



Talking about depression

A corpus investigation of discourse presentation in interviews with general practitioners and psychiatrists

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In memory of my dad

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English summary

In Denmark, as in other countries, there is a declared intention to establish shared care between general practice and psychiatry for the increasing number of patients with depression. It has been suggested that the lack of shared care in the Danish health care system may be due to different understandings of depression in the two sectors. By applying a literary-stylistic framework – designed to capture uses of discourse presentation from a scalar perspective I investigate how general practitioners and psychiatrists use discourse presentation to conceptualise depression as condition, the doctor-patient relationship and professional identities. The thesis has two main objectives: 1) to investigate how discourse presentation is employed in a corpus of institutional, spoken Danish and how discourse presentation within this context compares to previous corpus studies of scalar discourse presentation; and 2) to investigate how the two groups of health care professionals employ discourse presentation as well as grammatical category features, and how these uses may be viewed as conceptualisations of depression. Based on an annotation framework I have adapted for the present purpose, I annotate the material at three levels: at the level of discourse presentation mode, i.e. speech, writing and thought; at category level for each presentational mode; and finally at the level of grammatical category features. The quantitative results show several significant differences relative to previous corpus studies and among the two groups of health care professionals. In particular, the results for grammatical category features provide new evidence for uses of discourse presentation. Hence, I argue that these realisation patterns and associated uses indicate relatively sharp divisions in the health care system, in which the general practitioners conceptualise the doctor-patient relationship as symmetrical and themselves as critical towards and to some extent detached from the established system, but with minimal distance to ‘real life’. In contrast, the psychiatrists’ discourse presentation use indicates conceptualisations as specialists, with a larger degree of asymmetry in the doctor-patient relationship and a general tendency to express ownership of the treatment and the health care system. Through two supplementary studies I argue that these added perspectives confirm the conceptualisations of depression I claim to have found in the corpus, and the validity of a corpus approach. While most linguistic studies of health care communication focus on doctor-patient interactions, this study is a contribution to studying health care communication in a context of representation. From an interdisciplinary perspective, the thesis offers a structural approach to uncovering conceptualisations in a context which, within the field of social medicine, is mostly examined from a thematic, phenomenological perspective.

Danish summary

I såvel Danmark som i andre lande er der et ønske om øget samarbejde, 'shared care', mellem almen praksis og psykiatrien i behandlingen af et stadigt stigende antal patienter med depression. Grunden til det manglende samarbejde i Danmark kan skyldes forskellige forståelser af depression i de to sektorer. Min afhandling undersøger ved hjælp af en stilistisk-litterær teori om gengivelse af tale, skrift og tanke som et kontinuum af realisationsmuligheder, hvordan praktiserende læger og psykiatere anvender disse fænomener til konceptualisering af depression som lidelse, læge-patient-relationen samt professionelle identiteter. Afhandlingen har to hovedformål: For det første undersøger jeg, hvordan tale, skrift og tanke anvendes i et korpus bestående af institutionelt, dansk talesprog ved at sammenligne mit korpus med tidligere korpusundersøgelser af tale-, skrift- og tankegengivelse baseret på den skalære tilgang til gengivelse. For det andet undersøger jeg, hvordan henholdsvis praktiserende læger og psykiatere anvender gengivelse af tale, skrift og tanke – samt en række grammatiske fænomener knyttet hertil – som udtryk for konceptualiseringer af depression. På basis af en kodningsmanual, jeg har afstemt til mine data, opmærkes korpusset på tre niveauer: ift. gengivelsesmodus, ift. tale-, skrift- og tankegengivelseskategorier og endelig ift. grammatiske realiseringer af disse kategorier. Undersøgelsen viser en række signifikante resultater, både i sammenligningen med tidligere korpusundersøgelser og af de to lægegrupper. Særligt viser de grammatiske fænomener, der knytter sig til kategorierne, hidtil ubeskrevne realiseringsmønstre. I forlængelse heraf argumenterer jeg for, hvordan disse mønstre viser klare grupperinger i sundhedsvæsenet, hvor de praktiserende læger i høj grad konceptualiserer læge-patient-relationen som symmetrisk, og sig selv som systemkritiske behandlere med kort afstand til 'det virkelige liv'. Psykiaternes sprogbrug, derimod, peger i retning af forståelser, der knytter sig til deres specialistrolle, med en højere grad af asymmetri i læge-patient-relationen og en generel tendens til ejerskab ift. behandling og behandlingssystem. Derudover viser jeg gennem to supplerende studier dels hvordan disse supplerende sproglige tilgange bekræfter de konceptualiseringer af depression, jeg argumenterer for i korpusundersøgelsen; dels validiteten af korpusanalyse som metode til undersøgelse af disse konceptualiseringer. I et sundhedskommunikativt perspektiv kan min afhandling ses som et bidrag til undersøgelse af sundhedskommunikation som strukturelt funderede *repræsentationer*, hvor størstedelen af sproglige undersøgelser i dag undersøger *interaktioner* ved brug af konversationsanalysen. I et bredere anvendt perspektiv kan afhandlingen betragtes som et strukturelt bidrag til studere forståelser, som i dag inden for socialmedicin primært foregår på baggrund af fænomenologiske, tematisk-baserede analyser.

CHAPTER 1 INTRODUCTION

1.1 Background and motivation

This PhD thesis investigates how the concept of discourse presentation, as operationalised in the work of the so-called Lancaster group (e.g. Semino & Short 2004, McIntyre et al. 2004), may be applied to a corpus of spoken, institutional, predominantly non-narrative Danish-language interviews about depression, and how such a framework of discourse presentation may serve to illuminate the differences in understanding depression between two groups of health care professionals, viz. general practitioners and psychiatrists.

In Denmark, as in other countries, there is a declared intention to establish more systematic cooperation, known as *shared care*, between general practice and psychiatry for the increasing number of patients with depression (e.g. Gask 2005, Eplov, Lundsteen & Birket-Smith 2009, Eplov et al. 2014.). In countries such as the US and the UK, different collaborative care models have been introduced and tested with only moderately successful results and with somewhat different outcomes depending on the health care system employed (Archer et al. 2012, Richards et al. 2016, Coventry et al. 2012). In Denmark, a literature review carried out in 2009 concluded that collaborative care was the most effective form of shared care for patients with depression (Eplov et al. 2009). This led to the launch of a research project with the aim of testing the collaborative care model in a Danish health care setting (Brinck-Claussen et. al 2017). However, it turned out to be difficult to engage general practitioners (GPs) more broadly in the project. The project also showed some implementation problems primarily related to different working conditions and treatment cultures in the two sectors (Overbeck, Davidsen & Kousgaard 2016, Kousgaard, Overbeck & Davidsen 2017, Overbeck, Kousgaard & Davidsen 2018a).

It has been suggested that the lack of shared care in the Danish health care system may be due to different understandings of depression in the two sectors (e.g. Davidsen & Fosgerau 2014a, Davidsen & Fosgerau 2014b, Fosgerau & Davidsen 2014). The present PhD thesis intends to contribute to a further exploration of this proposition and add knowledge to this ongoing interdisciplinary, qualitative research project focusing on understandings of depression among

general practitioners (GPs) and psychiatrists (PSs) in Denmark (<https://nors.ku.dk/forskning/centre-og-forskergrupper/inmedic/projekter/>).

Linguistic investigations into health care communication, including those about depression, have mainly focused on doctor-patient interaction (e.g. Weiste et al. 2018, Lindell 2017, Fogtman & Davidsen 2014b, Ijäs-Kallio et al. 2010, Nielsen 2007. For a review up to 2010, see Nielsen 2010). These have typically been carried out within the frameworks of Conversation Analysis (e.g. Sacks et al. 1974, Heritage & Maynard 2006), focusing on sequential meaning-making between doctor and patient, or Systemic Functional Linguistics, focusing primarily on how so-called *lexicogrammatical* choices construe meaning in interaction (e.g. Matthiessen 2013), or Critical Discourse Analysis, focusing on how e.g. pre-defined power structures are expressed in a given interactional context (Fairclough 1989, Wodak 1997). How depression, and patients with depression, are talked about has primarily been investigated by other fields such as medicine and psychology (e.g. Chew-Graham et al. 2000, Davidsen 2008, Dowrick 2009, Davidsen & Reventlow 2011). In contrast, my PhD thesis is a linguistic contribution to the analysis of healthcare communication, in that doctors and psychiatrists talk *about* depression and depressive patients. In addition, choosing the interview setting as the object of investigation provides an opportunity to gain additional perspectives to supplement the studies of doctor-patient interactions in the ongoing research project (Davidsen & Fosgerau 2014b, Fosgerau & Davidsen 2014). The present thesis may therefore be regarded both as a contribution to expanding the interactional tradition within linguistics in the study of health care communication, and as a structurally defined alternative to other fields' approaches to researching representations.

I approach investigating possibly diverging understandings of depression by means of discourse presentation (Leech & Short 1981, Short 1996, Semino & Short 2004). The concept of discourse presentation has a long tradition (e.g. Bloom 1968, Aristotle 1969, Voloshinov 1973, Goffman 1981, Bakhtin 1978) and is also a well-established area of research within linguistics, most studies focusing on direct – and occasionally indirect – speech (e.g. Coulmas 1986, Tannen 1989, Møller 1994, Macaulay 2005, Buchstaller 2006, Rathje 2011). My thesis will employ a *scalar* notion of discourse presentation, conceived as a continuum of different degrees of speaker authority for managing e.g. perspective and interactional roles in represented discourse. By adding a layer of grammatical category features presentation I intend to identify more detailed patterns of discourse

presentation uses. My argument is that such patterns can disclose conceptualisations of depression that are not readily accessible to the doctors themselves, as behaviour may be in doctor-patient interactions or in thematisations of a given topic for phenomenological analysis, in this case depression.

Even though the scalar discourse presentation paradigm was designed primarily in order to examine literary texts, broader application was already invited at an early stage: "... the tools which linguists in literature have developed for (rhetorical) analysis might also be usefully used on texts not normally thought of as literary" (Short 1988: 62). Almost two decades later, Semino and Short again encourage additional perspectives on the paradigm: "There is clearly need for further work in order to test and complement our findings. More specifically [...] on spoken as opposed to written data, and on languages other than British English." (Semino & Short 2004: 230-231). Even though these exhortations now date back some years, the scalar approach to discourse presentation in spoken language remains underexplored at the time of writing.

1.2 Thesis statement

This double focus – the application of a scalar discourse presentation framework to my spoken corpus as well as a scalar discourse presentation approach to examining general practitioners' and psychiatrists' conceptualisations of depression – has led me to pose the following two main research questions:

- 1) how is discourse presentation distributed in a corpus of spoken, institutional, predominantly non-narrative Danish-language interviews, and how do the distributional patterns within this context compare to previous corpus studies of discourse presentation?
- 2) how are discourse presentation and associated category features distributed in the two groups of health care professionals and how may such uses be viewed as conceptualisations of depression?

In order to answer the first research question I first present, contextualise and explain the distributional patterns of discourse presentation in my corpus, and in the light of these findings, I then discuss and analyse previous findings of corpus-based discourse presentation, with the aim of providing a more nuanced description of the Lancaster discourse presentation framework from a corpus-based perspective. My assumption is that the application of the discourse presentation

framework to a different discursive setting than those previously examined will contribute to an evaluation of the existing framework.

In order to answer the second research question, I first present the two speaker groups' distribution patterns for the discourse presentation categories and category features, and then I discuss these patterns in relation to the doctor-patient relationship, professional identity and depression as a mental condition. My assumption is that the discourse presentation framework (and the associated features approach) will enable me to provide specific, structural evidence for identifying conceptualisations of depression in the two groups of health care professionals. Part of this assumption depends on an extra level of analysis: instead of looking at general patterns only, I investigate how category features form characteristic patterns which identify speaker group differences that would otherwise have been overlooked.

1.3 The structure of the thesis

Chapter 2 presents an overview of the discourse presentation landscape and its origins, as well as the scalar discourse presentation framework. The chapter consists of two main parts. The first part introduces four main areas: discourse presentation in written language; discourse presentation in spoken language, including interactional communication; the Danish tradition; and finally, studies of health care communication incorporating discourse presentation phenomena. The second part presents the literature on the Lancaster discourse presentation framework, including major revisions of the theory. Chapter 3 introduces the thesis' methodological framework, the participants, the data collection method, the transcription conventions and the selection of data for analysis. The chapter also includes the technicalities of the annotation of my corpus, reflections on the corpus approach, and statistical tests. Chapter 4 comprises my annotation procedures, including the annotation of category features. Chapter 5 presents and discusses the results for the distribution patterns in my corpus in comparison with previous corpus studies on discourse presentation in relation the corpora's contextual variables. Chapter 6 presents and discusses the distribution patterns of discourse presentation and associated category features for the two speaker groups: general practitioners and psychiatrists, and suggests how the distribution patterns may be regarded as differing conceptualisations of depression. Chapter 7 is a supplementary study of one specific and highly underexplored discourse presentation phenomenon: *Report of Language Use*. The phenomenon is adapted into a grammatical framework in order to further illuminate diverging

understandings of depression in the two speaker groups. Chapter 8 presents a qualitative study focusing on the two groups of doctors' elicited stories about a typical patient with depression and how the stories are framed in the interview context. Chapter 9 comprises the thesis' discussion and is divided into three sections: 1) the stylistic perspective, focusing on the explanatory potential of the discourse presentation framework in my corpus; 2) the sociolinguistic perspective, focusing on the two speaker groups and possible explanations for their diverging understandings of depression; 3) the applied perspective, focusing on the applicability of the discourse presentation framework to health care communication.

PART 1: THEORY, METHODOLOGY, AND ANNOTATION

CHAPTER 2 THEORETICAL FRAMEWORK

Structure of the chapter

This chapter consists of two main parts. The first part focuses on theories of discourse presentation other than scalar approaches, and the second part presents the Lancaster discourse presentation framework. The first part begins with a brief overview of discourse presentation in written language since discourse presentation is traditionally regarded as a literary phenomenon. I then introduce discourse presentation in spoken language, including discourse presentation in interaction. The first part also looks at Danish contributions to the field, as well as studies of health care communication incorporating discourse presentation phenomena.

The second part presents the scalar discourse presentation framework developed by the Lancaster school, including elaborations and major revisions. Here, I also introduce other contributions that take their point of departure in the Lancaster framework. The second part of Chapter 2 links to the annotation framework in Chapter 4. The bulk of this chapter will be on discourse presentation in spoken language and on the Lancaster framework, since these two areas form the basis of my thesis.

It should be noted that I will not cover studies that apply individual categories, such as Direct Speech, in this chapter. Instead, I will draw on such studies where relevant in the annotation in Chapter 4 and in the discussion of my results in Chapters 5 and 6. In addition, specific characteristics related to discourse presentation in accounts other than those of the Lancaster School will not be presented in this chapter, but will be referred to where relevant in Chapters 4, 5 and 6.

2.1 The origins of discourse presentation

The origins of the notion of presenting discourse can be traced back to the classical philosophical tradition where thinkers such as Plato and Aristotle formulated ideas about fundamental distinctions within the art of narrational performance. In his legendary work *The Republic*, Plato distinguished two poetic modes, *diegesis* and *mimesis*. The former mode implies strong narrational intervention that conceals the voices of the characters. In Plato's own words: "[...] If the poet nowhere hid himself, his poetic work and narrative as a whole would have taken place without imitation." (Plato, transl. by Bloom 1968: 72). Conversely, we are exposed to the latter mode, *mimesis* "[...] when someone takes out the poet's connections between the speeches and leaves the exchanges." (Plato, transl. by Bloom 1968: 72). As will become evident, Plato's notion of *diegesis* and *mimesis* has had significant impact on the arts in general, literature being no exception, and has served as a basic analytical distinction in the perception and description of art, not least in literary research. This dichotomy is often also termed *telling and showing* or *summary and scene* (e.g. McHale 1978, Fludernik 1993).

The Greek philosophical tradition of *mimesis* and *diegesis* has also had significant impact on the understanding of speech and thought presentation in more recent times. Two of the most prominent commentators in the area are Bakhtin and Voloshinov. One of Bakhtin's main ideas is the notion of *polyphony*, which anticipates that all language is per se dialogic and that all language use reverberates the voices of another situation (Bakhtin 1983). Whereas Bakhtin may be regarded as representing a broader philosophical stance, Voloshinov offers a linguistically based account, which operationalises his, and Bakhtin's, idea of voices and the dialogic nature of communication: "Reported speech is speech within speech, message within message, and at the same time also speech about speech, message about message" (Voloshinov 1973: 149).

The study of discourse presentation is a well-established discipline within literary analysis, including areas such as narratology and stylistics. As Semino and Short point out in their most recent account, the primary research object in the field has long been literary works (Semino & Short 2004: 3). Among the most significant contributions are Cohn (1978), Fludernik (1993), Banfield (1982) and McHale (1978) (see also Semino & Short 2004: 3). McHale proposed a scalar approach to discourse presentation some years before Leech and Short, but without distinguishing presentational modes (McHale 1978). As a consequence, McHale could be considered the inspiration for Leech and Short when they first introduced their scalar approach in 1981, but now

with two separate scales (Semino & Short 2004: 3). A number of contributions have a typological scope. The most central of these include Coulmas (1986), Li (1986), Haberland (1986) and Gldemann et al (2002). Gldemann et al. (2002) provide a comprehensive bibliography of the field of discourse presentation. An older account of contributions made to the field can be found in McHale (1978).

2.2 Discourse presentation in spoken discourse and interaction

In the following, I will present the contributions which serve as the foundation for a considerable number of studies on discourse presentation in spoken language and which therefore may be regarded as some of the most central contributions to the field.

The sociologist Erwin Goffman's concepts of *footing* and *production format* play a central role in the description of speech presentation in interaction. According to Goffman, "a change in footing implies a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance." (Goffman 1981:128) The notion of *alignment* is central here because it denotes the participants' attention to each other in a given speech situation. A change in alignment can involve a change in footing, and this can be either explicit or implicit. A quote framed by a traditional reporting clause is an example of an explicit change in footing, whereas a quote presented through a change in prosody provides a more implicit expression of the phenomenon (Goffman 1981: 128). According to Goffman, the dynamics of interaction cannot be described adequately by means of the traditional concepts of speaker and listener since the roles established in a given situation may be more complex. Goffman proposes alternative understandings of the participant roles, which he labels *production format* and *participation framework* (Goffman 1981: 145, 137). Production format is particularly relevant to the notion of discourse presentation since it allows for shifts between the ongoing speech situation and other, reported worlds, i.e. a change in footing (Goffman 1981: 128). Thus, instead a one-dimensional understanding of the speaker, Goffman introduces a three-layered model to capture the potential roles of a speaker in a given speech situation: "The notions of animator, author, and principal, taken together, can be said to tell us about the "production format" of an utterance." (Goffman 1981: 145).

Goffman's notion of production format and the concept of animator may be said to assume an anterior speech situation. This notion has been challenged by e.g. Tannen (1989), who represents a different view of discourse presentation. Her well-known chapter *Constructed dialogue* lets the reader know from the very beginning that her position is not one of representation. Instead, Tannen puts forward the claim that "[...] even seemingly "direct quotation" is really "constructed dialogue," that is, primarily the creation of the speaker rather than the party quoted." (Tannen 1989:99). Having established her standpoint, the remaining two thirds of the chapter is concerned with providing linguistic evidence to support the claim that reported speech is a construction (Tannen 1989:110-133). Tannen builds her argument at two levels, albeit they are interconnected: at one level she explicates her view of the phenomenon as serving interactional rather than representational goals (Tannen 1989: 105), at another and more concrete level, she argues that linguistic cues in the description of constructed dialogue bear witness to the lack of authenticity or faithfulness as the fundament for the representation of discourse (e.g. Tannen 1989: 111-114). In other words, according to Tannen, it does not matter whether an utterance is evidently constructed through linguistic markers such as negated or choral features (Tannen 1989: 110, 113), her fundamental view of discourse presentation is based on a notion of construction, linguistically traceable or not. Goffman does not explicitly touch on the notion of authenticity, but Tannen's view of the use of voices may be said to differ from Goffman, in that she opposes the concept of discourse as representation: "The conveyor of information is seen as an inert vessel [...] a mere animator: [...] I want to claim that there is no such thing, in conversation, as a mere animator [...]" (Tannen 1989: 108). With their well-known contribution "Quotations as Demonstration", Clark & Gerrig (1990) represent a similar view as that proposed by Tannen. Their main argument is that quotations are actions that function as resources in interaction rather than representations of anterior discourse (Clark & Gerrig 1990). Other contributions include Baynham (1991, 1996), Mayes (1990) and Macaulay (2005).

The description of discourse presentation in sequentially embedded stretches of conversation, i.e. from a conversation analytical perspective, is a more recent trend within studies of discourse presentation. The anthology *Reporting Talk: Reported Speech in Interaction* is an example of this trend (Holt & Clift 2006, eds.). This situated approach to discourse presentation implies that the phenomenon is viewed as an interactional resource rather than representations of anterior discourse. The anthology comprises accounts of a variety of topics, such as complaints, narratives, non-narrative interaction, and contextual settings such as courtroom discourse, ceremonies and

broadcasts. Going through the chapters in *Reporting Talk*, it is interesting to notice how all the studies are conducted based on just one discourse presentation form: Direct Speech (although there is one chapter focusing on Direct Thought). This relatively isolated approach to discourse presentation seems, however, to be a general trend within studies in the field of spoken language. In a review of the anthology, Mick Short also points to the fact that this approach fails to acknowledge parallel and already well-described phenomena in discourse presentation in written language as it “[...] presents as new observations things which have already been pointed out in relation to written discourse [...]” and that it “is unable to make the more general point that many of the findings claimed for spoken interaction apply equally to written discourse presentation, whereas some others do not” (Short 2009: 309).

The landscape outlined for discourse presentation in spoken language in general, and in interactional settings in particular, evidences the fact that there is a gap between the spoken and written traditions, and between spoken language and the scalar approach to discourse presentation. This also means that the potential benefits of bringing more than just one discourse presentation form into play when describing uses and functions within a given contextual framework in spoken language are still to be explored. However, accounts such as those by Thompson (1996), Chafe (1994) and Fairclough (2003) build on both written and spoken language in their discussion of the scalar approach. These contributions will be contextualised after I have presented the Lancaster framework in 2.5.

2.3 Discourse presentation in Danish

Since this thesis is concerned with spoken Danish and may be regarded as a contribution to describing discourse presentation in a Danish language context, I will provide an overview of the research into discourse presentation in a spoken Danish language context. The most central contributions are Møller (1994), Rathje (2009, 2011) and Pedersen (2009). These studies deal with discourse presentation from a sociolinguistic perspective. I should also mention Brøndum-Nielsen (1953), who demonstrates how, contrary to common belief, Free Indirect Speech has been a common feature in spoken Danish since at least the fifties. I return to this discussion in Chapter 5 and Chapter 9. Pedersen (2009) applies the Lancaster discourse presentation framework to spoken narrative. I present this study in more detail in Chapter 5.1.

Møller's research is concerned with discourse presentation in spoken narratives in a sociolinguistic interview setting, his primary objective being to describe the pragmatic aspects of discourse presentation in relation to sociolinguistic variables (Møller 1994: 4,10). Møller briefly sketches the two major paradigmatic trends within the field, *construction* versus *non-construction*, and places himself in between, concluding that the degree of construction is based on a contract between audience and narrative content; he therefore regards discourse presentation as a graded phenomenon (Møller 1994: 5-6). In contrast to, for example, Rathje (2009, 2011), Møller's main concern is not the authenticity of discourse presentation. Instead, he discusses representation versus non-representation (in Danish *gengivelse* and *ikke-gengivelse*) (Møller 1994:7). Møller's discussion of representation versus non-representation is distilled into an operationalisation of the two categories Direct Speech and Indirect Speech, plus the blended form Free Indirect Speech. Møller sets up a number of variables on which he bases his study (Møller 1994: 8-13). Even though his study examines spoken language in an interactional setting, the sociolinguistic interview, it does not take into account how the interaction may influence the production of discourse presentation. Of course, every study has its scope and limitations, but I believe that there are points to be made about the relation between interactional structure and discourse presentation, not least because one of the objectives of my study is to apply the Lancaster framework to spoken discourse. Møller's study is also of relevance to my thesis as he also examines interviews, although there are both differences and similarities in the contextual settings of the two studies. I return to these in Chapters 3 and 5. Møller also points out the potential, but as yet unexplored, differences across different contextual settings (Møller 1994: 6,8). I expect that my study of a different interview setting can add to Møller's findings, leading to a discussion about the relation between discourse presentation and its contextual implications.

Some of the most recent discourse presentation research in spoken Danish has been carried out by Rathje (Rathje 2009, Rathje 2011). Her research has a double focus, namely the definition of a quote and using quotations as a resource in generational language. Rathje commits herself to the tradition of discourse presentation as a constructed phenomenon, along the lines of Tannen (1989) and Clark and Gerrig (1990). She does not, however, make any reference to Møller's work, which is surprising since they both carry out research in the field of sociolinguistics. Rathje's view of discourse presentation as a construction may be said to lie at the one end of the spectrum, representing a more constructionist view than, for example, Møller, and may be seen as a reflection

of the larger ongoing debate within the field as a whole in terms of discourse presentation as representation or construction.

Examining the existing research on discourse presentation in spoken Danish raises at least three points which seem particularly relevant to my thesis: Firstly, none of the studies are concerned with interactional phenomena in a quantitative frame. It should be noted, however, that Rathje does draw on sequences of interaction to illustrate her points about quotations, although it is not the focus of her research (Rathje 2009: 131). The Danish contributions, Rathje, Møller and Pedersen, can be categorised as sociolinguistic¹ studies, which is an approach that, historically, has been regarded as incompatible with an interactional perspective (Schegloff 1993, cf. Fosgerau et al. 2009). However, since the object of study is spoken language, the question is whether it would be possible to match a quantification of discourse presentation phenomena with the occurrence of these phenomena in a sequential environment. As will become evident in Chapter 4, where I present my annotation procedures, this thesis should not be seen as an integration of a corpus approach with interactional uses of discourse presentation. Such an attempt, I believe, deserves a thesis of its own. However, my contribution will be to scratch the surface in setting interactional uses within a quantitative framework.

Secondly, apart from Pedersen (2009), the studies conducted within a Danish context take into account at most only three forms of discourse presentation. Semino and Short, apart from encouraging the application of the framework to spoken language, also call for the inclusion of other languages to test the Lancaster framework: “There is clearly need for further work in order to test and complement our findings. More specifically, similar work could be carried out on [...] languages other than British English.” (Semino & Short 2004: 230-1). My thesis can therefore also be seen as a contribution to this call.

Thirdly, working with three separate scales of discourse presentation, it is interesting to note that neither Møller nor Rathje make any reference to the function and effects of the different presentational modes. At one point, Møller does distinguish thought from speech, but without going into a discussion of possible differences between presentational modes (Møller 1994: 39). However, Møller’s separation of the presentational modes is only momentary, and for most part he treats them as one mode. Any additional insight from working with separate modes is thereby missed, as pointed out by the Lancaster School (Semino and Short 2004: 9) My study, based on three different

¹ However, these studies are not variationist in the Labovian sense (e.g. Labov 1972).

clines as well as the scalar approach, may therefore add to the knowledge of how representations of speech, thought and writing are manifested in a Danish language context.

2.4 Discourse presentation in health communication

Health care communication as a research field has within the last decades attracted more and more attention. This increasing focus on health care communication indicates an acknowledgement of the central role of language in interaction to ensure successful treatment, or in using patients' accounts as part of the diagnostic process (e.g. Peräkylä 2002, Dowrick 2009, Fosgerau & Davidsen 2014, Lindell 2017). As I pointed out in the introduction, the predominant linguistic method used to examine health care communication is conversation analysis. Similarly, there are a very few studies of discourse presentation in a mental health context (see introduction below), and what studies there are typically incorporate only one of the categories on the discourse presentation cline, Direct Speech, occasionally contrasted with Indirect Speech. This focus resembles the broader tendency within the field of discourse presentation to focus on isolated categories of presentation.

Petersen (2011) investigates patients with schizophrenia and how Direct Speech, among other linguistic markers, is used by this group of patients according to a fictive/factive parameter. Her findings indicate that this group, in contrast to a control group, do not tend to create fictive scenarios by means of Direct Speech and that this may be due to an inability to shift perspective because of their mental condition (Petersen 2011). Davis and Mclagan (2018) examine how patients with dementia employ Direct Speech in accounts about themselves. Mildorf (2008) investigates how speech and thought presentation is used in patients' oral narratives about personal experiences of health and illness. The study is based on extracts from an online database, DIPEX, comprising interviews with patients suffering from a wide range of conditions. Mildorf's main objective, however, is not an investigation into a particular health care context, but to examine how free indirect thought and direct speech (Mildorf uses Tannen's term, *constructed dialogue*) may function as narrational strategy in other contexts than literary text. Brunero, Buus and West (2017) look at how Direct Speech is used by medical surgical nurses to categorise patients suffering from mental conditions. Hall, Sarangi and Slembrouck (1999) investigate how direct and indirect speech presentation is used among professionals, including doctors, and between professionals and patients in social work settings, including e.g. health care centres.

In a study of general practitioners' narratives about patients with psychological problems, Davidsen and Reventlow (2011) make use of Direct Speech in their analysis of different narrative styles employed by the general practitioners. As an illustration of a narrative style that is focused on the patient's own life situation, the following observation is made about a GP's story: "K's active treatment approach and the engagement in the patient's situation were stressed by using direct speech rather than simply reporting what happened in a more removed manner. This creates credibility and pulls the listener into the narrated moment." (Davidsen & Reventlow 2011:963). Later in the same study, Davidsen and Reventlow conclude the following about a narrative style that is centred on the doctor-patient relationship: "This story is again dramatized by direct speech [...] to emphasize the energy and the conflict." (Davidsen & Reventlow 2011: 964). It is interesting to note that, in both cases, no literature is provided to substantiate the effects and functions of direct speech in the narratives, and that the authors assign different functions to the uses of direct speech ('credibility' and 'energy'). I expect that a more comprehensive approach to analysing discourse presentation will provide structural evidence for conceptualisations of depression.

2.5 A scalar approach to discourse presentation

2.5.1 Introduction

In this section, I will present in more detail the discourse presentation framework developed by the Lancaster Group. For sake of consistency, I will use the term *discourse presentation* (abbrev. *DP*) as the overarching term for the three clines: speech, writing and thought, even though the framework was first developed to describe two of the presentational modes, namely speech and thought presentation (Leech & Short 1981, also Short 1996). In cases where I wish to make points about a specific cline, I will refer to the individual cline in question.

McHale (1978) is considered to be one of the first and most influential scalar accounts of discourse presentation (Fludernik 1993: 289) Inspired by Page (1973), McHale introduces seven categories, ranging from "'purely' diegetic" to 'purely' mimetic" (McHale 1978: 254-255). The main difference from Leech & Short's framework is that McHale does not distinguish between the presentation of speech and thought, which is a fundamental distinction in Leech and Short's framework (Leech & Short 1981, Short 1996, Semino & Short 2004). The Lancaster group adopts

McHale’s scalar notion of discourse presentation according to the degree of narrational intervention in the presented discourse, illustrated by a *presentational scale*:

Table 2.1: The speech presentation scale

Narrator apparently in total control of report		Narrator apparently in partial control of report		Narrator apparently not in control of report at all	
→	→	→	→	→	→
NRA	NRSA	IS	FIS	DS	FDS

One end of the cline represents the narrator’s most visible intervention in the discourse presented and the other end represents total freedom in the characters’ speech: “When a novelist reports the occurrence of some act or speech act we are apparently seeing the events entirely from his perspective. But as we move along the cline of speech presentation from the more bound to the more free end, his interference seems to become less and less noticeable, until [...] he apparently leaves the characters to talk entirely on their own” (Leech & Short 1981:324). This scalar notion of discourse presentation can be seen as a development of the classic distinction between *diegesis* and *mimesis* as proposed by Plato. Since the introduction of the Lancaster framework intended for literary analysis, the range of genres has been expanded to include newspaper discourse and autobiographies (Short 1998, Semino & Short 2004). This expansion was based on a desire to test the framework on more genres (Semino & Short 2004: 3). The application of the framework to spoken language is also a result of this aim (McIntyre et al 2004: 51-52).

The original speech and thought presentation framework first proposed in *Style in Fiction* in 1981 comprised five categories on each scale: *Narrative Report of Speech/Thought Acts (NRSA/NRTA)*, *Indirect Speech/Thought (IS/IT)*, *Free Indirect Speech/Thought (FIS/FIT)*, *Direct Speech/Thought (DS/DT)* and *Free Direct Speech/Thought (FDS/FDT)*. Since its introduction in 1981, the framework has been developed and refined, most recently by Mick Short in two articles from 2007 and 2012 (Short 2007, Short 2012). However, the 2004 account *Corpus Stylistics* may be regarded as the most extended contribution to the framework since its introduction. In the rest of this chapter, in the annotation procedures in Chapter 4, as well in my presentation and discussion of results in Chapters 5 and 6, I will draw on the Lancaster literature where relevant.

I will now go on to present the discourse presentation clines, the categories and subsequent revisions, starting with speech presentation.

2.5.2 Speech presentation

Direct and Indirect Speech

I will start by presenting the two most well-known speech presentation categories, Direct Speech and Indirect Speech. I will do this by comparing how the categories differ in terms of structure as well as function. As pointed out in the Chapter 1, Direct Speech may be regarded as the most well-described category within the field of speech presentation in general. Leech and Short view Direct Speech as the prototypical speech presentation form, and the category constitutes a starting point for a description of the speech presentation cline: “[...] DS [HSP: Direct Speech] is a norm or baseline for the portrayal of speech” (Leech & Short 1981: 334). By means of Direct Speech, the audience is presented with the full, verbatim version of the anterior utterance. Moving towards the indirect end of the speech presentation cline, the distance between the original utterance and the current speech situation gradually increases, as does the visibility of the narrator (Leech & Short 1981: 324).

Direct Speech is often described by comparing it with Indirect Speech (e.g. Coulmas 1989, Mayes 1990, Møller 1994, Baynham 1991). The notion of Direct Speech as the prototypical speech presentation form, and of Indirect Speech as its traditional counterpart, is also reflected in Leech & Short’s presentation of the two categories: they convert an instance of Direct Speech into Indirect Speech, indicating that the two forms are defined as structural opposites (Leech & Short 1981: 318-319). Tables 2.2 and 2.3 list the structural properties of DS and IS: Table 2.2 concerns the reporting clause. Table 2.3 presents the differences related to the reported clause. It should be noted that these dichotomies are representative of written language and that in spoken language, the realisation of the two forms may be different. This issue will be treated in detail in the annotation guidelines in Chapter 4.

Differences between Direct and Indirect Speech related to the reporting clause in written language:

Table 2.2 Structural differences between DS and IS in the reporting clause

Structural characteristics	Direct Speech	Indirect Speech
Punctuation	<ul style="list-style-type: none"> • The quote marked by inverted commas. 	<ul style="list-style-type: none"> • No inverted commas.
Syntax	<ul style="list-style-type: none"> • No subordinating conjunction. • Paratactic relation between reporting and reported clause. • Reporting clause usually placed <i>after</i> reported clause. 	<ul style="list-style-type: none"> • Possible subordinating conjunction. • Hypotactic relation between reporting and reported clause. • Reporting clause usually placed <i>before</i> reported clause.

The differences between DS and IS related to the reported clause in written language are outlined in the table below:

Table 2.3 Structural differences between DS and IS in the reported clause

Structural characteristics	Direct Speech	Indirect Speech
Pronouns	<ul style="list-style-type: none"> • Primarily proximal pronouns (first and second person) 	<ul style="list-style-type: none"> • Primarily distal pronouns (third person pronouns).

	pronouns).	
Tense	<ul style="list-style-type: none"> • Primarily present tense. 	<ul style="list-style-type: none"> • Primarily past tense.
Deixis	<ul style="list-style-type: none"> • Primarily proximal deictic markers, including adverbs. 	<ul style="list-style-type: none"> • Neutral and/or distal deictic markers, including adverbs.
Sentence structure	<ul style="list-style-type: none"> • All realisations are possible. 	<ul style="list-style-type: none"> • Declarative.

These differences are displayed in two contrasting examples provided by L&S:

Example 2.1

He said: ‘I’ll come back here to see you again tomorrow.’

Example 2.2

He said that he would return there to see her the following day. (Leech & Short 1981: 319).

In the conversion from Direct to Indirect Speech, the sentence structure changes from hypotactic to paratactic, which is also indicated by replacing the colon with the subordinating conjunction *that*, and omitting the inverted commas. The pronoun use changes from proximal to distal, in that *I* becomes *he*, and the tense marking shifts from present to past tense.

Leech and Short point out that the differences between the two categories also imply functional differences in terms of communicative value. This is due to the assumed faithfulness of the presented speech: “[...] when one uses direct speech [...] one quotes the words used verbatim, whereas in indirect report one expresses what was said in one’s own words.” (Leech and Short 1981:318). Also, the reported clause in Direct Speech is at another discoursal level than is Indirect Speech, the former belonging to the character and the latter belonging to the narrator (Leech & Short 1981:324). This observation is similar to what Goffman would term *a change in footing*

(Goffman 1981). By contrast, the use of Indirect Speech maintains the narrational flow since no change in footing takes place (Leech & Short 1981:320). As a consequence, Indirect Speech becomes a more visible product of the narrator. Although Direct Speech and Indirect Speech are described in terms of ownership and assumed faithfulness, Short also points to Direct Speech as a possible *foregrounding* device, which may be used to intensify particularly important points in narrative text (Short 1996: 293, 299). Similarly, Indirect Speech may serve as a *backgrounding* device, with a focus on the content rather than the form of the presented utterance (Short 1996: 293).

Free Direct Speech (FDS)

Free Direct Speech is positioned at the utmost end of the cline and is regarded as the most direct category of speech presentation. In Free Direct Speech “[...] the characters apparently speak to us more immediately without the narrator as an intermediary [...]” (Leech & Short 1981: 322). In Free Direct Speech the quotation marks and the reporting unit characteristic of Direct Speech may be left out. This means that Free Direct Speech has a number of realisation patterns. The least filtered variant is illustrated by the example below:

Example 2.3

I’ll come back here to see you again tomorrow. (Leech & Short 1981: 322).

The instance of Free Direct Speech in Example 2.3 has no reporting unit and the quotation marks are omitted. These omitted narrator traces imply that the ownership of the utterance must be deduced from contextual clues and inferencing, which may also be exploited for effect. In this respect, Free Direct Speech shares similarities with the Free Indirect category, which I return to in the following section.

Short later pointed out that there was no justification for upholding a divide between Direct Speech and Free Direct Speech (1988). The faithfulness claim seems particularly vulnerable to a charge that there is no distinction, as do the (minor) functional differences between the two variants (Short 1988: 71). As a result, in the subsequent versions of the discourse presentation framework, the two variants are considered as one category (Short 1996, Semino & Short 2004: 88). I will return to a

discussion of the divide between FDS and DS (and corresponding categories on the other two clines) in Chapter 4.2.

Free Indirect Speech

Free Indirect Speech blends Direct and Indirect Speech. From a scalar perspective in which Direct Speech is regarded as the prototypical speech presentation category, Free Indirect Speech may be considered a step away from the unfiltered directness characteristic of Direct Speech and therefore a step away from the speech presentation norm (Leech & Short 1981: 334). Structurally, Free Indirect Speech shows the narrator in the tense marking and pronominal choices belonging to Indirect Speech, whereas it typically presents the idiosyncrasies and lexis associated with Direct Speech (Leech & Short 1981: 325). Just as with Free Direct Speech, Free Indirect Speech has a relatively broad realisation potential (Leech & Short 1982: 329-330). The most free of the three examples provided by Leech and Short, which is a conflation of Examples 2.1 and 2.2, is illustrated in Example 2.4:

Example 2.4

He would come back there to see her again tomorrow. (Leech & Short 1981: 325).

Example 2.4 contains no reporting clause, and the proximal deictic markers *come back* and *tomorrow* are a product of Direct Speech. By contrast, the distal markers – the pronoun *he*, the past tense and the adverbial *there* – are all associated with Indirect Speech and maintain the narrational flow (Leech and Short 1981: 325). As a result, it is not possible to discern features exclusive to Free Indirect Speech. In Semino and Short's words: "It is this mixture of DS and IS features that is the defining characteristics of FIS." (Semino & Short 2004: 84). Leech and Short point out that: "Our definition, then, is one in terms of 'family resemblance' rather than one dependent upon the presence of a particular defining feature." (Leech & Short 1981: 329-330). By contrast, McHale (1978) represents a more formal view of Free Indirect Speech (McHale 1978). Leech and Short's less rigid approach also underlines the semantic status of FIS, which at the same time embraces and challenges the faithfulness claim of Direct Speech (Leech & Short 1981: 325).

