating interpersonal involvement, focusing on certain topics that need elaboration, and agreeing with a statement. Self-expression is the focus of analysis of Pawelczyk and Erskine's study (2008), which investigates synchronic repetition in relational psychotherapy. They found that repetitions have high frequency and serve as a communicative strategy for the therapist. By using repetitions, the therapist aims to encourage the client's self-expression and to create interpersonal involvement. Both are important for successful psychotherapy. Furthermore, they facilitate a client's verbalization of troublesome experiences, emotions, memories and self-reflections, with which the therapist will work in order to help her/him to see things from a new perspective and to change behavioural patterns.

An indirect request for elaboration and empathic agreement is what Ferrara (1994) found to be the functions of repetitions in her data from family psychotherapy. A key point is that repetition should match the intonation contour of the original utterance in order to achieve its function, namely — to express empathy in the case of *echoing* and to ask for elaboration in the case of *mirroring*.

What follows are the results from the analysis and discussion of functions of the mirroring and echoing repetitions found in the data.

5.4.2. Results and discussion

Mirroring

The concept of mirroring in Ferrara's study includes only the partial repetition of the client's statement. In contrast, doctor's repetitions in the analyzed alternative medicine sessions almost equally demonstrate partial (16 instances) and full reiterations (17 instances) of a patient's statement. As seen in Table 22, full repetitions show preference for clausal and NP repeats, while partial repetitions show no particular preference.

Table 22 Allocation of mirroring according to syntactic form

SYNTACTIC FORM	FULL REPETITION	PARTIAL REPETITION	TOTAL
Clause	6	3	9
NP	6	3	9
VP	0	4	4
AP	0	1	1
PP	0	5	5
AdvP	2	0	2
TOTAL	17	16	33

A repetition of a clause naturally includes a deictic shift from “I” to “you” (Example 55). Such shift is not considered a linguistic choice because it simply reflects the change of speaker and respectively their perspective.

Example 55

- 1 Franca: Well, it could be biomechanical, it could be something that you put
- 2 your feet in, could be that new shoe, it could be that orthotic that
- 3 you put periodically. This is why I am asking you.
- 4 Richard: ***I always wear it for running***
- 5 Franca: ***You always wear it for running***
- 6 Richard: So that has never changed and I've been doing that for 10 years so
- 7 I don't think that's the problem. The shoes that I got were, maybe
- 8 they are lower and, and they are not as much absorbent, more
- 9 walking shoes rather than been...

In the example above the doctor and Richard are discussing at length Richard's persistent foot problem. She asks specific questions about his new running shoes and offers a variety of reasons for why he still gets the problem, which, however, does not sound convincing to Richard. He replies that he always wears the same pair of shoes for running. In response, the doctor chooses a syntactic and prosodic repetition of his utterance. It appears that she does not contribute to the ongoing conversation with new information, however, she does contribute to the conversation through interpersonal involvement. By repeating his statement, she highlights the importance of it and draws the focus on a single fact that she considers relevant for the discussion. Her repetition serves as a fine tool for redirecting the topic and as an indirect appeal for elaboration. If we look at the subsequent turn we find that what follows is indeed elaboration on the part of the patient (lines 6-10).

Eliciting information through mirroring can be observed on a lexical level as well. In Example 56 Christie complains about her extreme dry skin. The doctor picks up just one word from Christie's talk and incorporates it in her utterance with flat intonation. By singling out the word "dry", the doctor foregrounds the term. What she tries to elicit is not about the semantic content, but what the word means for the patient. Christie provides an expansion of her statement in an elaborated fashion, which is encouraged by the doctor's backchanneling (lines 8, 10, 12, 15). Christie shares some embarrassing moments when she visited the hairdresser and then continues with another example of frustration, describing how she was unable to touch her pants because her hands would hurt and bleed. There are two processes taking place as a result of the doctor's repetition. One is topicalization of the word "dry", and the other is the verbalization of the problem on the part of the patient.

Example 56

- 1 Erika: And have you been feeling like crap or have you been feeling well? Tell me
2 about it.
- 3 Christie: **I'm really good but really *dry*.**
- 4 Erika: **You feel *dry*.** Ok.
- 5 Christie: And well, yeah, like that guy, my friend does hair. He noticed like
6 thing on my head. And I mean there was, a a few days ago, I think,
7 it was like crust thing.
- 8 Erika: Interesting.
- 9 Christie: Oh!
- 10 Erika: OK
- 11 Christie: I mean, I've had it all year but only like, I don't know, maybe once a month
- 12 Erika: OK
- 13 Christie: which is so bad. Yeah, and I, my hands, I remember, this was on
14 Wednesday night, 'cause I touched my pants with my hand
- 15 Erika: Right
- 16 Christie: and I was like "Aaah!". I was so much pain like I can't touch anything,
17 I can't move my hands but I put gloves on.

An invitation for elaboration is also witnessed by the repetition in line (3) in Example 57. Ingrid tells about a homeopathic remedy she started taking. The doctor's turn in line 3 repeats her answer but also matches her flat intonation and ends with "OK". That prompts a further explanation of the remedy. In spite of the fact that the doctor intervenes in Ingrid's

turn (lines 8 and 10), this intervention is not interruptive — the floor is mainly occupied by the patient. Ingrid adds bits and pieces continuously throughout her turns.

Example 57

- 1 Erika: What dosage you take?
2 Ingrid: **1M**
3 Erika: **1M**. OK
4 Ingrid: And I took it... The day before I've got the cold, I got it.
5 Last time I was here... it was [three weeks]
6 Erika: [three weeks] ago
7 Ingrid: That's when I started the Arnica
8 Erika: You did?
9 Ingrid: Yeah.
10 Erika: OK
11 Ingrid: So, I'm having this cold for three weeks.

The examples above are found in stages that are subsequent to the *history taking* stage of the sessions. Let us now consider the following example from the *history taking* stage of a visit. Shelley describes her severe back pain while addressing the doctor's request to locate the pain. Again, the reiterated clause performed by the doctor is aligned with the original utterance and it is with a flat intonation contour. Shelley's turn in line 8 illustrates an attempt for expansion, although shorter than Richard's, Christie's and Ingrid's elaboration in the previous examples. The doctor facilitates her expansion by completing the sentence.

Example 58

- 1 Erika: There, the top right there?
2 Shelley: Yeah. Right to the growing and down
3 Erika: OK
4 Shelley: So it's just, it blocks me. Like isn't... you know...
5 Erika: Yeah?
6 Shelley: **it blocks me from taking a step forward**
7 Erika: Gotcha. **Blocks you from taking a step forward**. OK.
8 Shelley: I feel it like an elastic, just... =
9 Erika: = springs back
10 Shelley: Yeah

Encouragement of further elaboration can be performed by a mirroring unit, which is phrasal. The patient Kate is in the doctor's office with her baby boy who is sleeping at the moment this talk is produced. In the example below, Kate volunteers to elaborate shortly in line (4), telling a bit of detail about the baby's feeding. After Kate's brief elaboration, the doctor carries on with the agenda for the treatment that will follow.

