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How clients solicit medication changes in psychiatry

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Abstract

In psychiatry, practitioners are encouraged to adopt a patient-centred approach that emphasises shared decision-making. In this article, we investigate how clients with severe mental illnesses (e.g., schizophrenia) advocate for their treatment preferences in psychiatric consultations. The study uses Conversation Analysis to examine audio-recorded medication check appointments in a comprehensive treatment program known as assertive community treatment (ACT). The analysis shows that clients solicit medication changes at activity boundaries and design them in one of the following ways: reporting a physical problem; reporting a medication problem; explicitly requesting a medication change; and demanding a change. These formats put pressure on the psychiatrist to respond by either offering a solution to the client's problem or by accepting or rejecting the client's request. Through a detailed analysis of clients' communicative behaviours, we show that, in soliciting a medication change, clients ordinarily respect boundaries of medical authority and present themselves as "good" patients who are reliable witnesses of their own experiences. Overall, the paper advances our understanding of patient advocacy in psychiatry and mental health interactions more generally.

Keywords

psychiatry; requesting medications; conversation analysis; provider-patient communication

Introduction

In psychiatric treatment, medication decisions were traditionally seen within an authority-centred model whereby patients present their symptoms and psychiatrists recommend corresponding medications to treat those symptoms. Since the advent of patient-centred medicine, however, consumer advocates have been advancing an autonomous self-determination approach where patients direct their treatment (Corrigan et al. 2012). Resting between these two approaches is the middle ground philosophy of shared decision making (SDM), defined as a collaborative process wherein clinician and patient share information about risks, benefits, preferences, and values related to a health care decision (Angell et al. 2015). SDM has been promoted in the field of psychiatry as a critically important direction for operationalizing foundational values of choice, self-determination, and empowerment

(Drake and Deegan 2009). In fact, “consultations for patients with chronic mental health conditions are increasingly conceived as meetings of experts: medical and experiential, respectively. Treatment decisions, in these terms, become a joint responsibility rather than handed down ex-cathedra” (Thompson and McCabe 2017).

Although SDM is promoted widely as a philosophy and style of practice, recent research suggests that it is only partially actualised in mental health treatment (Frosch et al. 2012, Matthias et al. 2012, Salyers et al. 2012, Woltmann and Whitley 2010). Observational studies of psychiatric practice show that even when clients and providers agree nominally upon treatment decisions, the process that leads to this agreement tends to omit important components of SDM, such as discussion of alternatives and negotiation about the client’s role in making the decision (Matthias et al. 2012, Salyers et al. 2012). Further, research into client preferences suggests that many desire a more participatory role and perceive acquiescence to their providers as both expected and naturalised (Adams et al. 2007, Woltmann and Whitley 2010). Yet, in chronic psychiatric care, the negotiation of treatment decisions is particularly delicate since patients might not possess awareness of their illness and may resist taking the medications, putting psychiatrists in the position of persuading clients to accept and adhere to the treatment (Carter 2003, Olfson et al. 2006). However, this exercise of clinician authority does not mean that decisions are necessarily made unilaterally and that patients are passive recipients of clinicians’ proposals. In treatments for chronic conditions, participation in decision making is more fruitfully viewed as a process which may unfold over the course of an encounter, or even multiple encounters (Say et al. 2006), and, in the case of psychiatric disorders, is inextricably tied to the context of an on-going therapeutic relationship (Matthias et al. 2013).

Understanding how such communicative processes unfold in actual interactions between psychiatric providers and their patients/clients requires methods that capture these processes *in situ*. Research into psychiatric interactions conducted in the conversation analytic tradition (Sidnell and Stivers 2013) has brought to light some of the ways in which psychiatrists make medication treatment recommendations. The analysis of actual recorded psychiatric consultations has shown that psychiatrists commonly present their treatment decisions as shared by designing their recommendations in ways that convey a degree of patient agency, formatting them as, for example, proposals, suggestions, and offers (Thompson and McCabe 2017). At the same time, psychiatrists tend to steer the treatment discussion towards a particular outcome. For example, psychiatrist may apply pressure on their clients by eliciting a commitment from them or direct them towards a particular treatment by marking it as a best option (Quirk et al. 2012). Psychiatrists may also design their recommendations so as to fit the client’s perspective (Kushida and Yamakawa 2015) and address the client’s concerns (Angell and Bolden 2015, 2016); they may also justify and account for their recommendations in ways that draw on their medical authority (Angell and Bolden 2015, 2016).

