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Copyright HolderName	The Author(s), under exclusive license to Springer Nature Switzerland AG	
Corresponding Author	Family Name	<b>Stinesen</b>
	Particle	
	Given Name	<b>Baukje B.</b>
	Prefix	
	Suffix	
	Role	
	Division	
	Organization	HU University of Applied Sciences Utrecht
	Address	Utrecht, The Netherlands
	Division	
	Organization	Maastricht University
	Address	Maastricht, The Netherlands
	Email	baukje.stinesen@hu.nl
Author	Family Name	<b>Sneijder</b>
	Particle	
	Given Name	<b>Petra</b>
	Prefix	
	Suffix	
	Role	
	Division	
	Organization	HU University of Applied Sciences Utrecht
	Address	Utrecht, The Netherlands
	Email	
Author	Family Name	<b>Smeets</b>
	Particle	
	Given Name	<b>Rob J.E.M.</b>
	Prefix	
	Suffix	
	Role	
	Division	
	Organization	Maastricht University
	Address	Maastricht, The Netherlands
	Division	
	Organization	CIR Revalidatie
	Address	Eindhoven, The Netherlands

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Abstract

This chapter describes a discursive psychological study on how chronic pain-related disability is negotiated during interviews on admission to chronic pain rehabilitation. Nine patients participated in audio recordings of their admission interview at a rehabilitation unit. Six practitioners were involved in these consultations. The analysis shows that patients' pain-related disability is not treated as a matter of course. Patients make an interactional effort to construct their disabilities as factual. They construct their inability to perform certain actions as consequential to their pain and present adjustments in their behaviour as inevitable. Practitioners, however, challenge such representations by constructing patients' behaviour as insufficiently accounted for and by proposing treatment directions that imply that patients could become more active.

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# 4

## Negotiating (Dis)ability in the Context of Chronic Pain Rehabilitation: Challenges for Patients and Practitioners

Baukje B. Stinesen, Petra Sneijder, and Rob J.E.M. Smeets

### Introduction

Pain that initially functioned as a signal of tissue damage—urging the individual to protect him/herself—may in some cases persist despite the fact that the injury has healed. Psychological factors (e.g. emotions and thoughts) and social factors (e.g. social support and cultural norms) play an important role in the evolvement of chronic pain and pain-related disabilities (Gatchel et al., 2007). The origins of chronic pain

B. B. Stinesen (✉) · P. Sneijder  
HU University of Applied Sciences Utrecht, Utrecht, The Netherlands  
e-mail: [baukje.stinesen@hu.nl](mailto:baukje.stinesen@hu.nl)

B. B. Stinesen · R. J.E.M. Smeets  
Maastricht University, Maastricht, The Netherlands

R. J.E.M. Smeets  
CIR Revalidatie, Eindhoven, The Netherlands

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and suffering are thus complex and multifactorial, making chronic pain difficult both to explain and to treat.

If patients with chronic pain experience that their pain strongly interferes with their daily life activities, their general practitioner or a medical specialist (e.g. neurologist or orthopaedic surgeon) may refer them to a chronic pain rehabilitation unit. As no medical cure exists for this pain, chronic pain rehabilitation programmes are aimed at helping patients to increase their functioning despite being in pain, thereby improving their quality of life. They take a biopsychosocial approach (see Gatchel et al., 2007), taking into account the complex interplay of the biomedical, social and psychological factors that are involved in chronic pain and pain-related disability. Depending on the patient's specific needs, chronic pain rehabilitation programmes may consist of a combination of various forms of therapy provided by an interdisciplinary team of practitioners (i.e. a rehabilitation physician, physiotherapist, occupational therapist, psychologist and social worker). Improving patients' self-management skills is a central component of chronic pain rehabilitation programmes, which aim to enable patients to regain control over their lives and cope with their pain more actively and resiliently (Nicholas & Blyth, 2016).

However, conversations between patients and practitioners about how the patient could deal with his/her pain in a different way can be interactionally challenging. That is, practitioners seek to explore the social and psychological factors that may contribute to the patient's pain and disabilities and that potentially could be targeted to increase the patient's functioning (Swaan et al., 2019). Patients, however, may steer towards receiving a clear biomedical explanation for their pain and a treatment aimed at pain relief (Verbeek et al., 2004). In this chapter, we explore how the patient's health situation and specifically the patient's pain-related disabilities are constructed and negotiated in interaction by patients with chronic pain and their practitioners.

## Relevant Literature

Whereas historically dominant framings of disability have tended to individualize and pathologize the phenomenon of disability, over the last

decades the field of (critical) disability studies has challenged such framings by shedding light on its social and cultural dimensions (Goodley et al., 2019). There has been a growing concern for the role of discourse, since “what is understood or accepted to be a ‘disability’ is socially and culturally located and constructed via discourse” (Lupton & Seymour, 2003, p. 248).

There is, however, a dearth of research on how physical disabilities may be locally produced through talk. Several studies have examined the construction and negotiation of the *aetiology* of patients’ physical symptoms, specifically when there is no univocal biomedical cause assignable (as is also the case for chronic pain) (e.g. Burbaum et al., 2010; Horton-Salway, 2001; Monzonin et al., 2011). These studies indicate that patients tend to undermine psychological explanations for their health situation and that they may alternatively work up the physical nature of their health complaints. From a discursive psychological perspective, it is then considered particularly relevant to examine the interactional business that such constructions perform (Wiggins & Potter, 2017). A study by Horton-Salway (2001) has illustrated that, for patients with chronic fatigue syndrome, these constructions may work to manage issues of personal accountability and blame for the limitations on their everyday functioning.

The lack of a clear and univocal biomedical cause for chronic pain may render also the everyday functioning of patients with chronic pain to be treated as an accountable issue. Various studies have in fact addressed that the lack of a clear biomedical explanation may threaten patients’ credibility. For example, several interview-based studies have reported that patients indicate fearing or actually experiencing others, including healthcare professionals, questioning the legitimacy of their complaints and consequently their moral characters (e.g. Åsbring & Närvänen, 2002; Anne Werner & Malterud, 2003; Holloway et al., 2007; Nettleton, 2006). Other researchers found that their interviewees with chronic low back pain actively constructed themselves as believable narrators of their own pain experiences (Ong et al., 2004; Snelgrove & Liossi, 2009). It is worthwhile to examine how such interactional work takes shape in real-life conversations about chronic pain and disability between patients and their practitioners (Stinesen et al., 2019).