Example 59

- 1 Franca: When did he...when was the baby fed? Because we had the baby last year.
- 2 Kate: **Couple of hours ago**
- 3 Franca: **Couple of hours ago**
- 4 Kate: When he wakes up he's gonna, wanna eat
- 5 Franca: OK. So here is the thing. And he will probably wake up after three hours
- 6 maximum, I would think...

A different function of repetition is at work in Example 60, taken again from the *history taking* stage of another visit. Here, the doctor's repetition "You had a C-section" in line 3 appears on the surface as a statement with rising intonation. As Bolinger (1989) notes, repetition of a phrase with changed intonation alters the meaning of the phrase. In contrast to the previous examples, it does not aim at eliciting further elaboration from the patient. Neither is it one of the functions that Sacks describes as trying to locate something that one of the participants did not hear. Instead, the doctor's rejoinder aims to clarify and confirm some piece of information, which in the course of the treatment would turn out to be important. Similar to Example 58 and Example 59 above from the *history taking* stage, the doctor resumes questioning. After Kate's positive reply, a question masked as a statement follows.

Example 60

- 1 Kate: Oh my god, never have had an IV before. Oh, yeah, in the hospital,
- 2 of course. **I had a C-section**, so...
- 3 Franca: **You had a C-section?**
- 4 Kate: Uh-huh
- 5 Franca: Ok. Aaa, and you stop, you said that you stop taking the vitamins.
- 6 Kate: I do! I took (...) like finish the bottle.

The examples above (Example 55, Example 56 and Example 57) reveal a pattern of sequences of *statement-repetition-longer elaboration* which tend to appear later in the

session, when a specific problem is picked up and being investigated (Figure 10). The doctor repeats certain chunks of the patient’s speech which she considers to be of particular importance. *Mirroring* in this sequential order is a way to give the floor, to invite elaboration and, in a broader sense, share the power over the discourse space.

On the other hand, sequences of *statement-repetition-shorter elaboration* show a tendency to emerge in the *history taking* stage (Example 58, Example 59 and Example 60). Repetition is followed by a validation (Example 60) or a brief elaboration (Example 58, Example 59). The mirroring unit here is part of a more concise, interview-like discourse and aims at nothing other than eliciting minimum information, which, however, would have important consequences. In that sense, repetition here is not so much a tool for keeping the talk going on, but rather a kind of “pausing” device. The doctor needs to pause at this particular bit of information in order to clarify, confirm or verify before continuing with a next question. It is a process that is crucial for determining the correct diagnosis and treatment afterwards.

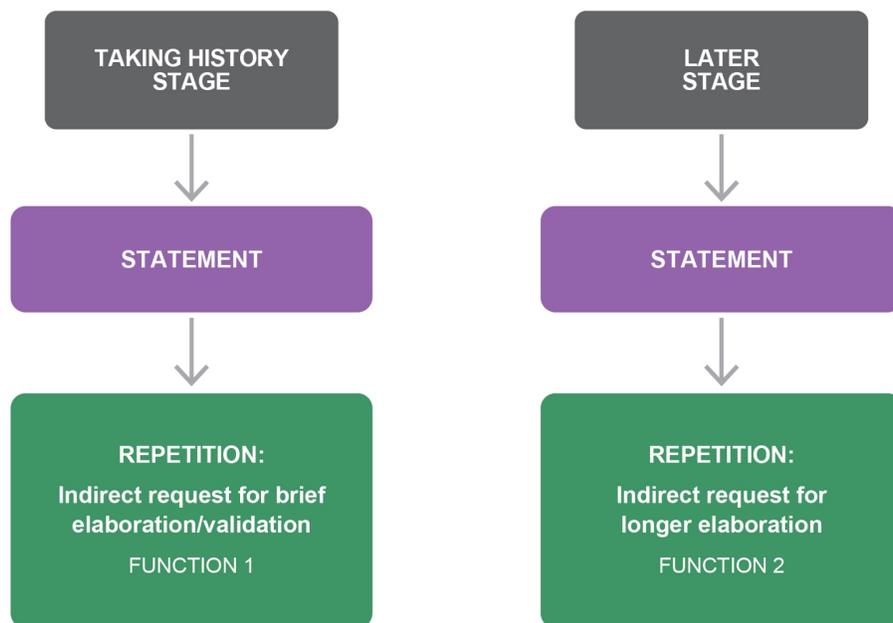


Figure 10 Functions of mirroring

In summary, *mirroring* in this set of data differs from the pattern described by Ferrara. Ferrara’s corpus is characterized by matching only falling intonation and by including only partial repeats. In contrast, the mirroring repeats in alternative medicine sessions show various types of grammatical forms — lexical, phrasal, and clausal, as well

as flat intonations. Pawelzyck demonstrates similar findings by investigating repetition in relational therapy sessions. Patients provided elaboration and further self-disclosure not only after falling intonation partial *mirroring*, but also after rising intonation *mirroring*. The grammatical forms of the repeated portions range from a single word to a declarative statement.

Echoing

Echoing is a strategy involving the patient's repetition of the doctor's statement. Interestingly, the number of *echoing* occurrences is almost equal to that of *mirroring* with 30 instances. Again, unlike Ferrara's *echoing* examples, they are not exclusively clausal, as they occur on a phrasal and lexical level too.

Table 23 Allocation of echoing according to syntactic form

SYNTACTIC FORM	FULL REPETITION	PARTIAL REPETITION	TOTAL
Clause	4	3	7
NP	3	3	6
VP	1	5	6
AP	1	4	5
PP	3	0	3
AdvP	1	2	3
TOTAL	13	17	30

In Example 61 Ingrid performs a narrative about her sleeping problems due to a harsh cough. She explains how one night she would wake up at four o'clock, then another night at three o'clock, and another night at two o'clock until finally on the following night her sleep would become totally non-interrupted. What follows is the doctor's statement, "So it's going backwards", in line 10, which summarizes what Ingrid has been explaining. With this assessment the doctor a) displays attentiveness and b) cooperatively participates in the verbalization of the problem. We can consider her utterance as a formulation in a sense that it is "manifestly offering a candidate reading" (cf. (Berceli et al., 2008; 2011) of what the patient has meant. Then Ingrid incorporates it in her next utterance in line 11. With the act of repetition, the patient accomplishes two things. She validates the summary and, at the same time, emphasizes it. In line 14 another *echoing* follows. This time it is a single word offered by the doctor, who, again behaving cooperatively, completes Ingrid's sentence initiated in line 13. Ingrid's repetition is accompanied by rising intonation, which signals emphatic agreement.

