Managing the Challenge:
Conflict and Resolution in the Diagnosis of Depression

Paper Outline

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Background.

Despite the massive medical and policy-based literature on recognising and managing Major Depression Syndromes (MDS) in primary care, and the popular focus on 'correct consultation techniques' therein, it appears that there is surprisingly little written on they key matter of actually 'giving the diagnosis' itself. The focus of contemporary health research instead tends to centre around two main themes: firstly, methods for improving the chance of a correct diagnosis (many of which are summarised in Priest et al., 1996), and secondly, schemes for combating the patient's difficulties with adjusting to *being* depressed, or more broadly 'mentally ill', and accepting their label, post-diagnosis – issues largely conceptualised in terms of 'public knowledge' (Link et al., 1989; Link et al., 1997; Link and Phelan, 1999; Kravetz, Faust and David, 2000; Van Vorhees et al., 2005 and 2006). This paper is an exploratory exercise concerned with a set of practical matters pertinent to both – the activities surrounding the delivery of a diagnosis of MDS in the primary care consultation itself and the issues that arise in such a consultation when that diagnosis is given and *unfavourably received.* These matters are, however, examined in a manner methodologically distinct from any of the aforementioned studies. Drawing

extensively on insights from the tradition of Conversation Analysis (Sacks, 1992; Hutchby and Wooffitt, 1998), I will explore some of the dynamic communicational strategies employed by a General Practitioner (GP) and his patient during a visibly 'troublesome' diagnostic phase in one such consultation. Using pertinent findings, I will then reflect upon some salient matters relating to research into the diagnosis of MDS in front-line primary care that go largely unexplored in the bulk of empirical studies. The core concern is, thus, with what actually, empirically happens in a consultation when resistance is encountered, and the implications of this activity for research. With a view to highlighting the value of this approach, it is important to initially investigate the broader contemporary medical literature on the phenomenon of resistance to a diagnosis of mental illness. The review below is by no means exhaustive; it is designed as an illustrative exercise highlighting some broad, problematic trends in current work on the issue at hand.

1. Mental Illness and Resistance: Trends in Research

In contemporary health research there are a significant number of practical research studies, predominantly emanating directly from the medical profession itself (for example, Van Vorhees et al., 2005 and 2006), which explore in some detail the problems patients have in accepting diagnoses of MDS and other mental illnesses. As outlined in the introduction above, however, it is noteworthy that few, if any, of these really address resistance/rejection of a diagnosis as it occurs in the original diagnostic encounter. Instead, and largely employing retroactive social survey methods, they explore post-diagnostic attitudes/behaviours of subjects with respect to their illness. As a rule, this type of research works, to varying extents, from the foundational assumption that reluctance to accept a diagnosis of mental illness is a direct result of

lack of information on the part of the patient, or a distorted view of the condition effected by social stigma or troublesome cultural/religious norms. There is, consequently, a tendency to argue that 'educating the patient' in the true nature of their condition is the only realistic solution, a mantra echoed extensively in policy literature (National Collaborating Centre for Mental Health, 2004). This approach proposes a relatively 'static' patient, whose 'misguided' beliefs and understandings of their condition, although problematic, are modifiable by a healthcare professional. Once in possession of the correct knowledges relating to the real character of any pertinent mental illness, the patient will generally acquiesce and the diagnosis will be accepted with obvious benefits for their rehabilitation - though it is not suggested that this process of education is in any way 'easy'. As Kravetz et al. summarise, 'Rehabilitation literature generally encourages persons with chronic disabilities to accept their medical diagnosis as a step toward maintaining and possibly improving the quality of their lives.' (2000:323).