In Free Indirect Speech, the reporting unit may often be omitted. This lack of anchoring means that the reported speech is not framed as such, which may blur the boundary between speech

presentation and narration (Short 1996: 306). Example 2.4 is presented without a reporting unit, which implies that it is the deictic markers as well as contextual inference that tell us that we are dealing with an instance of speech presentation rather than mere narration. The lack of a reporting unit may also cause doubt in terms of speaker roles in the narrated world: “[...] the frequent absence of reporting clauses in Free Indirect Speech means that readers have to infer the identity of the relevant speaker from contextual clues [...]”. (Semino & Short 2004: 83).

The ambiguity often associated with Free Indirect Speech makes this speech presentation form particularly inference-rich and may be used for effect such as ironic distancing of characters in the narration (Leech & Short 1981:334-335). It may also be used in combination with other speech presentation forms to achieve a sense of “[...] ‘light and shade’ of conversation [...]” (Leech & Short 1981: 335).

Free Indirect Speech may also occur in a first-person narration: “[...] the pronoun choice must be consistent with the primary discourse situation. In an I-narrator novel, the pronoun selection for FIS will inevitably include the possibility of first person.” (Leech & Short 1981: 329). In such cases, we must often rely on contextual clues in order to decide whether it is the character or the narrator who is speaking:

Example 2.5

Yes, I would devote all my life to the child’s welfare. (Leech & Short 1981: 329).

In order to determine the ownership of the utterance, we must rely on the context, the response marker *yes* and the modal *would*, which are features that indicate that the utterance is the second part of an adjacency pair serving as a reply and thus as speech presentation. I go into further detail of this aspect of Free Indirect Speech and contextual clues in the annotation procedures in Chapter 4.

The Narrative Report of Speech Acts (NRSA)

In Leech and Short’s 1981 version, Narrative Report of Speech Acts is the most summarising category on the speech presentation cline and thereby the form with the most visible traces of the

narrator. The category is defined as “[...] more indirect than indirect speech [...]”, providing “[...] only a minimal account of the statement [...]” (Leech & Short 1981: 323-324):

Example 2.6

Everyone gave him advice (Leech & Short 1981:324).

Narrator’s Representation of Speech Act has the function of condensing the report: “It is useful for summarising relatively unimportant stretches of conversation [...]” (Leech & Short 1981: 324). This significant narrational mouldering means that we are unlikely to be exposed to the actual words that were presumably uttered; instead we are given a summarised version of the utterance. The 1981 version does not provide any structural description of the category and its linguistic realisations, even though the examples contain both nominalisations as in Example 2.6 and verbal constructions (Leech & Short 1981: 324). The description is elaborated in the 2004 version in which Semino and Short, in addition to the less frequent nominal realisation, point out that “NRSA tends to be realized in single-clause structures, where the verb is a speech act verb, and may be followed by [...] noun phrases or prepositional phrases [...]” (Semino & Short 2004:77). A minimal variant of the category, as in Example 2.6, is distinguished from the variant with topic specification, realised as a prepositional phrase:

Example 2.7

He answered me in the fewest words possible. (Semino & Short 2004: 52).

This more fine-grained description leads Semino and Short to conclude that “[...] NRSA(p) is a rather flexible form of presentation, ranging from minimal references to speech acts (in the prototypical NRSA form) to fairly detailed but concise summaries of one or more utterances (in the NRSAP variant).” (Semino & Short 2004: 73). Along the lines of Leech and Short (1981) and Short (1996), Semino and Short (2004) emphasise the category’s potentially backgrounding effect (Semino & Short 2004: 75). Another highlighted function is iterations, which “[...] refer to a number of different utterances produced over a period of time on different occasions.” (Semino & Short 2004: 77). Further, they have found that Narrator’s Representation of Speech Act without

topic specification is also used to introduce a subject that is elaborated later on in the text (Semino & Short 2004: 75). Narrator's Representation of Speech Act is similar McHale's term *diegetic summary* and Baynham's *lexicalization* (Baynham 1991).

Narrator's Representation of Voice (NV)

Narrator's Representation of Voice is a relatively recent addition to the speech presentation cline. It was first introduced by Short as *Narrator's Representation of Speech* in the 1996 edition (Short 1996). The current label, *Narrator's Representation of Voice*, was added by Semino and Short (2004: 65). Narrator's Representation of Voice captures instances of speech presentation that are even more minimal than Narrator's Representation of Speech Act: "This category merely tells us that speech occurred, without any indication of what was said." (Short 1996: 297):

Example 2.8

He could hear two persons talking in the pantry. (Short 1996: 297).

The level of specificity and the semantic density characteristic of Narrator's Representation of Speech Act is absent in Narrator's Representation of Voice, making it the most minimal category of the speech presentation forms. Short's (1996) definition of Narrator's Representation of Voice is based on semantic criteria, and it is not until the 2004 version that we are presented with a more detailed description. Here, Semino and Short point out that the category covers a wider range of linguistic realisations than Narrator's Representation of Speech Act (Semino & Short 2004: 77). The category is typically realised by a "[...] verb of speech, which may be rather general (e.g. 'speak', 'talk') or more specific (e.g. 'shouted', 'motored on')." (Semino & Short 2004: 73). It may also be realised as "[...] a delexicalized verb and a direct object [...]" (e.g. 'gave a series of interviews')." or as a noun phrase (Semino & Short 2004: 73). In terms of use, Semino and Short have discerned two main functions: just as Narrator's Representation of Speech Act, it may serve as a minimal reference to speech. It may also function as what Semino and Short term *summary reference*, denoting speech produced by more than one person, typically groups of people (Semino & Short 2004: 45). Other than that, Narrator's Representation of Voice can also convey a general setting (Semino & Short 2004: 71).

Narrative Report of Action/Narration (NRA, N)

Narrative Report of Action or simply *Narration*, as Semino and Short name it, captures actions, events, descriptions of states etc.:

Example 2.9

Agatha dived into the pond

Example 2.10

She felt furious (Short 1996:295-296).

The category is only treated illustratively in the 1981 edition, where it is depicted on the speech presentation cline (Leech & Short 1981: 324). Short (1996) draws a parallel between Narration and the summarising categories Narrator's Representation of Speech Act and Narrator's Representation of Voice. Neither of the two summarising speech presentation categories present propositional content and thus approximate actions. In Short's words they are "[...] the speech equivalents of the narration of actions and events [...]", leading him to draw a parallel to the ideas behind speech act theory (Short 1996: 306). Narration is probably best considered a residual category, which is useful for e.g. quantitative studies that aim at mapping the relative proportion of discourse presentation in a text or a corpus.

Summary of the speech presentation categories

The basic mechanisms behind the SP cline are summarised by Short: "[...] the scale of speech presentation is a scale of the relative weighting of the apparent influence of the character and the narrator over what is reported." (Short 1996: 306). This notion is reflected in the self-invented Example 2.11 below, which I have borrowed from my master's thesis (Pedersen 2009: 18). The instances of speech presentation illustrate a gradual decrease in the directness and specification of the utterance and a gradual increase in the narrator's visibility as we move through the variants:

Example 2.11

Emma asked Claire: "What subject do you like the best?"

- (1) FDS: “Speech presentation is definitely my all-time favourite”
- (2) DS: “Speech presentation is definitely my all-time favourite”, Claire said
- (3) FIS: Claire said that speech presentation was definitely her all-time favourite
- (4) IS: Claire said that speech presentation was her favourite subject
- (5a) NRSAP: Claire informed Emma about her preferences
- (5b) NRSA: Claire answered Emma
- (6) NV: Claire was chatting to Emma

In (1)-(4) we are presented with the propositional content of the utterance, whereas this is not the case with (5a)-(6).

2.5.3 Writing presentation

The writing presentation scale is a more recent addition to the Lancaster discourse presentation framework and was introduced as a third cline in the 2004 account (Semino & Short 2004). The motivation for adding a third scale of discourse presentation was primarily the result of findings in the two non-literary genres press and (auto)biography). Here, writing presentation seemed particularly prevalent compared to fiction (Semino & Short 2004: 48). Semino and Short point out that there has been a tendency in studies of discourse presentation to conflate writing and speech presentation. This also means that Semino and Short (2004) and McIntyre et al. (2004) are the only studies that distinguish writing from speech, McIntyre et al. evidently doing so in that they, with a few modifications, apply the existing Lancaster discourse presentation framework to spoken language (McIntyre et al. 2004). Semino and Short do, however, draw attention to Fairclough referring to a conflation of the two presentational modes (Semino & Short 2004: 47). This implies that even though Fairclough does not uphold a functional distinction between the two presentational forms, he nevertheless acknowledges that the two modes differ.

If we accept the faithfulness claim – at least as a theoretical construct – writing presentation poses more similarities with speech presentation than thought presentation, at least in relation to the apparent authenticity of original utterance. This is due to both presentational modes being

externalised modes of communication (Semino & Short 2004: 98, 111). In fact, Semino and Short point out that it is questionable whether this claim is sustainable in relation to thought presentation at all (Semino & Short 2004: 98). As regards the differences between speech and writing presentation, Semino and Short argue that writing presentation actually makes a stronger faithfulness claim because writing presentation may more easily be traced back to its source (Semino & Short 2004: 50).

In terms of realisation of the categories, the patterns for the writing presentation categories are assumed to be the same as those for speech presentation, which means that I will not go through each of the categories here. Instead, I will exemplify the writing presentation categories in the annotation in Chapter 4, using material from my own corpus.

2.5.4 Thought presentation

Leech and Short (1981) was the first account of discourse presentation to separate the presentation of speech from the presentation of thought (Semino & Short 2004: 9). There were several reasons for doing this, rooted in semantic and functional rather than formal, structural arguments. As pointed out by Leech and Short: “The modes of speech and thought are very similar formally [...]” (Leech & Short 1981:387). The differences between the two presentational modes are to be found in the very nature of their communicative outlook and consequently in the accessibility to and effect on the reader (Leech & Short 1981: 345, Semino & Short 2004:15). As mentioned in 2.5.2, Direct Speech is viewed as the prototypical speech presentation form, i.e. it constitutes the norm on the speech presentation cline. The reason for giving Direct Speech this status is that speech is an externalised and communicative phenomenon. It is by means of Direct Speech that we are presented with the assumed verbatim rendering of the previous utterance, i.e. by using Direct Speech, access to the utterance is readily available to the reader. The presentation of thought is a somewhat different matter. Here, Indirect Thought is perceived to be the norm: “[...] other people’s thoughts are not accessible to such direct perception, and so a mode which only commits the writer to the content of what was thought is much more acceptable as the norm. Thoughts, in general, are not verbally formulated, and so cannot be reported verbatim.” (Leech & Short 1981: 345). As pointed out in 2.5.2, one of the common effects associated with Free Indirect Speech is irony and sarcasm. This effect is achieved by moving away from the norm, Direct Speech. In the presentation of

thought, the directionality of the movement is different (Leech & Short 1981: 345, Semino & Short 2004: 9, 124). While Indirect Thought is the assumed prototypical thought presentation, Free Indirect Thought holds a different status associated with directness and access to the thoughts presented. This is, Leech and Short argue, because Free Indirect Thought on the thought presentation cline “[...] is seen as a move to right and hence away from the author’s most directly interpretative control and into the active mind of the character.” (Leech & Short 1981: 345). As a result, such differences in the ontological status of the presentational modes affect the notions of prototypicality within the discourse presentation framework.

Thought presentation categories

As mentioned in the previous sections, the formal criteria for the presentation of thought are similar to those for the presentation of speech. For this reason, I will not go into a detailed description of these features. Instead, I will present, by replicating Leech and Short’s list of thought presentation examples, the categories from the early thought presentation account:

Example 2.12

Free Direct Thought: Does she still love me?

Direct Thought: He wondered, ‘Does she still love me?’

Free Indirect Thought: Did she still love him?

Indirect Thought: He wondered if she still loved him

Narrator’s Representation of Thought Act: He wondered about her love for him

(Leech & Short 1981: 337).

Direct Thought (and Free Direct Thought)

Whereas Direct Speech is the prototypical choice for the presentation of speech, its structural counterpart on the thought presentation scale, Direct Thought, holds a different position. According to Leech and Short, Direct Thought is “[...] perceived as more artificial than more indirect forms.” (Leech & Short 1981: 345). Even though Indirect Thought is considered the prototypical thought

presentation category, Leech and Short note that Direct Thought is quite a common phenomenon in literary text (Leech & Short 1981: 345). Nevertheless, in their corpus study, Semino and Short find that Direct Thought constitutes the least frequent of the thought presentation categories (Semino & Short 2004:115). This may be due to the markedness associated with Direct Thought, especially in literary text where Free Indirect Thought is much more common (Semino & Short 2004: 123). I return to Free Indirect Thought in the following section. The relative infrequency of Direct Thought in the corpus study confirms the line of argumentation suggested in the earlier account (Leech & Short 1981: 345, Semino & Short 2004:118-119).

As with Free Direct Speech, Free Direct Thought is characterised by the omission of the reporting clause and/or quotation marks (Leech & Short 1981:337-8). Since the prototypicality in thought presentation is assumed to be different than in speech presentation, this most extreme form of thought presentation, Free Direct Thought, may be exploited for dramatic effect and can be regarded as an even more marked choice than Free Direct Speech. Neither of the accounts actually compares the two free direct forms. However, Free Direct Speech is often highlighted as a component in represented dialogue (e.g. Macaulay 2005, Semino & Short 2004: 90). Evidently, due to its private ontology, Direct Thought does not invite the same interactional pattern when it represents an exchange between speakers (even though Free Direct Thought may be used as evaluation of speech presentation in represented dialogue, see e.g. Labov & Waletzky 1967: 35). Such differences in interactional potential may also explain why Free Direct Thought and Free Direct Speech differ in terms of frequency.

Free Indirect Thought

Free Indirect Thought is a well-described phenomenon within the literary tradition, where it is often associated with stream of consciousness writing (Semino & Short 2004: 123ff., see also e.g. Cohn 1978, McHale 1978). If we return to the cline of thought presentation on which Indirect Thought is considered the prototypical thought presentation form, the use of Free Indirect Thought is regarded as a move *towards* the norm. If we recall the cline of speech presentation, the directionality here was the opposite, with Direct Speech as the norm for the portrayal of speech and Free Indirect Speech constituting a movement away from the norm, DS, “[...] towards authorial intervention [...]” (Leech & Short 1981:345). Free Indirect Thought, on the contrary, represents a move “[...]”

away from the author's most directly interpretative control and into the active mind of the character" (Leech & Short 1981:345).

Indirect Thought

Since thought, as opposed to speech, is not an explicit means of communication, the main function of indirect thought is to communicate content, such as ideas and opinions (Leech & Short 1981: 345, Semino & Short 2004: 127. See also Chafe 1994: 219-220). Even though Indirect Thought is considered the norm on the thought presentation cline, in their corpus investigation, Semino and Short find that quantitatively, Indirect Thought is less frequent than the blended Free Indirect Thought.² If we compare Indirect Thought and Indirect Speech, the two categories match in terms of structural features, with a reporting clause and a proposition realised as a subordinated clause (Leech 1981: 338). For this reason, I will not go further into the realisation patterns of Indirect Thought, but will refer the reader to 2.5.2 concerning Indirect Speech.

Narrative Report of a Thought Act (NRTA)

In the 1981 account, the NRTA constitutes the most summarising thought act on the thought presentation cline. The category is only sparsely treated, with the account merely stating that in this realisation the reporting clause is nominalised ('her love for him') making the report minimal (Leech & Short 1981:338). The status of NRTA as projecting a thought act is left aside until Semino and Short (2004) point out that talking about illocutionary force in connection with thought presentation is somewhat problematic due to the private nature of thoughts (Semino & Short 2004: 130, see also Short 2011). In his 1996 account, Short states that the three most summarising forms on the thought presentation cline are 'relatively rare' (Short 1996:311).

² In fact, Indirect Thought is only the third most frequent category in Semino and Short's corpus, since the more recent category Internal Narration is by far the most frequent category (Semino & Short 2004: 115). However, the somewhat questionable status of the category on the thought presentation cline makes the comparison in terms of relative frequency rather problematic (see Chapter 2.5.4 and Chapter 4.8)

Internal Narration (NI) and Narrator's Thought (NRT)

The introduction of the category Internal Narration was a result of Semino and Short's corpus investigation of discourse presentation in which they found a tendency for characters to be often depicted through internal states but without any specific thought act being explicated:

Example 2.13

For a moment she did not know where she was.

Example 2.14

I hurried to her room and was immediately filled with alarm. (Semino & Short 2004: 46).

As a result, Semino and Short decided to tag such instances as Internal Narration “[...] where the narrator reports a character's cognitive and emotional experiences without presenting any specific thoughts” (Semino & Short 2004:46). However, when comparing the thought presentation scale with the other two scales, Internal Narration takes on a somewhat different position, which in some ways is closer to the residual category *Narration* and which is also described by Semino and Short: “It is not clear whether or not NI should be regarded as a thought presentation category” (Semino & Short 2004:147). The Internal Narration category, and the degree to which it corresponds to the summarising categories on the other two presentational scales, is also noted in further instances (e.g. Semino & Short 2004: 148). Even though all of the three most summarising categories on each scale, Narrator's Voice (NV), Narrator's Writing (NW) and Internal Narration (NI), capture minimal references, experiences presented through NI do not allow for a paraphrase or modulation into any other category on the scale, as is the case with the most summarising forms for the presentation of speech and writing:

“the fact that these experiences are normally non-verbal in nature means that writers could not easily have chosen to represent them using the other categories of thought presentation [...] This contrasts with speech and writing presentation, where, in principle, any speech or writing activity can be presented using any of the categories on the respective scales” (Semino & Short 2004:148).

This lack of correspondence between the summarising forms on the three scales also touches on issues of a more general character with regard to the comparability of the three scales, namely that “thought is ontologically different from speech and writing” (Semino & Short 2004:149), which is

an issue of recurrent interest in the recent works of the Lancaster group (Short 2012:23, Short 2007, Short 1996). At the same time, this ongoing discussion confirms that are substantiated reasons for distinguishing between the different modes of presentation, something which is not common practice in many other accounts of discourse presentation.

In the discussion of the results of the corpus investigation, in which Internal Narration is the most frequent category, followed by Free Indirect Thought, Semino and Short seem essentially undecided as to what stance to take towards the Internal Narration category. After all, there seems no doubt that the status of Internal Narration is one of less integration than all other categories in the framework: “Given that, as we will argue, NI is quite different from other forms of presentation, FIT is perhaps best regarded as the most frequent of the canonical thought presentation categories” (Semino & Short 2004:123).

Both before and after the introduction of the Internal Narration category, there have been attempts to align the scales of discourse presentation. As early as 1996, Short actually proposes the variant Narrator’s Representation of Thought (NRT³), but without going into detail about the ontological status of the form or mentioning the fact that the form is introduced here for the first time: “I will not discuss NRT, NRTA or IT in detail as the effects associated with them are roughly the same as for speech presentation” (Short 1996: 311). In Semino & Short (2004), Short’s use of the variant is not mentioned at all. Instead, in the concluding chapter, they touch briefly on the possibility of introducing an NT category, which could ensure increased comparability with the other two scales (Semino & Short 2004: 229). This thread is taken up by Short in his 2007 article in which he concludes that Internal Narration is best seen as not belonging to the thought presentation cline (Short 2007).

³ ‘NRT’ here should not be confused with Semino and Short’s use of the same abbreviation in their 2004 account of reporting units. In Semino and Short (2004) ‘NRT’ is referred to as ‘NT’.

2.5.5 Category features

The concept of category features is first introduced in Semino and Short (2004), when they use the term *specific phenomena*; the subsequent publication by McIntyre et al. (2004), however, employs the term *category features*. I have chosen to adopt the latter term since I find this more self-explanatory and specific than the one used in Semino & Short. I will refrain from giving an elaborate presentation of the individual category features here, since these will be presented and discussed partly in Chapter 4 where I introduce my annotation procedures, and partly in Chapter 6 where they are relevant to the discussion of speaker group differences.

2.6 Other accounts based on the Lancaster discourse presentation framework

There are, to the best of my knowledge, a handful of accounts focusing on the Lancaster framework in spoken language. Apart from McIntyre et al. (2004), these include Chafe (1994), Thompson (1994), Fairclough (2003) and Pedersen (2009). None of these (apart from Pedersen (2009), which will be presented in Chapter 5) are quantitative studies, but rather accounts which integrate the framework into their own theories of language use. They will be presented briefly in the following sections.

The American linguist William Chafe is concerned with the individual and the role of consciousness in linking past events to the present speech situation: “An obvious but remarkable fact of human consciousness is that it need not be restricted to event and states that coincide with the time and place of the conscious experience itself” (Chafe 1994:195). Chafe describes two modes, ‘the immediate’ and ‘the displaced’ mode, the immediate mode being the here and now, the current speech situation, and the displaced mode the past. Chafe’s primary focus is on the displaced mode, since it is here, according to Chafe, that the possibilities of the consciousness are exploited (1996: 196-201). By using vocabulary such as ‘repeat’ and ‘originate’ (Chafe 1994: 212), Chafe seems to anticipate the presentation of anterior discourse, and more so than, for example, Tannen, even though Chafe’s overarching argument actually reflects Bahktin’s concept of voice more than anything: “Much of what people know was acquired through language that originated in and was first represented by a consciousness other than their own” (Chafe 1994: 212). Of the speech presentation variants, Direct Speech holds the most potential for bringing immediate qualities to past experience, whereas Indirect Speech and what Chafe terms *Referred to Speech* (i.e. the

summarising speech presentation forms) maintain to different degrees the distance between anterior speech and the present reporting context (Chafe 1994: 212-215). Chafe claims that Free Indirect Speech is almost exclusive of written language, an observation which leads him to omit a treatment of this speech presentation variant in his account of conversational language (Chafe 1994: 212).

Thompson (1996) also builds on Leech and Short's account on speech and thought presentation. He includes more dimensions of speech and thought presentation in his framework, which is modelled on a wide range of text types. Thompson introduces four dimensions, *voice*, *message*, *signal* and *attitude* (Thompson 1996: 507). The first dimension, *voice*, concerns the 'ownership' of the report, i.e. who is made responsible for the presented discourse. The second dimension, *message*, renames Leech and Short's speech and thought presentation categories but without introducing new forms. The third dimension, *signal*, deals with reporting units and extends the notion of the reporting verb to include other grammatical forms as reporting signals. The fourth dimension, *attitude*, deals with the reporter's stance, *neutral*, *positive* or *negative*, towards what is being reported. The main change to Leech and Short's framework is the introduction of more layers, of which *message* (i.e. the speech and thought presentation forms) is just one aspect in a more comprehensive study of speech and thought presentation. Because he examines non-fictional written discourse as well as spoken discourse, Thompson's describes his approach as being more discourse-oriented than Leech and Short's (Thompson 1996:506). Thompson's integration of more dimensions than merely the discourse presentation may be seen as an attempt to account more fully for types of discourse other than literary. Even though Semino and Short, in their description of the categories and in their specific examples, refer to concepts such as multiple speakers and assigned roles by use of speaker voice, these parameters are not explicated as category features and are hence not systematically examined in their corpus (e.g. Semino & Short 2004: 76) . Thompson's contribution may be seen as an example of how to explicitly elaborate on the original Lancaster discourse presentation framework.

CHAPTER 3: METHODOLOGY

This chapter consists of two parts. In the first part, I present the study's participants, data collection method and data. This involves reflections upon the interview as a speech event and the participant framework. The second part discusses how I selected material for my corpus as well as the technicalities of the annotation and data handling. The second part also presents the statistics used to test my results.

3.1 Participants, data collection method, and data

3.1.1 Participants

The material in my corpus has been kindly lent to me by one of my supervisors, Associate Professor, Dr. Med. Annette Davidsen, who collected the data in 2011-2012 as part of a research project on understandings of depression in the Danish health care sector (e.g. Davidsen & Fosgerau 2014a). The data consists of 23 interviews in total, 12 with GPs and 11 with psychiatrists. In addition, a series of these same GPs' doctor-patient consultations and these same psychiatrists' interactions with their patients were recorded. In my study, I have chosen to focus on the interviews, for reasons set forth in Chapter 1.1.

The participants were selected from two regions in Denmark in order to control for demographic differences among the doctors. All participants were covered by a collective agreement with the health authorities or were employed at a public hospital. The gender distribution is equal in the two groups, and the age range is comparable: 45-62 years for the psychiatrists and 43-66 years for the GPs. The informant group was purposively selected based on the principle of theoretical saturation (Strauss & Corbin 1998). The basic idea behind theoretical saturation is that data is collected until the researcher assesses that all objectives are covered by the material (Strauss & Corbin 1998). The interviews were audio recorded and lasted 45-55 minutes each. In Section 3.1.2, I consider how the length of the interview may play a role in interaction between the participants.

The collected data takes the form of qualitative, semi-structured, in-depth interviews (Kvale 1997, Gubrium & Holstein 2001, Patton 2002). An interview guide consisting of six main themes with a number of sub-questions was designed to ensure that all desired areas were covered and to consider

foreseen difficulties (see Appendix 1). The guide was suggestive, not prescriptive. Questions were neutral and open and addressed participants' understandings and conceptualisations of depression (Smith & Osborn 2003). All interviews were conducted by the same interviewer, Annette Davidsen, who is herself a trained and certified GP. Davidsen has, however, also spent five years working in psychiatry and was working as a psychiatrist at the time of the interviews.

Because I used pre-existing interviews collected for qualitative health care research purposes rather than for linguistic purposes, I did not have any influence on the data collection and its design. As a result, my own role in relation to the data entails a greater degree of distance than had I collected the data myself. During my PhD employment, I had the privilege of being part of a depression research group at University of Copenhagen that included Annette Davidsen. My affiliation with the research group means that I have had unique access to the interviewer's reflections on the interviews, on her objectives for carrying out the interviews, and on her perceptions regarding interviewing the two professional groups. I will return to how I used this source of knowledge in my approach to the data in Chapter 8. In terms of my own role in relation to the data, the fact that the design of the larger research project and data collection were carried out by others also means that the construction of the corpus was not designed specifically with the production of discourse presentation in mind. This is not the case for the selection processes of the two corpora with which I will compare my own. I will return to this issue in Chapter 5, where I compare the design of my corpus with those of Semino and Short (2004) and McIntyre et al. (2004).

3.1.2 Data collection method: The professional interview

One widely used method of examining language in an interview context is the so-called sociolinguistic interview. The sociolinguist William Labov developed this type of interview on the basis of dialectological practices, seeking to study what he termed *the vernacular*, which he saw as a speaker's most authentic speech (Labov 1972: 355, Labov 2013: 3). Labov hypothesised that the vernacular could be obtained by engaging informants in conversations about their lives, often involving personal or critical topics from the informant's life course (Labov 2013: 4-9) The participant framework in the sociolinguistic interview context includes an outsider (often a researcher) conducting the interview and a layman (the informant) providing the information about his or her life, often in the informant's own home. A central aspect of the interviewer-interviewee

relationship in the sociolinguistic interview is the transformation of the interviewer's role from a professional into what Albris has termed *the intimate stranger* (Albris 1991, Gregersen et al. 2009). The context may thus be characterised as predominantly private rather than professional.

This brief overview of the sociolinguistic interview highlights the contextual circumstances under which speech for certain kinds of linguistic research is produced. Of course, linguistic researchers make use of other types of interview methods for analysing linguistic or interactional phenomena in interview settings, such as ethnographic interviews or standardised interviews (e.g. Spradley 1979, Fowler and Mangione 1990, see also Sørensen 2014). However, a brief comparison with the sociolinguistic interview allows me to highlight some of the traits that define the in-depth research interview and consequently how the discourse produced in this type of interview may be of a different nature than that produced by sociolinguistic interviews. One aspect that differs markedly from the sociolinguistic interview is the relationship between interviewer and interviewee. In the sociolinguistic interview, the objective is to get through to and explore the private sphere. In contrast, the sphere of in-depth research interviews may be characterised as professional rather than private, with the medical professionals acting as institutional representatives. The doctors may be said to professional experts, but so too is the interviewer. The fact that the interviewer shares her professional background with both the GPs and the psychiatrists makes for a symmetrical and in-group relationship throughout. In Chapter 6.4.4, I will return to how this context may influence the interaction and production of discourse presentation in the interviews.

The length of the interviews, ranging from 45 to 55 minutes, means that the interviews do not exceed what is considered as the time frame within which a professional relationship may be maintained. Albris has suggested that, generally, if a sociolinguistic interview lasts longer than one hour, the professional distance between interviewer and interviewee tends to lessen, and the style of the interview tends to become increasingly informal (Albris 1991). This is why researchers conducting sociolinguistic interviews often aim to make the interview last longer than one hour, precisely because one of the goals of this type of interview is to create an informal atmosphere as a gateway to the informant's vernacular. In relation to the interviews in my corpus, the fact that the interviews do not exceed one hour gives good reason to assume that the professional distance between interviewer and interviewee is maintained. In other words, any distinct variations in the interaction are less likely to be a consequence of the time variable.

Turning to the interviews' participant structure, it is inevitable that the differing backgrounds of the two informant groups will affect the outcomes of the research. Each group of informants occupies a domain within the healthcare sector: the general practitioners are generalists, and many see their patients on a regular basis or at least maintain some kind of continuous relationship with their patients. In contrast, the psychiatrists are certified specialists and only see patients suffering from or suspected suffering from mental illnesses. Furthermore, the diagnostic criteria for depression are formulated within psychiatry, not in general practice, underlining the different positions of the two groups of doctors within the health care system (Gask, Klinkman, Fortes & Dowrick 2008). These differing contextual circumstances for the two groups of doctors give grounds for assuming that they enter into the interview with different backgrounds and different kinds of knowledge. The psychiatrists may be said to 'own' the specialist knowledge about depression, whereas this is less so the case with the general practitioners.

Turning to the interviewer's background, she has a long history as a general practitioner as well as five years' experience from the psychiatric sector. This suggests that when conducting the interviews she is already, at least to some extent, knowledgeable of both general practice and psychiatry, which positions her as more than just as an outsider seeking information and reflections about depression. The interviewer instead has the capacity to align with both professional identities in the interviews. At the same time, the interviewer's wide-ranging medical background may also affect informants' behaviour and speech. In her account of interviewing in social research contexts, Cameron has pointed to this premise: "The answers people produce to questions about their experiences, habits, affiliations, opinions and preferences are not just designed to convey relevant factual information, then, but also very often to address what the respondent rightly or wrongly believes to be the intentions and preconceptions behind the question." (Cameron 2001: 148). Cameron's observation could of course be applied to many interview situations, but I would argue that this is especially pertinent to the interviews in my corpus, due to the participant structure involving medical professionals on both sides of the table as well as the highly specialised topic at the core of my interviews. This may be particularly prominent in the interviews with the psychiatrists, partly because they are interacting with someone who is also knowledgeable within the field, and partly because the psychiatrists are the specialists within the field and therefore could have the desire to uphold and confirm this position in the interviews. An inability to provide sufficient answers may quite simply represent a threat to their professional face, not least because the interviewer is at least to some extent able to decipher their level of knowledge. Conversely, the

GPs could have the same desire to orient themselves toward what the interviewer is seeking in order not to lose face. In any case, the highly professional context of the interviews implies that there is a considerable amount of professional face to maintain. In Chapter 6, I discuss possible relations between the interview participants and the production of discourse presentation. In Chapter 8, I aim to show how the doctors' narrative styles when constructing stories about a typical patient may be linked to the interview context.

3.2 Constructing and annotating my corpus

3.2.1 Construction of the corpus

In this section, I present the steps taken in constructing and handling my corpus. This involves how I selected the data to be used, the methodological steps involved in annotating the data, and the technical details related to annotation. I also introduce the statistical tests used to reveal significant differences between my corpus and previous corpus studies on discourse presentation as well as between speaker groups. The analytical choices related to the content of the annotation will be described in Chapter 4, in which I present the annotation manual.

For the corpus investigation, I selected a total of 12 interviews: six GPs and six psychiatrists. It should be highlighted, however, that the annotation manual is based on coding observations from all 23 interviews since these were all included in the first round of annotation. I chose to focus on 12 of the 23 interviews due to time restrictions and resources available since a highly detailed annotation such as the one I propose is rather time consuming. In order not to avoid bias in interview selection, I simply selected the first six interviews that I had coded from each group. The size of the selected corpus is 111,537 words. This word count includes transcription of pauses, false starts, laughter, etc. (see Appendix 2). For the two additional studies (see Chapter 7 and Chapter 8), I have included all 23 interviews. Including all interviews in these supplementary studies offers a perspective on the corpus results, either by lending weight to or challenging the patterns found in the corpus study. The size of this larger corpus is 178,958 words⁴.

⁴ The count for the total 23 interviews is based on earlier, less detailed transcriptions, whereas the count for my core corpus is based on the Transcriber transcriptions (see Chapter 4). This may mean that the figure for total count is lower than had the count been conducted on basis of the Transcriber transcriptions. I only use the figure for the total count in one instance. This is in Chapter 7, where I make an index calculation for the two speaker groups.

The interviews were transcribed in the Transcriber transcription program by students working at the LANCHART Centre (see Appendix 2 for the Transcriber manual, including transcription conventions), which at that time had a long tradition of reliable transcription in accordance with the manual. The Transcriber conventions ensure a detailed transcription of the speech produced as well as a marking of basic interactional features such as back-channelling and overlapping turns. The Transcriber conventions do not result in as detailed a transcription as conventions used in conversation analysis. Since my PhD thesis is predominantly quantitative rather than qualitative or interactional in its objectives, I found the Transcriber conventions to be more than adequate for my needs in handling and analysing data. This does not mean, however, that I disregard the interactional dimension's potential to influence the production of discourse presentation. In Chapter 4.6.4, I will return to the analytical steps I have taken to account for interactional aspects related to the production of discourse presentation.

3.2.2 Annotation of the corpus

I began the annotation process by hand coding the interviews as printouts. The initial annotation was based on the core discourse presentation categories from the existing Lancaster framework as well as some of the category features already formulated within the Lancaster framework (see Chapter 4). As I gradually became acquainted with my data, I decided to add features that seemed characteristic of my material as well as excluding some existing categories and features, such as the somewhat peripheral Internal Narration category (see also Semino and Short 2004: 51, 147). By the end of the initial round of annotation, I had delineated the categories and features that I felt adequately covered the uses of discourse presentation in my corpus. This approach was chosen in order to capture recurring features in the interviews, which might prove characteristic of the particular discursive context under examination, i.e. research interviews about understandings of depression. The initial phase of the annotation may be characterised as a mix of exploration and theory-based annotation. Lampert and Ervin-Tripp (1993) highlight this interaction between theory and empirical material: "Regardless of whether a coding system begins with a theory or evolves one as part of the coding process then, every investigator who studies language must recognise that underlying assumptions have an influence on the decisions that are made at every step of the construction process with each decision affecting subsequent ones and the end product as a whole" (Lampert & Ervin-Tripp 1993: 172). Apart from adjusting the framework to fit the use of discourse presentation in my corpus, the dynamic relationship between theory and data was also present in the

highly iterative process taking place after the initial round of hand coding. Here, I started from the beginning and went through the interviews again to ensure that all the material was annotated consistently and in accordance with the updated coding criteria.

I marked up the annotations from the print outs in the Praat text grid program. Praat was originally developed for phonetic analysis in that the program is capable of aligning sound files with transcriptions (Juel Jensen 2010). However, it also provides the opportunity for annotate and, in particular, for annotating data intended for purposes other than phonetic analysis, e.g. grammatical or lexical analysis or, as in my case, discourse presentation analysis. I chose Praat as annotation tool for two reasons. First, and most importantly, the program is linked to the LANCHART centre's search engine, which I will introduce in the following section. This means that Praat functions as the mediating channel between the transcribed data and the search engine (Jensen 2010). Second, I was already familiar with using Praat from my time as a student worker at the LANCHART centre from 2005 to 2008.

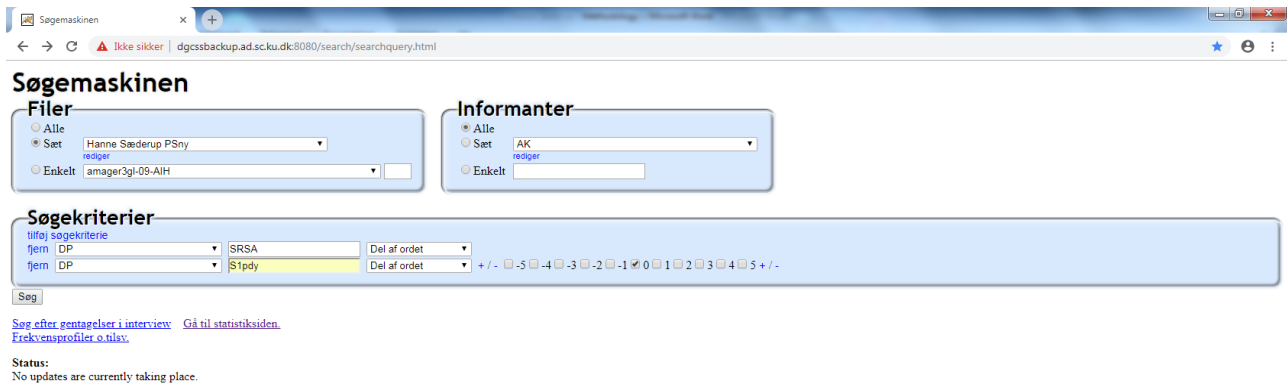
Table 3.1 below shows Praat's interface, consisting of a series of so-called *tiers*, i.e. strings linking to the transcription file as well as to the sound file. Two tiers are relevant for my purpose: Tier 1, which is the orthography tier for the informant, and Tier 2, the DP (Discourse Presentation) tier, which I added manually after the transcription and alignment with Praat had been carried out by student workers at LANCHART. The discourse presentation tier comprises the annotation of the units of discourse presentation and associated category features. The highlighted example below (yellow marking) provides an example of a coding unit. *TFITe* identifies that the discourse presentation mode is **Thought (T)**, and the thought presentation category is **Free Indirect Thought (FIT)** with **embedding (e)**. The **Speaker (S)** is 3rd person singular, **Patient (p)**, and the **Representation (R)** is **specific (s)**.

Table 3.1 Praat interface

Time (s)	Orthography (BMP)	Phonetic (BMP)	Morphology (XAD)
3.34917000	de fysiske	[d [fɨyːsɨs]	P ANP.S
3.38766000	sygdo	[sɨyːd	NCCS V V
3.400000	h gjo	[[gj	V V PA
3.410000	he	[he	V PA
3.420000	deprim	[[deprɨ	V PA
3.430000	o d	[[o	V PA
3.440000	er	[[er	V PA
3.450000	h i	[[hi	V PA
3.460000	o	[[o	V PA
3.470000	al	[[al	V PA
3.480000	det	[[det	V PA

In Chapter 4, I present the discourse presentation categories and their associated features in detail. After the annotation was complete, the files were merged with the original Transcriber files, thereby providing me with a version of the documents to be linked up to the LANCHART search engine, illustrated in Table 3.2:

Table 3.2 Interface of LANCHART search engine



The search engine (Danish: *søgmaskinen*) allowed me to search for counts of specific categories and associated features. In the above example, under *Filer* (English: *Files*), I selected the psychiatrist speaker group (*Hanne Sæderup PSny* (English: *PSnew*)). In the specific example, the search concerns *SRSA* (*Speech Presentation, Representation of Speech Act*), combined with the speaker group *S1pdy* (Speaker (S) **1**st (1) plural (p), doctor (d), psychiatrist (y), which were entered into *Søgekriterier* (English: *Search criteria*). A sample of the hits for the selected search combination is shown in Table 3.3:

Table 3.3 Sample of search results in search engine



As indicated by the light blue label at the top of the screen, the search combination SRSA + S1pdy in the psychiatrist speaker group resulted in 15 hits, which are shown one by one in the list of results. Searches like this allow me to extract figures for discourse presentation phenomena in the corpus as a whole by combining the figures for the psychiatrist group and the GP group. They also allow me to compare figures for the two speaker groups.

