**It does take two to tango: An applied conversation analysis of interactions between a psychiatrist and service-users discussing medication.**

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**Abstract**

**Decisions concerning psychiatric medication are complex and often involve a protracted process of trial and error. We examine three recorded meetings for power-sharing and power-taking discourse strategies employed by both the psychiatrist and mental health service-user, when discussing psychiatric medication. We identify examples of good practice, as well as missed opportunities to engage service-users in co-constructed dialogue and highlight that participation and active involvement in decisions is not best seen as a fixed pattern, but is a complex interplay that changes both between and within interactions.**

**Key words: Shared decision making, mental health, communicative practices, conversation analysis**

**Introduction**

Shared decision-making (SDM) is recommended in policy and has been proposed to offer specific benefits to medication management practices in mental health services (National Institute of Clinical Excellence, 2009). Emerging from other health care arenas and the wider consumerisation of health care services, it has also been embraced in the transformation of mental health service culture and practices. Here, SDM is associated with increased emphasis on psychological and social interventions, valuing service-users as *experts by experience* and the promotion of recovery, social inclusion and empowerment (Deegan & Drake, 2006). SDM sits in the middle of a spectrum of patient participation, between paternalism on the one end (derived from the biomedical paradigm of health where the doctor makes the decision after evaluation of the diagnosis, treatment options, and risks and benefits) and the informed model of decision-making on the other (which assumes that the service-user has ultimate responsibility for the decision made and the professional acts as an adviser). Within SDM, priority is placed on communication and shared deliberation with a respect for service-users’ experiential knowledge, values and preferences (Edwards & Elwyn, 2009). As such, the defining characteristic of SDM is its interactional nature. SDM presents specific opportunities for medication management practice in psychiatry where decisions are made over time, in a protracted process of trial and error. Service user knowledge and preferences need to be at the centre of psychiatric consultation encounters for a number of reasons: a) relations between mental health professionals and service-users often revolve around medication since the vast majority of people who receive mental health services in the UK are prescribed psychiatric drugs: b) diagnosis, aetiology and approaches to treatment are complex and highly contested (Moncrieff, 2009), and c) the growing awareness of long-lasting adverse effects associated with long-term psychiatric medication use has provided more doubt over the ‘cost - benefit’ ratio for psychiatric medication use.

Research investigating communicative practices in mental health settings has identified different discursive strategies employed by mental health practitioners, which can shut down or enable possibilities for SDM and service-user involvement. For example, research has shown how psychiatrists control topics that are open for discussion (McCabe, Heath, Burns, & Priebe, 2002; McCabe, Khanom, Bailey, & Priebe, 2013) and often use closed and negatively framed questions thereby controlling how information on sensitive topics is disclosed by service users (McCabe, Sterno, Priebe, Barnes, & Byng, 2017). In conversations concerning medication, psychiatrists have been found to directly employ pressure and persuasion in encounters with service-users, and often resist engaging in service-users’ concerns about adverse effects (Quirk, Chaplin, Lelliott, & Seale, 2012; Seale, Chaplin, Lelliott, & Quirk, 2007). Other research in a variety of psychiatric and non-psychiatric health-care settings finds that treatment proposals distinguish between pronouncements, suggestions, proposals, offers, and assertions, and their use differs depending on the clinician’s perception of clinical risk, the likelihood of acceptance/resistance, and the perceived accountability of the decision by patients (Stivers et al., 2017; Thompson & McCabe, 2017). In addition, doctors use linguistic devices such as euphemisms and jargon which limit possibilities for discussing patient preferences and knowledge and therefore reduce possibilities for SDM (Chou et al., 2017).

