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Peräkylä, Anssi

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Invoking a hostile world: Discussing the patient's future in AIDS counselling*

ANSSI PERÄKYLÄ

Abstract

Conversational practices related to talk about future in AIDS counselling are analysed in this paper. A particular type of questioning is examined, where the counsellor's description of a hypothetical future situation is followed by an enquiry focusing on the patient's fears or ways of coping in this particular situation. It is argued that a favorable conversational environment and management of the epistemological framework of the discourse are key factors facilitating the patients' answers to such questions. The observations are tied with discussion about construction of 'reality' in conversation.

Keywords: *AIDS counselling; conversation analysis; counselling; dying; future; hypothetical questions.*

Introduction

The AIDS epidemic has brought with it new professional practices, one of which is AIDS counselling. In many countries, people who come for an HIV test are counselled by medical professionals, and those diagnosed as HIV positive are offered regular support through counselling given by social workers, doctors, psychologists or nurses (Carballo and Miller, 1989; Chester, 1987).

One of the most central tasks of AIDS counsellors, in particular when dealing with people already diagnosed as HIV positive, is to prepare their patients for dreadful things happening to them in the future (George, 1989). Their future may include phases of illness, deterioration and finally death caused indirectly by the virus. In the counselling sessions, the patients are encouraged to confront these future possibilities and helped to find ways of coping with them. In this paper, conversations between AIDS counsellors and their clients about the future will be examined.

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The future as a linguistic construct

If any two or more persons talk about the possible death or possible illness of somebody who at the moment is not dead or ill, they are creating a possible world, an alternative reality, through linguistic means. They are not talking about the world as it appears at the moment around them, but about the world as it can be imagined.

Michael Moerman (1988) has recently argued that the practice of conversation is our major means in producing reality. In conversation we 'put our minds together by building a world to co-inhabit' (Moerman, 1988: 119). This holds true for what we call 'objective' realities as well as for those which we call 'fantasy'. By noticing the objects around us through conversational means, Moerman argues, we orient ourselves and our co-conversationalists towards them. By talking about our fantasies we invoke them as an intersubjective reality, which we can invite others to co-inhabit.

Words have the power to invoke realities. Perhaps that power makes us sometimes very reluctant to put things in words: we may want to avoid bringing about realities that are difficult for us to cope with. But people have also — e.g., in religious practices and psychotherapy — recognized the healing potential of words. In the protected environment of confession or therapy, invoking a threatening reality may lead us to find ways to deal with the threats.

The use of words to invoke realities is, then, a key aspect of social practices which Berger (1967: 80), following Weber, calls 'theodicies'. The human experiences of evil, suffering and death require a societal response which renders them meaningful and thus bearable. This response has been, and is, carried out largely (though not exclusively) through the use of words, ritualized or situationally composed.

Generating talk about illness and death, when the patient is not very ill, is an essential part of the work of the AIDS counsellors. It is believed that through talking about potentially dreadful aspects of their future, the patients can be helped to cope with their fears, and also to prepare themselves in practical terms for what might happen (Miller and Bor, 1988; Bor and Miller, 1988).

Invoking a 'hostile world' (Moerman, 1988: 119) of illness and death, and inhabiting that together with the patient during the counselling session, is achieved through a consistent and skillful use of a limited number of linguistic devices. In the following, I will examine some details of the conversational practices involved in this. In particular, I will examine how the counsellors, during the course of the interview, introduce and constitute as sensitive issues such as illness and death. My observa-

tions will focus on the sequential organization and the intra-turn design of the counsellors' questions and the patients' answers in sessions involving such talk.

Data description

The results presented in this paper are a part of a larger research project on HIV and AIDS counselling, recently completed at the Department of Sociology, University of London Goldsmiths' College. The data used in this paper are video recordings from counselling sessions at two clinics in a London teaching hospital. The bulk of the data is from the Haemophilia Centre of that hospital, and some additional data has been collected from the HIV/AIDS clinic of the same hospital.

The HIV/AIDS counselling sessions in this hospital are routinely video-recorded, with the purpose of using them for preparation of future sessions with the same clients, and in teaching and research. Recordings are only made if the patients give their consent. For this paper, 27 sessions were studied; 7 counsellors and 20 patients were involved in these sessions. Some of the sessions were one-to-one counselling, but in most of them, two or even three counsellors were present; and there were often more clients than just one (the patients and their family members or partners). Most of the sessions involved haemophiliac patients carrying the HIV virus;[1] only two were pre-test counselling. From the 27 interviews, all the episodes involving talk about the patient's future were transcribed. There were 76 such extracts, making altogether 6 hours of talk.

For the reader, the counsellors' questions in some of the cases presented below may appear as odd — not only because of their content, but also in terms of the turn-taking. Therefore, a brief comment about the modifications of the speech-exchange system in these sessions may be needed. In the clinic observed, counselling methods based on Milan School Family Systems Theory (see, e.g., Hoffman, 1981; Campbel and Draper, 1985) have been consistently applied and developed. This counselling theory has direct consequences to the organization of the conversational interaction between counsellors and patients.

In the practice which in the Family Systems Theory is called 'circular questioning', the counsellor asks one client a question concerning another client's inner experience, before posing the same question to the person himself (see Peräkylä and Silverman, 1991). In 'direct open supervision', the co-counsellor (C2) first addresses a question, targetted to the client, to the main counsellor (C1).. Thereafter C1 may relay the query to the client, or alternatively, the client may respond immediately (Peräkylä, 1992, Chapter 4). 'Circular questioning' is applied in extract (3), and 'direct open supervision' in extracts (7), (10) and (11).

Methods of building a possible world

Basically, in my corpus there appear to be three methods which can be used in the invocation of the world of illness and death. In the following, I will briefly introduce two methods, and thereafter analyse in detail the third one.

