Imagined Constructed Thought: how staff interpret the behaviour of patients with intellectual disabilities

Joseph C. Webb (corresponding author)
joseph.webb@bristol.ac.uk

Norah Fry Disability Research Centre,
School for Policy Studies,
University of Bristol,
8 Priory Road,
Bristol
BS8 1TZ

Alison Pilnick
alison.pilnick@nottingham.ac.uk

School of Sociology and Social Policy,
University of Nottingham,
University Park,
Nottingham
NG7 2RD

Jennifer Clegg
jennifer.clegg@nottingham.ac.uk

j.clegg@latrobe.edu.au
Institute of Mental Health,
University of Nottingham,
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

This research was funded in part by the Institute of Mental Health, University of Nottingham

Abstract

This paper examines 'imagined constructed thought': speakers giving voice to the inner world of a non-present other. Drawing on 9 hours of video footage of health-care staff discussing patients with intellectual disabilities during Discovery Awareness sessions, we explored times when the staff presented a possible version of a patient's thoughts. They used those versions to take a stance on the patient's inner world, often as a bridge between description of objectively observable phenomena and subjective interpretation of its meaning. It also projected staff's own stance on what the patient was thinking, both in first-position descriptions, and as a competitive resource in those given in second position. The findings suggest that presenting the patients' thoughts from a first-person perspective can be a versatile way of enacting a variety of complex epistemic and empathic actions in this setting. Data are in English.

Background

Speaking as another person

People commonly appropriate the words of others into a new context (Günthner, 1999; Tannen, 1989). Existing research has largely focussed on reported speech: quoting an utterance and re-presenting it in the present (Tannen, 1995). Reported speech can be used in a variety of way to accomplish different actions such as taking a stance or adding detail to a story-telling sequence (see Myers, 1999; Berger & Doehler, 2015; Clift, 2006). Bakhtin's (1984, cited in Tannen, 1989) work on the use of reported speech and 'polyphony' in literature distinguished the different ways people bring past speech into present interactions, including using direct reported speech, stylisation and parody. What they share is that they are "double-voiced" (p.187): two voices are represented in one utterance. When a person speaks for another, the words assume the speaker's own interpretation (Holt, 1996) which listeners evaluate. Tannen (1989) suggested the alternative descriptor 'constructed dialogue' because the selecting words and transposing them to a new context is a creative act; speech is never merely 'reported'. Speaking as another need not involve representing words that were *actually* spoken. Goffman (1974) suggests the term '*ventriloquizing'* for when a speaker animates the

voice of another. For example, a mother speaking from her baby's perspective; '*Daddy, my diaper is dirty*!' (Tannen, 2003, p. 51). Like direct reported speech, or constructed dialogue, ventriloquizing contains a kind of 'frame-shift' (Tannen, 2003) whereby a speaker 'animates' another person's voice *without* quoting them.

Ventriloquizing most commonly involves someone who *cannot* speak for themselves and whose inner dialogue is voiced by a third party in order to talk to another person (Tannen, 2003; 2004). The words do not represent what the animator believes the agent to be thinking, rather they communicate what the speaker thinks or to pass information to another person. The ventriloquized voice is therefore not a 'best guess' about inner dialogue; rather it is often used to communicate something which may be problematic if spoken in their own voice. When a mother says "Daddy, my diaper is dirty" whilst her husband is present, a request is communicated for him to change the diaper, not a representation of the baby's thoughts (Tannen, 1989).

Presenting the thoughts of someone else is an example of talk which is *entirely* constructed (Tannen, 1995). Although the phenomenon has been identified, there has been surprisingly little work CA work about what actions this accomplishes. Egbert (2012) revealed that researchers in User-Centred Design meetings on hearing aid fitting adopted first-person pronouns to talk from the point-of-view of users in the fitting sessions in audiology consultations. She argued that the researchers therefore took an empathic and affiliative stance towards the users. Here, the researcher's voices were backgrounded in favour of the imagined voice of the user. The researchers conveyed plausible utterances as the client (e.g.,'I can't hear the fridge alarm', p. 214). These instances represent the imagined *speech* the client could say to the audiologists, but not a representation of their *thoughts*. Anderson (2005) observed a related phenomenon in interactions in a corporation undergoing organizational change. Here represented discourse was not tied to one specific person but to what categories of people may say (e.g. customers) or to future predictions ('*and what you'll say is…*'). Here, the speaker's words are treated as *hypothetical* speech, not reported speech (see McCarthy, 1998).

There are also occasions when constructed dialogue represents thoughts. Gunther (1999) uses the term 'heteroglossia' to describe the reconstruction of an internal state. Constructed dialogue is also used to portray the inner-speech of others (e.g, 'he says to himself… "She's up to no good"': Tannen 1995, p.205). These instances, like reported speech, often occur in story-telling scenarios (Gunther, 1999). While the research reviewed here is relevant to our

analysis, none encapsulates the actions voicing inner-speech accomplishes in our data. Research has shown how reported speech can be mobilised to take a stance (see Clift, 2006). If and how inner-speech can be used towards the same ends same ends has not yet received the same level of analytic scrutiny. Here we consider how taking a stance is accomplished by voicing what we term 'imagined constructed thoughts' (hereafter ICT) of a *non-present other*. Specifically, we examine intellectual disability staff interactions within Discovery Awareness (DA) sessions.

DA is a video-analysis based meeting aimed at increasing staff attunement towards people with intellectual disabilities, encouraging positive interactions and motivating the desire to interact (Heijkoop, 2015) [1]. Participants are normally health-care staff from a variety of professions who regularly work with the patient. Participants are asked to focus on a video of a non-present patient, giving their impression and interpretation of the patients' behaviour. One aim of DA is for staff to focus on the patient's speech, body language and interactions with others to reflect upon how the patient may experience the world (Heijkoop, 2015). This requires interpreting kinesics, gesture and tone. However, understanding the inner world of another is rarely straightforward. This can be especially true of patients with challenging behaviour and ID, whose motivations may be difficult to understand. Pomerantz (1980) distinguished between knowledge that is directly experienced, and 'second-hand' knowledge. DA participants could be argued to be situated between the two states. They have direct, and equal, access to the video (type 1). However, they do not have access to what the patient thinks or feels other than through interpretative (and subjective) means. This makes the issue of 'taking a stance' a potentially tricky interactional goal. Here, we explore what role the use of 'Imagined Constructed Thoughts' plays in stance formation.

Data

The data were drawn from 6 Discovery Awareness (DA) sessions, each lasting 90 minutes. The patient is filmed interacting with staff under normal circumstances. DA is led by a chairperson trained in the method who facilitates the exploration of the patient at the centre of the session. Sessions were recorded in two settings: a day Assessment and Treatment Unit for adults with ID with challenging behaviour, and a short-term Assessment and Treatment Unit

[1] For an overview of Discovery Awareness, see Heijkoop & Clegg (2012)

for psychologically distressed adults with ID. Sessions were filmed over 10 months whenever they occurred. Frequency of the meetings during the data collection period limited the amount of data possible to collect.