## Theorizing Disability and Discursive Psychology

In this chapter, we adopt the discursive psychological perspective (Wiggins & Potter, 2017) to explore how, in the context of chronic pain rehabilitation, pain-related disability is treated by both patients and practitioners as negotiable rather than a given reality. Discursive psychology studies how participants in talk orient to mental or cognitive states and the interactional work they accomplish by doing so (Edwards & Potter, 2005). Psychological categories such as identities or attitudes are treated as negotiable and variable in interaction, rather than reflecting a static internal world (Potter, 1998). Wiggins (2014) has illustrated that people's talk does not only offer an alternative understanding of people's internal worlds. We can also use discursive psychology to study how (the features, functions and limits of) people's material bodies are produced in interaction and particularly what social actions are being performed by doing so. In line with this theoretical standpoint, rather than treating pain-related disability as a fixed physical state, this chapter re-specifies it as being managed and constructed in interaction to achieve local interactional goals.

The described—potentially challenging—nature of the conversations between patients with chronic pain and their practitioners makes such conversations particularly interesting from a discursive psychological standpoint, as discursive psychology has a key concern for how mind-world relations are managed in interaction (Edwards, 2007). That is, it has an analytical interest in how participants in interaction make sense of what constitutes the (subjective) mental world 'within' and what constitutes the (objective) world 'out-there', and how such notions are deployed in interaction. As such, discursive psychology also offers the analytic tools to reveal how participants deal with mind-body relations. Wiggins' (2014) work on embodied identities, for example, has illustrated that even though mind and body are often treated as separate entities (the mind/body dualism), particular ways of talking may in fact blur the boundaries between mind and body (e.g. when bodily states and processes are constructed as part of a person's identity). By studying how mind-body relations are managed in patient–practitioner

interaction about chronic pain and rehabilitation, the conflicting realities that are involved in chronic pain-related disability are made visible. We show, for example, that whereas patients tend to construct their pain and their body, rather than themselves, as determining their actions, practitioners may construct patients as actors. Such types of subtle mechanisms in language, consciously or unconsciously, fulfil important interactional goals in conversations between patients and practitioners.

In this chapter, we consider the ways in which constructions of mind-world relations, and more specifically mind-body relations, play a role in patient–practitioner negotiations of disability in the chronic pain context. We specifically examine interviews during admission to chronic pain rehabilitation. In the next section, in which we describe our methods, we further explain this focus and provide more details about how we have gone about it. We then present our analysis, in which we illustrate how patients and practitioners negotiate the patient’s disability throughout the course of the admission interviews. We finish this chapter with a discussion of our findings and a conclusion.

## Methods

### Data

Our analysis focuses on the patient’s first consultation at the rehabilitation unit: the admission interview. As much is at stake for both patient and practitioner, these interviews can be challenging. During the admission interview, the practitioner (usually a rehabilitation physician or physician assistant) assesses whether the patient is eligible for treatment from a biopsychosocial perspective on pain and disability (Swaan et al., 2019). The interview functions to identify causal and maintaining factors that contribute to the patient’s pain and disability. The practitioner also aims to assess which of these factors potentially could be targeted to increase the patient’s functioning, and most importantly, whether the patient is open to and willing to undergo such an approach. Patients, however, may enter the consultation with specific hopes and expectations regarding the consultation, such as to receive a clear biomedical

143 explanation for their pain and a treatment aimed at pain relief (Verbeek  
144 et al., 2004).

145 Our corpus consists of nine admission interviews that were audio  
146 recorded at five different chronic pain rehabilitation units in the Nether-  
147 lands, after the first author had conducted a short ethnographic study  
148 to become familiar with their institutional practices (e.g. she inter-  
149 viewed practitioners and attended admission interviews as well as various  
150 types of treatment sessions). The recordings of the consultations ranged  
151 from 34 to 73 minutes. Approximately 7.5 hours of audio material was  
152 collected.

153 Nine patients were included, all having chronic (i.e. lasting for more  
154 than three months) musculoskeletal pain with no univocal biomedical  
155 cause assignable. Seven of the patients who participated had back and/or  
156 neck pain and two of them had fibromyalgia. The duration of their pain  
157 varied from less to one year to more than twenty years. Six different prac-  
158 titioners (three rehabilitation physicians, two physician assistants and one  
159 rehabilitation physician trainee) were involved in conducting the admis-  
160 sion interviews. An accredited research ethics committee approved the  
161 study and participants gave written informed consent.

## 162 Data Analysis

163 Our full corpus was transcribed at word-level accuracy and, during the  
164 course of our analysis, relevant sections were transcribed according to  
165 Jefferson's methods (Jefferson, 2004). In this paragraph, we describe the  
166 main stages of our analysis. It is important to note, however, that—  
167 as is common for analysis in discursive psychology (Wiggins & Potter,  
168 2017)—our analysis was an iterative process.

169 During the first stage of the analysis, the first listenings and readings  
170 of the material, we noticed that when exploring the ways in which pain  
171 affects the patient's functioning and its implications for rehabilitation,  
172 patients' and practitioners' conversations often seemed to go around in  
173 circles. That is, participants seemed to engage in an ongoing negotiation  
174 of the patient's ability or inability to perform daily life activities. In order



to study such dynamics in detail, we coded all fragments in which participants addressed the effect of pain on the patient's ability to perform daily life activities.

According to discursive psychology, social realities are constructed through language, as people interact (Edwards & Potter, 2001). In the next stage of our analysis, we started *describing* the ways in which patients and practitioners constructed the patient's ability or inability to engage in certain activities. We made notes on the fragments in our collection in terms of *what* was being constructed (content), *how* it was being constructed (style and structure) and *when* it was produced within the sequential organization of the conversation (situatedness) (Wiggins, 2017).