In addition to providing me with figures to subject to statistical analysis, the search engine has proven useful for annotation: before extracting the figures, I conducted a round of revision on the individual categories and associated category features. The benefit of such a final round of revision using the search engine is a comparison of all occurrences within a single category, with the aim of ensuring consistency in the sample. Retrieving a list of all occurrences in a given category may also function as a valuable starting point for qualitative analyses. I return to this aspect in the following section, in which I present preliminary advantages and disadvantages of a corpus-based approach.

3.2.3 A corpus-based approach

A precondition for carrying out traditional corpus analysis is that the corpus must be comprised of what Biber et al. (1998) term a “large and principled collection of texts” (Biber et al. 1998: 4). This type of corpus linguistics most often aims at language description. However, my goal is somewhat

different in that I am interested in describing uses of discourse presentation in a particular context. Gries (2009) highlights the difference between general and specific corpora, with specific corpora being “by design restricted to a particular variety, register, genre” (Gries 2009: 1232). The use of a specific corpus means that the material is more homogeneous than had the corpus been balanced in terms of, for instance, text types. My corpus is homogenous with regard to interviewer and her dual qualifications and with regard to the symmetry between informant and interviewer. The genre is fixed, and the focus is the same throughout. As a consequence, my corpus may be characterised as highly controlled with regard to contextual variables. This stability in the corpus provides solid foundations for exploring what is presumably the only differing variable, namely the medical backgrounds of the two groups of medical professionals.

Basing my investigation on quantitative analysis presents significant advantages for the study of discourse presentation: It allows me to compare my results with previous quantitative studies of discourse presentation as well as to look for general patterns in my highly context-specific corpus. Certainly, quantitative analysis also entails weaknesses, both in terms of its explanatory potential and in terms of consistency issues (Fludernik 1993, Semino & Short 2004, Schegloff 1993). One of the demands – and thereby trade-offs – when categorising phenomena is the choice of one meaning over another. There are, however, ways to accommodate for this. One such way is by using ambiguity tags, which allow for borderline cases to be captured quantitatively (Semino & Short 2004: 32). In Chapter 4.7, I explain how I have dealt with such ambiguous instances in my data. Another way of nuancing generalised patterns is by supplementing the quantitative results with detailed qualitative analysis. Relevant materials for qualitative analysis are particularly those instances that are ambiguous, especially if the objective is of a more typological nature, i.e. to refine and nuance the existing discourse presentation framework. Qualitative analysis may also nuance the ways in which certain categories are put to use in the highly specific context I am examining, particularly when wishing to compare how the two groups of medical professionals make use of discourse presentation. Lampert and Ervin-Tripp (1993) discuss how annotations may serve as a baseline for qualitative purposes by looking at realisations within a given annotated category (Lampert & Ervin-Tripp 1993: 200-201). I return to an operationalisation of this approach in the discussion of differences between the two groups of medical professionals in Chapter(s) 6 and 9.

I have annotated all the data myself. This means that a possible lack of inter-coding and thereby inter-coder reliability must be taken into account (Lampert & Ervin-Tripp 1993: 196). In terms of reliability, Semino and Short (2004) made use of inter-coding (Semino & Short 2004: 26-27). McIntyre et al. do not explicitly state their annotation procedures (2004). The main idea behind reproducibility is that another researcher than me should be able to reach the same results with a margin of 5-10 percent discrepancy (Lampert & Ervin-Tripp 1993: 196). However, due to restricted time and resources, I have been unable to accommodate the aspect of inter-coder reliability. Instead, I have sought to make the annotation manual sufficiently general to cover the data material at hand, while also aiming to provide sufficient detail in the annotation manual to ensure transparency. The level of detail is, of course, a balance between the general and the specific, aiming not only to serve as a reference for my own coding in case of doubt but also to facilitate reproducibility.

3.2.4 Statistical analysis

I have made use of the web-based open source tools available on the Social Science Statistics website (www.socscistatistics.com). To test my results, I have mainly used the χ^2 test, which is one of the most commonly used tests for significance in corpus linguistics (e.g. McEnery & Hardie 2012: 51). Using the χ^2 test reveals general patterns in the corpus as a whole as well as within the two speaker groups. Due to my study design, which entails a built-in contrast between general practitioners and psychiatrists, my thesis may be characterised as hypothesis driven. The χ^2 test is useful for this purpose as it allows me to consider significant deviations from the presupposed normal distribution (McEnery & Hardie 2012: 51). The χ^2 test is also used in Semino & Short (2004) and McIntyre et al. (2004), allowing a direct comparison between my results and those of existing quantitative studies of discourse presentation. One disadvantage of the χ^2 test is that it is poorly suited for low occurrences. In such cases, I have had to use the Fisher's Exact Test (McEnery & Hardie 2012: 52).

Statistical analyses are of course helpful for answering empirical questions, in this case conceptualisations of depression. Apart from that, they may also contribute to developing the employed framework. As Lampert and Ervin-Tripp note, "statistical analyses are important for uncovering relationships among variables, leading to law-like generalizations. However, they also play an important role in the evolution of a coding system" (Lampert & Ervin-Tripp 1993: 204).

Because my corpus differs significantly from those used in previous quantitative examinations of discourse presentation, there is good reason to assume that the results will be different and consequently enter into a dialogue with the previous approaches to annotating discourse presentation.

In order to reach valid results based on the tests for significance, I have ensured that the range of the discourse presentation occurrences for each speaker in each speaker group does not deviate markedly from the median. I do so to avoid the results being skewed by outliers in the corpus, which would clearly impact the validity of my comparison with other corpora as well as between the two speaker groups (see also Ervin-Tripp 1993: 203). Also, in cases where no occurrences are found in one group and relatively many in the other (e.g. 0 vs 10), I regard such results as significant, even though it is not possible to run a test for significance for zero occurrences. Further, since the size of my corpus is relatively small (approx. half the size of the two Lancaster-based corpora, see Chapter 5.1), I have made the calculations at significance level 0.05.

CHAPTER 4 ANNOTATION OF THE CORPUS

CHAPTER 4 ANNOTATION

Introduction to the chapter

This chapter concerns the manner in which the framework was adapted to the present purposes as well as the methodological steps taken to annotate my corpus of 12 interviews with GPs and PSs, totalling 111,357 words (see Chapter 3.1 for a presentation of the data sample).⁵ I begin by presenting the categories that were employed to identify speech, writing, and thought presentation in my data sample. The annotation framework used for the present purposes takes its point of departure from the Lancaster School's work on discourse presentation, including modifications and additions designed to investigate discourse presentation in spoken language (Semino & Short 2004, McIntyre et al. 2004). Furthermore, in getting acquainted with my data sample, I discovered the need for new category features for describing recurrent phenomena in my data. I will also introduce these features in this chapter.

As proposed by McIntyre et al. (2004), I distinguished between categories belonging to the actual discourse presentation cline and categories found outside the discourse presentation cline, partly to avoid quantification skews, and partly to account for phenomena that are related to the presentation of discourse but that do not constitute actual discourse presentation categories on the discourse presentation cline (McIntyre et al. 2004).

I first introduce the categories comprising the actual clines for speech, writing, and thought presentation used to annotate my sample, then I present the categories found outside the clines. After this, I present the category features. As mentioned in Chapter 3.2.1, the annotation procedures are based on all 23 interviews, not just the 12 that were chosen for my quantitative analysis. This approach could suggest that some of the annotation phenomena may not be particularly frequent in the data selected for the final corpus investigation. However, I argue that it actually strengthens the annotation procedure since it enables me to provide a more comprehensive description of how discourse presentation is deployed in a Danish medical professional interview context.

⁵ As was pointed out in Chapter 3.2.2, my annotation manual is a result of an exploration of all 23 interviews, of which 12 were selected for the corpus.

4.1 OVERVIEW OF CATEGORIES AND FEATURES

Table 4.1 provides an overview of the categories comprising the actual discourse presentation clines. Inspired by McIntyre et al (2004), I have listed Semino and Short's corresponding categories for the written framework next to the categories applied for my present purpose.

Table 4.1: Categories *inside* the discourse presentation cline

Speech presentation categories			
Written corpus		Spoken corpus	
NV/NRS	Narrator's Voice/Narrator's Representation of Speech	RV	Representation of Voice
NRSA	Narrator's Representation of Speech Act	RSA	Representation of Speech Act
NRSAp	Narrator's Representation of Speech Act with Topic	RSAp	Representation of Speech Act with topic
IS	Indirect Speech	IS	Indirect Speech
FIS	Free Indirect Speech	FIS	Free Indirect Speech
DS	Direct Speech	DS ⁶	Direct Speech
Writing presentation categories			
Written corpus		Spoken corpus	
NRW	Narrator's Representation of Writing	RN	Representation of Writing

⁶ The direct forms (DS, DW, and DT) include the free direct forms (FDS, FDW, and FDT), which previous accounts have debated whether to treat as separate categories (see Chapter 2.5.2). When presenting instances from my sample, I will provide arguments for conflating the two forms. See Section 4.2 for a discussion concerning the boundaries between the two categories.

NRWA	Narrator's Representation of Writing Act	RWA	Representation of Writing Act
NRWAp	Narrator's Representation of Writing Act with Topic	RWAp	Representation of Writing Act with topic
IW	Indirect Writing	IW	Indirect Writing
FIW	Free Indirect Writing	FIW	Free Indirect Writing
DW	Direct Writing	DW	Direct Writing
Thought presentation categories			
Written corpus		Spoken corpus	
NI	Internal Narration		
	N/A	RT	Representation of Thought
NRTA	Narrator's Representation of Thought Act	RTA	Representation of Thought Act
NRTAp	Narrator's Representation of Thought Act with Topic	RTAp	Representation of Thought Act with topic
IT	Indirect Thought	IT	Indirect Thought
FIT	Free Indirect Thought	FIT	Free Indirect Thought
DT	Direct Thought	DT	Direct Thought

Table 4.2 provides an overview of the categories found outside the actual clines:

Table 4.2 Categories *outside* the discourse presentation cline

Written corpus		Spoken corpus	
Tag	Category	Tag	Category

NRS	Narrator's Representation of Speech	RS	Report of Speech
NRW	Narrator's Representation of Writing	RW	Report of Writing
NRT	Narrator's Representation of Thought	RH	Report of Thought
		RU	Report of Language Use ⁷

For sake of clarity, in the actual annotation to Praat, I extend the acronyms with a letter indicating presentational mode. This means that an instance of Representation of Speech Act is annotated as SRSA, with the initial *S* referring to *speech presentation*.

Table 4.3 below presents the category features:

Table 4.3 Category features

Tag	Subcategory
h (hp, hn, hf)	Hypothetical: hf = Hypothetical, proper hn = Hypothetical, negation hm = Hypothetical, future
i	Non-specific discourse presentation (generic and iterative)
s	Specific discourse presentation

⁷ Report of language use was a category first introduced by McIntyre et al. (2004) to encompass habitual language use in their corpus of spoken English and is not treated by Semino and Short (2004). I will touch upon the category very briefly in this chapter but will provide a more detailed study of this category in Chapter 7. My motivation for doing so is partly because I have found the phenomenon to be frequent in my data and partly because it is a category within the Lancaster framework that has not received any attention, apart from being listed as a category for annotation (McIntyre et al. 2004: 63).

e	Embedded discourse presentation
p	RV/RW/RN or RSA/RWA/RTA with topic (topic = p)
m	Metonymic discourse presentation
inel	<i>Interactional, elicited</i>
in	<i>Interactional discourse presentation</i>
u	<i>Unfinished discourse presentation</i>
s1sing, s3sing, etc.	Speaker Voice (relevant for all instances of discourse presentation)

I will present a prototypical instance for each of the categories and subcategories. Where relevant, I will discuss recurrent queries related to the categorisation of the discourse presentation forms, such as general decisions made in relation to adjacent categories, e.g. RV/RSA and FIS/Direct Speech. For speaker voice, I will present the full table of categories and accompanying examples in 4.6.5.

4.2 SPEECH PRESENTATION CATEGORIES

Representation of Voice (RV)

RV encompasses minimal speech presentation and thus indicates maximal interference from the speaker. The audience is only presented with an overall reference to the presumed anterior speech situation, as in the following example:

Ex 4.1

Da: Jeg tænker, **Kim og jeg, vi kunne tale om sagerne**, men jeg savnede det at være i sådan et fast samarbejde med psykolog.

Eng: I'm thinking, **Kim and I, we were able to talk about the cases**, but I missed having a more fixed arrangement with a psychologist.

Here, RV is realised as a verb, *tale* (Eng: *talk*) with a prepositional phrase *om sagerne* (Eng: *about the cases*).

RV can also be realised as a noun, in this case, *contact*:

Ex. 4.2

Da: Jeg ser mange af de, dem hvor man er i tvivl om det er en depression eller en belastningstilstand. Det kan også være det i virkeligheden er det samme nogen gange. Det er svært at sige. Øhm – Øhm hvis jeg er i tvivl om det **så ser jeg det som regel lidt an og holder lidt tæt kontakt med dem øhh i en periode**, indtil jeg tænker nu burde det have lagt sig lidt. (GP11)

Eng: I see many of those, those where you are not sure if it is a depression or a strained condition. It may also be that in reality it is the same thing sometimes. That's hard to say. Eh, eh if I am not sure about it **I usually wait a little and keep in close contact with them eh for a while** until I am thinking now it ought to have calmed down a bit. (GP11)

As regards the topic variant, Semino and Short only treat this feature in connection with RSA (as well as the corresponding writing and thought presentation categories). However, due to the same single clause structure as in RSA, RV may also occur with a topic, which entails that the level of detail in the presentation increases. In order to encompass the category's potential, I have thus chosen to annotate topic in connection with RV. The topic is typically realised as an object or a prepositional phrase, with ex. 4.2 above denoting an instance of the latter (*with them for a while*).

Representation of Speech Act (RSA)

The second-most summarising category on the discourse presentation cline is RSA, which entails use of a speech act verb or noun. The example below shows a prototypical instance, here realised as a verb:

Ex. 4.3

Da: Men jeg meldte mig alligevel, men tænkte, skal jeg, skal jeg aflyse alle patienter, og det viste sig så, at der var så lidt tilslutning, **så det blev aflyst** (GP?)

Eng: I signed up anyway but thought do I do I cancel all patients and it then turned out that there was very little interest **so it was cancelled** (GP?)

As with RV, RSA can also be realised as a noun:

Ex. 4.4

Da: Men altså, der er **meget forhandling** i de her ting (GP4)

Eng: Well, there's **a lot of negotiation** related to these things (GP4)

In 4.7, I introduce general queries related to identification of the two most summarising categories (RV and RSA) as well as their counterparts on the scales for writing and thought presentation. Here, I also discuss borderline cases of these non-propositional forms and whether such instances should be regarded as discourse presentation or merely as action.

Representation of Speech Act with Topic (RSAp)

As is the case with RV, RSA can also be realised with a topic, typically an object or a prepositional phrase (Semino & Short 2004: 52). This suggests an increased level of detail in the report. Although

it is materialised in a single clause structure, the topic variant in RSA approaches the adjacent IS on the speech presentation cline in terms of informational loading (Semino & Short 2004: 53):

Ex. 4.5

Da: Så ringer jeg nogen gange og **spørger om råd enten ved psykiatrisk bagvagt, eller ved en af speciallægerne.** (GP3)

Eng: So sometimes I call and **ask for advice either from the psychiatric on call or from one of the specialists.** (GP3)

Indirect Speech (IS)

Ex. 4.6 shows a prototypical instance of IS with a reporting clause and a subordinated proposition:

Ex. 4.6

Da: Man er jo næsten deprimeret, hvis man siger, at **man har været det i tre uger,** ikke.

Eng: You are almost depressed if you say that **you have been so for three weeks,** right.

Semino & Short view infinitive constructions as IS (Semino & Short 2004: 82). I have chosen to follow this approach:

Ex. 4.7

Da: Og nogen af dem må jeg så bruge nogle gange til at overtale dem **til at tage det**

Eng: And with some of them I have to spend a few times persuading them **to take it**

It seems that the infinitive construction, possibly due to the specificity of the wording, bears more resemblance to an independent proposition in an IS construction than to an instance of RSA with topic. An assumed original utterance could very likely have been worded something along the lines of: *I really think you should take it (Da: Jeg synes altså, du skal tage det)*. This means that the infinitive construction offers the same amount of information as had the construction been realised with the proposition characteristic of a subordinated IS construction.

Free Indirect Speech (FIS)

FIS represents what Leech and Short term a *half-way house* between DS and IS (Leech & Short 1981: 325). This mix of linguistic features, including a frequent combination of proximal and distal deictic markers from the direct and indirect forms respectively, is illustrated in the following example:

Ex. 4.8

Da: Så det for eksempel er, at patienten et kort øjeblik, når vedkommende fortæller om sin store interesse for pétanque eller bowling eller hvad det er, lyser op med et stort smil og fortæller, at **hun er i øvrigt også ved at arrangere en stor turnering, og de havde fest forleden dag i bowlingklubben, og den var gået godt den fest der**, så tyder det, så synes jeg det tyder på, at der er nogle, at det er svært at forstå sådan en patient som dybt deprimeret, ikke (PS3)

Eng: So it could be that when the patient for a brief moment when the person is describing her big interest in pétanque or bowling or whatever it is lights up in a big smile and says that **she by the way is arranging a big tournament and that they had a party the other day in the bowling club and it had gone down well that party**, then that indicates then I think it indicates that there are some that it is hard to see such a patient as deeply depressed right (PS3)

The report in pure DS could have been as follows:

Ex. 4.9

Da: Hun sagde: “Jeg er i øvrigt også ved at arrangere en stor turnering og vi havde fest forleden dag i bowlingklubben, og den gik godt den fest der”

Eng: She said: ”By the way, I’m arranging a big tournament and we had a party the other day in the bowling club and it went well, this party”

And in ‘pure’ IS:

Ex. 4.10

Da: Hun fortalte, at hun var ved at arrangere en stor turnering, og at de havde fest for nylig i bowlingklubben, og at den gik godt

Eng: She told me that she was arranging a big tournament and that they had a party recently in the bowling club and that it went well

The instance of FIS in ex. 4.8 contains the colouring adverb *i øvrigt* (*by the way*) and the proximal deictic marker *forleden dag* (*the other day*), which are assigned to the character (the patient) rather than to the current speaker (the doctor), along with a mix of proximal and distal tense markings: the present *er ved at arrangere* (*is arranging*) and the past perfect *var gået* (*had gone down*). The past tense form *havde* (*had*) is compatible with both the character and the current speaker since the current speaker is letting the character narrate an event that is anterior to the time of speaking in the character world. *Den fest der* underlines the spoken, colloquial nature of the utterance. By leaving traces of characters’ speech in the report, Culpeper and Fernandez-Quintanilla suggest that FIS may be used as a bottom-up narrational device that contributes to characterisation in fictional text, often with an ironic flavour (Culpeper and Fernandez-Quintanilla 2017: 110). The distal pronouns *hun* (*she*) and *de* (*they*) are narrator-centred pronoun uses, providing the blended feel characteristic of FIS.

It should be noted that spoken Danish presents a growing tendency to adopt main clause word order in subclauses (e.g. Jensen & Christensen 2013). This tendency means that potential colourings of the proposition through DS main clause word order, distinguishing an instance of FIS or DS from IS, cannot always be used to rule out the utterance being an instance of IS. The position of ‘i øvrigt’

(‘by the way’) in ex. 4.8 conveys this structure. In this example, however, additional indicators of DS features support the FIS categorisation.

A more general challenge associated with FIS is the relationship between narration and representation: which words belong to the narrator and which to the character? The following example illustrates this issue:

Ex. 4.11

Da: det er jo nogen patienter siger jo ikke, jeg har det rigtig dårligt, og nogen siger **de har det frygtelig dårligt** (PS7)

Eng: there are some patients who say right I feel really bad and some say **they feel terribly bad** (PS7)

The intensifier, a possible marker of FIS, *frygteligt* (*terribly*) could be assigned to both the characters and the narrator. In the latter reading, the intensifier functions as the narrator’s own evaluative take on the utterance. There are no other markers of FIS in the representation, which makes this instance a borderline case between IS and FIS. FIS is often mentioned as a contrastive form to bring out the light and shade of a represented conversation (Leech & Short 1981: 335), in this case a general one in which two types of patients are opposed, using DS and FIS. The most direct form (DS) is used to capture what may, in the doctor’s eyes, be the more modest patients. This stretch of projecting one group of patients is then contrasted with another group of patients who tend to approach the doctor with what nearly amounts to a self-imposed diagnosis. The narrator chooses to present this group through FIS, a form that has been described as often projecting an ironic distance to the character (Leech & Short 1981:334-335).

The interviews contain uses of the verbs *ville* (*want*) and *synes* (*think (as opinion)*). Consider the following examples:

Ex. 4.12

Eng: altså de:t øh # det er nok <INT: # ja> sådan det # største skisma jeg ser # i øjeblikket at <INT: ja #> **unge synes at at de # problemer de nu kan få sådan # hvor tingene er lidt op ad bakke # de lige skal hjælpes med # med medicin**

Dan: well i:t eh # it is probably <INT: # yes> like the # biggest schism I see these days that <INT: yes #> **young people think that that the # problems they can get kind of # where things are a bit uphill # they just need to be sorted with # with medication (GP5)**

Ex. 4.13

INF: øh så hvis jeg selv er presset så ryger de hurtigere til en psykolog end hvis {den} end ellers # <INT: # ja> #

INT: får de så også hurtigere medicin #

INF: ja nogle gange #

INT: ja #

INF: **hvis ikke de vil til psykolog (GP8)**

INF: eh if I am busy myself then they get sent off quicker to a psychologist than if {it} than other times <INT: # yes> #

INT: do they also get medication quicker #

INF: yes sometimes #

INT: yes #

INF: **if they don't want to see a psychologist (GP8)**

Instances such as ex. 4.12 and ex. 4.13 may best be characterised as weakened forms of speech presentation. This highly weakened use makes it impossible to decipher the speech acts of the presented speech. Use of non-specific representation, which is characteristic of the vast majority of instances of discourse presentation in the corpus in general, moreover contributes further to the weakening of the presented speech. In ex. 4.12, the use of *synes* in combination with the colloquial *tingene er lidt op ad bakke* indicates that the doctor is presenting speech uttered by patients. I have

also chosen to include uses of *ville* that express intention and thus may be said to denote a thought process, as is the case in the patients' presumed expressions of these intentions in ex. 4.13.

Direct Speech (DS)

The annotation of DS is often straightforward. Here is an instance of DS situated as a report of anterior discourse, with a reporting clause in the historical present serving as the frame:

Ex. 4.14

Da: hun starter med at sige, jeg tror jeg, jeg ved godt hvordan jeg fungerer, men jeg har godt nok svært ved at fungere. (PS1)

Eng: She starts by saying I think I I do know how I cope but I do have a hard time coping (PS1)

This example of DS resembles many of the prototypical examples described by Semino and Short, with a shift in tense and pronouns (see chapter for an introduction to Direct Speech).

Due to the general mode in the interviews, DS is often used to state a general condition, often in a paraphrase-like manner:

Ex. 4.15

Da: det første skridt må være at få beskrevet problemet. Det må være at formulere **hvad er det, du synes, der er et problem, og hvad er det, du er ked af**, og så videre, og så videre (GP7)

Eng: the first step must be to have the problem described/identified. It must be to formulate **what is it you think that the problem is and what is it that you are sorry about** and so on and so on (GP7)

The Lancaster School has in some accounts of speech presentation divided the most direct form into two categories, Direct Speech (DS) and Free Direct Speech (FDS) (Leech and Short 1981, Semino & Short 2004). DS suggests use of a reporting clause or other reporting signal, while FDS marks speech presentation without any accompanying report. For my purposes, I treat FDS and DS under one umbrella.⁸ There are a number of reasons for this:

- Spoken language is more irregular and fuzzier than written language (see also criteria for unit length), meaning that the boundaries between FDS and DS are harder to delineate (see the section *New quotatives, quotative particles and interjections* for a discussion of the boundary between Direct and Free Direct Speech).
- In Semino and Short (2004), the two variants are often conflated in the presentation and discussion of results. This is presumably a result of the varying stances in the previous Lancaster School publications concerning whether to operationalise a division. Semino and Short even mention the artificiality of keeping the forms separate due to the constant faithfulness claim across the two variants (2004:197).
- Conflation of the two forms maintains a focus on the scalar approach to discourse presentation by comparing forms on the cline that are essentially different in terms of the faithfulness claim.
- Thus far, my data has contained relatively little DS compared to e.g. the more summarising forms, making a division between FDS and DS less sustainable.
- Most other studies of DS do not distinguish explicitly between the direct and the free direct variant, so keeping the two forms conflated increases comparability with other investigations of Direct Speech. At the same time, studies of reporting signals vs e.g. *the zero quotative* (Macaulay 2005:153) could be regarded as just another way of addressing the boundary between FIS and Direct Speech, focusing on the framing rather than the

⁸ Please note that this approach also applies to DW/FDW and DT/FDT.

faithfulness claim and the proposition itself. The category Report of Speech/Writing/Thought used in my annotation addresses this issue in relation to the direct forms, thereby allowing a conflation of the two forms to describe variations within Direct Speech, such as issues related to sequential embedding in reported interactions (see e.g. Macaulay 2005, Møller 1994).

4.3 WRITING PRESENTATION CATEGORIES

Presentation of speech and presentation of writing share several traits, especially in terms of the faithfulness claim, which establishes a contrast with presentation of thought (Semino & Short 2004: 98, 111). Presentation of writing has long been subsumed under presentation of speech in the works of the Lancaster School, with the need for distinguishing speech from writing arising when the framework was applied to a wider range of genres (Semino & Short 2004: 47-8). The distinction between speech and writing is also relevant in relation to my sample since many of the discourse presentation references are context-related jargon denoting, for example, the handling of official documents in the healthcare system. Below, I present examples for each of the categories on the writing presentation scale. Although the fundamental discussions raised in connection with the annotation of speech presentation will not be repeated here, they remain relevant to writing presentation. After the presentation of prototypical examples of the writing presentation categories, I will discuss central general issues related specifically to the annotation of writing presentation in the corpus.

Representation of Writing (RN)

Ex. 4.16

Da: **v- vi har lavet os sådan en liste! over psykologer** som i hvert fald jeg kender

Eng: **w- we have made this list! of psychologists** who at least I know (GP7)

Representation of Writing Act (RWA)

Ex. 4.17

Da: **vi skriver rigtig mange statusattester # på de her deprimerede patienter**

Eng: **we write a lot of status certificates # for these depressed patients (PS6)**

Representation of Writing Act with Topic (RWAp)

Ex. 4.18

Da: Og der glemmer man jo, at **det er ikke kun mod depression vi udskriver** det er også mod angst

Eng: And here you tend to forget that **it is not only for depression we prescribe** it is also for anxiety (PS4)

The topic here is realised as a cleft sentence, which is a typical feature of spoken (Danish) language (e.g. Hansen 1995: 126). In written mode, the sentence could have been structured along the lines of “we do not only prescribe against depression”, making ‘against depression’ the topic, whereas I regard the entire cleft sentence unit as the topic in this spoken version.

Representation of Writing Act, metonymic (RWAm)

Ex. 4.19

Da: **jeg prøver! # at holde hænderne fra: receptblokken # den første gang** men det er jo ikke altid let

Eng: **I try to keep my hands off the prescription pad # the first time** but it is not always easy right (GP2)

In ex. 4.19 above, the GP uses the expression *to keep his hands off the prescription pad* in which *hands* are used metonymically to refer to his resistance toward prescribing medicine at the early stage of depression.

Indirect Writing (IW)

Ex. 4.20

Dan:

INT: hvad med psykologerne giver de tilbagemeldinger og {så videre} # <INF: # de skriver>

INF: tit **at de er startet # # på en** <INT: mm #> **behandling #**

Eng:

INT: what about the psychologists do they report back and {so on} # <INF: # they often write>

INF: **that they have started # # up a** <INT: mm #> **treatment #** (GP9)

Free Indirect Writing (FIW)

Ex. 4.21

Dan: der kunne godt være lidt mere service det der med a:t ja det gør vi så også nogle gange det der med at de skriver **at der at der er noget andet og kunne vi ikke lige tage ind til vurdering** og så gør vi det

Eng: there could be a little more help this thing tha:t yes we also do that sometimes this thing when they write **that it that there is something else and could we just see them for an evaluation** and then we do that (PS6)

Direct Writing (DW)

Ex. 4.22

Da: Ja, og jeg synes psykiatrien, de, altså, jeg har sådan nogle sætninger fra nogle udskrivningskort: **da patienten ikke passer ind i vores terapeutiske miljø, udskrives patienten**. Altså, hvem skal passe, tilpasse sig til hvem (GP6)

Eng: Yes and I think psychiatry, they, well, I have these sentences from discharge cards: **since the patient does not fit into our therapeutic environment, the patient is discharged**, I mean, who is supposed to fit, adapt to whom (GP6)

General annotation queries in relation to writing presentation

Process vs product

On a general note, the interviews contain a large number of written documents, which are presented as products rather than writing processes. Consider the following example:

Ex. 4.23

Dan:

INT: ja er der begrænsninger sådan overenskomstsmæssigt i forhold til hvor # hvor længe de må gå i {en} # speciallægepraksis #

INF: øh # altså de kan jo gå! øh # op til tredive gange #

INT: ja #

INF: øh # på en! # henvisning

Eng:

INT: there are restrictions in relation to agreements as to how # how long they can see a specialist

INF: eh # well they can go! eh # up to thirty times #

INT: yes #

INF: **øh # on one! referral**

(PS9)

Henvisning (Eng: *referral*) may be considered a verbal noun, the *-ing* form indicating a processual aspect, which suggests a co-occurrence of process and product. However, since we are not presented with the writing process but only with the usage of the finished product (*henvisning*), which allows for patients to see a specialised doctor, I would argue that such instances are best regarded as falling outside writing presentation. Semino and Short also focus on writing as an activity or a process rather than a product (Semino & Short 2004: 102), pointing out that an instance of writing presentation is more likely to occur with a written product than is the case for speech presentation (Semino & Short 2004: 103). This tendency also seems to be present in my data, due to the prevalence of jargon. As a general rule, only written products accompanied by a writing process are annotated as writing presentation.

Speech presentation vs writing presentation

It has been suggested that speech presentation has a broader applicability than writing, in that speech has the potential to convey writing (e.g. Semino & Short 2004: 113, 230). I annotate such instances based on a contextual reading rather than from a purely semantic perspective:

Ex 4.24

Dan:

INT: men I har mulighed fo:r psykoterapi til alle patienterne o:g #

INF: ja til alle de patienter vi henviser ja <INT: # der hvor det er relevant ja ja # ja> det er meget få <INT: # ja #> de **afviser** (PS2)

Eng:

INT: but do you have the possibility fo:r psychotherapy for all the patients a:nd #

INF: yes for all the patient we refer yes <INT: # where it is relevant yes yes # yes> it is very few
<INT: # yes #> they **reject** (PS2)

Afvis (Eng: *reject*) may be regarded as a speech act verb, which within this professional jargon is likely to consist of a written act of communication and on these grounds is annotated as writing presentation. Generally speaking, I see the performative weight of the writing act as outweighing the potential speech involved in the communicative act.

I have also identified instances of writing presentation that are metonymic. A considerable proportion of the metonymic instances are realised with the verb *sende* (*send*):

Ex. 4.24

Dan: og ellers vil jeg sige hjælper # øh Eflexor ikke # i # sådan # gode doser **så: sender jeg dem videre #**

Eng: other than that I would say if # ehm Exefor does not help # in # like # good doses **then I pass them on #** (GP5)

In 4.7 I discuss how I have handled such occurrences in terms of

4.4 THOUGHT PRESENTATION CATEGORIES

In this section, I present the principles for annotation of thought presentation in the corpus. I begin by going through each category and subsequently discuss general annotation principles that I deem to be relevant specifically in relation to thought presentation. I will not repeat the general structural principles related to the individual categories that are the same as those for speech and writing presentation.

Representation of Thought (RT)

As noted in Chapter 2.5.4, the categories on the thought presentation cline have been subject to some debate and subsequent modification in the accounts from the Lancaster School. For the present purposes, I follow Short's latest contribution, in which he replaces the broader category *Internal Narration* with the narrower category at one end of the thought presentation cline termed *Narrator's Representation of Thought* (Short 2011). This makes it easier to maintain a focus on pure thought presentation. A replacement of Internal Narration with RT also increases comparability with the other presentational clines when e.g. seeking to compare distribution patterns.

Ex. 4.25

Da: Og så er der også sommetider nogen, der får påvirkning af det anankastiske, altså OCD-lignende symptomer, noget med at **man får tvangstanker** og tvangshandlinger. (PS4)

Eng: And then sometimes there are some who are affected by the anancastic, well symptoms similar to OCD, something about that **you have compulsive thoughts** and compulsive behavior (PS4)

Representation of Thought Act (RTA)

Ex. 4.26

Da: Som regel prøver man noget mildt, hvis man har **besluttet sig** for det. For det er der, hvor der er færrest bivirkninger

Eng: Usually you try something mild if you have **decided to** do it. Because that is where there are the least side effects (PS4)

Ex. 4.27

Da: Så vil de jo i hvert fald ikke i behandling, altså. Det er ikke fordi jeg har ret mange af dem, egentlig. Jeg tror egentlig mest, at **folk de accepterer det**

Eng: Then they really don't want treatment. It's not that I have that many of them actually. I mostly think that **people they accept it** (GP3)

Representation of Thought Act with topic (RTAp)

As with speech and writing presentation, RTA can also have a topic:

Ex. 4.28

Da: jeg har det som en hovedregel, at **den diagnose, den kan jeg faktisk ikke stille på én konsultation**, så jeg har sådan et par stykker inden vi ligesom beslutter os

Eng: I have as a main rule that **this diagnosis this I actually cannot make in one consultation** so I have a couple before we like make the decision (GP4)

In continuation of the discussion introduced in the previous section concerning writing in relation to the dual meaning potential of some communicative acts (see Chapter 4.3), I have chosen to regard the frequent, context-specific representation *to make a diagnosis* as a thought act since it is closely linked to the decision-making thought process. Despite containing other elements of communicative actions, such as writing and dialogue with the patient and potentially other professionals, the diagnosis is ultimately a conclusion reached by the doctor himself, and therefore I regard thought to be the predominant characteristic of this communicative action.

Indirect Thought (IT)

Ex. 4.29

Da: Bagefter kan man så spekulere lidt på, om **det var en person der startede med at være depressiv og derfor ikke kunne præstere på sit arbejde**

Eng: Afterwards you can then kind of wonder if **it was a person who started by being depressive and therefore could perform at the workplace** (GP10)

Free Indirect Thought (FIT)

Ex. 4.30

Da: Øh så det er jo ikke fordi jeg har noget imod at fortælle historien. Det var en beslutning jeg traf, da jeg blev syg, at **det var i øvrigt ikke nogen hemmelighed**

Eng: Eh so it is not that I have anything against telling the story. That was a decision I made when I got ill that **it by the way was no secret** (PS10)

Direct Thought (DT)

Ex. 4.31

Da: Øhm men, men, men min rutiner er at hvis patienterne bliver henvist med depression, så kigger jeg efter og tænker **kan det passe kunne det være noget andet** (PS10)

Eng: Eh but but my method is that if the patients get referred with depression then I doublecheck and think **is that really so could it be something else** (PS10)

General annotation principles for thought presentation

The general mode in the interviews also influences the annotation of thought presentation (which also applies to writing and speech presentation):

Ex. 4.32

Da: Eller de fleste gange er man ikke i tvivl om at så spiseforstyrret er mange af patienterne ikke

Eng: Or most times you do not question that many of the patients are not that ill from eating disorders (GP11)

In cases like ex. 4.32, the habitual genericity blurs the line between DT and IT, with the present tense *er* being a proximal deictic marker functioning as a general – rather than specific – reference. As such, this grammatical feature cannot be used to determine whether the presentation suggests a shift in footing. Had the presentation been a report of anterior discourse, the temporal deixis would have ruled out the ambiguity:

Ex. 4.33

IT: I was in no doubt that many of my patients did not have an eating disorder.

DT: I was in no doubt many of my patients do not have an eating disorder.

In the indirect example, we see the distal temporal marker *did not have* in the proposition, and in the direct representation, we see the proximal deictic marker *do not have*. Consequently, the annotation of ex. 4.32 above must rely on other features. In this case, I have chosen to regard the example as IT due to the conjunction *at (that)*.

Another general query concerning the annotation of thought is the question of thought vs opinion:

Ex. 4.34

Dan: øh nogle gange bliver jeg i tvivl i forhold til nogle kollegaers tvivl fordi der er nogle bestemte grupper bestemt psykologer **der mener at bag en depression findes en personlighedsforstyrrelse** (PS8)

Eng: eh sometimes I have doubts in relation to some colleagues' doubts because there are certain groups of psychologists **who believe that behind a depression is a personality disorder**

In ex. 4.34, we see the verb *mene* (Eng: *think/reckon*), which means that the proposition advanced on behalf of the psychologists is an opinion rather than a report of thought. Another frequent use bordering on thought presentation is the verb *tænke* (Eng: *think/believe*). In English, *think* is commonly used as a marker of opinion. However, in Danish, the use of *tænke* to denote opinion rather than thought is also possible:

Ex. 4.35

Dan: **jeg tænker det er smertetilstande der sådan primært giver eller hvor de også kommer og er triste** og så er problemet så er det med at finde ud af hvad der er hvad

Eng: **I think it is pain conditions that kind of mostly cause or where they also come in being sad** and then the problem is then it is about figuring out which is which (GP5)

In ex. 4.35, the GP expresses his general opinion of somaticised patients, here marked by the present tense. Such uses of *think* are excluded from the annotation.

4.5 CATEGORIES OUTSIDE THE DISCOURSE PRESENTATION CLINES

In this section, I present the annotation principles for categories that fall outside the discourse presentation clines. These are the reporting units *Report of Speech*, *Report of Writing*, and *Report of Thought* as well as the category capturing habitual language use *Report of Language Use*. I will compare the latter with the category feature *Quotation Phenomenon*, which I have decided not to include in my annotation.

Report of speech, thought, and writing

The categories Report of Speech, Thought, and Writing These do not form part of the clines as such since they do not present any propositional content of anterior discourse but instead serve as introductions to the reported discourse. For quantification purposes, both Semino and Short and McIntyre et al. annotate these stretches separately (Semino & Short 2004: 36, McIntyre et al. 2004). I have chosen to follow the same procedure, as this approach allows for rapid identification of reporting clauses in isolation, which I also expect to be useful for more qualitative analyses.

Prototypical instances of Report of Speech, Writing, and Thought are presented below:

Ex. 4.36

*Da: **Og så siger vi** kom igen om nogle dage (GP6)*

*Eng: **And then we say** come back in a few days (GP6)*

Ex. 4.37

*Da: Jamen, det kan være sådan en **så står der** brudt sammen på arbejde, eller brudt sammen på studiet, eller græder hele tiden, **står der**. (GP8)*

*Eng: **Well, it can be one of those then it says** broken down at work or broken down in school or is crying all the time **it says** (GP8)*

Ex. 4.38

*Da: **Så jeg tænkte på i første omgang, da du ringede, tænkte jeg** har jeg overhovedet nogen med depression (PS7)*

*Eng: **The first thing I was thinking when you called, I was thinking** do I have any [patients; HSP] with depression at all (PS7)*

Reporting clauses and reporting signals

Decisions as to what should count as reporting units must be made in order to ensure consistency and transparency in the annotation process. One example is interjections, which in some places in the literature are viewed as reporting signals (Buchstaller 2002, Rathje 2011, Macaulay 2005, Møller 1994, Tannen 1986). An interjection effectively belongs to the proposition (the reported stretch), whereas other reporting signals such as verbs and adverbials belong to the reporting stretch. If interjections are not viewed as Report of Speech, then issues such as whether a stretch should count as FDS or DS would need to be considered. I follow the approach laid out by McIntyre et al. (2004) and Semino and Short (2004) in keeping propositional content separate from the reporting situation. I have furthermore chosen to conflate free direct forms and direct forms in

the quantification, which means that I do not need to determine the status of the RS/W/T and the analytical consequences relative to DS/W/T vs FDS/W/T. This allows the relationship between the reporting signal/clause and the reported content to instead be subjected to qualitative analysis. The annotation of report of speech, writing, and thought will have both quantitative and qualitative outcomes in terms of how and to what extent the doctors choose to structure and colour units of reports. Below is an example of a reported sequence of Direct Speech, the first instance introduced by a *new quotative*, and the second instance introduced by an *interjection* (Rathje 2011, Mathis & Yule 1994):

Ex. 4.39

Dan: Nej, det [depression; HSP] er mere accepteret generelt, det er også der er også nogen, **der kommer bare**, jeg skal til psykolog. **Nå** skal du det, og sådan, altså.

