Misunderstandings, communicative expectations and resources in illness narratives: Insights from beyond interview transcripts

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Abstract

Interactional misunderstandings in interviews are often glossed over in analysing narratives, so overlooking important clues about how interactants frame the interview discussion. Such misunderstandings will influence ongoing talk, shaping knowledge researchers produce about participants. We discuss whether interpretations of illness narratives may be enhanced if we analyse misunderstandings in conjunction with other contextually-available data not visible within interview transcripts. Using research interviews with people with asthma, we adopted linguistic-ethnographic methods to analyse the manifestation and specific consequences of interactional tensions and misunderstandings between interviewer and interviewee. Misunderstandings can indicate inequalities in communicative expectations and discursive resources available to interactants, which may lead to participants' talk being inappropriately identified as indicating a particular narrative. Incorporating ethnographic contextual features may make visible pertinent discourses not overtly evident within interviews. This may help theorize interview talk, like health and illness narratives, as manifesting within cycles of discourse that will intersect differently in each interaction.

Keywords: context; discourse; illness narratives; linguistic ethnography; misunderstandings; research interviews

1. Introduction

What happens when interactional tensions and misunderstandings occur within research interviews? This question informs this article's contention that examination of ways in which misunderstandings occur may importantly contribute to the production of illness narratives in research interview settings. Instead of analysing interview transcripts for patterns in participants' perspectives, investigating misunderstandings entails analysing transcripts for evidence that the interviewer and/or interviewee are misunderstanding one another, with the consequences this has for subsequent talk and what this may mean for how participants' narratives come to be understood by researchers.

However, our understanding of these interactional sequences and the illness narratives themselves may be enhanced if we incorporate other contextual features not visible within the interview transcript. Doing so may offer insight into how discourses and contexts, not accessible to a narrative analysis alone, play an important role in the production and interpretation of talk within interviews about health and illness. Such an analysis raises epistemological questions about the meaning of health and illness narratives and also how analyses of clinical interactions could benefit from incorporating contextually available data not directly visible within transcripts of patient–provider interactions.

To address these issues, we examine a sequence of an interview transcript where an instance of misunderstanding between the interviewer and interviewee appears to arise. We analyse how our interpretation of this misunderstanding, the sequence of interaction and the overall interview may be enhanced by incorporating data not visible within the transcript but contextually available to the research-

ers. We conclude this analysis of misunderstandings by offering a theoretical framework which may help researchers conceptualize and identify features of context that shape talk within research interviews.

2.   Literature review

Qualitative research has provided extensive critical reflection on the production of illness narratives within interviews, including: unpicking how talk is shaped by roles constructed within the interview dynamic (Gwyn 2002); the performative nature of interviews (Denzin 2001); interactional dilemmas faced by interviewees on being asked questions about their health (Radley and Billig 1996); theoretical presuppositions of interviewers conducting and reporting research (Seale 1999); and analysing interviews as communicative events (Mishler 1991). Such reflection has highlighted how the research interview imposes communicative norms which are accepted or resisted by interviewees. There is, however, an absence of any systematic analysis of how *differences* in communicative expectations, interviewers' and interviewees' presuppositions, understanding of roles, and discursive resources shape ongoing talk produced about health and illness. Similarly, little attention has been paid to sequences of interaction within interviews where some kind of interviewer–interviewee interactional 'trouble' (Schegloff 1987) arises.

