Revealing moments: formulating understandings of adverse experiences in a health appraisal interview

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Abstract

Analysis of a health appraisal interview reveals how an interviewer employs formulations to organize talk about a patient's medical history. When selected reportings by patient are paraphrased, a three-part formulations cycle is initiated: (1) interviewer's formulated understandings, (2) patient's confirmation, and (3) topic shift by interviewer. The reenactment of this interactional pattern promotes increasing attention to patient's adverse experiences as "root problems" underlying adult health status (e.g. molestation, obesity, depression). Creating an environment for patient's emergent disclosures is facilitated by displaying non-judgmental sensitivity to patient's stated concerns, soliciting alignment to particular reconstructions and avoidance of moving the interview forward prematurely and to issues not grounded in patient's illness circumstances. The identification and utilization of communication techniques for attending to patient's bio-psycho-social history is critical for refining understandings of empathic interviewing, enhancing diagnosis and treatment (e.g. referrals), decreasing patients' utilization of health care systems, and ultimately reducing costs for quality medical care. © 2000 Elsevier Science Ltd. All rights reserved.

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Introduction

Communication in medical encounters reveals moments where interviewers paraphrase and summarize patients' descriptions of their medical condition. Following a stated concern about their illness, or an extended story offered as central to the medical history, interviewers demonstrate that selected features of what a patient had offered was both heard and understood by them. Three decades ago, formulations were initially characterized as speakers' attempts to describe, summarize, and in other ways "furnish the gist" of ordinary conversational involvements (Garfinkel & Sacks, 1970; Schegloff, 1972). Within "service" encounters such as counselor-client, radio and television interviews (Heritage & Watson, 1979, 1980; Heritage, 1985), formulations have been described as retrospective devices for inspecting parts and/or the whole of a conversation while displaying multiple functions: soliciting "neutral" clarification "for the record", alignment and expansion on specific issues from speakers, as well as preserving, repairing and thus "fixing" understandings attributed to particular topics.

While speakers' formulations have been shown to exhibit, check and preserve understandings, it has also been argued that they inevitably, and simultaneously, gloss, delete and alter others' reportings. Davis (1986), for example, draws attention to how a pychotherapist employing successive formulations "was able to transform the client's initial difficulties in her situation as full-time housewife and mother into a strictly personal problem: not being able to express her emotions openly and honestly in therapy.. .'candidate readings' of the problem ... [which] serve to construct a rather arbitrary behaviour into a full-fledged therapy problem" (pp. 48, 54). Similarly, during negotiations between union members and management at a large engineering

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company, Walker (1995) observed that formulations were at times employed by "selecting to excavate and focus on one or more inferrables whilst disattending to other possible aspects of the prior talk..." (p. 115). Informal discussions and work groups among physicists have also been examined (Gonzales, 1996), occasions where formulations are employed to momentarily fix, crystallize and even "push" particular positions conveyed through others' talk. Formulations or (re)formulations, then, have been examined as communication techniques transforming (Davis, 1986; Grossen & Apotheloz, 1996) and even biasing psychotherapeutic interviews (Bavelas, McGee, Phillips, Routledge & Wade, 1999) and mediation sessions (Phillips, 1999). Most recently, Drew (2000) has offered a comparative

formulations enacted throughout a single medical interview, and the multiple social actions they are recruited to achieve. While prior attention given to formulations has tended to be decidedly retrospective in nature, focusing more on constructed understandings of prior talk-in-interaction than on how such upshots create and constrain unfolding understandings (see Heyman, 1986), we also examine the diagnostic consequences of an interviewer's attempts to reveal potential health problems while avoiding other concerns raised by patient.

Excerpts in this investigation are drawn from a health appraisal interview (see Data, below), including the following formulations (INT and PAT are abbreviations for "Interviewer" and "Patient"):

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1)   ***SDCL: Kaiser: Nine Formulating Moments in a Medical Interview*** [1]

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INT:   O:ka:y so:,  hh one thirty five to one fo- >you've put on
       thirteen pounds< in the last ye:ar:.=

INT:   So from what I'm understa:nding hhh in the last year
       you've gained about thirteen pounds. (continues)

INT:   Mmkay.  hhh So from what I'm understanding you play one role
       at work. (continues)

INT:   So:o in other words uh uh you have this like kind of a  fals:e
       (.) person, [°in these different areas of your life']

4      INT:   Okay so::  hhh U:hmm from what I'm understa:nding your
              grandfather's death was his anniversary of his death was two
              days ago, (continues)

INT:   So you were [molested by]=
PAT:               [((sniffle))]
INT:   = your grandfather and then by your brother.

INT:   Mm hmm. So she still doesn't know about this, she just
       knows about (your father's past).

INT:   =So your parents were separate[d (continues)

INT:   Oka::y. TWhat I've heard,is that Lynda has been giving giving
       gi:ving (continues)
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analysis of formulations in psychotherapy, news interviews, radio talk shows and industrial negotiations. Attention is drawn to how speakers manage core activities (e.g. soliciting agreement, concession or even "trapping" others) as resources for maneuvering through and thus shaping institutional involvements.

Attention has not, however, been given to how interviewers formulate and patients collaborate in producing medical histories. We examine repeated

We begin with three basic observations drawn from these nine instances, features analyzed in more detail as the analysis proceeds.

[1] In this heading, "SDCL" stands for "San Diego Conversation Library", a collection of recordings and transcriptions of naturally occurring interactions; "Kaiser" represents the source of the data (see Data, below); in following excerpts, line numbers represent ordering in the original transcription of the

First, notice that all but one of these nine utterances are "so-prefaced". We propose that this prefacing-design is consequential in three key ways, as interviewer: (1) provides an <u>upshot</u> of patient's prior talk, selectively representing yet maintaining patient's experiences for subsequent topical talk (see Heritage, 1985); (2) in so doing, attributes responsibility for introducing the talk to patient's reportings. The interviewer explicitly documents that she is working closely (and contingently) with patient's talk as a <u>neutral</u> (i.e. non-judgmental) <u>monitor</u> of the issues being addressed; and (3) produces a <u>natural continuation</u> of patient's preceeding reportings, in each instance (as will become evident) en route to shift of topic. These moments repeatedly display "the fitting of differently focused but related talk to some last utterance in the topic's development" (Schegloff & Sacks, 1973, p. 305).

Second, five of these instances are "pre-prefaced" with "Okay", "Mmkay", or "Mm hmm". It will be shown that these actions are non-trivial, pre-closing devices (Schegloff & Sacks, 1973; Beach, 1993, 1995) recruited by the interviewer to acknowledge yet enforce closure on patient's immediately prior elaborations. Such work also facilitates transitioning to interviewer's formulated upshots, which themselves give rise to topical movements.

Third, when considering the interactional environments from which the nine utteraces above were drawn, we propose a "formulations cycle" revealing a distinct pattern of interaction: (1) interviewer's formulated understandings, (2) patient's confirmation and (3) topic shift initiated by the interviewer. These three basic features are apparent in excerpt 2:In (1 <u>-*)</u> INT brings

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2)   **SDCL:Kaiser:Lines 60-67**

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        ||PAT had reported gaining weight over the past two years.))

   INT:   How much did you weigh in December last year.=
   PAT:   =I'll be around one thirty f:i:ve (°      [              °)
1* INT:                                    [ O k a y  s-
          O:ka:y so:,   hh one thirty five to one fo- >you've put on
          thirteen pounds< in the last ye:ar:.=
2---> PAT: =Right.=
3-* INT:  =Oka:y. Have you had any major changes, in your life over the
          last year?=
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to a close prior discussion of PAT's weight gain. She exhibits understanding that PAT's reportings amounted to "thirteen pounds", and solicits confirmation of her calculation, which PAT next provides (2 <u>-></u>). Only then does INT move the interview forward by shifting topic to changes in PAT's life (3 -*).

As summarized in Table 1, we first examine how additional excerpts reveal these three elements (1 <u>-></u>- 3 <u>-*)</u> comprising the basic organization of formulation involvements. Attention will then be given to how these fundamental features recur when speakers work together to focus on emergent problems, <u>expanding</u> and thereby accommodating ongoing issues and concerns (e.g. ensuring understandings of health circumstances, addressing PAT's tearfulness, pursuing delicate topics such as PAT's mother and molestation).