Eng: No, it [depression; HSP] is more generally accepted, it is also some people **just come** I need to see a psychologist. **Oh**, you do and such, well (GP8)

Whereas the new quotative *just come* will be annotated as Report of Speech, the interjection *nå* (Eng: *oh*) will not since it is placed inside the proposition. In the latter case, the speaker voice will be categorised as *zero*. I return to the annotation of speaker voices in 4.6.5.

RV/W/T, RSA/W/T vs Report of Speech, Thought, or Writing

In annotating the sample, I have encountered a phenomenon relative to Report of Discourse that allows for multiple interpretations:

Ex. 4.40

Da: **jeg har sådan nogle sætninger fra udskrivningskort** da patienten ikke passer ind i vores terapeutiske miljø udskrives patienten

Eng: I have these sentences from discharge cards since the patient does not fit into our therapeutic environment the patient is discharged

The question is whether to regard the bolded stretch as an instance of Report of Writing (RW) (i.e. as a report of the subsequent stretch of Direct Writing) or whether it is best analysed as a separate instance of writing presentation, in this case as an instance of the most summarising writing presentation form, RN. In written texts, a colon vs a full stop would often rule out the ambiguity. In ex. 4.40 above, I have chosen to annotate the bolded part as RN since it is a general introduction indicated by the plural and the habitual present tense marking. The stretch of DW could then be justified as having the status of an exemplification rather than a representation of a specific event. Another example concerning the presentation of speech:

Ex. 4.41

Da: Det er mere sådan i starten der, **hvor man sådan forsøger – altså ved hjælp af kvalitative skalaer at – altså ligesom at stille nogle spørgsmål.** Har du det, eller har du det ikke. (PS4)

Eng: It is more like in the beginning **where you try to you know by means of qualitative scales to well like ask some questions** do you have it or don't you have it. (PS4)

In contrast, when the introduction to the proposition and the actual proposition match in terms of specificity, so that the proposition functions as a paraphrase of the specific preceding introduction, I have chosen to code the introduction as RS/W/T:

Ex. 4.42

Da: Altså som regel er det faktisk det sidste, fordi der er ikke ret mange voksne, der synes at **det er sjovt af få den diagnose stillet, stukket i ansigtet,** du er – du har en ADHD, eller du er voksen-DAMP-patient (PS4)

Eng: Well, generally it is the latter because there are not very many grown-ups who find it amusing **getting that diagnosis, having it in your face** you are you have ADHD or you are an adult DAMP patient (PS4)

Report of Language Use and Quotation Phenomenon

The category Report of Language Use (*RU*), which was introduced by McIntyre et al. for annotating the spoken corpus, covers a naming function, “such as the words or expressions habitually used to refer to things, or the ways words were spelled or pronounced” (McIntyre et al. 2004: 63). McIntyre et al. observe that, in their corpus, this category is particularly frequent in contexts concerning people’s pasts (McIntyre et al. 2004: 58). In my data sample, I expect this category to be particularly relevant relative to doctors’ identification of jargon related to depression, as in the following example:

Ex. 4.43

Da: **De der gamle endogene, som det hed i gamle dage**, dem ser man jo ikke så mange af, vel, synes vi ikke, **eller det der hed agiteret depression, var der også noget der hed**, det synes jeg heller ikke, vi ser ret mange af. (GP8)

Eng: **Those old endogene as they were called in the old days** those you do not see that many of, right, we do not think, or **was it called agitated depression there was also something that was called** I do not think we see much of that either (GP8)

I will not delve further into the annotation of Report of Language Use here since the category will receive an in depth-treatment in Chapter 7. I have chosen to conduct a detailed study of the category’s realisation, use, and function for two reasons: partly because the phenomenon may be regarded as under-illuminated within the Lancaster discourse presentation framework, and I expect that a detailed study will contribute to a description of the framework; partly because use of jargon-related terminology seems prevalent in the doctors’ discourse concerning depression, which may be used to explain the two groups’ conceptualisations of depression.

Quotation Phenomenon is a feature that bears some resemblance to Report of Language Use. This feature was first introduced by Semino and Short in their corpus investigation (Semino & Short 2004: 54-55, 153-9). I regard the similarity between the two phenomena Report of Language Use and Quotation Phenomenon as lying in the fact that the reported material only concerns a single word or a few words, rather than an entire clause, as is the case in the propositional forms. An extra layer of report may be said to be added to the presentation in this manner. In the case of Report of Language Use, it is the naming function realised by *is called* or something similar, often accompanied by a shift in intonation. The category is not included in the framework for annotating written language, but if it had been included, the highlight would most likely have been shown by use of quotation marks. In Quotation, quotation marks signal highlighted words within a report using a non-direct discourse presentation category (Semino & Short 2004: 54-55). Apart from intonational cues, this means that the integration of another person's (or one's own) words within a non-direct discourse presentation category are not necessarily explicitly introduced in spoken language. McIntyre et al. include Quotation in their annotation manual (McIntyre et al. 2004: 65). In my opinion, however, without listening meticulously to the recorded interviews, Quotation Phenomenon is much harder to locate in spoken language than is the case with the quotation marks in written language. Due to time constraints with regard to listening, I have chosen not to annotate this feature but to instead focus on Report of Language Use for the aforementioned reasons.

4.6 SPEECH, WRITING, AND THOUGHT PRESENTATION CATEGORY FEATURES

In this section, I present the category features that I have selected as supplementary annotation of the core discourse presentation categories. My selection of features takes its point of departure from the Lancaster framework on written as well as spoken language. In getting acquainted with my own data sample, I have discovered a need for additional categories in order to describe how discourse presentation manifests itself in my interview data. The adaptation of the existing framework and the formulation of new categories are located at the intersection of the methodological steps taken to annotate the sample and the analytical outcome: on the one hand, the categories must be formulated if we are to code the data; on the other hand, these additions hopefully represent a step toward a discourse presentation framework suited for other contexts than those previously examined. Please see Chapters 3.1 and 5.1 for an introduction to the context examined and Chapter 3.2 for a description of my annotation procedure.

The category features included in my annotation are listed in Table 4.4 below.

Table 4.4 Overview of category features.

Tag	Subcategory
H • Hp • Hn • Hf	Hypothetical discourse presentation • hypothetical, proper • hypothetical, negated • hypothetical, future
R • Rs • Ri	Genericity Specific Non-specific
e	Embedded
p	RV/RW/RN or RSA/RWA/RTA with topic
m	Metonymic discourse presentation
el	Elicited
in	Interactional
u	Unfinished
Please see Table 4.5	Speaker voice – relevant for all instances of discourse presentation

4.6.1 Hypothetical Speech Presentation

Given the subject matter of my thesis, I expect a more finely grained division of Semino and Short's *h* tag to add explanatory potential to my corpus. In my sample, doctors' stances towards their patients, the condition, and the system are also explicated. By considering different types of hypothetical discourse presentation in the sample, I expect to be able to describe the constructions of depression, institutional frame, patients, etc. with greater precision than can other approaches used in areas, such as psychology and social medicine (see Chapter 9, in which I resume the methodological discussion).

The three examples below are representative examples of the subdivisions I have made for hypothetical discourse presentation in the sample: *hypothetical, proper*; *hypothetical, negated*; and *hypothetical, future*. The first example encompasses *hypothetical, proper*. In this case, it is realised as a conditional clause in which the doctor sets up an imagined scenario:

Hypothetical, proper

Ex. 4.44

Da: jeg synes validiteten, den bliver ofte ringe, hvis det er at man sådan skal, hvad skal jeg sige, om jeg så må sige diagnosticere ud fra sådan en systematisk udspørgen omkring det ene eller andet symptom (PS3)

Eng: I think the validation, it often gets poor if you are to, how do I put it, diagnose on the basis of a kind of systematic questioning on different symptoms so to speak (PS3)

The hypothetical conditional construction presents similarities to what have been termed *Course of Event* clauses (Juel Jensen 2005: 38, Athanasiadou & Dirven 1996), which are a means of sequencing recurrent actions. In this type of construction, *hvis (if)* is interchangeable with *når (when, whenever)*, with the tense marking being generic rather than hypothetical, as suggested by

Juel Jensen (2005: 38). This means that instances such as the following are not assigned a hypothetical tag in the annotation:

Ex. 4.45

Da: hvis vi mistænker, hvad hedder det, narkotikamisbrug af nogen slags, så urintjekker vi dem, så siger vi, at vi vil have en urinprøve, og hvis vi mistænker alkohol, så tager vi den her nye sladrehanke, der er kommet, den hedder CDT (PS6)

Eng: if we suspect what do you call it drug abuse of any kind then we take a urin sample from them, then we say that we want a urin sample and if we suspect alcohol then we take this new telltale unit that has arrived, it is called CDT (PS6)

This example also forms part of the narrative genre *general account* (Gregersen & Barner-Rasmussen 2011), leading to a non-specific tag in terms of genericity, which will receive attention in Section 4.6.2 below.

The next category feature (*hypothetical, negated*) is illustrated by an example in which a GP discusses with the interviewer whether the patients typically accept the suggested diagnosis:

Hypothetical, negated

Ex. 4.46

Da: Jamen, **nogen lykkes det mig egentlig ikke at overbevise om det**, men andre de køber den egentlig efter at vi så har snakket det igennem

Eng: **Well, with some I actually don't succeed convincing them about it**, whereas others actually buy it after we have talked it through

This example depicts how the doctor fails to convince some patients about their condition, which is a hypothetical instance of RSA realised as a negation.

In the given example, the doctor contrasts the negated hypothetical construction as with the other, less sceptical group of patients, using the negative/positive distinction to group and contrast patient identities.

Hypothetical, future

The hypothetical variant pointing toward the future comprises the third subcategory of hypothetical discourse presentation in the annotation framework. A future reference is potentially semantically different from prototypical hypothetical and negated constructions in that it points forward, potentially conveying hope, a wish for change, plans and possibilities for the future, etc. I feel that this semantic potential lends weight to the operationalisation of future references as a separate category. Here is an instance of thought presentation realised as general DT, from a psychiatrist who would like more guidance on how to communicate with the rapidly growing number of patients with ADHD:

Ex. 4.47

Da: Og det, når det er helt der oppe, øh sådan i efterspørgslen, så **kan det jo være rart at vide**, hvad kan man konkret sige og ikke sige. (PS9)

Eng: And it when it is all the way up there eh like in the demand **then it can be good to know** what can you actually say and not say (PS9)

Below is a psychiatrist's response to the interviewer's question regarding possible future scenarios in the psychiatric sector:

Ex. 4.48

Da: Vi skulle have nogle færre møder. Psykiatrien snakker meget. Vi snakker meget om patienterne. *Vi skulle snakke noget mere med dem,* det er sådan en af psykiatriens svøber (PS6) (TJJ, s. 60).

Eng: We ought to have fewer meetings. The psychiatry (psychiatrists) talks too much. We talk a lot about the patients. *We should talk more with them.* That is like one of the curses of (the) psychiatry (PS6)

4.6.2 GENERICITY – *specific and non-specific representation*

I distinguish between specific and non-specific presentations of discourse in my sample. This choice arises from an observation that the speech produced by the doctors contains a considerable amount of general reflection about depression as well as standard routines associated with their daily work. This distinction also provides an opportunity for discussing my results in comparison to Semino and Short's corpus, which is based on narrative text primarily conveying specific utterances. The specific/non-specific divide did not form part of the annotation framework in Semino & Short's (2004) study. In McIntyre et al., the category *reiterated* was introduced to encompass instances denoting recurrent discourse (McIntyre et al. 2004: 65). As we shall see in ex. 4.50 below, the reiterated variant is subsumed under the non-specific tag. In addition to the reiterated instances, I also annotate instances that are even more generic, in that I include general reflections on states, descriptions, opinions, etc. under the non-specific heading. As a consequence, my understanding of non-specific discourse presentation may be said to be broader than that of McIntyre et al. A few previous studies have dealt with speech presentation in non-narrative language (e.g. Clift 2003, Baynham 1996). Tannen (1989) also treats habitual uses of Direct Speech, which she terms *dialogue as instantiation* (Tannen 1989: 111). However, these studies focus almost exclusively on one of the discourse presentation forms, DS, and from an interactional perspective. I expect the marking of genericity to nuance the comparison of the doctors' constructions of depression in this highly contextually stable sample. In order to determine the annotation principles for the non-specific variant, let us first consider a specific example, which is a representation of a single patient in a particular circumstance:

Ex. 4.49

Da: Ja, altså **hun** er oplyst om det fra både mig og psykologen og så er det jo hendes valg

Eng: Yes, well **she** has been informed about it both by me and the psychologist and then it is her choice (GP3)

Let us now move on the non-specific variant. In Section 4.6.1, I argued that the *if* construction was an instance of *Course of Event representation* rather than hypothetical speech presentation:

Ex. 4.50

Da: hvis vi mistænker, hvad hedder det, narkotikamisbrug af nogen slags, så urintjekker vi dem, **så siger vi, at vi vil have en urinprøve**, og hvis vi mistænker alkohol, så tager vi den her nye sladrehank, der er kommet, den hedder CDT (PS6)

Eng: if we suspect what do you call it drug abuse of any kind then we take a urin sample from them, **then we say that we want a urin sample** and if we suspect alcohol then we take this new telltale unit that has arrived, it is called CDT (PS6)

Resembling McIntyre et al.'s *reiterated* category, this type of general presentation is often used to mark chronological sequencing of recurrent events, frequently forming part of the narrative genre *general account* (see Chapter 8).

Another type of general language use to which I have also assigned the non-specific tag are non-narrative, general reflections or descriptions, as in the following example:

Ex. 4.51

Da: Det er en af mine, **mine opgaver er at, at øh tænke kunne det være, kunne det være en anden historie. Kunne der gemme sig noget andet.** (PS10)

Eng: That is one of my, **my task is to, to eh think could it be, could it be another story. Could there be something else underneath.** (PS10)

In cases in which I am unable to distinguish between specific and non-specific representation, the occurrence is marked as ambiguous, as in the following example:

Ex. 4.52

Da: hun var vokset op i en familie: hvor # det første barn var dødt øh # to_tre år gammelt **så hele sit liv # havde hun fået at vide at sådan {ville} # en_eller_anden ikke have gjort # så hele livet var hun bleven sammenlignet med den der afdøde søster** # [smasker] og det snakkede vi også noget om (PS7)

The psychiatrist's rendering concerns one specific patient from a specific consultation, in which they discuss the patient's background. However, the rendering contains reiterated occurrences of the family's utterances to the patient (bolded). In my opinion, this blend prevents a clear-cut distinction between the presentation as either specific or general. I have therefore chosen to assign an ambiguous tag to such uses of discourse presentation.

4.6.3 Embedded Discourse Presentation

An instance of discourse presentation may be presented as embedded within another stretch of discourse presentation (Semino & Short 2004: 171-182). Digging into the layers of discourse presentation provides an opportunity to consider how the speaker uses added levels to enable the characters to represent discourse through a filter or a perspective embedded within the pre-

established discourse presentation frame. The phenomenon, as described by Semino and Short, “occurs when a character or participant within a narrative is presented as reporting words or thoughts produced by others (or by themselves) in a separate speech, thought or writing event” (Semino & Short 2004: 34). Semino and Short note that the embedding may be either clausal or non-clausal (Semino & Short 2004: 35). I have encountered both realisations in my sample. Here is an example of the clausal variant:

Ex. 4.53

Da: jamen jeg bliver sgu træt af det, fordi **man tænker**, hvad fanden **tænker de om psykiatrien nogen gange**, ikke, **når de skriver**: patienten er trist, **vil gerne snakke med en psykiater, henvises hermed**. (PS6)

Eng: well I get darn tired because you wonder what the heck do they think about psychiatry sometimes, right, when they write: the patient is sad, would like to talk to a psychiatrist, is hereby referred. (PS6)

In this example, we find several levels of embedded discourse presentation: the report is framed by a reporting clause ‘man tænker’ (‘you wonder’), projecting an instance of DT, which comprises the rest of the report. Embedded within this stretch of DT is an instance of RT with a topic, into which is embedded an instance of Direct Writing, marked by the reporting clause ‘når de skriver’ (‘when they write’). This instance of DW has embedded within it another two clausal, though elliptical, instances of discourse presentation: first an instance of RV (‘vil gerne snakke med en psykiater’ (‘would like to talk to a psychiatrist’)) and then an instance of RWA (‘henvises hermed’ (‘is hereby referred’)).

Example 4.54 illustrates the non-clausal variant:

Ex. 4.54

Da: Og det, når det er helt der oppe, øh sådan i efterspørgslen, så kan det jo være rart at vide, hvad kan man konkret sige og ikke sige. Så jeg har det, har da henvist eller bedt egen læge **henvise en enkelt patient derover til** (PS9)

Eng: And it when it is all the way up there eh like in the demand then it can be good to know what can you actually say and not say. So I have, sure I have referred or asked the GP to refer one patient to them (PS9)

This instance is annotated as IS with *bede* (*ask*) as the reporting verb and ‘henvise en enkelt patient...’ (‘to refer one patient...’) as the proposition. Embedded within the proposition is an instance of RWA, *refer*, grammatically realised as the non-clausal infinitive construction.

McIntyre et al. (2004) also include this category feature in their annotation manual but without providing any results of how it presents itself in the corpus, most likely because the adaptation of the framework to spoken language had only reached its initial stages. Even though I will not conduct a detailed study of embedded discourse presentation, my annotation of the levels of embedding may contribute insights into potential differences between the embedding of discourse presentation in written and spoken corpora and may be a stepping stone for future analyses of the phenomenon.

4.6.4 Elicited and interactional discourse presentation

The interviews include a large number of stretches of discourse produced by the informants. Some have termed these *chunks* (e.g. Eggins & Slade 1997). Since the interview is a dialogical setting, it is nevertheless relevant to pay methodological attention to the possible influence of the interaction in the annotation process. I have been unable to locate any descriptions of this methodological step in previous annotation procedures, so for my purposes I will propose new categories to encompass interactional features. Two variants recur in my sample. I will present them in the next two sections.

Elicited discourse presentation

I term the first variant *elicited discourse presentation*, which is illustrated in ex. 4.55:

Ex. 4.55

Dan: INT: Kunne de også snakke med nogen af de deprimerede?

INF: **Det kunne de måske egentlig godt.** (GP3)

Eng: INT Could they also talk to some of the depressed patients?

INF: **Perhaps they could, yes** (GP3)

Here, the interviewer poses a question to the doctor, realised as an instance of RV (*snakke med*). Instead of replying *de kunne måske egentlig godt snakke med nogle af de deprimerede* (Eng: *perhaps they could actually speak with some of the depressed*), the doctor summarises *snakke med nogle af de deprimerede* in the anaphoric reference *det* (Eng: *it*). As a consequence, we see a reference to a speech event in terms of meaning, but this is not matched in terms of form. In the annotation, this could be handled in two ways. The first option would be to allow the interviewer's choice of discourse presentation form to be reflected in the doctor's answer by transferring the interviewer's choice of discourse presentation form to the doctor's turn, in this case RV. The doctor's reply could then be annotated as an implicit reference to a speech event, such as RV, *implicit*. This first option would signal a strong link between the interviewer's production and the doctor's reply by adapting the interviewer's chosen discourse presentation form. However, given that much of the strength of the scalar approach lies in the resources of various realisation patterns in which speakers can create meaning through their choice of form, I regard this approach as somewhat devaluing the potential of the discourse presentation cline. A second option would be to invent a new category that reflects the elicited realisation. I have chosen this second option since, as Ex. 4.55 shows, the doctor does not repeat the interviewer's speech presentation form but merely responds by advancing an agreement. Repeating the speech presentation form itself would seem marked, and the informant's response may be considered an expected treatment of the second part of an adjacency pair (Cameron 2001: 94-97). I would argue that this type of elicited use of discourse presentation provides a clearer picture of the production of discourse presentation in the sample – to the extent to which use of discourse presentation is directly interactionally motivated. This interactional pattern could also enhance the explanatory potential of the comparison between the two professional groups, the GPs and the PSs.

Interactional discourse presentation

In continuation of the above description of elicited instances of discourse presentation, I have also found it useful to mark another variant of interactionally prompted instances of discourse presentation. This second variant comprises full-fledged instances of discourse presentation produced by the interviewee but initiated by the interviewer:

Ex. 4.56

INF. Men der er forholdsvis mange forløb – nej det er der nok ikke – men der er i hvert fald mange forløb, hvor det kører et godt stykke tid, før jeg ser patienterne igen.

INT. **Men hvor I vel drøfter det.**

INF. **Ja, ja, så bliver jeg jo løbende orienteret**, ikke også, og vi bruger også i høj grad serum-monitorering, fordi vi nogen gange bruger nogle lidt mere potente stoffer end de praktiserende læger. (PS6)

Here, the psychiatrist renders his cooperation with nurses, who are often the group that monitors patients after they have received diagnoses. The psychiatrist's use of speech presentation, realised as an instance of RV, may be regarded as an immediate result of the interviewer's question in relation to the doctor's visibility in the monitoring process. In terms of quantification, I expect this category to provide a more refined picture of the doctors' management of discourse presentation and of the extent to which their production is self-initiated or sequentially prompted.

4.6.5 Speaker Voice Categories

In his mapping of discourse presentation, the linguist Thompson introduces the notion of *voice* as one of four dimensions within which discourse presentation may be examined (Thompson 1996). Thompson's approach may be regarded as essentially qualitative, operationalising the four types of voices: *self*, *other – specified*, *other – unspecified*, *community*, and *unspecifiable others* (Thompson 1996: 507-511). Some grammatical accounts include a functional treatment of speaker reference, which e.g. in Systemic Functional Linguistics, is known as 'Sayer' (Halliday 1994: 140), just as Critical Discourse Analysis – mainly represented by Fairclough – includes the concept of speaker voice (Fairclough 2003: 39-61). The investigations conducted by the Lancaster school do not

include annotation of speaker reference. I have chosen to include this parameter in my annotation since my corpus consists of data collected from a specific context about a specific topic with a relatively limited number of potential sayers (the patient, family members, the doctors, other clinical staff, etc.). I expect this parameter to shed light on dimensions such as perspective marking and attribution of speaker roles, especially in relation to the discourse presentation forms and to subcategory features such as reality and specificity. I take a more grammatical approach than does Thompson, and I annotate speaker reference in the following manner:

- 1st person singular
- 2nd person singular
- 3rd person singular
- 1st person plural
- 3rd person plural
- Noun
- Passive
- Zero
- Adjective
- Infinitive.

Apart from these grammatical categories, I have added a qualitative tag to the speaker categories. These tags denote patient or professional group. The professional group is subdivided into GPs and PSs, as I anticipate that distinguishing between these two speaker groups will add significantly to the explanatory potential of use of discourse presentation in the corpus. The tags are as follows:

- p = patient
- g = general practitioner
- y = psychiatrist
- o = other (other professionals, patient relatives etc.).

Table 4.5 provides an overview of the speaker voice categories:

Table 4.5 Speaker voice categories.

Speaker voice category	Example
1 st person singular	Dan: så siger jeg men altså måske det bare er et udtryk for din depression Eng: then I say but maybe it is just a sign of your depression (GP11)
2 nd person, singular	Dan: når du ser tilbage på det så har hun formentlig haft en depression på et halvt års tid Eng: when you look back on it then she has most likely had a depression for half a year (PS5)
3 rd person singular, patient	Dan: altså: vi har jo et par gamle damer de:r på f:ireogfirs som # som øh er # egentlig er # ikke # fejler ret meget men som den ene siger # hver! morgen # der er jeg klar til at begå selvmord # Eng: well: we have a couple of old ladies who are eightyfour who # who eh are actually not # who are not really ill but as one of them says # every! morning # I am prepared to commit suicide # (GP2)
3 rd person, singular, doctor	Dan: jeg synes først og fremmest at det e:r # øh vigtigt at man k:an # øh # finde en: en alliance med patienten <INT: # mm #> om # hvor de skal hen Eng: first and foremost I think it i:s # eh important that one/you c:an # eh # find an: an alliance with the patient <INT: # mm #> about # where they are going (PS9)
3 rd person, singular, other	Dan: min sekretær har besluttet at jeg skal holde noget mere fri Eng: my secretary has decided that I should take some more time off (PS7)
1 st person plural, doctors' group voice	Dan: det er ikke så meget de deprimerede vi afviser det er mere # øh al mulig andet (PS6) Eng: it is not so much the depressed patients we decline it is more # eh all sorts of other things (PS6)

1 st person plural, doctor-patient	<p>Dan: det kan tage # rigtig rigtig lang tid før at øh # vi egentlig kommer frem til det handler om det #</p> <p>Eng: it can take # a long long time until eh # we actually figure out that it is about that # (GP11)</p>
3 rd person plural, other doctors' voices	<p>Dan: men jeg vil sige det der med at at de # at de praktiserende læger at de ringer og s- # tager en snak # <INT: ja #> det! Var noget som # <INT: ja #> og det er vel også det er også shared care ikke</p> <p>Eng: but I would say this thing that the # that the general practitioners that they call and s- # want to have a talk # <INT: yes #> this! was something that # <INT: yes #> and I guess that is also shared care right (PS4)</p>
3 rd person plural, doctors' voice, own group	<p>Dan: jeg har været [her] så mange år så jeg er holdt op med at undre mig ikke # jeg tror hvis du få:r en nynedsat så vil de have helt! andre spekulationer</p> <p>Eng: I have been [here] so many years so I have stopped wondering right # I think if you ge:t a newly educated them they will have completely! other speculations (PS7)</p>
3 rd person plural, patients' voice	<p>Dan: det at man har kendt dem i tyve år at der har man selv en enorm! terapeutisk # effekt de behøver bare at komme ned og snakke så er det # så så er de sådan lidt på s- # noget! på sporet igen</p> <p>Eng: the fact that you have known them for twenty years that there you have an enourmous therapeutic # effect they just need to come down and talk then it is # then then they are somewhat on t- # quite! back on track (GP6)</p>
3 rd person plural, other	<p>Dan: altså vi {har} jo ergoterapeuter! og de er faktisk rigtig! gode til a:t # at {g-} # dels at gå ind og vurdere hvad de kan!</p> <p>Eng: well we {do} have occupational therapists! and they are actually really! good a:t # at {e-} # partly deciding what they can! (PS6)</p>
Noun	<p>Dan: jamen det kliniske interview # øh <INT: # ja #> det er jo: først og fremmest <INT: # ja #> # {dronningen} i: # <INT: # ja> i klinikken</p> <p>Eng: well the clinical interview # eh <INT: # yes #> that is: above all <INT: # yes #> # {the queen} i: # <INT: # yes> in the clinic (PS8)</p>
Passive	<p>Dan: og og så # bliver de selvfølgelig introduceret til modellen</p> <p>Eng: and and then # they are of course introduced to the model (PS8)</p>

Zero	<p>Dan: jamen det er! jo ikke så enkelt # i hver fald ikke i de der øh # er det livskrise hvad er det vi snakker om # her</p> <p>Eng: but it is! not that simple # not in those eh # is it a life crisis what is it we are dealing with # here (GP8)</p>
Adjective	<p>Dan: og s- og selvfølgelig synes jeg at det er velovervejet # når j-> når jeg g- # når jeg gør det ikke</p> <p>Eng: and o- and of course I think that it is well-considered # when I-> when I d- # when I do it right (GP6)</p>
Infinitive	<p>Dan: jamen det er så let at stille depression:s:diagnosen og så give folk noget medicin</p> <p>Eng: well it is so easy to make the depression diagnosis and then give people some medication (PS7)</p>

In the event that the speaker voice refers to more than one speaker, and these speakers have different roles (e.g. *psychiatrist* (y) and *other* (o)), or the speaker voice reference is ambiguous, I have added the necessary speaker role tags to the occurrence, as in the following example:

Ex. 4.57

Dan: de der mange der bliver indlagt så {tal-} e:j så sagde **personalet** # hun! er bare personlighedsforstyrret nu! <INT: # mm #> splitter hun os nu gør hun dit og dat # men når depressionen! # blev velbehandlet # så fremstod der et menneske

Eng: those many who are hospitalised så {tal-} u:h then the **staff** said # she! just has a personality disorder now! <INT: # mm #> she is splitting us now she is doing this and that # but when the depression! # was treated properly # then a human being emerged (PS5)

Example 4.57 is thus annotated as *third person plural, psychiatrist/other*. Such instances that include multiple speaker voices from different groupings are excluded from the quantitative analysis of group membership relative to discourse presentation. An exception to this principle are instances of the doctor-patient references belonging to the category *first person plural, doctor-patient*.

4.7 GENERAL ANNOTATION QUERIES

In this section, I introduce some recurrent ambiguities in the annotation process. In order to ensure clarity and transparency as well as to avoid lengthy discussion of what are perhaps best regarded as analytical issues and consequently potentially theoretical discussions relative to the Lancaster discourse presentation framework, I will briefly introduce the most common ambiguities matters and their consequences for the annotation. Such ambiguities may be considered analytical matters meriting investigation in future research on discourse presentation.

Annotation of the summarising forms: RSA/RV vs actions

The sample contains instances of potential speech or writing presentation that can be regarded as bordering actions. Semino and Short mention the concept *turnovers*, which are actions leading up to the presentation of a proposition (Semino & Short 2004: 39). This phenomenon is relevant in relation to forms that project propositional content and have the potential of being presented without a reporting clause (FIS and DS and their corresponding categories on the other two scales). In written language, ambiguities as to whether actions function as turnovers are often ruled out on the basis of orthographical features such as punctuation, as in the case of DS/DW/DT colon and quotation marks. However, when it comes to forms without propositional content, categorising something as a reference to speech (or writing or thought) or as an action requires the establishment of criteria for the annotation process. Semino and Short discuss the example of *hailing a taxi* and highlight its ambiguity in terms of verbal and kinetic communication (2004: 188-9).

Allusions to speech can be made in relation to almost any activity since human interaction in most contexts involves some degree of verbal communication. Like Semino and Short, I establish relatively strict inclusion criteria, which increases comparability with the investigations conducted by the Lancaster research group. For my purposes, this means that an instance must contain an actual reference to speech/writing in order for it to be coded as speech/writing presentation. For example, *to meet up with somebody* is very likely to involve speech, but I consider this reference too broad and unspecific to be included as RV. Another group of speech presentation allusions

comprise less abstract references to speech, which can be considered metonymic instances of speech/writing presentation (Burke 1941, Leech 1969: 150). Many of these are context specific, relating to clinical jargon. Examples of such instances were provided in the sections presenting the summarising categories RSA/RWA as well as RV/Representation of Writing.

Unit length

General criteria

Common features of spoken language such as false starts and hesitations are included in the annotation of instances of discourse presentation. Furthermore, as a general rule, repetitions referring to the same propositional content are regarded as one instance (see Example 4.51). However, please note my delineation of units of DS above (the same goes for DW and DT) and associated reporting clauses.

Tags and modifications that occur at the end of a report realised as a proposition are not counted as part of the report since these markers belong to the narrator-speaker rather than the character-speaker:

Ex. 4.58

Da: det første skridt må være at få beskrevet problemet. Det må være at formulere: hvad er det, du synes, der er et problem, og hvad er det, du er ked af, **og så videre, og så videre** (GP7)

Eng: the first step must be to have the problem described/identified. It must be to formulate what is it you think that the problem is and what is it that you are sorry about **and so on and so on** (GP7)

Only the unit/clause in which the actual report occurs is tagged, as in the following example:

Ex. 4.59

Da: Nej jeg har også andre, **der går fast til samtaler**. (GP 3)

Eng: No, I also have other patients **who come regularly to talk to me** (GP3)

In e.g. cleft sentences, only the sub-clause is annotated:

Ex. 4.60

Dan: det er heller ikke altid **de har fået diagnosticeret de tidligere depressioner**
Eng: it is not always **they have been diagnosed for their earlier depressions**
either (GP11)

Unit length and propositional forms

A central point of clarification involves how I counted instances of discourse presentation forms containing a proposition (DS/W/T, FIS/W/T, IS/W/T) since the propositional content may consist of multiple represented utterances, and the two forms DS/W/T and FIS/W/T also occur with a change of character roles without deictic shifting (e.g. a reporting clause). I set forth my criteria for counting occurrences of the direct forms below.

I choose to count as one instance whenever there is a change in what Goffman terms ‘footing’ (Goffman 1981: 128, see also Chapter 2.2 for a presentation of Goffman in relation to speech presentation) or what could also be referred to as a change in the discursive layers (e.g. Møller 1994). The following example illustrates this principle:

Ex. 4.61

Dan: INT: hvad kommer de så med når <INF: # {det er} #> de kommer på en akut tid #
INF: jamen det kan være sådan en så står der brudt sammen på arbejdet eller brudt sammen på studiet eller <INT: # okay #>
INT: ja #
INF: eller # <INT: # ja> # græder hele tiden står der sådan et eller andet ikke

Eng: INT: what do they bring along then when <INF: # {it is} #> they come in for an urgent appointment #

INF: well, it can be one like then it says **broken down at work** or **broken down at college or** <INT: # okay #>

INT: yes #

INF: or # <INT: # yes> # **is crying all the time** it says something like that right (GP8)

This example contains three instances of DW due to the narrator-speaker's conjunctive 'or' between the direct representations, given that each 'or' marks a change in footing. If the example had occurred in written language, the three instances would most likely have been shown with three sets of quotation marks.

Multiple clauses of DS/DW/DT are annotated so that a stretch belonging to the same character within the same occasion – which may consist of one or several represented turns though without shifts back to the ongoing discourse situation – counts as one instance of DS/DW/DT. This principle is illustrated here by means of an instance of DT:

Ex. 4.62

Da: Øhm, og så kan man jo blive vældig træt, og øh bange. Og øh, ja ulykkeligt, stresset, u ja øhm hvad hedder det. Ja utryg ved **hvad skal det her blive til og hvad skal der blive af mig og jeg vil gerne være som jeg plejer**. Øhm ja, det er vel sådan lidt rundt om det, tror jeg. (GP10)

Eng: Eh and then you can become quite tired and eh scared and eh unhappily stressed uh yes eh what is it called, yes unsure about **where is this going to go and what will become of me and I want to be as I used to**. Eh yes, that covers it pretty well I think. (GP10)

The report has a summary-like character, expressing the patients' most central concerns as general statements (see the use of 'man'), which are likely to be paraphrases rather than word-for-word

representations. This listing of concerns also presents ambiguity regarding the ownership of the conjunction ‘and’ between the utterances: they could be argued as belonging to the narrator rather than to the character, which would mean that the report is composed of three individual instances of DT. However, the ‘and’s could also be regarded as a rhetorical strategy on the part of the narrator, producing an accumulative effect on behalf of the patients and thereby underlining their frustration associated with the condition. I have chosen the latter interpretation, leading me to annotate the report as one instance of DT.

Instances of sequential representation such as a reported dialogue within the character-world and without shifts back to the ongoing discourse situation, e.g. in the shape of reporting signals, but with shifts in assigned character roles count as a new instance every time a change in character-speaker occurs:

Ex. 4.63

Da: Nej, det [at gå til psykolog; HSP] er mere accepteret generelt, det er også der er også nogen, der kommer bare, **jeg skal til psykolog. Nå skal du det**, og sådan, altså

Eng: No, it [seeing a therapist; HSP] is more generally accepted, it is also some people just come **I need to see a therapist. Oh, you do** and such, well (GP8)

Furthermore, the conflation of the direct and the free direct forms excludes some potential points of ambiguity, such as where a unit changes from DS/DW/DT to FDS/FDW/FDT and to which reported utterance the reported units belong.

For a clarification regarding annotation of reporting units as opposed to discourse presentation forms, see Example 4.40, in which I discussed the relationship between nouns as introducing a proposition in comparison to an independent status of a summarising form (RSA/W/T, RV/W/T).

Ambiguity tags

Throughout the chapter, I have presented borderline instances where relevant (e.g. direct vs indirect forms, speech vs writing presentation, specific vs non-specific representation). However, I will now introduce a few general guidelines regarding my approach to ambiguity tags. The sample contains instances that cannot be assigned one tag or another, often due to a lack of formal features that otherwise distinguish one form from another, such as quotation marks, which the literature mentions as markers often separating speech from thought (Leech & Short 1981, Short 1996) or a lack of intonational patterns, which might otherwise imply a change in footing and thereby separate an instance of e.g. DS from IS or an instance of the blended FIS from IS.

It should be noted that, whenever possible, I have sought to assign just one tag in order to minimise use of ambiguity tags. This has often involved a contextual reading of the occurrence, as when determining the use of speech vs thought:

Ex. 4.64

DS vs DT

Da: INT: Så det er ikke så stigmatiserende mere?

INF: Nej, det er mere accepteret generelt, det er også – der er også nogen, der kommer bare, **jeg skal til psykolog. Nå skal du det**, og sådan, altså. (GP8)

Eng: INT: So it is not that stigmatising anymore?

INF: No it is more generally accepted, it is also, some also come just **I need a psychologist, oh you do**, and so on, well (GP8)

In ex. 4.64, we first have the voice of the patient ('I need a psychologist') represented through Direct Speech, immediately followed by the doctor's response, also presented as direct presentation, which – because of the lack of a reporting clause or signal – could in fact be interpreted as both speech and thought (see also Buchstaller 2002, Semino & Short 2004 for treatment of ambiguity as a rhetorical device). A contextual reading of the 'oh you do' could support tagging the stretch as DS as the second part of an adjacency pair (request-answer). However, as suggested in the literature,

thought presentation is often used as an evaluative device to contrast the outer world (represented by speech) with the inner world (represented by thought), with the latter often functioning as a quiet criticism of the conversation the I-character himself takes part in (e.g. Haarkana 2008, Semino & Short 2004). Because I regard these two readings as equally likely due to the lack of a reporting signal, I tagged the instance as DS/DT.

In 4.3, I explained how I have categorised instances that are ambiguous in terms of the speech-writing distinction. I explained how the written cline often outweighs the spoken cline but also that the categorisation must be contextually inferred. One recurrent use of discourse presentation is a metonymic variant *to send (off)*:

Ex. 4.65

Dan: der va:r # en patient som jeg syntes havde noget hukommelsesbesvær # og hende **sendte** jeg **op** til hukommelsesklinikken og hun blev {kom} hun kom {t-} stor- # -grinende tilbage til mig og sagde # de synes jeg er dybt! depressiv

Eng: there wa:s # a patient who I reckoned had some degree of amnesia # and I **sent** her **up** to the amnesia clinic and she was {came} she came {t-} back to me laughing # her head off and said # they think I am deeply! depressive (PS7)

It is most likely that a formal referral has been involved in the patient's visit to the amnesia clinic. However, the subsequent stretch presents the clinic's conclusion as presented by the patient (*they think I am deeply! depressive*). The patient thus provides an answer to the psychiatrist's initial initiative, which I would argue could then also be interpreted as an instance of RSA. As a consequence, I have chosen to annotate this (and similar instances) as ambiguous.

Another recurrent ambiguity concerns genericity. In 4.6.2, I presented an ambiguous example and discussed it in relation to the specific/non-specific divide.

Contrary to Semino and Short (2004) and McIntyre et al. (2004) I have chosen to include such instances in my tests. I have chosen to do so because of the relatively small size of my corpus.

4.8 Excluded annotation phenomena

Internal Narration

Internal Narration is a relatively recent addition to the Lancaster framework, and even though it is operationalised in both Semino and Short and McIntyre et al., its status as a thought presentation category has questioned by Semino and Short themselves (Semino & Short 2004: 147-148).

McIntyre et al. do not voice concerns about the category in their relatively short article on discourse presentation in spoken language but merely adapt the core framework from Semino and Short (2004), with modifications at the level of category features alone (McIntyre et al. 2004)). *Internal Narration* is considered a somewhat liminal category, one that is not immediately comparable with the corresponding categories on the speech and writing presentation scales. For this reasons, I have decided not to include the category in my annotation framework. Instead, as noted in 4.4, I have incorporated Short's *Representation of Thought* as the most summarising category on the thought presentation cline (Short 1996: 311).

Inferred thought presentation

The category feature *inferred thought presentation* was first introduced by Semino and Short (2004). The phenomenon encompasses instances in which the reporter has lacked immediate access to the presented thoughts (Semino & Short 2004: 55-56). I have decided not to include this category feature for two main reasons. First, the material in my corpus is characterised by being predominantly generic, rather than specific (see 4.6.2). As a result, we are not for most part dealing with instances of discourse presentation referring to one specific situation from which the inference can be deduced, making the phenomenon more difficult to encompass in the type of discourse I am investigating. Second, the features I have chosen to include in my annotation apply to all three presentational modes (speech, writing, and thought presentation). This focus means that the features will be consistently comparable across presentational modes and their categories.