Briggs demonstrated how divergence in and lack of access to each interactant's presuppositions, goals and understanding of the purpose and meaning of research interviews and their communicative procedures are revealed through 'communicative blunders' (Briggs 1986: 39–60). Such blunders, he argues, manifest through confusion over contextual or indexical meanings and frequently occur in interviews. Alongside this is a transformative process whereby participants are asked questions which force them to artificially summarize and provide abstract meaning from everyday experiences, a process bearing little relation to the experience itself. Briggs demonstrated how talk within interviews may be influenced by resources interactants bring to interview settings, for example: linguistic resources (e.g. ability to use medical terminology); institutional resources (understanding of the format of research interviews, question–answer format); and bureaucratic resources (understanding of the functions of consent forms, patient information sheets). Briggs argued that researchers frequently fail to recognize these processes and, as a consequence, the analyst often interprets talk of interviewees in ways which typically fit their own conceptualization of the interview and mask indexical meaning by asserting its content as 'real'. Talmy (2011) offers a similar argument by making a distinction between analytical approaches that aim to unpick the 'whats' or 'themes' of research interviews with those that examine the production of interviews, what he calls the 'hows'. By examining the 'hows' and not just the 'whats', Talmy shows how research interviews can be seen to be a site of production where themes are co-constructed by interviewer and interviewee, thereby questioning any sense that they accurately represent a reality beyond the interview setting.

Research on clinical interactions has analysed how differences in patient–provider understanding affect communication within consultations (Barry *et al.* 2000; Britten *et al.* 2000; Roberts *et al.* 2005), highlighting how interactional misunderstandings may result in patients' perspectives not being voiced, potentially leading to confusion, misinformation and inappropriate treatment outcomes. Roberts *et al.* (2005) analysed primary care consultations in multilingual settings and identified interactional misunderstandings occurring whenever there is: insufficient understanding for both parties to continue; the illusion of understanding, only revealed as such later on; and where there are unresolved ambiguities. Roberts also identified interactional tensions as pertinent, which although not misunderstandings *per se*, display uncomfortable, disruptive or confusing moments. Misunderstandings may result from 'slips of the tongue' or use of medical jargon and potentially may be quickly resolved. However, misunderstandings may also result from inequalities in access to resources including phonetic, grammatical, metaphorical, bureaucratic, and institutional resources. Interactants' understanding of the meaning of an interaction and the talk within it therefore has consequences for how those interactions proceed. Gumperz (1999) analysed what Levinson (1997) referred to as the 'mini-tragedies' of institutional interactions, whereby misunderstandings have a cascading effect on interactions leading to individuals' communicative performances being interpreted and evaluated, not their abilities, preferences or lifeworld. Gumperz (1999) suggests that, in order to learn from interactional difficulties in institutional settings, we need to understand how interactants' communicative resources are activated within interactions and whether or not these resources are shared. The research interview presents a genre of

interaction where 'mini-tragedies' are likely to occur, where researchers control the resources used to design, collect, analyse and report on the 'data' they have collected about research participants.

2.1. *Analysing interview transcripts using ethnographically-available data*

Blommaert offers a set of conceptual tools to analyse the resources interactants bring to research interviews, and in doing so identifies the importance of looking beyond interview transcripts in his analysis of a different type of interview: the asylum interview (Blommaert 2005: 56–67). Blommaert examined ethnographic contextual features including: the linguistic resources asylum seekers brought to interviews; the 'text trajectories' of asylum seekers' stories, involving the shifting and recontextualization of their narratives into new formats across contexts; and data histories of how asylum interviews (and the researchers' own interviews) were gathered, recorded and treated by the analyst. Incorporating what Blommaert called 'forgotten contexts' enabled him to demonstrate that successful asylum interviews were not a result of applicants' accurate portrayal of their life circumstances, but, rather, their ability to mobilize the appropriate linguistic resources within the interaction. Blommaert argued that a purely textual analysis fails to account for these contexts because they are not features of single texts but of larger economies of communication and textualization. Whilst a very distinctive form of interaction and approach to health research interviews, his analysis clearly evidences features of context available for analysis external to the interview transcript which may have an important bearing on the knowledge produced about the people in our study.