Ethical approval was granted by the NHS before commencing data collection. All participants present in the filmed DA sessions gave consent to take part in the research. When patients enter the assessment and treatment units, permission was sought by experienced care staff in line with the Mental Capacity Act (2005) to be filmed for DA sessions as part of standard clinical practice. The patient is always asked if it is okay to film them, even if they have previously given consent. If they are unable to give informed consent, a best interest decision is made on behalf of the patient by people who know them well – this decision would normally involve friends or relatives as well as staff. The camera is never concealed, and Discovery Awareness is never a covert process. The ethics committee regarded the wider research project as evaluative of, and feeding into, clinical practice and therefore part of the initial consent process for the DA video to be filmed. The researchers did not have access to the films of the patients made for DA beyond viewing them once whilst recording the staff in the session. The videos of the patient made by the staff were deleted by the staff after each session. Our camera was positioned in such a way that the video of the patient was not visible. In the eventuality that this was not possible, the video recorded for this project was digitally blurred for any occasion that it would be shown to others. All patients were given pseudonyms throughout the transcription process, and all identifiable information was altered.

We used CA to identify instances where speakers spoke from the patients' point of view. These instances were then analysed for the actions they accomplished. A collection of 38 sequences of 'imagined constructed thoughts' by one or more speakers amassed across the data set. Extracts were chosen for their representativeness of the phenomenon across the data set.

1. 'Imagined constructed thoughts' in first-position

Taking a stance on an unknowable subject

A central aim of the DA session is to attune to the patient's behaviour; this requires the subjective interpretation of various elements that may be hard to understand, as well as taking a stance on an unknowable subject in front of their peers. Take the following extract; the

group have studied a video of a patient, Lydia, who remained motionless whilst the staff member tried to engage her in a craft activity. Eleanor (the chairperson) asks Tom (learning disability nurse) to elaborate on his previous point about the patient's lack of movement. Five other staff members are present.

Extract 1: **DA4**

```
3430  E:   And lets the-the second point erm (0.2) you were making about,
3431       (0.3) her her-what-yeah a- her movements. What's she actually
3432       (.) doing what are we watching.
3433  T:   Yeah um (0.2) she- (2.2) I think it was jus- (.) >(her) eyes
3434       seemed to be looking downwards< she seemed to be a sort of (1) a
3435       sutta-sort of (0.4) s:sadness a sort of (.) melancholy I suppose
3436       really sort of sadness mixed with (1.8) not caring or
3437       [really] caring about anything.
3438  P:   [Mmm  ]
```

In lines 3430 - 3432, Eleanor redirects Tom to his prior observation that the patient remained motionless. She pursues elaboration through two interrogatives ('***what's*** *she actually doing'* and '***what*** *are we watching'*), which Tom treats as seeking an *interpretation* of the patient's stillness (lines 3433 - 3437). Tom's 'yeah' prefaced response is punctuated with pauses (3433, 3434, 3456), initial 'um' hesitation (line 3433), and personally marked epistemic mitigation ('*I think'*) downgraded with a minimizer ('*I think it was* ***just'***). When describing the patient stillness, he also uses the epistemic modal 'seemed' (line 3434), further downgrading his tentative assertion that the patient's eyes were looking down; an objective phenomenon that could be easily evidenced from the video.

On lines 3434 – 3435 Tom adopts a stance which *cannot* be evidenced from the video without interpretation: that the patient is sad. He accomplishes this by using 'seemed to be' and 'sort of' to downgrade his upcoming subjective stance. 'Sort of' is employed multiple times (3433 – 3436), deintensifying and mitigating commitment to the stance (Caffi, 1999). Tom's interpretation of what the patient may be feeling increases in granularity as the turn progresses, moving from a 'sort of sadness' to 'a sort of melancholy' to 'sadness mixed with not really caring or caring about anything'. The latter is a far greater claim than those presented previously, and takes a stance not just about patient's emotions with a general descriptor (sadness/melancholy), but a wider interpretation of how the patient relates to the

world. This interpretation is aligned with by Padma who produces an overlapping agreement token (line 3438).

Tom's stance on what the patient is thinking and/or feeling is downgraded in a variety of ways, attesting to the difficulty of the interactional task; he cannot know for sure what the patent is feeling, his stance is therefore necessarily a 'guess', and he is tasked with taking a stance in front of his peers who may disagree with his interpretation. 'Downgrading' is typical of how speakers in this data go about taking a stance, corresponding to research on the prevalence of epistemic downgrading in first position (Heritage & Raymond, 2005). Thus the speaker adopts a 'lowered' and mitigated stance about the patient's inner state, ameliorating the risk that comes from going first, and taking a stance on an inaccessible epistemic domain.

'Imagined constructed thoughts'

Following on immediately on from the previous extract in which Tom was asked by the chairperson to elaborate on an earlier point about the patient's lack of movement. Tom took a stance in first-position with the inclusion of elements that deferred from claiming epistemic authority. Following this, Tom utilises ICT to talk as the patient.

Extract 2: DA 4

3439	T:	I mean it's (0.5) maybe not even the sadness it's
3440	→	just sort of (.) I'm not really bothered about where
3441	→	I am what what I- what I do.=
3442	J:	=Mm↑

On line 3439 Tom extends his turn after a possible TRP on line 3437. His turn extension prefaced with 'I mean' signals the upcoming adjustment to his previous stance (Schiffrin, 1987). This is followed by 0.5 second pause indicating the difficulty of word selection. Tom then makes his upcoming reformulation explicit ('*maybe not even sadness'*). Tom uses the personal pronoun to talk from the patient's point of view (lines 3440-3441 -*'it's just sort of 'I'm not really bothered about where I am what what I- what I do*'). This can be seen in context of the gradual increase in specificity regarding his reading of the patient's body language, moving from 'sort of sadness' and 'sort of melancholy', increasing in specificity to 'sort of sadness mixed with not really caring about anything' and finally to 'I'm not really

bothered about where I am what what I- what I do'. Tom uses ICT to make a *stance* about an unknown subject, *without* overtly indicating that he has moved into speaking as the patient (i.e.- **she is thinking** 'I'm not really bothered…') *or* has taken a stance by including a grammaticised expression of evidentiality. However, his appropriation of the patient's inner voice is treated as Tom speaking from the patient's point of view, evidenced by the speed of Julie's latched agreement; a turn unlikely to occur with a swift change of tone and subject matter (e.g, if she interpreted Tom as speaking as himself).