Quotation phenomena

Please see Chapter 4.5 for my argument for excluding this phenomenon from my annotation.

PART 2

CORPUS RESULTS AND DISCUSSIONS

CHAPTER 5: CORPUS CONTEXT STUDY

Introduction to Chapter 5

This chapter explores corpus-based uses of the Lancaster discourse presentation framework and thus attempts to answer my first research question: how is discourse presentation distributed in a corpus of spoken, institutional, predominantly non-narrative Danish-language interviews, and how do the distributional patterns within this context compare to previous corpus studies of discourse presentation?

The baseline for the chapter will be the results from my corpus containing discourse about depression. This will then be compared with existing corpus studies on discourse presentation, primarily those based on the Lancaster discourse presentation framework, which, due to the application of the same discourse presentation categories, is immediately comparable with my annotations. Apart from the present study, there are at present two corpora that apply the Lancaster discourse framework in its entirety. Semino and Short (2004) was the first corpus-based investigation of the Lancaster discourse presentation framework. McIntyre et al.'s subsequent study was conducted with the aim of comparing a corpus of spoken English with Semino and Short's corpus of written English (McIntyre et al. 2004: 51-52). My study stands on the shoulders of these two contributions in order to describe the distribution patterns of a corpus of spoken Danish. I furthermore hope to add nuance to the findings of the previous corpus studies and thereby provide new insights into the application of the Lancaster discourse presentation framework within a corpus-based frame. As will become evident from the description of the corpora in Section 5.1 below, the contextual parameters of the three corpora distinguish them very clearly from one

another. I thus expect that the application of the Lancaster discourse presentation framework to a corpus with different contextual parameters will provide insight into how the highly controlled discourse presentation frame may be sensitive to contextual variability.

Consequently, this chapter has three main objectives: 1) to present, contextualise, and explain the distribution patterns of discourse presentation in my corpus about depression; and in the light of these findings, 2) to discuss and nuance previous findings of corpus-based discourse presentation; with the aim of achieving 3) an elaborated description of the Lancaster discourse presentation framework from a corpus-based perspective.

In order to be able to reach valid conclusions about the distribution patterns and differences in these across the different corpora, I wish to secure the highest possible comparability across the compared studies. I have thus set up different contextual parameters, which are sufficiently stable to be comparable across the different corpus-based studies of discourse presentation. As a consequence, the discussion will centre on the following distinctions:

- Narrative vs. non-narrative discourse
- Written vs. spoken discourse
- English vs. Danish discourse

Where relevant, I will also draw on potential explanations such as *serious* and *entertaining discourse* and *fictional* and *non-fictional discourse*. I have not included these traits as contextual variables since the variability of these traits is too great to ensure coverage across the different corpora and thereby ensure contextual comparability.

After introducing the corpora and their contextual traits, I present the results of discourse presentation in my corpus (Section 5.2). The section comprises an introduction to the overall results for discourse presentation as well as results relative to each of the three presentational modes (speech, writing, and thought) and each of the categories within each mode of presentation. I compare the findings with the existing corpora-based studies. Section 5.3 comprises a discussion of the findings for each of the presentational modes and their categories relative to previous findings, mainly those based on the Lancaster discourse presentation framework. Section 5.4 provides a summary of the chapter's most important findings and conclusions.

5.1. DESCRIPTION OF THE CORPORA

In order to secure the best possible foundations for describing the results from my corpus, I will compare my corpus with existing corpus studies based on the Lancaster discourse presentation continuum. As mentioned in Chapter 2's presentation of the theoretical framework, only two full-fledged quantitative corpus studies based on the Lancaster discourse presentation continuum have previously been carried out. These are Semino and Short (2004) and McIntyre et al. (2004). Pedersen (2009) contributes to the description of one of the presentational modes (speech presentation) in Danish and Canadian spoken narrative, while Møller (1994) is a quantitative investigation of discourse presentation in Danish spoken narrative, based on the three variants (direct, free indirect and indirect discourse presentation). These four studies constitute the foundations for a comparison with my corpus. The focus will be on the two studies that apply the Lancaster discourse presentation framework in full, i.e. Semino and Short (2004) and McIntyre et al. (2004). The other two studies, Møller (1994) and Pedersen (2009), will be used as comparisons in relation to the categories described in their accounts.

Semino and Short (2004)

Semino and Short's corpus contains approximately 260,000 words. The study quantitatively explores the distribution patterns of discourse presentation in a range of narrative text genres. The study thus investigates speech, writing, and thought presentation in a corpus of written English discourse within the three genres of fiction, press language, and (auto)biography. Within each genre, Semino and Short distinguish between popular and serious text. The corpus material is selected with the aim of making a collection of narrative texts: "For our purposes, narrative texts are relevant because they include the presentation of participants' words and thoughts as a central and almost inescapable element" (Semino & Short 2004: 20). We are thus faced with a design that is contextually controlled in terms of language (English), narrativity (narrative text), and mode (written).

McIntyre et al. (2004)

McIntyre et al. (2004) investigate a corpus of spoken English, which is constructed to match the corpus of Semino and Short (2004). McIntyre et al.'s objective is to set up a spoken corpus that is

comparable to Semino and Short's collection of written text in order to identify differences in distribution patterns between spoken and written English. The size (approximately 260,000 words) matches Semino and Short's corpus. The material consists of a collection of spoken discourse from two different archives: the spoken section of the British National Corpus, and an oral history archive including interviews from two different sub-archives (McIntyre et al. 2004: 52-53). The historical archive comprises one-on-one interviews with inhabitants of the Lancaster region, speaking about past life in their region. The contextual frame may be characterised as private rather than institutional. As is the case with Semino and Short, the corpus is comprised of material that is narrative in structure. McIntyre et al. point out that they purposively identified narrative passages from the two databases in order to secure a sufficient amount of speech, writing and thought presentation (McIntyre et al. 2004: 54). As is the case with Semino and Short's corpus, McIntyre et al. have construed a corpus that is contextually controlled in terms of language (English) and narrativity (narrative discourse), which enables comparison of the parameter that differs from Semino and Short's corpus, namely the spoken mode.

Pedersen (2009)

Pedersen (2009) investigates how the categories in the Lancaster speech presentation cline are put to use in a collection of Danish-language and English-language spoken narratives. The collection comprises 48 spoken narratives that are primarily monologic clusters of discourse from sociolinguistic interviews (see Chapter 3 for a brief introduction to the sociolinguistic interview). The narratives were produced by 16 speakers and are extracted from two different language contexts, one Danish and the other Canadian. Pedersen's design is therefore comparable in terms of language (English and Danish), narrativity (narrative discourse), and mode (spoken mode).

Møller (1994)

Møller (1994) is a study of Danish spoken narratives and how discourse presentation is used in this context. This investigation is not based on the Lancaster discourse presentation framework but makes use of the three more traditional variants (direct, free indirect, and indirect presentation). The data is extracted from sociolinguistic interviews. Møller's design is comparable in terms of language (Danish), narrativity (narrative discourse), and mode (spoken). Møller's corpus consists of

100 narratives from 20 conversational interviews (Møller 1994: 13). Møller does not explicitly state the number of words in his corpus. The conversational interview is what other studies using the same interview material have termed *the sociolinguistic interview* (Gregersen et al. 1991, see Chapter 3 for a brief introduction to the sociolinguistic interview). To the best of my knowledge, Møller (1994) is the only Danish study, apart from Pedersen (2009), to quantitatively investigate more than one discourse presentation form. I anticipate that more nuanced insights into the use of discourse presentation in Danish may be substantiated by comparing Møller’s results with my results and those from existing corpus research into discourse presentation.

My corpus

My corpus is comprised of 12 social research interviews, consisting of six interviews with psychiatrists and six with general practitioners. The corpus size is 111,357 words. The contextual parameters are controlled in terms of language (Danish), narrativity (non-narrative), and mode (spoken). The interviews are conducted in a professional and institutional – rather than private – setting (see Chapter 3 for an elaborated description of my data).

Table 5.1 Overview of quantitative studies of discourse presentation

Study	Source	Language	Mode	Narrativity	Size of corpus
Semino & Short (2004)	Fiction, press text, and (auto)biography	English	Written	Narrative	258,348 words
McIntyre et al. (2004)	British National Corpus + historical interviews	English	Spoken	Narrative	260,000 words
Pedersen (2009)	Sociolinguistic interview	Danish and English	Spoken	Narrative	48 narratives of personal experience ⁹

⁹ A word count of the corpus was not conducted and is therefore unavailable.

Møller (1994)	Sociolinguistic interview	Danish	Spoken	Narrative	100 narratives of personal experience ¹⁰
My corpus	Social research interview	Danish	Spoken	Non-narrative	111,537 words

5.2 RESULTS

5.2.2 OVERALL RESULTS OF DISCOURSE PRESENTATION IN THE CORPORA

If we start by looking at the total discourse presentation in my corpus (i.e. the total presentation of speech, writing, and thought), we find 2605 instances of discourse presentation, as indicated in Table 5.2:

Table 5.2 Occurrences of speech, writing, and thought presentation

DP mode	My corpus	Semino & Short	McIntyre et al.
Speech	1214	6034	4872
Writing	288	502	801
Thought	1103	697 ¹¹	1334 ¹²
Total	2605	7233	7007

The size of my corpus is 111,537 words, whereas Semino and Short's corpus contains 258,348 words. McIntyre et al. do not provide an exact figure for the size of their corpus, which was built to match the size of Semino and Short, but state that it is approximately 260,000 words (McIntyre et al. 2004: 52). These different corpus sizes render invalid any direct comparison of the discourse presentation occurrences in the three corpora. In order to accommodate the different corpus sizes, I have used an index calculation, which shows that my corpus contains 23.4 occurrences of discourse

¹⁰ Møller does not state the corpus size but only states the number of narratives analysed (Møller 1994: 13).

¹¹ Internal Narration subtracted to ensure comparability (see Chapter 4.8).

¹² In the calculation of thought presentation in McIntyre et al.'s corpus, I have omitted the figure for Internal Narration, which has not been annotated in my corpus. See Chapter 4.8 for an elaboration on this issue.

presentation per 1000 words. The figure of the index calculation for Semino and Short's corpus is 28 occurrences per 1000 words, and the figure for McIntyre et al.'s corpus is 27 occurrences per 1000 words. These figures indicate that the distribution of discourse presentation is relatively even in the three corpora, with the two English-language corpora containing just slightly more than my corpus even though they contain nearly double the amount of words.

If we look at the distribution patterns relative to the three presentational modes (speech, writing, and thought) presented in Table 1, speech presentation is the most frequent mode in my corpus, occurring 1214 times. Use of thought presentation is almost as frequent, with 1103 occurrences. Use of writing presentation is relatively sparse compared to the other two presentational modes, occurring just 288 times. This rank order of the three presentational modes matches those of Semino and Short (Semino & Short 2004: 59) and McIntyre et al. (McIntyre et al. 2004: 67-68), suggesting that the three presentational modes follow certain relative distribution patterns. A comparison of the rank order of the three modes across Semino and Short's and McIntyre et al.'s corpora shows a similar distributional rank order (McIntyre et al. 2004: 67-68). In Møller's study of the three variants (direct, free indirect, and indirect discourse), he mainly discusses the three modes of presentation under one umbrella as *speech*. However, at one point he separates the presentation of speech, writing, and thought and finds that the presentation of speech is far and away the most employed presentational mode, followed by thought. The presentation of writing is extremely sparse and ranks last (Møller 1994: 39). This pattern matches the distribution of the three discourse presentation modes in the three corpora based on the Lancaster framework.

For the Lancaster-based investigations of discourse presentation, I have carried out χ^2 tests to compare the relative differences of each corpus. The motivation for doing this is to explore how each of the three modes of presentation is distributed and whether it is possible to discern patterns of use according to the context in which they occur. The results of the comparison with Semino and Short's figures are provided in Table 5.3:

Table 5.3: Discourse presentation in my corpus compared with Semino and Short

	My corpus	Semino & Short's corpus	Significance
Speech	1214	6034	X (Semino & Short)

Writing	288	502	X (my corpus)
Thought	1103	697	X (my corpus)
Total	N = 2605	N = 7233	

The results show that the presentation of speech is more frequent in Semino and Short's corpus than in my corpus. As concerns thought and writing presentation, the tendency is reversed in that these presentational modes are used significantly more often in my corpus than in Semino and Short's. A similar comparison with McIntyre et al.'s spoken corpus study provides us with the following results:

Table 5.4 Discourse presentation in my corpus compared with McIntyre et al.

	My corpus	McIntyre et al.	Significance
Speech	1214	4872	X (McIntyre et al.)
Writing	288	801	No significance
Thought	1103	1334	X (my corpus)
Total	N = 2605	N = 7007	

The statistical test shows a significant difference between the two corpora in the use of speech presentation, indicating that speech presentation is used significantly more often in McIntyre et al.'s corpus. In relation to writing presentation, the statistical test reveals no significant difference. As concerns the result for thought presentation in the two spoken corpora, this statistical test also shows a significant difference, with thought presentation being significantly more employed in my corpus than in McIntyre et al. In terms of speech and thought, these results confirm the tendencies found in the tests comparing my corpus with that of Semino and Short.

The comparisons with the existing corpus studies allow us to draw the following quantitative conclusions regarding the distribution patterns of the three presentational modes:

- An index calculation shows that the three corpora contain approximately the same amount of discourse presentation.

- The three Lancaster-based corpora display roughly the same distribution pattern. This pattern is also found in Møller (1994).
- Speech presentation is used significantly more often in the two narrative corpora than in my corpus.
- Writing presentation is used significantly more often in my corpus than in that of Semino and Short. No significant difference is found relative to McIntyre et al.'s corpus.
- Thought presentation is used significantly more often in my corpus than in the other two corpora.

I will return to these findings in the discussion concerning the three discourse presentation scales and their categories.

5.2.3 SPEECH PRESENTATION RESULTS

This section presents the results for each of the discourse presentation categories in my corpus and compares the findings with existing results from the two Lancaster-based corpus studies on discourse presentation. I begin by presenting the results for speech presentation, followed by writing presentation, and finally thought presentation. After presenting the results, I discuss the findings in my corpus relative to the existing corpus studies, primarily the two full-fledged corpus studies based on the Lancaster discourse presentation framework but also Pedersen's findings of speech presentation in Canadian and Danish spoken narratives (Pedersen 2009) and Møller's findings of discourse presentation in Danish spoken narratives where relevant (Møller 1994).

Table 5.5 below lists the figures for speech presentation in my corpus as well the results for Semino and Short and McIntyre et al.:

Table 5.5 Speech presentation in the three corpora based on the Lancaster framework

Variant	Occurrences, my corpus	Rank order	Occurrences, Semino & Short	Rank order	Occurrences, McIntyre et al.	Rank order
DS	213	3	2974	1	2043	1
FIS	125	5	157	5	88	5
IS	162	4	1114	3	588	4
RSA	257	2	1398	2	1305	2
RV	457	1	391	4	848	3
Total	1214		6034		4872	

The results for the tests for significance are shown in Tables 5.6 and 5.7:

Table 5.6 Significance: My corpus versus Semino & Short

	Significance	P-value	Who
DS	X	< 0.0001	Semino & Short
FIS	X	< 0.0001	Me
IS	X	0.000019	Semino & Short
RSA		0.130033	N/A
RV	X	< 0.0001	Me

Table 5.7 Significance: My corpus versus McIntyre et al.

SP category	Significance	P-value	Who
DS	x	< 0.0001	McIntyre et al.
FIS	x	< 0.0001	Me
IS		0.226456	N/A
RSA	x	0.000061	McIntyre et al.
RV	x	< 0.0001	Me

Direct speech (DS)

A comparison with the other two corpus studies on discourse presentation shows a significant use of DS in Semino and Short's corpus as well as in McIntyre et al. compared to my corpus. In both of these corpora, DS is also the most employed category, whereas in my corpus, this category ranks third. The χ^2 test between Semino and Short and McIntyre et al. shows a significant difference, with direct speech being employed significantly more often in the written corpus ($p < 0.0001$).¹³ Semino and Short divide their texts into serious and popular and find that DS is almost twice as frequent in the popular genre (Semino & Short 2004: 67). The predominance of DS in the two English corpora is also found in Pedersen (2009), both overall and relative to the Canadian-Danish divide. Of the three categories (DS, FIS and IS, Møller (1994) finds a clear prominence of DS in the corpus of Danish narratives.

Free Indirect Speech (FIS)

FIS is the least frequent speech presentation category in my corpus, which is also the case in the other two corpus studies. Even though the representation of FIS is relatively sparse in all three corpora, the χ^2 tests show that the category is used significantly more often in my corpus than in those of Semino and Short and McIntyre et al. ($p < 0.0001$ and $p < 0.0001$). Across the two English corpora, no significant difference is found (McIntyre et al. 2004: 67). Møller finds that FIS is more frequent than is IS (Møller 1994: 25). This result is consistent with the findings in Pedersen (2009). Applying the Lancaster speech presentation framework, I found that FIS is the second-most employed variant in the corpus of spoken narratives (Pedersen 2009: 54). These rankings of FIS are somewhat remarkable seen in the light of the quantitative studies in which FIS consistently holds the lowest ranking of all categories. In a sub-analysis, Pedersen (2009) distinguishes between Canadian and Danish narratives and finds that in the Danish speaker group, FIS matches the overall result, being the second-most frequent form, whereas in the Canadian group, FIS ranks fourth out of

¹³ Separate tests for the two categories Free Direct Speech and Direct Speech were already made by McIntyre et al. (McIntyre et al. 2004: 67). However, in order to match the setup in my corpus, I have conflated the categories Free Direct Speech and Direct Speech so that the calculation is comparable to my result. In McIntyre et al., Free Direct Speech ranks fifth, and Direct Speech ranks first, which means that a conflation of the two variants would not have influenced the ranking of IS, which I would argue makes a comparison with their ranking of IS valid. See Chapter 4 for my arguments for conflating Free Direct Speech and Direct Speech in the annotation of my corpus.

five. Based on this distinction, it becomes evident that it is the Danish speakers who are responsible for the frequent use of FIS in the corpus.

Indirect Speech (IS)

The frequency of IS in my corpus is relatively low, and the category ranks fourth out of five, being more frequent only than its neighbouring category FIS. In Semino and Short's corpus, IS ranks third out of five, not far behind the second-most employed variant, RSA, and with a large gap between this variant and the fourth-ranked variant representation of Voice (Semino & Short 2004: 67). A test of significance between the two corpora provides a significant result, with the category being employed significantly more often in Semino and Short's corpus ($p = 0.000019$). In McIntyre et al.'s corpus, IS holds the same ranking as in my corpus, being the second-least frequent category. This tendency is confirmed by a significance test, which shows no significant difference between their corpus and my corpus ($p = 0.226456$). The difference between Semino and Short's corpus and McIntyre et al.'s corpus is significant, with IS being more frequent in the written corpus (McIntyre et al. 2004: 67). Møller finds an underrepresentation of IS compared to the other two variants in the study, DS and FIS (Møller 1994: 40). In Pedersen 2009, this tendency is confirmed in that IS is far and away the least employed speech presentation variant of the five speech categories (Pedersen 2009: 54).

Representation of Speech Act (RSA)

In my corpus, RSA ranks second. This is also the case in Semino and Short as well as in McIntyre et al. The χ^2 test shows no significant difference between Semino and Short's corpus and my corpus ($p = 0.130033$), which is also the case in a comparison of Semino and Short with McIntyre et al. (McIntyre 2004:67). A comparison of my corpus with McIntyre et al.'s corpus shows that RSA is employed significantly more often in McIntyre et al. ($p = 0.000061$). Pedersen (2009) finds a rather low representation of the category, which ranks fourth out of five in overall use of speech presentation. In the Canadian group, it is a bit more frequent, ranking third, whereas the overall ranking is replicated in the Danish speaker group, in which it ranks fourth.

Representation of Voice (RV)

RV is the most frequent speech presentation category in my corpus. In Semino and Short's corpus study, the tendency is different: here, the category ranks fourth out of five, and is considerably less frequent than the third-most employed category, IS (Semino & Short 2004: 67). In McIntyre et al.'s study, RV ranks third, after DS and RSA. The statistical tests comparing my corpus with those of Semino and Short and McIntyre et al. respectively both show a significant difference, with RV being employed significantly more often in my corpus ($p < 0.0001$ and $p < 0.0001$). If we turn to a comparison of the results of the two English corpora, the statistical test shows a significant difference in use of RV, which is employed significantly more often in McIntyre et al.'s corpus (McIntyre et al. 2004: 67). Pedersen finds that RV is the third-most employed category after two the most direct categories, DS and FIS. In relation to the Danish-Canadian divide, the category is more frequent in the Canadian group, ranking second, whereas it ranks third in the Danish group (Pedersen 2009).

5.2.4 WRITING PRESENTATION RESULTS

In this section, I present the results for use of writing presentation in my corpus, which also comprises a comparison of the results from the existing studies. The occurrences and rank order of the categories are listed in Table 5.8 below, with corresponding figures for the other two corpora's writing presentation as comparison.

Table 5.8 Writing presentation in the three corpora based on the Lancaster framework

WP category	Occurrences, my corpus	Rank order	Occurrences, Semino & Short	Rank order	Occurrences, McIntyre et al.	Rank order
DW	21	4	141	2	203	2
FIW	11	5	32	5	25	5
IW	32	3	74	3	45	4
RWA	172	1	215	1	350	1
RN	52	2	41	4	178	3

Total	288		503		801	
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The results for the tests for significance are shown in Tables 5.9 and 5.10:

Table 5.9 Significance: my corpus versus Semino & Short

WP category	Significance	P-value	Who
DW	x	< 0.0001	Semino
FIW		0.130687	N/A
IW		0.29192	N/A
RWA	x	0.000004	Me
RN	x	0.00003	Me

Table 5.10 Significance: my corpus versus McIntyre et al.

WP category	Significance	P-value	Who
DW	x	< 0.0001	McIntyre
FIW		0.569695	N/A
IW	x	0.001815	Me
RWA	x	0.000003	Me
RN		0.137337	N/A

Direct Writing (DW)

DW in my corpus is relatively sparse and ranks fourth out of five. The category is far more frequent in both Semino and Short and McIntyre et al., ranking second in both corpora.¹⁴ The tests for significance confirm this observation, showing that DW is employed significantly more often in both of the other corpora ($p < 0.0001$ and $p < 0.0001$). The test comparing Semino and Short and

¹⁴ As mentioned in relation to the presentation of the figures for (Free) Direct Speech, in order to secure a high level of comparability, I have conflated Free Direct Writing and Direct Writing and carried out a test for significance for the conflated figures.

McIntyre et al.'s frequencies of DW (conflated with Free Direct Writing) shows no significant difference ($p = 0.293234$)¹⁵. Møller finds no occurrences of DW in his corpus (Møller 1994: 40).

Free Indirect Writing (FIW)

The frequencies of FIW are generally low in all three corpora, in which the category ranks fifth. The statistical tests show no significant difference between my corpus and those of Semino and Short ($p = 0.130687$) and McIntyre et al. ($p = 0.569695$), just as the statistical test between Semino and Short and McIntyre et al. shows no significant difference (McIntyre et al. 2004: 68). The low ranking of FIS is replicated by its written counterpart, the only difference being that my corpus contained significantly more FIS than did the other two studies. Møller's study contains no instances of this variant of writing presentation (Møller 1994).

Indirect Writing (IW)

IW ranks third in both my corpus and that of Semino and Short (Semino & Short 2004: 100). In McIntyre et al.'s corpus, this variant ranks fourth. The statistical test shows no significant difference between my corpus and that of Semino and Short ($p = 0.29192$). However, the test comparing my corpus and McIntyre et al.'s corpus does show a significant difference, with IW being employed significantly more often in my corpus ($p = 0.001815$). The difference between Semino and Short's corpus and McIntyre et al.'s corpus is also significant, with a significantly larger proportion of IW in Semino and Short (McIntyre 2004: 68). Three instances of writing presentation occur in Møller's corpus, all of which are conveyed as IW (Møller 1994: 39-40).

Representation of Writing Act (RWA)

RWA is the most frequent writing presentation category in my corpus. This pattern is replicated in the other two corpus studies as well: in Semino and Short and McIntyre et al., this is also the most commonly used variant (Semino & Short 2004, McIntyre et al. 2004: 68). Even though RWA holds high rankings in all three corpora, the χ^2 test shows that the category is used significantly more often in my corpus relative to both of the other corpora ($p = 0.000004$, $p = 0.000003$). The test

¹⁵ I have carried out the test for significance combining the occurrences for Free Direct Writing and Direct Writing in Semino and Short's and McIntyre et al.'s corpora. This was done in order to have the same grounds for comparison between their corpora as when comparing their results with mine.

comparing Semino and Short with McIntyre et al. shows no significant difference (McIntyre et al. 2004: 68).

Representation of Writing (RN)

The most summarising writing presentation category, RN, ranks second in my corpus. In Semino and Short's study, RN ranks fourth out of five, whereas the variant is more frequent in McIntyre et al.'s spoken corpus, ranking third. The χ^2 test comparing my corpus with that of Semino and Short shows that the category is used significantly more often in my corpus ($p = 0.00003$), whereas the test comparing my corpus with that of McIntyre et al. shows no significant difference ($p = 0.137337$). When testing Semino and Short against McIntyre et al. the significant difference emerges, with RN being used significantly more often in Semino and Short (McIntyre et al. 2004: 68).

5.2.5 THOUGHT PRESENTATION RESULTS

In this section, I present the results for use of thought presentation in my corpus, which also comprises a comparison of the results from the existing studies. The occurrences and rank order of the categories are listed in Table 5.11 below, with the corresponding figures for the other two corpora's writing presentation as comparison.

Table 5.11 Thought presentation in the three corpora based on the Lancaster framework

TP category ¹⁶	Occurrences, my corpus	Rank order	Occurrences, Semino & Short	Rank order	Occurrences, McIntyre et al.	Rank order
DT	213	3	107	4	180	3
FIT	83	4	275	1	10	4
IT	301	2	201	2	748	1
RTA + RT	506	1	114	3	396	2
Total	1103		697		1334	

¹⁶ In the annotation of my corpus, I have decided to leave out the category Internal Narration for reasons presented in Chapter 4.8. It is questionable whether this category should be considered a category of thought presentation (see also Semino & Short 2004: 132-135).

The results for the tests for significance are shown in Tables 5.12 and 5.13:

Table 5.12 Significance: my corpus versus Semino & Short's

TP category	Significance	P-value	Who
DT	x	0.032332	Me
FIT	x	< 0.0001	Semino
IT		0.47542	N/A
RTA + RT	x	< 0.0001	Me

Table 5.13 Significance: my corpus versus McIntyre et al.

TP category	Significance	P-value	Who
DT	x	0.000102	Me
FIT	x	< 0.0001	Me
IT	x	< 0.0001	McIntyre
RTA + RT	x	< 0.0001	Me

Direct Thought (DT)

The most direct category of thought presentation, DT, ranks third in my corpus, with only FIT being less frequent. The rankings are similarly low in the two Lancaster corpora, with DT being the least frequent category in Semino and Short's corpus. The ranking in McIntyre et al. resembles that of my corpus, with DT ranking third. Nevertheless, when tested for significance, my corpus contains significantly more DT than do either of the Lancaster corpora ($p = 0.032332$ and $p = 0.000102$). This result also matches the overall significance of thought presentation in my corpus relative to the other two corpora; they seem to be complementary. The significance of DT in my corpus tallies with the tendency that DS was employed significantly more often in the other two corpora. Of the three categories, DT, FIT and IT, DT is far and away the most frequent in Møller's corpus, accounting for 43 of 48 instances of thought presentation (Møller 1994: 40).

Free Indirect Thought (FIT)

In my corpus, FIT is the least employed variant, ranking last of the thought presentation categories. This result matches the tendency in McIntyre et al.'s spoken corpus, whereas in Semino and Short's study of written language, FIT is the most frequent of the thought presentation forms. The chi² tests show that FIT is significantly more common in Semino and Short's corpus relative to my corpus ($p < 0.0001$), as is the case when comparing Semino and Short and McIntyre et al. (McIntyre et al. 2004: 68). Even though FIT holds the lowest ranking in both the spoken corpora, the test for significance shows a significantly higher usage in my corpus than in that of McIntyre et al. ($p < 0.0001$). In Møller's corpus, FIT is very sparsely represented, with only four occurrences, out of a total of 48 instances of thought presentation, ranking second of his three thought presentation categories (Møller 1994: 40).

Indirect Thought (IT)

In all three corpora, IT is fairly prevalent within thought presentation. IT ranks second in both my corpus and that of Semino and Short.. In McIntyre et al.'s corpus, the category is the most frequent of the thought presentation forms. The statistical test shows no difference when comparing my corpus with that of Semino and Short ($p = 0.47542$), whereas IT is used significantly more often in McIntyre et al.'s corpus compared to my corpus ($p < 0.0001$) and compared to Semino and Short's corpus (McIntyre et al. 2004: 68). Møller's corpus only provides one instance of IT presentation, out of a total of 48 instances (Møller 1994: 40).

Representation of Thought Act (RTA) and Representation of Thought (RT)¹⁷

RTA is the most frequent thought presentation category in my corpus. In McIntyre et al.'s corpus, the category ranks second, and in Semino and Short's corpus, it ranks third. When tested for significance, we see that this most summarising variant is used significantly more often in my corpus than in the other two corpora ($p < 0.0001$ and $p < 0.0001$). The category is also used significantly more often in McIntyre et al.'s spoken corpus than in Semino and Short's written corpus.

¹⁷ Neither Semino and Short nor McIntyre et al. distinguish RT from RTA. For sake of comparability, I have conflated these two most summarising forms in my treatment of the results and use the term *RTA* to encompass both variants.

5.3 DISCUSSION OF THE DISCOURSE PRESENTATION FINDINGS

The tests for significance comparing use of discourse presentation in my corpus with those of Semino and Short and McIntyre et al. have shown several significant results. In fact, 21 of 28 tests showed a significant result (see Tables 5.14 and 5.15 below). Despite equal proportions of discourse presentation in the three corpora relative to corpus size (see Section 5.2.2), the high number of significant results provides an ideal foundation for discussing the results relative to the corpora's contextual variables outlined in Section 5.1.

Table 5.14 Number of significant results in my corpus versus Semino and Short's corpus

	My corpus	Semino & Short	No significance
SP	2	2	1
WP	2	1	2
TP	2	1	1

Table 5.15 Number of significant results in my corpus versus McIntyre et al.'s corpus

	My corpus	McIntyre et al.	No significance
SP	2	2	1
WP	2	1	2
TP	3	1	0

5.3.1 DISCUSSION OF SPEECH PRESENTATION RESULTS

Even though the literature provides ample evidence of DS being used in non-narrative contexts, this variant is most often described as a classic mimetic tool for intensifying purposes in narrative contexts (e.g. Chafe 1994, Mayes 1990, Macaulay 2005). Comparison with Semino and Short and McIntyre et al., in which the statistical tests show significant differences in favour of the two narrative corpora, substantiates the widespread assumption that DS is a common feature of narrative discourse. Pedersen (2009) also concludes that in the spoken Danish and Canadian narrative corpus, DS stands out as the most frequent speech presentation category of the five possible choices

on the speech presentation cline. With regard to the three categories DS, FIS and IS, Møller reaches the same conclusion, finding that DS is far and away the most employed speech presentation form. In my corpus, the most summarising category (RV), which is found at the opposite end of the speech presentation cline, is far and away the most frequent form, followed by the second-most summarising category, *RSA*. It thus seems that the speakers in my corpus choose to convey speech by means of the less enacting variants. An explanation for the relatively low frequency of DS relative to the other two corpus studies could be rooted in the highly non-narrative mode of the research interviews that constitute my corpus. The predominance of DS in the four narrative corpora compared with the relatively low frequency of DS in my non-narrative corpus lends weight to the assumption that DS is mainly a feature of narrative discourse. As suggested in the presentation of the corpora, which constitute the foundation for the comparisons in this chapter, it may be possible to characterise the corpora as predominantly serious or entertaining, while my corpus is best regarded as serious. Semino and Short introduce the *serious* and *popular* distinction as an analytical parameter and find that DS is consistently most common in the popular subsections of all three genres (fiction, press, and (auto)biography). The corpora in the two studies Møller (1994) and Pedersen (2009) both consist of sociolinguistic interview data, and McIntyre et al.'s corpus also consists of interviews that, in their description, has many similarities with sociolinguistic interviews. These may be regarded as a very different type of interview than the social research interview (see Section 5.1). The combination of the predominance of DS in Semino and Short's popular subsections with the predominance of DS in the other three corpora consisting of more entertaining or informal content than my interviews indicates that DS is used as intensifying feature to enhance climactic passages in narrative discourse (e.g. Labov & Waletzky 1967: 35). This kind of intensity may be toned down in more serious contexts. As a result, DS in my corpus may be seen as an added layer to the tendency found in Semino and Short and McIntyre et al., suggesting that predominant usage of DS is context sensitive.

Free Indirect Speech (FIS) is the least frequent speech presentation form in my corpus.

Nevertheless, it is used significantly more often in my corpus than in Semino and Short's corpus and McIntyre et al.'s corpus. This variant is typically associated with literary, narrative text since it holds a narratological potential unique to this type of blended presentation (see Chapter 2.5.2). So even though the free indirect variant is the least employed in all three Lancaster-based corpora, it is somewhat surprising that this presentation type is used significantly more often in my non-narrative corpus. In a qualitative treatment of the Lancaster speech presentation framework within a cognitive

psychological frame, the linguist William Chafe observes that FIS “is used predominantly in certain kinds of writing” (Chafe 1994: 212). As a result, Chafe omits this variant in his treatment of speech presentation in spoken language. In Pedersen (2009), I argued against Chafe’s claim by providing empirical evidence for the widespread use of FIS in spoken Danish narratives (Pedersen 2009: 59-60). At the same time, I found an absence of the variant in spoken Canadian narratives i the speakers instead mainly used the neighbouring category (DS to mark directness (Pedersen 2009: 58-60). Møller finds that FIS is more frequent than IS in his corpus of Danish spoken narratives (Møller 1994: 40). This result strengthens my observation that the free indirect variant is indeed present in spoken language. In an account of FIS from 1953, Brøndum-Nielsen demonstrates that this form of representation is not a phenomenon rooted in literary text but was in fact a common feature of everyday spoken language long before it became a well-established literary phenomenon (Brøndum-Nielsen 1953: 17-22). Møller also mentions Brøndum-Nielsen’s account of FIS in order to establish the same argument as mine – that FIS is a legitimate feature of spoken language. Møller concludes that “The assumption that the form is literary is still found in the international literature as recent as in e.g. Coulmas 1986a” (Møller 1994: 10).¹⁸ Chafe’s assumption aligns with Møller’s observation that FIS internationally is regarded as a literary phenomenon. Møller’s quote, combined with the quantitative results from his data material, substantiates Pedersen’s (2009) observations that English-language and Danish-language contexts differ with regard to uses of FIS. This tendency is further substantiated by the significant difference found in my present corpus relative to both Semino and Short and McIntyre et al. The quantitative results for use of FIS in spoken Danish (Møller 1994, Pedersen 2009, and the present study), in combination with Brøndum-Nielsen’s observation, suggest that use of FIS in spoken language is closely linked to a Danish-language context: we now have several indications that FIS leans toward being culturally dependent – or at least language specific.

The results for IS showed a significant difference between Semino and Short and my corpus, as did the test between Semino and Short’s corpus and that of McIntyre et al., in which IS in both cases was significantly more frequent in Semino and Short’s written corpus than in the spoken corpora. These results could indicate that IS is a trait of written rather than spoken discourse. The results of the other quantitative studies substantiate this assumption: the lack of significant difference between McIntyre et al.’s and my corpus, the underrepresentation of the variant compared to the other two

¹⁸ ”I den internationale litteratur finder man dog stadig den opfattelse at formen er litterær, så sent som i fx Coulmas 1986a.” (Møller 1994: 10)

forms in Møller's corpus, and the ranking as the least employed speech presentation category in Pedersen (2009) are all results that lend very little prominence to IS in spoken speech presentation contexts. In the literature on speech presentation, DS and IS are frequently paired as contrasting forms, structurally as well as semantically. Here, IS is often described as the variant that conveys factual information and DS as the variant that is used for enactment or entertainment purposes (Short 1996: 293, Tannen 1986: 311, Macaulay 2005: 144, Mayes 1990: 358). The distinction between popular and serious in Semino and Short's study confirms this assumption, with IS being consistently more frequent in the serious subsections of the corpus (Semino & Short 2004: 67). If we adopt this notion that IS is associated with factual or serious discourse and apply it to the professional, institutional context of the interviews in my corpus and the seriousness of the interviews' topic, IS could be expected to have a higher representation in the corpus.

In Semino and Short's discussion of IS, they draw upon Halliday, who states that IS "is the normal way of representing what people say, in most registers of English today" (Halliday 1994: 255). Semino and Short highlight that their findings contradict this claim, in that other variants have a higher representation in their corpus (Semino & Short 2004: 78). Like Halliday, Polanyi (1982) notes that even though DS is a typical feature of spoken language, "Indirect discourse is even more common" (Polanyi 1982: 160). Halliday's and Polanyi's observations also stand in sharp contrast to my results in spoken discourse. My results support the tendencies revealed by McIntyre et al. (2004), Møller (1994), and Pedersen (2009), studies that all find a very low ranking of IS. In fact, the findings by McIntyre et al. and me support Semino and Short's findings when testing the frequencies of IS. Furthermore, Semino and Short's observation that other forms in their corpus are more prominent than IS seems even more pronounced when dealing with spoken language. In terms of degree of directness, it becomes evident – across the three Lancaster-based investigations – that the even more indirect form RSA, which is placed adjacent to IS on the speech presentation cline, is a more frequent choice in all three corpora.

The results for *Representation of Speech Act (RSA)* showed that this category ranks second in all three Lancaster-based corpora but that the form is used significantly more often in McIntyre et al.'s corpus than in my corpus, which was the only significant result of the various tests of significance. Semino and Short note that the category is more frequent in the serious genres than in the popular genres as well as in the two non-fictional genres (press and (auto)biography), arguing that the complex noun phrases often used in connection with RSA are "better suited to the formal, documentary style of serious (auto)biographies than to the informal narrative style of popular

(auto)biographies” (Semino & Short 2004: 73). This argument seems to be based on RSA being regarded as a highly written style feature. We actually see, however, that there is no significant difference between Semino and Short’s written corpus and McIntyre et al.’s spoken corpus, just as there is no significant difference between my corpus and Semino and Short’s corpus. The only significant difference lies between McIntyre et al.’s corpus and my corpus. These results indicate that RSA is just as frequent in spoken language as in written language. Semino and Short’s linking of their results of RSA to factual reporting and the ‘formal, documentary style’ of serious genres likewise seems highly relevant to explaining the results in my corpus. The context in which the discourse presentation in my corpus is produced may be characterised as a speech event with a high degree of seriousness and factuality, which I argue also helps explain why the most direct category, DS has a relatively low ranking among the various categories of speech presentation in my corpus. In fact, it is the two most summarising forms, RSA and RV, that are most frequent in my corpus: choices that are possibly prompted by the serious and non-narrative context. In such a context, the choice of more dramatising forms seems less fitting or relevant, as I argued in the discussion concerning DS. In contrast, the two most frequent forms in both Semino and Short and McIntyre et al. are DS and RSA. This clustering at the summarising end of the speech presentation cline in my corpus indicates that, whereas the overall picture in the two English corpora points in different directions, the overall picture in my corpus points toward the summarising end of the cline, of which RSA is a central component.

The results for *Representation of Voice* (RV) show that the form is far and away the most frequent category in my corpus and that it is also significantly more frequent in my corpus than in either Semino and Short’s or McIntyre et al.’s corpora. RV is also significantly more frequent in the spoken English corpus relative to the written corpus (McIntyre et al. 2004: 67). This predominance of RV in the two spoken corpora could suggest that the form is more likely to be chosen in spoken than in written discourse presentation contexts. When comparing with McIntyre et al.’s spoken corpus, the fact that use of RV is significant in my corpus could imply that the form is particularly predominant in a non-narrative, spoken discourse context, whereas in all the narrative corpora, DS is the predominant form of speech presentation (Semino & Short 2004, McIntyre et al. 2004, Pedersen 2009, Møller 1994). This tendency was also statistically substantiated by the χ^2 tests for DS, which showed significant differences in favour of both Semino and Short’s and McIntyre et al.’s corpora when compared to my corpus. It also seems that the frequency of DS in the two narrative corpora quantitatively substantiate the assumption concerning prototypicality.