Incorporating both linguistic and ethnographic features of context in our analysis of communication contrasts with the body of narrative analysis and Conversation Analysis (CA) literature on medical interviews. Such approaches typically focus solely on talk, oriented to by interactants, as organizing subsequent interactional sequences (Woofitt 2005). The purpose of presenting the data in this article is not to provide a summary of research findings, but to consider how a linguistic-ethnographic approach can enhance our understanding of interactional misunderstandings within research interviews. To do so, we will present a case example, using ethnographically-available data to understand interactional misunderstandings and tensions apparent within one interview with a person discussing their asthma. We use a linguistic-ethnographic approach to examine some examples of 'forgotten contexts', so as to make sense of 'communicative blunders' evident within this interview. We propose that such an analysis opens new possibilities for interpreting and reporting the talk provided by people within health research interviews.

3.   The study

The qualitative study described was undertaken in East Anglia, England, as part of a large randomized controlled trial called ELEVATE (Price *et al.* 2011),[1] which compared the clinical and cost effectiveness of different asthma medications. Qualitative study participants were recruited from those taking part in the ELEVATE study who were previously known to have been (or labelled as) non-adherent to prophylactic asthma treatment (n=54). The qualitative study (Murdoch *et al.* 2013) aimed to provide a critical counterpoint to social-cognitive approaches to how people take, or 'adhere' to prophylactic medications, using a variety of methods to examine the structuring and production of talk about asthma management and medicine-taking. The first author conducted face-to-face interviews with all those who consented (n=26) and a focus group in which findings from the interviews were shared with participants. In addition, texts on the causation and management of asthma were examined, to identify broader discourses of illness management. These included contemporary asthma guidelines, published literature on perceptions of asthma management, historical texts on the causes of asthma and the ELEVATE study recruitment materials. For the present analysis we focus on the ELEVATE recruitment materials and the interview setting to identify which discourses and activities could be seen to surround the interview talk, before examining the interviews themselves.

4.   Linguistic ethnography in an analysis of misunderstandings

Linguistic ethnography (LE) has been described as a site of encounter for different disciplines to help resolve some common difficulties identified in the analysis of text and talk, particularly with regard to communication (Rampton *et al.* 2004). A central

area of difficulty lies in definitions of context, how context is investigated and what implications these issues have for how power can be seen to operate in text and talk. LE forums in which the analysis of communication has been explored have generally agreed that important contextual influences on communication can be seen as both ethnographic and linguistic, and that context should be investigated and not assumed. Adapting the elements of context set out by Harris and Rampton (2009) for this article's focus on interactional misunderstandings, context can be understood as:

1. the institutional and network relations amongst the interviewer and interviewee, and their recent histories of interaction;
2. the types of activity interviewer and interviewee are involved in and interactional arrangements;
3. the broader discourses, ideologies and moralites in play; and
4. the acts and utterances leading up to and immediately following interactional tensions and misunderstandings.

Each element of this contextual framework can be further conceptualized as interrelated in producing interview talk. Interviewer–interviewee relations and histories of interaction will inform the choice of discursive topics and activities of the interview. The activation of particular discourses within interviews, meaning systemic, culturally-circulated explanations (for example, illness management discourses) will influence both how interactants make sense of this kind of social activity and the ongoing sequences of interaction. This sense-making of face-to-face interactions is what Goffman referred to as the interactant's 'frames' of the norms, roles and communicative expectations of the interaction taking place: 'what it is that is going on here'(Goffman 1974: 8). We can therefore view interactants' framings of interactions as shaping ongoing talk according to the resources interactants have available and consider appropriate to deploy within the activity of the research interview.

Tables 1, 2 and 3 below take the first three elements of context in an analysis of the contextual conditions which preceded this study's interviews. This analysis will then be used to examine the interview transcript for how these pre-textual conditions came to be recontextualized within the interview themselves, revealed through interactional tensions and misunderstandings.