1.1. The Problem with Cognition

The assumptions that guide the characterisation of the problem of resistance to diagnoses of mental illnesses are also, invariably, the self-same assumptions that guide research design with respect to exploring it – these are, prevalently, the assumptions of cognitive science (Silverman, 1997). As a variety of studies in the social sciences have shown, however, it is very difficult to unproblematically attribute the complexities of social activity in a primary care consultation (or anywhere else) directly to cognitive structures without running into significant theoretical and practical problems (Edwards and Potter, 1992; Harré and Gillett, 1994; Widdecombe and Wooffitt, 1995; Silverman, 1997; Coulter, 2005; Potter, 2005; Antaki, 2006).

Briefly, cognitive 'information transfer' models of action operate, at their core, from the Cartesian theoretical standpoint that global intrapsychic schemata administer the flow of sensory data acquired from the (measurable) outside world, adjusting/distorting perception, and the individual then acts on this information to produce (measurable) words and behaviours. Crucially, these processes are resolutely *individual* in nature; as Tajfel (1981) highlights, however, this treatment of the social world as mere 'information' to be processed by the singular mind does little justice to the multifarious organisation of societies, cultures, groups and contexts. People, things and actions are reduced to representations within the head of an individual – representations which are the primary determining factor in social (re)activity. From a research point of view, there are two core reductions here:

- That representation causes action and, therefore:
- Action, largely linguistic, reveals the underlying representation to the diligent analyst.

With respect to the topic at hand, the most problematic aspect of the first of these reductions is that, should a patient resist their diagnosis of MDS, the *only* available conclusion is that this activity is the result of an 'improper' internal representation of MDS itself - stemming from an social, cultural or educational diathesis. Patient resistance to, or rejection of, the label becomes, therefore, an inescapable property of patient ignorance. This denies a substantial range of alternative possibilities and, moreover, portrays the patient as a 'dope' (Garfinkel, 1967) to their socio-cultural apparatus (which has provided them with the falsehoods, or at least shielded them from the truth) and/or their cognitive apparatus (which has slavishly reproduced these

falsehoods). Van Vorhees et al. embody this determinism in their statistical survey of young American adults with difficulties in accepting a diagnosis of MDS;

> 'Negative beliefs and attitudes and social norms, a variety of past treatment experiences…are the most important predictors of the intent not to accept a diagnosis of depression in young adults. Those with beliefs and attitudes of disagreeing with a biological approach to depression development and treatment are most likely to express intent not to accept a physician's diagnosis of depression.' (2005:43)

Note that in this account it is the 'beliefs and attitudes' that actually disagree with the biological approach, and that are treated as the 'real things' here; the human subjects of the study themselves are conceptualised as largely passive vessels through which the hard currencies of cognitive analysis speak to the world (Billig, 1997). The endgame of this reasoning is that these people's activities with respect to diagnosis are inevitably 'misguided' until the underlying negative schemata are modified, or replaced. This is a process which requires a knowledgeable agent with access to the 'real' (biological) nature of the condition. Within such a frame of understanding, the possible types of finding that the research can produce are, more or less, set in stone before a study is even conducted.

This reification of cognitive structures is a process also reflected in the popular methodologies chosen for conducting this kind of research. Rather than investigate the local production of resistance to diagnosis as a complex communicative issue for healthcare professionals and their patients alike, the 'true' (cognitive) character of the problem is presumed to be known already. As a consequence, structured interviews

and questionnaires can be administered to a pertinent population which reduce possible explanations for the phenomenon to controllable, causal variables. Largely unexplored in much of the medical corpus on resistance to diagnosis is the very matter of what constitutes 'resistance' to the GP and patient themselves, and how it operates (and is dealt with) *in the consultation in which it first arises*. Instead, the phenomenon under investigation is taken to have a global definition in the quest to locate its causes.