It was earlier noted that formulations have been observed to display and preserve understandings while also deleting, altering/transforming and even biasing other's reportings. The interplay of these interactional possibilities - displaying understandings in the midst of achieving role-incumbent tasks central to medical interviewing - are given due consideration as this analysis proceeds. Following close analysis of a series of basic and expanded involvements, we conclude this paper by discussing how or if these apparently

Table I
Basic and expanded formulation sequences

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        Basic Organization              Expanded organization

1->    INT's FORMULATION           1 *INT's FORMULATION
2-4    PAT'S CONFIRMATION          2-* PAT'S CONFIRMATION
3-4    INT'S TOPIC SHIFT
                                       [FOCUS ON EMERGENT PROBLEMS]

                                    5- INT'S TOPIC SHIFT
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contradictory functions are apparent in the materials examined. We also describe key implications for a number of interrelated concerns this interview provides an opportunity to address: relationships among "empathic opportunities" and "adverse childhood experiences" when diagnosing and treating health problems.

Data, medical setting, and background

Data and medical setting

Data for this study were videorecorded in 1994 as part of an Annual Review for Health Appraisal in the Department of Preventive Medicine at Kaiser Permanente in San Diego. As more than 50,000 Kaiser members undergo yearly appraisal visits, this department is the largest single-site provider of complete medical evaluations and risk abatement in the world. Segmented into two patient visitations, the first includes blood and urine analysis, pulmonary, hearing and/or radiographic studies, while the second visit involves a detailed medical history and a complete physical examination. At the conclusion of the health appraisal, patients are classified into one of three broad categories: well (nothing further needs to be done); at risk (offered assistance through risk abatement programs); or ill (referred to the most appropriate type of physician for their problem). Assessing the impact of prevention on health status is predicated on the availability of (1) access to knowledge about patient's current state of health and any underlying risk factors, and (2) access to appropriate medical or other help required to bring about change.

Drawn from an ongoing corpus of several hundred interviews recorded by Kaiser Permanente, the transcribed medical encounter examined herein occurs between a physician's assistant (INT) and a middle-aged female patient (PAT), married and mother of two children. As the recording analyzed herein was the first interview released by Kaiser staff for purposes of communication research, specific and additional criteria for selection were thus not relevant for the present investigation. Comprised of a medical history (18:24) and physical examination (13:43), we focus on the medical history only of this two-part health appraisal visit. Mailed between the two visits, a bio-psycho-social health risk analysis enables each patient to come prepared to discuss concerns, while also informing the interviewer (in advance) of self-reported and potentially problematic health/risk behaviors and issues. As will become evident, these health questionnaires are important yet problematic interactional resources as the interviewer attempts to raise and pursue specific topics self-reported by patient.

Background

The interview begins with PAT presenting problems of feeling sluggish, overweight (feet and back hurting) and having vaginal infections, and from these symptoms INT focused on PAT's weight gain (see excerpt 2, above). As a result of repeated listening sessions of the videorecording, and in unison with a full and detailed transcription, we noted an apparent discrepancy: patient initially reports "a lot of stress" at work, "everything's going good at home". It became increasingly apparent, however, that this latter "no problem" reporting is inaccurate: PAT reports considerable difficulty dealing with simultaneous and ongoing demands of work and home. For example, she describes herself as a workaholic, takes little time for herself (e.g. doesn't have much fun, has a difficult time relaxing and would feel guilty if she took time to do so), is preoccupied with pleasing and giving to others but cannot receive, wears "many masks" and often conflicting personalities and is concerned with depression (which she has been treated for previously). Even more revealing, however, are two key factors: first, PAT reports loving her husband but is

involved in an <u>extramarital affair;</u> second, as apparent in excerpt, 1, she reports being <u>molested</u> by both her grandfather and brother at an early age (disclosed for the first time to a health professional).

The question thus arose: how was it interactionally possible that INT and PAT collaborated in moving from a "no problem" reporting (i.e. about the patient's home environment), to increasingly revealing disclosures about family and ongoing marital troubles contributing to her health status? The primary focus of this analysis on formulations, and their interactional consequences, emerged as they were employed by the interviewer as one set of resources for addressing patient's past and current circumstances.

The fundamental organization of formulating moments

Over the course of this single medical encounter, an interviewer's formulations prominently, and progressively, solicit confirming responses and elaborated disclosures by the patient. To identify and establish the fundamental organization and significance of such formulating moments, we begin by inspecting excerpt 3 below:First, INT offers her understandings (1 -*) of two

Even though the upshot offered by INT is grammatically incorrect (e.g. INT's repeating of "death" followed by "From it was one year ago."), in (2 -)PAT nevertheless responds as though INT has made an adequate attempt to characterize what PAT had stated. With an initial affirmation ("°Umhmm°.") preceding confirmation (°Right°.=), PAT withholds elaboration by partitioning and aligning with TNT's version of a portion of PAT's earlier story.

Third, INT is responsive to PAT having displayed herself as "on board" with emergent and now shared (though partial) understandings of her medical history. By grounding her next utterance in PAT's prior talk, INT moves next and immediately by focusing on a related and reported concern: "=You said you and your mother are going through a difficult time right now. =" (3 ≃). Decidedly not a question, but an alternative to "going on to a next question" (Heritage, 1985, p. 115), this reference invites elaboration by PAT on related and potentially delicate matters, a topic shift aided in part by attributing what was said to PAT (" = You said"). Such actions essentially detoxify topic shift, therefore minimizing the likelihood that movement forward in the interview can be framed as INT's heavy-handed pursuit of a medical "agenda" <u>removed</u> from PAT's concerns.

3)   SDCL: *Kaiser:* *Lines 413-425*

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⌈⌈PAT had been elaborating that she and her mom were having a
difficult time addressing how both had been molested by PAT's
grandfather/mom's father.))

      PAT:   And when I brought it out (0.5) °you know it was the same thing°,
             [.hhh   hhh]
1-a   INT:   [Okay so::].hhh U:hmm from what I'm understa:nding your
             grandfather's death was his anniversary of his death was two
             days ago.
2-4   PAT :  °Umhmm°.
1-4   INT:   From it was one year ago. hh uh:mm And apparently your mother
             was molested by him and you were molested by him. hh A::nd the
             two of you shared this about six months after his death.
2-4   PAT:   °Right°.=
3-3   INT:   =You said you and your mother are going through a difficult
             time right now.=
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related events reported previously by PAT: the death of PAT's grandfather, followed by a discussion some six months later with her mother regarding their both having been molested by him. It is important to note that INT prefaces this formulation with "from what I'm understa:nding", one form of caveat acknowledging that the summary-to-follow is not offered as a direct reconstruction but TNT's version. By hearably presenting herself as "doing the upshot", INT also makes clear that she is neither attempting to include all relevant details of PAT's reportings, nor to "own" PAT's experience (see Perakyla, 1995).

Notice, however, that by referencing PAT's mother in (3 ≥), INT also avoids addressing (at least for the moment) two reportings of "molestation". Thus, by shifting focus to certain concerns (PAT's mother), other delicate matters are momentarily disattended (molestation). **In** this way, INT displays sensitivity to selected matters raised by PAT, while also shaping the emergent trajectory of the interview toward other issues nominated for discussion.

From excerpt 3, therefore, the basic three part "formulating sequence" is apparent wherein INT's displayed understandings solicit and receive confirming

response from PAT, immediately prior to INT's initiating shift of topic. Next, consider excerpt 4 where the basic three part "formulating sequence" is also readily identifiable:As INT shifts from prior talk about PAT's concerns with her inability to complete a "project", she moves to bring closure on PAT's reportings via "Mmkay" (see Beach, 1995) before prefacing her utterance with "So from what I'm under-standing". As with excerpt 3 (above), INT produces this

shift (3 >). Notice that INT's "And-prefaced" conclu-sion (see Heritage & Sorjonen, 1994) brings closure to the formulation, setting-up a queried version of the bottom-line, critical issue: "Who is Lynda > .(0.5) Who is she."