Example 61

- 1 Ingrid: So, I've stopped just that, recently, because I wasn't... and I was getting
2 such, it was the dry cough
3 Erika: [Yeah, yeah, yeah]
4 Ingrid: [that was getting me at night]. Four o'clock, every night. So I know it's my lungs.
6 Erika: OK
7 Ingrid: Then...
8 Erika: Yeah, go ahead.
9 Ingrid: I was getting four o'clock, then I will be getting three o'clock, then two o'clock.
10 Erika: Oh, interesting. **So, it's going backwards**
11 Ingrid: I've been **going backwards** till finally
12 Erika: [laughter]
13 Ingrid: yesterday was the first day I woke up and had =
14 Erika: (0.7) = **a sleep**.
15 Ingrid: **A sleep!** Like... I've slept the night.
16 Erika: Yeah.
17 Ingrid: So I'm OK, I'm on the other side of this thing.

In Example 62 there is another single word *echoing*. Shelley recounts the degree of back pain that she was experiencing each day since her last visit. She comments that she works from 9:00 am — 5:00 pm and that makes the painful sensations harder to bear. The doctor recalls that Shelley's last visit was the previous Wednesday so she concludes that maybe on the following day, the previous Thursday, it must have been dreadfully painful because of the treatment that Shelley received during the visit. She offers a strongly emotional word, "crazy", that expresses her understanding of what the patient might have been going through. She feels empathy for Shelley's physical suffering and offers understanding. Not only does Shelley accept, but she also repeats the adjective twice, which brings an additional intensifying effect. She continues with a short expansion, which also carries emotionally loaded words related to pain, like "sucking it up", which she reiterates. Singling out the word "crazy" from the doctor's utterance makes it foregrounded. It emphasizes the assessment in an agreeable manner. This particular excerpt displays how a crucial aspect of healing discourse like empathy is conveyed on a conversational level. According to Wynn and Wynn (2006) empathy in therapy settings is conveyed through three necessary phases: the doctor resonates with the patient's experience, expresses it, and the patient receives/validates it. Such co-construction of the patient's

traumatic experience contributes to the function of connection and interpersonal involvement (Roter, 2000) that *echoing* brings about.

Example 62

- 1 Shelley: But you know, as I said, I am working, so...
- 2 Erika: Yeah, it's-
- 3 Shelley: standing
- 4 Erika: Yeah, that keep... how was today?
- 5 Shelley: Forget about today, Thursday was like
- 6 Erika: Nuts?
- 7 Shelley: Hugh
- 8 Erika: So when I saw you Wednesday then.
- 9 Shelley: Yeah
- 10 Erika: **your Thursday was a crazy day.**
- 11 Shelley: **Crazy, crazy**, yeah. It's been crazy. It's just been busy. I just
- 12 can't, I had to get through with it and suck it up.
- 13 Erika: [laughter]
- 14 Shelley: I feel that I am still sucking it up. But it's better.

Another repetition of assessment is offered in the following example from the session with Kate. Her nights are split between sleeping and feeding her baby, which brings her anxiety and irritation. The doctor summarizes Kate's experience with the statement "So it's totally interrupted". Similar to the previous *echoing*, here the doctor's assessment indicates attuned talk and a high degree of attentiveness. She does not just listen to the patient's descriptions, but participates in the interpretation of the facts and builds a joint narrative over the patient's problem. Kate's *echoing* appears along with an ordinary confirming element "yeah" at the end. She could only choose to express her agreement with "yeah", "yes", or another positive answer, but by choosing a repetition she adds more weight to the doctor's assessment. She also chooses to change "actually" to "totally", which intonation-wise she pronounces more prominently than the rest of the lexical items in the utterance. This intonation prominence serves as reinforcement of her acceptance.

Example 63

- 1 Franca: So, right now how much sleep are you getting?
2 Kate: I, aah, he is waking once or twice a night so I go to bed, I wake for
3 about... I don't know, I would say six or seven hours but divided up...
4 Franca: Uh-huh
5
6 Franca: **So, it's actually interrupted.**
7 Kate: **It's tOtally interrupted**, yeah

And lastly, I want to discuss an example from the session with Shelley. The doctor is just about to perform a physical intervention and warns her that it will be painful. Echoing the VP “hurt”, Shelley intensifies verbally the sensation of feeling in pain with the adjective “freaking”. By doing that the patient offers emphatic agreement and assures the doctor that this is exactly what she is enduring. In a similar fashion, in Example 64 the strong acceptance and agreement are accompanied by stress on a specific word, in this case the verb “does”.

Shelley's emotional comment prompts the doctor to choose laughter as a response, which is a strategic choice to comfort and alleviate Shelley's pain in order for her to be distracted from the physical sensations of the treatment. In this particular excerpt the doctor expresses emotional support toward Shelley in two ways. First, she expresses concern about Shelley's bodily perceptions, and second, manifests empathy with a friendly laugh and elaborating further on why she decided on this specific procedure and how this will speed up Shelley's healing.

Example 64

- 1 Erika: **Cause this will hurt.** I mean this will...
2 Shelley: Oh, yeah. Freaking dOes **hurt**.
3 Erika: [laughter] And that's what I wanna do. I just wanted to flush out some
4 of the stuff.

In terms of their sequential features and functions, the above examples exhibit the following characteristics. *Echoing* functions as an emphatic agreement when it is preceded by a doctor's assessment about mental, physical, or emotional affairs related to the patient's experience. The patient's perception of the doctor's empathy shows a tendency to lead to further self-expression. Although not generalized, Bachelor (1988) reached the

same finding in her study on perceived empathy in therapeutic settings. She identifies four empathic categories, two of which are “affective” and “nurturant”. The former is related to the therapist partaking in the same feeling, and the latter is associated with providing attentiveness, support, or safeness. In this study, the type of empathic appraisals demonstrated by the doctors reveal a combination of the two. In the context of alternative medicine settings, doctors engage with the patient’s ongoing feelings, while at the same time demonstrating attentiveness and support. In this context, it is very likely that patients feel understood and comforted.

The fact that patients choose to repeat empathic statements and not only factual ones suggests that they react in a positive way to emotional support provided by the doctor. This contributes to the perception of the alternative medicine visit as a safe and trustful place. Similar to the psychotherapy setting, the visit unfolds as a speech event in which participants verbally create interpersonal involvement (de Haes & Bensing, 2009; Mead & Bower, 2000) in a collaborative fashion.

Let us now consider a few other examples that reveal a different pattern. In Example 65, Tom describes how he copes with back pain when it becomes too acute. He explains that his car has heated seats and this helps him to ease the pain. The doctor formulates Tom’s explanation and concludes “So warmth makes it better”. She states a fact which is confirmed by Tom’s *echoing* in the next line.

Example 65

- 1 Tom: The bonus with my car is that I have heated seats so I can, I can
- 2 actually get heat,
- 3 Erika: That’s right.
- 4 Tom: which helps. Sometimes that is, may be a bad crutch to follow, I
- 5 realize, but that, to have that heat all the time.
- 6 Erika: That’s worth 10K alone. I use to have that on my Land Rover, yeah,
- 7 Erika: OK. I hear you. **So, warmth makes it better.**
- 8 Tom: **It makes it better.** But there are times that’s like: “Oh, okay”.
- 9 And when I am really busy and doing things, it’s like: “Okay, it seems
- 10 I’m not even noticing it anymore”.
- 11 Erika: Of course.