In contrast, in my corpus, it seems – at least in terms of frequency – that RV is the presentational norm. McIntyre and Semino and Short both argue in quantitative terms about presentational norms (Semino & Short 2004: 89, McIntyre et al. 2004: 68-70), but as their observations are based on narrative foundations, this assumption may be somewhat problematic when dealing with a non-narrative corpus. In the description of RV, we also find clear narrative traces, e.g. in the description of how a summarising variant may be used in connection with a more direct variant of speech, writing, or thought in order to sequence passages to foreground and background effects (Short 1996: 297-8). Semino and Short explain the low frequency of the variant in their corpus as follows: “This is probably because NV [RV; HSP] is the most distanced and minimal form of speech presentation, and therefore the one that least lends itself to the provision of detail and the production of dramatic effects” (Semino & Short 2004: 69). With ‘the provision of detail’ and ‘the production of dramatic effects’, Semino and Short seem to describe their observations in light of prototypical DS, which also makes sense in terms of the frequency in both Lancaster studies, in which DS is far and away the most frequent speech presentation form. Semino and Short’s account of the results for RV is an example of the close interrelationship between discourse presentation and its contextual frame, which – as evidenced by the superlative predominance of RV in my corpus – is obviously different in my corpus.

In the subcategorisation of genres, Semino and Short provide a more detailed result for RV: “The two non-fictional genres have slightly higher numbers of occurrences than fiction, and, overall, the serious sub-sections have more occurrences than the popular sub-sections” (Semino & Short 2004: 69). Due to the professional, institutional context and the seriousness of the topic in the interviews in my corpus, my data may be more comparable with the serious section than with the popular since the latter is characterised by drama-enhancing traits, which may limit credibility in more serious discourse (Semino & Short 2004: 89-90). As expected, sub-results from the serious section of Semino and Short’s corpus match the tendency found in my corpus, strengthening the argument that RV is contextually sensitive and used to fulfil other communicative goals than, for example, its counterpart, DS.

On basis of the discussion of the results for speech presentation, an overview of the suggested correlations between the speech presentation results and the contextual variables is provided in Table 5.16:

Table 5.16 Speech presentation by contextual variable

	DS	FIS	IS	RSA	RV
Narrative vs. non-narrative	Narrative				Non-narrative
Spoken vs. written			Written		Spoken
Danish vs. English		Danish			

5.3.2 DISCUSSION OF WRITING PRESENTATION RESULTS

The status of writing presentation as a separate discourse presentation mode is a relatively recent analytical distinction within the Lancaster framework (Semino & Short 2004: 47-48). Semino and Short highlight how writing as a public, externalised phenomenon is quite similar to speech (Semino & Short 2004: 98, 111). Their results provide empirical evidence to support this comparison, the only difference being that RWA is the most frequent form of writing presentation, whereas DS is the most frequent on the speech presentation scale. The distribution pattern for writing presentation in McIntyre et al.'s corpus also matches the distribution pattern of speech presentation in their corpus, the exception being – as is the case with Semino and Short – that DW switches places with RWA as the most frequent category.

As far as speech presentation is concerned, we saw that the distribution of speech presentation in my corpus differs from the results in Semino and Short and McIntyre et al. As is the case with the replication of the pattern of speech presentation in Semino and Short and McIntyre et al.'s respective results for writing presentation, a replication of the pattern from speech presentation in my corpus is also found in the results for writing presentation: the rank order of the two most summarising writing presentation categories (though in reverse order) matches the pattern of speech presentation in my corpus, in which the two most summarising forms, RV and RSA are also the most frequent. These parallel rank orders between speech and writing presentation at the summarising end of the scale thus far substantiate the tendency for my corpus' discourse presentation to focus on the summarising end of the discourse presentation scales. My results also

lend quantitative weight to Semino and Short's claim that speakers are more likely to choose from the indirect forms of writing presentation due to faithfulness constraints in the presentation. The argument is that the source of writing is more easily traceable than is the source of speech (Semino & Short 2004: 111-113). I will now discuss the findings concerning the individual categories on the writing presentation scale.

Direct Writing (DW): The χ^2 tests for DS showed a significantly higher frequency in both of the Lancaster corpora when tested against DW in my corpus. The figures for DW echo the tendency observed with DS, namely that both of the Lancaster corpora comprise significantly more DW than does my corpus. In relation to DS I suggested that the different proportions of the most direct form of presentation could be due to the narrative mode of the Lancaster corpora and, just as importantly, the non-narrative mode of my corpus. Even though the distribution for writing presentation is in some senses similar to that of speech presentation, we see that DW holds a lower ranking compared to the ranking of DS in all three corpora. According to Semino and Short, writing tends to lack the immediacy associated with speech, just as it tends to be more formal than speech, which leads them to conclude that "the effects of dramatization and immediacy associated with (F)DS are considerably diluted with (F)DW" (Semino & Short 2004: 109). These aspects of writing may explain the lower frequency of DW in all three corpora. Nevertheless, the category remains significantly more frequent in Semino and Short and in McIntyre et al. than in my corpus. It may well be because of the increased level of formality and reduced immediacy of writing presentation that the most direct form of writing presentation is even less frequent in my corpus of non-narrative, serious discourse. I also argued that these features could be a deciding factor in relation to the relatively low frequency of DS in my corpus compared to the other forms of speech presentation as well as in relation to the figures for DS in the two narrative corpora. Along the same lines as Semino and Short, McIntyre et al. highlight that DW is not an obvious choice when presenting writing, as is confirmed by the low frequency in their corpus, thereby strengthening the observations by Semino and Short (McIntyre et al. 2004: 69). The fact that my result for DW replicates previous findings validates Semino and Short's and McIntyre et al.'s observations. In addition, the lack of significance and the low ranking in my corpus compared to the two other corpora seem to take this observation a step farther, yet again demoting the prominence of DW in writing presentation. In this respect, my finding of DW both confirms previous observations and suggests that DW is generally relatively infrequent. In addition, the significantly lower frequency in

my corpus may suggest that DW – as was the case for my result for DS in speech presentation – is less used in non-narrative contexts than in narrative contexts.

Free Indirect Writing (FIW) replicates the pattern seen relative FIS, being the least employed writing presentation form in all three corpora. Whereas the result for FIS was significant in my corpus compared to the other two corpora, no significance was found in any of the tests carried out in connection with FIW. Semino and Short note that free indirect forms are “linguistically more complex and potentially more ambiguous than other forms of presentation” (Semino & Short 2004: 107) and that this may explain the low ranking of the free indirect forms. In relation to my corpus, the suggestions I proposed for the significant use of FIS compared to the other two corpora are not valid in relation to FIW. Semino and Short suggest that the lower ranking of DW in their corpus compared to the ranking of DS may be due to the fact that the dramatisation and vividness associated with DS do not equally apply to its written counterpart and “that the use of direct quotation from written sources normally imposes higher faithfulness constraints than from spoken sources” (Semino & Short 2004: 111-113). We saw that the frequency and ranking of DW in my corpus was even lower than for DS, which matches Semino and Short’s claim. The fact that DW showed significant differences for Semino and Short and McIntyre et al.’s corpora when compared to my corpus may underline that the discourse in my corpus does not involve much dramatising and vivid rendering, which is possibly also due to the non-narrative nature of the interviews. This may also explain, alongside the faithfulness constraint proposed by Semino and Short, the low frequency of FIW in my corpus. An explanation for the lack of the free indirect form in presentations of writing could be related to the mode of presentation (writing) along with the professional discourse situation represented: as we will see in Chapter 6, writing presentation in my corpus is mostly used to refer to journals, referrals, prescriptions, etc., which are highly institutionalised documents, sometimes even formalised writing acts. Such documents are perhaps less likely to be subjectivised and evaluated, functions otherwise often associated with the free indirect forms in speech presentation – a presentational mode which in many ways resembles the presentation of writing (see Chapter 2.5.3). Taking this aspect of the free indirect forms into consideration, I would argue that there is a functional explanation for the finding that most instances of writing presentation in my corpus are realised through the more indirect and summarising forms on the writing presentation scale.

Indirect Writing (IW) ranks third in my corpus, after RWA and RN. Consequently, the top three forms of writing presentation in my corpus are indirect variants, and the ranking of IW seems to substantiate the notion that both writing presentation and speech presentation in my corpus is presented by forms conveying indirectness rather than directness. As I suggested when discussing speech presentation, an explanation could be found in the non-narrative mode of my corpus as well as the seriousness of the context. IW is also significantly more frequent in my corpus than in McIntyre et al.'s corpus, whereas the χ^2 test showed no significance when comparing Semino and Short's frequency of IW with my own. Semino and Short also note that IW is extremely sparse in the fictional subsection of their corpus. These results suggest that IW, as well as writing presentation as a whole may be chosen in contexts that are more formal, serious, and (perhaps) non-narrative. In fact, DW is the only category used significantly more often in McIntyre et al.'s corpus than in my corpus. The only significant result in favour of Semino and Short's corpus is also found in relation to DW. Møller (1994) found only three occurrences of writing presentation in his corpus, all of which were presented as IW. Even though the empirical foundation for making this claim is sparse, the absence of the two most direct forms of writing presentation match the tendency in my corpus for these two forms to hold the lowest ranking. The more summarising forms of presentation are outside the scope of Møller's analytical framework. Given the extremely sparse writing presentation in Møller's study, it would have been interesting to see if the more summarising categories were actually the preferred means of conveying writing presentation in that data, as is the case in my corpus. Møller's findings could point in the direction of Semino and Short's claim that writing presentation generally favours the more indirect forms of presentation. I will treat the two most summarising categories of writing presentation in the following sections.

Representation of Writing Act (RWA) is far and away the most frequent category of writing presentation in my corpus, followed by RN. Even though the frequencies are distributed in reverse order, the pattern echoes the distribution of speech presentation in my corpus, in which the two most summarising forms, RSA and RV, were also the most frequent. This pattern lends weight to Semino and Short's claim that speech and writing presentation share similarities in terms of being public and verbal forms of communication (Semino & Short 2004: 98, 111). Nevertheless, the correlations in distribution patterns across the two modes highlighted by Semino and Short turn out differently in my corpus. Furthermore, the fact that the speech presentation pattern is replicated in the presentation of writing in my corpus substantiates – despite a different correlational pattern than in the other two corpora – Semino and Short's argument of similarity between speech and writing

presentation. This is because we see a consistency *within* each corpus in terms of replication of speech and writing patterns and because these differences across the corpora in the distribution of categories may be explained by contextual differences. If we turn to the distribution patterns in Semino and Short and McIntyre et al., the top rankings are (again in reverse order) also occupied by the same categories as in speech presentation, with RWA being the most frequent category in both corpora, followed by DW. These consistencies in the three corpora across the two presentational modes add strength to the contextual explanations of the distribution patterns. The results for all three corpora showed that RWA was the most frequent form of writing presentation. However, the significant difference between both of the Lancaster corpora and my corpus could indicate that the summarising choices are due to the non-narrative nature of my corpus. If we turn to depression as a condition dealt with by the healthcare system, which is the theme throughout my corpus, this theme is situated in an institutional healthcare context. Consequently, part of this frame consists of institutional writing acts and thereby constitutes part of the discourse associated with talking about the illness. These writing acts include writing journals, prescriptions, and cross-communication between the different sectors, which often takes place in writing. Rather than presenting specific wordings of, for instance, written documents, it could be argued that it is these conventionalised writing acts themselves that are central when discussing how the system and its actors deal with written communication. This could explain why the two most summarising forms are chosen over the direct variants projecting propositional content. How exactly this summarising form is put to use in the interviews concerning depression will be dealt with in Chapter 6.3.2, in which we will see in more detail that the writing acts presented are highly context specific.

As established in the description of the corpora that introduces this chapter, the interviews in my corpus may be regarded as serious discourse, which is a dimension that is built into Semino and Short's corpus and contrasts with popular discourse (Semino & Short 2014: 21-24). Semino and Short find that writing presentation is a genre-specific mode of presentation, which is more common in autobiographies and to some extent press language than in fiction (Semino & Short 2004: 100). They also find a general tendency for writing presentation to be more frequent in the serious sub-section of the corpus, particularly with respect to DW and RWA (Semino & Short 2004: 100, 105, 109). These observations strengthen the claim that RWA is predominantly found in serious discourse, as is the case in my corpus. The figures for RSA in the serious sub-section also showed a higher figure than for the popular sub-section, which again substantiates the hypothesis that the summarising categories are a trait of serious discourse.

Representation of Writing (RN) is the second-most employed writing presentation in my corpus. The significance relative to Semino and Short’s written corpus, the lack of significance relative to McIntyre’s spoken corpus, and the significance between McIntyre et al. and Semino and Short in favour of the spoken corpus could indicate that this form is more frequent in spoken than in written writing presentation. In contrast, I found that the most summarising speech presentation category, RV, is used significantly more often in both McIntyre et al. and my corpus compared to that of Semino and Short. As a result, it seems that RN is primarily a written phenomenon, whereas RV seems to be associated with spoken rather than written discourse.

As suggested in relation to speech presentation, the relative weight of the summarising variants in my corpus in combination with the consistently low frequencies of the most direct form – both relative to the summarising end of the speech and writing presentation scales in my corpus as well as when compared to the uses of the direct form in the narrative corpora – seem to be related to the non-narrative mode of my data. This assumption seems substantiated by the results for writing presentation. In conclusion, it seems that, perhaps due to genre differences, the different corpora largely replicate the patterns of speech presentation in relation to writing presentation.

Based on the discussion of the results for writing presentation, Table 5.17 provides an overview of the suggested correlations between the writing presentation results and the contextual variables:

Table 5.17 Writing presentation by contextual variable

WP	DW	FIW	IW	RWA	RN
Narrative vs. non-narrative	Narrative			Non-narrative	
Written vs. spoken					Spoken
Danish vs. English					

5.3.3 DISCUSSION OF THOUGHT PRESENTATION RESULTS

Direct Thought (DT) holds a relatively low ranking in all three corpora. Even though DT is used significantly more often in my corpus than in the other two, it is still the most summarising forms that dominate my corpus. This echoes the findings in relation to both speech and writing presentation, where the most direct variant was also superseded by the more summarising forms. This replicated pattern further substantiates the choices of discourse presentation in a corpus that comprises predominantly non-narrative discourse. The results also showed that DT was used significantly more often in McIntyre et al.'s corpus compared to Semino and Short's written corpus, which indicate that use of DT, though superseded by other forms, is found in contexts of spoken rather than written discourse. The relatively low ranking of DT in all three corpora also lends quantitative weight to the notion that, in relation to thought presentation, it is not the most direct form that is the norm or prototypical thought presentation form (Semino & Short 2004: 127).

If we move on to *Free Indirect Thought (FIT)*, we recall that, as far as speech presentation is concerned, the free indirect variant ranked last in all three corpora. Based on the test for significance, which was supported by previous Danish studies encompassing FIS, I also argued for a cultural dimension to use of FIS. The free indirect variant relative to the presentation of thought seems to behave differently: in Semino and Short, it is the most frequent category, which means that FIT holds a completely opposite ranking compared to FIS. Semino and Short explain the predominance of FIT relative to a written literary tradition (Semino & Short 2004: 123-126). The assumption that the variant is closely connected to a written, literary tradition seems substantiated by the significant differences between Semino and Short's written corpus and both of the spoken counterparts. This seems further substantiated by the fact that FIT ranks last in both of the spoken corpora.

Based on the assumption that IT is the baseline for rendering thought, Semino and Short suggest that FIT, as opposed to FIS, is a move toward directness and the closeness that readers may experience in narrative fiction (Semino & Short 2004: 124). However, because DS is the prototypical form of presentation in speech presentation, FIS may be regarded as a movement away from immediate access to speech in the narrative (Semino & Short 2004: 124). In my non-narrative corpus, such narrative strategies may be said to be suspended. Nevertheless, McIntyre et al. suggest that it is not in fact the written mode itself but instead the fictional dimension that invokes the significant proportion of FIT in Semino and Short's corpus (McIntyre et al. 2004: 71). In light of

the low proportion of FIT in McIntyre et al.'s corpus of non-fictional, spoken narratives, this assumption seems appropriate. My results indicate that FIT is nearly absent in spoken, non-narrative discourse, lending quantitative weight to the argument that FIT may be a feature of written – as opposed to spoken – discourse.

The thought presentation results indicated a consistently high ranking of *Indirect Thought (IT)* across the three corpora. They also showed that the significance was to be found in McIntyre et al.'s corpus, both when compared to Semino and Short's corpus and my corpus. If we recall the notion of prototypicality in relation to the speech presentation cline, DS is characterised as the prototypical speech presentation form (Leech and Short 1981: 334). This assumption was confirmed by the empirical material from the two narrative corpora but was not quantitatively confirmed by my non-narrative corpus. The different notion of prototypicality in relation to thought presentation, due to the private and nonverbal characteristics of thought and the lack of accessibility to the source, implies that the baseline should instead be IT, which is focused on content rather than actual wording (Leech & Short 1981: 344-5). The corpus results somewhat reflect the notion that the private mode of thought is matched by indirect presentation: McIntyre et al.'s corpus matches the notion of prototypicality in terms of quantitative ranking. In Semino and Short, IT is superseded by the free indirect variant, indicating a step toward the immediate closeness of the characters in written fiction. In my corpus, IT is superseded by the even more summarising form, RTA, indicating a step in the other direction, toward indirectness in the presentation. IT seems to be a relatively frequent thought presentation form, which is quantitatively substantiated by my corpus. This result lends quantitative weight to previous corpus findings, suggesting that IT is relatively independent of specific contextual parameters. It is worth pointing out, however, that Semino and Short find that, whereas FIT is far and away the most frequent of the 'proper' thought presentation categories in their corpus overall, IT is the most frequent category in the non-fiction genres of their corpus. McIntyre et al.'s corpus may also be described as non-fiction, just as my corpus clearly is. This could indicate that IT is preferred in contexts that are non-fictional rather than fictional.

If we turn to the results for the most summarising forms, *RTA* and *RT*, the significant use in my corpus compared to the other two corpora supports the findings of speech presentation, in which the most summarising form (RV) was used significantly more often in my corpus. It also supports the findings of writing presentation, in which the two most summarising writing presentation forms (*RWA* and *RN*) were used significantly more often in my corpus. The pattern of thought

presentation in the two spoken corpora seems to confirm the idea that there is a separate thought presentation cline and a different presentational norm oriented toward indirectness rather than directness (Leech and Short 1981).

In McIntyre et al.’s corpus, RTA ranks second, superseded only by IT. However, in Semino and Short’s corpus, RTA ranks third, instead lending prominence to the literary variant FIT as well as IT. Semino and Short explain the relatively low frequency of RTA in their corpus as follows: “RTA is even less dramatic and immediate than IT, which may explain why it is a relatively infrequent form of thought presentation in our corpus” (Semino & Short 2004: 131). This observation could explain the predominance of RTA in my corpus of serious, non-narrative discourse. I return to this premise in Chapter 6.3.3, where I discuss examples of how RTA is put to use in my corpus.

In an earlier account of speech and thought presentation, which was published some years before the corpus studies, Short states regarding thought presentation that he “will not discuss NRT [RT; HSP], NRTA [RTA; HSP] or IT in detail as the effects associated with them are roughly the same as for speech presentation. In any case, these three categories are relatively rare” (Short 1996: 311). This statement contrasts with Semino and Short’s observations about RTA in particular (they do not distinguish RT in their corpus investigation) behaving in a radically different manner from RSA and RWA. They state for example that “suggesting an equivalence between thought acts and speech acts is rather problematic” (Semino & Short 2004: 130). According to Semino and Short, the problem lies in the lack of the illocutionary force in thought acts due to the private nature of the presentational mode (Semino & Short 2004: 130). In terms of quantitative evidence, however, the three corpus studies, in each their own way, seem to counter Short’s statement. Table 5.18 below shows the rank order of IT and RTA in the three corpora:

Table 5.18 Rank order of IT and RTA in the corpora.

	My corpus	Semino & Short	McIntyre et al.
IT	2	2	1
RTA	1	3	2

For Semino and Short’s corpus, we see that the two categories rank second and third (of four possible). In fact, DT, which Short (1996) regards as one of the more frequent categories, is the least frequent category in Semino and Short’s corpus. These are all results that counter Short’s

claim that only DT and FIT are frequent forms of thought presentation. In fact, the only finding consistent with Short's observation is the predominance of FIT in Semino and Short's corpus.

However, almost all the instances of FIT in Semino and Short's corpus are located in the fiction section. This aligns well with Short's description of thought presentation on the basis of literary text. If we apply Short's observation to the quantitative results of my corpus and McIntyre et al.'s corpus, the rankings show that the two categories left undescribed by Short are actually the two most frequent categories in these corpora. An explanation could be that the spoken mode – as argued above – prefers the more summarising thought presentation forms and does not rely on the free indirect form as a well-established stylistic feature, as is the case in written text. We also saw that DT ranked third in the two spoken corpora, meaning that this category is less prominent than Short suggested. These quantitative results from three full-fledged corpus studies of thought presentation show how certain assumptions may be validated quantitatively, as is the case with the free indirect form in the written corpus. They also show, however, how the application of the framework may provide insights into other types of discourse that rely on other contextual premises.

Based on the discussion of the results for thought presentation, Table 5.19 provides an overview of the suggested correlations between the thought presentation results and the contextual variables.

Table 5.19 Thought presentation by contextual variable

	DT	FIT	IT	TRTA + TRT
Narrative vs. non-narrative	Non-narrative	Narrative		Non-narrative
Spoken vs. written	Spoken	Written		Spoken
Danish vs. English				

5.4 SUMMARY OF THE CORPUS CONTEXT STUDY

5.4.1 Summary of overall results for the three discourse presentation modes

- An index calculation showed similar distributions of discourse presentation in the three corpora. This observation suggests that discourse presentation is just as frequent in a corpus that is not purposively constructed so as to obtain the largest amount of discourse presentation possible, as is the case with Semino and Short's and McIntyre et al.'s corpora. A corollary is that discourse presentation is just as frequent in a non-narrative discourse context. This suggests more than just that discourse is a phenomenon that is not exclusive to narrative discourse; it suggests that it may be just as common in several other discursive settings. These findings indicate that the realisation of the discourse presentation framework, originally grounded in and intended for the study of narrative discourse, varies according to the discourse's context and communicative goals.
- The frequencies of the three discourse presentation modes follow consistent distribution patterns across the three corpus studies. My results may thus be seen as a quantitative validation of the distributions found in Semino and Short and McIntyre et al. This consistency in the distributions across the three corpora with large contextual variation also indicates that this distribution pattern is independent of contextual factors.
- Speech presentation is significantly more frequent in Semino and Short's and McIntyre et al.'s corpora, which could indicate that speech presentation is particularly frequent in narrative contexts.
- Writing presentation is significant in my corpus relative to Semino and Short's corpus. When tested against McIntyre et al.'s corpus, no significant difference is found. These results could indicate that writing presentation is more frequent in spoken than in written discourse.
- In my corpus, the speech and writing categories have fairly similar rankings, whereas thought behaves differently. This result replicates the findings of Semino and Short and McIntyre et al. (McIntyre et al. 2004: 69). The result also quantitatively substantiates the argument for making an analytical distinction between speech and writing on the one hand and thought on the other. This was a basic motivation of the original Lancaster speech and thought presentation framework introduced by Leech and Short (1981: 337) (see also Semino and Short 2004: 2, McIntyre et al. 2004: 71).
- Across the three presentational modes, the summarising ends of the clines (i.e. the forms that do not project propositional content) are prevalent in my corpus. Relative to Semino and Short, all the summarising categories (except for RSA, which showed no significant difference between the two

corpora) are significantly more frequent in my corpus (see Table 5.20). A comparison of McIntyre et al. and my corpus shows that three of five summarising forms are significantly more frequent in my corpus, one form carries no significance, and only one form is significantly less frequent (see Table 5.21). A comparison of McIntyre et al. versus Semino and Short shows that three of five summarising forms are significant in McIntyre et al.'s corpus and that two forms show no significance (see Table 5.22). The fact that none of the summarising forms are significant in Semino and Short's corpus strongly indicates that the summarising forms of discourse presentation are traits of spoken rather than written discourse. In addition, the fact that three of the five tests comparing my corpus with McIntyre et al.'s corpus show significance in my corpus suggests that the non-narrative and serious context of my corpus favours these forms in order to fulfil non-narrative communicative goals.

Table 5.20 Significant results for summarising forms in my corpus versus Semino & Short's corpus

DP category	My corpus	Semino & Short	No significance
RSA			x
RV	x		
RWA	x		
RN	x		
RTA	x		

Table 5.21 Significant results for summarising forms in my corpus versus McIntyre et al.'s

DP category	My corpus	McIntyre et al.	No significance
RSA		x	
RV	x		
RWA	x		
RN			x
RTA	x		

Table 5.22 Significant results for summarising forms in Semino & Short’s corpus versus McIntyre et al.’s corpus

DP category	Semino & Short	McIntyre et al.	No significance
RSA			x
RV		x	
RWA			x
RN		x	
RTA		x	

5.4.2 SUMMARY OF SPEECH PRESENTATION

- DS in both McIntyre et al. (2004) and Semino and Short (2004) showed significant differences compared to my corpus. In the two other quantitative studies of speech presentation in spoken narrative (Møller 1994, Pedersen 2009), DS was also the most frequent speech presentation form. These findings provide quantitative weight to the widespread assumption that DS is used for narrative purposes.
- FIS was significantly more frequent in my corpus than in the other two Lancaster-based corpus studies. Pedersen (2009) also found a large difference in use of FIS in Danish relative to Canadian English (Pedersen 2009), just as FIS was more frequent than IS in the study of Danish spoken narratives conducted by Møller (1994). Based on these results as well as language-specific claims from the existing literature, use of FIS seems to be a phenomenon that is closely linked to speech presentation in Danish.
- IS was found to be significantly more frequent in Semino and Short’s corpus, both relative to my corpus and when compared to McIntyre et al. At the same time, no significant difference was found between McIntyre et al.’s corpus and my corpus. In Møller (1994), IS was the least frequent of the three forms DS, FIS and IS. These results indicate that IS is a speech presentation form that is particularly associated with written text.
- The two most summarising categories, RSA and RV, were the most frequent in my corpus, which I argued may be due the non-narrative discourse in my corpus. RSA was also the second-most employed category in both of the other corpora studies, with no significant difference between

my corpus and Semino and Short's corpus and no significant difference between the two English corpora. The category was significantly more frequent in McIntyre's corpus compared to my corpus. There are no apparent explanations in the comparisons with the other two corpora, but from a broader perspective, the speech presentation in my corpus mainly clustered at the one end of the speech presentation cline, whereas both of the other corpora displayed a more varied selection across the speech presentation scale, mainly due to the high frequencies of DS in both of these corpora.

- The most summarising speech presentation category; RV,, was far and away the most frequent in my corpus and also significantly more frequent when compared to the other two corpora. I argued that RV in my corpus replaced the predominance of DS in the two narrative corpora, which may be due to the non-narrative nature of my corpus, in which traits such as dramatic enhancement and climactic passages are less prominent. RV was also significant in McIntyre's corpus compared to that of Semino and Short, which could indicate that the category is associated with spoken discourse, which may favour lexical choices that are less semantically dense than is the case with the more semantically specific RSA.

5.4.3 SUMMARY OF WRITING PRESENTATION

- DW was relatively sparse and ranked fourth in my corpus. The frequency of DW was significant in both Semino and Short's and McIntyre et al.'s corpora when compared to my corpus. This result replicates the comparisons from DS and suggests that the most direct forms are consistently more prevalent in narrative discourse presentation than in my non-narrative corpus. At the same time, DW was not the most frequent writing presentation category in the two narrative corpora, which was the case with DS. This could be due to an orientation toward indirectness in the presentation of writing, as pointed out Semino and Short and McIntyre et al. The sparse representation of DW in my corpus adds quantitative validation to the observations in the other two corpus studies and suggests that DW is a relatively infrequent choice in the RN, irrespective of context.
- FIW was the least frequent writing presentation form in all three corpora, and no significant differences were found in any of the tests for significance. This result suggests that FIW is a relatively rare writing presentation category, regardless of contextual factors, perhaps due to its linguistic complexity and also perhaps due to the increased traceability of the source, as suggested

by Semino and Short (Semino & Short 2004: 111-113). This result furthermore substantiates the assumption that the direct categories of writing presentation are generally replaced by more summarising forms (Semino & Short 2004: 111-113).

- The writing presentation in my corpus clustered at the summarising end of the writing presentation scale in that IW, RWA and RN were the most frequent forms in my corpus. In terms of overall discourse presentation in the corpus, this result substantiated the tendency in my corpus for discourse to orient toward indirect forms of presentation.
- Even though writing presentation in the three corpora to some extent replicated the patterns found in speech presentation, there seemed to be a general tendency in all three corpora toward a more summarising use than in speech presentation, in that RWA was the most frequent writing presentation form in all three corpora. This finding substantiated Semino and Short's observation that writing presentation is mainly conveyed through indirect forms.
- The most summarising writing presentation category (RN) was used significantly more often in my corpus and McIntyre et al.'s corpus than in Semino and Short's corpus. This result replicated the pattern found in relation to the most summarising speech presentation category (RV), for which the frequency in both my corpus and in McIntyre et al. was significant compared to Semino and Short. This pattern suggests that RN is mainly associated with spoken discourse.

5.4.4 SUMMARY OF THOUGHT PRESENTATION

The distribution pattern of thought presentation in my corpus was different than the patterns of speech and writing presentation. This finding supports the findings by Semino and Short and McIntyre et al. that thought presentation is also distributed differently in their corpora compared to speech and writing presentation. The thought presentation results in my corpus lend quantitative weight to the assumption that this presentational mode, unlike speech and writing presentation, is primarily conveyed by indirectness due to its non-verbal and private ontology. These results – that the presentation of thought was primarily conveyed by indirectness and that it behaved differently than the other two presentational modes – add quantitative substance to the motivation for treating speech/writing and thought as separate modes of presentation. This stability in the distribution pattern of thought presentation seems valid independent of contextual factors.

- Even though the my findings showed that the categories on the thought presentation scale were distributed differently than those for speech and writing presentation, thereby supporting a fundamental distinction between the presentational scales, the pattern in my corpus seemed to differ from the grounds on which the thought presentation scale was created: whereas the other two corpora found FIT and IT to be the most frequent, the prevalence of DT and the summarising categories (RTA and RT) in my corpus indicates that use of thought presentation is highly context dependent.
- In terms of frequency, I found a significantly high proportion of thought presentation in my corpus compared to Semino and Short and McIntyre et al. I have argued that this result could be due to the topic of depression in my corpus. The precise manner in which thought presentation is being put to use in my corpus will be treated in detail in Chapter 6, in which I compare the two speaker groups in my corpus.
- McIntyre et al.'s corpus contained significantly more thought presentation than did Semino and Short's corpus, which could indicate that thought presentation is generally more frequent in spoken discourse than in written discourse.
- DT was significantly more frequent in my corpus than in the other two corpora. This result contrasted with the findings of DS as well as DW and reflected the prevalence of thought presentation in my corpus overall. As suggested by Semino and Short, DT seems to fulfil different narrative purposes from DS and DW (Semino & Short 2004: 118). FIT seems to be the predominant category in written narrative text. If DT is not a typical feature of narrative discourse, then the significant result in my corpus relative to the two narrative corpora could indicate that DT is used for non-narrative purposes.
- FIT ranked last in my corpus, as was the case in McIntyre et al.'s corpus. The result in Semino and Short's corpus reversed the rank order found in the two spoken corpora, with FIT being the most frequent category in the written corpus and significantly more so when compared with my corpus and that of McIntyre et al. The vast majority of instances of FIT in Semino and Short's corpus were found in the fiction section, which confirms the status of FIT as a traditional written phenomenon in literary text. This position of FIT was substantiated by the absence of the category in the two non-fictional, spoken corpora. In fact, it was the only thought presentation category that was significantly more frequent in the written corpus.
- IT was relatively prevalent in all three corpora. In my corpus and Semino and Short's corpus, the category ranked second, and in McIntyre et al.'s corpus, it ranked first. The high rankings of

the form across the corpora lend quantitative weight to the notion of prototypicality in thought presentation, which seems to be largely independent of contextual factors. Despite the high frequency of thought presentation in my corpus in general, the result for IT was not significant: when compared to Semino and Short, no significance was found, and the category was significantly more frequent in McIntyre et al.'s corpus than in my corpus. Instead, the predominant forms in my corpus were the summarising categories.

- The lack of significance of IT in my corpus was replaced by the most summarising thought presentation category (RTA– encompassing RT, for sake of comparability with the other two corpora). RTA was also the most frequent thought presentation form in my corpus and showed a significant result when tested against the other two corpora. My corpus' favouring of the summarising forms is consistent with the distribution patterns for speech and writing presentation and provides further weight to the assumption that non-narrative discourse favours summarising discourse presentation forms.

CHAPTER 6

GP AND PS USES OF DISCOURSE PRESENTATION

Introduction to the chapter

In this chapter, I answer the second of this thesis' main research questions: how are discourse presentation and associated category features distributed in the two groups of health care professionals and how may such uses be viewed as conceptualisations of depression?

I focus on the built-in notion of the project design, i.e. the two groups of medical professions, by comparing the two groups' uses of discourse presentation and associated category features, and through that explore whether there are differences in the two groups' conceptualisations of depression. In order to arrive at an answer, I take the following steps. The first half of Chapter 6 (6.1 and 6.2) presents the results for the two groups' use of discourse presentation (Chapter 6.1) and category features (Chapter 6.2). I outline the quantitative results for each presentational mode (speech, writing, and thought) as well as for the individual categories. After the category level results, I present the results for category features. The features are as follows:

- 1) Hypotheticality, i.e. whether the instance is presented as real or hypothetical
- 2) Genericity, i.e. whether the instance is presented as a specific occurrence or a general one
- 3) Embedded discourse presentation, i.e. whether a given instance of discourse presentation is layered within another instance of discourse presentation
- 4) Speaker reference, i.e. the sayer, writer, or thinker associated with the presented discourse
- 5) Interactional discourse presentation.

Features 2) and 4) apply to all instances of discourse presentation, whereas features 1), 3), and 5) are occasional features that may or may not apply to a given instance of discourse presentation. The category features may be regarded as a linguistic framing of the discourse presentation instances. My assumption is that an analysis of these features will be capable of anchoring and nuancing the two groups of doctors' use of the presentational modes and will thereby bring further knowledge to

the quantitative results of the discourse presentation categories for the two speaker groups.

The second half of Chapter 6 (6.3 and 6.4) discusses the quantitative results presented in 6.1 and 6.2. The results will be explained relative to meaning potentials such as the doctor-patient relationship, doctors' professional identities, and doctors' conceptualisations of depression as condition. I assume these topics to be relevant because they are valid for both groups of doctors, independent of their structural positions in the healthcare system, but possibly with divergent emphases. As already suggested in the presentation of the two groups of doctors' backgrounds in Chapter 3.1.2, it is precisely these different positions in the healthcare system that constitute the only obviously identifiable difference between the two groups of doctors. However, this also suggests different backgrounds for those occupying these different positions, such as medical schooling and level of speciality.

As a result, in order to reach tentative conclusions about understandings of depression in the Danish healthcare system, I investigate and discuss the two groups of doctors' uses of speech, writing, and thought presentation in a strictly controlled corpus with a high degree of comparability. Also, wherever possible, I relate the findings from this chapter to the overall results of discourse presentation presented in Chapter 5. This comparison only concerns the discourse presentation categories, which were the focus of the Chapter 5. The objective of doing so is to illuminate in even greater detail how use of discourse presentation presents itself in a highly context-specific corpus and how such an investigation may add to existing knowledge retrieved from investigations based on the Lancaster discourse presentation framework.

6.1 DISCOURSE PRESENTATION RESULTS IN THE TWO SPEAKER GROUPS

The results for the overall use of discourse presentation in the two speaker groups show that the GP group produces 1378 instances of discourse presentation, while the PS group produces 1227 occurrences. The total number of words in the GP group is 59547, and 51990 in the PS group. An index calculation displays a fairly similar distribution of discourse presentation in the two groups: the GP group produces 23.1 occurrences per 1000 words, and the PS group 23.6 occurrences per

1000 words. Table 6.1 shows the distribution of discourse presentation in the two speaker groups by presentational scale.

Table 6.1 Distribution of discourse presentation in the two speaker groups by presentational scale.

Presentation mode	GP	PS	P=value	Significance
Speech Presentation	656	559	0.29586	None
Thought Presentation	573	530	0.405647	None
Writing Presentation	149	139	0.675251	None
Total	1378	1227		

For both speaker groups, speech presentation is the most employed discourse presentational mode, thought presentation the second-most frequent, and writing presentation the least employed presentational mode. The distribution pattern within the speaker groups confirms the overall distribution pattern of the three presentational clines presented in Chapter 5.2.2. Considering the three presentational modes separately, the tendency toward a fairly even frequency across the two speaker groups is confirmed in that the tests for significance for each of the three presentational modes against the remaining occurrences of discourse presentation in each speaker group show no significant differences between the two groups. Instead, the main differences between the two groups are to be found within the main categories, i.e. relative to specific variants of the three presentational modes. A discussion of the variants within each presentational mode relative to the two speaker groups will thus set the framework for this chapter. Table 6.2 provides figures for speech, writing and thought presentation at category level:

Table 6.2: Distribution of discourse presentation categories in the two speaker groups.

DP category	GP	PS	P-value	Who
Speech Presentation				
DS	120	93	0.457888	

FIS	78	47	0.047583*	GP
IS	85	77	0.667239	
RSA	119	138	0.005085**	PS
RV	254	203	0.401741	
Total	656	558	0.29586	
Writing Presentation				
DW	13	8	0.332788	
FIW	4	7	0.298167	
IW	9	23	0.004582**	PS
RWA	96	76	0.091724	
RN	27	25	0.976222	
Total	149	139	0.675251	
Thought Presentation				
DT	118	95	0.26192	
FIT	63	20	0.000005***	GP
IT	171	130	0.047734*	GP
RTA	177	229	0.000023***	PS
RT	44	56	0.095219	
Total	573	503	0.405647	

Before I describe the results at category level, I present the results across the scales for the free indirect categories FIS/FIW/FIT and the ‘act’ categories RSA/RWA/RTA in Table 6.3:

Table 6.3: GP vs PS use of FIS/FIW/FIT and RSA/RWA/RTA.

Category	GP	PS	P-value	Who
FIS + FIW + FIT	145	74	0.000076***	GP
RSA + RWA + RTA	392	443	0.000005***	PS

6.1.1 SPEECH PRESENTATION IN THE TWO SPEAKER GROUPS

In this section, I present the results for speech presentation and each of the categories relative to the two speaker groups and relative to the results of the previous corpus studies based on the discourse presentation framework (McIntyre et al. 2004, Semino & Short 2004). Table 6.4 below shows the rank order of speech presentation categories in the two speaker groups:

Table 6.4: Rank order and significance of speech presentation by speaker group.

SP category	GP occurrences	GP rank order	PS occurrences	PS rank order	P-value	Who
DS	120	2	93	3	0.457888	n/a
FIS	78	5	47	5	0.047583*	GP
IS	85	4	77	4	0.667239	n/a
RSA	119	3	138	2	0.005085**	PS
RV	254	1	203	1	0.401741	n/a
Total	656		558			

DIRECT SPEECH (DS)

The overall results for DS showed that the category ranks third out of the five speech presentation categories and is used significantly less in my corpus than in the other two Lancaster-based corpora, in which DS is the most frequent speech category (Semino & Short 2004, McIntyre et al. 2004). In the overall corpus, DS accounts for 213 out of 1214 instances of the total speech presentation. 120 of these instances are produced by the GP group and 93 by the PS group. A χ^2 test shows no significant difference between the two groups' production of DS ($p=0.457888$). Of the speech presentation forms in the GP group, DS ranks second, followed closely by RSA (120 vs 119 instances). In the PS group, DS is less prevalent and ranks third, with a relatively large gap between this variant and the second-most employed variant, RSA (93 vs 138 instances).