Research has also shown how the patient can influence the professional’s recommendations in a variety of ways, for example by minimal agreements, silences and counter proposals (e.g. Costello & Roberts, 2001; Gill, Halkowski, & Roberts, 2001; Roberts, 1999), and that practitioners employ strategies to facilitate service-user involvement (e.g. Mishler, 1984). In mental health settings, professionals’ use of knowledge displays and pseudo- and hypothetical questions can assist service users expand on topics and express preferences on sensitive topics (Pino, 2017; Speer, 2010) and commonly used question types (e.g. declarative statements requiring confirmation) are associated with improved perceptions of the therapeutic relationship. In addition, psychiatrists have been found to use two different types of accounts to justify treatment recommendations: client attentive accounts and authority based accounts (Angel & Bolden, 2015).

These mixed findings on communicative practices point to the importance of setting, context, clinical judgement of risk, and the existence of pre-existing relationships for determining the function of talk in psychiatric encounters. In addition, the level of observed involvement, and patient resistance, will vary depending on both psychiatrist and service-user characteristics (Bergen et al., 2017; McCabe et al., 2013). Describing this difference, Quirk et al. (2012) propose a typology of open, directed and pressured shared decisions depending on the type of pressure applied by the psychiatrist.

In short, research to date provides some insight in understanding how SDM works in practice by identifying different general approaches adopted by psychiatrists and by showing the types of broad interactional behaviours which can shut down or enable possibilities for service-user involvement. In this paper, we extend this research by undertaking a detailed examination of the communicative patterns between psychiatrist and service user in a small set of examples. We explore how the service user can influence what SDM looks like in practice, investigating the interactions and communicative choices made by *both* participants when discussing psychiatric medication. In particular, this paper aims to examine how doctors’ behaviours adapt to the interactional turn of the service-user, with a particular focus on the power-claiming strategies employed by service-users in this context.

**Data and Method**

We adopt a mixed methods case study approach to the analysis, an applied conversation analysis supplemented with additional consideration as to how the meetings fit with the key defined criteria of shared decision making, We investigate how similar and different these appear to both what is already known about the interactional dynamics of real time encounters and also consider how they fit with the key criteria of shared decision-making models of patient involvement (a deliberation and agreement, following a full weighing up or the pros and cons and with full consideration of the service user experience, preferences and values). Rather than identifying typical patterns in such interactions, our aim was to explore in detail the different ways that conversations concerning a person’s psychiatric medication develop in a small set of examples.

***Applied Conversation Analysis.***

The principles of Conversation Analysis (CA) have been employed as it allows for a detailed inspection of the turn taking organisation of decision sequences within naturally occurring talk. Conversation analysis has been used extensively in research into communication practices between health care professionals and patients. The analysis draws on the literature presented above and what is known about power-claiming and power-enabling strategies employed by physicians as well as the active and power-claiming discursive strategies that service-users employ. By adopting an Applied Conversation Analysis, presentation of relevant background and contextual data is afforded (ten Have, 2001).

***Data***

We present three case studies, based on interviews and recorded meetings between a psychiatrist and service users discussing medication. The meetings took place in the East of England within an NHS foundation trust. Participants were recruited from a community mental health team / pathway (CMHT) that served approximately 260 people with diverse needs, who were broadly considered to have severe and potentially enduring mental illness. The data formed part of a primary research project that took place in the CMHT between 2010-14 which involved a series of interviews with service-users, psychiatrists and CPNs investigating views and experiences of SDM for psychiatric medication management The cases were selected for inclusion because they illustrate three different patterns of power enabling and power claiming strategies employed by both actors. The first shows a more obviously successful process. The second appears successful up to a point, but then changes. The third shows a service-user only partly taking up opportunities to influence the decision, and the psychiatrist needing to make more effort. In each case we see the actors sensitively designing their utterances for the other, and in the second and third examples we see where opportunities for greater engagement are missed. The three recorded meetings presented take place with the same psychiatrist. Researchers were not present and meetings lasted between 13 and 38 minutes and recorded using a digital audio recorder. Only those parts of meetings where medication is discussed were transcribed and all data have been anonymised to protect the identity of the speakers. The Jeffersonian approach to transcription was employed to retain the characteristics of speech delivery (see Atkinson & Heritage, 1999). The NHS National Research Ethics Service granted ethical approval and participants provided full informed consent.