The second core reduction, meanwhile, is that the words people utilise are 'representations of representations': straightforward (falsifiable) reproductions of what is really going on in the head (and the life) of the individual (Heritage, 1984; Edwards, 1997). Therefore a voiced objection to a diagnosis is clear indication of a particular (dysfunctional, in these cases) belief-structure relating to the illness in question. It may also evidence the environmental source of this structure - typically 'stigma' or 'social norms' which distort an understanding, or 'lack of information' which limits it. As such, the patient's self-reporting in any context is taken to be an ostensibly passive and indicative activity, a substitute for what 'is'. There are a range of well-established objections to this notion, grounded in a central observation that will make sense to all medical professionals who regularly deal with the public (Silverman, 1997) – that talking is an activity *in itself*. Talk does not just 'reflect' or 'describe' structures in the world, or in the mind of the speaker, that pre-exist a particular context of transmission. Rather, people demonstrably use language constructively to create impressions of themselves, to reassure others, to delimit unfavourable implications and to portray particular versions of the world (Edwards and Potter, 1992; Hutchby and Wooffitt, 1998). The assumption that a patient's verbal objections to a diagnosis of MDS transparently reveals a semi-permanent underlying belief relating to MDS is, therefore, demonstrably problematic. Not only does it

presume that a researcher can grasp a subject's 'meaning' and 'motivation' better than they can themselves (Edwards, 1997), but it also blinds that researcher to the practical skills and activities that people (patients *and* their GPs, in this case) bring to real social contexts in order to actively achieve their particular, situated goals therein. Using structured survey methods further strips the activity being researched of its original context of production, and an understanding of how people themselves are actually involved in the core phenomenon is sidelined to a broader causal account of *why* it occurs. In these terms not only is the patient systematically disempowered, but so it the medical professional.

1.2. Social Science, Resistance and Stigma

Thus far I have concerned myself particularly with a critique of hard medical research into the topic at hand. It would be wholly unrepresentative, however, to suggest that these are the only studies of this phenomenon in the health sciences. Link and colleagues (Link et al., 1987; Link, 1989; Link et al., 1997; Link and Phelan, 1999), for example, have conducted an extended series of sociologically-leaning investigations into problems with the application, acceptance and public status of mental illness labels, particularly Major Depression itself. Given that their methods often draw on Thomas Scheff's labelling approach to mental illness (see Scheff, 1966), we might expect to see some substantial differences in the types of findings produced to those discussed above. In practice, however, the self-same basic assumptions about the interrelations between society, cognition and behaviour (and the manners in which they can be researched) are replicated throughout. Indeed, the only key difference between the two broad 'types' of literature reviewed here is one of emphasis. Research emanating from the medical establishment is primarily

concerned with negative beliefs and attitudes to mental illness themselves, and their modifiability, while the more sociologically-oriented work largely places greater focus on the environment causing, and caused by, these beliefs. It is with a view to this critique that I shall now move to explore an alternative means of addressing the problem at hand.

2. Medical *Inter*action: Conversation Analysis

The empirical sections of this paper draw extensively on the tradition of Conversation Analysis (CA) in exploring resistance to a diagnosis of MDS as a contexted social action. It is important to note that the analysis here is exploratory and illustrative; it does not provide a full and systematic CA-type investigation of the data at hand, but rather works to elucidate how the types of finding CA produces can shed important light on this topic, both substantively and methodologically.

2.1. Data

As demonstrated extensively by conversation analysts, challenges to a GP's diagnosis are unusual in any form (Frankel, 1984; Heath, 1992) and even when they do occur they are frequently deployed in such a way as to assume the character of 'guesses' or 'hunches' (Heath, 1992), thus avoiding compromising the relative roles of the GP as 'expert' and patient as 'client'. Direct challenges to a medical opinion run a range of risks: for example, disrupting the consultation, implying that the patient 'knows better' than the GP or even causing the patient to appear 'unreasonable' or 'irrational'. What is initially striking from an examination of the corpus of data collected for this project is that, while the vast majority diagnoses are indeed accepted unproblematically (though this is not to say 'with gratitude'), the diagnoses of *MDS* are, in virtually all cases,

questioned or actively challenged in the patient's first turn after the diagnosis itself. In these consultations, the challenge to the diagnosis always then makes relevant a particular set of activities on the part of the GP – not simply 'elaborating' the diagnosis subsequent to the usual accordance as he may well expect to do (Have, 1989), or giving advice on how to 'follow it up', but actually *justifying and defending* his medical opinion in an attempt to reach any accordance at all. The diagnostic 'phases' of these consultations are, then, visibly punctuated by two negotiative 'sub-phases':