By focusing on the communicative work *psychiatrists* do to promote their treatment decisions, this research has provided an important but limited insight into shared decision-making processes. To advance our understanding of how *clients* advocate for their preferences, this paper examines communicative practices clients use to solicit changes in

their medication regimens – for example, to eliminate or lower dosages of psychotropic medications or to prescribe a new medication (see also Kushida et al. 2016). The present study thus advances our understanding of patient advocacy in mental health settings, adding to a small but growing body of conversation analytic literature on psychiatric interactions (e.g., Angell and Bolden 2015, 2016, Bergmann 1992, Bolden and Angell 2017, Kushida and Yamakawa 2015, 2018, McCabe et al. 2013, McCabe et al. 2002, Quirk et al. 2012, Thompson and McCabe 2016, 2017).

Across medical contexts, including psychiatry, soliciting a particular treatment from a medical provider is an interactionally difficult task for patients (Gill 2005, Gill et al. 2001, Robinson 2001, Stivers 2002a, 2007). First, medical consultations are organised so as to facilitate the medical provider in making a treatment recommendation (Robinson 2003). Doctors do not ordinarily invite medication requests from patients, and there is no structurally provided place for patients to make such requests. Second, medical treatment decisions fall squarely within doctors' professional expertise, which means that if patients are to solicit a medication, they are normatively expected to design their inquiry so as to respect the boundaries of medical authority (Byrne and Long 1976, Curl and Drew 2008, Drew and Couper-Kuhlen 2014a, Drew and Heritage 1992, Heritage 2013, Parsons 1951, Peräkylä 1998, Starr 1982, Stivers 2002a, 2007). In psychiatry, and especially in long-term psychiatric care, patients may have opinions about how well their medications are working for them, both therapeutically and in terms of side effects. However, their opinions may not be seen as legitimate by providers since patients lack professional authority to judge medication effectiveness and they might not have insight into their illness (Chong et al. 2013).

Given the delicacy involved in advocating for particular medical treatments, it is not surprising that, across medical contexts, patients rarely request a treatment explicitly. Prior research, conducted in primary and paediatric care, has found that when patients pressure medical providers for particular treatments, they ordinarily deploy a variety of implicit strategies, such as: producing a candidate diagnosis (e.g., ear infection) that implies a certain treatment (an antibiotic prescription; Stivers 2002a, 2007); stating their preferences, making inquiries, mentioning prior experiences with particular treatments; emphasising severity of their symptoms; citing precedents, third parties, or praising other providers who prescribed a desired treatment (Gill 2005, Gill et al. 2001, Robinson 2001, Stivers 2002a, 2007). These communication practices allow patients to advocate for their treatment preferences in rather subtle ways that respect doctors' professional authority and expertise with regards to prescription decisions.

Our findings both support and extend current understanding of how patients advocate for their treatment preferences. In line with the prior research, our analysis shows that, in psychiatry, clients commonly convey their preference for a medication adjustment implicitly rather than request a change directly, by either simply reporting a physical problem that might be a medication side effect or reporting a problem with a medication (15 cases). Further, when requesting a medication change explicitly (8 cases), clients ordinarily design their requests in ways that convey their orientation to the psychiatrist's decision-making authority and to the contingent nature of the request. However, unlike other medical settings

studied so far, clients in our dataset sometimes openly demand a medication change (e.g., “I want my meds lowered”; 2 cases), a type of solicitation that conveys the client’s entitlement to having the prescription changed. The analysis shows that ways in which clients initiate a medication change discussion are fitted to the context of their deployment, with more direct requesting practices typically used after the psychiatrist has raised the issue of medication in some way. The analysis also demonstrates that different ways in which clients communicate their medication preferences exert different kinds of pressures on the psychiatrist. First, when clients report problems they experience, the psychiatrist is put in a position to propose a treatment to address the problem. Second, when clients attribute a problem to a particular medication, in addition to offering a solution, the psychiatrist has to either accept or reject the client’s attribution. Finally, when the client requests or demands a medication change, the psychiatrist’s response is normatively constrained to either granting or rejecting the client’s request.

Setting, Data and Methods

This study examines psychiatrist-client interactions in the context of a comprehensive treatment service known as assertive community treatment (or ACT). ACT programs provide intensive community-based support via an interdisciplinary treatment team, frequently including social workers, nurses, psychologists, and a psychiatrist. Treatment plans are tailored to client needs, incorporating medication management, training in everyday life tasks, supportive psychotherapy, and assistance with gaining disability benefits and housing. A hallmark of the model is the assertiveness of efforts to offer services to clients, even if they exhibit reluctance or ambivalence about treatment. ACT services include the prescription and on-going (daily, if necessary) monitoring and delivery of psychiatric medications, ensuring that clients follow prescribed medication regimens. Our analysis focuses on how psychiatrists and clients negotiate on-going changes in medication type and dose during regularly scheduled consultations, commonly referred to as “medication check” appointments (see also Angell and Bolden 2015, 2016, Bolden and Angell 2017).