To summarize excerpts 3 and 4, INT's formulations reveal practical consequences for how mutual under-standing gets shaped at key and ongoing junctures in the medical interview:

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4)   **SDCL:Kaiser/Lines 331-348**

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      ((Prior discussion had focused on PAT being worried about having
      "different personalities".))

      PAT:   That's what I was °experiencing°. I still am.
      INT:   (°Hmm.°)                         —
      PAT:   I- (0.7) I- (0.5) it's very rare now that I can complete
             a project?
      INT:   Mm hm.
      PAT:   Without allowing myself to get distracted and go onto something
             else.
1-4   INT:   Mmkay hhh So from what I'm understanding you play one role
             at work.
2-9   PAT :  °Mm hm°.
1-9   INT:   Where you have a certain personality,[.hh
2-*   PAT:                                        |°Mm hm°
1-4   INT:   You play another role at home which is comple- and the
             personality is completely different [than at home.
2-4   PAT:                                       |Tuh different.
1-4   INT :  .hhh And you're concerned about having many masks and
3-9          many different types of personalities.  hh <Who is
             Lynda>.
             (0.5)
3-    INT:   Who is she.
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upshot by first qualifying that subsequent versions in which the PAT is a central figure ("you/You're") are not verbatim, but a consequence of the sense INT has made of what PAT has offered.

Throughout INT's summarized version (1 --p), and at each clearly recognized juncture in her evolving for-mulation (see Sacks, Schegloff & Jefferson, 1974; Ochs, Schegloff & Thompson, 1996), PAT offers alignment through acknowledgment of and agreement with INT's paraphrases (2- , "°Mm hm°/Tuh different"). These placements are a matter of precision timing, revealing PAT's careful monitoring of the course and progression of INT's multi-functional formulating actions. Appar-ently, the descriptions offered by INT are treated by PAT as reasonable evidence that INT has both heard and understood PAT's predicament. Such comprehen-sion and alignment are also facilitated by the way that INT's (1-) is itself organized as a "three part list construction" (see Jefferson, 1990), one interactional resource enacted here by INT en route to delicate topic-

- Rather than disattending or altogether avoiding key and selected discussion topics, INT displays a sensitivity to them as an upshot of her own under-standings, actions soliciting PAT's confirmation of the adequacy of their reformulation. Once offered by PAT, but only following PAT's previous alignment, movement toward next and potentially delicate topic(s) is initiated as a collaborative venture.
- It is apparent that INT's formulations represent non-judgmental techniques for pursuing delicate, even risky and potentially stigmatizing topics: in excerpt 3, PAT's adverse childhood experiences (molestation) and their impacts on present circum-stances (difficulties with mother); in excerpt 4, the patient's "many masks and many different types of personalities". By qualifying that verbatim recon-structions will not be forthcoming, and by attributing the initiation of topics to PAT's reportings, INT's avoids heavy-handed movements to selected and next topics.

- These non-judgmental orientations, displayed within the privacy of a health appraisal clinic, can be usefully contrasted with the "neutral stance" of news interviewers in more public settings: "It appears that for an interviewer, whose task is to avoid adopting the position of the primary addressee of interviewee's reports, there is no such thing as an overly neutral utterance ... By their formulating activities, which both represent prior talk and prompt its onward development, interviewers orient to the overhearing news audience and thereby invite their respondents to speak on the record" (Heritage, 1985, p. 115).
- Offered by INT as displays of understanding, her formulations also retain options to select specific topics for elaboration (e.g. PAT's mother) and disattend others (e.g. as with excerpt 3 and as will be shown, related prior reportings by PAT about work and home, molestation).

Throughout this interview, INT's formulations function as devices for clarifying and directing attention to PAT's present life circumstances. Framed not as isolated events, but as impacted through prior adverse experiences, attention is drawn to PAT's personal issues which may have clinical implications. By focusing on how communication within the medical interview can weave together past issues with patients' current health status, formulating practices for addressing (and in some cases, overlooking) such diagnostically-relevant information are recognizable. These shifts of footin by INT, "in and

out of business at hand" (Goffman, 1981, p. 128), continually solicit PAT's alignment. Yet, in so doing, such actions also address different sets, or stances, or postures, or projected selves and identities of PAT as varying issues get invoked and addressed (e.g. see excerpt 4; Button & Casey, 1985, 1988-89; Clayman 1992).

Focusing on emergent problems

The following four excerpts reveal that interviewer's formulations solicit alignment from patient while pursuing what may appear to be contradictory tasks: on one hand, acknowledging and displaying sensitivity to PAT's described predicaments and emotional reactions, thus treating various actions as inherently problematic and deserving of attention prior to topic shift; on the other hand, adapting the attention that is given to specific social actions such as making and emphasizing a point, and even disattending other patient-initiated topics.

Making and emphasizing a point

In excerpt 5 (below), examined in more detail, the basic "formulating sequence" is apparent (1 - , 2 --+, and 5 -) - but here in slightly expanded fashion as 3 - and 4 ~ are "inserted" into it (see Sacks, 1992; Schegloff, 1972):Here INT formulates a chronology of

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5)   **SDCL:Kaiser/Lines 168-186**

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((PAT had been describing that commitments between work and home kept
her from relaxing and spending time by herself.))

       PAT:   Is when I go off an- (0.2) to church (.) on Thursday nights.
              And that's very- maybe once a month when it should be like
              every Thursday night.
1-9    INT:   So from what I'm understa:nding hhh in the last year
              you've gained about thirteen pounds. (0.2) In the last four
              months,  you've been feeling a >little bit< sluggish:. The
              demands at wor:k which you say I am a workaholic
              [ and ] so you tend to work hard there an- and work at=
2---)  PAT :  [°Umhm°]
1-*    INT:   = home as well. hh And then the demands at home are from your
              husband on one side and your children on the other. .hh And
              >basically the only time that I hear that you have for yourself
              = is once a month on a Thursday night when you go to church.<
2-4    PAT:   °Right°.
              (0.4)
2-a    PAT:   [Hhhh uh huh]
3-*    INT:   [That doesn't] sound like very much.        PROBLEM FOCUS:
4-*    PAT:   $It's not much.$ [.hhhh heh hhh]              MAKING A POINT
5-4    INT:                    [° O  k  a  y °]. Tell me about depression=Has
              that been an issue fforl vou.
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several prior reportings (1 -+). Notice, for example, that TNT leaves unspecified just what working hard at home is comprised of in terms of ordinary tasks (e.g. cooking, cleaning, laundry). Instead, she references simultaneous demands from husband and children. So doing reveals INT repeating only a portion of what PAT has earlier offered as a problem, information which contributes significantly to eventually "making a point": encouraging PAT's recognition that she has too little time for herself, and is therefore experiencing health stressors.

In (2-) PAT first quietly affirms INT's summary with "°Umhm°", an acknowledgment also treating the list INT was formulating as in progress and thus incomplete. Upon TNT's completion, PAT quietly agrees ("°Right°", 2->) but she does not elaborate nor does INT seek fuller response. Rather, following the (0.4) pause PAT appears to sigh ("[Hhhh") and next repeats her alignment with INT's version ("uh huh]"). In overlap, INT (3 ->) focuses attention on the nature of the problem (see Heritage & Sell, 1992; Drew & Heritage, 1992) by formulating the upshot with "[That doesn't] sound like very much,".

This assessment by INT acknowledges rather than disattends PAT's predicament. But it also makes definitive the fact that TNT's extended formulation in (1--*) offers irrefutable evidence about PAT's troubling life circumstances, information which, it should not be overlooked, PAT has affirmed as sufficiently accurate. In this excerpt it is thus obvious that formulations can be recruited by interviewers not just to check and reveal understandings, but also to "make a point" - one alternative resource for increasing patients' understandings of their medical history, impacts on current symptoms, and (assumedly) to ultimately aid in motivating positive changes in health behavior.