Firstly, the counsellor may offer the client an opportunity to name any issues he or she might want to raise during the session. Typically, this is done through eliciting the client's 'concerns'. As a response, in some cases, the client produces a description of his or her fears concerning a distressing possible future situation. Extract (1) is an example of the use of this technique.

(1) ((C = Counsellor, P = Patient, W = Patient's wife))

1	C:	(1)→	Can I just ask you what are your greatest
2			conce:rns:: (.) Liz.
3	P:		[Liza
4	C:		[Liza: I ca:n't get it [( )
5	W:		[((coughing))
6	C:		Liza about- .hh (.4) at this mo:ment in ti:me. (.)
7			can you s:ay alou:d.
8			(3.0)
9	W:	(2)→	Erm:: (.) the uncertainty[:?
10	C:		[mmh:
11			(1.5)
12	W:		obviously:? (.6) an::d (3.0) trying to get John to
13			cope with it (.2) an:d-(.3) lead as normal a life as
14			possible? (.) I'd (.) I don't see .hhh (1.0) I don't
15			really see any f::easible r:ealistic alterna:tive.=
16	C:		=mm:h
17			(.5)
18	W:		than (.) (both) to carry on:: (.3) as (.) as
19			no:r[mal.
20	C:		[mmh
21			(1.6)
22	Baby:		gjuu
23			(.7)
24	W:		an::d (1.6) what would happen to me:?
25	W:		mmh
26	W:		and the children (2.1) if he did devel[op something?
27	C:		[mmh
28			(.2)

29 C: mmh
30 (.6)
31 C: (3)→ What's your greatest fe:ar about that?

In (1), W responds to C's elicitation by proffering the gloss 'uncertainty:' (arrow 2). The counsellor encourages W to produce more through her continuers and silence. A long narrative by W ensues, ending up with the delivery of the description of a distressing future situation 'what would happen to me:? and the children (2.1) if he did develop something?' Now the counsellor can generate further discussion about the worry (arrow 3).

Another method that the counsellors use in the invocation of a threatening future world involves topical stabilization (Jefferson, 1984) of a worry indicative theme that has appeared in the patient's prior talk. In response, the patient may explicate his worry in terms of a fearful future situation. We can see that happening in extract (2) below.

(2)
1 P: (...) you know I mean I've had a really (0.2)
2 sort of a quite a hectic weekend, quite a busy
3 ti:me, =and it's not as though I've been sitting
4 down moping again. (0.6) But you know it's just
5 sort of like as though- as though it just
6 clicks:. (0.5) And then I think
7 (1)→ it will all ( ) what's going
8 to happen wi:th (.4) so and so if you know what
9 I mean.
10 C1: (2)→ Can I (s[ay) what's your greatest (0.6) fear=
11 C2: [( )
12 C1: =for th- what might happen.
13 (0.3)
14 P: My greatest fear:?
15 C1: Mm
16 (0.7)
17 P: (3)→ Uh::m (1.5) Well obviously at the moment I mean
18 I don't (.) particularly want to get aids or
19 nothing like that. (0.5) You know (.) but I
20 still suppose there's- there is that on the
21 back of your mind still. And I know
((continues))

In (2) the patient first alludes to his thoughts concerning the future (arrow 1), whereafter the counsellor produces an explicit query about his fears (arrow 2). This leads the patient to begin to talk about AIDS (arrow 3).

The third method used in invoking a world of illness and death nvolves hypothetical questions. In such questions, the counsellor first produces an initial description of a possible future situation, thereafter invting the client to discuss it.

In Family Systems Theory, the applicability and the power of hypothetical questions has been recognized and discussed (Penn 1985). Themanual of AIDS counselling produced in the clinic that my data is from, trongly recommends such questioning. It is argued that hypothetical qiestions make it possible to address '"dreaded issues" about loss, disfigurement, death and dying ... in a way that encourages patient to talk about them' (Miller and Bor, 1988: 17). Below, I will analyze segments of talk involving hypothetical questions, trying to find out the interactional pɒperties which make them so useful in AIDS counselling.

The perspective on the future in hypothetical questions

Hypothetical questions are exemplified in extracts (3)–(5).

(3)

C1: A:nd (1.6) from what you know: of Ga:ry I mean: (2.0) if it was to be positive what d'you think his main concern would be?
(1.4)
C1: [Or how d'you think- (.3) how would you see him=
(P): [( )-
C1: =coping.

(4)

1 Cl: s : : S a y : : (.2) we can't say and you can't say,
2 P: Ye[ah
3 Cl: [but say you did begin to get i:ll (0.8) or say
4 you got so ill that you couldn't kind of (0.2) make
5 decisions for yourself. = who would (.4) you have to
6 make them for you:. (.3) Who do you: (.2) consider
7 your:

(5)

1 C: .hhhh If Christian die:d (1.0) in the next=
2 P: =Mm
3 C: few months
4 P: M[m
5 C: [I'm not saying he's going to but if he did. = how
6 would that change your life.

In (3), the clients are a gay couple. The counsellor elicits the view of one party (who has just been diagnosed as HIV positive) about the concerns and ability to cope of the other party, should he also turn out to be positive. In (4), the counsellor asks the patient who he would like to make decisions on his behalf, if he became so ill that he couldn't make them himself. Finally, in (5), the counsellor asks the patient how his life would change if his brother should die (both the patient and his brother are HIV-positive haemophiliacs). All these questions follow the pattern recurrently appearing in this type of enquiries made by the counsellors: a description of a possible hostile future situation is followed by a question orienting to the client's fears or ways of coping in this particular situation.

