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Abstract

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



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

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

0 Introduction

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

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

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

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

37 Relevant Literature

38 Whereas historically dominant framings of disability have tended to indi-
39 vidualize and pathologize the phenomenon of disability, over the last

40 decades the field of (critical) disability studies has challenged such fram-
41 ings by shedding light on its social and cultural dimensions (Goodley
42 et al., 2019). There has been a growing concern for the role of discourse,
43 since “what is understood or accepted to be a ‘disability’ is socially and
44 culturally located and constructed via discourse” (Lupton & Seymour,
45 2003, p. 248).

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

61 The lack of a clear and univocal biomedical cause for chronic pain
62 may render also the everyday functioning of patients with chronic pain
63 to be treated as an accountable issue. Various studies have in fact
64 addressed that the lack of a clear biomedical explanation may threaten
65 patients’ credibility. For example, several interview-based studies have
66 reported that patients indicate fearing or actually experiencing others,
67 including healthcare professionals, questioning the legitimacy of their
68 complaints and consequently their moral characters (e.g. Åsbring &
69 Närvänen, 2002; Anne Werner & Malterud, 2003; Holloway et al.,
70 2007; Nettleton, 2006). Other researchers found that their interviewees
71 with chronic low back pain actively constructed themselves as believable
72 narrators of their own pain experiences (Ong et al., 2004; Snelgrove &
73 Lioffi, 2009). It is worthwhile to examine how such interactional work
74 takes shape in real-life conversations about chronic pain and disability
75 between patients and their practitioners (Stinesen et al., 2019).

Theorizing Disability and Discursive Psychology

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

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

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

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

128 **Methods**

129 **Data**

130 Our analysis focuses on the patient’s first consultation at the rehabilita-
131 tion unit: the admission interview. As much is at stake for both patient
132 and practitioner, these interviews can be challenging. During the admis-
133 sion interview, the practitioner (usually a rehabilitation physician or
134 physician assistant) assesses whether the patient is eligible for treatment
135 from a biopsychosocial perspective on pain and disability (Swaan et al.,
136 2019). The interview functions to identify causal and maintaining factors
137 that contribute to the patient’s pain and disability. The practitioner also
138 aims to assess which of these factors potentially could be targeted to
139 increase the patient’s functioning, and most importantly, whether the
140 patient is open to and willing to undergo such an approach. Patients,
141 however, may enter the consultation with specific hopes and expecta-
142 tions regarding the consultation, such as to receive a clear biomedical

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

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

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

162 Data Analysis

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

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

175 to study such dynamics in detail, we coded all fragments in which partic-
176 ipants addressed the effect of pain on the patient's ability to perform daily
177 life activities.

178 According to discursive psychology, social realities are constructed
179 through language, as people interact (Edwards & Potter, 2001). In the
180 next stage of our analysis, we started *describing* the ways in which
181 patients and practitioners constructed the patient's ability or inability
182 to engage in certain activities. We made notes on the fragments in our
183 collection in terms of *what* was being constructed (content), *how* it was
184 being constructed (style and structure) and *when* it was produced within
185 the sequential organization of the conversation (situatedness) (Wiggins,
186 2017).

187 In the following stage, we examined the functions of such construc-
188 tions, as discursive psychology is particularly concerned with the social
189 actions participants in interaction perform (such as making compli-
190 ments, making requests, complaining, and specifically, managing issues
191 of stake and accountability) (Wiggins & Potter, 2017). In order to iden-
192 tify social actions, we used the discursive devices that are available in
193 our data as analytical tools to "help us to 'unpack' interaction" (Wiggins,
194 2017, p. 176). These discursive devices are specific features of talk that
195 help participants to perform social action and have been found to be
196 recurrent in diverse interactional contexts previously studied by other
197 researchers (Wiggins, 2017).

198 Validating Procedures

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

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

217 Findings

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

227 **Willing but Unable: Building Authenticity of Pain** 228 **and Pain-Related Disabilities**

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

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

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

242 **Extract 1A (admission interview 1)**

1. Pa: .hh ja hh
 .hh yes hh
2. (1.3)
 (1.3)
3. °ik° (.) kzal altijd proberen om mij niet
 243 °I° (.) I'll always try not to
4. ziek te melden tenzij dat dat niet anders gaat,
 call in sick unless there is no other way,
5. Pr: hmhm
 hmhm