Likewise, the function of *echoing* in Example 66 below is that of confirmation. Richard gives a bit of a background story of his problem and tells about his new sport shoes. The doctor summarizes in line 9 what he is explaining. Richard accepts this summary and in echoing it validates it as correct. He continues with further elaboration.

Example 66

- 1 Richard: And it's... I always buy neutral shoes, right?
- 2 Franca: Uhum
- 3 You buy neutral shoes and when you put your correction in
- 4 Franca: Uhum
- 5 that makes it compensate for you
- 6 Franca: Uh-huh, yeah
- 7 Richard: what adjustment he has been made.
- 8 Franca: Uh-huh, **customizes it**.
- 9 Richard: Yeah, **customizes it** for me. And I haven't had that problem before.
- 10 It hasn't come up as an evident like sore joints, like, I guess it's from
- 11 My toe joints and the rest of the foot.
- 12 Franca: But...
- 13 Richard: But pushed on that it feels like it's broken or stiff and sore.
- 14 Franca: Uh-huh.

In Example 67, the echoing is monolexemic and is again followed by confirmation and further disclosure by the patient. Shelley has visited another doctor who performed acupuncture on certain spots. The doctor asks her where exactly the other doctor applied needles. The adverb "more" gets repeated by the doctor in order to clarify something that she assumed to be the case. Shelley confirms it in line 4 and then she herself repeats it one more time when she resumes her explanations (line 6).

Example 67

- 1 Erica: Where did she put her needles?
- 2 Shelley: **More here**.
- 3 Erica: So **more** neat.
- 4 Shelley: Yeah.
- 5 Erica: OK
- 6 Shelley: More and I needed the groin and in the front you see bruises.

The repetitions in this second set of examples (Example 65, Example 66 and Example 67) show a function distinct from emphatic agreement, and that is of confirmation. *Echoing* signals a confirmation/validation when it is preceded by a doctor's statement that communicates facts. Patients echo the doctor's utterance and resume their report with additional specifics. The two functions that echoing performs are depicted in Figure 11 below.

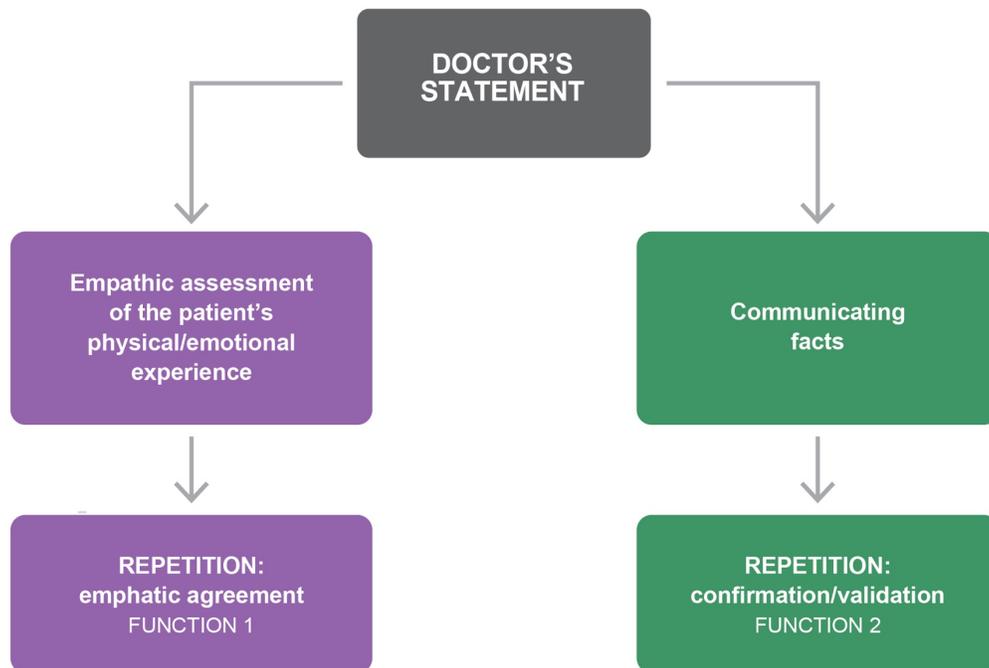


Figure 11 Functions of echoing

5.4.3. Conclusion

In this section I provided a summary on the literature of linguistic repetition and presented results from the analysis and discussion of the findings. I examined repetitions performed by doctors and patients, and demonstrated how in the course of the session they create rapport and interpersonal involvement. I have addressed the research questions related to the functions of repetitions and their social meaning.

One of the conclusions that can be made from the analysis is that neither *mirroring* nor *echoing* provide propositional novelty to the conversation. The value they possess is not contained in their referential quality, but in their interactional power. *Mirroring* and *echoing* serve as meaning-making strategies realized through the process of re-

contextualization. The intonation contour, the immediate next-turn position and the choice of which portion of the original utterance is to be reiterated — all contribute to this re-contextualization. When they are re-contextualized, the repeated utterances carry new meaning, which advances the therapeutic agenda and creates interpersonal involvement.

It was shown that repetitions realize different interactional strategies. *Mirroring* can trigger verbalization of the problem by the patient, invokes short but necessary expansions, and obtains confirmation of crucial bits of information. *Echoing*, on the other hand, predisposes the patients to emphatically agree or validate a fact. The syntactic representation of these two types of repetitions includes lexical, phrasal and clausal levels.

Similar to joint productions, repetitions in the present data demonstrate convergent accomplishment through which participants build relationships. In the alternative medicine setting they work toward a dialogue in which doctor-patient rapport occupies an important place. In other words, it is a communication which contributes to a potentially enhanced emotional state. This is in opposition to mainstream medicine, in which the communication revolves around the “task-instrumental” dimension (Heritage & Robinson, 2006; Robinson & Heritage, 2006). That is, the dialogue is primarily oriented towards producing concrete results and outcomes. There is also a tendency to minimize emotional involvement, mainly exhibited by doctors (Engeström, 1999; Josephson et al., 2015).

Chapter 6.

What it all means: Discussion and conclusion

In this final chapter I reflect on the study as a whole. I start with a summary of the dissertation that includes a restatement of the research problem, describe the gap in the literature and outline some of the contributions. Next, I provide a discussion on the findings in regards to the previous literature on medical discourse (6.1), more specifically patient-centred communication, which I reviewed in Chapter 2. I discuss some of the implications of the present work (6.2) as well as limitations and ideas for future research (6.3).