There are a number of significant points about this extract. Firstly, Tom's move into speaking as the patient is prefaced by minimizers and hedges which defer from claiming authority (Caffi, 1999; Markkanen & Schroeder, 1997), facilitating understanding of what follows as a guess before shifting footing to portray the reported speaker's inner dialogue. However, the ICT is delivered *without* such devices. Here, Tom uses the patient's voice to take a stance on a non-objective event. Speaking as the patient seems to enable Tom to give an un-hedged account of what the patient may be thinking or feeling. As this is not something the patient has *said*, it is Tom's *interpretation* of the patient's inner world, and is therefore a subjective stance the evidentiality of which Tom does not grammaticise. Secondly, Tom uses words the patient did not say, with vocabulary and sentence structure the patient would be unlikely to use. This is therefore not presented as the patient's 'true' voice, but an interpretation of their inner monologue. Thirdly, the move into speaking as the patient *is* signalled lexically and temporally. Tom outlines he will move away from his previous interpretation of the patient's behaviour ('*I mean it's* (0.5) *maybe not even the sadness'*) indicating the possibility of a new interpretation on the interactional horizon. Speaking as the patient is preceded by 'it's just sort of…' . Having established what the patient's behaviour is *not* (sadness), Tom then moves to outline a hedged stance of what it *is*. Fourthly, the patient's thoughts are delivered in the present tense. This relates to research on reported speech delivered in the present tense as a device for dramatising events in a story-telling sequence (Holt, 1996; Myers, 1999). However, the difference here is that Tom is not recounting something that actually happened, but an interpretation of what *could have happened* internally.

Lastly, Tom's voicing of the patient is 'double-voiced' (Bakhtin, 1984; cited in Tannen 1989); it is not neutral as it acts as his interpretation of what the patient is thinking. As previously mentioned, reported speech is never merely 'reported'; the speaker selects the words, they stress words or manipulate prosody to make their point (Tannen, 1989). In this

extract the words spoken as the patient are *entirely* invented, but are intended to represent what patient is thinking; the pause before shifting footing to talk as the patient acting as a temporal barrier to separate 'speakers'.

We have explored how ICT can be used to take an un-hedged epistemic stance on patient's inner thoughts and behavioural motivations whilst noting that the prior talk was downgraded by various means. In the following extract we explore how a speaker shifts back to their own voice, and what difference (if any) speaking as the patient can make to their subsequent talk. The patient in the following extract is Mary, a woman with mild intellectual disabilities. In the video Mary walks by herself around the hospital. The video is paused at a point where Mary walks in front of the camera. David, a Speech and Language Therapist, gives his impression of what is going for the patient at this point. The extract also features Samantha, (clinical psychologist and chairperson), Raquel (health care assistant), Padma (psychiatrist), and Aghali (doctor). Five other staff members are present.

Extract 3: DA1

```
680   D:   Just befor:e she sort of when she first goes in (0.6) I think
681        she sort (.)of looks round the [room]
682   P:                                  [hmmm]
683   D:   she sort of pause and looks round the room (0.8) and then,
684        (0.8) >kind of focuses on the window and the hands< go behind
685        the back and it's sort of (1.4) there's an initial bit
686   P:   Mmmmm
687   D:   where it's kind of (0.7) okay wha-what do I do with this space
688        (0.5)
689   S:   ((begins to write on the white board a summary of what D is
690        saying))
691   D:   and then she finds some sort of focus and th-and she finds her
692        posture,
693        (0.3)
694   P:   Mmmmm
695   S:   ((S is writing on board))
```

David begins his turn with a description of Mary's actions which is formed in the present simple tense ('*when she first goes in she sort of looks round the room*'). He describes her actions as unfolding in the present. Lines 680 - 681 show David speaking about what can be evidenced from the video footage. Even so, he acknowledges the status of this description as disputable with the use of downgraded assessment forms such as 'I think' (Line 681) and the repeated use of 'sort of' (lines 680, 681, 683, 685). This kind of downgraded formulation is also typical in assessments in first position (Heritage & Raymond, 2005).

Following his description of Mary's actions on the video (683-685), he switches perspective into speaking *as* Mary on line 687 ('*where it's kind of okay wha-what do I do with this* space'). This shift shares common traits with the previous extract. In both cases, the shift to speaking as the patient is preceded by the contraction "it's" + a downgrading element (sort of, kind of) + a pause before shifting into ICT.

David frame-shifts whereby he makes Mary's thoughts immediate whilst also making his assessment of what is going on for Mary at that particular moment. As in the previous extract, David's turn on line 687 - 688 contains two speech centres (Bakhtin, 1984, cited in Tannen 1989). However, commonly 'double-voicing' refers to the practice of quoting someone else and speaking as them in your present interaction, reflecting simultaneously the original speaker and the present speaker. Here, David is both voicing the patient thoughts whilst simultaneously serving as David's assessment of what *he believes* she is thinking.

David's turn preceding line 687 is descriptive and can be evidenced from the video. His move into speaking as Mary signals a shift into his subjective interpretation. As in the previous extract, the talk preceding ICT is marked by elements that defer from claiming a high epistemic stance, such as hedges and personally marked epistemic mitigation (e.g., 'I think'). In addition, there are multiple pauses suggesting difficulty or delicacy in constructing the talk. This is likely to be because of the K- epistemic state (Heritage, 2010) speakers have about thoughts motivating the patient's behaviour. Given the fact that ICT is itself delivered without pauses, downtoners, hedges or other means of lowering the stance, it seems likely that Mary's represented inner voice functions as a device to give legitimacy to David's interpretation.

Immediately following David speaking as Mary, the chairperson begins to write an approximation of his turn on the whiteboard (lines 689-690), an activity normatively associated with the chairperson displaying understanding of a participant having 'made a point'. The chairperson therefore orients to David's utilisation of ICT as his assessment of what her actions means. On lines 691 - 692 David extends his turn ('*and then she finds some sort of focus and th- and then she finds her posture*'). Following a gap and David's grammatically complete turn, this turn extension does not contain a hearsay evidential as was previously used in line 680 - 681. Instead of saying 'I think she finds some sort of focus', David does not grammaticise this into an epistemic stance but presents it as a hedged declarative via the use of 'sort of'. It is noticeable that this turn extension is delivered without many of the elements that defer from claiming authority that the build up to speaking as Mary

contained. It may be the case that using Mary's voice as evidence enables David to make a greater epistemic claim to what happens next. Whereas claims about Mary's posture can be tied to what is readily visible on the video, the claim that she has found focus cannot be so easily 'read'.

Notably, in the previous examples, ICT was used to take a stance on what might be going through the patient's head when the patient has not said anything. We found in our collection that it could also be used in an assessment sequence to *reinterpret* words that were spoken. The following extract comes from the same DA session as the previous extract. The staff are watching a video of Mary (the patient) interacting with Camille, who is also present in the session. Camille brings coffee for herself and Mary and they talk together. In the moments preceding the extract, Raquel (care assistant) has asked for the video to be paused after Camille (nurse) said to Mary 'hello my lovely, how are you?' to which Mary replied 'I'm alright'. Raquel starts a discussion about the meaning of Mary's utterance, 'I'm alright', and whether it represents her true feelings. Speakers in the extract are Raquel, David (speech and language therapist), and Samantha (psychologist and chairperson). There are 7 other staff present.