The perspective on the future established by these enquiries is radically different when compared to the perspective entailed in the two other methods mentioned earlier. In eliciting and reporting concerns, or in the conversational moves involving topicalization of worry indicative themes in the patients' prior talk, the counsellors and the patients usually preserve the present moment in time as the time point establishing their perspective. In other words, they elicit and proffer descriptions of the patients' current fears or worries, concerning their future. Hypothetical questions involve a more radical departure from the present time. In them, the objects of the patients' fears are assumed to have been realized. The counsellors invite the patients to examine their (or their relations') life in the hypothetical world at some future point where the dreaded crisis is either taking place, or has already taken place.

In AIDS counselling, hypothetical future oriented questions are delivered in a manner that displays the counsellors' orientation to the issues raised in the questions as delicate matters. At least two kinds of considerations are taken into account by the counsellors: The hypothetical questions are produced only in specific conversational environments, and in producing them, the epistemological status of the description of the possible hostile future is often attended to.

The favorable conversational environment

The counsellors never produce hypothetical questions involving descriptions of a distressing future situation 'out of the blue'. Only when the participants' prior talk has provided a proper environment can they be delivered. A proper environment is one where the possible future situation has already been hinted at, but not yet explicated. Extracts (3)–(5) each were preceded by such hints.

(3) [Extension]
C1: What d'you think at the moment Gary's main concerns.
are.
(1.5)
P: hhhhh (1.0) Of course he's very concerned about my
health.
C1: Mm:
(0.6)
P: You know (and what-) (.4) what I'm going through:,
(.2) Of course he has to be concerned about
himself. = Worrying .hhhh
C1: Have =
P: = about the test for him[self of course,
C1: [umh
C1: M[m:
P: [A:nd the doubts he may have:, er[:
C1: [Have you just had
the test[t Gary?
BF: [Yes I have.
P: Uhm
(.3)
C1: A:nd (1.6) from what you know: of Ga:ry I mean:
(2.0) if it was to be positive what d'you think his
main concern would be?

(4) [Extension]
P: (Can you-) (.) what are the main uhm symptom- (0.5)
what actually does pneumonia (.3) do to you? (.4)
Once it's ( ) (within your system).
C2: It gives you a cough,
P: Yeah.
C2: breathlessness
(3.5)
C1: Are these things you've thought about before or not
really.
(2.0)
P: Uh::m (.2) Sorry what d'you mean- what
(lik[e the-)
C1: [All these this discussion we're having
about. = Symptoms and things.
(0.4)
P: Yeah I had (.2) I have thought about

[them, = [(as I said) I thought before: mo:re =
C1: [Mm
P: = so [that (.2) err: (1.0 ( ) that I am =
C1: [Mm
P: = thinkin more- (.4) about them more now because
(.6) I'm a little bit more settled in this
work (.) [job. And if it's (you sort of) =
C1: [Right.
P: = ( ) (so now: I've got more) time
(I) will be-
C1: ([ )
P: [(actually) taking a [leave (so)-
C1: [s : : Say : : (.2) we
can't say and you can't say,
P: Ye[ah
C1: [but say you did begin to get i:ll (0.8) or say
you got so ill that you couldn't kind of (0.2) make
decisions for yourself. = who would (.4) you have to
make them for you:. (.3) Who do you: (.2) consider
your:

(5) [Extension]
C: .hh Now last ti[me you came to the orthopaedic =
P: [Mm
C: = clinic (0.5) you wanted to [have your: (.3) knee =
P: [Mm:
C: = done. [What d'you feel about that now.
P: [Mm:
(.3)
C: Because that means being in hospital for weeks,
(0.6)
P: Yeah I know: I don- I don't know: I just don't know
what to do. = I mean if Christian's ou:t I mean er
(0.5) I ju- I just don't know:. (0.8) To be honest I
really don't know.
(2.6)
P: er: And things are getting a bit (.) complicated
with- because he- he s- he seems to me to be getting
much worse.
(1.2)
P: Especially er er- medically anyway. A:nd you know
it's very hard to know what to do:,

21 C: .hhhh If Christian die:d (1.0) in the next=
22 P: =Mm
23 C: few months
24 P: M[m
25 C: [I'm not saying he's going to but if he did.=how
26 would that change your life.

In (3), P2's (Gary's) partner is first asked to describe P2's main concerns. As we can see, the counsellor uses the topic elicitation procedure mentioned above. In the course of his response, P1 (who has recently tested positive) asserts that P2 is very likely to be concerned about the test for himself (lines 9–12). As a response to this, the counsellor first checks with P2 that he has just had the test; and thereafter, she producesa her turn where she nominates the stressful possible future situation: 'if it was to be positive'. The counsellor prefaces her turn with 'An:d', which emphasizes the continuity between the preceding talk (probably the factual enquiry in lines 16–17) and the forthcoming question (cf. Sorjonen and Heritage, 1991). Thus, in (3), the counsellor seems only to have spelled out what already was implicated by the patient; or to put it in the terminology of Jefferson (1986), the counsellor 'unpacked' the 'gloss' that the patient had initially produced.