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

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

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

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

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

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

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

288 After a 1.7 intra-turn pause (line 9), the patient provides an answer
289 to this question by adding ‘and then it depends on how much pain
290 I have (0.7) or else I just lie down in bed.’ (lines 10–12). Discursive
291 psychology attends to how participants in interaction often make rele-
292 vant their level of agency in a particular course of events (Wiggins, 2017).
293 That is, they may position themselves as an active agent (e.g. as having
294 the capacity to act/decide) or a passive subject (e.g. as having no choice
295 but to undergo something), or somewhere in between. By doing so,
296 speakers also make available inferences regarding the extent to which they
297 can be held accountable for an event or behaviour (Edwards & Potter,
298 1993; Wiggins, 2017). In line with our observations in Extract 1A, we
299 see that in lines 10–12 the patient constructs himself as having limited
300 agency regarding his behaviour, which is now specified as lying down in
301 bed. Whether or not to lie down in bed is presented as an outcome that
302 depends on a bodily experience: ‘how much pain I have’. And, it is being

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

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

332 **Practitioners' Challenges to the Self-evidence**
333 **of a Patient's Disability**

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

348 **Suggesting Directions for Treatment that Involve**
349 **a Behaviour Change**

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

356 **Extract 2A (admission interview 2)**

1. Pr: e:hm (0.8) stel dat wij zouden zeggen tegen u
e:hm (0.8) suppose that we would say to you
2. ehm (2.4) pij- 'f eh ;ja be|wegen kan geen kwaad?
ehm (2.4) pai- 'r eh ;well ;moving does no harm?
3. (1.5)
(1.5)
4. ga [maar gewoon doen.
just [go do it.
5. Pa: [hmm.
[hmm.
6. Pr: wat zou dat-,
what would that-,
7. wat zou d'r dan (0.8) ge|beuren wat eh
what would then (0.8) ;happen what eh

357

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

367 During the description of the hypothetical situation, the word 'pain'
368 is aborted and followed by a repair "r eh ↑well ↓moving does no harm?"
369 (line 2). Note that the version that *pain* does no harm, could potentially
370 be problematic, as it could be understood by the patient as brushing
371 aside the problems and complaints which he has presented as a conse-
372 quence of his pain. In spite of the repair, the hypothetical question is
373 followed by a 1.5 silence (line 3), as no answer is being provided by

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

384 Interestingly, the team's hypothetical suggestion to 'just go do it' (line
385 4) does not merely underline the message that moving does no harm. The
386 word 'just' also downplays potential challenges or difficulties associated
387 with moving, and it presents moving as an ordinary thing to do. This is in
388 line with previous studies that have illustrated that 'just' can function as
389 a minimisation and normalisation device (see for example, Clarke et al.,
390 2004). In this case, to 'just' go do it implies that there are no obstacles
391 to be expected, and that moving is something the patient *could* do, or in
392 other words, *should be able* to do.

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

405 **Extract 2B (admission interview 2)**

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

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

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

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

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

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

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

460 **Treating the Patient's Current Behaviour** 461 **as Insufficiently Accounted for**

462 The next extract, Extract 3, takes place later on in the same admission
463 interview. The extract starts approximately five minutes before the end
464 of the consultation with another example of the practitioner suggesting a
465 change in behaviour (Extract 3A), after which the practitioner constructs
466 the patient's current behaviour as insufficiently accounted for (Extract
467 3B).

468 **Extract 3A (admission interview 2)**

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

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

476 After reminding the patient that the team is unable to take away
477 the pain, the practitioner provides a description of what their focus is
478 on instead: 'despite the pain complaints to nonetheless (.) ↑move, and
479 < in that > (0.9) to go do something,' (lines 6-7). Like in Extract
480 2AA, the practitioner manages to distance herself from any inferences
481 regarding the patient's ability. This time, the pronoun 'we' (line 4) works
482 to construct movement despite the presence of pain complaints as some-
483 thing the rehabilitation team, in a general sense, aims for. Thus, the
484 practitioner refrains from explicitly referring to what is expected from
485 the patient.

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

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

501 **Extract 3B (admission interview 2)**

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

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

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

518 By constructing the patient's coming to a standstill as insufficiently
519 accounted for, the practitioner undermines the self-evidence of the
520 patient arriving at such a state. Also, this construction suggests that the
521 patient's coming to a standstill cannot be explained by the presence of
522 pain only, as there must be more to it. Note that the hedges within the
523 practitioner's delivery mark the talk as delicate (Wiggins, 2017). The talk,
524 for example, appears hesitant and includes several pauses within the prac-
525 titioner's turns (lines 9, 11, 13, 15, 19). Also, the origin of the patient's
526 coming to a standstill is presented by the practitioner as not 'quite clear'
527 (line 10) to *her* (line 9) (rather than, for example, totally and in general
528 'not clear'). In addition, the evidentially downgraded assessment that the
529 patient *seems* to come to a standstill (line 19) diminishes the practitioner's
530 claim to know (see Sidnell, 2012). Finally, we can see that the practi-
531 tioner orients to the delicacy of her account, as she takes a detour in lines
532 13–17. That is, after a 0.7 pause (line 13), she produces the following
533 disclaimer: '(bec'z) those are there, those those- (0.5) > I eh I don't say <
534 >>that they are not (t) < <,' (lines 14–16). Thereby, the practitioner pre-
535 emptively counters any inference that she would have doubts regarding
536 the authenticity of the patient's pain.