Within the ACT model, medications are a cornerstone of treatment and are provided via a long-term relationship with a psychiatrist, who is often employed directly by the program. Psychiatric appointments are scheduled at regular intervals as part of the program’s comprehensive medication support function, which frequently includes procurement and daily delivery of medications to clients in addition to prescribing and monitoring activities (Allness and Knoedler 2003). While the explicit purpose of these appointments is medication management, psychiatrists working within ACT tend to adopt a generalist orientation to treatment that involves discussing lifestyle issues (such as living arrangements, family relationships, and work activities) in addition to the medication regimen. Because of the variable course of serious mental disorders, psychiatric appointments serve to monitor the client’s stability and responses to medication, and to make adjustments to the medications in order to optimise the client’s capacity to cope with the illness and pursue personally determined psychosocial goals.

The data for this study come from audio-recordings of medication check appointments collected in 2009–2010 in an established ACT program in a mid-sized city in the United

Sates. We examined 36 audio-recorded interactions between a team psychiatrist and her clients (sometimes with a case manager present), each lasting between 15 and 45 minutes. In all of the recorded visits, the clients have been on various psychotropic medications for several years, and, as a result, have accumulated a substantial amount of knowledge about their functioning and side effects. All names and other identifiers on the transcripts are pseudonyms. Informed consent to audio-record and use collected data for research purposes was obtained from all participants.

The study uses the methodology of Conversation Analysis (Sidnell and Stivers 2013). The audio-recorded consultations were transcribed following conversation analytic transcription conventions (Hepburn and Bolden 2017). A collection of cases in which clients may be seen as soliciting (directly or implicitly) a medication adjustment has been analysed for this study (27 in total, from 15 consultations in which medication adjustment solicitations were found), with a focus on both positional and compositional features of these solicitations. The data excerpts included in the article are representative of the corpus and were selected for their clarity.

Sequential placement of medication change solicitations

Psychiatric visits analysed for this study have an explicit institutional agenda as “medication check” appointments. While other topics are typically discussed (such as the client’s living arrangements and family relationships), the medical agenda is evident throughout the visit (cf. Robinson 2004). A routine medication check appointment in ACT unfolds quite similarly to other medical visits (Robinson 2003), especially those dealing with chronic illnesses (Bolden and Angell 2017, Koenig et al. 2014). Following the opening of the visit, the initial phase of the appointment is *data gathering*, during which the psychiatrist asks a series of probing questions into how the client is feeling, thinking, sleeping, managing social relationships, etc. The clients in this data set have had a psychiatric diagnosis for a long time, so the issue is not whether they have a particular psychiatric condition but how well the condition is being managed by the current medications. These questions – not unlike history taking in other kinds of medical interactions – serve to evaluate how well the medications are working, both therapeutically to control the client’s psychiatric symptoms and in terms of the harmful side effects. Next, the psychiatrist offers an *assessment* of the client’s *current clinical status*. Subsequently, possible changes in the *treatment plan* – i.e., whether (and how) to modify doses or types of medication the client takes – may be discussed extensively (Bolden and Angell 2017).

We have found that clients’ initiations of medication change discussions typically occur at activity boundaries. As we show, clients may raise a medication change just as the psychiatrist begins the move into the business of the visit after the opening (see the discussion of Excerpts 3 and 4 below). Additionally, clients may launch the topic later in the visit, sometimes quite disjunctively, taking advantage of other activity transitions during the data-gathering phase (as in Excerpts 1, 2 and 5 below). The analysis suggests that the design of clients’ solicitations of a medication change relates to whether or not the psychiatrist has topicalised medications in some way, with more direct solicitation forms used in the environment of explicit topicalisation of medications.

The design of medication change solicitations

In this section we present different ways in which clients initiate medication change discussions, starting with less explicit turn designs that imply rather than articulate a request for a medication change and continuing with more overt request forms which exert more pressure on the psychiatrist to respond in a particular way.

Reporting a physical problem without attribution to medications

One way for the client to initiate a discussion of a medication change is to simply report a current physical problem that is hearable as a medication side effect (such as drowsiness, drooling, or tremor), without connecting it explicitly to a medication – similarly to the practice Stivers (2002b, 2007) refers to as “symptoms only” presentation. The client’s problem report invites the psychiatrist to offer a solution to the problem, leaving a particular solution entirely up to the psychiatrist. Problem reports may be offered in response to an initial inquiry about how the client is doing, following a prompt by a case manager who is present for some of the appointments, or, opportunistically, at other interactional junctures (as in the following excerpt).