Insight into these pre-textual identities, histories of interaction, activities of the interview and discourses in play illustrates the potential for research interviews to be open to inequalities in interactants'

Table 1. *Institutional and network relations, histories of interaction*

Recent interactional history	To assess eligibility for the ELEVATE trial, each potential participant had to complete two questionnaires and a symptom diary to determine their level of asthma control and asthma quality of life. To be eligible, questionnaire responses had to be scored as indicating the individual had 'inadequate control of symptoms' and 'impaired asthma-related quality of life'. In addition, potential participants undertook breathing tests to measure air flow rate. Nurses within general practice assessed each individual patient's eligibility for ELEVATE using this mixture of tools. The nurse then prescribed eligible participants a prophylactic asthma medication to take on a daily basis. Interviewees were selected from ELEVATE participants who had a history of 'non-adherence' to prophylactic asthma medications. They were then asked to complete an adherence questionnaire prior to interview. The interviewer (first author) was also a researcher on ELEVATE and known to participants through participating on the main trial.
Potential institutional identities preceding interview (pre-textual identities)	*Interviewee*: research participant; patient; person with (suffering from? living with/diagnosed with/given the label of?) asthma; person with impaired quality of life and inadequate asthma control; person who is non-adherent to medications. *Interviewer*: researcher on ELEVATE trial/health research; expert on asthma; healthcare worker; NHS representative; social scientist; student.

Table 2. *Types of activity interviewer and interviewee involved in and interactional arrangements*

Main activity	Interview about asthma management and medicine-taking. Standard interview format of question-and-answer regulates interviewees' talk. Involves series of sub-sequences: opening question from interview schedule; participant's narrative, interviewer providing listening confirmation cues; possible clarification questions interrupting narrative; follow-up questions.
Subsidiary activities	Review of adherence questionnaire required short responses from interviewees, potentially blurring communicative expectations for interviewees.
Interactional arrangements	One-to-one interaction utilizing focused questions directed at participant about their asthma management. Location either in participant's home or local GP surgery.

Table 3. *Broader discourses, ideologies and moralites in play*

Constructing participants as moral agents prior to interview	Pre-textual identities (Table 1) can be seen as embedded, institutionalized categories implicitly constructed within the nurse consultations and process of recruitment. The effect is arguably that research participants in this study were constructed as 'moral agents' within a medical discourse of adherence.
Discourse of qualitative interviews about health	Researcher and participant had potentially very different understandings about what 'research interviews' are about. Using the term 'interview' with participants to describe the conversations taking place, imposed a set of conventions on that situation, not only about who should ask the questions but what sort of questions were to be asked, i.e. open-ended questions aimed at eliciting narratives. Interactional arrangements reproduced individualized discourse of asthma management.

understanding of what the interview may be about and how it should proceed. The issue is therefore how these elements of context helped organize the ongoing talk between the researcher and the participants. We can now turn to the fourth element of context, the acts and utterances surrounding interactional tensions and misunderstandings, for evidence of how one participant made sense of the interaction, how they framed the type of social activity taking place and how the talk produced was consequentially affected.

4.1. *The circulation of a discourse of adherence to interviews about asthma management*

The interview excerpts presented here illustrate one example in which the discourse of adherence could be seen to be activated within an ongoing face-to-face interaction about the participant's asthma management. Two interview excerpts from the same interview, with Dawn (pseudonym), are presented (Excerpts 1a and 1b), because they provide an example of interactional misunderstandings and

tensions, revealing evidence of a divergence between interviewer's and interviewee's framing of the interaction. Dawn's interview also illustrates an issue common to several interviews where interviewees did not talk as the interviewer had expected, in that she did not provide a 'typical' illness narrative with lots of justification for her 'non-adherence' to asthma medications. In presenting excerpts from just one interview, we are not arguing that this was representative of our dataset, but as a means of demonstrating how to analyse interactional misunderstandings in conjunction with ethnographically-available data. The two excerpts from the interview with Dawn revealed evidence of how the pre-textual conditions helped shape the interactional misunderstandings and tensions. Transcription is adapted from conversation analytic conventions (Atkinson and Drew 1979) to enable close scrutiny of the moments of misunderstanding (see Appendix).