In the following stage, we examined the functions of such constructions, as discursive psychology is particularly concerned with the social actions participants in interaction perform (such as making compliments, making requests, complaining, and specifically, managing issues of stake and accountability) (Wiggins & Potter, 2017). In order to identify social actions, we used the discursive devices that are available in our data as analytical tools to "help us to 'unpack' interaction" (Wiggins, 2017, p. 176). These discursive devices are specific features of talk that help participants to perform social action and have been found to be recurrent in diverse interactional contexts previously studied by other researchers (Wiggins, 2017).

## Validating Procedures

In order to warrant our analytical claims, we have drawn upon several validating procedures (see Potter, 1998; Wiggins & Potter, 2017), while analysing our data and building this chapter. For example, in order to validate our analytical claims about the social actions participants perform, we made use of the *next turn proof procedure*. This means that we looked at how participants in the interaction themselves display their understanding of each other's talk. In addition, we took into consideration *coherence*. That is, we checked that the phenomena we report on are grounded in the data that we coded. Also, we discuss the coherence

of our analytic findings with previously published work. Another important validating procedure is *transparency* of the analysis. In the foregoing, we have described our data and analytic stages in detail. Also, in the next paragraph, we present our analytic findings stepwise, using fragments of our transcribed data, including the original production of talk in Dutch. Transcript sections that are reported in this chapter have been translated to English with help of a native speaker (we opted for a translation that is as literal as possible). The transparency of the data and our analytic steps enable the reader to assess the validity of our analytic claims.

## Findings

As we will show, patients construct their inability to perform certain actions and consequential adjustments in their behaviour (e.g. no longer engaging in certain activities, taking a rest) as an inevitable outcome of their pain. Practitioners, on the other hand, suggest that the patient could in fact become more active, after which patients, again, tend to underscore their inability to do so. We illustrate this circularity using representative examples from two admission interviews, indicated as ‘admission interview 1’ and ‘admission interview 2’ in the extract headings. These interviews lasted, respectively, 50 minutes and 1 hour.

### Willing but Unable: Building Authenticity of Pain and Pain-Related Disabilities

Our analysis of admission interviews showed that mind/body distinctions play an important role in the construction and negotiation of disability in the chronic pain context. If we consider the ways in which patients present their health situation, it becomes clear that patients contrast the limits to what their body permits with their willingness of mind. In this section, we look at an example of how such contrasts work up the authenticity of the patient’s pain and pain-related disabilities.

We first share part A of Extract 1, derived from admission interview 1. The extract starts after the patient (Pa) has presented the practitioner

AQ2



(Pr) with the problem that his hip tends to turn outwards, which he presents as a potential cause of his back pain. The practitioner has asked the patient whether he has any idea of what he could do to lessen his complaints when he experiences this situation.

#### Extract 1A (admission interview 1)

1. Pa: .hh ja hh  
           .hh yes hh
2. (1.3)  
       (1.3)
3. °ik° (.) kzal altijd proberen om mij niet  
       °I° (.) I'll always try not to
4. ziek te melden tenzij dat dat niet anders gaat,  
       call in sick unless there is no other way,
5. Pr: hmhm  
       hmhm

After the patient has confirmed having thoughts on what he could do to lessen his complaints (line 1), but before he actually elaborates on those, the patient starts by mentioning that he would always try not to call in sick, unless there is no other way (lines 3–4). Previous discursive psychological work on script and breach formulations has pointed to how people may describe actions or events as being routine or, on the contrary, exceptional (Edwards, 1994). In lines 3–4, the patient describes calling in sick as an exception to his usual conduct. From a discursive psychological point of view, it is particularly relevant to examine the interactional business that is being performed by such a specific description. Script and breach formulations are central to how participants in interaction deal with accountability and, therefore, they may be used as a discursive device for building a person's character or disposition

(Edwards, 1994). Note how by describing calling in sick as an exception to his usual conduct, the patient constructs it as a norm-breaching and accountable action. Thereby he makes available inferences about his moral disposition (see Edwards, 1994). That is, the patient constructs himself as having a good work ethic, and, by doing so, he anticipates any inference that he would be the type of person who malingers. Presented thus, this account contributes to the construction of the authenticity of the patient's pain and pain-related disabilities, which—as we can see in Extract 1B—he is about to present.

### Extract 1B (admission interview 1)

6. Pa: als het zo erg is dat ik niet ken lopen,  
if it is this bad that I cannot walk,
7. (1.0)  
(1.0)
8. dan kan ik niet lopen en dan ben ik gedwongen om-  
then I cannot walk and then I am forced to-
9. (1.7)  
(1.7)
10. en dan ligt >d't eraan< hoeveel pijn dat ik heb  
and then it depends on how much pain I have
11. (0.7)  
(0.7)
12. en anders dan ga ik maar in bed liggen.  
or else I just lie down in bed.

At line 6, the patient further specifies the type of situation in which there would be no option but to call in sick: 'if it is ↑this bad that I cannot

walk,’. After a 1.0 pause (line 7) he adds ‘then I cannot walk ↑and then I am forced to-’ (line 8). By using a declarative form, rather than a subjective format, the inability to walk is presented as factual and out there (at both line 6 and line 8) (cf. Potter, 1996), and its consequences (though not yet specified) are also presented as beyond the patient’s control. The patient constructs himself as being ‘forced’, or, in other words, as having no choice with respect to his consequent actions.

Note that due to its *if-then* structure the account takes the shape of a script formulation. The *if-then* format is a powerful discursive device “for treating events and actions as expectable, and for drawing inferences, in which temporal sequence, causality, and rational accountability are mutually implicative” (Edwards, 1997, p. 288). It suggests a logical connection between the inability to walk and the patient’s lack of control over his consequent actions. Also, by using this format, the course of events is presented as a recognizable and routine pattern that makes relevant the patient’s experiential knowledge, which provides the basis for answering the practitioner’s question about what the patient could do to lessen his complaints.