In Excerpt 1, the client reports experiencing a tremor, a common side effect of several psychotropic medications. Immediately prior to this segment, the client and the psychiatrist have been discussing whether the client’s neighbours keep her awake. In responding to a more general question about her sleep (in line 1), which is a common diagnostic question in this setting, the client introduces a new issue – a tremor (line 5). While this is simply a description of a physical problem, the psychiatrist treats it as medication related one.

Excerpt 1: Tremendous tremor (205P; 13:45)

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1   PSY:    But now you're sleeping okay?
2   CLT:    Yeah:, but here's the thing I was trying to te:ll
3           (1.0) t!=Pamela before you showed up,
4           (0.8)
5   CLT:    t! Uh:m: (0.8) I'm having a (0.5) tremendous t- tremor.
6           (.)
7   PSY:    Okay.
8   CLT:    I ca[n't hardly:
9   PSY:    [yeah cuz we need to talk about- like kinda
10          the meds and meds side effects.
11          (.)
12  CLT:    I ehm (1.0) Well u(h)h heh heh .HH
13          an' this is how it is if I'm out in public,
14          (due to) eat or:: .hh a:n' I'm just like this.
15          If I go to the meal site: >I mean< I almost have
16          to get e- a stra:w. I ca:n't pick up the cup.
17          (.)

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18 PSY: >Okay.Is< it (ends) when you're doing things
19 that you notice it gets worse;=like if you're
20 trying t- (.) to dri:nk, or ea:t,

Observe, first, that the client simply reports a problem she is experiencing without any explicit suggestion about its possible causes. Given the long-term nature of the client's involvement in psychiatric care, she may well be aware that the tremor is a side effect of some of the medications she is taking. By simply reporting the problem without providing a diagnosis for it, the client orients to the diagnostic assessment as being outside of her (lay) expertise, thereby respecting the psychiatrist's professional authority. Second, in terms of its sequential placement, the client raises this topic opportunistically, packaging it as a response to an apparently unrelated question (about her sleep). Third, the client formulates the problem as a severe one – as “tremendous t- tremor” (rather than simply “tremor”). Using an extreme case formulation (Pomerantz 1986) may be a way to subtly pressure the psychiatrist to offer a solution, such as a medication adjustment (Robinson 2001). Additionally, in lines 2–3, the client prefaces this formulation with a reference to a prior conversation with the case manager (“Pamela”), thus presenting this as a problem that has been on her agenda to discuss, and thus, serious (Angell and Bolden 2016). Finally, even though the problem formulation makes no mention of medications, the psychiatrist sees it as medication relevant (as seen from her uptake in lines 9–10). After further unpacking of the problem by the client (in lines 12–16), the psychiatrist launches a series of diagnostic questions about the tremor (lines 18–20), and eventually proposes to reduce the dosage of one of the medications as a solution to the tremor problem (data not shown).

Reporting a medication problem

Another way to launch a discussion of a medication change is to report a problem with a particular medication or to report something as a side effect of a medication (cf. “candidate diagnosis” presentations; Stivers 2002b, 2007). When clients attribute a problem they experience to a particular medication, they constrain a range of appropriate responses, and thereby exert more pressure on the psychiatrist. Now rather than simply offering a solution to a problem, the psychiatrist is expected to validate (or reject) the client's attribution and to grant (or reject) the implicit request for a medication change (on physician responses to parental pressure for antibiotics, see Stivers 2002a).

Excerpt 2 takes place at the very beginning of the visit, before it has properly started. The psychiatrist is having trouble accessing the “med list” on the computer, and the case manager (CM), who is also present, is trying to help (data not shown). In lines 1–5, the psychiatrist is attempting to access the medication list, and is working on the keyboard. By voicing her difficulties in accessing the medication list, the psychiatrist indexes its relevance for the consultation. It is in this environment – in the transition to the consultation proper, where medications have been topicalised – that the client reports a problem with one of his medications, Risperdal (line 6). His report, thus, is topically occasioned – yet launches a new, disjunctive course of action, in the environment where the psychiatrist is otherwise preoccupied.

Excerpt 2: Like rock (232P; 1:15)

01 PSY: S:o then I do have to get on the computer.
 02 (0.8)
 03 PSY: to see:: h the med list.=Hh
 04 [(1.8)
 05 [((intermittent sound of keyboard up to end of line 10))
 06 CLT: **The Risperdal makes- makes me feel like ro:ck.**
 07 (0.6)
 08 CM: Yeah. ((from far away))
 09 CLT: **Might be too hi:gh.**
 10 (1.2)
 11 PSY: Can ye: (.) e- (.) Like a ro:ck?=
 12 CLT: =Like sto:ne.