Dawn (D) was in her 50s at the time of interview and had had asthma for 12 years. As with other interviews, the researcher sought to uncover tensions between Dawn's presentation of her asthma man-

agement and any advice she had received from her doctor or nurse. Excerpt 1a presents an attempt by the interviewer to go over earlier comments to pursue these points further because little such material had been obtained, despite there being a strong indication and assumption by the interviewer that tensions existed between Dawn's perspective and the medical perspective and that Dawn would orientate to this. Unlike other participant accounts seen in the wider body of the interview data, she did not appear to justify her asthma management using a range of rhetorical devices, but instead offered a much more straightforward explanation with few rhetorical devices.

Excerpt 1a: Interview with Dawn (J = interviewer)

J: Did he how did he say you should use it over a long period of time cos you sort of mentioned did you mention to him that you stopped using it?

D: Yes yeah (1) ahhh well he sort of (.) hhh ((sounding slightly exasperated)) I mean his advice is really that I should use it all the while and its totally down to me that I don't because his advice to me is to use it y'know most of the time but I mean I feel fine without it I don't really know why I need to use it because without using it I'm alright I don't get breathless or get any asthma symptoms

J: And do do you actually share that view with him or

D: Yes he know I stopped using it yes yeah spose he just you know he just said you know if I you know its up to you really (??) SO I I MEAN IF I'M IF I'M do have a bad attack alright I will start using it (1) for any reason um have a bad attack but normal run of the day things I don't I don't want to use it hh every day

J: I'm just trying to understand why exactly heh heh ((slightly nervous laughter))

D: WELL I I DON'T KNOW I THINK IT'S JUST AS I SAY ITS JUST THE THOUGHT OF TAKING IT EVERYDAY WHEN I DON'T REALLY FEEL I NEED IT

J: ˚Okay that's fine˚…

We can see Dawn does display awareness of potential tension between her view and that of medicine with the use of the modal '*should*', perhaps triggered by J's own use of '*should*'. However, Dawn did not seem to manage this potential tension any further other than to say her doctor said she could

do what she liked. Dawn seemed to avoid being too confrontational, with phrases which hedged her position – '*sort of*', '*yes he know…*' – and switched from a position that perhaps blamed herself for not following her doctor's instruction, '*down to me*', to one which was more empowering, '*up to me*'. There was little evidence Dawn was preoccupied with managing different moral positions in her talk about her asthma management despite being aware of potential tensions between her view and medicine's, instead simply asserting her view in a very clear voice.

Excerpt 1a can exemplify two interpretations of Dawn's account of her asthma management. The first is that Dawn's ability to justify her medicine-taking was perhaps constrained when she had to reproduce the voice of medicine (Mishler 1984), spoken through the voice of her doctor. However, unlike clinical consultations where the power of medicine can be interactionally analysed as embodied in the voice of the clinician (Mishler 1984), here it is reproduced through Dawn 'his advice really is…'. As a result, it is difficult to assess what talk is being restricted and by whom. A second interpretation, perhaps seen in conjunction with the first, could be that Dawn did not frame the discussion as a 'qualitative interview' with a social scientist (not an asthma expert) where participants are often expected to talk at length about experiences and viewpoints. If we consider the pre-textual conditions of the research interviews and how they might be manifested as misunderstandings and interactional tensions, then the evidence available enhances our interpretation of Dawn's talk.