After a 1.7 intra-turn pause (line 9), the patient provides an answer to this question by adding ‘and then it depends on how much pain I have (0.7) or else I just lie down in bed.’ (lines 10–12). Discursive psychology attends to how participants in interaction often make relevant their level of agency in a particular course of events (Wiggins, 2017). That is, they may position themselves as an active agent (e.g. as having the capacity to act/decide) or a passive subject (e.g. as having no choice but to undergo something), or somewhere in between. By doing so, speakers also make available inferences regarding the extent to which they can be held accountable for an event or behaviour (Edwards & Potter, 1993; Wiggins, 2017). In line with our observations in Extract 1A, we see that in lines 10–12 the patient constructs himself as having limited agency regarding his behaviour, which is now specified as lying down in bed. Whether or not to lie down in bed is presented as an outcome that depends on a bodily experience: ‘how much pain I have’. And, it is being

suggested that, with certain levels of pain, there is no choice other than to 'just lie down in bed'. Thus, the pain, and not the patient himself, is constructed as determining the course of the patient's behaviour. In this way, the patient downgrades his accountability for the action of lying down in bed. Note how the particular formulation 'or else I just lie down in bed.' suggests both a preference for a different course of action and a somewhat resigned stance, as 'just' minimizes the gravity of this inevitable outcome.

The foregoing analysis provides an illustration of how patients construct themselves as subject to what their pain and body permit and that, when doing so, they tend to draw on experiential knowledge. Since such knowledge is only knowable by the speaker (Heritage, 2011), it may be difficult to argue against. The analysis also shows that these constructions of disability may be contrasted with constructions of willingness of mind. Broadly, our data show that patients provide a variety of disposition-implicative descriptions that reinforce their willingness of mind. In addition to their good work ethic, they may for example orient to their ambitions to make a valuable contribution to society, their pursuit of independence, or their enjoyment of an active lifestyle in the past. Constructions of body/mind distinctions may be put to use as an interactional resource to build up the authenticity of the patient's pain and disabilities. Therefore, they may also work to underscore the legitimacy of the patient's visit to the rehabilitation centre (see Heritage, 2009; Nielsen, 2018). That is, although the cause of their pain may be intangible, its physical consequences (e.g. not being able to walk and being forced to lie down) provide concrete proof that their pain is real, as well as burdensome. And, by constructing themselves as someone who finds a higher level of functioning preferable, patients underscore the relevance of treatment in order to achieve this.

## Practitioners' Challenges to the Self-evidence of a Patient's Disability

In the previous section, we have illustrated how patients tend to construct their pain and disability as factual, and how they present adjusting their behaviours (e.g. lying in bed) as an inevitable outcome of what their pain and body permit. In this section, we pay attention to the fact that the practitioner is then faced with the challenging task of directing the conversation towards potential psychosocially oriented explanations for the patient's behaviour, such as fear that movement will inflict bodily harm. In doing so, practitioners do not always take the patient's body-oriented accounts for granted, and, in fact, they may undermine the inevitability of the patient's actions. They may do so, for example, by suggesting directions for treatment that involve a change in the patient's behaviour or by treating the patient's current behaviour as insufficiently accounted for. In this section, we illustrate both such actions.

## Suggesting Directions for Treatment that Involve a Behaviour Change

Extract 2A starts approximately half way through another admission interview with a patient with back pain. The practitioner has just indicated that each of her questions has now more or less been answered, and she wishes to go more into the patient's pain, in line with the notion that the rehabilitation team's focus is on patients learning how to cope with their pain complaints.

### Extract 2A (admission interview 2)

1. Pr: e:hm (0.8) stel dat wij zouden zeggen tegen u  
e:hm (0.8) suppose that we would say to you
2. ehm (2.4) pij- 'f eh ːja beːwegen kan geen kwaad?  
ehm (2.4) pai- 'r eh ːwell ːmoving does no harm?
3. (1.5)  
(1.5)
4. ga [maar gewoon doen].  
just [go do it.
5. Pa: [hmhm.  
[hmhm.
6. Pr: wat zou dat-,  
what would that-,
7. wat zou d'r dan (0.8) geːbeuren wat eh  
what would then (0.8) ːhappen what eh

Extract 2A starts with the practitioner posing a hypothetical question ‘e:hm (0.8) suppose that we would say to you ehm (2.4) pai- ‘r eh ↑well ↓moving does no harm?’ (lines 1–2). Research in a different setting has illustrated that hypothetical questions can function as a tool for health-care professionals to assess whether a patient is an appropriate candidate for treatment (Speer, 2006). The hypothetical question in Extract 2A can be read in a similar way, as it orients the institutional goal of assessing whether the patient is willing to undergo treatment that starts from the assumption that moving will not cause the patient’s body any harm.

During the description of the hypothetical situation, the word ‘pain’ is aborted and followed by a repair “r eh ↑well ↓moving does no harm?” (line 2). Note that the version that *pain* does no harm, could potentially be problematic, as it could be understood by the patient as brushing aside the problems and complaints which he has presented as a consequence of his pain. In spite of the repair, the hypothetical question is followed by a 1.5 silence (line 3), as no answer is being provided by



the patient. A study by Monzoni et al. (2011), which examined clinical encounters between neurologists and patients with functional symptoms, has illustrated that patients' responses to psychological treatment recommendations are often characterized by interactional resistance. The study illustrates that such resistance often takes a passive form, comprising actions such as providing only a minimal response or remaining silent, like the patient does in line 3. After the 1.5 silence, the practitioner adds 'just go do it.' (line 4). The patient then provides a minimal response in overlap ('hmm.', line 5), after which the practitioner poses the question as to what would happen in such a situation (lines 6–7).

Interestingly, the team's hypothetical suggestion to 'just go do it' (line 4) does not merely underline the message that moving does no harm. The word 'just' also downplays potential challenges or difficulties associated with moving, and it presents moving as an ordinary thing to do. This is in line with previous studies that have illustrated that 'just' can function as a minimisation and normalisation device (see for example, Clarke et al., 2004). In this case, to 'just' go do it implies that there are no obstacles to be expected, and that moving is something the patient *could* do, or in other words, *should be able* to do.