Here, in contrast to Excerpt 1, the problem report explicitly names the culprit of the client's difficulties – Risperdal. By formulating a causal connection between a medication and his negative experience (feeling like a rock), the client offers a diagnosis and implicitly suggests a remedy – lowering or possibly eliminating the cause, Risperdal. Following no uptake from the psychiatrist (who is still on the keyboard) and a weak uptake from the case manager (in line 8), the client extends his problem report with “might be too high” (line 9). Here, the remedy – lowering the medication – is more explicitly invoked. Note, however, that the client downgrades this assertion with “might be,” displaying an orientation to the psychiatrist's authority on the matter. This shows that diagnostic assertions that attribute a negative experience to a medication tread on the psychiatrist's area of expertise and authority. Clients orient to the limited entitlement to make these connections by epistemically downgrading their assessments of the medication (Gill 1998, Heritage 2013).

Explicitly requesting a medication adjustment

Clients may also produce explicit requests for medication changes. Unlike problem reports (discussed above), explicit requests require the psychiatrist to respond by either granting or rejecting the requested medication change (Drew and Couper-Kuhlen 2014a, Stivers 2002a). Previous interactional research on requesting (e.g., Drew and Couper-Kuhlen 2014b) has shown that, across a range of languages and contexts, the design of the requesting turn is sensitive to a number of interactional considerations, including: how grantable or *contingent* the requested action is (Antaki and Kent 2012, Craven and Potter 2010, Curl and Drew 2008) and the speaker's *entitlement* (or lack thereof) to direct the addressee's actions (Craven and Potter 2010, Curl and Drew 2008, Heinemann 2006, Lindström 2005, Stevanovic and Peräkylä 2012). For instance, Curl and Drew (2008) found that speakers may display an orientation to a host of institutional (and other) constraints that might interfere in granting their request and their low entitlement to the requested action by deploying such forms as *I wonder if...* (and its variants). In our data, the delicateness of requesting a medication adjustment is enacted in the design of the requests (see also Kushida et al. 2016).

We find that clients tend to design their explicit requests for medication changes in ways that convey their low entitlement to making the request and high contingencies involved in granting it.

In Excerpt 3, the client initially reports a medication problem, and subsequently explicitly requests to discontinue the medication. The segment is taken from the very beginning of the visit, as the psychiatrist explains that the appointment is to see how things are going in light of recent medication changes. In line 10, the psychiatrist solicits an update with “what’s ↑up”, a typical question format for soliciting “chronic-routine” patient concerns (Robinson 2006). While not specific to the medications, in the context of medications just being presented as a reason for the visit, the question creates an opportunity for the client to raise his medication problems. In line 11, the client begins to report a problem with one of his medications, Geodon.

Excerpt 3: Geodon (213P; 0:40)

1 PSY: Well, (.) we haven't checked in in a while
2 an' we're kinda in the middl:e o:::f (.)
3 changin::: (0.2) the meds >a little<.
4 A::[n' so:::=
5 CLT: [Hm mm,
6 PSY: =I know they wanted you to come in an' jus'
7 see how things are goin'.
8 CLT: Right.
9 (.)
10 PSY: So what's ↑up
11 CLT: Uh::: we:ll, **Geodon's the problem now**=That's eh-
12 that's the one that'sh:: like the sedation
13 of it whatever it is; .hhh I keep getting a dro:wsy=
14 =sleepiness feelin',
15 (1.0)
16 CLT: .hh Uh::: (.) t! **I was wonderin' if you could take it awa:y,**
17 an' (.) make #e-um:: .hhhh li:ke uh:: whatever med I'm on
18 make it more higher or something;
19 (.)
20 CLT: to-to replace that or something;
21 PSY: Oka:y,
22 CLT: Cuz' that's the pro:blem=I seem like (0.2) I'm ge-
23 jus coming back to that dro:wsy sleepiness feeling.
24 PSY: Ok[ay
25 CLT: [that I- that I used to get back the:n, .h
26 PSY: So is it coming back, or has it been there all alo:ng.
27 CLT: It's kinda it's kinda coming back.
28 It hasn't been there for a-A whi:le ago it wasn't the:re,

It should be noted that the client takes several medications, some of which may cause drowsiness, so his claim (in line 11) that “Geodon is the problem” is very strong and thus potentially suspicious. The client immediately extends his turn to formulate a possible connection between Geodon and drowsiness. This extension is epistemically downgraded (with “whatever it is”). In the course of the extended report, the client replaces more technical terms “sedation” and “drowsiness” with a less technical one “sleepiness feeling,” thus displaying an orientation to treading onto the psychiatrist’s professional expertise (Kitzinger and Mandelbaum 2008). Following this problem presentation, there is a one second gap (line 15) where an uptake from the psychiatrist is due (such as, beginning of a series of questions into the reported problem). This lack of pursuit may be hearable as delegitimising the reported problem. In line 16, the client extends his turn further, now articulating an explicit request to discontinue Geodon.