The lack of rhetorical narrative deployed by Dawn in this sequence is evident, despite the interviewer providing a number of 'contextualization cues' (Gumperz 1999) to refer Dawn to a specific context. Contextualization cues are signals (verbal and otherwise) to indicate what context is being referred to within an interaction and which are relied upon in everyday interactions to interpret a speaker's intentions. Cues provide signals to indicate 'what it is that is going on here?', allowing interactants to frame the interaction. To do this, the interviewer's initial cue suggested a problem, rather than directly pointing out the issue that needed addressing. Phrases were deployed by the interviewer to highlight the specific context, using the modal verb '*should*' to activate the medical voice and '*did you mention*' to position Dawn's own previously iterated position. However, Dawn seemed exasperated by continued questioning on this point, perhaps because she felt she had already provided an answer and had nothing to add, or did not appreciate the point about her asthma

management the interviewer was trying to get at. This appeared to be an insufficient response for the interviewer, as he subsequently attempted to get the response required with a further contextualization cue, '*do you actually share that view with him*'. However, Dawn still did not address the issue, of her and the doctor having different views, in a way that appeared satisfactory for the interviewer. As a result, another bid for information was made, '*I'm just trying to understand why exactly heh heh*', with nervous laughter suggesting the interactional tension was increasing. Dawn then stated very loudly her position, but only after saying '*I DON'T KNOW*', again suggesting she did not see the point being sought. This appeared to demonstrate increasing pressure for Dawn to say something assertive about her view, which led to an immediate let-up by the interviewer, '*°Okay that's fine°*'. This signalled a different contextualization cue, that J would stop asking this question and they were now moving to another topic. Although Dawn provided a clear reason for not wanting to take the brown inhaler, spoken in a louder tone, her lack of elaboration was not what the interviewer was expecting or, apparently, hoping for. Whilst we can see a moral discourse of adherence being orientated to by Dawn, her lack of rhetoric suggested she was unable to access or utilize the particular discursive framework of asthma management the interviewer was constructing within the interaction, summed up towards the end of the interview in the following Excerpt 1b:

Excerpt 1b: Interview with Dawn (J = interviewer)

D: SORRY I'M NOT VERY HE(h)LPFUL
J: NO YOU ARE NO NO WHAT I WANT TO DO is understand your point of view.

What is being proposed is that health and illness narratives may be regulated by the ongoing interactional sequences but also by interactants' possession or absence of particular sets of linguistic resources: in Dawn's case the interviewer's expectations of what qualitative interviews are about, how participants have been framed through their participation in an asthma study, and how health research and researchers persist with a dominant epistemology that says we can and must understand an individual patient's position on medicine-taking. Here the participant is demonstrating she does not have access to these resources and, consequentially, her explanation is open to being interpreted according to how she performs this interactional task rather than how she actually manages her asthma. Dawn's response suggested she was unable to respond to the interviewer's cues, and her lack of access to or use of

these contextual resources resulted in very different interactional sequences from that which appeared more usual in the wider body of interviews. This suggested that interviewees in this study were likely to engage with the pre-textual conditions within interviews in a number of ways, appearing to play a key role in influencing whether participants justified their medicine-taking.

However, the limitations of this analysis clearly lie in pointing to discourses whose influence on interactions is open to interpretation, and not, as proponents of CA might argue (Maynard 2003), set within the 'hard evidence' of participants' orientations to ongoing talk. Strengthening such interpretations therefore requires doing more to address an ethnographic context beyond describing the research setting or identifying pre-textual discourses. The focus group designed in this study was an exercise in constructing different interactional conditions in order to obtain different evidence of how participants talked about asthma management, and this evidence has been discussed elsewhere (Murdoch *et al.* 2010). However, it is worth drawing briefly on these data to highlight how the interviewer's pre-textual identity of 'asthma expert' was revealed and reframed through the process of interaction within the focus group. This provides further evidence, from a different set of interactional conditions, of how institutional roles, pre-textual discourses and identities circulate to play a central role in the kind of talk produced within research interactions. Excerpt 2 is taken from the focus group, in which participants, who had previously been interviewed, discussed findings from those interviews. The focus group facilitator, J, reminded participants prior to the interviews and focus group that he was not medically trained. J refrained from participating in the focus group discussion, to orchestrate a different interactional dynamic and to elicit different talk about asthma management from that obtained within the face-to-face interviews.