Note how the practitioner's hedged talk indicates that she orients to the potential delicacy of such inferences (Wiggins, 2017). The hypothetical question format ('*suppose* that..', line 1) marks the talk as tentative and by in addition using 'we' (line 1) rather than 'I' (thereby positioning herself as speaking on behalf of the rehabilitation team), the practitioner manages to distance herself from any particular stance. Thereby she protects herself from being held personally accountable for making this recommendation. The hypothetical question format thus does not only orient to the institutional business of assessing the patient's willingness, it also performs interactional business. If we take a look at the patient's response in Extract 2B, we see that the ability to move is indeed what is made relevant.

#### Extract 2B (admission interview 2)



8. Pa: dan zou'k eh da ja (d) sowieso=eh,  
then I would eh yes (d) in any case=eh,
9. veur zo ↑ver als dat gaat e::h,=°ja°.  
as ↑far as possible e::h,=°yes°.
10. Pr: hmhm,  
hmhm,
11. (1.3)  
(1.3)
12. Pa: ('kzeg) dat probeer ik nou:.  
(say) that's what I try to do no:w.
13. probeer toch steeds wel (.)  
do keep try to anyhow (.)
14. ↑ja iedere keer e:h toch wel de grens ↑op te zoeke:h  
↑yes every time e:h to anyhow ↑push the limit

Although the practitioner's question 'what would then (0.8) ↓happen what eh' (line 7, Extract 2A) is designed as 'agentless' and allows for a range of different responses that could be made relevant, it is seized by the patient to formulate specifically his own likely behavioural pattern in this hypothetical scenario: 'then I would eh yes (d) in any case = eh,' (line 8). Similar to Extract 1, the patient thus starts his account by underlining his willing character by means of a script formulation.

Note that this script formulation is carefully designed to preserve the legitimacy of the visit. The scripting device 'would' (line 8) underscores the patient's disposition to comply with advice that may be given by the rehabilitation team. Previous work by Edwards (2006) has illustrated, that modals with an iterative aspect, such as 'would' and 'will', provide for a sense of predictability regarding a person's behaviour. At first sight, it might seem that the patient could have underscored his willingness to comply even more firmly by using the modal verb 'will' instead of 'would' ('then I will eh yes (d) in any case = eh'). However, such determinedness

would have undermined the patient's doctorability. That is, it would have undermined the worthiness of his health situation to engage the doctor's time and attention (see Heritage, 2009; Nielsen, 2018). After all, if he could simply change his behaviour, there would be no need for him to come to a rehabilitation centre for treatment. Thus, in this case, using 'would' has the advantage that it provides for the inference that what the patient *would* do is "dispositionally predictable, if it were not for circumstances preventing it" (Edwards, 2006, p. 498).

In line 9, the patient adds a conditional clause that reinforces his doctorability, 'as ↑far as possible e::h,' as it sets up the possible limits of compliance. Note that this utterance could as well be labelled as a relatively active expression of resistance (Monzoni et al., 2011). It is, however, directly followed by another, quieter 'yes°.' (line 9), which emphasizes the patient's positive stance in spite of this condition, thereby anticipating any inference that he would not be cooperative. Thus, as in our observations in the previous section, the patient constructs himself as willing to act, while at the same time having limited agency with respect to his behaviour.

After the practitioner's 'hmhm,' (line 10) and a 1.3 silence (line 11), the patient continues with another script formulation (Edwards, 1994): '(say) that's what I try to do no:w. do keep try to anyhow (.) ↑yes every time e:h to anyhow ↑push the limit' (lines 12–14). Thus, whereas the patient initially presented his *future* behaviour as likely to be, as far as possible, compliant with the rehabilitation team's (hypothetical) advice, he now depicts his *current* behaviour pattern as already and consistently being in line with this. Note that the idiomatic expression 'push the limit' makes relevant an extremeness with respect to his efforts. Previous work on extreme case formulations has indicated that such formulations are often used to strengthen claims against disagreement (Pomerantz, 1986). By claiming that he already tries to push himself to the limit every time, the patient reinforces both his willingness to keep moving and the likelihood that he will try to comply with the rehabilitation team's advice in the future. With this particular formulation, the patient also makes relevant having experiential knowledge regarding the limits to his own control; thus, the inference that he could 'just' start moving, which was

available in the hypothetical scenario presented by the practitioner, is being undermined.

## Treating the Patient's Current Behaviour as Insufficiently Accounted for

The next extract, Extract 3, takes place later on in the same admission interview. The extract starts approximately five minutes before the end of the consultation with another example of the practitioner suggesting a change in behaviour (Extract 3A), after which the practitioner constructs the patient's current behaviour as insufficiently accounted for (Extract 3B).

### Extract 3A (admission interview 2)

1. Pr: ja wat ik al in't begin  
yes as I already at the beginning
2. al al aangaf hè,  
already already indicated right,
3. dus wij wij ↓kunnen de pijn niet wegnemen,=  
so we we ↓cannot take the pain away,=
4. =maar wij zijn [(eigk/echt) gericht op  
=but we are [(actually/really) focused on
5. Pa: [hmhm  
[hmhm
6. Pr: ondanks de pijnklachten toch (.) be↓wegen,  
despite the pain complaints to nonetheless (.) ↓move,
7. e[n <daarin> (0.9) wat te gaan doen,  
a[nd <in that> (0.9) to go do something,
8. Pa: [ja  
[yes

Extract 3A starts with the practitioner making reference to something that she specified earlier, at the beginning of the consultation (lines 1-2); that is, that the rehabilitation team cannot take the patient's pain away (line 3). The repetitions of the words 'already' (line 2) and 'we' (line 3) make the delivery of the talk appear stammering and indicate that the message is oriented to as delicate by the practitioner.

After reminding the patient that the team is unable to take away the pain, the practitioner provides a description of what their focus is on instead: 'despite the pain complaints to nonetheless (.) ↑move, and < in that > (0.9) to go do something,' (lines 6-7). Like in Extract 2AA, the practitioner manages to distance herself from any inferences regarding the patient's ability. This time, the pronoun 'we' (line 4) works to construct movement despite the presence of pain complaints as something the rehabilitation team, in a general sense, aims for. Thus, the practitioner refrains from explicitly referring to what is expected from the patient.