**Findings**

The first example illustrates an interaction where the service-user, Lara, has active involvement in the decision-making process. The psychiatrist provides her opinion, but phrases it in such a way that allows it to be challenged, and Lara takes up this opportunity. In the second example, the service-user (Rosie) is actively involved in the medication decision up to the point it is agreed, but then is not engaged in the subsequent discussion of side-effect management. In the final example, the service-user (Linda) is less assertive, and her experiential knowledge less apparent. While she has opportunities to contribute, she only partly takes these up. In this example, we can see the paradox that more psychiatrist persistence and direction might be necessary in order to produce a more fully equitable encounter.

***Lara: actively claiming speaker rights***

Lara (woman, 42) has received services from the community team for a number of months. Extract 1 is taken from a review meeting with Dr Kos, whom Lara has been seeing approximately once per month. Lara was seeing another psychiatrist prior to Dr Kos, and this changed when the psychiatrist left the team. A male friend / family member is present with Lara in the meeting. Lara has had her psychiatric medication changed in recent months, and is currently being prescribed Lamotrigine, a mood stabiliser.

This meeting lasts 20 minutes, of which 10 minutes are spent discussing medication. The extract below occurs 10 minutes into the meeting. Up to this point, Lara said that her mood has improved since increasing the dose, although she is having difficulty concentrating, is a bit disorganised, her memory is worse than normal, and she has had a recent breakout of eczema.

[[ INSERT EXTRACT 1 HERE]]

Here, Lara often claims speaker rights. She overlaps Dr Kos’s speech to confirm (6) and then modify (7) the doctor’s suggestion (see Drew, 2009, for discussion of overlaps in conversation), and asks questions about the maximum dose (14-15, emboldened). Dr Kos proposes leaving the medication dosage unchanged in line 23-24 ‘I would leave it to the three hundred with a view to increasing if you feel that winter is coming …’. Note that Dr Kos leads up to this opinion by first stating two considerations, Lara’s skin condition and the fact that her mood has already started to improve (for analysis of how doctors provide rationales before treatment recommendations see Roberts, 1999). Dr Kos does not issue this as a directive, but in a less authoritative way: as her personal preference (‘I would leave …’), and finally she leaves open the possibility of increasing the dose in the future. This allows the possibility for Lara to disagree.

Looking at this in more detail, Lara’s request to increase the dose in line 40 is worked up to gradually, starting with the question (line 14) ‘is it at the top end of how much you should take’ – a way of testing the water (see Gill et al., 2001, for other examples). Dr Kos appears to pick this up, explaining that the dose could be increased, but then suggests the dosage should remain as it is, albeit with the ‘get out’ of possibly increasing it in the winter if Lara has a dip in her mood. Lara then declares she does not ‘normally have much of a seasonal change’ (26-27), the use of ‘normally’ and ‘much of a’ acting to soften the challenge. . Lara’s explicit proposal to increase the dose in lines 38-40 begins with a minimal agreement with the doctor’s suggestion (yeah that’s possible) followed by an ‘I-mean-prefaced utterance’ (Maynard, 2013). This is a device often used tie back to the speaker’s earlier utterance, and and complete a course of action when there has been less than full uptake of the speaker’s previous turns by the recipient. Here we see it used when the more implicit ways of making the request are not picked up by the doctor. Then she states she is willing to take the risk of eczema, thus dealing with another of Dr Kos’s arguments for leaving the medication unchanged. Her suggestion to increase the medication doseis phrased as her own preference (‘I would quite like to..’), and she seeks the approval of the doctor (‘If you’re all right with that’). Lara therefore asserts her own medication preference in contradiction to the doctor’s in a delicate way avoiding threatening Dr Kos’s professional authority and identity (see also Costello & Roberts, 2001; Gill et al, 2001). Dr Kos accepts Lara’s proposal by saying ‘I agree with that’.