1. Delivery of Diagnosis. (GP)
    a. Resistance to diagnosis. (Patient)
    b. Defence of diagnosis. (GP)
2. Accordance or Further problems. (Patient)

Extract (1), on the data sheet, is a good example of this occurrence of this sequence in action. Prior to the actual diagnostic phase (lines 47-76), the patient complains of symptoms which he himself consistently characterises as 'vague' - persistent fatigue, sleep disturbances and extreme difficulty concentrating - he has, indeed, consistently apologised to the GP for their 'vagueness' and contended that he was not sure whether such symptoms were really a matter for the GP at all. He has conceded that he has begun feeling a little 'down' recently, but that this is the outcome of his longer-term somatic problems. The GP, meanwhile, in line with NHS directives on assessing the risk a potential depressive may pose to themselves (see National Collaborating Centre for Mental Health, 2001 and 2004), tentatively inquires if the patient had thought in any way if 'it was all worth it, or that he couldn't carry on' – something the patient emphatically denies.

This particular extract was chosen as especially illustrative herein because, superficially, the diagnostic phase itself might seem to fully support the medical-cognitive mantra that 'educating' the patient leads to acceptance of the diagnosis. The patient here raises problems with the diagnosis (in lines 59 through to 62), providing a very narrow (possibly 'misguided') account of MDS as a means of disputing it, the GP explains the 'true' nature of the condition (lines 64-70) and the patient then concedes the validity of the diagnosis (line 76). Leaving the explanation at this level, as will become apparent, however, leads to a set of insurmountable contradictions. A detailed exploration of the *organisation* of the interaction, however, reveals some rather different mechanisms at work.

2.2. Mitigated Diagnosis

The first important observation here is that the diagnosis itself is delivered in what we might call a 'weak' form. Its implications, in terms of severity, are downgraded by the GP in a number of ways:

1. It is explicitly pre-announced as 'nothing serious'.
2. It is constructed in minimal form (a *little* depression).

As Peräkylä (1998) has demonstrated, it is not the symptomatic information provided by a patient that primarily informs the *manner* in which a diagnosis is delivered, but the *stance* that the patient adopts towards this information when telling it. This patient's emphasis on the somatic nature of his symptoms in this case, his apologies for the

indistinct character of those symptoms, and his fervent refusal of any implication that he may be subject to suicidal ideation are, thus, resources for the GP to draw upon when approaching the situated practicalities of diagnostic delivery. It is of note, then, that the diagnosis in lines 49 to 53 is structured as *dispreferred* (Sacks and Schegloff, 1979); it is visibly designed to anticipate an unfavourable reception and, potentially, deal with any 'difficult' outcomes in advance. Not only does he deliver in 'weak' form as described above, but also explicitly characterises the diagnosis as the logical upshot of *what the patient has told him* ('looking at what you've said') and formulates it as a 'likely possibility' rather than an outright fact. In doing so, he negates any draw-able inference that the patient 'appears' depressed, is 'clearly' depressed, or is 'very' depressed. Far from representing a 'lack of confidence' or even 'diagnostic uncertainty', such *expressive caution* (Silverman, 1997) evidences a contextual sensitivity to, and anticipation of, the kind of reception a particular diagnosis may receive, grounded in the GP's own practical analysis of prior goings-on in the consultation itself. Simply put, had the patient at some point explicitly stated that he felt 'depressed', the manner in which the diagnosis was voiced would most likely have been very different. The GP's diagnostic delivery is clearly not, therefore, *demonstrably* oriented to a large scale sense of the 'stigma' MDS may carry in general, but visibly so to the problems the diagnosis may cause *in situ*.