Extract 4 : DA1

```
1317   R:   .hhh It's almost as if she was see:king with the low tone and
1318        like saying (0.2) the way she actually said (0.3) oh im
1319        al↓right as if she wanted then (0.4) for Camille to say (0.5)
1320        oh ↑why what's the matter↓(0.7) indicating to sort of say (0.5)
1321        well I'm al↓right (0.7) but giving out the signal of (1)
1322   D:   [°I'm not alright°]
1323   R:   [Well I'm not      ]
1324   D:   [Hmmm]
1325   R:   [I'm ] not alright (0.2) and I need you to ask me.
1326        (2)
1327   R:   That's what I interpreted from that
1328   S:   So she's seeking, (1)
1329   R:   Yeah
1330   S:   someone to enquire after her [further]
1331   R:                                [yes:  ]
1332
```

The extract begins with Raquel self-selecting to further elaborate an earlier turn regarding the meaning of Mary's utterance, 'I'm alright'. As in previous extracts, interpreting the meaning of a patient's words or behaviour is preceded by discussing events objectively evidenced from the video. Here, Raquel provides the reported speech of Mary herself with exaggerated falling intonation on the second syllable of 'alright' and a flat, depressed tone projecting her

following interpretation that Mary is not *really* alright. Raquel ties this evidence presentation firmly to what happened on the video when she self-repairs on line 1318 from 'and like saying' to the much stronger 'the way she ***actually*** said…'. Raquel's reported speech exaggerates certain aspects of prosody to demonstrate her interpretation that Mary is *not* alright. This point is further emphasised with repetition with the same inflection on line 1321.

Raquel then animates Camille's voice (lines 1319 - 1320 - '*as if she wanted then for Camille to say, 'oh why, what's the matte*r?'). This turn performs a complex action: Raquel animates Camille's voice as imagined by Mary, whilst representing her own opinion of what Mary wanted Camille to have said. Raquel signals the shift to Camille's imagined dialogue with pauses before and after her constructed dialogue, presenting an alternate series of events that could have led to a different outcome.

In one turn Raquel represents what the patient actually said with exaggerated prosody to highlight her earlier and later points, followed by imagined desired dialogue speaking as Camille (line 1320) and then as the patient's thoughts (line 1325). Raquel subtly modifies the patient's reported speech, forecasting her own upcoming position. Whereas previously she quoted the patient as saying 'oh I'm alright', this shifts to '*well* I'm alright'. Given this is spoken in 'response' to Camille's imagined question, it conforms to previous research on well-prefaced turns forecasting disagreement or disaffiliation with a prior turn (Pomerantz, 1984, p.72). The primary difference here is that the 'prior turn' is produced and responded to by Raquel herself. Further evidence that she has used prosodic features to forecast her reading of the juxtaposition between the patient's words and what she 'really' means can be seen in David's pre-empting of both her meaning *and* her frameshift (line 1322 -'*I'm not alright'*). Here, David's TCU is affiliative with Raquel's; it also uses ICT to talk as the patient in the present in overlap with her aborted turn at line 1323. This sequence is extended at line 1325 where Raquel shifts footing to speak as the patient: 'I'm not alright and I need you to ask me'. This turn acts as evidence for the case Raquel builds in lines 1317 – 1321, that the patient's words and their meaning were at odds.

As in the previous extracts, in the act of speaking as the patient the speaker adopts a higher, less hedged epistemic stance than the speech leading up to it. Speaking as the patient therefore seemingly enables the staff members to voice a more certain stance than they otherwise would speaking from their own point of view. Perhaps this is because hedges,

mitigators and downgraded epistemic stances are only commensurate with the staff member speaking *as themselves* from a K- point of view when they take a stance in first position (Heritage & Raymond, 2005). If the patient *themselves* were to speak about what they were thinking or feeling in a particular moment, they would naturally treat themselves as having primary right to narrate their own experiences (Sacks, 1984). In voicing the thoughts of the non-present patient, speakers treat themselves as temporarily unbounded by the features that often mark stances on a subject that the speaker does not have primary right to assess. That the ICT was indeed intended to function as Raquel's interpretation is confirmed by her turn extension (line 1328); 'that's what I interpreted from that'. She explicitly frames her prior turn as subjective interpretation, likely to deal with the previous TCU not being epistemically downgraded after her declarative turn on line 1326 is followed by a two-second gap indicating trouble in speaker transition. The chair's so-prefaced response ('*so she's seeking'*) marks a shift in conversational activity (Bolden, 2009) to gist-formulating Raquel's turn and checking the summation is accurate (1330).

Whilst this extract shows a more complex use of ICT, animating multiple speech centres to create an imagined dialogue, the action it accomplishes (taking a stance on the patient's inner world) and the means by which it is done (increasing granularity, moving from objective to subjective interpretation, lowering accountability before ICT, pauses before frameshifting) is consistent with the patterns outlined previously. However, by animating multiple voices, we see how ICT can be used as a 'response' in an imagined dialogue, and therefore take a stance by contrasting imagined thoughts with actual speech.

2. 'Imagined constructed thoughts' in second position

So far we have explored the common features of ICT in first position and the ways that it enables the staff in this circumstance to take a higher epistemic stance on a non-objective matter. The prior extract demonstrated how a single speaker could animate multiple speech centers and utilise ICT to 'trump' reported speech; i.e., what the patient *said* versus what the patient really *meant*. We now move on to explore its use in second position. In the following extract the staff are watching a video of Harriet, a woman with moderate ID. Harriet had been looking through the newspaper and Camille (staff nurse also present in the session) had asked her if there was anything interesting in the paper, to which Harriet had shaken her head. Shortly afterwards, Harriet saw naked bodies in the newspaper, causing her to laugh. Camille

then looks through the newspaper whilst Harriet watches. Preceding the extract below, Samantha (the chairperson) stopped the video at a point where Harriet smiled. The extract begins with the group discussing the meaning of the smile. The extract features Emma (junior doctor), David (speech and language therapist), Samantha (psychologist and chairperson) and Camille (staff nurse). Six other staff members were also present.