Furthermore, whereas in Extract 2A in which moving was suggested as a harmless course of action, leaving aside whether or not the patient would be in pain, the presence of pain complaints is now explicitly mentioned in combination with moving. Contrary to what was observed with respect to patients' constructions of pain and disability, the practitioner thus does not treat pain as a reason for being unable to move. Instead, movement is constructed as something that *can* be done in the presence of pain complaints. Note, however, that by using and stressing the adverb 'nonetheless' (line 6), the practitioner at the same time orients to the fact that the presented course of action may be against expectations.

In Extract 3B, which follows directly after a minimal affirmative response by the patient ('yes', line 8, Extract 3A), we offer an example of the practitioner treating the patient's current behaviour as insufficiently accounted for.

#### Extract 3B (admission interview 2)

9. Pr: .hh en (i i) e::hm: (0.5) mij is niet-  
 .hh and (i i) e::hm: (0.5) to me it is not-
10. nog steeds niet ¶hemaal duidelijk van-  
 still not ¶quite clear like-
11. ja (0.2) hoe komt het,=dat u (.)  
 well (0.2) what makes,=that you (.)
12. ¶ondanks de pijnklachten,  
 ¶despite the pain complaints,
13. (0.7)  
 (0.7)
14. (w'nt) die zijn d'r wel,  
 (bec'z) those are there,
15. die die- (0.5) >'k eh ik zeg ook niet<  
 those those- (0.5) >I eh I don't say<
16. >>dat die 'r nie (z)<<=  
 >>that they are not (t)<<=
17. =[maar dat u toch,  
 =[but that you nonetheless,
18. Pa: [hmhm.  
 [hmhm.
19. Pr: ja zo ¶stil: (0.2) lijkt te vallen hè,  
 well seem to come to such a standstill right,

After the patient's affirmative 'yes' (line 8, Extract 3A) in response to the practitioner's description of the rehabilitation team's focus, the practitioner addresses the specific situation of the patient. She continues that it is still not quite clear to her (lines 9–10) why the patient, despite his pain complaints (lines 11–12), seems to come to such a standstill (line 19). By using the extreme point on the relevant descriptive dimension, 'such

a standstill' (line 19), she produces a sharp contrast between the patient's current state and the team's aim of moving nonetheless. As mentioned, extreme case formulations are generally used to strengthen a case (Pomerantz, 1986). The extreme case formulation 'standstill' does not suggest merely that the patient is *physically* less active; rather, it suggests total passivity, and thereby strengthens the claim that the patient's state is still insufficiently explained. The specific formulation 'to me it is not- still not ↑quite clear' (lines 9–10) highlights that it is the patient who is responsible for providing an explanation that is satisfactory.

By constructing the patient's coming to a standstill as insufficiently accounted for, the practitioner undermines the self-evidence of the patient arriving at such a state. Also, this construction suggests that the patient's coming to a standstill cannot be explained by the presence of pain only, as there must be more to it. Note that the hedges within the practitioner's delivery mark the talk as delicate (Wiggins, 2017). The talk, for example, appears hesitant and includes several pauses within the practitioner's turns (lines 9, 11, 13, 15, 19). Also, the origin of the patient's coming to a standstill is presented by the practitioner as not 'quite clear' (line 10) to *her* (line 9) (rather than, for example, totally and in general 'not clear'). In addition, the evidentially downgraded assessment that the patient *seems* to come to a standstill (line 19) diminishes the practitioner's claim to know (see Sidnell, 2012). Finally, we can see that the practitioner orients to the delicacy of her account, as she takes a detour in lines 13–17. That is, after a 0.7 pause (line 13), she produces the following disclaimer: '(bec'z) those are there, those those- (0.5) > I eh I don't say < >>that they are not (t) < <,' (lines 14–16). Thereby, the practitioner preemptively counters any inference that she would have doubts regarding the authenticity of the patient's pain.

In the previous section, we argued how patients' constructions of their everyday-life experiences of disability may function to work up the authenticity of their pain. In this section, we have illustrated two important ways in which practitioners may undermine the inevitability of a patient's disabilities being an outcome of their pain: suggesting directions for treatment that imply that the patient could become more active and treating the patient's current behaviour as insufficiently accounted for. As our analysis shows, these actions are at odds with patients' interactional

efforts to present themselves as willing but unable. There is a risk that patients will treat them as a challenge to the authenticity of their pain and disabilities and therefore to their willingness to improve their functioning. Practitioners, on the other hand, tend to orient to this tension, as we can see from the delicate ways in which they perform these actions.

## Patients as Active Agents: Issues of Agency and Blame

The foregoing analyses have illustrated some of the ways in which patients tend to present their actions as subject to their pain and physical limitations and that practitioners do not always take such representations for granted. In fact, it is their task to stimulate patients to take back charge of their daily functioning, instead of letting themselves be governed by their pain. In this section, we show that, in line with this, practitioners may construct their patients as active agents. However, as will become clear, attributing agency is a delicate interactional business that may incur issues of accountability and blame. We explicate this point with Extract 4, which comes from the same admission interview as Extract 1.

Part A of Extract 4 starts after the practitioner has conducted a physical examination. She has just indicated that there are no signs that there is anything wrong with the patient's bones, nerves or tendons and that the problem seems to be with the muscles, which appear to be somewhat hardened.