The request is designed in the “I was wondering” format, which is a way to convey the client’s low entitlement to making the request and a high contingency of the requested outcome (Curl and Drew 2008). This format underscores the delicacy of the action and displays an orientation to respecting the psychiatrist’s professional authority on the matter. In lines 17–18, the client extends the request with the proposal to raise another medication he is taking. This is again produced quite tentatively (“whatever med I’m on”; “more higher or something”; “replace that or something”), which works to preserve the psychiatrist’s expertise and downgrade the client’s epistemic authority. At the same time, by offering an alternative, the client removes a possible hearing of his request as asking to be off his medications entirely, thus working to present himself as a “good patient” who understands the need for medications. The psychiatrist subsequently agrees with the client’s assessment that Geodon is the problem (“the culprit” in her words) and agrees to reduce the dosage.

This extract shows that soliciting a medication change is a delicate (and a dispreferred) action (Kendrick and Drew 2014, Robinson and Bolden 2010). In Excerpt 3, the explicit request is sequentially delayed, i.e. deployed when a more subtle method of reporting a medication problem receives no uptake. It is also mitigated in a variety of ways to preserve the psychiatrist’s decision-making authority and downplay the client’s own expertise.

Demanding a medication adjustment

Clients in our dataset also occasionally demand a medication change. These demands are designed as reports of a personal preference or desire: “I want something done”. This format orients to the psychiatrist’s institutional authority to prescribe and control the medications (by putting her in a position to grant or reject the demand), yet it presents the client as highly entitled to get his/her wish fulfilled. The high entitlement conveyed by this format may relate to the particularities of this institutional context, such as, clients’ long-term history with mental health care (and thus perceived expertise with various medications and their effects) and the subjective nature of many mental health assessments that are based, to a large extent, on clients’ own reports of their symptoms. While clients’ demands are initially produced as single turn constructional units (Sacks et al. 1974), they are subsequently accounted for, which indicates that clients still see the fulfilment of the demand as contingent on adequate justification.

Excerpt 4 is from an early part of the visit. In lines 1–5, the psychiatrist characterises the visit as “behind schedule” and sets the agenda as focused on medications. She then solicits the client’s acceptance of this plan (line 9). In response, the client immediately asserts that he wants to be taken off Seroquel (line 10).

Excerpt 4: Wanna be taken off (219P 1:35)

01 PSY: Since we 'ev/uh (.) work'd behind schedule,=Way o:ff,
 02 I'm gonna g- jus' get real focused today
 03 on the med issue.=So forgive me cus: (0.2)
 04 CLI: [°It's okay°
 05 PSY: [We have other things to talk about_
 06 (0.5)
 07 PSY: Um we'll catch up an: set up another time to do that,
 08 CLI: [Okay.
 09 PSY: [Does that sound oka[y?
 10 CLI: [I wanna be taken off Seroquel.
 11 PSY: >Why's that.<
 12 (.)
 13 CLI: Because I don't like the side effect that makes me
 14 eat like hors:e, a:nd .hh uh the side effect
 15 where if I have the opportunity:, to work past
 16 six o'clock, an' I take a medication, (0.2)
 17 a:n' it makes me sleepy, so: (0.2)
 18 I don't (.) like that.<An' Risperido:l (.)
 19 I've been [on that before
 20 PSY: [What time are you gettin it Franz?
 21 (1.0)
 22 PSY: The med the: (.)
 23 CLI: Between six an' eight.
 24 PSY: Okay. S::o: °let me grab your med sheet° he:re,

The form of the client’s solicitation (“I wanna be taken off Seroquel”; line 10) and its placement may be shaped by the psychiatrist’s characterisation of the visit as “behind schedule” and focused exclusively on medications. Specifically, the client starts his turn early, in terminal overlap with “Does it sound oka[y?” (line 9), and uses a very direct form (“I wanna”) and the name of a specific medication (“Seroquel”). In response (line 11), the psychiatrist immediately solicits an account, before any account might be volunteered by the client, thereby treating the client’s demand as accountable (Bolden and Robinson 2011). The quick production on this account solicitation (marked with >< on the transcript) continues to embody a “we are behind schedule” stance. In lines 13–18, the client formulates his reasons for his demand. He grounds wanting to be taken off the medication in its side effects – weight gain and sleepiness. The client emphasises the severity of the side effects, by using an idiomatic expression “eat like a horse” (cf. Drew and Holt 1988) and presenting