Extract 5: DA3

```
2385  S:  >But (.) what do we< (.)>cos I::# I was wondering whether or
2386      not,=
2387  E:  =°If she saw the naked ↑bodies aga↓in
2388  S:  Yeah [sh-huh][↑huh ei    ]ther she flicked through
2389  C:       [Heh heh]
2390  D:                [Yeah I'd s-]
2391  S:  tha:t or o:r u:m, erm .tch (0.8)(°if) she ↑gone- she'd gone
2392      through the paper you'd-you'd said (.) to her (0.4) oh there
2393      was nothing in there it's boring isn't it (0.2).hh and then
2394      you're flicking through it your↑↑self so maybe she's finding
2395      that amusing you're reading something that (0.4) you've just
2396      acknowledged is ↑bo↓ring °I don't°
2397  C:  Mmmm
2398  S:  [.hh °huh]
2399  D:  [Or-      ]o:r
2400  S:  Huh huh
2401  D:  whether (0.3) I mean we're ki::nd of
2402      guessing aren't we but (0.8) but my thought is whether
2403      actually, (0.5) she's sort of thinking,(.)↑oh she's ↑going
2404      to ↑come ↑ac↓ross those naked
2405  S:  O[h yeah        ]
2406  D:   £[pi(h)ctu(h)res] in [a £minute.]
2407  C:                    [°mmmm     ]
2408  D:  Yeah? She's saying there's nothing
2409      interesting in here but actually (0.3) I know in a minute
2410      if she carries on [fli]ck[ing]
2411  E:                    [mmhuh]
2412  C:                             [mh]uh
2413  D:  she's going to come across those naked ↑pictures
```

The extract begins with Samantha, the chairperson, repairing a collectively proposed action (‘*what do we’*) to a personally marked tentative epistemic stance which builds in the possibility of disagreement (‘*I was wondering whether or not*’). The move into taking a stance that the chairperson had been building towards on line 2385-6 is pre-empted by Emma who completes Samantha’s turn (‘*if she saw the naked bodies again’*). The stance Emma pre-emptively presents (and assumes Samantha was working towards) is that Harriet smiles

because she has seen the naked bodies in the newspaper. Despite the fact that Samantha offers an agreement token ('yeah') in response to Emma's 'reading' of her projected turn (line 2387), she immediately provides a contrasting alternative stance through the use of 'either' and 'or' (line 2388 and 2391), suggesting Emma's 'reading' not what Samantha was building towards.

On lines 2391 – 2396 Samantha ties the incongruity of the staff member's words and actions as a possible catalyst for the smile. Samantha does this through two kinds of evidence: reported speech and observable action. The reported speech is used as evidence in building her case (*you'd said to her* ***'there's nothing in there it's boring isn't it'***), which is contrasted with the observable action of the staff member presented on lines 2392-2393 ('*and then you're flicking through it yourself'*). After presenting the evidence, Samantha moves to subjective interpretation of these objective events: the patient smiles because of the incongruity of the staff member's words and actions on lines 2393- 2394 ('*so maybe she's finding that amusing you're reading something that you've just acknowledged is boring'*). This is followed by the tailing off 'I don't', which is projectably 'I don't know'. This could be read as retroactively downgrading her assessment to protect her own face rights (Goffman, 1967).

On line 2399, David responds to Samantha's stance with his repeated turn initial disjunction ('or') forecasting an alternative point of view, compounded by his use of 'whether' (line 2401), which in turn initial position also projects a contrastive turn. David delays his stance with a mitigating insertion ('*I mean we are kind of guessing aren't we').* This serves to mark his upcoming interpretation overtly as a 'guess', lowering the commitment afforded to the stance and marking the upcoming assessment as disputable (Heritage & Raymond, 2005).

On lines 2403-4 and 2406 David 'frame shifts' into ICT. ('*but <u>my</u> thought is whether actually, she's sort of thinking, oh she's going to come across those naked pictures in a minute'*). The shift is lexically projected *(', she's sort of thinking… '*), whilst 'sort of' hedges and mitigates commitment to the upcoming stance by de-intensifying its status (Hübler, 1983; Caffi, 1999), a common characteristic across the data-set. His move into speaking as the patient is also preceded by a slight pause functioning as a temporal marker between speech centres. Corresponding to previous extracts, when David begins talking as Harriet (lines 2401-2411) there and no hedges or mitigated stance markers. His turn also adopts a high epistemic stance (***I know*** in a minute if she carries on she's going to come across those naked

pictures') (Heritage & Raymond, 2005). Perhaps David adopts a K+ epistemic stance (Heritage, 2012) precisely because he is *not* speaking as himself. He is speaking as the only person who can speak with authority about the patient's inner thoughts; the patient herself.

David's frameshift on lines 2401, 2404, 2406-2408 and signals a shift not just in perspective but into his subjective interpretation. He continues his turn as Harriet on 2408-2410 and makes the case that her smile originates from *anticipation* of the staff member coming across the naked photos. Samantha had interpreted the cause of the smile to be the incongruity of the staff member acknowledging the newspaper is boring, yet proceeding to read it. David therefore build his own interpretation of the catalyst for the smile (the tension around the imminent viewing of the naked pictures) in partial opposition to Samantha's stance. That it is indeed understood as an assessment can be evidenced from the agreement tokens from the other staff (2405, 2407, 2411, 2412).

Pertinently for the analytic focus, his use of ICT comes in response to Samantha use of staff *reported speech* to build a case for her interpretation of the smile. David's version however reports the *thoughts* of the patient. This could be seen as conferring an epistemic authority over the first claim via presented access to the patient's inner world. In essence, Harriet's thoughts are utilised as a device by which the second account can be positioned favourably with respect to the first. The function of using reported speech to act as evidence has been well documented (Holt, 1996; Tannen, 1989;), as has its use in environments of competitive assesment (Clift, 2006). Using ICT for the same purpose has, thus far, not received the same level of analytic scrutiny.

The analysis here shows the common features connecting the use of ICT (how it is preceded, delivered, at what point in the turn it is delivered, its function as device for taking a stance). However, it also demonstrates it can be used to confer epistemic authority in a second position stance. Next, we explore how ICT in second position as a competitive resource to combat its use as a stance-marker in first position.

Extract 6 comes from DA1. The speakers here are Samantha, Camille, Raquel, David, Padma and Tejal (doctor). Four other staff are also present. The group are watching a video interaction between the Camille and Mary, the patient. While Camille and Mary sit down facing each other to have coffee, another patient walks into view: Samantha pauses the video.

Extract 6: DA1

```
1484  S:  I just want to pause it there because I think it's really
1485      interestin-J (0.5) the other
1486      pa[tient's coming in]
1487  C:    [.HHHH huh huh    ]
1488  S:  and she's not eve[n ack]nowledged her what so [ever]
1489  R:                  [J C  ]                      [yeah]
1490  C:  Huh [°no ]
1491  S:      [I won]der what that's about whether or not this is (0.4)
1492      about(.) this is my space this is my time this is my
1493      interaction with (0.5) erm (0.4)with this staff memb[er  ]
1494  C:                                                  [yeah]
1495  S:  I don't want you invading↑ (0.3)>where she's< clearly not even
1496      [noticing   ]
1497  C:  [she doesn't]
1498  S:  [her] [(much)]
1499  T:  [I-I]  [don't] know I think they don't get along very well
1500  P:  [No ]
1501  D:  [Yeah]
1502  S:  [They]don't get[along]
1503  R:                 [No  ][they don't      ]
1504  T:                 [( )]d[idn't think so so](0.4) maybe she's like
1505      (.) I don't (0.6) you know I'll pretend yo(h)u're no(h)t
1506      he(h)re huh huh [huh]
1507  S:                 [yeah]
```

As in previous examples, the extract begins with the outlining what can be objectively verified from the video; the chairperson notices Mary has not acknowledged another patient despite being in close proximity (lines 1484 – 1486 and 1488). In line 1491 she begins to formulate a possible reason for this 'snub'. Samantha's turn is front-loaded with the epistemic subjective marker 'I wonder'. She continues 'whether or not this is about…'. Conforming to the pattern previously outlined, this works to preface an upcoming stance as a 'guess'. Such a formulation helps minimize the social effects of disagreements or counter-readings later, as disagreement would be minimised on the basis that the assessment has been explicitly raised as a possibility, not a high-commitment epistemic stance. This is underlined by following it with 'whether or not this is about…', suggesting a non-firm commitment to what will follow.