### Extract 4A (admission interview 1)



1. Pr: .hh ehm en als je dan over revali↑datie nadenkt,  
 .hh ehm and if you then think about rehabili↑tation,
2. .hh dan is revalidatie d'r eigenlijk vooral  
 .hh then rehabilitation is actually primarily
3. op gericht <om te kijken of je>  
 focused on <having a look at whether you>
4. het functioneren over het algemeen  
 can get the functioning in general
5. wat sta↑bieler kan krijgen.  
 somewhat more ↑stable.
6. Pa: hmhm  
 hmhm

Extract 4A provides another example of a treatment recommendation that implies a change in the patient's behaviour, that is, 'having a look at whether you > can get the functioning in general somewhat more ↑stable.' (lines 3–5). Just as in the previous examples, the suggestion of a behaviour change is delivered in a rather cautious way, this time, by using a script formulation: if you then (i.e. given the findings of the physical examination) think about rehabilitation (line 1), 'hh then rehabilitation is primarily focused on < having a look at whether you > can get the functioning in general somewhat more ↑stable.' (lines 2–5). This *if-then* formulation, in which the generic you is being used, works to present this course of events as a universal, institutional routine (see Edwards, 1994). It makes relevant what rehabilitation is about in general, and at the same time it marks the talk as tentative ('if you think about..', line 1), so that it avoids putting the patient on the spot. Hepburn and Potter (2011, p. 231) have noted that such scripting "may be a useful device in advice giving (especially where there is resistance) as it avoids a stark ad hominem suggestion". Also research on healthy eating advice during family mealtimes has illustrated that generic advice is less likely to have

immediate consequences for the participants involved in the interaction (Wiggins, 2004).

Just as in Extract 3, the practitioner's rather general description of rehabilitation leads to a minimal response by the patient ('hmhm', line 6) that invites the practitioner to continue (Extract 4B) and to then construct her talk in such a way that it *does* specifically address the patient. Note that in the original production of talk in Dutch, this involves a pronoun shift from 'je' (the informal, and in this case generic, 'you') to 'u' (which is more formal and polite).

**Extract 4B (admission interview 1)**

7. Pr: hè want wat u nu eigenlijk doe:t.  
right because what you actually do no:w.
8. .hh is op (0.2) goede dagen (0.3) hè als u  
.hh is on (0.2) good days (0.3) right when you
9. weinig pijn heeft.=doet u gewoon al↓les.  
have got little pain.=you just do every↓thing.
10. en (.) dan bent u gewoon actief,  
and (.) then you are just active,
11. gaat u naar 't werk,  
you go to work,
12. doet u ↑thuis alles  
at ↑home you do everything
13. .hhh op dagen dat u pijn heeft,  
.hhh on days that you have pain,
14. doet u juist heel weinig.  
you only do very little.
15. gaat u in ↑bed liggen,  
you lie down in ↑bed,
16. beweegt u eigenlijk bijna niet.  
you actually almost don't move.
17. .hh e[hm.  
.hh e[hm.

Having stated that rehabilitation is about achieving a more stable functioning (Extract 4A), the practitioner starts to depict the patient's specific behaviour (lines 7–16). It is particularly the *instability* of this behaviour that she makes relevant, thereby suggesting the relevance of rehabilitation for the patient. A combination of script formulations (Edwards, 1994), lists (Jefferson, 1990) and extreme case formulations (Pomerantz, 1986) work up a contrast between the patient's activity on days on which he has little pain versus his inactivity on days on which he has more pain. At lines 8–9, the patient's active behaviour on 'good days' is presented as scripted ('on (0.2) good days (0.3) right when you have got little pain. = you just do every↓thing.') and reinforced by the extreme case formulation 'everything'. At lines 10–12, this representation is further worked up by means of a list ('then you are just active, you go to work, at ↑home you do everything'). Lists can serve to emphasize the generality of something (Potter, 1996), in this case of the patient's behaviour on good days. This behavioural pattern is then contrasted with the patient's inactive behaviour on days on which he does have pain (lines 13–16). Note that this description is presented in a rather similar format and that it includes a reference to a specific feature of the patient's behaviour (lying down in bed, line 15), which was introduced by the patient himself earlier on in the interview (Extract 1B).

What is important here is not only that the patient's current behaviour is being problematized and contrasted with the proposed approach for rehabilitation, so as to underscore the relevance of such an approach. Particularly notable is the way in which the patient's behaviour is described by the practitioner. That is, in each of the descriptions of the patient's actions, both on good days and on days when he is in pain, the patient is constructed as an active agent (e.g., 'you lie down in ↑bed', line 15, instead of for example 'you have to lie down in bed'). Such constructions make relevant the patient's agency and, thereby, the inference that the patient might have a choice (and could, potentially, take back charge). Attributing agency, however, thereby also makes relevant the patient's accountability for his past or current actions. And, if we

take a look at what comes next (Extract 4C), we see that this is the first and only thing that the patient makes relevant in his response.

#### Extract 4C (admission interview 1)

18. Pa:                   [<ja (maj) om>dat 't niet gaat,  
                              [<yes (but) be>cause it doesn't work,

The patient accounts for his behaviour (line 18). In doing so, on the very basis of his experiential knowledge he counters the suggestion that he is in control. Thus, he challenges the applicability of the practitioner's previously displayed institutional knowledge that rehabilitation should be about achieving a more stable functioning.

In this section, we have illustrated the delicacy of shifting from more general descriptions towards addressing the patient's individual behaviour and constructing the patient as having agency. Constructing the patient as an active agent may be a discursive device by which practitioners characterize the patient as having choice. However, it may also incur issues of accountability and blame, and thereby bring patients to a position whereby they have to (re)account for their behaviour in a way that reinforces their inability. Thus, patients and practitioners may get themselves into an interactional fix, thereby hindering the exploration of opportunities for rehabilitation.

## Discussion

Various studies have addressed the fact that the lack of a clear biomedical explanation for chronic pain may threaten patients' credibility (e.g. Ong et al., 2004; Snelgrove & Liossi, 2009; Werner et al., 2004). We believe that our study is the first to provide discursive psychological insights into how, in the context of chronic pain rehabilitation, the authenticity of chronic pain and pain-related disability is oriented to as delicate, by both patients and practitioners. Our analysis has shown that patients with chronic pain tend to construct themselves as willing but unable and

that such constructions work to build up the authenticity of their pain and pain-related disabilities. Also, we have illustrated that practitioners may orient to the potential delicacy of their institutional practices (such as proposing directions for treatment) in case those practices could be understood as undermining the authenticity of the patient's pain and pain-related disabilities.