sleepiness not just as inconvenience but as interfering with his work. Then, in line 18, the client rushes through a possible completion of his turn constructional unit (Sacks et al. 1974) to bring up an alternative to Seroquel – Risperdal. In this way, he displays his willingness to continue with psychotropic medications, rather than to discontinue them completely. In overlap, the psychiatrist begins investigative questioning (line 20) and eventually agrees with the client to switch to Risperdal (data not shown). Thus, in this case, the form of the solicitation (i.e., the demand) may be sensitive to the interactional environment it occurs in. The high entitlement conveyed by the turn design is subsequently mitigated in the client's account (solicited by the psychiatrist), where the client works to produce justifiable grounds for the demand and to present himself as a reasonable and responsible patient (Robinson 2016).

In Excerpt 5, the client also uses a demand format (to have his meds lowered; line 3). Earlier in the visit, the client says that he is doing “terrible” (data not shown). Leading into this segment, the client and the psychiatrist are discussing whether or not the client practices safe sex. In line 1, the psychiatrist transitions back to the business of the visit, and the client uses this as an opportunity to demand a medication change (line 3). (There has been no prior discussion of medications.)

Excerpt 5: I want my meds lowered (211P; 4:45)

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01 PSY:    So we got a liddle off topic the:re unless::_
02      (1.7) u:m:
03 CLI:    I wan' my meds lowered.
04      (0.8)
05 CLI:    'S third time ya'll lowered mah meds for no reason.
06      First time's: (0.5) back in two thousan 'n six when
07      (.) .dhh Beth said (0.3) '↑oh he need 'is meds raised.'
08          an just c's Beth said it ya'll raised my meds. .Hh (.)
09      An' then second time was when I went to the hospital .hh
10      when a dude call the p'lice on me (0.6) because he w-
11      he was you- <he wasn' on the right medication.
12      (0.8)
13 CLI:    And uh: so he just decided the best way to get rid o' me
14      .hh was de lie to the police and tell em dat I wanna
15      kill 'im.
16      (0.4)
17 PSY:    Mhm:.
18 CLI:    .dhh No matter how you look at it I did not wanna kill
19      that ma:n. I knew he wun' doin no'hin' to: me,
20      (.)
21 CLI:    .hh Anyway 'e call'd th' police on me an > 'n then all of
22      a sudden I godda< go to a hospital:. .hh Ya'll raised my
23      meds fifteen milligrams fer that °shit°.

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24 (.)
 25 PSY: Mhm=
 26 CLI: =That's bull shit.
 27 (0.4)
 28 CLI: An' then uh: (.) all'a sudden, (0.5) three months
 29 ago,=ya'll raised my meds again.=It's bull shit.
 30 (0.2)
 31 PSY: .Hhh (.)
 32 PSY: ↓Mm hmm:↓,=
 33 CLI: =I wan' ma meds lowered.
 34 (0.5)
 35 CLI: Back to ten milligram:s.
 36 PSY: Oh Ro:[na::ld_
 37 CLI: [(Ten milligrams) Yap,
 38 PSY: Ten milligrams wadn't really helpin you much at a::ll.
 39 #back th[en.#
 40 CLI: [Yes it wa:s:.
 41 PSY: (Ah) Th't wasn't <↑my: recollection,>=

In line 3, the client solicits a medication change in a form of a demand “I wan’ my meds lowered.” When the psychiatrist produces no uptake (line 4), the client begins to account for the demand (lines 5–29; although he misspeaks on line 5). Unlike Excerpt 4, where the client grounded his demand in harmful side effects, here the client narrates a series of prescription decisions, which has resulted, in his view, in an unjustifiably high dosage. The psychiatrist responds with only a minimal uptake throughout the telling (lines 17 and 25), and a resistant continuer “↓Mm hmm:↓,” (line 32), where the client’s telling is possibly complete and an action-relevant uptake is due (Schegloff 1982). The client then reiterates his demand (“I wan’ ma meds lowered.”), and (after no uptake in line 34) extends it to specify the dosage (“Back to ten milligram:s.”; line 35).

In line 36, rather than begin investigative questioning (as we saw, for example, in Excerpt 4), the psychiatrist immediately rejects the demand with a dismissive ““Oh Ro:[na::ld_”. This *oh*-prefaced, prosodically exaggerated address term response (see Hepburn and Potter 2011, Heritage 1998) seems to treat the client’s demand as undeserving of a serious consideration. In lines 38–39, the psychiatrist justifies this rejection by claiming that the dosage the client wants was not therapeutic. The rest of the visit continues along these lines, with an open dispute about whether or not the client needs the medications. Overall, this segment shows that demanding a medication change may be an interactionally risky strategy if no appropriate account (i.e., an account based on clients’ own experiences with a medication) is provided.