It is in line with this trajectory that INT's (3 =) further pursues and solicits corroboration from PAT, which is validated in (4 -*) as PAT repeats with "$It's not much$ [.hhhh heh hhh]": a verification, marked with laughter ($) in the form of a voiced chuckle while speaking. This utterance by PAT also displays "trouble resistance", i.e. an ability for PAT to take the trouble lightly, while simultaneously admitting that having little time for herself is trouble (see Jefferson 1984a, 1984b, 1988; Beach, 1996). This is a delicate matter and treated as such through PAT's laughter (see Silverman, 1997; Haakana, 2000). And although PAT's acknowledgment and laughter is itself responsive to the point INT has constructed, evidence which INT worked to make sure PAT has recognized and affirmed/admitted, it is important to observe that just as PAT's laughter does not invite INT to share in the laughter, so too does INT move forward as though no invitation were offered (see also endnote 11, 2-). West (1984), for example, suggests that doctors routinely decline to share in laughter with patients. While laughter declinations do

occur across a variety of medical and family interactions focusing on health and illness (see Jefferson, 1979; Beach, 1995, 1996), the instance in excerpt (5) does not provide evidence that PAT's laughter was built to invite INT, but to treat as delicate the inherent problem of not having enough time for herself.

In overlap, INT's "Okay-prefaced" turn clearly fails to offer shared laughter, but in contrast works pivotally in this moment to actually constrain further elaboration on the point just made (again, through formulation, that PAT's reportings are troublesome) en route to next-positioned matter (see Beach, 1993, 1995). And with "°Okay°. Tell me about depression", movement forward on INT's medical agenda is doubly-enforced: she does not ask a question but rather issues a command-like utterance in the form of a request, yet bearable as a personal request displaying interest in PAT's story. This action by INT is clearly occasioned because of INT's having noted that PAT, prior to the interview and available for inspection, had reported "depression" on her health questionnaire. It is possible, then, that INT's attempt to move forward the interview via a personalized request was itself an upshot of attempting to read, and integrate, PAT's self-reported information. This moment reflects a difficulty in managing simultaneous sources of written and spoken information during a medical interview. Having occurred on the tail of having just made an important point (3 --) further complexifies interviewers' real-time work: attending to PAT's talk-in-interaction, while also attempting to address key and symptomatic underpinnings such as those revealed in (1 ->-4-).

Notice, however, that in (5 -f) INT immediately reshapes her request into a query via "=Has that been an issue [for] you". In so doing, INT compensates for having moved the agenda forward via "Okay" + [command/request], but now more delicately so by shifting to an alternative question format. In this way INT displays recognition that she has prematurely moved the interview forward, a remedial action (see Goffman, 1981) which accommodates PAT by rephrasing her question. It is also worth noting that even though PAT has reported being treated for depression in the past on the health questionnaire, INT does not announce PAT to be depressed. Rather, she solicits her to elaborate on how it may have been an issue grounded in her life experiences.

From this expanded instance (see Table 1) it is apparent in excerpt 5 (above) that INT may formulate updated and paraphrased understandings of PAT's reported circumstances through summary (1 -), next through "problem focus" addressing the "upshot" (3 --4) of PAT's predicament, and by so doing attempt to "make a point" to PAT regarding the cumulative impacts of reportings about her health status. These actions are designed to (and do) receive

acknowledgment, agreement and verification from PAT prior to INT's initiation of topic shift toward more delicate issues (at this point in the interview, depression). In this interactional environment, in the ways INT displays an empathic ability to understand

Attending to patient's tearfulness

We now turn to excerpt 6, where an alternative expansion of the basic "formulating sequence" (2 — — 5b) occurs:This excerpt begins with PAT reporting a

6)   **SDCL:Kaiser/Lines 359-384**

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      ((PAT had described herself as a person requiring a lot of love and
      attention, but also one who gives fully of herself and is loveable,
      affectionate, and playful.))

      PAT:  An- and I'm really happy like that. There's only one person in
            my life that I know I can express that and <knows me that close>
            to see Lynda.
      INT:  Who's that.
      PAT:  Um (.) I'd rather $not say$.
      INT:  Okay, °that's fair°.
      PAT:  U:h But uh everyone else sees different parts of (1.0) of I-
            I can't say Lynda (0.4) I won't °say Lynda°.
1-3   INT:  So:o in other words uh uh you have this like kind of a false
            (.) person, [°in these different areas of your life°]
2-*   PAT:            [I  do:  I  feel  like  every ] where
            I'm going, I'm putting on a play- a performance for every
            place I go.
            (0.4)
- *3-  INT:  You're almost tearful, as you talk about this no:w ƒ—
            I can hear the choking as you [(      ]   )          PROBLEM
4-    PAT :                               [° Yeah ° ]            FOCUS:

            (0.7)
5a-*  INT:  U:mm <one of the things I noticed that you checked
3a-*        off on your uh (1.2)((Paper turning)) I'm sorry this     ATTENDING
            looks like [it must be hard for you]                       TO
4a-*  PAT:            [T h a  is    O k a y.] °It's okay.°           TEARFUL
3b-*  INT:   hh Would ju like uh tissue?                            DISPLAY
-+4b--* PAT: ((cough)) °That's okay.°                        4 —
5b-*  INT:  One of the thi:ngs that I was concerned about when
            I reviewed your-yer history was, you checked off you
            had been raped or molested.
```

PAT's predicament and works to make sure PAT understands the seriousness of her medical situation, PAT is now predisposed to what INT treats as an appropriately next-positioned topic: depression. It is also apparent that INT has paved-the-way to pursue a related yet more sensitive topic by first sufficiently evidencing her understandings-thus-far, evidence grounded in PAT's own talk and self-reportings on the health questionnaire. While INT has presented herself as not responsible for PAT's health circumstances per se, she does display accountability by remedying an attempt to move the interview forward prematurely. Indeed, as PAT reveals ongoing alignment with TNT's summarized versions, increased possibilities are made available for addressing "root issues" as the interview continues.

person with whom she can express herself and is known closely. It is in response to INT's "Who's that." that PAT withholds an identification, a preference marked once again by PAT treating the issue as a delicate matter through laughter ("$not say$."). And having not been invited to laugh, INT next and respectfully acknowledges PAT's decision with "Okay, °that's fair'." Having indicated a willingness not to pursue the matter further, PAT shifts to "everyone else" who fail to see what is implied as PAT's real identity.

In (1 -->) TNT's "in other words" eventuates as "fals:e (.) person," not as PAT's self-description but, once again, as INT's summarized version of PAT's earlier reportings. A more detailed response to INT's formulations is apparent in (2 -ƒ) than has been observed in prior excerpts, as PAT both agrees and elaborates her

feelings. Following a (0.4) pause, INT draws attention to PAT's "<u>tear</u>ful/choking" (3 -*) rather than not observing it or, upon noticing, letting it pass as unattended and insignificant. Apparently, it was PAT's briefly unpacking the details of "putting on a play- a per<u>for</u>mance for every place I go" in (2 -) that involved what turns out to be, upon review of the videotape, PAT's first tearful release in this medical interview. And although PAT responds with a softly uttered agreement in (4 <u>-></u>), it is also important to note that it was PAT's own elaboration that occasioned her apparent emotional reaction that INT attended to.

   Following a (0.7) pause, INT begins to move the agenda forward by glancing at and thus shifting attention to an item checked by PAT in the health questionnaire (5a <u>-p</u>). This shift is momentarily put on hold, however, when in (3a ->) INT again focuses on a problem - PAT's continued tearfulness - by stating "I'm sorry this looks like [it must be hard for you]". Here INT prefaces her problem focus with an apology, apparently for prematurely moving forward <u>in the very midst of PAT's emotional reaction.</u> She does not step outside her institutional role as "interviewer" during this "time out". However, this apology does set-up a specific acknowledgment of PAT's difficulty as INT offers an empathic, non-judgmental observation regarding how "hard for you". This stance is hearable in and through the idiomatic and maximal quality of the utterance "hard for you". As Drew and Holt (1989) have observed, utterances such as these frequently contribute to "halting" further topic elaboration <u>and</u> soliciting uptake from the other speaker (see also Beach, 1996, Chap. 5). As noted, by attending to PAT's tearful condition (rather than passing it by) sensitivity is being displayed which is also, in part, apparent in her assisting by offering PAT a tissue in (3b <u>-></u>). And in response to INT's attentiveness, PAT's repeated "That's/it's okay" (4a,b <u>-></u>) minimizes the severity of her condition, reassuring INT that she'll be fine (i.e. is resistant to troubles).

   Only then does INT re-initiate topic shift (first attempted in 5a ~) by recycling (see Schegloff, 1987) with "One of the thi:ngs" (5b-). But now, and curiously so, INT's description has changed from "one of the things I noticed" (5a ->) to "One of the thi:ngs I was concerned about". We propose that INT's shift in descriptive language - from a more distant "I noticed" to more personalized "I was concerned about" - is itself responsive to (a) the intervening and "tearful" sequence INT and PAT have just worked through together, (b) immediately following INT's apology for shifting topic while PAT's tearfulness went unattended. As first evidenced in excerpt 5 (5 ->), such a remedial adjustment is <u>contingent</u> upon INT's recognition of, and accommodation for, the impacts her actions might have on PAT's orientations to the emerging interview.

   To summarize excerpt (6), rather than moving directly to topic shift following PAT's agreement in (2 -j), INT is responsive to PAT's elaboration by relying on the problem focus in (3 ->) - essentially, a "time out" from moving the official agenda forward in favor of attending to PAT's tearful state. However, the agenda-driven character of interviewing (and, for example, ever present time constraints) is only momentarily suspended as INT initiates topic shift following PAT's affirmation (4 <u>-*</u> – 5--4). But this too is suspended (3a <u>--4b</u> <u>-></u>) as INT attends to ongoing difficulties, which PAT minimizes and offers reassurance about. Then, and again only then, does INT reinitiate topic shift (5b <u>-></u>) and hearably in a more concerned tone.

Attending to family secrets

   The expanded sequence evident below reveals how a basic "formulation sequence" about a delicate topic (molestation) gets further elaborated (3 <u>-+</u> -4b <u>-></u>) as INT focuses on a related problem regarding PAT's mother:

---

7)   ***SDCL:Raiser/Lines 437-463***

      ((PAT had been describing how difficult yet relieved her mother was
      when it "came out" that she (mother) had been molested.))

      PAT: And I've never said it to anyone in my <u>life.</u>
      INT: Um hmm.=
      PAT: =I um- when I was about (0.4) **six or seven.**
      INT: Um hmm.
      PAT: Probably around that age.[My brother was the same way with me too.
      INT: [Uhm
1-*   INT: So you were [molested by]=
      PAT: [((sniffle))]
1-a   INT: = your grandfather and <u>then</u> by your brother.
2-4   PAT: °Right°.