In summary, this extract shows evidence of a shared encounter. Dr Kos provides medical opinion and expertise about psychiatric medication, but phrases this in a way that is open to challenge by Lara. When faced with Lara’s challenge, Dr Kos does not push on or try to persuade Lara to reconsider (e.g. see Quirk et al., 2012). Instead, Lara brings her own experience, preferences and openness to risk to bear on the decision but phrases her challenge in a way that attends to issues of authority and face.

***Rosie: a shared encounter, well to a point...***

Rosie (woman, 24) has been in contact with Dr Kos for a number of months, but has recently missed a few scheduled routine appointments. Rosie has recently been in contact with the out-of-hours crisis team. At the time of the meeting, Rosie was being prescribed an anti-depressant, *Venlafaxine* and the anti-psychotic medication, A*ripriprozole.* Rosie has been prescribed various psychiatric medications for approximately 8 years and has previously experienced adverse effects of different anti-psychotic medications (including problems with weight gain and prolactin levels).

The key decision in this meeting is to change the type of anti-psychotic medication. The following excerpt occurs at approximately 12 minutes into the conversation. In the extract below Rosie asks explicitly about changing the medication. She is subsequently actively involved in discussion about medication alternatives, however, once a decision has been made to try the new medication, the conversation about adverse effects is brushed over.

[[INSERT EXTRACT 2 HERE]]

In previous work, Gill et al. (2001) showed how patient requests can be built subtly over long sequences. Before this extract, topics related to medication were discussed at two separate points (describing problems her voices are causing her, and problems of drowsiness). In the extract above, after providing reasons why she finds it hard to answer Dr Kos’s question due to her mood (03) and the voices (05), Rosie moves onto the sequentially related topic of changing her medication (07-08). Rosie requests this using a question that has three features that attend to the delicacy of the matter. She does not state which of her two medications she would like to change (leaving this issue open for discussion), she uses polite phrasing *(‘*would it possible’*)* which suggests deference to the doctor’s authority, and she adds ‘at sometime’, which downplays the urgency (for another example of this see Gill et al., 2001). Dr Kos treats the question as a proposal to which she agrees (‘Yes, I think it might be a good idea..’) (09) followed directly by a description of the previous rationale for the prescribing aripripozole (10-14). This protects Dr Kos’s ‘face’ since it defends against the possibility that the previous decision was not properly justified. Dr Kos then uses two gateway closed questions about whether Rosie is happy with the Venlafaxine (17-18). Rosie responds with the affirmative, which leads Dr Kos to move back to the issue of whether to change the aripripozole (21). She does this with a sequence of questions about Rosie’s previous experiences of the same group of antipsychotic medications. This shows Dr Kos respecting Rosie’s greater experiential knowledge of these medications (as opposed to her own professional knowledge - for a discussion of epistemic status see Heritage, 2013), and can be seen as serving an empowering and collaborative function (as opposed to, for example, referring directly to Rosie’s medical notes and making a treatment proposal) (see Thompson, Howes & McCabe, 2016).

Rosie responds to the questions about medication by stating she has tried them and each had adverse effects, making her feel ‘strange’ and ‘fragile’ (32). The only one she has not tried is Olanzapine (36). However, she expresses a concern in line 38-- that ‘I have heard it makes you eat lo:::ads’. Again, she attends to issues of voice: she attributes the potential problem to other sources rather than expressing a direct opinion herself. Through their use of voice, both parties acknowledge the epistemic gradient between them (Heritage, 2013). Rosie does not claim direct knowledge about the side effects (since she has not tired the medication herself), while Dr Kos, with professional knowledge of such things, does claim the knowledge (‘yes I mean this can be’). Note that Rosie phrases the problem as definite: ‘it makes you..’. Dr Kos only partly supports this – she modifies Rosie’s definite statement by using the word ‘can’: ‘Yes I mean this can be a side-effect’. This transforms the problem into only a possibility, which therefore might not actually happen. In the next section Rosie proposes trying Olanzapine, but at a low dose (41-42).