Conclusions

This study has investigated interactional practices clients use to advocate for changes in their medication regimen. Indirect ways of reporting a problem, with or without an attribution to a particular medication, are commonly used by clients to initiate a medication change

discussion. This practice has an advantage of preserving the boundaries of medical authority and expertise – in fact, it invites the psychiatrist to draw on her professional expertise and offer a solution to the client’s problem. Additionally, problem presentations are more easily fitted into the organisation of a psychiatric visit, in that they can be offered in response to the psychiatrist’s initial inquiry into how the client is doing.

Clients may also use direct requests for medication changes. Such requests put more pressure on the psychiatrist to respond in a particular way, i.e., to either grant or decline the requested change. These requests are treated as accountable, and clients typically report their negative experiences with medications to ground the request. Clients ordinarily design their requests to convey low entitlement to making the request and high contingencies involved in getting it granted (Antaki and Kent 2012, Craven and Potter 2010, Curl and Drew 2008, Heinemann 2006, Lindström 2005, Stevanovic and Peräkylä 2012). Further, requests may be deployed after other, less direct methods, received no uptake. On occasion, however, clients launch a discussion of a medication change more forcefully in the form of a demand. This may be a risky strategy if no appropriate (that is, medication experience based) account is given (cf. Baranova and Dingemanse 2016). Data analysis also shows that more direct requesting practices tend to be used in contexts where the psychiatrist has raised the issue of medications in some way, providing more of a warrant for clients to request medication changes.

This study has examined ways in which clients in routine, long-term psychiatric care communicate their medication treatment preferences. Initiating a medication discussion is an interactionally delicate task for at least two reasons: first, clients need to find a way to raise the issue without there being a systematic opportunity to do so within the organisation of a routine appointment and, second, they have to articulate their medication preferences in ways that are sensitive to the fact that medical providers have the institutional authority to make (and in this psychiatric context, enforce) treatment decisions (Gill 2005, Gill et al. 2001, Robinson 2001, Stivers 2002a, 2007). These difficulties are further exacerbated for patients suffering from a severe mental illness since they may be seen as not having sufficient insight into their illness and because they may resist taking psychotropic medications, many of which have uncomfortable side effects (Velligan et al. 2010). Clients’ in-situ interactional solutions to these challenges involve raising medication discussions opportunistically and formulating and accounting for their medication preferences in ways that present them as “good” patients who are reliable witnesses of their own experiences and who respect boundaries of medical authority (cf. Angell and Bolden 2015). Thus, in spite of suffering from a severe mental illness, clients are able to act as subtle and tactical social beings to steer the interaction in a particular direction while maintaining an orientation to the psychiatrist’s professional authority.

Assertive community treatment programs, from which our data are drawn, have institutional mechanisms for enforcing medication decisions (through monitoring and delivery of medications). Yet, in our data, the psychiatrist makes efforts to listen to clients’ treatment preferences and, as we have shown in prior work, to achieve consensus about treatment plans (Angell and Bolden 2015, Bolden and Angell 2017). It may be worth pointing out that clients in our dataset rarely get precisely what they asked for, even when the psychiatrist

agrees that a medication change might be needed. For example, if a client asks to be taken off a medication, after an investigation, the psychiatrist may propose to lower the medication, begin a gradual shift to a different medication, adjust the regimen in some other way, or to postpone any changes until more tests are conducted. However, no matter what course of treatment is adopted, the psychiatrist works to ground the decision in the client's voiced concerns (Angell and Bolden 2015, Bolden and Angell 2017), thereby balancing her institutional authority with the sensitivity to building a trusting treatment relationship with her clients (e.g., Matthias et al. 2013).

The findings presented here have important implications for advancing shared decision making in psychiatry. Previous research suggests that patients hesitate to assert themselves in clinical encounters out of deference to clinician authority (Frosch et al. 2012, Woltmann and Whitley 2010). It is not enough, therefore, to exhort psychiatrists to listen to their clients' preferences when they express them; rather, it may be necessary to train them to create explicit openings for their patients to articulate their experiences, such as, for example, explicitly raising medications as a discussion topic. Additionally, patient advocates in the United States have been creating and testing electronic decision support systems that create a list of items the client may want to bring up in their psychiatric session (Angell et al. 2015). Psychiatrists are then trained to ask the clients about what is on their checklist of concerns. The research presented here suggests that it would be useful to examine the extent to which shared decision making interventions promote opportunities for clients to solicit medication changes and how they are responded to by practitioners.

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