Excerpt 2: Focus group (P = participant; J = facilitator)

P5:   I thought that um I was expecting you to inform us of all the er
P2:   yeah
P5:   all the things we should and shouldn't be doing
P2:   yeah
J: what gave you that impression
Several: heh heh heh
P1:   we thought you were an expert
J: what do you think now?
P1:   Not sure heh heh heh

Given the initial context in which J met participants for interviews (a health researcher working on EL-EVATE, in which they were participating) it is not surprising that, despite informing them to the contrary, participants continued to frame J as an asthma expert until his (lack of) interactional involvement suggested otherwise. This reframing of the researcher was reflected in a shift in the group discussion, away from upholding medical discourses of illness management to participants voicing concerns about presenting an asthma diagnosis in public, safe limits on medicine-use and the quality of care they had received (Murdoch *et al.* 2010). This further emphasized how research methods used to elicit health and illness narratives are organized not only by how interactions proceed but by the contextual conditions surrounding their implementation.

5.   Discussion

Eliciting individual health narratives through research interviews has been shown as a useful technique to gain insight into the worlds of people living with different conditions. In doing so, researchers have often identified samples of people 'living with illness X' or 'doing behaviour Y' and subsequently have treated interview transcripts as a coherent data set in which individual narratives can be coded and used to develop analytical categories specifically to reflect those illness experiences. However, the findings presented in this article illustrate that interpreting health and illness narratives also requires us to attend to those sequences of research interviews where interactional tensions and misunderstandings manifest between interviewer and participant. Such sequences are evident where the interviewer or participant responds to the other's contextualization cues in unexpected ways. These are not necessarily well-articulated, explicit statements, but, instead, may be discursive tokens tentatively proffered to influence the interaction, in which nuanced hints and hesitations indicate how the speaker negotiates the intricacies of the interviewer–interviewee dynamic. Where the interviewee provides 'unexpected talk', subsequent attempts may be made by the interviewer to 'reframe' the interviewee's understanding of the discussion taking place. The relative success of these attempts will affect the direction the interaction takes within the interview. Similarly, when the interviewer inadvertently mimics the medical interaction, it is perhaps unsurprising if the interviewee responds in a patient role.

Tensions and misunderstandings can therefore provide insight into the interactant's different framings, enabling researchers to contextualize narratives more precisely to participants' understanding of the interaction taking place. Participants may provide lengthy narratives for a number of reasons, including framing the interview as an opportunity to share experiences and as a genre of social interaction where talking at length is expected. As Radley and Billig (1996) argue, and as identified in this study's findings (Murdoch 2010), participants may also frame interviews as an interrogation of their illness management, leading to lengthy justifications of behaviour. However, while people with chronic illness may be used to discussing their illness with health professionals, the communicative expectations of the research interview are likely to be a much less usual occurrence in the everyday lives of many interviewees. Similarly, if the interviewer (inadvertently) reproduces many of the prerequisites and communicative expectations of medical interviews in the research interview, this can encourage interviewees to treat the interview like a clinical discussion with a health professional.

Research interviews, while having well-defined boundaries and definitions from an academic perspective, may be less than clear to participants. As Mishler (1991) points out, discussion topics, researcher and participant agendas, backgrounds, experience and roles are potentially unclear, leading to different interpretations of researchers' questions. The production of talk within interviews is influenced by these different participant framings, which will affect interviewees' consideration of which linguistic resources they will see as pertinent to deploy from the repertoire of resources available to them. Sarangi (2003) emphasizes this point further by arguing that although participants may initially frame the interview and themselves in institutionally-sanctioned interviewer–interviewee role identities, these frames are unlikely to be maintained throughout the interview, and instead participants attempt to negotiate alignments across and within different institutional, professional and lifeworld frames.