In lines 1492 - 1493 Samantha frame-shifts to talk as Mary *('this is my space, this is my time, this is my interaction…with this staff member'*). As in previous examples, the frame-shift is prefaced with pauses. Camille response on line 1494 ('*yeah'*), suggests she interprets Samantha's utterance as voicing the patient rather than speaking as herself. Samantha relates Mary's behaviour to ownership and threat to ownership of the interaction with the staff member. As in previous extracts, ICT is delivered without the elements that defer from claiming authority commonly found in the build up to the frame-shift. The move back to speaking as herself is marked by a pause (line 1495) providing demarcation between speech

centres. Samantha then reiterates the (relatively) objectively verifiable evidence for her interpretation (‘*she’s clearly not even noticing her much’*) delivered in overlap with Camille’s aborted turn (line 1497).

In line 1499 Tejal presents a possible reason why Mary does not react to the other patient (‘*I-don’t know I think they don’t get along very well*’) which is confirmed by other staff members (lines 1500-1503). Her formulation is prefaced with ‘I don’t know’ functioning as a hedge lowering commitment to what will follow in her turn (Weatherall, 2011). It also tentatively paves the way for an alternative assessment; perhaps Mary ignores the other patient because she does not like them, rather than because she wants ownership of the staff interaction. On lines 1504 - 1506 Tejal also adopts ICT to offer an alternative explanation for Mary’s non-acknowledgement of the other patient *(‘maybe she’s like, I don’t – you know, I’ll pretend you’re not here’*). Her continued turn on line 1504-5 functions to protect her positive face-wants (Goffman, 1967) by prefacing her utterance with two disclaimers (‘*maybe’* and the projectable ‘I don’t know’). Here then, two speakers use ICT in order to take different stances regarding the patient’s inner world. As demonstrated, ICT is often used in first position to negotiate the shift from objective description to interpretative stance delivered in an unqualified, high epistemic stance. Whilst the ability to deliver a stance without downgraded elements (at least whilst speaking as the patient) constitutes a compelling claim to epistemic authority, participants are able to ‘push back’ using the *same* form for alternative stances in second position. Corresponding to Clift’s (2006) findings on reported speech, ICT can be countered by use of its own form, revealing its limits as a competitive means. Whilst enabling speakers to upgrade the delivery of their stance, it can be countered through the same format.

This paper has highlighted the common elements in turn design, sequence, and stance formation of ICT. For example, the segue into ICT is signalled through temporal, prosodic, or grammatical means. This allows others to understand whether the interlocutor is speaking as themselves or as someone else. The ‘pre-work’ done by interlocutors also establishes their epistemic rights and lowers accountability before launching a non-mitigated report of the patient’s mentation. The following extract presents a somewhat deviant case which, although is used to take a stance, does not conform to many of the patterns previously outlined.

In this session Eleanor (chair-person and clinical psychologist), Padma (psychiatrist), Jacky (care assistant), Nina (music therapist), Wilma (occupational therapist) and Tom (staff nurse) are analysing a video Lydia, a patient. Lydia had recently become increasingly lethargic and

unresponsive. One other staff member is present. The video shows Jacky trying unsuccessfully to engage Lydia in a craft activity.

Extract 7: DA4

```
1692  E:   Can I just (.) sorry about the older thing's a-a-another point
1693       but (0.2) l#et's go back to she's got (.) she's rigidly held
1694       (0.4) down and her chin is down and back
1695  N:   Mmmhmm
1696  E:   Umm un what were we thinking about that↑
1697  E:   That's tha[t's backing away]
1698  W:              [I was just think-]
1699  E:   [the demand  ]
1700  W:   [it's another] (0.6)possibly yeah
1701  E:   [Is that what we're thinking?]
1702  N:   [Not particularly            ][com]fortable about[being]there
1703  W:                                  [mmmm]
1704  P:                                                    [↓oh  ]
1705  N:   is she? She'[s not]
1706  J:               [No   ]
1707  P:   What are you making me do.
1708  N:   Y[e:[s  ]
1709  W:    [Mm[mmm]
1710  E:       [mmm]
1711  N:   Don't like [this]
1712  J:              [Why] have you got me sat at this
1713       table [wat[ching] you
1714  D:          [mm [mmmm]
1715  P:              [mmmm ]
1716  D:   Mmhmm. Yeah
1717  N:   Mmmm. Or what are you doing?=
1718  P:   =mmmm
1719  N:   Don't know what's going to happen
1720  D:   [Hmmm]
1721  P:   [Mmmm]
```

The extract begins with the chairperson asking the group to go back to a previous point about the patient's head and neck posture (lines 1692 to 1694). She frames this as a question for the group to answer in line 1696 ('*what were we thinking about that?*'). On line 1697 Eleanor's turn extension offers a possible interpretation for the group to consider ('*that that's backing away'*) which refers to the patient's chin being pushed down as a way of physically 'backing away' from interaction. Wilma's turn on line 1700 ('*it's another…possibly yeah'*) seems to be a continuation of her previous abandoned turn (line 1698) to answer the chairperson's turn expansion (lines 1697 and 1699). Wilma's 'possibly…yeah' is a qualified agreement assertion (Pomerantz, 1984) displaying only partial agreement ('*possibly'*) whilst aligning with the chairperson's turn ('*yeah'*).

In line 1701 the chairperson pursues a response to her original questions ('Is that what we're thinking?'). This partial reformulation serves to intensify the request for the participants to respond from an open question ('*what are we thinking about that*?') into a 'yes seeking' interrogative (Raymond, 2003). Nina's turn (line 1702) avoids agreeing or disagreeing with the chair's yes-preferred interrogative question, instead offers her stance of the patient's behaviour ('*not particularly comfortable about being there is she*?'). The tag question does the work of downgrading her epistemic stance in first position by pursuing alignment. Like previous examples, the interpretative stance in first position is downgraded, however in this instance through a tag question as opposed to using hedges. As the subject of interest from the video had already been outlined in the prior talk, Nina did not have to do work to introduce this before launching into an interpretation of its meaning. Nina continues to talk (line 1705), but abandons her turn, most probably because of the Jackie's overlap (1706).