The present work was guided by the main research question – “What is the nature of the talk in alternative medicine sessions and how is it affected by the holistic approach of the discipline?” I was inspired by my personal encounters with alternative medicine doctors. During those visits I could certainly identify elements that facilitated the active role of the patient. I, as a patient, felt that I was being given the opportunity to contribute to the negotiation of meaning. I felt my voice was acknowledged. I thus became interested in investigating how the patient-oriented behaviour of alternative medicine doctors was realized through linguistic choices. The object of analysis was the exploration of two dimensions that are common in patient-centred communication (PCC) – elicitation and rapport (Epstein & Street, 2011; Roter, 2000). By applying Conversation Analysis (CA), I investigated elicitation by examining certain speech acts and backchannels, and rapport by examining joint productions and repetitions. It has been previously reported in the literature that these features were common occurrences in the field of PCC (de Haes & Bensing, 2009; Heritage, 2010). Their high frequency served as a starting point for investigation, as it was assumed that, based on the holistic approach to health, these features are likely to have frequent use in the context of alternative medicine, too. The study aimed at providing answers to questions related to how elicitation and rapport are realized in the conversation. This involved analyzing the types of speech acts used in alternative medicine as well as their distribution; the interactive functions of backchannels and the effect on the discourse; the motivations and social meaning of joint productions and repetitions. Based on this, the present study revealed that alternative medicine speech event is an institutional genre with characteristics of PCC.

This work contributes to the existing research on medical discourse by investigating an unexplored area such as alternative medicine. Although alternative medicine is an old field of medical practice, it has received little attention in terms of linguistic analysis applying CA. Since the study follows the framework of CA in order to explore individual segments from recorded sessions, can be seen as a contribution to the field of CA and sociolinguistics. The focus of analysis was simultaneously on the local sequential structures and the context in which the interaction occurred. One of the goals was to find out whether the examined four features were systematically and strategically used by participants as a mean to negotiate meaning and perform institutional roles. The negotiation of meaning was mainly managed by the use of elicitation techniques. While doing this, participants also accomplished the institutional roles ascribed by the encounter – that of a doctor and that of a patient.

6.1. Findings

In this study, I addressed two research questions related to the exploration of the processes of performing elicitation and constructing rapport between alternative medicine doctors and their patients. My main methodological tool was CA, but I also drew on the SFL framework to analyze the genre of the texts.

The findings from this study are based on data comprised of nine recorded sessions between two alternative medicine doctors and nine patients, native speakers of English. The corpus contains 5,378 turns and 3,139 units of analysis in total for all dyadic conversations. The sessions follow a six-phase format of a primary care visits (ten Have, 1989). The format consists of *opening*, *problem presentation*, *data gathering (history taking and physical examination)*, *diagnosis*, *treatment*, and *closing* stages. In Chapter 4 I performed a genre analysis within the SFL framework. I included an overview of the stages of the visit and a description of salient lexico-grammatical features. I presented how stages were delineated based on functional criteria, I devised the scheme of the total generic potential of the structures (Hasan, 1996), and I discussed the optionality and embedding aspects of the *diagnosis* stage. In my account of lexico-grammatical features, I drew attention to interpersonal resources of language related to discourse and semantics.

By applying CA to transcribed audio files, I studied the dimensions of elicitation and rapport and explored their linguistic representations in the form of speech acts, specifically questions, backchannels, joint productions, and repetitions. I looked at how sequences were locally managed and how participants oriented to certain patterns using language in the institutional setting of alternative medicine visits.

I will now review the research questions (1.1.1) that guided the analysis. The first research question searched for mechanisms of elicitation. In terms of speech acts, I found that elicitation performed by alternative medicine doctors was realized mainly through certain speech acts, that is, questions, and that the doctors' questions outnumbered the patients' questions across all sessions. Although not statistically significant due to the small size of the data, there are three additional findings that are worth mentioning because they are indicative of patient-centred interaction. The first finding is the higher number of questions asked by the patients. This statement is taken in reference to doctor-centred general practice visits in which patients are restricted in terms of questions (ten Have, 1991). The second finding is the existence of frequent inquiries related to psychosocial aspects of the patients' life. I have observed that such verbal acts encouraged reflections, a practice which is central to client-focused psychotherapies. Although within a limited time frame, patients in the study's data were granted time to share subjective experiences. These unfolded narratives present the patient as a person and, at the same time, contribute to a psychotherapeutic alliance – two central elements in PCC models (de Haes & Bensing, 2009; Epstein & Street, 2007; Mead & Bower, 2000). The third finding is that doctors were willing to provide rationale for the diagnosis and engage in a discussion with the patient. In a few of the sessions, arriving at a particular diagnosis occurred as an incremental process. This happened in a series of diagnostic information followed by clinical reasoning using lay medical language where the patients asked further questions in cases in which they felt that the explanation was not sufficient. By responding to the patient's questions, the doctor simultaneously met the patient's needs for cognitive information and for emotional support, which are two important aspects of patient-centred communication. The incremental aspect of a diagnosis delivery can be interpreted as knowledge co-construction (Engeström, 1999) as the doctor offered the patient the opportunity to join in with clarifications and questions at each step of the process of reaching the diagnosis.

Two observations were made related to the conversational control of the doctor expressed first, in the choice of topics and second, in the performance of active elicitation techniques. Throughout the transcripts, I observed that the doctor was mainly the one who framed the discourse with the choice of topics. This dominance can be justified by the fact that doctor follows an agenda which imposes time limits for achieving the institutional goals. However, it was found that in alternative medicine encounters patients also initiated topics. They introduced new subjects by the use of questions that were conversational in nature. Neither of the two doctors avoided or neglected the demand for information. In this respect, the doctors' attitude of responsiveness and sharing could be seen as working toward creating rapport and building a social relationship within the institutionalized interaction.

The second observation on doctor's conversational control is linked to the main finding mentioned above, the disproportionate amount of questions between doctor and patient. Skilled doctors make efforts to follow an institutional agenda that includes three main goals: "to establish and maintain an effective doctor-patient relationship; to diagnose the patient's problems; and to educate and motivate the patients to cooperate with treatment recommendations" (Cole & Bird, 1991 p.3). It is the second goal, to find the correct diagnosis, that is the main motivation for doctors in alternative medicine to take on a power-driven role. This is especially noticeable in the *history taking* stage, because this stage exhibits the most active elicitation techniques. The higher frequency of questions is functionally motivated. The goal of this stage from a generic point of view is to gather information and the most direct way to do this is to pose questions. The doctors' power behavior decreases when later in the visit treatments and decisions are negotiated. This observation is in alignment with the powershift model (Byrne & Long, 1976) according to which the doctor is not the one who exclusively decides the treatment perspectives of the patient (Bensing, 2000; Byrne & Long, 1976). It should be acknowledged that the patients vary in their desire to negotiate treatment decisions (Bensing, 2000). I noticed that those who decided to negotiate, had their questions answered by the doctors. In that respect, the alternative medicine sessions demonstrate another important component of PCC, that of a shared decision making (de Haes & Bensing, 2009; Epstein & Street, 2007; Mead & Bower, 2000).

In summary, the findings related to the elicitation through speech acts reveal that the questioning is more or less a well-balanced power event and that alternative medicine

doctors act as professionals who exert conversational control in alignment with the patient-centred approach.