Despite the context-sensitive manner in which the diagnosis *is* delivered, however, the diagnostic phase of the consultation does not pass in an unproblematic way. Much like the diagnosis itself, the patient's the initial 'objection' is done in dispreferred form, herein via a 'yes-but' structure (Sacks, 1987). A guarded agreement ('oh (.) yeah? (.) spose it °migh°'), is followed by a question ('ya °um° s<u>u</u>re?') which leads into a more explicit challenge (lines 71 and 72). This formulation avoids any direct

assertion at the outset that the GP is simply 'wrong' or 'mistaken' – the potential consequences of which have been previously outlined - while also opening up conversational space for the patient to expand his objection. In the context of this consultation it is the character of the objection, and the manner of its subsequent resolution, that are particularly illustrative of the importance of an attention to sequential organisation when attempting to derive 'sense' from the interaction. It is to this matter that I now turn.

3. Resistance and Resolution: Problems of Abstract Analysis

The main challenge itself, on the surface, provides a brief account of the patient's own recent wellbeing which is, of course, also ultimately a truncated summary of the detailed descriptions of symptoms he provided previously in the consultation.

> snot like ahm (.5) ºlikeº sui<u>ci</u>dal or anythin like ah said (1.0)
>
> jus: a bit (.) ya know (.) run down

He is not, in this sense, making available any 'new' information that might shed new light on the diagnosis; in fact he makes explicitly available that the details are *not* new ('like ah said'). Cosmetically, the account appears to comprise two separate components. The first is the refusal of the GP's diagnosis through an appeal to a symptom the patient does not have ('suicidal motivation' we might call it). Cognitive/survey methods would likely reveal that the utterance 'snot like ahm (.5) ºlikeº sui<u>ci</u>dal or anythin' *as* an objection to a diagnosis is a representation of a deeper 'silent belief' (Beck, 1964) relating to the connection between depression and suicide. This belief would take a form something like the syllogism:

- Depressed people are suicidal people.

- I am not suicidal.

- Therefore I am not depressed.

The DSM-IV, conversely, stipulates that while 'suicidal ideation' is a symptom of MDS, one does not have to be suicidal to be depressed (APA, 1994). Comparing these constructions would then reveal a shortfall in the patient's knowledge of the topic, which is impeding his acceptance of the diagnosis. By the same logic, the second component of the account can be read as the deployment by the patient of an alternative (self) diagnosis, providing direct access to an internal state of affairs; he is 'jus: a bit (.) ya know (.) run down'. This may be judged as a 'lie' to obstruct the diagnosis, a 'misguided self assessment' predicated on a misunderstanding of MDS, or the truth in which case it does actually seem like rather a bizarre thing to 'admit'. One could ask:

- If this is 'all' that is wrong, why go to the GP in the first place?

- If you *know* what is wrong, why wait for a diagnosis?

- If you did want a new diagnosis, why then correct the GP afterwards?

Presumably, the patient booked the consultation because he did not feel well, indeed, he explicitly claimed as such throughout the consultation – a diagnosis of an 'illness' in some form would, it is hardly speculative to suggest, have been an expected outcome. A contesting of the diagnosis, in the light of this, could therefore be very easily read as a simple orientation on the part of the patient to a standing 'stigma' with respect the character of MDS at large – he would rather be considered 'difficult' or 'obstructive'

than 'depressed'. This 'resistance at all costs' thesis is, however, undermined by the fact that fairly soon afterwards, in line 76, he does actually and explicitly *accept* the diagnosis. We could, of course, then explain this shift in position by the patient as representative of a 'change of mind', but then the supposed power of social stigma is yet further undermined – its influence can be utterly eradicated by a few words from a GP. However, to use 'change of mind' – coercively induced, perhaps, by the GP's institutional 'power' - as an explanatory mechanism here equally portrays the patient as a passive agent in the interaction, which sits rather ill at ease alongside his actively challenging the diagnosis in the first place. There are, thus, clear analytic problems that arise from any attempt to 'logically' explain away this activity in terms of an interplay between cognitive and social structures.