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

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

550 **Patients as Active Agents: Issues of Agency** 551 **and Blame**

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

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

568 **Extract 4A (admission interview 1)**

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

570 Extract 4A provides another example of a treatment recommendation
 571 that implies a change in the patient's behaviour, that is, 'having a look
 572 at whether you > can get the functioning in general somewhat more
 573 ↑stable.' (lines 3–5). Just as in the previous examples, the suggestion of a
 574 behaviour change is delivered in a rather cautious way, this time, by using
 575 a script formulation: if you then (i.e. given the findings of the physical
 576 examination) think about rehabilitation (line 1), 'hh then rehabilitation
 577 is primarily focused on < having a look at whether you > can get the
 578 functioning in general somewhat more ↑stable.' (lines 2–5). This *if-then*
 579 formulation, in which the generic you is being used, works to present
 580 this course of events as a universal, institutional routine (see Edwards,
 581 1994). It makes relevant what rehabilitation is about in general, and at
 582 the same time it marks the talk as tentative ('if you think about..', line
 583 1), so that it avoids putting the patient on the spot. Hepburn and Potter
 584 (2011, p. 231) have noted that such scripting "may be a useful device
 585 in advice giving (especially where there is resistance) as it avoids a stark
 586 ad hominem suggestion". Also research on healthy eating advice during
 587 family mealtimes has illustrated that generic advice is less likely to have

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

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

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

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

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

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

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

634 **Extract 4C (admission interview 1)**

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

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

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

651 **Discussion**

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

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

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

679 Awareness of such identity concerns is important for better under-
680 standing why patients may challenge particular types of expert knowl-
681 edge (Versteeg & te Molder, 2019), such as the knowledge about chronic
682 pain and pain rehabilitation presented by the practitioners in our study.
683 Patients in our study challenge such knowledge primarily on the basis
684 of their own experiential knowledge of living with pain and disability,
685 to which the practitioner does not have epistemic access (cf. Heritage,
686 2011).

687 Such dynamics become clear, for example, when we consider reha-
688 bilitation practitioners' descriptions that suggest that patients can be in
689 control of their own lives. We have shown, for example, that they may
690 construct their patients as active agents, thereby making available the
691 inference that patients themselves are in charge. Our analysis has revealed
692 that such constructions may backfire, however, as they also make avail-
693 able issues of accountability and blame. Therefore, they may provoke
694 defensive responses, in which patients draw on their experiential knowl-
695 edge to underscore the realness of their inability. Future research on

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

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

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

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

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

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

760 Conclusion

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

765 on disability so far have first and foremost addressed how participants in
766 interaction may negotiate (dis)abilities in the context of mental health
767 problems (see, e.g., Fasulo & Fiore, 2007; Lester, 2014; Rapley et al.,
768 1998). In this study, however, we adopted the discursive psycholog-
769 ical research perspective to study patient–practitioner interaction about
770 chronic pain-related physical disabilities. In line with Wiggins’ (2014)
771 theoretical notion of ‘discursive bodies’, we have paid close attention to
772 how the features, functions and limits of patients’ bodies are produced
773 in and through patients’ and practitioners’ talk. Our analysis has illus-
774 trated that, in interviews on admission to chronic pain rehabilitation
775 programmes, patients’ pain-related disability is not treated as a matter
776 of course. Disability is in fact negotiated throughout these interviews.
777 Thus, on a theoretical level, our analysis has illustrated that discursive
778 psychology allows for a counter-perspective to the notion of physical
779 disability as a static construct and it contributes to the growing body
780 of research that suggests that (disabled) bodies are located in discourse.
781 Moreover, our study has shown that the discursive psychological research
782 perspective provides for a rich and nuanced understanding of how
783 disabled bodies may be negotiated in interaction. That is, it specifically
784 lends itself to reveal the delicacies of such negotiations. It has become
785 clear, that patients’ and practitioners’ negotiations of patients’ disabil-
786 ities are subject to issues of agency, accountability and blame. These
787 insights may help practitioners to reflect on and further develop their
788 communication practices.

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Chapter 4

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