FREE INDIRECT SPEECH (FIS)

The overall count for FIS showed that it is the least employed category in my corpus. At the same time, the category is significantly more present in my corpus compared to in Semino and Short's and McIntyre et al.'s corpora. FIS in my corpus amounts to 125 out of 1214 instances of the total speech presentation. The GPs use this variant in 78 of 656 instances of speech presentation, whereas the figure for the PS group is 47 of 558. The ranking of FIS in both speaker groups compared to the remaining speech presentation forms shows that this variant is the least frequent in both groups. Despite this tendency, a χ^2 test shows a significant difference between the two groups, with the GP group employing this category significantly more often than does the PS group ($p=0.047583$). A comparison of the conflation of the two most direct speech presentation categories (DS and FIS) shows that the GP group uses the two most direct categories 198 times and the PS group does so 140 times. A χ^2 test shows a significant result in favour of the GP group ($p=.048474$). This result suggests that the GP group occupies the direct end of the speech presentation scale.

Table 6.3 shows the total figure for the free indirect forms across the three presentational scales. The result shows a hugely significant result in the GP group ($p=0.000076$). This conflation across the scales confirms that it is the GP group which most prefers the free indirect forms.

Indirect Speech (IS)

After FIS, IS is the least used speech presentation variant in the corpus, with a representation of only 162 out of 1214 instances of speech presentation. The category ranks fourth in both speaker groups. In the GP group, IS accounts for 85 of the total of 656 speech presentation instances. In the PS group, the figure is 77 out of 558 instances. A comparison of use of IS in the two groups shows no significant difference when tested for significance ($p=0.667239$). The ranking in both speaker groups matches the overall ranking, in which IS also ranks fourth, but it is significantly more frequent in Semino and Short's corpus than mine (no significant difference when compared with McIntyre et al.).

REPRESENTATION OF SPEECH ACT (RSA)

RSA accounts for 257 out of the 1214 occurrences of speech presentation in the corpus overall. 138 of these are produced by the PS group and 119 by the GP group. In the PS group, RSA is the

second-most frequent speech presentation form, whereas in the GP group, this variant ranks third, following RV and Direct Speech. However, the GPs' use of RSA and DS are almost identical (119 and 120 instances), whereas the gap in the PS group between the second- and third-most employed form (RSA and Direct Speech) is considerably larger (138 and 93 instances respectively). When tested for significance, the frequencies in the two speaker groups show a difference: the PS group employs RSA significantly more often than do the GPs ($p=0.005085$). Whereas use of the second-most direct form (FIS) showed a significant difference in favour of the GP group, the result for the second-most summarising form (RSA) reverses this tendency: the fact that the PS group employs this variant significantly more often than do the GPs could suggest that, in terms of significance, each group occupies their respective ends of the speech presentation scale. In the overall results, RSA consistently ranked second across the three large corpus studies. This indicates that the PS group follows the overall ranking, whereas the GP group chooses DS as the second-most employed category.

If we turn to the feature *topic* in connection with RSA, 35 instances out of the total of 257 instances of RSA are realised with *topic*. In Semino and Short's corpus, the *topic* variant represents 989 out of 1398 instances of RSA (Semino & Short 2004: 74). A χ^2 test comparing the two corpora's frequencies indicates a marked significance in Semino and Short's corpus ($p>0.0001$). McIntyre et al. do not distinguish the *topic* variant, which rules out a comparison with their corpus. 16 out of 119 instances in the GP group are realised with a *topic*, and the figure for PS group is 19 out of 138. A χ^2 test shows that the distributions are virtually identical in the two speaker groups ($p=0.947703$).

The metonymic variant of RSA comprises 21 out of 119 occurrences in the GP group, whereas the figure for the PS group is 22 out of 138 occurrences. A test for significance for use of metonymy in the two groups shows no significant difference relative to the proportion of the remaining instances of RSA ($p=0.715$). Semino and Short and McIntyre et al. do not distinguish the metonymic variant in their annotations, which rules out a comparison of this feature with the existing corpus studies. The results of these tests for the two category features associated with RSA suggest that the significant difference between the two speaker groups in overall use of RSA does not come down to use of metonymic and *topic* variants.

Table 6.3 presents the total figure for ‘act’ categories across the three presentational scales. The result shows a hugely significant result in the PS group ($p=0.000005$). This conflation across the scales confirms that it is the PS group which prefers the summarising ‘act’ categories.

REPRESENTATION OF VOICE (RV)

The overall results showed that RV is the most frequent category in my corpus and that it is also significantly more frequent in my corpus than in either of the other two Lancaster-based corpora. The predominance of RV in my corpus is reflected in both speaker groups: the GPs use the category 254 times out of the total of 556 instances of speech presentation, and in the PS group, RV accounts for 203 out of 558 instances of speech presentation. The high frequency in both speaker groups is reflected in the result of the χ^2 test, which shows no significant difference between the two speaker groups ($p=0.401741$).

6.1.2 WRITING PRESENTATION IN THE TWO SPEAKER GROUPS

Table 6.5: Rank order and significance of writing presentation by speaker group.

WP CATEGORY	GP	PS	P-value	Who
DW	3	4	0.332788	n/a
FIW	5	5	0.298761	n/a
IW	4	3	0.004582**	PS
RWA	1	1	0.091274	n/a
RN	2	2	0.976222	n/a

In Chapter 5, we saw that writing presentation is far and away the least employed discourse presentation mode in the corpus. This result matches the findings in Semino and Short (2004) and McIntyre et al. (2004). The relatively low frequency of Writing Presentation is replicated in both speaker groups, with the GPs producing 149 instances of writing presentation and the PSs producing 139 instances. Below, I present the results for each of the writing presentation categories.

DIRECT WRITING (DW)

The overall results showed that DW ranks third in the corpus and that the category is used significantly more in Semino and Short's and McIntyre et al.'s corpus. In the GP group, DW is the third-most employed writing presentation variant after RWA and Representation of Writing, whereas in the PS group, it ranks fourth out of five variants. However, only 13 out of 149 occurrences in the GP group and 8 out of 139 in the PS group are realised as Direct Writing, which indicates that the most direct variant of writing presentation is not particularly prevalent in either speakers group. This tendency is confirmed by a χ^2 test, which shows no significant difference between the two groups' use of DW ($p=0.332788$).

FREE INDIRECT WRITING (FIW)

The overall result for FIW showed that the category is the least employed of the writing presentation categories in all three corpora. This tendency was confirmed by the χ^2 tests, which showed no significant differences. The frequency of FIW is generally very low, accounting for only 4 out of 149 instances of writing presentation in the GP group and 7 out of 139 instances in the PS group. Although this variant is the least employed of the writing presentation categories in both speaker groups, as is the case with the corresponding categories in the other two modes of representation (speech and thought), the figures show an interesting difference: FIW is the only free indirect category that is used more by the PSs than by the GPs. However, the difference between the two speaker groups is not significant ($p=0.298761$).

INDIRECT WRITING (IW)

The overall result for IW showed that the category ranks third out of the five writing presentation categories. The figures showed no significant difference when compared to Semino and Short's corpus, whereas a significant difference was found when compared to McIntyre et al.'s corpus. In the GP group, IW ranks fourth out of all the writing presentation variants: there are 9 occurrences out of a total of 149 instances of writing presentation, with only FIW being less frequent. In contrast, in the PS group, IW ranks third, with 23 occurrences out of a total of 139 instances. When tested for significance, this difference between the two groups is confirmed as significant

($p=0.004582$). In fact, IW is the only category on the writing presentation scale to provide a significant result between the two groups. Another point concerning the two speaker groups relative to IW is that, if we consider the three variants across the three presentational scales projecting propositional content, which comprises a total of nine variants, IW is the only of these nine propositional variants that is employed significantly more by the PSs than by the GPs. By comparison, three out of nine propositional forms are used significantly more by the GP group (FIS, FIT, IT).

REPRESENTATION OF WRITING ACT (RWA)

The overall results showed that RWA is the most frequent writing presentation category in the corpus and that it is employed significantly more in my corpus than in those of Semino and Short and McIntyre et al. In both speaker groups, RWA is far and away the most employed writing presentation variant. The GP group employs this form in 96 out of 149 instances of writing presentation. The corresponding figure for the PS group is 76 out of 139 instances. Interestingly, this variant is the only of the three speech/writing/thought act variants that is used more by the GPs than by the PSs, though still with no significant difference ($p=0.091274$) between the two groups. This result suggests that the predominance of RWA is independent of speaker group, which supports the overall results in the three corpora, in all of which the category is the most frequent.

REPRESENTATION OF WRITING (RN)

The overall result for RN showed that is the second-most frequent category of writing presentation in my corpus and is significantly more frequent compared to in Semino and Short's corpus. The test comparing my corpus and McIntyre et al. showed no significant difference. The prominence of RN in my corpus is replicated relative to both speaker groups, in which RN is also the second-most employed variant. When tested for significance, there is no difference between the two groups ($p=0.976222$). If we conflate the two most summarising forms (RWA and Representation of Writing) in my corpus, the tendency toward a summarising use in writing presentation is substantiated: in the GP group, the two categories comprise 123 out of 149 instances of writing

presentation, while in the PS group, the figure is 101 out of 139, which means that a considerable proportion of the writing presentation is conveyed through the most summarising forms. Even though the summarising forms are prevalent in both groups, a χ^2 test provides a slightly significant result for the GPs' use of the indirect end of the writing presentation scale (i.e. RWA and Representation of Writing) ($p=0.043693$). If the third-most summarising variant (IW) is added, the figure for the GP group is 132 out of 149 instances belonging to the summarising end of the writing presentation scale, and the figure for the PS group is 124 out of 139 instances. The test for these three categories combined shows no significant difference between the two speaker groups ($p=0.867553$) and confirms that the indirect end of the writing presentation scale is highly preferred in both speaker groups.

6.1.3 THOUGHT PRESENTATION IN THE TWO SPEAKER GROUPS

The results for thought presentation in the overall corpus showed that it is the second-most employed discourse presentation mode and that use of thought presentation in my corpus is significantly more frequent than in Semino and Short's and McIntyre et al.'s corpora. My corpus contains a total of 1176 instances of thought presentation, of which 573 occurrences are produced by the GP group and 503 by the PS group, with no significant difference between the two speaker groups. Table 6.6 below provides an overview of the rank order of the thought presentation categories in the two speaker groups:

Table 6.6: Rank order and significance of thought presentation by speaker group.

TP category	GP	PS	P-value	Who
DT	3	3	0.26192	n/a
FIT	4	5	0.000005***	GP
IT	2	2	0.047734*	GP
TRTA	1	1	0.000023***	PS
TRT	5	4	0.095219	n/a

DIRECT THOUGHT (DT)

In both speaker groups, DT ranks third out of the five thought presentation categories, meaning that both groups follow the overall ranking of DT. As with the figures for Direct Speech, the result for DT shows that the GPs use this variant slightly more than do the PSs, in that 118 out of 573 of the GPs' thought presentation instances are realised as DT while the corresponding figure for the PSs is 95 out of 503 instances. In the overall results, we saw that DT is used significantly more in my corpus than in the other two Lancaster-based corpora. However, in relation to the two speaker groups, no difference is found when tested for significance ($p=0.26192$).

FREE INDIRECT THOUGHT (FIT)

In the overall results, FIT was the least frequent of the thought presentation categories in my corpus, as was the case in McIntyre et al.'s corpus. In contrast, in Semino and Short's corpus, the tendency was quite different, with FIT being the most frequent of all the thought presentation categories. If we go back to the results for speech presentation and use of FIS in the two speaker groups, we find that – even though the variant ranked fifth in both speaker groups – the GPs employed this variant significantly more often than did the PSs. The pattern with FIT is the same, in that the variant ranks fourth in the GP group and fifth in the PS group, which indicates that both groups seem to prefer other variants of thought presentation over the free indirect style. Nevertheless, a test for significance shows a hugely significant difference between the two groups ($p=0.000005***$), which replicates the tendency found in use of FIS in the two speaker groups.

A conflation of the figures for the two most direct forms on the speech presentation cline (DS and FIS) shows a significant difference between the two speaker groups. A similar conflation of Direct and FIT also shows a highly significant result for the GPs' use of these direct categories ($p=0.01385$).

INDIRECT THOUGHT (IT)

IT is prevalent in the overall corpus, where it ranks second. In terms of significance, the category was significantly more frequent in McIntyre et al.'s corpus, whereas no significant difference was

found when compared to Semino and Short's corpus. The overall ranking is replicated in both speaker groups. Compared to its speech presentation counterpart (IS), which ranked fourth in both speaker groups, IT is one of the most preferred realisations of the presentation of thought, especially in the GP group, in which only six occurrences separate the first and second ranking (177 vs 171). The gap between the most-employed and the second-most employed form in the PS group is remarkably wider (229 vs 130). Whereas the statistical test for IS in the two groups showed no significant difference, the result for IT is different in that the GPs use IT significantly more often than do the PSs ($p=0.047734^*$).

REPRESENTATION OF THOUGHT ACT (RTA)

The overall results showed that RTA is the most frequent thought presentation category in my corpus, whereas its ranking was lower in the two Lancaster-based corpora. In order to ensure comparability in the test for significance, I conflated the two most summarising thought presentation forms (see Chapter 5.2.5), and the χ^2 tests showed that the frequency of RTA (including RT) in my corpus was significant compared to Semino and Short's and McIntyre et al.'s corpora. When considering the two speaker groups, RTA is also the most frequently employed variant in both groups: 177 instances out of a total of 573 of the GPs' instances of thought presentation are realised as RTA, while the corresponding figure for the PS group is 229 out of 530 instances. In the GP group, the gap between the first-most and second-most employed variant is rather small, in that IT, as the second-most employed category, is employed 171 times. In the PS group, this gap is much larger, in that the second-most employed category, which is also IT, is only employed 130 times. The PSs' strong preference for this variant is confirmed by the test for significance, which shows a hugely significant difference between the two speaker groups ($p=0.000023$).

REPRESENTATION OF THOUGHT (RT)

The overall results showed that RT occurs 101 times in the corpus, ranking fourth out of the five thought presentation categories. No separate statistical test was carried out for this category relative to the other two corpora since they do not distinguish RT from RTA (see the result for RSA above).

The frequency of this variant in my corpus is rather low compared to most of the remaining thought presentation categories: in the GP group, the variant ranks fifth, and in the PS group, it ranks fourth. Similarly, there is no significant difference between the two groups when tested for significance ($p=0.095219$). Instead, the two speaker groups seem to be more semantically specific when presenting summarising thought, as indicated by the top ranking of RTA in both groups.

6.1.4 SUMMARY OF DISCOURSE PRESENTATION FINDINGS BY SPEAKER GROUP

The tests for significance comparing the two speaker groups' uses of the discourse presentation categories provided the following significant results:

- FIS is used significantly more by the GP group than by the PS group
- RSA is used significantly more by the PS group than by the GP group
- IW is used significantly more by the PS group than by the GP group
- FIT is used significantly more by the GP group than by the PS group
- RTA is used significantly more by the PS group than by the GP group, and the result is highly significant.
- A conflation of the three free indirect categories across the presentational scales provides a hugely significant result for the GP group.
- A conflation of the three summarising 'Act' categories across the presentational scales provides a highly significant result for the PS group.

6.2. DISCOURSE PRESENTATION FEATURES IN THE SPEAKER GROUPS

In this section, I outline the results for the category features associated with the discourse presentation categories. Throughout, the primary focus will be on the comparative dimension of the results in the two speaker groups, the general practitioners and the psychiatrists. The first part presents the results for hypothetical discourse presentation in the two speaker groups, followed by a presentation of the results for specific and non-specific presentation. The third part comprises the

results for embedded discourse presentation, and the fourth and final part of this chapter presents the results for use of voices in discourse presentation.

6.2.1 HYPOTHETICAL DISCOURSE PRESENTATION

The hypothetical discourse presentation in my corpus amounts to 470 instances out of a total of 2578 instances. The figure for Semino and Short’s corpus was 368 out of 7233 instances. McIntyre et al. do not provide any figures for hypothetical discourse presentation. A χ^2 test comparing my corpus with Semino and Short’s corpus indicates that use of hypothetical discourse presentation is remarkably significant in my corpus ($p < 0.0001$).

The instances of hypothetical discourse presentation were subcategorised into three types of hypotheticality: *proper*, *future*, and *negated* (see Chapter 4.6 for an introduction and examples). The figures for hypothetical discourse presentation – in the two groups overall and in relation to the subcategories – are shown in Table 6.7 below:

Table 6.7: Hypothetical discourse presentation by speaker group.

Variant	GP	PS	P-value	Who
Hf	39	30	0.814396	n/a
Hp	80	73	0.373563	n/a
Hn	141	107	0.479077	n/a
Total	N = 260	N = 210	0.369562	n/a

The χ^2 tests for hypothetical discourse presentation in the two groups show no significant differences, neither when comparing the two groups’ total use of hypothetical discourse presentation ($p = 0.369562$) nor for any of the hypothetical variants (see Table 6.7 above). We have established that hypothetical discourse presentation is significant in my corpus compared to that of Semino and Short, but with no significant difference between the two groups’ use of the phenomenon. The next step is to investigate the distribution patterns of hypothetical discourse presentation for the two speaker groups in accordance with the three presentational modes (speech, writing, and thought) as well as the specific discourse presentation categories for each of the presentational modes. The figures are shown in Tables 6.8 to 6.19 below:

HYPOTHETICAL SPEECH PRESENTATION

Table 6.8: Overall hypothetical speech presentation by speaker group.

Overall hypo	GP	PS	Total	P-value	Who
DS + H	18	8	26	0.157172	n/a
FIS + H	6	6	12	0.350975	n/a
IS + H	14	6	20	0.093574	n/a
RSA + H	27	30	57	0.854972	n/a
RV + H	56	39	95	0.457962	n/a
Total	121	87	208	0.188475	n/a

Table 6.9: Negated speech presentation by speaker group.

Negated hypo	GP	PS	Total	P-value	Who
DS + Hn	7	2	9	0.3045	n/a
FIS + Hn	5	2	7	0.7085	n/a
IS + Hn	8	0	8	n/a	n/a
RSA + Hn	17	20	37	0.962399	n/a
RV + Hn	24	15	39	0.433589	n/a
Total	61	39	100	0.144653	n/a

Table 6.10: Future hypothetical speech presentation by speaker group.

Future hypo	GP	PS	Total	P-value	Who
DS + Hf	2	0	2	n/a	n/a
FIS + Hf	1	1	2	n/a	n/a
IS + Hf	0	0	0	n/a	n/a
RSA + Hf	4	4	8	1.	n/a

RV + Hf	11	6	17	0.44025	n/a
Total	18	11	29	0.379651	n/a

Table 6.11: Proper hypothetical speech presentation by speaker group.

Proper hypo	GP	PS	Total	P-value	Who
DS + Hp	9	4	13	0.3979	n/a
FIS + Hp	0	3	3	n/a	n/a
IS + Hp	6	6	12	0.858727	n/a
RSA + Hp	6	6	12	0.792537	n/a
RV + Hp	21	18	39	0.81977	n/a
Total	42	37	79	0.872266	n/a

HYPOTHETICAL WRITING PRESENTATION

Table 6.12: Overall hypothetical writing presentation by speaker group.

Overall hypo	GP	PS	Total	P-value	Who
DW + H	1	0	1	n/a	n/a
FIW + H	0	2	2	n/a	n/a
IW + H	2	3	5	0.6042	n/a
RWA + H	28	15	43	0.156091	n/a
RN + H	3	5	8	0.4583	n/a
Total	34	25	59	0.309861	n/a

Table 6.13: Negated hypothetical writing presentation by speaker group.

Negated hypo	GP	PS	Total	P-value	Who
DW + Hn	1	0	1	n/a	n/a
FIW + Hn	0	0	0	n/a	n/a

IW + Hn	1	1	2	n/a	n/a
RWA + Hn	21	7	28	0.027861	GP
RN + Hn	1	4	5	0.1829	n/a
Total	24	12	36	0.055298	n/a

Table 6.14: Future hypothetical writing presentation by speaker group.

Future hypo	GP	PS	Total	P-value	Who
DW + Hf	0	0	0	n/a	n/a
FIW + Hf	0	0	0	n/a	n/a
IW + Hf	0	0	0	n/a	n/a
RWA + Hf	5	4	9	1.	n/a
RN + Hf	1	0	1	n/a	n/a
Total	6	4	10	0.7511	n/a

Table 6.15: Proper hypothetical writing presentation by speaker group.

Proper hypo	GP	PS	Total	Significance	Who
DW + Hp	0	0	0	n/a	n/a
FIW + Hp	0	2	2	n/a	n/a
IW + Hp	1	2	3	n/a	n/a
RWA + Hp	2	4	6	0.4074	n/a
RN + Hp	2	1	3	n/a	n/a
Total	5	9	14	0.218714	n/a

HYPOTHETICAL THOUGHT PRESENTATION

Table 6.16: Hypothetical thought presentation by speaker group.

THOUGHT PRESENTATION	GP	PS	Total	P-value	Who
DT + H	10	8	18	0.988862	n/a

FIT + H	6	4	10	0.2436	n/a
IT + H	36	28	64	0.918729	n/a
RTA + H	41	45	96	0.390285	n/a
RT + H	11	13	24	0.835581	n/a
Total	104	98	202	0.734469	n/a

Table 6.17: Negated hypothetical thought presentation by speaker group.

Negated hypo	GP	PS	Total	P-value	Who
DT + Hn	3	0	3	n/a	n/a
FIT + Hn	4	2	6	0.6276	n/a
IT + Hn	23	19	42	0.772611	n/a
RTA + Hn	18	30	48	0.364401	n/a
RT + Hn	8	5	13	0.172006	n/a
Total	56	56	112	0.466047	n/a

Table 6.18: Future hypothetical thought presentation by speaker group.

Future hypo	GP	PS	Total	P-value	Who
DT + Hf	3	3	6	1.	n/a
FIT + Hf	2	2	4	n/a	n/a
IT + Hf	6	2	8	0.4732	n/a
RTA + Hf	3	7	10	0.5239	n/a
RT + Hf	1	1	2	n/a	n/a
Total	15	15	30	0.717228	n/a

Table 6.19: Proper hypothetical thought presentation by speaker group.

Proper hypo	GP	PS	Total	P-value	Who
DT + Hp	4	5	9	0.5165	n/a
FIT + Hp	0	0	0	n/a	n/a

IT + Hp	7	7	14	0.598295	n/a
RTA + Hp	20	8	28	0.002084	GP
RT + Hp	2	7	9	0.2917	n/a
Total	33	27	60	0.780133	n/a

The results for use of hypothetical discourse presentation in the two speaker groups and its distribution by the three presentational scales show that, in the GP group, the rankings of hypothetical discourse presentation follow the overall ranking of the three presentational modes: the largest number of hypothetical instances in the GP group is found in the most frequent presentational mode (speech presentation), which accounts for 121 out of the 260 instances of hypothetical discourse presentation. In the GP group, thought presentation also holds the second largest number of hypothetical instances (104 out of 260), which corresponds to thought presentation being the second-most frequent presentational cline in the GP group. The figure for writing presentation is relatively low (34 out of 260 instances), which aligns with writing presentation being the least employed of the discursual modes. If we turn to the PS group, the situation is different: the PS group uses hypothetical discourse presentation slightly more in connection with thought presentation than with speech presentation (98 vs 87 instances). As in the GP group, use of hypothetical writing presentation in the PS group ranks last out of the three presentational modes, which follows the pattern that writing presentation is the least frequent of the three presentational modes. The two speaker groups' figures for hypothetical speech presentation, which amounted to 121 instances for the GP group and 87 instances for the PS group, shows no significant difference ($p=0.188475$). If we move on to hypothetical writing presentation, the GP group uses this variant 34 times, and the PS group uses it 25 times. As was the case with hypothetical speech presentation, a χ^2 test for hypothetical writing presentation shows no significant difference between the two speaker groups ($p=0.309861$). Hypothetical thought presentation for its part occurs 104 times in the GP group and 98 times in the PS group. Again, the test for significance shows no difference ($p=0.734469$).

If we take the discourse presentation categories and consider the results for the statistical tests for each of the categories, in use of hypothetical discourse presentation overall as well as relative to the three sub-varieties of hypothetical presentation (negated, future, and proper), it becomes evident that only one of these tests shows a significant result between the two speaker groups. The one

significant result is found with GP speakers who use the variant *hypothetical proper* in connection with RTA ($p=0.002084$). I will treat this one significant result in the treatment of significance and non-significance in the following section, in which I return to the overall results for the discourse presentation categories. The χ^2 test comparing the two speaker groups' overall use of the discourse presentation categories provides a significant result in the following categories:

- FIS (GP)
- RSA (PS)
- IW (PS)
- FIT (GP)
- IT (GP)
- RTA (PS).

Table 6.20 below provides an overview of the significant results in the overall tests of the discourse presentation categories as well as the results for the tests of the hypothetical variant and the three hypothetical sub-varieties.

Table 6.20: Significant discourse presentation categories and their hypothetical variants.

	Significance, overall	Significance, hypothetical overall	Significance, hypothetical proper	Significance, hypothetical future	Significance, hypothetical negated
FIS	GP	None	None	None	None
RSA	PS	None	None	None	None
IW	GP	None	None	None	None
FIT	GP	None	None	None	None
IT	GP	None	None	None	None
RTA	PS	None	GP	None	None

As Table 6.20 shows, the significance from the discourse presentation categories overall is either dissolved relative to hypotheticality, or the figures for the hypothetical instances are so low as to be untestable. As far as hypotheticality is concerned, there thus seems to be a distribution pattern of

non-significance in the categories providing a significant result in the overall tests. On a general note, this suggests that the differences between the two speaker groups are located within the hypothetical discourse presentation parameter. However, as noted above, one test – related to use of RTA – provides a significant result. The PSs use this category significantly more often than do the GPs in the overall count. In relation to hypothetical use, the significance is reversed. If we turn to writing presentation, the only significant difference between the two groups in overall use was found in IW, which was used significantly more by the PSs. As with the majority of significant results, the difference is dissolved in relation to hypothetical IW. In the overall results, we saw a significant difference in use of the two summarising categories RSA and RTA in the PS group. As noted above, these two categories do not show the same differences in the hypothetical uses in the PS group. In the overall results, RWA showed no significant difference, but when we turn to the hypothetical instances, we see that the negated use of RWA is used significantly more by the GP group ($p=0.027861$). These two results (the GP group's significant use of hypothetical proper in RTA and hypothetical negated in Representation of Writing) are noteworthy because they indicate a change in significance from the overall result, either transferring the significance from one group to the other (as is the case with RTA) or revealing a significance that was not present in the overall result (as is the case with RWA).

Summary of hypothetical discourse presentation

- Hypothetical discourse presentation is used significantly more often in my corpus than in Semino and Short's corpus.
 - Hypothetical discourse presentation in each of the discourse presentation modes is used significantly more often in my corpus than in Semino and Short's corpus.
 - The overall significant results for the two speaker groups are not present in the results for hypothetical discourse presentation. As a consequence, the differences between the two speaker groups are not located on this parameter.
 - The statistical tests for hypothetical discourse presentation only provide two significant results:
1) The significance of RTA in the PS group overall is reversed, now being significant in the GP group relative to *hypothetical proper*. 2) The GPs use the variant *hypothetical negated* significantly more often than do the PSs.
-

6.2.2 GENERICITY – SPECIFIC AND NON-SPECIFIC REPRESENTATION

In Chapter 4.6.2, I explained how I have marked the instances of discourse presentation in my corpus as either general/recurrent/habitual or specific. The annotation in the existing corpus studies applying the Lancaster framework do not distinguish between specific and general discourse presentation. McIntyre et al., however, do identify instances of discourse presentation that convey recurrent or habitual discourse and provide an example of this phenomenon as part of their annotation procedure (McIntyre et al. 2004: 65). Nevertheless, McIntyre et al. only present figures for the core discourse presentation categories and not for any category features. This means that I am not able to compare my findings for this feature with existing studies. However, as will become evident, this feature is central in explaining the nature of my corpus data.

The figures for specific and non-specific representation in the two speaker groups are listed in Table 6.21 below:

Table 6.21: Specific and non-specific representation in the two speaker groups.

	GP	PS	P-value
Non-specific	1077	998	p=0.157046
Specific	165	128	
Total	N = 1242	N = 1126	

The figures for use of specific vs non-specific representation in the corpus show that the generic variant is far and away the most frequent in my corpus, with as many as 2075 out of 2368 occurrences of discourse presentation being realised as non-specific. This leaves only 293 instances that are realised as specific instances of discourse presentation. This distribution pattern is replicated in the two speaker groups: the non-specific variant accounts for 1077 out of the GPs' 1242 instances of discourse presentation, whereas the specific variant in this group is only chosen 165 times. In the PS group, 998 out of the 1126 instances of discourse presentation are realised as non-specific presentation, and the specific variant is realised 128 times. This similar distribution

pattern in the two speaker groups is confirmed by a chi² test, which shows no significant difference (p=0.157046).

Table 6.22 provides the figure for genericity in speech presentation:

Table 6.22: Genericity in speech presentation.

Category	GP, SPECIFIC	GP, NON- SPECIFIC	PS, SPECIFIC	PS, NON- SPECIFIC	P-value	Who
DS	22	98	21	72	0.44373	n/a
FIS	32	46	16	31	0.6046	n/a
IS	26	59	18	59	0.302743	n/a
RSA	29	90	21	117	0.064577	n/a
RV	52	202	28	175	0.061904	n/a
TOTAL	161	495	104	454	0.013061	GP

Table 6.23: Representation in writing presentation.

CATEGORY	GP, SPECIFIC	GP, NON- SPECIFIC	PS, SPECIFIC	PS, NON- SPECIFIC	P-value	Who
DW	2	11	0	8	n/a	n/a
FIW	2	2	1	6	n/a	n/a
IW	2	7	6	17	1	n/a
RWA	9	87	14	62	0.083443	n/a
RN	7	20	3	22	0.2957	n/a
TOTAL	22	127	24	115	0.562625	n/a

Table 6.24: Representation in thought presentation.

CATEGORY	GP,	GP, NON-	PS,	PS, NON-	P-value	Who
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	SPECIFIC	SPECIFIC	SPECIFIC	SPECIFIC		
DT	17	101	12	83	0.707274	n/a
FIT	10	53	6	14	0.162917	n/a
IT	28	143	22	108	0.899161	n/a
RTA	25	152	23	206	0.206664	n/a
RT	7	38	5	51	0.30629	n/a
TOTAL	87	487	68	462	0.266251	n/a

Non-specific presentation is far and away the preferred realisation mode in both speaker groups. Generally, the tests for significance show no differences between the two speaker groups. One test does, however, provide a significant result: at the level of discourse presentation mode, the GPs employ specific speech presentation significantly more often than do the PSs. The overall results show significant differences between the two speaker groups in six discourse presentation categories: FIS (GP), RSA (PS), IW (PS), FIT (GP), IT (GP), and RTA (PS). Furthermore, the results for RSA show that the overall significance in the PS group is close to being reversed in the GP group's use of specific representation ($p=0.064577$). The result for FIS also shows a relatively high proportion of specific occurrences in the corpus compared to the distribution in the other speech presentation categories (48 specific vs 77 non-specific). I return to the specific use of FIS in 6.4.2.3.

6.2.3 EMBEDDED DISCOURSE PRESENTATION

Embedded discourse presentation is one of the category features also examined by Semino and Short (2004). I will thus begin by comparing the figures from my corpus with their findings and then proceed to present the findings for this category feature relative to the two speaker groups.

There are 288 instances of embedded discourse presentation in my corpus. In Semino and Short's corpus, this figure is 1104 (Semino & Short 2004: 171-182). A χ^2 test comparing the two corpora's frequencies shows that embedded discourse presentation is significantly more frequent in Semino and Short's corpus ($p<0.0001$). 131 of the 288 instances in my corpus are realised as speech presentation, whereas the figure in Semino and Short's corpus is 327. When tested for significance, the difference from the overall comparison of the two corpora is confirmed,

with embedded speech presentation being significantly more frequent in Semino and Short's corpus ($p < 0.001$). Embedded writing presentation occurs 96 times in my corpus and 80 times in Semino and Short's corpus. The χ^2 test confirms that embedded writing presentation is used significantly more often in my corpus ($p < 0.0001$). In terms of thought presentation, the embedded variant occurs 111 times in my corpus, whereas the figure for Semino and Short's corpus is 327. The χ^2 test indicates that embedded thought presentation is significantly more frequent in my corpus ($p = 0.003687$).

If we now turn to use of embedded discourse presentation in the two speaker groups, the figures reveal a relatively even distribution between the two speaker groups: 141 instances are produced by the GP group and 147 by the PS group. A χ^2 test comparing the embedded uses against the total discourse presentation in each group shows no significant difference ($p = 0.153627$). Tables 6.25, 6.26, and 6.27 show the figures for embedded speech, writing, and thought presentation respectively by speaker group.

Table 6.25 Embedded speech presentation by speaker group.

Category	GP	PS	Total	P-value	Who
DSe	2	7	9	0.0436	PS
FISe	2	2	4	0.6311	n/a
ISe	3	6	9	0.3109	n/a
RS Ae	18	18	36	0.63147	n/a
RVe	40	33	73	0.882878	n/a
Total SP	65	66	131	0.282718	n/a

Table 6.26 Embedded writing presentation by speaker group.

Category	GP	PS	Total	P-value	Who
WDWe	0	1	1	n/a	n/a
WFIWe	0	0	0	n/a	n/a
WIWe	0	2	2	n/a	n/a
WRW Ae	19	14	33	0.820655	n/a

WRNe	2	8	10	0.0356	PS
Total	21	25	46	0.367677	n/a

Table 6.27 Embedded thought presentation by speaker group.

Category	GP	PS	Total	P-value	Who
TDTe	6	4	10	1.	n/a
TFITe	7	2	9	1.	n/a
TITe	16	13	29	0.851382	n/a
TRTAe	21	25	46	0.765209	n/a
TRTe	5	12	17	0.183502	n/a
Total	55	56	111	0.408959	n/a
Total SP, WP, TP	141	147	288	0.153627	n/a

The tests for significance for the two speaker groups in use of embedded speech, writing, and thought presentation provide two significant results, i.e. DS and Representation of Writing. In both cases, it is the PS group that uses the variants significantly more often than does the GP group.

6.2.4 WHOSE VOICE?

Identifying who the speaker makes responsible for the speech, thought, or writing can provide insight into how roles and responsibilities are assigned in the presented discourse (e.g. Fairclough 2003, Thompson 1996). In the annotation, I have coded speaker by number (singular or plural) and person (first, second, third) as well as passive voice, zero speaker, noun, adjective, and infinitive constructions. Where relevant, I have also added identification of the speaker role as either general practitioner, psychiatrist, or patient (or multiple roles) (see Chapter 4.6.5).

I have tested the frequencies overall, at presentational level (speech, writing, and thought), and at category level. Overall tests for the different speaker reference categories have been conducted, comparing the number of occurrences for each speaker group against this group's total number of speaker references/discourse presentation instances. In order to compare the two speaker

groups' production of the various types of reference at category level, the voices of each category have been tested against the remaining occurrences of the discourse presentation category in question.

In order to delineate the extent to which the different choices of speaker reference are used in the corpus and by whom, I have carried out statistical tests for 16 different types of speaker reference (i.e. categories that had enough occurrences to be tested). Of these, ten showed a significant difference between the two speaker groups. Six of the ten significant results are associated with the PSs and four with the GPs. Below is an outline of the significant uses of speaker reference, with the speaker group 'owning' the significance listed in brackets (figures for the significant categories will be provided in the course of the chapter):

Significant results

- 1st person singular (GP)
- 2nd person singular (PS)
- 3rd singular patient (PS)
- 1st person plural as a professional group voice (PS)
- 1st person plural as a shared doctor-patient voice (GP)
- 3rd person plural as own doctor group's voices (PS)
- 3rd person plural as the other doctors' voices (PS)
- 3rd person plural as patients' voices (GP)
- Passive voice (PS)
- Zero voice (GP).

Non-significant results

- 3rd person singular – doctor's voice
- S3sdg/y – other group
- S3sdg/y – own group

- Noun
- Infinitive

Only results that showed a significant result in the overall test will be treated in relation to the discourse presentation clines and their categories. I have chosen to do so because I am interested in describing speaker group differences.

6.2.4.1 SINGULAR VOICES

First person singular – the doctor’s voice

In the GP group, first person singular is used 433 times out of a total of 1343 occurrences. In the PS group, the figure is considerably lower, with the variant only being used in 258 out of 1176 instances. This difference in the two speaker groups is confirmed by the statistical test. The figures for realisations of first person singular in speech presentation are listed in Table 6.29:

Table 6.29: First person singular in speech presentation.

SP category	GP	PS	P-value	Who
DS	33	26	0.941077	n/a
FIS	13	4	0.197562	n/a
IS	25	20	0.625656	n/a
RSA	33	16	0.001024	GP
RV	57	51	0.502449	n/a
TOTAL	N = 161	N = 117	0.139579	n/a

The overall results show that the PSs use RSA significantly more often than do the GPs. However, if we look at the instances of RSA realised from a first person perspective, the figure for the GP group is 33, whereas the figure for the PS group is 16. A χ^2 test confirms this difference, indicating that the GPs use first person singular significantly more often in connection with RSA than do the PSs ($p=0.001024$). This suggests that the overall significance in the PS group’s use of the speech presentation category is reversed when linked to first person singular. The other significant result in the overall use of speech presentation in the two speaker groups is the GPs’ use

of FIS. Even though the GPs use first person significantly more often than do the PSs, the significance of FIS in the overall results is outweighed by the two groups' use of the category from a first person perspective. The results for Direct Speech, IS, and RV are replications of the overall results for Direct Speech, showing no significant difference in first person marking.

Proceeding to use of first person singular in writing presentation, Table 6.30 below shows the figures for the two speaker groups:

Table 6.30: First person singular in writing presentation.

WP category	GP	PS	P-value	Who
DW	4	1	n/a	n/a
FIW	0	2	n/a	n/a
IW	1	1	n/a	n/a
RWA	33	9	0.000871	GP
RN	5	3	None	0.705
TOTAL	43	16	0.000267	GP

As was the case for the overall results for writing presentation, the figures for first person are generally relatively low. However, one result stands out: the GPs use of first person in RWA shows that more than a third of all of this group's realisations of this writing presentation form are conveyed from a first person perspective (33 out of 96), while the proportion in the PS group is considerably smaller (9 out of 76). A χ^2 test confirms that the GPs use first person perspective significantly more often than do the PSs ($p=0.000267$). This predominant use of RWA in connection with the first person singular in the GP group leads to an overall significant result in writing presentation in relation to the first person singular. The significance in the PSs' use of IW is not replicated in connection with first person singular, where the speaker groups only produce one instance of IW each.

If we proceed to use of first person singular in thought presentation, the results for the two speaker groups are listed in Table 6.31:

Table 6.31: First person singular in thought presentation.

TP category	GP	PS	P-value	Who
DT	51	33	0.207918	n/a
FIT	19	2	0.070812	n/a
IT	95	47	0.000838	GP
RTA	46	39	0.027807	GP
RT	21	11	0.003715	GP
TOTAL	232	132	<0.0001	GP

In the overall use of thought presentation, no significant difference was found between the two speaker groups. If we turn to use of first person reference in thought presentation, the figure shows that the GPs – as is the case for the general use of first person reference within this group – use this voice significantly more often than do the PSs when presenting thought. The significance found in the overall comparison of the two speaker groups relative to IT is replicated in this sub-analysis, and the overall significance in the PS group for use of RTA is reversed relative to first person singular, now being significantly more frequent in the GP group.

Second person singular – the generic voice

The figures for second person singular show that the GPs use this variant 9 times, and the PSs do so 26 times. When tested against the remaining numbers of voices, the results show that the PSs' use of second person singular is significant. Tables 6.32-6.34 below show the figures for second person occurrences in each of the discourse presentation categories. Whereas the limited number of occurrences in the GP group are relatively evenly distributed across the three presentational scales, we see the highest number of occurrences within the PS group on the thought presentation cline (15 out of 26) and nearly half as many on the speech presentation cline (8). As for the GP group, the second person singular in writing presentation is only used very sparsely in the PS group (3 occurrences).

Table 6.32 Second person singular in speech presentation.

SP category	GP	PS	P-value	Who
DS	0	0	n/a	n/a

FIS	0	1	n/a	n/a
IS	0	0	n/a	n/a
RSA	2	1	n/a	n/a
RV	1	6	n/a	n/a
TOTAL	3	8	0.1251	n/a

Table 6.33 Second person singular in writing presentation.