What is particularly interesting in the next passage of talk is the manner in which the GP manages to close down the challenge, and ultimately secure agreement with the diagnosis (lines 64-70), by apparently releasing 'new information' about the character of MDS itself.

> ya::h (.) a lot of people <u>do</u> think that (.) ahm: (.) depression is <u>ju</u>st about
>
> feeling really down and hopeless (.5) an a lot of the (.) time yes it <u>is</u> (.)
>
> but ah: (.) ºwellº (.5) not a:lways
>
> …
>
> you might just feel ahm (.) run down for a long time (.)
>
> or low and just not well (.) like you said

The key point is, however, that the information released is not to any extent 'new' unless we are to attribute a very short memory to the patient.

1. It has been established previously in this consultation that the patient does *not* have 'suicidal thoughts' and that his main symptom is 'feeling run down';

    a. Indeed he reasserts all these things *as* having been previously said during this diagnostic phase, which negates any suggestion that his memory is 'flawed'.

2. A diagnosis of depression was nevertheless made.

3. It is, therefore, readily available from the local interactional context that feeling 'run down' *is* a symptom of depression, while 'thinking about suicide' is *not* necessarily key to its diagnosis.

This raises a critical issue relating to both the challenge and the resolution - it seems inexplicable that the GP should be able to produce a successful accordance with a previously resisted diagnosis by adding no new 'information' to the proceedings at all, without directly *assuming* groundless deficits on the part of the patient. It is only through an exploration of the situated functionality *of* the GP's 'explanation' within the broader context of the consultation that any real 'sense' can be derived.

4. Resistance and Resolution: Sequential Sense

All social categories used in interaction by speakers are 'inference-rich' (Sacks, 1974 and 1979), they carry many potential connotations with them according to their deployment in any given context. Diagnosis is, therefore, not simply the description of an illness, but the offer of admittance to such a category. Acceptance of this diagnosis constitutes an acceptance of the category and *all that it implies*. As Harvey Sacks notes, '…any person who is a case of a category is seen as a member of a category, and what's known about the category is known about them …' (1979:13).

The patient, throughout the consultation to the point of diagnosis, has been at pains to emphasise the veracity of his reasoning process with regard to his symptoms; even prior to both the diagnosis and the question relating to suicidal intent, he has constructed them *as* unclear, and consistently delimited any inference that his symptoms are a product of his 'mental state' rather than vice-versa. All of his activity has thus been geared toward the construction of an identity as an ordinary person doing a rational thing in consulting a GP – a 'reasonable witness' (Zimmerman, 1992) to his own state of health. The acceptance of a diagnosis of an inferably 'mental' illness challenges this interactional work in a way that admission to the category 'asthmatics' does not. Outright refusal of a diagnosis, however, also runs the same risk; it is readable as evidence of 'irrationality' in itself. What actually occurs, however, is mitigated resistance to the diagnosis *in the patient's first turn*, followed by an accordance subsequent to an the GP's 'explanation'. This activity is neatly illuminated by Widdecombe and Wooffitt's (1995) work on 'resistance to category ascription'. They note how their interviewees, when asked a question about their style or appearance, sometimes produce a first turn which actively avoids generating a self-categorisation relevant to that question. In one particular case, they argue,

> 'By producing a turn which does not address those parts of the prior turn which make relevant, and invite her to confirm, a particular kind of categorical self, she makes available the inference that the identity is not relevant to her. In this sense, her first turn in the exchange thereby invokes, and makes salient for that stage in the interaction, her identity as an ordinary person. Through her utterance she is doing 'being ordinary'.' (Widdecombe and Wooffitt, 1995:100)

Crucially, they also note that by doing this in the first available turn speakers manage to avoid denying potential categorical relevance outright, while marginalising that category-affiliation as 'only one aspect of them' (Widdecombe and Wooffitt, 1995:104).