Our study has shown that, in order to work up their willingness, patients constitute their identities in situ. These findings are consistent with findings of Horton-Salway (2001), who studied the talk of patients with chronic fatigue syndrome, an illness which is also difficult to explain from a biomedical perspective. Similar to our study, Horton-Salway's study showed that, by drawing on certain aspects of their character, patients work up the factuality and the physical nature of their condition. It should be noted that, by doing so, patients also manage their personal accountability for their health situation. This means that our findings should not be seen as merely providing evidence that the authenticity of patients' pain and pain-related disabilities is at stake: patients' moral identity as sufferers from a condition that is difficult to explain on the basis of biomedical evidence seems to be at stake too.

Awareness of such identity concerns is important for better understanding why patients may challenge particular types of expert knowledge (Versteeg & te Molder, 2019), such as the knowledge about chronic pain and pain rehabilitation presented by the practitioners in our study. Patients in our study challenge such knowledge primarily on the basis of their own experiential knowledge of living with pain and disability, to which the practitioner does not have epistemic access (cf. Heritage, 2011).

Such dynamics become clear, for example, when we consider rehabilitation practitioners' descriptions that suggest that patients can be in control of their own lives. We have shown, for example, that they may construct their patients as active agents, thereby making available the inference that patients themselves are in charge. Our analysis has revealed that such constructions may backfire, however, as they also make available issues of accountability and blame. Therefore, they may provoke defensive responses, in which patients draw on their experiential knowledge to underscore the realness of their inability. Future research on

whether and how practitioners can design their communication in such a way that their patients' agency is reinforced without the threat of loss of face is important to advance patient–practitioner interaction s about chronic pain-related disability.

The notions of agency, control and responsibility are important in critical disability studies (Ellis et al., 2019). In relation to this, Goodley et al. (2019) have pointed to the importance of recognizing that the capacity to affect or to be affected involves a complex interplay of both material and discursive properties that make up reality. Our study has illustrated, that discursive psychological research can provide valuable insights with respect to the ways in which participants in interaction orient to such properties and manage their interrelations to accomplish interactional work.

We have shown that, in the specific context of patient–practitioner interaction, building authenticity of their health complaints may be an important way for patients to manage their doctorability. According to Heritage and Robinson (Heritage, 2009; Heritage & Robinson, 2006), patients may feel the need to justify their visit to a physician, and they may do so by establishing that they have a doctorable problem; that is, a problem that is “worthy of medical attention, worthy of evaluation as a potentially significant medical condition, and worthy of counselling and, where necessary, medical treatment” (Heritage & Robinson, 2006, p. 58). Our analysis has shown that patients' constructions of a willing mind vs. a disabled body work up the doctorability of their health situation. That is, patients use these constructions to present their pain as real and burdensome. Moreover, by presenting themselves as a person who wishes for a higher level of functioning, patients further underscore the relevance of treatment.

However, our analysis also indicates that, in the specific context of chronic pain rehabilitation, establishing doctorability entails more than just establishing a doctorable *problem*: patients also need to present themselves as doctorable *persons*. Chronic pain rehabilitation demands that patients engage actively in their own rehabilitation and that they change their behaviour. Therefore, in order to establish their doctorability, patients need to show that they are willing to do so. According to the literature for healthcare professionals, it is important that they try

to get an impression of a patient's motivation so as to assess whether the patient is eligible for treatment from a biopsychosocial perspective (Swaan et al., 2019). Our analysis highlights that patients orient to the need to establish their motivation and that motivation is a situated discursive accomplishment. Patients may also use it as an interactional resource to work up their doctorability. We have also illustrated that, in doing so, patients are faced with an interactional dilemma. They balance between constructing themselves as *willing* to change their behaviour in accordance with their practitioner's advice, while at the same time preserving their *inability* to do so.

Instances in which participants addressed how pain interfered with patients' daily life activities and led to a decreased level of activity were widely available in our corpus. There was, therefore, a rich amount of data to draw on in our study of the construction and negotiation of chronic pain-related disability. However, it is important to note that patients visiting the rehabilitation centre do not necessarily always tend to decrease their activities as a consequence of pain. Some patients may (also) get themselves into trouble by persisting in their activities, despite being in pain (Hasenbring et al., 2014). Thus, although this was not the focus of our current study, in some cases, a patient's 'overdoing' may also be addressed in patient–practitioner interaction. It would be worthwhile for future research to look into the specific dynamics and delicacies of talk about persistence behaviour too. Presenting persistence behaviour may, for instance, contribute to the management of a patient's moral identity. On the other hand, there are indications that talking to patients about their persistence in behaviours that may add to their health situation may make available inferences regarding their personal accountability for their pain complaints (Stinesen et al., 2019).

## Conclusion

Discursive psychology has a particular interest in how discourse can be used to provide an alternative understanding of people's mental states and processes (i.e. as being variable and negotiable in interaction). It is maybe therefore that the relatively few discursive psychological studies



on disability so far have first and foremost addressed how participants in interaction may negotiate (dis)abilities in the context of mental health problems (see, e.g., Fasulo & Fiore, 2007; Lester, 2014; Rapley et al., 1998). In this study, however, we adopted the discursive psychological research perspective to study patient–practitioner interaction about chronic pain-related physical disabilities. In line with Wiggins’ (2014) theoretical notion of ‘discursive bodies’, we have paid close attention to how the features, functions and limits of patients’ bodies are produced in and through patients’ and practitioners’ talk. Our analysis has illustrated that, in interviews on admission to chronic pain rehabilitation programmes, patients’ pain-related disability is not treated as a matter of course. Disability is in fact negotiated throughout these interviews. Thus, on a theoretical level, our analysis has illustrated that discursive psychology allows for a counter-perspective to the notion of physical disability as a static construct and it contributes to the growing body of research that suggests that (disabled) bodies are located in discourse. Moreover, our study has shown that the discursive psychological research perspective provides for a rich and nuanced understanding of how disabled bodies may be negotiated in interaction. That is, it specifically lends itself to reveal the delicacies of such negotiations. It has become clear, that patients’ and practitioners’ negotiations of patients’ disabilities are subject to issues of agency, accountability and blame. These insights may help practitioners to reflect on and further develop their communication practices.

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Chapter 4

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