In (4), the patient first asks the counsellor about pneumonia.[2] After giving a short answer to the patient's question the counsellor asks him whether he has thought about these kind of things before or not. The patient responds by asserting that he is now thinking about them more than he did before. After that assertion, the counsellor produces her description of the possible future situation, where the patient would be too ill to make decisions about himself. Thus the counsellor produced the description of the hostile future, not only following the patient's questions involving the symptoms he could have if he got ill, but also after the patient had asserted that he is nowadays more than before thinking about 'symptoms and things'. The sense that the counsellor is only explicating what the patient has already implicated is further emphasized by the counsellor through the use of 'did' in line 32: 'Say you did begin to get i:ll' conveys that the theme has actually been touched upon earlier.[3]

In (5), the counsellor's initial question involves the patient's feelings about having his 'knee done', in an operation which would mean a long stay in hospital. (The patient, like many haemophiliacs, has persistent trouble with his knee joints.) The patient responds by expressing his current doubts about what to do, whereafter he produces the reason for his doubt: his brother's health is getting much worse. Exactly how his

brother's medical condition accounts for the patient's difficulties in deciding whether to have his knees done or not remains somewhat unclear here. Possibly the patient implies that he should not spend a long period in hospital while his brother's state of health is deteriorating, and he would need to take care of him. In any case, the patient's account for his difficulties in deciding about the knee operation has prepared the way for the counsellor to invoke the hostile future. The gloomy prospects involving Christian were initially hinted at by the patient; only after such hints did the counsellor produce her explication of the situation. In her turn, she unpacks the patient's gloss 'He- he s- he seems to me to be getting much worse ... especially er er- medically anyway' with the conditional but explicit assertion 'If Christian die:d'.

As a summary, the counsellors' turns where they nominate a possible distressing future situation occur only when the fearful situation has been elliptically or vaguely hinted at in the preceding talk. The preceding hints may have appeared as a response to counsellor's prior enquiries creating space for such talk to appear, or they may have appeared more or less voluntarily in the patient's talk; i.e., the counsellor can intentionally pursue a suitable environment, or it may appear spontaneously. In any case, the counsellors design the turns where they nominate the distressing future situations as turns which unpack something that has already, but incompletely, been referred to by the patient.

What do the counsellors achieve by locating their turns here rather than elsewhere? In the first place, they emphasize the continuity between what the patient has said earlier, and the current enquiry. By portraying the nominations of a distressing future situations as unpacking the patient's prior vague hints, the counsellors avoid the impression of a unilateral declaration in describing the distressing future. By emphasizing the continuity, they locally constitute the topics involved in their enquiries as something that has to be approached and talked about carefully (cf. Bergmann, 1992). On the other hand, they also make it more difficult for the patient to turn down the questions, because it now appears that the patient himself actually has initiated the theme.

Management of the epistemological framework

The other concern that the counsellors often attend to while nominating the distressing possible future situation is the epistemological status of their assertions. Not only do they use the standard conditional forms of English, but they regularly 'upgrade' the conditionality of their assertions. Alternatively, they can emphasize the universal character of the possible

future situation as something that anybody could one day find him or herself in. The likelihood of the use of these devices for the management of the epistemological framework seems to increase as the counsellor's description departs from what the patient has described as the objects of his fears earlier in the discourse.

There are two means available for upgrading the conditionality of the descriptions of the distressing future situations. One involves the use of formulations along the delivery of the description. That was done in extract (4) and (5). In (4) the counsellor began her question this way:

C: s : : S a y : : (.2) we can't say and you can't say,
P: Yeah

Here the counsellor formulates her own epistemological position vis-à-vis the assertions about the patient's future: neither of them really can say what will happen. Interestingly, the patient produces an affirmative response token after the formulation, thus probably agreeing with the characterization of their epistemological position.

In (5), the counsellor adds to the initial description of the possible future situation ('If Christian die:d (.5) in the next few months') a characterization of the limited force that she intends her words to have: 'I'm not saying he's going to but if he did'. Normally, the use of the conditional form in itself suffices to convey that the speaker is not committed to the truth of the expressed proposition in the same way as in the case of ordinary 'representatives'. Here, however, the counsellor decided to spell out, or formulate, the limited force of her words.

The formulations of the counsellor's statement's epistemological status and the force of their words recurrently accompanied the counsellors' descriptions of the possible distressing future. Three further examples:

(6)
C: .hh I mean taking things to their worst
(...) I mean as far as I understand if
→ one- (.7) I'm not saying this can happen
but taking it to its very worst (.) if .hh
you did begin to ((continues))

(7)
C: (...) Say he did (.2) get ai:ds and (.2)
the worst did happen, .hhh what (.5) does
he think (1.0) is (.2) Helene's greatest
fear. (.2) How: (.3) what- what- what

→ (1.3) just let's take it o:n and ifs this
is all hypothetical, but I'd just like to
know: ((continues))

(8)
C: → If you: if you- supposing I mean this is
just supposing, =supposing you: (.2) had
got infected (.) or were to get infected

In (6), the counsellor spells out the limited force of her words ('I'm not saying this can happen'), along with characterizing the motivation for the assertion ('taking it to its very worst'). In (7) and (8), the counsellors formulate the special character of the assertions made: 'this is all hypothetical' and 'this is just supposing'.

In extracts (3)–(8), the counsellors' formulations are accompanied by pauses and self-repairs. Both the 'content' of the formulations and the perturbations surrounding them seem to have a 'pre-delicate' character. The counsellors hearably propose that the matters involved in the descriptions may be sensitive and delicate for the patients (cf. Schegloff, 1980; Silverman and Peräkylä, 1990).

There are cases, however, where no formulation of the epistemic status of the statements or the force of the utterance was given. Extract (3) above was one of those cases.

(3) [Detail]
C: A:nd (1.6) from what you know: of Ga:ry I mean:
(2.0) if it was to be positive what d'you think his
main concern would be?

However, the conditionality of the description of the future situation seems to be emphasized here in another way. The counsellor does not ask simply 'if it is positive', not even 'if it were positive', but uses a more complicated formula 'if it was to be positive'. By substituting 'was to be' for 'is', and by emphasizing 'if' prosodically, she upgrades the conditional character of the description.

This kind of means of upgrading conditionality are used in a number of other cases. (9) provides another example.