```
1-4    INT:   First at age three by your grandfather and the age
               seven or so by your brother.
2--->  PAT :  °Umhmm°
~3-3   INT:   Did you- your mother did not know about this.=        4─
4-3    PAT:   No. (0.2) I (0.2) still will not tell anyone about it.      PROBLEM
3a-*   INT:   Mm hmm. So she still doesn't know about this, she just      FOCUS:
               knows about (your father's past).
               (0.6) (( PAT nods ))
3b-3   INT:    hh pt (Gee) that's an >awfully< (0.3) hard secret to    ATTENDING
               keep >isn't it<
4a-*   PAT:   pt  hh Ye::s?                                              TO
3c-*   INT:   Mm hmm. Yah.
4b-*   PAT:   But >I mean I've already< put that back on my head but   SECRETS
─~             now that ch'u:ve brought somethin' up i:t just hh    4─
5-*    INT:   U:h Tell me have you >ever had counse:ling<? When-
               when you were going through your counseling period
               about four years ago, was this issue addressed at that
               point?
```

Shortly after excerpt 3 (above), this set of interactional moments begins as a basic "formulating sequence": INT lists and summarizes PAT's prior reportings (1 =), actions which are verified and confirmed by PAT (2 ->) as she is "sniffling". But in (3 -+) two related actions are achieved. First, INT's "Did you- your mother did not know about this,=" focuses on a problem not explicitly raised by PAT, a follow-up question seeking information from PAT regarding her mother's knowing. This query is designed by INT in a manner that assumes PAT will verify its truthfulness. Second, though focusing on a problem, INT is also achieving on-topic shift to preceeding and related talk. Yet here, rather than summarizing or paraphrasing what PAT has reported, INT is soliciting new (apparently intuited) information.

By seeking verification of mother's lack of knowledge in (3 ≃), INT's query collapses "problem focus" with on-topic shift. This variation of the basic "formulating sequence", as INT pursues additional information on current topic (molestation), gets further elaborated in PAT's next response. From PAT's "No (0.2) I (0.2) still will not tell anyone about it" in (4 ->), the accuracy of INT's intuition about her mother not knowing is apparent, a problem which is immediately receipted and formulated on-the-spot by INT (3a ->) in order to further clarify understandings about mother's knowledge. And though PAT offers no verbal response in this (0.6) pause, she does nod affirmatively on the videorecording and thus corroboration is achieved.

In response (3b -*), INT delays topic shift by focusing once again on PAT's displayed predicament. Here, ".hh pt (Gee) that's an > awfully < (0.3) hard secret to keep" offers recognition and identification with PAT's history and present circumstances, and receives PAT's agree-

ment (4a-*). Next (3c-), INT's "Mm hmm. Yah." provides upgraded commiseration with keeping such a secret: Not sharing the burden of such traumatic experience is treated by INT as a lonely and frightening set of events to cope with. This is the case even though PAT repairs (see Schegloff, 1992) and again displays resistance to trouble (4b ---p). By downgrading the impact of these secrets, her description also implies repression of these events.

In (5-), however, notice that INT shifts topic to "counseling" rather than pursue what PAT failed to specify (i.e. with "it just" at the completion of her utterance in 4b -*). By so doing, INT neither acknowledges nor solicits PAT's elaboration of additional feelings and emotions triggered by talking about her molestation experiences.

From excerpt 7 is it clear that the topic of molestation is convoluted. Following INT's initial formulation (1 -) the problem is revealed as not simply rooted in the involvement of a grandfather and brother, but also the long-standing and secretive nature of their inappropriate conduct. Focusing on these related problems occasions the commiseration offered by INT in (3b ->), and its upgrade in (3b -) with "Mm hmm. Yah". Further, it was PAT's troubles-resistance and possible repression in (4c -) which INT treated as counseling-relevant in (5 ->). Nevertheless, in focusing on counseling rather than pursuing PAT's stated concerns in (4b-), it is once again evident that INT can and does enact the option to select particular topics while avoiding those PAT has made available for discussion.

We are now in a position to examine an extended and final set of moments drawn from this interview, actions revealing the "formulations cycle" and its consequences for organizing medical interviews.

Moving to closure: monitoring but not pursuing patient's disclosures

As the interview moves to a close of the medical history-taking, PAT increasingly elaborates by voluntarily disclosing background information (e.g. about her

excerpt below reveals that, and how, INT employs formulations to minimize their elaboration and thus constrain further talk about them.

Excerpt 8 begins where excerpt 7 (above) ended (i.e. INT's querying PAT about counseling), and includes two formulations (1 -+ and 5 -f):