In regards to the elicitation through backchannels I found that both doctors and patients used them in a way that worked simultaneously toward elicitation and rapport. Backchannels served to elicit information in an unobtrusive manner, but also displayed an affective stance by operating as a listening device and a means to assert understanding. The backchannels *yeah* and *mm hm* acted as acknowledgement, alignment, and agreement tokens. All these functions contribute to the argument that, in practice, the listener is also a co-constructor of the verbal interaction and not just a passive participant. Although their basic functions included “passive reciprocity” tokens (Jefferson, 1984) and a minimal “third turn” expansion in a question series (Schegloff, 1995), the backchannels performed more advanced functions. In a similar manner to client-based psychotherapy, the backchannels were loaded with interactional tasks of expressing empathy, understanding and affection. These two functions embody a partnership and rapport-building as conceptualized by Roter (2000). By active enlistment and emotionally-responsive verbal behavior, both sides participate in interaction which recognizes the other’s stance and experiences.

The second research question in this study explored the linguistic strategies for creating rapport. It was discovered that the occurrences of joint productions and repetitions demonstrated one way to create this dimension. I believe that I have successfully shown how employment of joint productions contributed to attuned and collaborative talk. The presence of a collaborative conversational floor suggested that participants were oriented toward the building of good social relations by sharing common ground. In terms of repetitions, I have demonstrated that their interactional power was achieved through re-contextualization. It was shown how the re-contextualization created a new meaning which worked towards interpersonal involvement. In my view, both joint productions and repetitions can be seen as vehicles for building intersubjectivity in the discourse. They demonstrated a way for participants to make sense of each other’s actions and share common practices.

Viewed broadly, questioning and backchanneling are activities akin to two opposite roles; questions are performed by the speaker, while backchannels are performed by the listener. Asking questions presents a prominent strategy for claiming discourse power by

directing the addressee to certain topics. Backchannels, on the other hand, express an empathic stance, however, they can also nudge in a subtle way. In this sense, backchannels might be interpreted as active agents, albeit less direct than questions, for exercising conversational control by the listener. Unlike questions and backchannels, joint productions and repetitions are collaboratively created by the speaker and the listener. Joint productions accomplish this by finishing a statement, while repetitions alter the meaning of an already uttered proposition. In both strategies, meaning is being negotiated until it reaches congruence. Therefore, taken together, all four features (speech acts, backchannels, joint productions, and repetitions) carry interactional power that reflects the roles of the participants. Substantial claims cannot be made, but the orientation of each participant to these recurrent features gives us insights as to how doctor and patient take on their discourse roles and construct a specific, task-oriented institutional talk.

Another finding in the present study is related to the generic structure of the texts. I have given the range of structural resources by providing the GSP of all instances of the genre. The GSP allows for text variation which in the present case took place in the embedding of one stage into another, or, in Hasan's terms "interspersed" (Hasan, 1996 p.55); in the reiteration of the *problem presentation* stage; and in the optionality of *diagnosis* and *closing* stages. I have shown that the text variation is a result of changes in the social context and this led me to conclude that the actual structural formula is context-dependent. Moreover, the variability of text unfolding manifests the capability of an appropriate response to a situational change. In addressing this change, participants remain oriented to the global purpose of the speech event while fulfilling local tasks. In terms of lexicogrammatical features, I have observed that the employment of imperative mood and lay medical language by doctors were motivated by stage-related purposes.

Lastly, I want to share my observations in relation to the formality level of the visits, in terms of both discourse and surroundings. The sessions were performed in a low formality level with a loose structure which is in contrast to other forms of institutional discourse, such as court cases or broadcast interviews. The style can be defined as quasi-informal (Arminen, 2005), meaning that both elements of ordinary conversation and institutional talk appeared in this type of interaction. The flexible structure allowed for shortening or lengthening of certain stages and in addition, accommodating the specific needs of the patient. Furthermore, turn-allocation was not strictly pre-defined between parties. Patients could initiate a turn on many occasions (more restricted in the *history taking* stage) without

being selected and could provide lengthy sequences. However, this did not prevent the doctor from completing all necessary stages of the visit.

I now want to comment on the settings and the communicative properties of the material things in regard to formality, power and rapport. In 3.5.2 I described the surroundings in which the sessions took place. It is a commonplace fact in social sciences that objects carry meaning (Barthes, 1967). The objects in our environment participate in the construction of the social world and meaning-making processes (Caronia & Mortari, 2015). In the description of the offices, I mentioned that doctors had their diplomas on the walls. There is room for interpretation when one considers their speech agency. Diplomas are artifacts representative for certain communities of practices. They certify that someone has successfully completed an educational program. From a physician's perspective, they assure competence and inspire confidence in the professional abilities. From a patient's perspective, they assure the necessary credentials to provide medical care or have specialist qualifications. In this respect, diplomas can be conceived as symbolic material things that communicate who the owners are, in which group they belong to and what practices they attend to (Csikszentmihalyi & Halton, 1981). From this point of view, the diplomas in doctors' offices are constitutive of their practices.

However, an observation of how the material aspects are embodied in participants' actions, that is, how the agency of the material object is being "traceable" in the participants' behavior (Cooren, Fairhurst, & Huët, 2012) raises the question of a possible additional meaning. Within the institutional structure, possessed knowledge enables the doctors to act as experts. In turn, the expertise legitimizes, or at least explains, the control over the conversation where doctors may push in certain direction to achieve a resolution (Fitzgerald, 2013). In that sense, the visibility of the diplomas may be conceived as a symbolic representation of power base on expertise, and therefore, contributing to the formality of situation.

The formality-informality continuum can be seen as reflected in the presence of various objects in the two offices. I differentiate between objects that manifest the professional medical practices (patients' files, laser equipment, supplies, medical bed-table, poster) and objects that display a more informal environment (leather couches, paintings in warm colors, blankets). To the latter, I also add the background chillout music. It is the second group that contribute to a certain level of coziness and relaxation. The ambience enhances

the informality of the situation, however, within the institutional context of the event. Such settings may contribute to creating rapport between participants. Patients seek help from alternative practitioners and part of this process is to construct the experience of pain. I believe that one is more predisposed to share a troublesome story in an inviting environment. People perceive non-verbal cues from their surroundings including color, light, space, and might not be aware how settings influence the emotions. Spaces that connote openness and security through the choice of color, furniture and appropriate physical proximity seem more conducive to self-disclosure. What I can infer from the positioning of the furniture, the physical distance between doctor and patient was close, yet culturally appropriate. Self-disclosure is essential because it is an important part of achieving the institutional goal of finding the correct diagnosis. As defined in 1.1, part of rapport is to express empathy. By responding empathetically to the troubled experience, doctors facilitate rapport between them and the patients.

In this section, I have listed the results of the study. In the next section, I turn my attention to some implications and possible consequences of the results.

6.2. Implications

In this section, I present the contributions of the study and discuss some of the implications of the findings.