(9)
C: (...) You've come up .hh here and in your review:
(0.6) a number of tests are done. =Do you know
anything about the tests that are done?=

P: = Uh:m no not really. = As far as I know it's just a blood test. Uh:m
((14 lines discussion about the patient's willingness to be told about the results of the test omitted))
C1: → What would happen say if Doctor Kaufma:n (0.6) did these tests and thought that your immune system wasn't quite as good as she (0.2) would want it to be. = What should she do with that information then.

In (9), after having talked about the tests that are routinely done in the clinic, the counsellor shifts into a conditional form when she addresses the possibility of troublesome test results. Instead of saying something like 'If Doctor Kaufman's tests show that your immune system isn't quite as good ...', the counsellor says 'What would happen say if Doctor Kaufma:n (.6) did these tests and thought that your immune system wasn't quite as good ...'. Again, the conditionality of the description of the possible future situation is upgraded by using the more complicated formula. By using 'say' at the beginning of the utterance, by referring in conditional to the tests that factually are done, and by saying 'your immune system wasn't as good' instead of 'isn't as good', the counsellor recurrently emphasizes the hypothetical character of her assertion.

Apart from the formulations of the speaker's epistemological status and the force of the utterances, and the use of 'compound conditional', there is a third strategy available in the management of the epistemic status of the description of the possible distressing future. The descriptions can be presented as general rules concerning everybody, not only the patient(s) attending the session. This strategy is applied in (10).

(10)
1 C: Say (.2) say Mister Brown did die what would be
2 → the hardest thing for Helena (0.5) any of us can die
3 in crashes or anything but just let's take it out
4 what would be the hardest thing for Helena

'Dying' is here presented as something that can happen to anyone 'in crashes or anything', not as something that would be relevant exclusively for Mr. Brown. Equally, in (11), the threatening future possibility is portrayed as a general rule.

(11)

1	C1:	Mrs Mackie is there anythi[ng (more- (.2) issues)
2	C2:	[(Well there- I don't)
3	C1:	=that you wanted to pursue:.
4	C2:	We:ll (.2) [it's not as though we have a s::]=
5	C1:	[In the short time we have le:ft]=
6	C2:	=[s::::::::::::::::::::::::::::]subject to pursue=
7	C1:	=[was there anything]
8	C2:	=but (.2) we (.3) always try to nowada:ys (0.7) do
9		what's best for individual patients and what's right
10		for Barry (0.2) may not be right for Christian.=And
11		one of the things .hh that we know we're sort of
12	→	faced with sometimes when people get very ill and
13		even die: is .hhh (0.9) of course views about
14	→	post-mortems in general and I just would like to
15		know what Barry feels about that just in gene[ral.
16	C1:	[Mm
17	C2:	I mean (0.2) how would he feel about it if he was
18		asked (to say on) (0.7) Christian and if b-Barry was
19		asked for hi:m,=and just his views.
20		

In (11), after the initial mitigation 'it's not ... a ... subject to pursue but', C2 begins her intervention in an 'individualizing' framework: she emphasizes that the clinic tries to follow each patient's individual wishes, and what is good for Barry may not be good for Christian. Barry and Christian are the two haemophiliac brothers with HIV virus. When she speaks about Barry and Christian in this individual way, however, she has not yet revealed what she is aiming at: the claim this far is that the clinic wants to do things that are best for Barry and Christian as individuals.

After this C2 starts a stepwise production of the description of the possible future situation. Thereby, she first switches into a 'universalistic' approach. She describes the situation involving that sometimes 'people get very ill and even die:', instead of focusing on the possibility of this individual patient or his brother getting ill or dying. Moreover, the counsellor speaks about the questions that 'we', i.e., the medical staff, face in such situation, instead of talking about the questions that this patient or his family might face; and the questions are about post-mortems 'in general'. Finally, when the counsellor spells out the first version of the question (lines 14–15) to the patient, she still elicits his feelings 'just in general'. Only thereafter does the counsellor become more specific, ending up by eliciting Barry's views about Christian's post

mortem and vice versa. This stepwise progression involves that the patient is first brought into a world 'in general' where people die and post-mortems are done; and only thereafter is he asked to locate himself in that world as a dying person or the brother of a dying person.

In (11), then, the issue of post-mortem examination is presented after an extraordinary amount of 'pre-delicate' work (cf. Schegloff, 1980). Through this work, the issue is constituted as one which may be extremely sensitive for the patient.[4]

As a summary, the recurrent management of the epistemelogical framework of the counsellors' descriptions of the clients' future seems to display the counsellors' orientation to such descriptions as sensitive and delicate matters. By mitigating the accuracy of their descriptions (by upgrading the conditional) or by escalating their applicability to everybody (by presenting their descriptions as general rules concerning everybody), the counsellors overtly minimize the threat that the descriptions constitute to the patients. However, what overtly appears as plain minimization of threat, may have other, more subtle functions, too. In the following, we will try to get one step further in analyzing the local, sequentially specific functions of the linguistic devices described above.

Patients' responses to the counsellors' descriptions

Apart from the interactants' general interest towards limiting threat, we can find a more specific and local function that the use of these devices may have. In order to identify it, we must first return to the sequential context in which these descriptions appear. They are always part of longer turns. The descriptions are followed by questions seeking to elicit the patients' fears or ways of coping given that the situation would arise. So the descriptions lead to questions, and the questions naturally elicit answers.

The questions that occur after the descriptions would not make sense alone: the questions presuppose the description. And further on, the answers that the questions project, also presuppose the descriptions. Or to put it in another way, both the question (uttered by the counsellor) and the answer (elicited from the patient) have as their horizon the description initially given by the counsellor.