```
8)      SDCL:Kaiser/Lines 460-508

     INT:    U:h tell me have you >ever had counse:ling<? When-
             when you were going through your counseling period
             about four years ago, was this issue addressed at that
             point?
     PAT:    pt Was it uh u:m? N:o it was more like (0.7) uh, I->I
             think somethin'< that (0.3) had (1.3) that um hh hh
             (bloomed) from that becaus[e
     INT:                              [(°Yah°.]
     PAT:    >When I say bloomed I mean< hh my fathe- hh uh I don't-
             >my father and I were (never) close.< So therefore I've
             always wanted attentio[n.
     INT:                          [Mm h[mm].
     PAT:                               [Uh] hugs, kisses. My father
             always gave me lectures on the time that I had
             visitation rights with him. So I didn't have that
             closeness with him. ‾
1-4  INT:    =So your parents were separate[d.
2-)  PAT:                                  [Right.
1--) INT:    And you had visitation rights with [(him)].
2-)  PAT:                                        [Ve]ry ] very
             early in my age. hh And then um (1.0) pt I
             turned out to ha:ve (0.6) um (3.1) looking for
             (0.5) love? L[ooking] for it everywhere I could.=
‾1°~3~ INT:
3-4  INT:    =Mmhm.=                                       PROBLEM
2-)  PAT:    =I ended u:p of course um (0.5) um (0.6) committing   FOCUS:
             adultery? (0.6) And I still have- I'm I-I (0.3) still
             haven't found that perfect person (yet). I love the
             hell, out of my husband- 'scuse my language (but)=
3-)  INT:    =Mm h:mm:=                                    MONITORING
2-9  PAT:    I have so much for my husband, I love him = I wouldn't
             leave him. I hh He's (0.3) very good to me.=
3-4  INT:    =Mm hmm.=                                     PATIENT'S
2-4  PAT:    =Bu:t it's not the same (or who) I'm looking for.
             (0.4)
2-   PAT:    (°I don't know if that makes any [difference°).  DISCLOSURES
3-4  INT:                                     [Uh h m m m
2--) PAT:    I need somethin an-
4---> INT:   =That's missing.
4a-> PAT:    That's missing.
5-)  INT:    [°O k a y°.]
4b-> PAT:    [.hh hhh ] Because Ly:nda is not really getting (.)
‾~           that from anywhere she's searched.            ,
5-4  INT:    Oka::y. T What I've heard, is that Lynda has been giving
             giving gi:ving.  hh ahh She gives at home, she gives at
             wo:rk. (0.8) And something is still missing. uh- How well
             are you able to sit back and receive.
```

father, committing adultery, giving to people and family). While the events raised by PAT provide meaningful descriptions of her life circumstances, the

In response to INT's initial query about counseling, PAT shifts by disclosing aspects of her relationship with her father. Notice, however, that in (1 -+) INT does not

address PAT's reportings that she was never close with her father and "therefore I've always wanted atten tio[." (including hugs and kisses). Rather, INT formulates by attending only to her parents' separation and "visitation rights with (him)". Notice also that while PAT begins by addressing "visitation" in (2 -), she immediately returns to articulating the impacts her father had on her "looking for (0.5) love? L[ooking] for it everywhere I could. = ".

And despite INT's prior attempts to not address such topics, she does offer ongoing acknowledgment (3 -) and attentiveness as PAT pursues yet additional disclosures regarding "committing adultery", her husband, and something "That's missing" (4 - and 4a --+). These concerns are produced as centrally important to PAT's life circumstances. In (4a ->) INT's attentiveness to PAT's stated concerns is particularly noticeable: she completes the thought PAT had been developing with "=That's missing.", a description that PAT quickly repeats and aligns with (see Lerner, 1987, 1993; Diaz, Antaki & Collins, 1996). Thus, it is not a matter of failing to hear and monitor PAT's reportings, but a reluctance to pursue them that is further revealed in INT's subsequent formulation (5   ).

With "Okay", INT twice moves to close PAT's further elaboration about her marriage, actions which are successful but only after PAT's (4b ->): a curiously distant reference to herself, a portion embroiled within an unsuccessful search for love and attention. In turn, INT tailors her response by similarly referencing PAT as "Liz/She" and focusing on "Living Living i~jving" (5 -) - a formulation steering attention away from PAT's disclosures toward a more general assessment of PAT's predicament.

In excerpt 8 (above) TNT's repeated acknowledgment of, yet unwillingness to talk further on potentially relevant topics is obvious. In this expanded involvement, INT's formulations re-focus not on what appear to be additional bottom-line concerns just initiated by PAT, but rather on more general issues (e.g. visitation rights, PAT's giving). These actions demonstrate that INT attends closely to specific features of what PAT is reporting (i.e. 3 -* and 4 -->), even though INT's two formulations are also employed to restrict the time and attention given to PAT's nominated concerns (again, relationship with father, wanting attention/searching for love, committing adultery).

As the medical history-taking portion of the interview draws to a close, this pattern is twice and contiguously repeated as a resource for constraining topic-expansion by PAT. First, while INT acknowledges PAT's elaboration that she has difficulty receiving from others, including compliments, she employs a formulation to move away from further discussion about PAT's efforts to give to others and her family. Second, when PAT reports that she had never been asked about molestation before, including prior counseling sessions, INT formulates by paraphrasing two understandings: this was the first time PAT was disclosing such information to a health professional; while it is hard for PAT to talk about such matters, she (INT) realizes the difficulty and proposes working on the problem together to facilitate a hopeful future.

Summary of "problem focus"

The "problem focus", therefore, is comprised of moments where problems are addressed before inevitable topic shifts are attempted. Specific moments, such as offering reassurance about patient's emotions (e.g. tears in your eyes, living with secrets), reveal how acknowledgments of patient's described predicaments occur en route to initiation of topic shift. In other moments, as with excerpt 8 (above), interviewer's formulations are resources enforcing closure on specific and often delicate topics pursued by patient, as well as overall interview focus, content and length.

Other kinds of problems emerged throughout this interview as well, and were treated by the interviewer as opportunities for making and emphasizing a point, acknowledging a PAT's tearful condition, displaying sensitivity to some topics (e.g. the difficulty of keeping secrets about having been molested) while altogether disattending others (e.g. by not soliciting additional feelings from the patient). Considerable and important work was thus achieved as interviewer focused on contingent problems: pursuing and soliciting PAT's corroboration, attending to PAT's displayed tearful/ choking difficulties, offering commiseration and reassurance (e.g. "hard secret to keep"), apologizing for moving forward too quickly with the interview, withholding fuller response by monitoring patient's continued elaborations. Collectively, these moments of "problem focus" functioned simultaneously as trouble-shooting and information gathering devices, apparently solidifying the relationship between participants while moving the interview forward in constructive and important diagnostic directions. By so doing, eventual topic shifts often emerged seamlessly and appeared to avoid "heavy handedness" as interviewer worked to manage time constraints and diagnostic agendas.

Discussion

We have examined formulations as communication techniques impacting provider-patient relationships and thus revealing important implications for preventive medicine. Working from the observation that "any initiative to transform behavioral features of the consultation is sensitive to the interactional organizations in and through which the diagnosis of disease and

its management are accomplished" (Heath, 1992, p. 264), the present investigation contributes to ongoing research which is uniquely situated to address interwoven issues comprising the delivery and receipt of diagnostic information, quality of patient care and the rising costs of medical treatment (see Perakyla, 1998; Lutfey & Maynard, 1998; Gill, 1998). Through close examination of acute primary visits, for example, Heritage and Stivers (1999) recently discovered how "online commentary" functions as a communication practice whereby "physicians can effectively build a case for a `no problem' evaluation, or against medical intervention, while reassuring patients of the rightness of their decision to seek medical assistance ... a simple but powerful communication resource with which physicians can resist implicit or explicit patient pressure for antibiotic medication" (pp. 26, 28).

We have identified three interrelated and consequential issues - the multifunctional nature of formulations, empathic opportunities, and adverse childhood experiences - which have emerged directly from close examination of this videorecorded and transcribed health appraisal visit.

The multifunctional nature of formulations in medical interviews

When a medical interviewer repeatedly makes available her hearings of patient's reportings about life and illness, these formulations accomplish multiple communication functions in both "basic" (excerpts 2-4) and "expanded" (excerpts 5-8) interactional environments. In most general terms, our findings confirm selected prior observations regarding dual functions which speakers' formulations have been observed to achieve: (1) exhibiting, checking and preserving understandings, (2) altering, deleting and disattending others' reportings (e.g. by focusing on certain topics while clearly avoiding others). More specifically, we have identified an interactional pattern for formulations and their consequences, replete with contingencies arising from formulation usages in a medical interview.

Clearly, a delicate balance exists between attending to PAT's reportings and displayed emotions, while also disattending other topics PAT clearly treats as relevant - actions both facilitating and constraining this medical encounter. Just as medical interviewers are responsible for establishing rapport and diagnosing problems in short time periods, so do formulations get recruited as resources structuring and imposing alternative orders (facilitating and constraining alike) as therapeutic and medical agendas get accomplished (see Bergmann, 1992; Beach, 1995). Seemingly contradictory interactional possibilities thus emerge from these findings.