Despite researchers' best endeavours to inform participants about the aims of the research, interviewer and participant framings of the interaction may differ. Yet it will still be the interviewer who sets the normative expectations of 'a person with illness who is discussing health, illness and medications'. The production of talk within interviews, in this case talk justifying medicine-taking, is therefore intimately connected to participants'

ability and inclination to access the framings and resources the interviewer possesses and attempts to activate within the interaction. Analysing tensions and misunderstandings demonstrates how researchers need to confront the challenge of understanding how these resources shape interview talk. This challenge can be better addressed if additional contextual data can be drawn on to strengthen our interpretations of participants' framings manifested in transcripts. These data can be found by examining linguistic and ethnographic contextual features of interviews, both prior to and also observable within the interview setting itself. If this is the case, the interview narrative must be treated as more deeply embedded within social-historical space than is shown in analysing the text of transcripts alone. This issue has particular implications for conversation analyses of clinical consultations, which typically focus on the organization of interaction as mediating the construction of patients, for example as 'compliant' (Lutfey 2004). The data presented here suggest, rather, that there may be discourses in place which are external to clinical interactions but which may also play a role in shaping clinicians' categorizations of patients, patients' framings of required responses and, potentially therefore, subsequent decisions about treatment.

This broader view of the relevant analytical context is what Rampton *et al.* (2004) referred to as 'opening linguistics up' to incorporate ethnographic features of context not accessible within interactional data, a point also argued by Cicourel (1992). The value of accounting for ethnographic features of context is particularly evident when interactants do not appear to be performing as they 'ought to' within the particular discursive framework set up for the research interviews taking place and the meaning of what the person's talk represents is then seen to be open to question. In contrast to those interviewees who do provide the health narrative expected by the interviewer, these interviews may display misunderstandings that betray an absence of discourses having circulated evenly and been successfully activated within the interview interaction. Scollon and Scollon (2004) provide a useful theoretical framework which can help conceptualize this intersection of discourse, interactants and the genre of the research interview, in what they call a nexus of three components of social action: individuals' 'historical bodies'; 'discourses in place'; and the 'interaction order'. In the case of research interviews about health, the historical body will refer to the interactants' goals, purposes for participating in the interview, experience of taking part in

such discussions and the history and experiences of the interactants with regard to the health topic under discussion. The interactants will select from all available discourses in place to carry out the interview those which they consider relevant for the discussion, whilst ignoring others. In the case of the study reported here, the interviewer and interviewee were therefore likely to discuss the interviewee's role in managing asthma but were unlikely to select and discuss the interviewer's physical appearance or the design of the room in which the interview took place. Finally, the research interview is designed with a particular interaction order in mind (whether effectively implemented or not); it is the researcher who asks questions, and not the interviewee, who is expected to talk at length about themselves. There is therefore a unique nexus between the historical bodies of the interactants, the discourses in place and the interaction order of the research interview. The data presented in this article suggests that interviewers and interviewees only make explicit some aspects of these components of social action, while other components (e.g. interactional arrangements) not manifested in transcripts will nonetheless shape the production of narratives in ways that will affect our interpretation of the participants' talk. The task for researchers in conducting an analysis of narrative is therefore to tease out both visible and invisible contextual features of social action for how they intersect and produce the narratives we analyse as a result.

Note

1. The study was approved by the Eastern Multi Centre Research ethics committee and local ethics and research governance committees. Signed informed consent was given by each participant.

Appendix: Transcription conventions

J:	Denotes speech of first author.
Underlining	Signals vocal emphasis; extent of underlining within individual words locates emphasis.
°I know it,°	'Degree' signs enclose quieter speech (i.e., hearably produced as quieter, not just someone distant).
(1)	Numbers in round brackets measure pauses in seconds, placed on new line if not assigned to a speaker.

(.)	A micropause, hearable but too short to measure.
((text))	Additional comments from transcriber, e.g. context or intonation.
(??)	Inaudible speech on tape with guess as to what was said.
heh heh	Voiced laughter.
sto(h)p i(h)t	Laughter within speech signalled by h's in round brackets.

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