Thus far, the dialogue is relatively shared and Rosie draws on her own experience and knowledge to direct the decision, taking an active role through ruling out some options and expressing concern over a side-effect of the only option she has not tried. Dr Kos responds positively to these turns, asking questions to encourage Rosie to bring her knowledge to bear in the encounter, while at the same time preserving social identity rights and saving face.

However, once the option to try Olanzapine is agreed by Rosie, Dr Kos immediately reinforces this as the preferred option, and from this point, little attempt is made to involve Rosie in exploring her concerns about adverse effects. Similar to Quirk et al.’s (2012) findings, at this point, Dr Kos instead appears to work towards securing the agreement and once Rosie has suggested a low dose (41-42), Dr Kos agrees and moves onto a monologue about a different side effect which Rosie has not raised (prolactin levels) (lines 43-49) without any invitation to Rosie for her involvement (‘I think what we should do..’). Dr Kos finally returns to the concern Rosie had expressed (50), but proposes a set of management strategies for the possible weight gain (lines 50-53) without soliciting Rosie’s participation.

***Linda: an inability to assert speaker rights?***

This is only the second meeting between Linda (woman, 26) and Dr. Kos. Prior to this, Linda has seen psychiatrists in other teams. At the time of this meeting, Linda was also seeing two other psychiatrists, one in the eating disorder team. This is unusual for this mental health team, and may be indicative of complexity of the problems at that time. Linda was being prescribed Venlafaxine, an anti-depressant and Gabapentin, a mood stabiliser. Other psychiatrists issued both prescriptions. Linda has many years’ experience of psychiatric medication and has previously received Electro-Convulsive Therapy (ECT). The meeting in total lasts for 38 minutes, and medication-related conversation lasts for approximately 8 minutes. There is no direct change to her prescription, however, the time of day the medication is taken is changed in this meeting. Plans for future possible changes are also discussed, including the future consideration of the anti-psychotic, *Quetiapine* and/or a course of ECT.

This discourse is highly asymmetrical in speaker rights, with Dr Kos asking *all* of the questions throughout the dialogue and, on a few occasions, making direct treatment proposals. This example portrays an interaction where Linda is offered opportunities by the psychiatrist to contribute but only partly takes these up.

[[INSERT EXTRACT 3 HERE]]

In Extract 3 Dr Kos asks a total of nine topic directing, closed or wh’ questions (see Thompson et al., 2016). The frequency of questions and short duration of turns is noticeably different from the previous excerpts presented. Notably, this was only Dr Kos’s second meeting with Linda, which may also indicate that formulation and assessment were priorities.

There are, however, also many demonstrations of Dr Kos attempting to engage Linda by creating slots for Linda to assess the effectiveness of the treatments she has tried before and bring her experience to bear in the encounter. For example, in lines 31, 33, and 35, Dr Kos repeats Linda's responses, which illustrates she is being heard and encourages additional narrative. In addition, Dr Kos does not attempt to repair Linda’s turn during a number of long pauses and silences (lines 19, 21, 26). In the CA literature, transitions (from one turn to a next) with no or only a slight gap and make up the vast majority of transitions (Sacks, Schegloff, & Jefferson, 1974) and, as such, the noticeable pauses in this excerpt are unusual. In line 19, Linda pauses three times in speech (in response to a direct question *which of those you find the most beneficial?).* It is striking that at no point in Linda’s turn does Dr Kos interject or attempt to repair the sequence by filling the silence, even during a very long pause (6.2 seconds). On Linda’s part, it could be that these extended pauses represent a form of resistance (common in institutional interactions), or are allowing time to cognitively prepare for talk. Avoiding the temptation to fill silences in conversation can be empowering, particularly when the speaker has less institutional power or needs longer to formulate their speech.