For example, getting a patient "on board" and thus in alignment should not be taken lightly. As this interview developed, interviewer's repeated formulations summarized what patient had previously stated in-so-many-words, and at times appeared unable and/or unwilling to put into such terms. So doing facilitated getting to selected "bottom line" issues central to diagnosis, and previously unarticulated problems were thereby made accessible for diagnosis and treatment. Produced in an environment where patient ongoingly treated interviewer's versions as adequate and even accurate, the likelihood of shared and cumulative understandings of, and commitments to resolving these problems, is enhanced considerably. Soliciting and receiving confirmation can thus be instrumental in collaborative transition to increasingly central and delicate topics revealing varying facets of underlying health conditions.

One central empirical question arising from these social actions might be stated as follows: does such collaboration in moving to next topics yield more valuable diagnostic information than, for example, environments where providers enact "heavy handed" agendas by shifting to issues patients do not recognize as relevant, or otherwise tied to, their expressed concerns? In this single interview such appears to be the case. Repeatedly, interviewer's non-judgmental displays of encouragement and assurance contributed in meaningful ways to patient's voluntary disclosures of delicate matters. And it was in the midst of these disclosures that patient displayed emotions, and elaborated concerns, that may not have otherwise surfaced.

It was also shown, however, that while these moments create additional empathic opportunities (see below) for the interviewer to acknowledge that such problems were heard and attended to, topics initiated and/or pursued by patient routinely emerged and were at times constrained by interviewer (e.g. her reported extramarital affair). One consequence was that several of patient's displayed concerns about troubling life circumstances remained unaddressed. Such moments may be summarized in the form of an interactional paradox: when interviewers successfully develop a rapport encouraging patient to gradually "open up" (as the interview examined herein clearly reveals), yet given the inevitable time limitations of medical interviews, how do interviewers respond to patients' pursuits of personally relevant topics? When is enough necessarily enough, and how do interviewers accomplish such critical tasks as diagnosing and moving the medical history to closure?

A related problem in psychotherapy involves patients resisting by offering counter-examples to therapists' formulations, creating a "tug-of-war" or "stale-mate" between participants (see Davis, 1986, pp. 65-66). In these circumstances, therapists attempt to persuade clients that the problems they have identified for therapy are legitimate, and patients resist by providing alternative explanations. Identifying and closely examining

these types of disjunctures in medical interviews could add significantly to understanding "lay" and "professional" orientations to diagnosis and treatment.

Situating <u>*empathic opportunities*</u> *in ongoing interaction*

As noted, the interview examined herein reveals both ongoing encouragement <u>and</u> moments where patient was not given license to elaborate concerns. This is not surprising in a time-constrained medical interview, nor does it stipulate that disattending patient's topics is necessarily a "bad" interviewing practice. Rather, such actions are inevitable not only because of the unavoidable glossing formulations demonstrate, but also because it must be kept in mind that referrals are routinely made for ongoing treatment. For example, during the physical examination following the medical history, interviewer referred this patient to the positive choice weight clinic to work with trained staff in a more focused and less time-constrained manner, i.e. a healing environment better suited to more fully address issues such as patient's obesity and depression.

Overwhelmingly, it was observed that when interviewer's formulations did impose constraints on patient-initiated actions (e.g. by disattending various topics), they were not produced in environments void of empathic concerns. On the contrary, despite interviewer's paraphrasing selected and disattending other concerns raised by patient, attentiveness to patient's reportings was prevalent (see Mishler, 1984; Cassell, 1985). As with the present focus on formulations, any attempt to locate closely related concerns with "empathy" in medical interviews must, therefore, take into account the interactional contingencies whereby interviewers offer <u>and</u> withhold acknowledgment and support on specific issues.

When addressing "signs of a growing shift in attitudes toward the values and interpersonal behavior contained within the consultation encounter", Maher and Rokosz (1992) cite a recent "requirement set by the American Board of Internal Medicine that all applicants who seek to take the specialty examination in internal medicine must be certified by the director of the residency program as demonstrating `humanistic qualities'" (p. 243). Just what counts as "humanistic qualities", of course, remains a largely unexplored set of interactional and thus empirical questions that, no doubt, will (and should) drive the future of assessing "quality care" across a host of medical and delivery systems.

And just as it is clear that "empathy" figures prominently in such an assessment, so is it apparent that conversation analytic research reveals significant potential for unpacking what glosses such as "humanistic qualities" might consist of <u>for interactional participants</u> (see Silverman, 1997). The medical interview is the most important device for establishing not just communication between providers and patients (see Heritage, 2000), but opportunities for empathic understandings displayed through sensitivity to patients' feelings and experiences (see Frankel, 1995). As Cassell observed, "Doctors treat patients, not diseases" (1985, p. 1).

Several *Journal of the American Medical Association* articles (e.g. Bellet & Maloney, 1991; Branch & Malik, 1993; Suchman, Markakis, Beckman & Frankel, 1997; Spiegel, 1999) have repeatedly argued that responding to "windows of opportunity" yields important insights and enhances the likelihood of healing outcomes. For example, interviewers' displayed capacity to understand has been associated with increased trust and decreased alienation by patients (Bellet & Maloney, 1991, pp. 1831-32). It has also been observed (Suchman et al., 1997) that patients rarely talked about their emotions directly and without prompting. Instead, patients provide interviewers with clues about how they feel (the potential empathic opportunity). When encouraged by interviewers (e.g. through continuers such as "Uh huh"/"Go on" or questions like "How do you feel about that?"), environments are created where emotions can be more readily expressed and elaborated by the patient. They also note that empathic opportunities can be "missed" or not taken up by the physician, often through the use of "potential empathic opportunity terminators", responses (or non-responses) that "cut off any further elucidation of the patient's emotional concerns at that point in the interview" (p. 680).

After investigating experienced practitioners "efficiently exploring their patients' psychological and social issues during brief interviews", Branch and Malik (1993, pp. 1667-1668) concluded: "One observation regarding these "windows of opportunity" and the empathic occasions they engender was that doctors employed facilitative skills such as "listening attentively to the patient". Summarized succinctly by Frankel (1995, pp. 233-234, 255), "Patients feel grateful when they have an opportunity to be heard and listened to ...To know and understand is obviously a dimension of being scientific. To be known and understood is a dimension of caring and being cared for". Exploring the interactional manifestations of these possibilities will, for decades to come, be central priorities for research protocols across diverse social scientific and medical communities.

The present analysis, however, provides unequivocal evidence that any attempts to understand matters such "empathy" or "listening attentively" <u>as interactional achievements</u> must examine specific and distinctive practices: empathic displays, including work involved in eliciting and responding appropriately to intimate self-disclosures (see Miller, Berg & Archer, 1983; Pegalis, Shaffer, Bazzini & Greenier, 1994); moments where actions such as attentiveness, support and

reassurance do not occur. Establishing the existence of these   practices is exacerbated by their interwoven emergence in real-time interactions. For example, Davis (1986) analyzes an instance where "The above formulation might be viewed as a particularly good example of empathetic listening" (p. 63). The therapist's very next formulation, however, functions to place the client in "an interactional double-bind" (p. 64) between her emotional and cool/intellectual orienations.

Having distinguished ways in which interviewer's formulations accomplish multiple social actions in a health   appraisal interview, arguably empathic and disattending in both function and consequence, one important implication of these findings might be stated as follows: there is a growing need to broaden our conceptualizations of "windows of opportunity" to include not only expressing interest and inviting discussion about patients' worlds (e.g. emotional, home and family circumstances), but also interviewers' techniques for actively avoiding patients' underlying and/or stated concerns given the contingencies of any encounter. In this sense, individualistic conceptions of "being empathic" (e.g. good listeners that identify with and offer support for others' problems, see Brown, 1989), stand in marked contrast with how empathy gets brought off in the midst of practical, collaborative achievements such as the interview examined herein. Indeed, a wide variety of interviewing formats reflect a balance   and tension between accomplishing the "institutional agenda" and creating "open, empathic, conversational" environments (see Suchman & Jordon, 1990; Perakyla, 1995; Mazeland and ten Have, 1996).