Most consequentially for this analysis, Padma moves into ICT when she says 'what are you making me do' (line 1707). This is likely to refer to patient's reluctance to participate in the activity. Padma's turn offers little clear linguistic clue that she is talking as the patient (e.g, prefacing her turn with 'she's thinking'), and yet the staff interpret Padma as not speaking as herself as Padma aligns with their interpretations of her turn as her speaking as the patient in lines 1715, 1718 and 1721 using minimal assenting responses (Schegloff, 1972) coupled with an affirmatory tone. So how do the staff immediately hear Padma's utterance as speaking as the patient as opposed to speaking as herself?

Firstly, Padma delivers an 'oh' in overlap with Nina on 1704. This could be read as a news receipt of Nina's interpretation. However, given Padma's following use ICT on line 1707, it could be seen rather as an oh-prefaced response in second position (Heritage, 1998). Her 'oh' may have functioned as a bid for speakership. Heritage (1998, p.330) also briefly mentions the phenomenon in relation to reported speech in the notes on his paper on oh-prefaced responses to inquiry. Therefore, Padma's 'oh' could have been understood as 'oh-prefaced' ICT. Secondly, the staff understanding her as speaking as the patient may be explained by the sequentiality of her utterance, coming shortly after Nina's own assessment (line 1702 and 1705) and following the chairperson specifying the activity is one were subjective thoughts are sought on the patient's behaviour (1696 & 1701).

Most pertinently, Padma's move into speaking as the patient catalyses a flurry of similar turns with staff adopting the *same form*: present simple tense first person formulations of the

patient's possible thoughts (1711, 1712-1713, 1717 and 1719). These turns respond to Padma's preceding action and renew the next action in lines 1712 to 1721. Where the first-person pronoun is omitted (lines 1711 and 1719), it is projectable given the surrounding talk. Whilst there are minimal response tokens from various members of staff, all utterances from the patient's point of view give differing interpretations of Lydia's thoughts. However, unlike differences of opinion or alternative interpretations in everyday conversation, they are not hedged, they are (mostly) not prefaced with agreement components and/or contrast conjunctions, and they are not delayed (Pomerantz, 1984). It therefore seems that speaking as the patient gives the staff equal epistemic rights to make an alternative assessment of what the patient may be thinking. The exception to this is on line 1717 where Nina prefaces her turn as speaking from the patient's point of view with a contrastive conjunction ('*or* what are you doing'). This suggests her turn is either intended to be taken as an alternative interpretation to the others that have gone before her, or may reflect that this is her *second* version of proposed ICT.

Previous extracts have shown temporal, prosodic and linguistic cues in which a move into ICT is signalled. This extract demonstrates that this is not always the case. Sequentiality can trump linguistic or temporal markers indicating when a person is speaking as another. Second, the use of ICT allows speakers to voice non-aligning turns which offer alternative assessments without the need for prefacing non-alignment and minimizing disagreement usually found in every day conversations (Pomerantz, 1984). Finally, when speakers speak as another drawing upon a referent of equal access (i.e, the video) they can use ICT to claim equal epistemic access to the patient's inner world. Thus, speaking as the non-present patient enables staff to take a firmer stance on a non-objective event, and to offer contradictory non-downgraded/hedged readings of the patients' mentation. Whilst ICT is utilised in this collection to take a stance, it can both in first-position to work up to a stance, or in second-position to offer alternative interpretations, undercutting the epistemic authority conferred on a speaker in first-position using the patient's voice to 'make their point'.

Discussion

This paper builds upon Clift's (2006) work on the role of reported speech in stance-taking. Here we demonstrate that animating the thoughts of a non-present other can be used to similar ends. Whilst reported speech can confer epistemic authority by providing evidence

(Holt, 1996), speakers also navigate related epistemic issues with ICT. The downgraded pre-work speakers do before launching into high-stance ICT can be examined through the lens of Heritage's (2012) work on epistemic stance and status. We showed that animating the inner-voice of the patient means adopting the grammatical epistemic stance one takes when speaking in the first-person about our own thoughts or experiences (Sacks, 1984). Interactants in our data (in general) go to lengths to lower their *epistemic status* before adopting a evidentially grammaticised high *epistemic stance* whilst delivering ICT. The dubious rights speakers have to interpret the patients' thoughts likely explains the downgraded turns preceding ICT, establishing the action as a 'guess' before launching into the patient's possible mentation. However, adopting a higher stance through ICT can lead to less-hedged turn extensions in the speaker's own voice (see extract 3).

We also explored the use of ICT in second-position as a means of producing a competing, or non-aligning stance. However, ICT also has limits as a competitive resource as participants can utilise it in second position to counter implied claims to epistemic authority. Interestingly, non-aligning turns can be delivered using ICT without the need for prefacing non-alignment and minimizing disagreement usually found in every day conversations (Pomerantz, 1984). We posit that ICT of a non-present other enables staff to make alternative assessments about what the patient may be thinking, temporarily unbound by the rules that govern differences of opinion *if speaking as themselves.*

There can be no 'right' answer in a DA session, and participants cannot claim epistemic authority or sole access to the patient's epistemic domain. Labov and Fanshell identified five classes of epistemic knowledge. A events which are known to A but not B; B events, which are known to B but not A; AB events which are known to both A and B; O events which are known to everyone present; and D events which are known to be disputable (1977, p.100). In DA, all staff have equal access to the video clip. There are usually one or two members of staff there who were present at the time of filming, who are treated (and treat themselves) as having epistemic authority over narrating contextual information about the video clip. However, DA participants are asked to explore the *meaning* of the patient's behaviour. This does not fit easily in Labov and Fanshell's classifications. Whilst the video seen by all participants could be classed as an O event, participants are also asked to imagine the world from the patient's point of view based on the video; a D event since any interpretation of the patient's thoughts is subjective and therefore disputable. This highlights the uncertain epistemic space staff must navigate in DA sessions. The prevalence of ICT in these

sequences suggests that narrating the inner dialogue of the person as if it were their own experience may help staff deal with the ambiguous rights they have to interpret the patient's thoughts.

We have demonstrated that once pre-work has been done to facilitate the hearers' uptake of their stance, the ICT formulation allows them to build up to a point of maximum granularity and take a stance without pausing, hedging and mitigating. The stance is more powerfully delivered, and presents a more compelling case, both in first position and as a competitive resource for proffering an alternative interpretation in second position. Just as reported speech can make a story more vivid (Myers, 1999) and provide evidence for a stronger stance (Clift, 2006), ICT enables a stance on an uncertain epistemic terrain to be more impactful. It is thus a compelling way to deliver an opinion on another's possible thoughts that would otherwise likely be downgraded if delivered from one's own perspective.