The implications of these observations with respect to this consultation are clear to observe. The patient, in the face of a diagnosis of depression, initiates a sequence which, while upholding the GP's role as 'expert' in its form, also *defers his admittance to the diagnostic category*. He challenges, then, as an 'ordinary/rational person' and, moreover, the very nature of his talk serves to reassert key features of such an identity:

- He makes a case for being *just* 'run down', like ordinary people get run down.
- He makes explicit his clear memory, and understanding, of prior events in the consultation.

The GP, meanwhile, collaborates in the construction of this identity by restating the implications of the particular diagnosis in purely somatic terms (sensitive to the patient's own prior 'self-diagnosis'), and by treating the challenge itself *as* reasonable, rational and legitimate. The final accordance is then reached as an outcome of this category consensus and, as such, any inferences arising from the diagnosis that could be potentially damaging to the patient's standing as a reliable author of his own accounts are delimited, while his status as 'unwell' is ultimately confirmed.

Finally it is also observable that for the duration of this activity the normal question-answer sequence of the consultation (Have, 1989) is suspended; the GP relinquishes topical control to the patient and makes no attempt to reassert it until an accordance is reached. As a result, the patient is allocated the status of a 'knowledgeable agent' within the interaction (Silverman, 1997) with equal conversational rights to those of the GP. This facilitates and reinforces the construction of a 'competent' identity *for* the patient.

4. Conclusion

From an analysis of a single diagnostic phase in a single consultation, it has been visible that interactional problems and solutions are produced, managed and solved in the flow of talk. Key matters raised have been:

1. The construction of the diagnosis is sensitive to the stance adopted by the patient with regard to his own symptoms throughout the consultation.
2. The patient's resistance is sensitive both to inferential business generated by the diagnosis with respect to this stance, and to the design of the diagnosis itself.
3. The resistance reasserts the patient's 'ordinary' identity, delimiting potentially damaging inferences while also avoiding compromising the local interactional context.
4. The GP collaborates with the construction of this ordinary identity, temporarily relinquishing control of task and topic, to achieve a mutually acceptable 'result'.

Possibly the most potent observations arising regarding actual practice regard the issues of 'inferior knowledge' and 'stigma' – central tools in the health sciences for

the explanation of a range of negative matters relating to 'bad' receptions, or outright rejection, of any diagnosis of a mental illness. The analysis presented here demonstrates some problematic aspects for these assumptions. Firstly, the patient resisted only briefly. This undermines the supposed monolithic power of environmental matters such as stigma or problematic social norms as forces 'blinding' the patient to reason. Secondly, the subsequent accordance was reached not as a result of the divulgence of 'new' information by the GP – the 'information' in question featured nothing that was not already explicitly or inferentially available from the context of the consultation. Thirdly, the patient's own resistance did not in any way demonstrate an 'ignorance' of the character of depression itself; indeed, it was constructed to make clearly available a particular reading of what depression can imply. Rather, the resistance was observably a functional strategy in the reworking of identity categories, a strategy understood and supported by the GP himself. As such, the accordance is reached not via the 'transfer of information' which is then 'processed' by the patient, but via the active and contextual reconstruction of publicly available categories. As Silverman (1997) summarises with reference to counselling:

'It is evident that, in this perspective, there are no *a priori* right or wrong ways of responding to clients. What works has to be interactionally devised on each occasion. This suggests a revision of the concepts we have about counselling (and indeed any profession involved in communicating with clients). The skills of the counsellors…are not primarily based on owning a special (professional) body of knowledge. Instead, such skills depend on an

apparatus of description that is publicly available to everyone –
including clients…' (1997:86-87)

In these terms, there is a clear case for further investigation of people's objections to
mental illness diagnoses not as outcomes of abstract and transsituational beliefs, nor
as evidence of the operation of external social forces, but as actions that are
meaningful to public and professionals actors alike in the specific contexts of their
occurrence.