However, at other points we see opportunities for shared exploration missed. For example, in line 5, Dr Kos asks two questions about whether Linda is happy with Venlafaxine and if she has any side effects. Linda only answers the latter question, saying she hasn’t ‘noticed any’, but fails to confirm that she is happy with the medication. This might indicate that Linda has some misgivings, particularly given her less than complete denial of side-effects (saying she hasn’t noticed any leaves open the possibility that there might be some side-effects of which she is not yet aware). However, when Linda doesn’t fill the short silence, Dr Kos then moves the topic on in line 8 rather than returning to the unanswered question of whether Linda is happy with the medication. In lines 20-21, Linda reports that a potential problematic experience with her past use of the same medication along with others she was taking at the time, namely that ‘then the effects just stopped and my mood went down again.’ In this case, Dr Kos suggests they cannot change the medication given it has just recently been increased in dosage (23). While this may indeed be clinically justified, it also does not provide Linda further opportunity to explore her possible misgivings.

In Extract 4, which occurs shortly after, Linda does exert more speaker rights.

[[INSERT EXTRACT 4 HERE]]

Here, Dr Kos seeks Linda's opinion on future medication plans (36-37) and Linda responds by suggesting trying Quetiapine / ECT (39-40). Linda voices the proposal through a third person who would be assumed to have expert knowledge and institutional authority: ‘Dr Shara um suggested ..’. In Roberts’ (1999) analysis of interactions in oncology consultations, patients sometimes voiced objections to the doctor’s recommendations and/or rationale by attributing them to other doctors or to something they had read. The difference here is that Linda is orienting to the controversial nature of what she herself is proposing, and is anticipating a possible objection by doctor. In response, Dr Kos asks for Linda's opinion directly (how would you feel about ECT again?). Linda replies using her own voice that she is not worried about it (perhaps orienting to the controversial nature of the treatment). Dr Kos next asks about Linda’s experience, using an either/or question which signals that Linda can disagree with the treatment suggested by Dr Shara. Linda replies by again using Dr Shara’s voice to claim it had positive effects (48-49). At this point, rather than pursuing the topic to find out whether Linda really felt about the two suggestions, Dr Kos changes the topic and introduces a new possible medication option ‘Lamotrogine’ (51).

In summary, Linda appears only partially takes up opportunities to claim her speaker rights and exert experiential knowledge, and Dr Kos misses opportunities to encourage her to discuss her possible misgivings further. In extract 3, Dr Kos does ask specifically about how she feels about her medication, but Linda replies in a limited way. She does provide some clues that she might not be satisfied, but these are not actively followed up by Dr Kos. When Linda does express an alternative course of treatment in extract 4, she voices it through an authority-figure. Voicing this through another person with institutional authority might be particularly important given the content of what is being proposed by Linda at these points (both Quetiapine and ECT are associated with serious side effects and ECT is a controversial and rare therapy in this context). Throughout, there appears to be no consideration of the possible adverse effects. While Dr Kos uses discursive techniques to engage Linda a close inspection of the interaction reveals that more opportunities were probably available.

**Discussion**

This article has examined the interactional and communicative choices that both participants (mental health service-user and psychiatrist) make when discussing psychiatric medication. The meetings took place in an institutional setting where structural and system level constraints to SDM exist. Some of these structural factors are specific to the mental health treatment context (e.g. judgement of insight, capacity, fear of coercion and, diagnosis, labelling and stigma). These structural features present particular challenges for different forms of knowledge having equal status in psychiatric encounters concerning medication. The analysis demonstrates the importance of viewing the practicalities of implementing SDM in context, as involving two participants in a complex interplay. Previous research in other settings have found that patients can influence the professional’s recommendations and that practitioners also employ strategies to facilitate service-user involvement in encounters (Costello & Roberts, 2001; Gill et al., 2001; Mishler, 1984; Roberts, 1999).