From a social science frame of reference, this work contributes to the study of how people accomplish institutional tasks by choosing different types of language features. From a CA perspective particularly, it is a contribution to the body of work on institutional discourse, namely, medical communication. The study looked at a type of spoken genre for which research has been very limited, and gained an initial understanding of how talk is carried out in the context of alternative medicine. In achieving that goal, CA proved to be a valuable tool for answering my research questions. It has been an established linguistic method for investigating institutional discourse (Schegloff, 1992) by looking at practices of talk. It analyses unfolding actions where utterances acquire meaning in the context of use. Since the context is dynamic and continually renewing, participants respond to these changes by orienting to different linguistic resources to achieve their communicative and practical institutional goals.

In my analysis, I examined linguistic features that are not excluded from other types of discourse, such as ordinary conversation or other institutional talk. By looking at turn-taking design, sequential order, lexical choice and forms of asymmetry, I showed that these features follow certain patterns, which are not randomly used, rather, served a purposeful communication. The employment of questions, backchannels, joint productions and repetitions by both doctors and patients in the present data are examples of how language can be used strategically.

CA analysts have continuously proved that individuals employ “a repertoire of conversational devices” (ten Have, 1990 p.10) when participating in an institutional interaction. The repertoire is used in a restrictive way, however, recognizable to both participants in the institutional episode and analysts. (Atkinson, 1982; Heritage, 1984b). One way of seeing this at work here is by imagining that there exists a pool of features or devices essential to medical communication. The practitioners draw the features that serve best the social and institutional purposes of the communicative event. Questions, for example, are exploited differently in the various medical fields. In general practice visits, close-ended questions are combined with open-ended to gather information, while in certain psychotherapy services, the open-ended questions take dominance in order for the psychotherapists to achieve the institutional goals. In actual practice, different types of questions, backchannels, joint productions, and repetitions tend to be combined and manipulated in various ways. Given the present findings, it would be nevertheless accurate to conclude that they assist in constructing elements of psychologization exemplified by emotional narratives and self-disclosure by both parties. This psychologization works simultaneously toward the rapport building (Roter, 2000), fostering relationship (Epstein & Street, 2007) and responding to emotions (de Haes & Bensing, 2009) components of PCC models.

This blend of practices is further supported by the ways in which participants take the floor. During the analysis, it was shown that the four linguistic features carry different potentials for expressing power. They can be positioned on a power continuum along which doctor and patient operate. On that continuum, questions carry the strongest power potential resulting in dominant conversational floor, joint productions generate a collaborative floor, and backchannels do not take the floor at all. According to Mischler (1984), this single-floor is realized by the dominance of the physician, which he called “the voice of medicine”. As discussed in Chapter 5, ten Have (1991) also considered the medical visits to be

heavily oriented toward questions, orders and proposals performed mostly by the physicians and “dispreferred” when presented by the patients. West (1984) and Weijtz et al. (1993) report that the floor is dominated by the questioning carried out by the doctor. Such tendencies create disproportional dynamics, with the doctor being the one in conversational power. In contrast, the tendency in PCC and in alternative medicine in particular, shows a more balanced distribution of power. The participants opt for diverse linguistic strategies, and in doing so, they vary the degree of dominance, which results in a decreased conversational asymmetry between doctor and patient.

Ten Have (1991) proposes that asymmetry in doctor-patient encounters is an achievement produced by both sides. From a knowledge point of view, this asymmetry is due to the fact that the doctor exerts power by virtue of possessing the knowledge and the skills. The patient, however, also possesses power by owning their experience and by having the choice of what to disclose (Fitzgerald & Leudar, 2010). From a CA point of view, the analysis revealed that the doctor is the one who has conversational control over the patient (Sacks, 1992 [1964-72]), because in both cases, the two alternative medicine practitioners ask more questions and sets more topics than the patients. Sacks (1992 [1964-72] p.55) states that “as long as one is doing the questions, then in part one has control of the conversation”. Yet simultaneously with the conversational dominance, alternative medicine visits show that doctors accommodate and collaborate with patients on different levels. First, they work towards involving the patient in addressing the issue and, as a result, involve the patient in the actual treatment as well. This approach is grounded in both PCC and alternative medicine philosophy, which considers the patient as an active agent in the process of healing. The observed practice is very similar to what Buttny (1996) found about psychotherapy. He noticed that psychotherapists made conscious attempts at involving clients in identifying and dealing with the problem at hand. Second, the doctors in the present study make efforts to engage the patient by means of asking conversational type questions. Their presence suggests the existence of a relaxed environment and a certain degree of accommodation on the part of the doctors. Third, the analysis showed that reaching a diagnosis is on several occasions an incremental process in which the two parties collaborate as the doctor seeks patients’ understanding and engages them in ongoing interactional meaning-making. This process illustrates Engeström’s view (1999) that the patient is “a knower and sense maker”, and that a “creative achievement of knowledge” is built through collaboration. More evidence for collaborative meaning-

making is provided by the strategically used joint productions, backchannels and repetitions by both sides. Instead of being two separate entities that do nothing but independently produce and receive information, doctors and patients behave as “interlocutors”. They act as active listeners in the same way as psychologists and clients do in psychotherapy sessions examined by Ferrara (1988).

From a genre perspective, the variation of the *diagnosis* stage supports the patient-centered orientation of the practitioners. It shows that they are willing to deviate from the ideal sequence of activities in order to respond to a change of context by accommodating the patient. The benefit of the deconstructed diagnosis is that it offers episodes of educational discourse which contribute to the empowering of the patient (Mead & Bower, 2000).

In the analysis, I have shown how the linguistic mechanisms of elicitation and rapport embody PCC practices. It has been proposed in the medical communication literature that doctor-patient communication has an impact on the psychosocial outcomes of the visits (Arora, Weaver, Clayman, Oakley-Girvan, & Potosky, 2009; de Haes & Bensing, 2009; Epstein & Street, 2007). Street, Makoul, Arora, and Epstein (2009) suggest that PCC elements such as information exchange and fostering relationship influence the proximal outcomes of the visits such as understanding, satisfaction, trust, patient’s involvement, and motivation. Given that more data is accumulated and analyzed, a generalized evaluation of elicitation and rapport in the context of alternative medicine could be acquired. This information could be used to explore the connection between the PCC elements and the psychosocial aspects of health outcomes in alternative medicine.

A practical implication of this study can be seen in relation to the training in communication skills informed by PCC that the two doctors received from the educational institutions. The practical guides contain organized knowledge about professional interaction in medicine. Peräkylä and Vehviläinen (2003) refer to this knowledge as “stock of interactional knowledge” (SIK). My CA analysis focused on linguistic practices *per se*, knowing only the general orientation of the training guidelines, that of patient-centredness. It was demonstrated throughout the analysis that the practitioners were oriented to patient-centred behavior in their interaction. The analysis could serve as a point of comparison and give insight into the “dialogue” between SIK and the actual performance of the doctors. Peräkylä and Vehviläinen outlined three possible relations in this “dialogue” – a

CA study can correct assumptions made in the SIK, can provide a more detailed picture, or can add a new dimension to the understanding of practices. A future study can compare SIK and the actual performance of practitioners where, however, the doctors' personal style should be taken as a variable.