Revealing impacts of adverse childhood experiences (ACE)

We conclude this discussion by situating our analysis within   ongoing work in Kaiser's Department of Preventive Medicine in San Diego, a single clinical unit among literally thousands within one of the world's largest health maintenance organizations.

Our analysis has offered an initial attempt to describe, in provider-patient interaction, how explicit connections are explored between patient's "adverse childhood experiences" (see Felitti et al., 1998) and later health and relationship problems (e.g. being overweight, depressed, involved in an extramarital affair, prior substance abuse by husband). It is important to note, however, that analysis of this medical encounter began ELL   to adverse childhood experiences findings being made available, was not driven by a priori concerns with root issues underlying adult illnesses, and thus emerged independently from clinical adverse childhood aexperiences concerns. Rather, early in this investigation it became apparent that this interview involved a host of delicate and revealing moments (e.g. weight gain, role

conflicts, family dysfunction, childhood molestation). Since we began our analysis with the beginning of the recording, it was at first apparent that patient's weight would comprise the predominant focus of the interview. However, it soon became obvious that weight per se was only symptomatic of patient's personal problems - a predominant conclusion also drawn by Kaiser staff, insights resulting from working with patients in health appraisal as well as approximately 20,000 obese patients referred to the Positive Choice Weight Clinic.

Readers   may indeed wonder what a physician's assistant, in a history-taking interview, is even doing addressing sensitive matters involving "adverse childhood experiences":   Aren't such discussions better managed by professional counselors (e.g. see Davis, 1986; Bavelas et al., 2000)? Of what relevance are patients' past and present family involvements, and related psychosocial concerns, to diagnosing and treating physical symptoms and encompassing biomedical conditions? While significant healing possibilities may exist, inherent problems emerge when engaging others in talk about a host of delicate and sensitive issues, in home and clinical environments alike (see Jones & Beach, 1995; Beach, 1996; Perakyla, 1995; Bergmann, 1992; Sharkey, 1997). Even traditional medical evaluations, generally void of attention given to underlying psychosocial concerns, are comprised of addressing topics patients may conceal (see Larson & Chastain, 1990) and/ or don't necessarily want to talk or hear about: their bodies (e.g. histories of sexual abuse, Sharkey, 1997), the choices they make and the consequences for caring (or not) about their own health condition.

However, a recent and extensive survey conducted across *13,494* Kaiser health plan members has revealed striking relationships among adverse childhood experiences and later adult medical problems (Felitti et al., 1998). This survey was associated with Kaiser Permanente's San Diego Health Appraisal Clinic, where "More than 45,000 adults undergo standard examinations there each year, making this one of the world's largest free-standing medical examination centers." (Felitti et al., 1998, p. 246). The adverse childhood experience study questionnaire focused on seven categories of adverse childhood experiences: abuse (psychological, physical and/or sexual); violence against mother; and related dysfunctions of household members (substance abuse, mental illness and/or suicidal tendencies, a history of being imprisoned).

Survey findings reinforce the ongoing commitment to utilize interviewing techniques focusing directly on patients' adverse experiences, rather than minimizing or altogether overlooking their significance for health and behavior. In Table 2, it can be observed that the greater the exposure to childhood abuse (emotional, physical and/or sexual) and household dysfunction (e.g. substance abuse and/or family members with a history

Table 2
The adverse childhood experiences study

Death	Early death
I	I
T	Disease, disability and social problems
l	Adoption of health-risk behaviors
I	l
T	Social, emotional and cognitive impairment
i	I
Birth	Adverse childhood experiences

of mental illness), the more likely patients were to display multiple health risk behaviors and diseases contributing to leading causes of death among adults (Felitti et al., 1998, p. 256).

For example, a comparison of patients reporting at least four types of childhood exposure with those having experienced none were 4-12 times as likely to engage in risky health behaviors (alcoholism, drug abuse, depression and suicide attempts). Related adverse childhood experience findings are equally alarming: "a 2- to 4-fold increase in smoking, poor self-rated health, >50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity" (Felitti et al., 1998, p. 245). At least within the United States, just as unhealthy lifestyle factors have been posited as actual or major causes of morbidity and mortality, so it appears that abuses in early life may themselves be fundamental root problems underlying later adult health status.

And in addition to these adverse childhood experience findings, preliminary Kaiser survey and cost-analysis data suggest that closely attending to patient's adverse experiences in health appraisal medical interviews markedly _decreases_ patient's utilization of the system, thus _reducing_ costs of medical care. If and when up-front time is invested in addressing (rather than avoiding) patients' backgrounds and current life predicaments, i.e. when patients believe they are heard and attended to, in unison with having root issues of their current physical symptoms addressed, they display less of a need to schedule return visitations. Patients report that they often visit a medical practitioner simply because their emotional needs were **not** met during prior appointments. Similarly, when adverse childhood experience-related issues are tied to adult behaviors as explanations for physical symptoms, evidence is emerging that those very same symptoms (e.g. sluggishness, headaches, lower back pain) are minimized over time and thus system utilization decreases proportionately.

By drawing attention to how formulations are employed as communication resources for addressing adverse experiences, future research will need to address how and whether these (and related) techniques promote a greater likelihood that the "root causes" of adult health problems (e.g. depression and stress) will be raised as factors influencing illness. In this health appraisal interview, interviewer was engaging in some set of behaviors encouraging and thus making possible PAT's disclosures - behaviors sufficiently sensitive to and supportive of PAT's reportings, rather than overly critical and evaluative of PAT's background and current life conditions. Equally obvious was the recognition that void of what might crudely be characterized as "interviewer's communication skills", problems rooted in patient's adverse childhood experiences may likely have remain unarticulated and thus been entirely overlooked. Consequently, past influences would not have become connected to present, here-and-now curcumstances such as weight, fatigue, depression, an extramarital affair and overall stress in both home and work environments. By further investigating the primordial and interrelated nature of bio-psycho-social issues, including such interactional tasks and impacts of integrating questionnaire data into the interview itself, different conclusions and thus alternative ways of treating health problems are arrived at.

Years ago, Engel (1977) drew attention to distinctions between "curing the disease" (focusing on physical and biomedical solutions) rather than "healing the illness" (by attending to patient-centered, psychosocial conditions). More recently, Felitti (1997) notes how experienced physicians realize they have been trained to diagnose and treat organic disease, even though most of medical practice consists of illness caused by personal distress: "Emotional expressions inherently are physical; they have evolved to unify mind and body in a common purpose. . The crowning achievement for any clinician is making the correct diagnosis and, with the patient, reaching an understanding of the underlying problem situation" (pp. 1-2). Yet, as Felitti argues, providers often develop a blind spot to the emotionality of the sickness by over-emphasizing the "medical" symptoms of the patient. Two brief examples will suffice: pain is usually diagnosed as an organic disease. According to a recent Stanford study, however, only 33% of the cases were actually organic; depression, a topic relevant to the data analyzed in this present investigation, is viewed as a disease rather than "a response to problems of the human condition ... the biology of depression is the result, not the cause, of feeling depressed" (p. 4).

Finally, while this single case study creates a foundation for future inquiry, it remains only a single medical encounter. Several additional and key questions have emerged from our analysis:

- In what precise ways is it critical that interviewers formulate patient's reportings in order to solicit confirmation of details reported, seek patient's

alignment with (i.e. an on-board orientation to) the evolving course of the interview, create opportunities for focusing on problems and facilitate transitions to "root issue" topics central to diagnosis and treatment?

- When might patients refute or otherwise revise interviewers' formulations? How and when do problems emerge from such actions, and with what consequences (if any) on medical consultations?
- What detrimental impacts might formulations reveal across interviewers with varying communicative skills and styles of interviewing? How might "skills and styles" be interactionally assessed – i.e. what kinds of interactional evidence are necessary to substantiate skills, styles and their impacts on quality of patient care and medical costs, and made available as resources for instructing and training medical professionals?

Answers to these queries will require examination of an aggregate of cases allowing for comparative analysis (see Drew, 2000). Collections need to be made of formulating moments across diverse medical encounters to more fully determine the shape of their organization and impacts on the delivery of health care. Contrasts with interviewers who do not employ formulations, as well as those who employ them ineffectively, are also needed to better determine the ultimate value and disadvantages of such actions for medical interviewing.

Acknowledgements

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