Re-examination of the three first extracts may illustrate the point. In (3), the counsellor's question about Gary's main concerns presupposes that he is positive; in the other words, the question appears in the horizon of Gary being positive. By producing his answer, the patient maintains this presupposition and horizon:

(3) [Extension]
1 C1: A:nd (1.6) from what you know: of Ga:ry I mean:
2 (2.0) if it was to be positive what d'you think his
3 main concern would be?
4 (1.4)
5 C1: [Or how d'you think- (.3) how would you see him=
6 (P): [( )-
7 C1: =coping.
8 (2.3)
9 P: I (don't) think he'd cope we:ll,=because we have
10 discussed it over the weeke:nd, (.) uh:m (0.6) (And
11 just) (1.6) er: hhh uh- (.2) following up on it.
12 Being very careful about everything.

After the counsellor's initial question, there is a gap of 1.4 seconds. Then the counsellor rephrases the question, focusing on 'coping' instead of 'main concern'. In his response, by asserting that Gary would possibly not cope well, and by referring to the idea of 'following up on it being very careful about everything', P1 effectively maintains the hypothetical assumption that 'Gary is positive' as the horizon of his talk.

In (4), the question about whom the patient would like to make decisions on his behalf presupposes that he would get so ill that he could not make decisions himself. The question is designed to provide for an answer preserving this hypothetical state of affairs as the horizon of discourse:

(4) [Extension]
1 C1: s : : S a y : : (.2) we can't say and you can't say,
2 P: Ye[ah
3 C1: [but say you did begin to get i:ll (0.8) or say
4 you got so ill that you couldn't kind of (0.2) make
5 decisions for yourself.=who would (.4) you have to
6 make them for you:. (.3) Who do you: (.2) consider
7 your:
8 (3.8)
9 P: I think I'd probably (get) one of my say closest
10 friends (0.5) uh:m (.4) a friend of mine called
11 Anselm (the one) I lived with because he's sort of
12 (.3) ehh
13 (1.0)
14 C1: Anselm?
15 P: Yeah:.=

By naming Anselm as the person he would like to make decisions on his behalf, the patient preserves the assumption that he became so ill that he couldn't make decisions for himself as the horizon of the discourse.

Equally, in (5), the patient's answer preserves the horizon set up by the counsellor:

(5) [Extension]
1 C: .hhhh If Christian die:d (1.0) in the next=
2 P: =Mm
3 C: few months
4 P: M[m
5 C: [I'm not saying he's going to but if he did.=how
6 would that change your life.
7 (2.5)
8 P: I don't know:. (.) Uh:m: (1.2) I don't think it
9 would change it that much to be honest. (0.8) We've
10 drifted very far apart over the las::t sort or er
11 few:
12 (2.4)
13 P: °(well)°
14 (0.8)
15 C: But would it make your [life easier then.
16 P: [( )
17 (1.8)
18 P: I think possibly it- (.4) it might do.=but uh::m
19 (0.6) what (I'm)- what I'm really- (0.5) thinking
20 about is er:: (0.9) doing or saying something that I
21 would er feel guilty about should it happen.
22 ((continues))

Here the horizon is the assumption 'Christian die:d (...) in the next ... few months', which the patient's answer preserves. After saying that his life wouldn't change much in the event of Christian's death, P produces the statement 'We've drifted very far apart over the las::t sort of er few:', as an account for the first part of the answer. Even though this focuses on past events instead of the future, it serves as an explanation for something that the patient says about the future. Accordingly, the counsellor's following turn 'But would it make your life easier then' maintains the initial horizon.

The hypothetical questions in AIDS counselling seem to be very cleverly designed. Almost any answer that the patient would possibly give to them would equally preserve the initial description as the horizon of the

discourse. So in (3), if P1 had said that Gary would cope fine, or if he had named any particular problems in his coping, he would equally have treated 'if it was to be positive' as the horizon. Or in (4), by naming anybody as the person who he would like to make the decisions, the patient would also have maintained the assumption of himself being too ill to make them for himself as the horizon. And in (5), naming any change, or reporting that nothing would change, would equally have maintained the initial horizon.

The local, specific function of the intensive management of the epistemological framework of the counsellors' descriptions is embedded in this particular sequential environment. The counsellors are not in the first place unilaterally delivering information to the patients about a possible future, but they are rather, through their questions, inviting the patients to share these descriptions, as horizons of their responses. Or to put it in Moerman's terminology, the counsellor is inviting the patient to collaborate in 'building a world to co-inhabit' (Moerman, 1988).

In this specific context, the specific management of the epistemological framework appears to be geared to secure the patients' collaboration in building this world. By applying the various techniques of the management of the epistemological framework, the counsellors publicly minimize their commitment to the accuracy of these descriptions, as predictions concerning this particular patient. The world that the counsellors invite the patients to collaborate in building is thus marked as a hypothetical one, or as a fantasy world. Through this marking, the counsellors seem to be conveying to the patients that they can answer the questions without having to think that those things really will happen to them. The patient is not openly required to make any more epistemic commitments than the counsellor does. Or to put it in another way, marking the world as a hypothetical one, the counsellors make it very difficulty for the patients to find valid accounts for refusing to cooperate in building this world. For example, it is difficult for the patient to say that he can't answer because he doesn't think this will happen, because, after all, it is all only hypothetical.

Marking the future world as hypothetical may also have another advantage, which is related to the counsellor's professional role. There is a potential tension between the two opposing poles of the counsellor's role: their speciality in social and psychological issues on one hand, and their membership in the medical team on the other. As 'psychological' and 'social' professionals, the counsellors are expected to generate talk about the patients' fears and their conception of future, even if the patients are currently fine and their medium term prospects good. But because the counsellors also are members of the medical team, their

words are easily heard as implying a prognosis. In any serious illness, giving a prognosis is an extremely sensitive issue. The doctors are expected to tell their patients beforehand if something dreadful is going to happen — but they easily lose their credibility if they warn about something that actually turns out not to be so (Sudnow, 1967). In HIV, this problem is particularly acute because the course of illness is very variable.