All extracts presented in this paper involve the same psychiatrist, Dr Kos, and all occur in the same treatment setting. Given the contextual similarities of these meetings, we might expect a level of similarity between these dialogues in terms of how the meetings conform to the requirements of SDM, and the discourse cues employed by the actors involved. On the one hand, aspects of the SDM process identified in the literature (Charles, Gafni, & Whelan, 1999; Edwards & Elwyn, 2009) are not fully adhered to. Dr Kos does not present a full or complete set of options in any of these meetings and this represents one way in which power is enacted (Kaminskiy, 2015). The weighing up of pros and cons and, in particular, consideration of potential adverse effects, and how these relate to the service-users’ ‘life world’, is also not fully considered (Mishler, 1984). On the other hand, experiential knowledge is both solicited and attended to by Dr Kos, and the idea of a ‘meeting of experts’ applies to some of the excerpts analysed (e.g. Lara and Rosie).

This mixed pattern supports Seale, Chaplin, Lelliott, & Quirk's (2006) study into psychiatrists’ experiences where juxtaposed discourses of doctor influence, professional judgement and expert knowledge were found alongside a genuine desire to support greater service-user autonomy and ownership of decisions.

In Quirk et al.’s (2012) study of anti-psychotic prescribing decisions between psychiatrists and mental health service-users, three decision types: ‘open’, ‘directed’ and, ‘pressured’ decisions were proposed. Directed decisions, where *‘*decisions are produced collaboratively, by the diplomacy of the doctor and by the absence of resistance by the patient’(p.105), and, open decisions, where the decision is made with little or no little or no pressure being exerted by the psychiatrist, occurred most frequently, and these are reflected in our findings.. However, our analysis also points to the changing nature of the interaction types over time, e.g. with Rosie’s interaction moving between features of open and directed decisions throughout the dialogue. However, Lara’s dialogue, at times, is less well described by the typology and represents, potentially, a more empowering portrayal of active service-user participation in practice. Further research could explore these complexities. In particular, further research that moves beyond investigations of how service-users respond to the interactional cues of the doctor, towards a more sophisticated understanding of how the doctor responds and supports the active and power-claiming strategies of the service-user is warranted.

Finally, our findings also suggest that missed opportunities to involve people in decisions need further investigation (see Linda). This is an important practical point, and suggests that the point at which the psychiatrist ‘gives up’ needs attention. With more reticent service-users, the psychiatrist might have to take more time and use more encouragement strategies in order to involve them. Additional research exploring the interactional cues of these more challenging interactions would be fruitful.

In summary, this article adds to our understanding of SDM in mental health, an under-researched context, by exploring in detail the different ways that conversations concerning a person’s psychiatric medication develop in a small set of examples. Much of the existing literature on treatment recommendations is prescriptive; by adopting an exemplar approach, a more detailed examination in the context of the history of each patient is afforded. Future research triangulating the scale and scope of this variation to other work is recommended.

Nonetheless, the findings provide important illustrations of how a physician encourages shared decision making, as well as where opportunities to engage service users fails. The findings also provide a detailed examination of how patients do and do not take part in the process. Findings suggest that some service users do not readily respond to doctors attempt to engage them while others take a much more proactive approach. Service users make proposals and suggestions in complex ways that attend to issues of power and authority, and within a single encounter doctors can vary from encouraging shared decision making, to shutting down topics emphasised as important by service users. At times, we suggest there may be missed opportunities to involve people in decisions. However, in circumstances where the patient actively brings their experiential knowledge to bear, opportunities emerge for meaningful and shared dialogue. This is particularly relevant for decisions concerning psychiatric medication where people often have extensive experience and strong preferences towards treatment and where the cost-benefit ratio is unclear.

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