After I have provided all major findings of the study and discussed some of the implications, I now want to conclude the thesis with a description of the limitations and an overview of ideas for future research.

6.3. Limitations and directions for future research

The first and foremost limitation of the study is its small size. I already mentioned in Section 3.3 the practical difficulties I faced with recruiting participants. The point that I want to make here is that this work is best seen as a case study that contributes to the linguistic research applying CA in the context of alternative medicine. In Chapter 2 I described CA as a framework that is discovery-oriented. With its focus on fine-grained talk-in-interaction and details, research is often performed on very small samples. In the CA literature, "small samples" refers to single case studies. They can focus on single episodes of interaction (Schegloff, 1987), on a single session as in certain types of institutional discourse (Gale & Newfield, 1992), or on a collection of several sessions (Leudar et al., 2008). Leudar et al. (2008) for example, perform an analysis on a data that is comprised of four child psychotherapy sessions and which they consider a single case study (p. 157). The authors' goal was to find out how the psychotherapists' discourse patterns follow the communicative practices of the psychotherapy school in which they were trained.

Given these studies, the sample used in the present thesis is not atypical in CA approaches. The study has no goal to make substantial claims or make any statistical generalizations. It simply makes efforts to address adequately the research questions posed at the beginning of the thesis taking into account the qualitative nature of the CA methodology, the number of hours recorded, the context, and the existing literature on medical discourse. The epistemological standpoint taken here is that of interpretivism (Crowe et al., 2011) in understanding the context and the shared social meanings between individuals. The analysis suggests candidates for linguistic devices that act as representatives for the type of institutional talk in question. The single case status serves

the purpose to generate ideas that potentially could be grounded in a collection study, if more data is gathered.

I have analyzed the data in relation to four linguistic phenomena which, by carrying certain interactional power, assist in managing the relationship between doctor and patient in a patient-centred manner. It is an impossible task for any work to analyze the full spectrum of features used in such a complex speech event. But most importantly, this is not the ultimate goal of the study. When analyzing the data, I have identified some potentially fruitful topics for investigations such as formulations, topic management, pauses, discourse markers, hedging, overlaps, and dysfunctional communication.

Furthermore, the study dealt with only certain alternative medicine modalities, namely, homeopathy, naturopathy and Traditional Chinese Medicine. Research focused on other alternative medicine modalities is likely to find that different linguistic strategies and features are used to accomplish a variety of purposes. The present study's data is comprised of transcribed audio files. I have tried to show the transparency of the analysis following CA methodological procedures. I demonstrated how I interpreted the selected excerpts using reasoning based on both common-sense knowledge and focus on the details of interaction. This process inevitably brings a certain degree of subjectivity and, as with any qualitative research, there is room for additional or alternative interpretations.

The gender of the doctors is a potential limiting factor, as both doctors in this study are females. The thesis does not include an analysis of data from sessions with male doctors and, therefore, a comparison between genders cannot be made. No conclusion can be drawn on whether doctor's gender would affect the choice of linguistic strategies and whether patients would behave differently if their doctor was a male. Researchers that have explored cross-gender and same-gender dyads report mixed results. There are studies that provide evidence for female doctors showing more affective behavior expressed through empathy, partnership building, and emotional support (Bensing & Brink-Muinen, 1993; Weisman & Teitelbaum, 1985) while other studies reported no difference between female and male doctors in that respect (Hall, Irish, Roter, Ehrlich, & Miller, 1994).

The patients had already an established relationship with the doctors, as each knew the doctor for at least a year. By concentrating on such dyads, the study excludes

visits with patients who are less familiar with the doctor. The question of how representative the exploitation of the linguistic strategies is in those cases can be raised. The number of sessions and doctors were dictated by the time limitations of this study. A future study might look into more data comprised of a higher number of recorded sessions from more doctors and patients. More data might reveal the influence of variables such as the effect of the patients' problem on the type of speech acts, particularly the questions. It is very likely that sessions with patients who are terminally ill will demonstrate, first, a different distribution of questions and choice of topics compared to sessions where the patients come with problems such as digestion issues or skin rashes; second, it is very likely that these patients will show different attitude toward shared decision making (Bensing, 2000). There is a tendency for patients with more severe health conditions to rely on the final decision made by their doctor (Johnston, Pfeifer, & McNutt, 1995).

As mentioned in 3.4, the participants were all native or near-native speakers of English. A future study might include multilingual speakers and for example, explore whether linguistic competence and cultural background interrelate with rapport in this particular institutional setting. A more heterogenous group of participants could deliver findings that reveal some universal or unique ways of creating rapport.

On a more positive note, all these limitations can actually serve as an inspiration for me and others to do additional research in these areas starting with acquiring more data. The ramifications could bring about an understanding of a new genre within the realm of medical discourse practices as well as its similarities and differences to the existing ones.

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Appendix

Speech Acts List

Label	Example	Form (How to recognize it)
DEMANDING INFORMATION		
Open questions	What's been going on with you?	Containing a wh-word (what, why, how)
Closed questions		
polar	Would this help with insomnia as well?	Polar or yes/no question
any-polar	Did you do anything with the Arnica?	Using "any" form of polar questions
close-ended	So, right now how much sleep are you getting?	Containing a wh-word (how much, how long, where, which, when, who)
alternative	Do you want first needles or do you want first this?	Conjunction "or"
Tag questions		
tag	And it ruins it, isn't it?	Containing a tag
tag-element	It's particularly when you have a cold you don't wanna feel that way, right?	Ending with an interrogative element (<i>right, eh, OK</i>)
Declarative questions	You had a C-section?↑	Surface form of a statement with rising intonation and functioning as a question
Elliptical questions		
elliptical/rising	Because of stuff?	Elliptical structures with rising intonation without a complete interrogative form
incomplete	Do you gather people around you or?...?	Incomplete interrogative sentence
Command	Describe me your typical day.	Imperative form
PROVIDING INFORMATION		
Answer	D: So, what's your routine after that? P: Ah, we go for a walk.	It provides information relevant to the question
Affirmation	D: So, you are making enough milk? P: Yes.	It expresses a positive answer to a yes/no question
Negation	D: You guys live close by? P: No, in Richmond.	It expresses a negative answer to a yes/no question

Label	Example	Form (How to recognize it)
Statement	D: You are enforcing all these thoughts. P: Yes.	Form of a statement usually followed by an acknowledgement
statement question	D: Oh, I am wondering if this is shifting things around for you. P: I don't know.	A statement that has question force
statement formulation	P: You buy a neutral shoe and when you put your correction in that makes it compensate for you D: Ahem, yeah P: what adjustment he has been made. D: Ahem, customizes it.	
Acknowledgment	P: I hate needles! D: Nobody likes them.	An agreement with provided information or provided disclaimer
Disclaimer	D: Oh, I am wondering if this is shifting things around for you. P: I don't know.	It follows a request for information in the form of a statement that denies something
Compliance	P: So, tell me what's going through your mind. D: Anything and everything.	Complying with the command
Non-compliance		Not complying with the command