Inviting patients to talk about a markedly hypothetical world provides for a means of navigating between these rocks. The counsellors create a space where their words markedly do not imply a prognosis. In that space, pursuing the patients' fears and fantasies is possible, even when some of the counsellors are medical doctors. It also enables those members of the team who do not have formal medical authority (social workers, nurses, psychologists) to address the issues related to the patients' future without needing to worry about saying something that they, as non-medics, would not have the authority to say.

In summary, then, the counsellors' technique of questioning, applied along with the management of the epistemological framework, provides for a means to create a discursive space where the clients' talk about the details of their distressing future is highly relevant. This space, however, is created without the counsellors themselves needing to go on record for asserting almost anything about this future.

The means for facilitating the clients' collaboration

It has been argued in this paper that the counsellors use two kinds of conversational means for securing the patients' participation in invoking realities that are hostile for them. Firstly, they locate the questions involving such invocation so that they appear to be in a continuum with the patients' preceding talk, and secondly, they carefully manage the epistemological framework of the discourse so as to avoid open commitment to the accuracy of the assertion made about the patients' future. A counsellor's own orientation to these conversational devices as means for facilitating the patients' collaboration is confirmed by a case where a client consistently refused to talk about a hypothetical future situation.

(12)

1	C1:	Did you know that (.) Mrs Wood, (.3) .hh that S:ay:
2		I mean we're talking hypotheticall[y now. = because I =
3	W:	[uh-hum
4	C1:	= I don't know- (.4) ex[act details say: .hhh Mister =
5	P:	[Mm

6	Cl:		=Wood was (.) negative.
7	W:		Um:
8	Cl:		Have yo- (.2) did you understand what he said (.)
9			that he could be negative at the m[oment and-]
10	W:		[Oh yes.]
11	Cl:		Rig[ht.
12	W:		[Yes.
13	Cl:	(1)→	S[o if:: (1.2) the test came out positive. =I mean=
14	W:		[( )
15	Cl:		=what are the thing:s- (1.5) how would you conduct
16			your life. =What are the thing:s
17	W:	(2)→	hhhhh [I dont know hh].hhh ((teary voice))
18	Cl:		[IF I WAS TO (SAY IT-)]
19	Cl:		We[ll-
20	W:		[I just don't know. ((teary voice))
21			(.4)
22	Cl:	(1)→	Well (.2) just have a guess? =I mean what- (1.0)
23			Mister Wood i[s sa- ( )
24	W:	(2)→	i[I think I'm at a stage) ( ) aids
25			just another thing.hh
26			(2.0)
27	W:		.hhhhh I'm at a stage where: I feel 's if- (1.0)
28			(there) would just be another thing.
29			(.5)
30	Cl:	(1)→	°( ).° Having heard what Mister Wood said (.)
31			that e:ven if he was negative. (.2) It wouldn't
32			make him conduct his life any different. (.7) What-
33			(3) affect would that have: if:-
34	W:		.hhhh
35	Cl:		I mean what are the things that it [would affect if=
36	W:		[hhhhhhhh
37	Cl:		=he was positive.
38	W:		gh hhhhh heh hh
39	Cl:		Umh:?
40	W:	(2)→	.hhhhhh I just don't know. (.4) I'm afraid, (.3)
41			.hhh (2.0) I'm in a frame of mind- (.2) mind at the
42			moment (.2) .hhh (3.0) that I'm not so (lots) of
43			use: f(h) or hypothe(h)ti(h)cal things. =.hhh I'm not-
43			(.2) err: (.3) very useful to you I mean. =Because
45			(.2) .hh (.5) I feel that as if- (1.6) the things
46			which are actually happening (.4) are as much as I
47			can cope with.

The clients in extract (12) are Mr. and Mrs. Wood, a couple in their forties. Mr. Wood is a haemophiliac who was not aware of his HIV status at the time of the interview. Now the counsellor is trying to elicit Mrs. Wood's views about the possible implications of a positive test result.

In the beginning of the extract, the counsellor first describes the discourse as 'hypothetical' (line 2); then (in lines 8–9) she formulates some of the preceding talk, where she has been asking Mr. Wood questions about the implications of a negative test result. In other words, the counsellor prepares a favorable environment for talking about the possibility of a positive test result, and deals with the epistemological framework. There then follows a series of questions where the counsellor tries to invite Mrs. Wood to collaborate in building a world where Mr. Wood has turned out to be HIV positive.

The counsellor's questions involving this invitation are marked with arrows numbered (1) and Mrs. Wood's responses with arrows numbered (2). Each question that has as its horizon the 'positive test result' is turned down by Mrs Wood, who proffers different accounts as reasons for not being able to answer. She first appeals to her lack of knowledge, and then, when confronted with the counsellor's persistent pursuit of her views, moves to other kinds of accounts.

The ways that the counsellor deals with Mrs. Woods successive refusals indicate that she, indeed, does orient to the favorable conversational environment and the epistemic framework as key factors facilitating the patients' participation. After Mrs. Wood has repeatedly claimed that she doesn't know, the counsellor rephrases her question (line 22): 'Well (.2) just have a guess? ...'. The invitation to 'guess' entails a move in the management of the epistemological framework. The counsellor has already prefaced the discourse as 'talking hypothetically' (line 2). By introducing the possibility of 'guessing' as a response to the patient's initial refusal, she reaffirms that by saying something here, Mrs. Wood would not commit herself to the accuracy of her statements as descriptions of future states of affairs.