Finally, ICT implies an empathic connection; the speaker temporarily animates the (presumed) innermost thoughts of the patient. Whilst acknowledging that definitions of empathy vary, it is commonly understood as the capacity to put oneself into the imagined mental state of another (Kalisch, 1973). Empathy is not an exact facsimile of what someone else feels, but what one *imagines* another to feel (Prinz, 2011). The staff in DA are attempting to understand the world from the patients' points of view (Heijkoop, 2015), and with ICT, they take an empathic stance. As Egbert (2012) argues, 'in all cases, by changing perspective, the researchers put themselves into an imagined situation in which they experience events from the perspective of the third party' (p.215). Researchers have previously argued that constructed dialogue enables immediacy to non-present speakers and their words (Holt, 1996; Tannen, 1989). We contend that ICT enables staff to bring a similar immediacy to representing the patient's *thoughts* whilst also enabling them to take a firmer stance on subject outside of their epistemic domain. By speaking as the patient, the staff can create a 'character who take(s) on life and breath' (Tannen, 1989, p.103). Where the task is to attune to how the patient sees the world, ICT can be crucial in keeping the patient at the centre of the discussion and making their inner world debatable.

References

Anderson, D. L. (2005). "What you'll say is?…?": represented voice in organizational change discourse. *Journal of Organizational Change Management,* 18 (1), 63-77.

Bakhtin, M. M. (1984). *Problems of Dostoevsky's Poetics* (C. Emerson, Trans.). Minneapolis: University of Minnesota Press.
Berger, E., & Doehler, S. P. (2015). Direct reported speech in storytellings: Enacting and negotiating epistemic entitlements. *Text & Talk*, 35 (6), 789-813.
Bolden, G. (2009) Implementing incipient actions: The discourse marker 'so'in English conversation. *Journal of Pragmatics*, 41 (5), 974-998.
Butterworth, B., & Beattie, G. (1978). Gesture and silence as indicators of planning in speech. In Recent advances in the psychology of language (pp. 347-360). Springer, Boston, MA.
Caffi, C. (1999). On mitigation. *Journal of Pragmatics*, 31, (7), 881-909.
Clift, R. (2006). Indexing stance: Reported speech as an interactional evidential. Journal of sociolinguistics, 10 (5), 569-595.
Egbert, M. (2012): Conversation Analysis Applied to User Centred Design: A Study of Who 'the User' Is. In: Antaki, C. (ed), Applied Conversation Analysis: Intervention and Change in Institutional Talk. London: Palgrave Advances, 207-221.
Goffman, E. (1967). On face-work, Interaction Ritual: Essays on Face-to-Face Behavior. *Pantheon, New York*, 5-46.
Goffman, E. (1974). Frame Analysis - an Essay in the Organization of Experience. Boston: Northeastern Press.
Günthner, S. (1999). Polyphony and the 'layering of voices' in reported dialogues: An analysis of the use of prosodic devices in everyday reported speech. *Journal of Pragmatics*, 31(5), 685-708.
Heijkoop, J., & Clegg, J. (2012). Introduction to the Heijkoop approach to challenging behaviour in ID. *Paper presented at the Ideas Exchange: Emerging Good Practice in ATU Intellectual Disability Specialist Services, Nottingham*, 1-7.
Heijkoop, J. (2015). *Ontdekkend kijken: basisboek Methode Heijkoop*. Heijkoop Academy.
Heritage, J. (1998). Oh-prefaced responses to inquiry. *Language in society*, *27*(3), 291-334.
Heritage, J., & Raymond, G. (2005). The terms of agreement: Indexing epistemic authority and subordination in talk-in-interaction. *Social Psychology Quarterly*, 68 (1), 15-38.
Heritage, J. (2012). Epistemics in action: Action formation and territories of knowledge. *Research on Language & Social Interaction*, 45 (1), 1-29.
Holt, E. (1996). Reporting on talk: The use of direct reported speech in conversation. *Research on Language and Social Interaction*, 29 (3), 219-245.
Hübler, A. (1983) *Understatements and hedges in English*: John Benjamins Publishing.
Jefferson, G. (1984). Notes on a systematic deployment of the acknowledgement tokens "yeah"; and "mm hm". *Pragmatics*, 7(3), 397-415
Kalisch B.J. (1973) What is empathy? American Journal of Nursing 73, 1548–1552.
Kärkkäinen, E. (2003) *Epistemic stance in English conversation: A description of its interactional functions, with a focus on I think*, vol. 115: John Benjamins Publishing.
Labov, W., Fanshell, D, (1977). *Therapeutic Discourse: Psychotherapy as Conversation. Academic Press*, New York
Markkanen, R & Schroeder, H. (1997) *Hedging and discourse: approaches to the analysis of a pragmatic phenomenon in academic texts*,Walter de Gruyter, Berlin
McCarthy, M. (1998). *Spoken language and applied linguistics*. Cambridge: Cambridge University Press.
Mental Capacity Act (2005). London: The Stationary Office.
Myers, G. (1999). Functions of reported speech in group discussions. *Applied Linguistics, 20*(3), 376-401.
Pomerantz, A. M. (1980). Telling my side: "Limited access" as a "fishing" device. Sociological Inquiry, 50, 186–198.
Pomerantz, A. (1984) 'Agreeing and Disagreeing with Assessments: Some Features of Preferred/Dispreferred Turn Shapes'. In J. M. Atkinson and J. Heritage (Eds.) Structures of Social Action: Studies in Conversation Analysis. Cambridge: Cambridge University Press.
Prinz, J. J. (2011). Is empathy necessary for morality? In P. G. A. Coplan (Ed.), Empathy: Philosophical and psychological perspectives (pp. 211– 229). Oxford, England: Oxford University Press.
Raymond, G. (2003). Grammar and social organization: Yes/no interrogatives and the structure of responding. *American sociological review*, 939-967.
Sacks, H. (1984). On doing" being ordinary".(pp. 413-429) In JM Atkinson and J. Heritage (Eds.) Structures of social action: studies in conversational analysis: Cambridge, England: Cambridge University Press.
Schegloff, E. A. (1972). Sequencing in conversational openings. *Directions in sociolinguistics*, 346-380.
Schiffrin, D. (1987). Discourse Markers. Cambridge University Press, Cambridge.
Tannen, D. (1989). Talking voices: Repetition, dialogue and imagery in conversational discourse, Cambridge: Cambridge University Press.
Tannen, D. (1995). Waiting for the mouse: Constructed dialogue in conversation. Pp.198-217 in *The dialogic emergence of culture*, in Tedlock, D. and Mannheim, B (Eds). Chicago: University of Illinois Press.

Tannen, D. (2003). Power maneuvers or connection maneuvers? Ventriloquizing in family interaction. *Linguistics, language, and the real world: Discourse and beyond*, 50-62.
Tannen, D. (2004). Talking the dog: Framing pets as interactional resources in family discourse. *Research on Language and Social Interaction, 37*(4), 399-420.
Weatherall, A. (2011). I don't know as a Prepositioned Epistemic Hedge. *Research on Language & Social Interaction*, *44*(4), 317-33