After Mrs. Wood's uncollaborative response to the counsellor's reformulated question (lines 24–28), the counsellor rephrases her enquiry once again. Now she reinstates the continuity of her enquiry with the preceding talk. She prefaces her question with a statement reiterating what Mr. Wood had just said (lines 30–32), which makes the current enquiry appear as a logical counterpart of what has been said before.

However, C's pursuit of W's answer is not successful. At the end of the extract, W formulates explicitly her unwillingness to collaborate in building up a hostile, hypothetical world:

I'm not so (lots) of use: f(h)or hypothe(h)ti(h)cal
things. = .hhh I'm not- (.2) err: (.3) very useful to you I
mean. = Because (.2) .hh (.5) I feel that as if- (1.6) the
things which are actually happening (.4) are as much as I
can cope with.

In her account, W contrast 'hypothe(h)ti(h)cal things' with 'things which are actually happening'. Dealing with the former is presented as something arising from the counsellor's interest, and the latter as matters of immediate urgency for W herself. This reorganization of the terms of the discourse amounts to an account for W not to answer C's question. In other words, W 'hijacks' the counsellor's initial formulation which characterized the talk as 'hypothetical' (line 3). The formulation, initially designed to facilitate W's answers to C's questions, is converted into a part of an account for not answering.

In sum, extract (12) demonstrates how a counsellor herself orients to the two conversational means discussed in this paper (concern for a proper conversational environment and the appropriate epistemic framework) as key factors facilitating the clients' collaboration in building up a future world. This extract also shows how precarious a reality the future world may be: it can be brought forth and sustained only through the continuous collaboration of the both parties involved.

Epilogue: Accent of reality in conversation

In this paper, we have seen how the counsellors create a discursive space marked as hypothetical to accommodate talk about the patients' future. Within the space so marked, assertions can be made about the clients' future without the participants openly committing themselves to them as accurate descriptions of what will happen.

One of the central tasks of the AIDS counsellors is to help their clients to come to terms with their possibly gloomy future. Now, it is interesting to ask how the conversation marked as hypothetical can contribute to the accomplishment of this task. Isn't there a possibility that whatever is said is treated by the patients as mere speculation, which has nothing to do with their real life?

From a syntactic point of view, the moods in English are unambiguously distinct from one another. The use of auxiliaries and verbal inflection makes the indicative ('He is ill' or 'He will be ill') distinctively and unambiguously different from the conditional (e.g. 'He would be ill').

On the level of the activities carried out in conversation, however, the

picture may be far more complicated and multi-facetted. The counsellors and the clients indeed do use predominantly conditional forms when talking about future in the extracts analyzed above. However, it appears that the conditional form may be used for giving descriptions and assertions involving a whole range of different 'accents of reality' (Schutz and Luckmann, 1974). But the accent of reality attached to words in a specific moment within a conversation may be very difficult to identify and 'pin down'.

If these conversations carry out successfully the task of preparing the patients for their future, then the world overly marked as hypothetical ends up being treated as more than mere fantasy. A hint of this possibility is given through the very marking of the discursive space. If we play the 'desert island games', we ask directly 'If you were alone in a desert island for five years, which book would you like to have with you? No management of the epistemological framework is needed, because it is obvious to everyone that the likelihood of such a situation occurring is extremely small. But by saying 'I'm not saying he's going to' die, the counsellor may indirectly be saying that he may indeed die.

Throughout the paper, I hope to have shown that the counsellors use a range of linguistic means which constitute the issues raised in the hypothetical questions as sensitive and delicate. Apart from the management of the epistemological framework, these linguistic means include the careful attention to the conversational environment of the descriptions of the patients' future, and even the extended self-repairs projecting such descriptions. By orienting to the delicacy of their descriptions, the counsellors may indirectly suggest to the clients that the issues they are raising are far from mere fantasy. The 'accent of reality' which is overtly tuned down, may be brought back and consolidated through these indirect means. Correspondingly, by collaborating in the invocation of the untoward reality, the patients may be agreeing to treat the objects invoked as something that may in the future be true in their lives.

It is possible, then, that in conversation there is not necessarily a clear-cut difference between 'hypothetical' and 'real'. The method of invoking a hostile world analysed in this paper appears to involve very fine grained movement between different 'accents of reality'. Facilitating the movement in the area between the two opposites may be a key aspect of the counsellors' work.

Notes

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1. These patients were exposed to the virus in transfusions of a contaminated blood product used in the treatment of haemophilia in the first half of the 1980s.
2. 'Pneumonia' appears to be an object loaded with meaning in HIV-related conversation. It seems to be treated as a 'paradigmatic' indication of the collapse of the patient's immunity and thereby, of 'full blown AIDS'. This means that talking about 'pneumonia' may convey much more in an HIV-related context than in other medical contexts.
3. The contrast would be the counsellor saying 'Say you begun to get ill.' That appears to nominate a future possibility without reference backwards in the talk. On the contrary, the use of 'did' in 'Say you did begin to get i:ll' seems to present 'getting ill' as a fulfillment of something referred to earlier.
4. The 'direct open supervision' format, where C2 addresses the enquiry to C1 (instead of P, to whom it is targeted) constitutes another aspect of the 'pre-delicate work'. For an analysis of this, see Peräkylä (1992, Chapter 5).

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Anssi Peräkylä is Assistant Professor of Sociology at the University of Tampere, Finland. He received his Ph.D. at the University of London in 1992. From 1989–1991 he worked as Glaxo Research Fellow at Goldsmiths' College, London, on a project on AIDS counselling. He has published various papers on interaction in health care settings in *Sociology of Health and Illness*, *Sociology*, *Text*, *Qualitative Health Research*, and *AIDS Care*.