WP category	GP	PS	P-value	Who
DW	0	0	n/a	n/a
FIW	0	0	n/a	n/a
IW	0	1	n/a	n/a
RWA	2	1	n/a	n/a
RN	2	1	n/a	n/a
TOTAL	4	3	1.	n/a

Table 6.34 Second person singular in thought presentation.

TP category	GP	PS	P-value	Who
DT	1	1	n/a	n/a
FIT	0	1	n/a	n/a
IT	0	6	n/a	n/a
RTA	0	5	n/a	n/a
RT	1	2	n/a	n/a
TOTAL	2	15	0.0008	PS

The count for representation of patients’ voices by means of third person singular shows that the GPs use this variant 76 times, whereas the figure for the PS group is 92. A χ^2 test shows a significant difference between the two speaker groups, revealing that the PS group assigns voices to the individual patient significantly more often than does the GP group. If we proceed to consider the distribution pattern relative to the three presentational clines, the tests for significance show no significant results for speech and writing presentation ($p=0.833614$ for speech presentation, not tested for writing presentation due to too few occurrences). Instead, the significance between the two groups is found in the presentation of thought ($p=0.009064$).

The pattern for the speech presentation categories follows the overall distribution patterns among the two speaker groups. However, the differences are insignificant relative to third person singular, as is the case with FIS and RSA in the overall comparison of the two speaker groups. In relation to thought presentation, the most notable difference relative to the individual categories is the PSs’ use of the most summarising form (RT), which they use significantly more often than do the GPs.

Table 6.35 Patient’s voice in speech presentation.

SP category	GP	PS	P-value	Who
DS	7	7	0.620822	n/a
FIS	12	7	0.94096	n/a
IS	6	3	0.5003	n/a
RSA	8	13	0.431158	n/a
RV	12	10	0.920277	n/a
TOTAL	45	40	0.833614	n/a

Table 6.36 Patient’s voice in writing presentation.

WP category	GP	PS	P-value	Who
DW	0	0	n/a	n/a
FIW	0	0	n/a	n/a

IW	0	0	n/a	n/a
RWA	1	2	n/a	n/a
RN	1	2	n/a	n/a
TOTAL	2	4	0.4339	n/a

Table 6.37 Patient's voice in thought presentation.

TP category	GP	PS	P-value	Who
DT	1	3	n/a	n/a
FIT	5	4	0.2089	n/a
IT	11	9	0.865648	n/a
RTA	10	19	0.3044	n/a
RT	2	13	0.0108	PS
TOTAL	29	48	0.009064	PS

6.2.4.2 PLURAL VOICES

First person plural as a professional group voice

In the annotation, I have marked those uses of first person plural that refer to the doctors' own professional group. This also means that instances involving another agent, such as a patient, are not part of this count (see chapter 4 for annotation procedures). The result for the GPs shows that 66 out of 1343 instances of speaker reference denote the GPs as a medical profession. The corresponding figure for the PS group is 131 out of a total of 1176 instances. This type of speaker reference shows a significant difference between the two groups ($p < 0.0001$), with the PSs employing the plural group voice significantly more often than do the GPs. In relation to the three presentational modes, the PSs' use of this variant is confirmed by significant results relative to speech as well as thought presentation (tested against the total numbers for speech and thought presentation respectively). Use of the first person plural group voice relative to the individual categories shows that the two speaker groups produce an equal number of the summarising writing presentation category RWA (15 each), which makes this category the most frequent of the writing presentation categories in both speaker groups, with no significant difference between the groups. The significant differences between the

two speaker groups at category level are found relative to IT and RTA. The significance of IT in the GP group in the overall comparison is reversed in use of the doctors' group voice, now being used significantly more often by the PS group. The summarising thought presentation category RTA is, as in the overall results, also used significantly more often by the PS group. In the overall results, we saw that the GPs used FIS significantly more often than did the PSs. In this sub-analysis, however, FIS is not used to denote this type of speaker reference at all in any of the two groups. The remaining speaker reference categories are employed more moderately, with some – primarily insignificant – variation between the two speaker groups.

Table 6.38 Own group voice in speech presentation.

SP category	GP	PS	P-value	Who
DS	6	10	0.114155	n/a
FIS	0	0	n/a	n/a
IS	3	8	0.1182	n/a
RSA	6	16	0.061198	n/a
RV	15	21	0.080043	n/a
TOTAL	30	55	0.000324	PS

Table 6.39 Own group voice in writing presentation.

WP category	GP	PS	P-value	Who
DW	1	2	n/a	n/a
FIW	0	2	n/a	n/a
IW	0	3	n/a	n/a
RWA	15	15	0.480356	n/a
RN	2	3	0.6624	n/a
TOTAL	18	25	0.159994	n/a

Table 6.40 Own group voice in thought presentation.

TP category	GP	PS	P-value	Who
DT	0	7	n/a	n/a

FIT	1	1	n/a	n/a
IT	4	11	0.029	PS
RTA	10	27	0.033014	PS
RT	0	3	n/a	n/a
TOTAL	15	49	0.000002	PS

First person plural as shared doctor-patient voice

In the annotation, I have marked first person plural instances referring to shared communication and thoughts between doctor and patients (see Chapter 4.6.5 for an introduction). The results show that, in the GP group, 49 out of 1343 instances refer specifically to a shared doctor-patient voice. In the PS group, this figure is 17 out of 1176. A chi² test shows a significant difference between the two groups of doctors' use of shared voices. The results for use of the shared voice according to the discourse presentation scales shows that the vast majority of instances are found in connection with speech presentation and that the two indirect forms (IS and RV) account for most of the occurrences. The results also show that writing presentation comprises no uses at all.

Table 6.41 Shared voice in speech presentation.

SP category	GP	PS	P-value	Who
DS	5	3	1.	n/a
FIS	1	1	n/a	n/a
IS	10	0	n/a	(GP)
RSA	3	0	n/a	n/a
RV	21	9	0.10008	n/a
TOTAL	40	13	0.001365	GP

Table 6.42 Shared voice in writing presentation.

WP category	GP	PS	P-value	Who
DW	0	0	n/a	n/a
FIW	0	0	n/a	n/a
IW	0	0	n/a	n/a

RWA	0	0	n/a	n/a
RN	0	0	n/a	n/a
TOTAL	0	0	n/a	n/a

Table 6.43 Shared voice in thought presentation.

TP category	GP	PS	P-value	Who
DT	2	1	n/a	n/a
FIT	0	1	n/a	n/a
IT	3	1	n/a	n/a
RTA	3	3	1.	n/a
RT	0	0	n/a	n/a
TOTAL	8	6	0.697887	n/a

Third person plural as own group's voice

The results for the voices that refer to the doctors' own group as third person plural show that the PSs use this type of reference 19 times: 8 in connection with speech presentation, 2 in writing presentation, and 9 in thought presentation. 7 out of 8 occurrences in speech presentation are realised as RSA, and 8 out of 9 occurrences are realised as RTA. In contrast, the GPs do not use this type of third person plural reference at all. The distributions of the occurrences by discourse presentation category are shown in Tables 6.44 to 6.46 below:

Table 6.44: Third person plural, own group's voice in speech presentation.

SP category	GP	PS	P-value	Who
DS	0	0	n/a	n/a
FIS	0	0	n/a	n/a
IS	0	1	n/a	n/a
RSA	0	7	n/a	(PS)
RV	0	0	n/a	n/a
TOTAL	0	8	n/a	(PS)

Table 6.45: Third person plural, own group's voice in writing presentation.

WP category	GP	PS	P-value	Who
DW	0	0	n/a	n/a
FIW	0	0	n/a	n/a
IW	0	1	n/a	n/a
RWA	0	1	n/a	n/a
RN	0	0	n/a	n/a
TOTAL	0	2	n/a	n/a

Table 6.46: Third person plural, own group's voice in thought presentation.

	GP	PS	P-value	Who
DT	0	0	n/a	n/a
FIT	0	0	n/a	n/a
IT	0	1	n/a	n/a
RTA	0	8	n/a	(PS)
RT	0	0	n/a	n/a
TOTAL	0	9	n/a	(PS)

Third person plural as the other doctors' voices

I have marked instances of discourse presentation produced by one group of doctors, assigning the voice to the other group of doctors. This type of speaker reference occurs 28 times in the GP group. In the PS group, the figure is 53. A chi² test shows a significant difference, indicating that the PS group assigns more voices to the GPs than vice versa (Figure). In terms of the three presentational modes, both groups use speech presentation most frequently with this type of speaker reference and with no significant difference between the two groups. For all three scales, the PS group uses each presentational mode more often than does the GP group, but the only significant difference is found in writing presentation (Figure).

Table 6.47 Other doctors' voices in speech presentation.

SP category	GP	PS	P-value	Who
DS	5	0	n/a	(GP)
FIS	4	4	0.4729	n/a
IS	2	3	0.6709	n/a
RSA	3	8	0.2308	n/a
RV	3	8	0.0686	n/a
TOTAL	17	23	No significance	n/a

Table 6.48 Other doctors' voices in writing presentation.

WP category	GP	PS	P-value	Who
DW	0	4	n/a	n/a
FIW	0	1	n/a	n/a
IW	2	2	n/a	n/a
RWA	2	7	0.045	PS
RN	2	3	0.6624	n/a
TOTAL	6	17	0.01028	PS

Table 6.49 Other doctors' voices in thought presentation.

TP category	GP	PS	P-value	Who
DT	0	1	n/a	n/a
FIT	1	0	n/a	n/a
IT	2	2	n/a	n/a
RTA	4	10	0.2856	n/a
RT	0	2	n/a	n/a
TOTAL	7	15	0.05519	n/a

Third person plural – patients’ voices

The result for the plural representation of patients’ voices shows that the GPs use this type of reference 139 times and the PS group does so 98 times. The difference between the two groups is confirmed by a χ^2 test showing that the GPs convey the patients’ voices significantly more often than do the PSs (χ^2 4.1487, $p=.041666$). Turning to the three presentational scales, the results show that, in both speaker groups, speech presentation is the most frequent choice when presenting patients’ voices, followed by thought presentation, with writing presentation as a very distant third in that this mode of presentation accounts for as few as 6 out of 139 occurrences in the GP group and 5 out of 98 occurrences in the PS group. At category level, we see that FIS is relatively frequent with this type of speaker reference, accounting for as much as a quarter of all instances of FIS in both speaker groups. The only significant difference at category level is found in use of IT, which is used significantly more often by the PS group.

If we consider the total representation of patient voices in the corpus (singular and plural), the figure is 405 out of 2605 instances of discourse presentation. This means that only 16% of the instances of discourse presentation in the entire corpus present patient voices. The total number of patient occurrences are distributed fairly evenly between the two speaker groups: 215 instances in the GP group (75 singular and 139 plural) and 190 instances in the PS group (92 singular and 94 plural), with no significant difference between the two groups of doctors (p -value: 0.872262).

Table 6.50 Patients’ voices in speech presentation.

SP category	GP	PS	P-value	Who
DS	16	12	0.926589	n/a
FIS	21	11	0.662366	n/a
IS	9	11	0.474962	n/a
RSA	8	5	0.258228	n/a
RV	27	14	0.165238	n/a
TOTAL	81	53	0.114354	n/a

Table 6.51 Patients' voices in writing presentation.

WP category	GP	PS	P-value	Who
DW	1	0	n/a	n/a
FIW	0	0	n/a	n/a
IW	0	0	n/a	n/a
RWA	3	3	1.	n/a
RN	2	2	n/a	n/a
TOTAL	6	5	0.849208	n/a

Table 6.52 Patients' voices in thought presentation.

TP category	GP	PS	P-value	Who
DT	4	1	0.3838	n/a
FIT	15	2	0.2218	n/a
IT	11	17	0.049325	PS
RTA	17	16	0.338511	n/a
RT	5	4	0.5013	n/a
TOTAL	52	40	0.363792	n/a

6.2.4.3 OTHER VOICES

Passive voice

The results for the count for passive voice show that this type of reference occurs 59 times in the GP group and 102 times in the PS group. The difference between the two speaker groups is confirmed by a chi² test. Results relative to presentational mode are listed in Tables 6.53-6.55:

Table 6.53 Passive voice in speech presentation.

SP category	GP	PS	P-value	Who
DS	0	4	n/a	n/a

FIS	1	4	n/a	n/a
IS	4	7	0.3532	n/a
RSA	17	22	0.712105	n/a
RV	8	18	0.008747	PS
TOTAL	18	55	<0.0001	PS

Table 6.54 Passive voice in writing presentation.

WP category	GP	PS	P-value	Who
DW	0	0	n/a	n/a
FIW	0	0	n/a	n/a
IW	0	1	n/a	n/a
RWA	14	20	0.055017	n/a
RN	2	3	n/a	n/a
TOTAL	16	25	0.078598	n/a

Table 6.55 Passive voice in thought presentation.

TP category	GP	PS	P-value	Who
DT	2	0	n/a	n/a
FIT	2	2	n/a	n/a
IT	0	3	n/a	n/a
RTA	12	20	0.468723	n/a
RT	0	1	n/a	n/a
TOTAL	16	26	0.066054	n/a

If we turn to the three presentational modes, the greatest difference between the two speaker groups is found relative to speech presentation: 18 instances in the GP group are realised as speech presentation, whereas the figure for the PS group is almost three times higher (55 instances), which makes the figure for speech presentation in the PS group significantly higher ($p < 0.0001$). The figures for total writing and thought presentation respectively show no significant differences

between the two groups. In the overall results for discourse presentation, we saw how thought presentation was almost as frequent in the corpus as was speech presentation, with writing presentation lagging far behind. In relation to passive voice, we see a rather different tendency, with writing presentation being just as frequent as thought presentation, which is also the case for both speaker groups.

Proceeding to the results at category level, a general tendency in use of passive voice points toward notably low frequencies in the two most direct discourse presentation forms on the three scales, accounting for only 5 out of 59 instances in the GP group and 10 out of 102 instances in the PS group. If we conflate the three forms that project propositional content (Direct/Free Indirect/Indirect Speech/Writing/Thought), only 9 instances in the GP group and 21 in the PS group are realised by passive voice. Instead, the vast majority of passive realisations are found in Representation of Speech/Writing/Thought Act categories. In fact, nearly all the instances of writing presentation are realised as RWA. The prevalence of these categories in both speaker groups are confirmed by the tests for significance, which show no significant differences. In speech presentation, RV is the only test at category level displaying a significant difference between the two speaker groups.

Zero voice

The count for the speaker category *zero voice* shows that the GPs use this variant 80 times, and the PSs use it 45 times. This difference, when tested against the total number of speaker references, is confirmed by a χ^2 test ($p=0.014039$). Proceeding to the three presentational modes, we see that zero reference is used almost exclusively in the presentation of speech and thought:

Table 6.56 Zero voice in speech presentation.

SP category	GP	PS	P-value	Who
DS	22	16	0.830968	n/a
FIS	13	4	0.2827	n/a
IS	2	0	n/a	n/a
RSA	0	1	n/a	n/a
RV	4	2	0.6971	n/a
TOTAL	41	23	0.098202	n/a

Table 6.57 Zero voice in writing presentation.

WP category	GP	PS	P-value	Who
DW	5	0	n/a	n/a
FIW	0	0	n/a	n/a
IW	0	0	n/a	n/a
RWA	0	0	n/a	n/a
RN	0	0	n/a	n/a
TOTAL	5	0	n/a	n/a

Table 6.58 Zero voice in thought presentation.

TP category	GP	PS	P-value	Who
DT	25	21	0.77296	n/a
FIT	12	5	0.565514	n/a
IT	0	0	n/a	n/a
RTA	1	0	n/a	n/a
RT	0	0	n/a	n/a
TOTAL	38	26	0.223251	n/a

Only 5 out of the GPs' 80 instances are realised as writing presentation, and none of the PSs' uses are realised using this presentational mode. At category level, the zero references cluster at the direct ends of the clines, in that the most direct forms (DS, FIS, DT and FIT) account for the vast majority of occurrences in both speaker groups: 35 out of 41 instances of zero reference in speech presentation in the GP group are realised by these two forms, and the figure for the PS group is 20 out of 23 instances. In thought presentation, 37 out of 38 instances in the GP group are realised by the two most direct forms, and all of the 26 instances of thought presentation in the PS group are realised by these two forms. No significant differences between the groups are found relative to any of the three presentational modes or at category level.

6.2.5 INTERACTIONAL DISCOURSE PRESENTATION

Elicited discourse presentation

The results for the total elicited discourse presentation in the two speaker groups as well as for the three presentational clines are listed in Table 6.59 below:

Table 6.59: Elicited discourse presentation

DP cline	GP	PS	P-value	Who
SP, elicited	51	36	0.373187	n/a
WP, elicited	12	10	0.783787	n/a
TP, elicited	18	29	0.030572	PS
Total DP, elicited	81	75	0.692806	n/a

The tests for significance provide one significant result, which is use of elicited discourse presentation in the PS group ($p=0.03572$). In Chapter 4 I explained how this variant is an independent discourse presentation phenomenon rather than a category feature. However, I have chosen to present the results in this section together with the other interactionally prompted variant, *Interactional* as both phenomena are interactionally dependent.

Interactional discourse presentation

The results for the total interactional discourse presentation in the two speaker groups as well as for the three presentational clines are listed in Table 6.60 below:

Table 6.60: Interactional discourse presentation.

DP cline	GP	PS	P-value	Who
SP, interactional	16	10	0.437785	n/a
WP, interactional	3	7	0.2052	n/a
TP, interactional	12	11	0.916512	n/a
Total DP,	31	28	0.887278	n/a

interactional				
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The tests for significance for interactional discourse presentation overall and for each of the presentational clines show no significant results between the speaker groups. The absence of significant results and the relatively low figures for the presentational clines have led me to not test this phenomenon at category level.

6.3 GP AND PS DISCUSSION: USE OF DP CATEGORIES

The following two sections, 6.3 and 6.4, discuss the results from the quantitative comparison of the two groups of doctors presented in 6.1 and 6.2. I focus on the results that are significant relative to the two speaker groups. I regard this as the best possible means of explaining the *differences* between the two speaker groups.

The chapter is structured as follows: Sections 6.3.1, 6.3.2, and 6.3.3 discuss use of the discourse presentation categories that provided significant results. These are FIS, RSA, IW, FIT, and RTA. The section also includes a digression on the use of lexical choices in the category RV. There are two reasons for including this digression: partly because it is the most frequent discourse presentation category in the corpus and partly because it may be regarded as underexplored in the existing literature on discourse presentation.

The following sections, 6.4.1-6.4.4, discuss use of category features. For hypotheticality, in 6.4.1, I treat the significant variants (*RWA, negated* and *RTA, proper*) by considering their uses and the speaker voices associated with them. This is followed by a discussion of significant uses of speaker voices in 6.4.2. This discussion is structured though a pairing of speaker voice categories: *first person singular* and *first person plural*; *third person plural, own group voice* and *third person plural, other group voice*; *third person singular, patient's voice* and *third person plural, patients' voices*; and finally *passive voice* and *zero voice*. I will devote considerable attention to the discussion of speaker voices for two reasons. One is empirical: when tested relative to speaker voice, a much more fine-grained pattern of results for the discourse presentation categories emerges, often disclosing different results than those gained from the overall tests. There are also theoretical and methodological reasons for a more detailed discussion of use of discourse

presentation relative to speaker voice: to the best of my knowledge, no corpus investigation of use of speaker voice relative to discourse presentation has previously been conducted. I am thus interested in exploring and discussing what this type of systematic, quantitative analysis can add to the investigation of understandings of depression in two different professional groups. Sections 6.4.3 and 6.4.4 discuss significant uses of embedded and interactional discourse presentation respectively. These last two sections will only receive a brief treatment since the occurrences and the significant results for these features are limited.

The results for the category feature *genericity*, presented in 6.2.2, showed no significant differences between the two speaker groups at the level of discourse presentation categories. I will thus not discuss this category feature separately but will incorporate it into my discussion where relevant.

On a more general note, I approach the results by discussing aspects such as lexical realisations, the communicative context being reported (i.e. doctor-patient interaction), the interview context, and interactional issues. Where relevant, I draw upon central assumptions or findings in the literature that may illuminate the two speaker groups' uses of discourse presentation and associated features.

6.3.1 SPEECH PRESENTATION IN THE TWO SPEAKER GROUPS

Free Indirect Speech (FIS) and Representation of Speech Act (RSA)

The results for the two speaker groups' use of speech presentation in my corpus provided two significant results: the general practitioners used FIS significantly more often than did the PSs, and the PSs used RSA significantly more often than did the general practitioners.

The overall results presented in Chapter 5.2.3 showed that, when compared to the two Lancaster-based corpora, FIS is used significantly more often in my corpus. I suggested that this prevalence in my corpus could be due to the Danish-language context in which FIS is produced. When tested in terms of the two groups from the medical profession, it becomes clear that it is the general practitioners who produce the majority of FIS in the corpus. Even though FIS is the least frequent speech presentation form in the corpus, and despite its downgraded position in the literature concerning speech presentation in spoken language, it is nevertheless here that we find the

significance when we focus on the direct end of the speech presentation cline, both relative to the other two corpora and also between the two speaker groups. FIS is a blend of the two speech presentation forms DS and IS, thereby serving as a ‘halfway house’ between character and narrator voice (Leech & Short 1981: 325). This suggests that, by employing FIS, the reporter relinquishes part of his reporting authority, leaving the reported voice more visible in the reporting context than had a more indirect or summarising form been chosen. The results for specific and non-specific representation showed that, when compared to the other speech presentation categories, FIS has a relatively large proportion of specific representations: 41% and 52% of the instances of FIS are specific in the GP and PS group respectively. By comparison, only 22% of the instances of DS in the GP group are specific, and the corresponding figure for the PS group is 29%. At the indirect end of the scale, 26% of the instances of RV in the GP group are specific, while the figure for the PS group is 16%. The relative prominence of specific representation in FIS could indicate that this variant is used in more narrative-like clusters – or at least is often used to refer to occurrences of speech that are specific. On this basis, it seems that it is the GPs who choose to establish scenarios that are both closer to the (imagined) source (by means of the speech presentation category) and more specific renderings of the implied source’s utterances. I will exemplify and discuss the GPs’ use of FIS in the section on patients’ voices. The reason for doing so – as will become evident when considering voices – is that a relatively large proportion of FIS is used by the GPs to give voice to patients.

In terms of the other significant speech presentation result (RSA) in relation to the two speaker groups, the significance is found in the PS group. The overall tests comparing RSA in my corpus with the existing corpora showed no significance when tested against Semino and Short, whereas the test relative to McIntyre et al. showed RSA to be significant in my corpus. I suggested that these results are linked to the serious and non-narrative context of my interviews (Chapter 5.3.1). The significant use of RSA places the PS group at the summarising end of the speech presentation cline. Semino and Short highlight the category’s summarising properties, in which we are not presented with any of the imagined original words of the utterance (Semino & Short 2004: 324). This summarising function of RSA is closely linked to narrational control: “When a novelist reports the occurrence of some speech act, we are apparently seeing the event entirely from his perspective” (Leech and Short 1981: 324). How the PS group actually puts the category to use in a wholly different context will be discussed in the section concerning speaker voices. For the moment, however, we can conclude that the highly significant use of RSA by the PS group suggests that the

PSs prefer a speech presentation form that implies strong speaker control and thus enhances the distance between the (apparently) original speech and the presentation to a much greater degree than do the GPs.

As far as DS is concerned, we saw that this category was insignificant when comparing the two speaker groups and that it was significantly more frequent in the two Lancaster corpora. I suggested that this relative infrequency of DS is due to the serious and predominantly non-narrative nature of my corpus. However, the GPs do produce more DS than do the PSs, and a conflation of the two most direct speech presentation forms (DS and FIS) also showed a significant result in favour of the GP group. This conflation adds quantitative weight to the argument that the GPs are more direct in their renderings of speech than are the PSs.

The results also showed that, across the three presentational scales, the GPs' proportion of the three free indirect forms combined was highly significant relative to the PS group. This result adds weight to the claim that the GPs make much greater use of the direct end of the discourse presentation clines than do their PS colleagues. A similar tendency is found for the PS group's use of the 'Act' categories across the three presentational scales, with a highly significant difference between the two groups. This result adds quantitative weight to the notion that the differences between the two groups of doctors place them at either end of the discourse presentation cline.

FIS equates with what Voloshinov terms *quasi-direct discourse*. According to Voloshinov, this means of presenting discourse "is not a simple mechanical mixture or arithmetical sum of two forms but a completely new, positive tendency in active reception of another person's utterance" (Voloshinov 1973: 142). According to Voloshinov, however, the premises change when we turn to indirect discourse: "Analysis is the heart and soul of indirect discourse" (Voloshinov 1973: 129). The figures for use of speech presentation tell us that we are dealing with significance differences between the two groups of doctors, which indicate that they take divergent approaches to discussing depression. What is it, precisely, that the speaker achieves when he chooses to present discourse in one way over another? This is a central point of investigation for the remainder of this chapter.

6.3.1.1. EXCURSION: Lexical choices in RV

The most summarising category on the present speech presentation cline (RV) did not form part of Leech and Short's initial account of speech and thought presentation. It was first introduced in Short's 1996 account under the term Narrator's Representation of Speech (1996). In the overall results, I found that RV was far and away the most frequent of all the discourse presentation forms in the corpus and was significantly more frequent in my corpus than in the other two corpora. This tendency was reflected in both speaker groups, and there was no difference between them when tested for significance. I suggested that the prevalence of RV in my corpus could be linked to the spoken language context (the amount of RV in McIntyre et al.'s spoken corpus was also significantly higher compared to Semino and Short's written corpus) as well as the predominantly non-narrative and serious mode of the interview discourse.

Because RV is so markedly frequent in my corpus, and because it is a relatively recent addition to the existing Lancaster discourse presentation framework, I wanted to delve further into how the category is operationalised by the two speaker groups. Apart from pointing to its status as capturing minimal speech, such as *to talk* or *to speak*, Semino and also emphasise RV as being used to refer very broadly to the type of speech event occurring, such as *row* or *gossip* (Semino & Short 2004: 69-71). As the healthcare system is characterised by institutionalised or ritualised speech events (such as consultations, interviews, and general communication between the different healthcare professionals as well as with their patients), I decided to look at the lexical choices employed by the two speaker groups to operationalise this most summarising – and, in my corpus, most frequent – speech presentation category.

In order to pinpoint possible lexical differences in RV in the two speaker groups, I have run tests for significance for the words that were realised as RV. To achieve this, I conducted a search in which I combined the tag for RV and the most common speech verbs (*talk*, *chat*, *tell*, etc.). The search was based on the lemma form as well as past tense and present perfect forms for verbal realisations of RV. To identify other lexical realisations with a lower frequency, I manually browsed through the results for RV and identified instances such as *story*, *call*, and *consultation*. It is important to bear in mind that a large number of the words are represented only very sparsely in the corpus, many with only one or two occurrences for each group, indicating that these lexical choices may be idiosyncratic rather than characteristic of a certain speaker group. Thus, I have only carried out tests for significance for those the lexical realisations occurring more than once or twice in at least one of

the speaker groups. Interestingly, just as the overall test for significance for RV showed no significant difference between the two speaker groups, of all the tests for significance carried out (where possible) for specific lexical realisations, only 4 out of 57 different realisations of the category provided significant differences between the two speaker groups. The lack of significant results between the two speaker groups in use of lexis could indicate that the category is realised with a default lexis, which is what we see in the widespread use of rather semantically light or general speech presentation references, such as *talk*, *speak*, *conversation*, etc. The four realisations of RV that did actually show significant results are listed in Table 6.59 below:

Table 6.59 Significant lexical realisations of RV.

Lexical variant	GP occurrences	PS occurrences	Significance
Kontakt/Contact (noun)	3	11	0.0122
Interview/Interview (noun)	1	11	0.0016
Eduktion/Education	1	11	0.0016
Forklare/Explain	1	6	0.0481

Example 6.1 illustrates how the speech event *interview* is employed by a psychiatrist:

Example 6.1

Dan:

1INFjeg kan jo sådan # koge fond på rigtig mange oplysninger!

2INT: ja #

3INF: før! jeg overhovedet møder patienten #

4INT: ja #

5INF: **så det vil sige jeg sådan målrettet kan gå i gang med interviewet #**

6INT: ja # ja #

7INF: der hvor jeg er usikker #

8INT: ja #

9INF: der hvor at man kunne tænke hov # er det i virkeligheden noget andet #

(PS5)

Eng:

1INF: I can you know so to speak # boil fond on a whole lot of information!

2INT: yes #

3INF: before! I even meet the patient #

4INT: yes #

5INF: **so that means I kind of targeted can start with the interview #**

6INT: yes # yes #

7INF: there where I am unsure #

8INT: yes #

9INF: there where one could think oh # is it actually something else #

(PS5)

The speech event *interview* (1.5) may be characterised as a speech event that suggests a relatively well-defined asymmetrical structure between doctor and patient, with the doctor asking the questions and the patient providing the answers. Instead of *interview*, the psychiatrist could have chosen a more symmetrical construction, such as *talk* or similar. Choosing *interview* may be said to underline the institutional aspect of the diagnostic process, underlining the PSs' professional role in the relationship. The speech event *edukation* (*instruction/training*) may similarly be said to encompass an asymmetrical relation: however, in this type of speech event, it is the psychiatrist who provides the patient with information, instructing the patient on how to handle the condition in his everyday life. Common to both events are clear, pre-defined roles and very visible guidance from the psychiatrist, who through these speech events may be said to manifest a strong professional position.

Even though the test for significance for the speech verb *snakke* (*talk*) showed no significant difference between the two speaker groups, a closer look at the distribution within the two speaker groups shows that the PS group in 32 out of 203 instances uses some form of *snakke*, and the figure for the GP group is 57 out of 254 instances. In the PS group, as many as 23 out of 32 instances are produced by two speakers alone (figures: 15, 8, 2, 2, 5) whereas the distribution within the GP

group is more even (figures: 13, 11, 16, 3, 5, 8). *Snakke* (*to chat, to talk*) may be characterised as an informal speech verb conveying a symmetrical relationship. Den Danske Ordbog defines *snakke* as follows: “at føre en (uformel) samtale; tale afslappet eller venskabeligt med.” (DDO, lookup: *snakke*). The rather widespread – and evenly distributed – use in the GP group suggests that this group chooses to present settings that are characterised by being relaxed and informal rather than institutionalised and asymmetrical. By choosing to talk about the doctor-patient interaction in informal terms, the GPs could be said to project a picture of a setting in which vulnerable patients are invited into a relaxed communicative space, encouraging a space in which the patient is better able to open up and receive the recommendations best suited for the condition at hand. A study of the same two groups of doctors’ doctor-patient interaction in consultations concerning depression finds a similar difference (Fogtmann & Davidsen 2014).

Finally, the tendencies found in the two speaker groups’ use of RV – that the GP group employs the informal *snakke* more consistently and that the PS group employs more specific, institutionalised, and asymmetrical speech events – also seem to match the PS group’s significant use in connection with RSA. RSA is by definition comprised of a lexis that is more semantically dense than that of RV (Semino & Short 2004: 44). Based on Voloshinov’s observation about the analytical work associated with indirect presentation, I have shown that this tendency, due to the significant use of RSA, is primarily characteristic of the PS group. What we see in relation to RV is actually a twofold use: a use of semantically specific speech events, which are associated with the PS group, and a use that is semantically lighter, which is associated with the GP group. From a theoretical perspective, my observation that the semantics seem to fade away (especially in the GP group) the further we move toward the summarising end of the speech presentation cline and as we approach RV may raise the question as to whether analytical processing at the most summarising end of the cline in fact increases or decreases. And in continuation of this, to which degree does the scalar notion of the speech presentation cline actually reflect the proposition laid out by Voloshinov? That, however, is a major discussion in itself and is outside the scope of this thesis, though I would argue that it is worth considering when approaching discourse presentation from a scalar perspective. In the next section, I return to the core discussion of the significant discourse presentation results in the two speaker groups, focusing on use of writing presentation in the two speaker groups.

6.3.2 WRITING PRESENTATION IN THE TWO SPEAKER GROUPS

The only significant result overall between the two speaker groups on the writing presentation scale is found relative to IW, with the PSs employing this category significantly more often than do the general practitioners. If we consider the results for the categories projecting propositional content on the three presentational scales (amounting to nine variants), IW proves to be the only variants that is employed significantly more often by the PSs, whereas three out of the nine propositional forms are used significantly more often by the GPs (FIS, FIT, IT). At least two points can be made concerning this difference: first, it is interesting that the one significant result for a propositional variant in the PS group is linked to an indirect rather than a direct or free indirect category. This observation may be suggestive of a broader tendency within the PS group to choose indirectness over directness, as I highlighted in the discussion of the results for RSA. I will return to this argument in the discussion of the thought presentation results. The second point concerns the degree of formality associated with writing presentation. In Chapter 5, in which I compared my corpus with those of Semino and Short (2004) and McIntyre et al. (2004), I discussed how writing presentation seems to be particularly associated with serious discourse and how the predominance of the more indirect writing presentation forms – in my corpus as well as in the other two corpora – may be due to faithfulness constraints and traceability of the (imagined) source (Short et al. 2002: 327). When the PSs choose a category that is less summarising than the forms that do not project propositional content (i.e. SRSA/WRWA/TRTA, SRV/WRN/TRT), the fact that they choose to do so by means of writing presentation, rather than speech or thought presentation, seems to maintain a certain level of formality and seriousness through the presentational mode itself.

Throughout the thesis, I have pointed out that the analytical distinction between speech presentation and writing presentation is a relatively recent elaboration of the Lancaster framework and that speech and writing presentation share more similarities in terms of phenomenological status and functions than is the case with thought presentation. If we turn to IS, this speech presentation form is often contrasted with DS (Pedersen 2009). Since IS suggests no change in footing, as is the case with Direct Speech, one of the functions of IS is to maintain the informational flow (Leech & Short 1981: 320). Consequently, whereas DS is often described as a dramatising and vividness-enhancing speech presentation form, IS is often referred to as the variant that is used for conveying factual information (e.g. Mayes 1990: 358). If we accept the notion of the close relationship between speech and writing presentation, it seems plausible that the factual function associated with IS is

also valid for IW, particularly given the contextual findings that writing presentation is closely associated with serious discourse. The finding that the PSs use IW significantly more often than do the general practitioners seems to lend further weight to the argument that the two speaker groups – by means of their choices of discourse presentation categories – convey rather different professional roles, in this case that the presentation of writing and factual information seems particularly prominent in the PS group. The significant result for the PS group could thus be indicative of how this group actually uses writing and of how aspects such as factuality and evidence in written sources – their own as well as those produced by others – may be particularly central to this professional group.

The manageable number of occurrences of IW allows for a closer look at the reporting verbs used by the two speaker groups:

Table 6.60: Reporting verbs for IW.

	GP occurrences	PS occurrences
Skrive (write)	6	4
Stå (say)	1	2
Sige (say)	1	1
Sende besked (send a message)	1	1
Anbefale (recommend)		1
Vise (show)		2
Registrere (register)		1
Råd om (advice about)		2
Forklare (explain)		1
Ifølge/i forhold til (according to)		2
Invitation til (invitation to)		1
Bruge sider på (spend pages on)		1

Fremgå (appear/say)		1
Kriterium (criterion)		1
Læse (read)		2
Total	9	23

I will not go into a detailed discussion of the individual realisations of the reporting verbs but will instead consider whether any realisation patterns are discernible when comparing the two groups. Of the GPs' nine instances of IW, six are realised by the most apparent writing presentation verb, *skrive* (Eng: *write*), which may be said to parallel *say* in the report of speech and *think* in the report of thought. The corresponding figure for the PS group is 4 out of 23 instances. The literature on reporting verbs and reporting signals has highlighted how a semantically neutral reporting verb may be said to indicate a low level of narrator or sender control. As far as speech presentation is concerned, there seems to be agreement that *say* is the most neutral reporting verb: "The reporter is apparently neutral in relation to the supposed saying, because s/he introduces it by using the verb *say*" (Caldas-Coulthard 1994: 295. See also Semino & Short 2004, Halliday 1994, Tannen 1989, Macaulay 2005). This also suggests that more semantically dense verbs leave a stronger trace of the reporter on the report and may therefore be seen as a means of influencing the report. The figures for use of the reporting verb *skrive* in the two speaker groups, in combination with a more varied and semantically specific use of other reporting verbs in the PS group – such as *registrere* (Eng: *register*), *anbefale* (Eng: *recommend*), and the noun *råd* (Eng: *advice*) – suggest that, by being more specific in their lexical choices, the PS group leaves a more visible trace in its reporting than is the case with the GP group's high frequency of the neutral *write*. This tendency echoes the findings from the previous section, in which I showed how the PSs use certain semantically specific realisations of RV significantly more often than do the GPs, leaving a more visible mark on the reported discourse. I also found *snakke/snak* to be a very frequent realisation of the RV category in my corpus, with the verb being used most evenly and consistently by the GP group. It seems that the two speaker groups leave differing degrees of imprint on the reported discourse they present. The different uses of reporting verbs in IW, in combination with the PS group's significant use of this writing presentation category, could strengthen to the notion that the PSs choose linguistic realisations that entail a greater level of formality, positioning them as the professional specialist group. In contrast, the GP group's choices more closely resemble what may be considered

vernacular everyday language, which is consistent with the idea of the general practitioner's position in the healthcare system.

6.3.3 THOUGHT PRESENTATION IN THE TWO SPEAKER GROUPS

FIT, IT and RTA

The results for the two speaker groups' use of thought presentation showed significance in three categories (FIT, IT and RTA). Two of these categories (FIT and IT) are significantly more frequent in the GP group. These are also two of the three significant categories that present propositional content. The test conflating the two most direct thought presentation forms (DT and FIT) also gave a highly significant result in favour of the GP group. In contrast, the summarising RTA is significantly more frequent in the PS group. This pattern closely resembles the one found in relation to use of speech presentation in the two speaker groups, with each speaker group occupying one end of the presentational scale. This time, however, an additional category (IT) also provides a significant result. In the following section, I will discuss these significant results in relation to the two speaker groups, leading to a possible explanation for these differences between the two groups of doctors.

The results for use of FIT in the two speaker groups showed this thought presentation category to be hugely significant in the GP group. In the overall findings, I found that the category was significantly more frequent in Semino and Short's written corpus but significantly more frequent in mine than in that of McIntyre et al. In Chapter 5's discussion of the discourse presentation results relative to contextual factors, I suggested that the predominance of FIT in Semino and Short's written corpus, combined with the low frequencies in the two spoken corpora, substantiates the argument that FIT is related to a written, literary tradition (McIntyre et al. 2004: 71-72). Semino and Short point out that the category is often used to "dramatise and foreground the protagonist's thoughts at particularly significant moments" and "to create sympathy or empathy at particularly heightened moments" (Semino & Short 2004: 126). These quotes emphasise FIT's function of pinpointing specific moments in the narration. Since the category holds such a strong position as a literary phenomenon, the significant proportion of FIT in the GP group raises the question as to whether the GPs' use of FIT adopts this function in their rendering of depression and of patients with depression. If we turn to the specific/non-specific distinction relative to FIT, the figures show

that only 10 out of 63 instances in the GP group denote specific occurrences. The figures for the PS group are 6 out of 20 instances, with no significant difference between the two groups. This suggests that the thoughts that are projected through FIT are non-specific, possibly habitual thoughts, which does not match the suggested function set forth by Semino and Short. However, the significance of FIT in the GP group does suggest that the GPs present apparently original thoughts in a less filtered form than do their psychiatric colleagues. If we accept Leech and Short's claim that IT is the prototypical means of presenting thoughts, as my corpus has confirmed quantitatively (see Chapter 5.2.5 and 5.3.3). FIT may be considered even more direct than its counterpart on the speech presentation scale, Free Indirect Speech: these movements associated with distance and closeness are linked to the prototypical forms on each of the two presentational scales. This means that, in speech presentation, the directionality is reversed: FIS on the speech presentation scale, which has DS as its prototype, may be seen as a move toward indirectness (see Chapter 2.5). According to the literature, including Semino and Short, FIS is often used as a distancing marker toward characters, frequently projecting irony or sarcasm; FIT, on the other hand, is often used as a marker of closeness and empathy toward characters (Semino & Short 2004: 124). In Bakhtinian terms, the GPs' renderings of thoughts are more dialogical than those by the PSs in that the presented thoughts are given space in the GP accounts in a manner that is impossible in the more summarising variants. Semino and Short find FIT to be the most employed of the proper thought presentation categories. However, a more extensive account of its use in non-narrative discourse is necessary to fully illuminate its function in this rather different context and is thus an area in need of further study. In 6.4.2, in which I consider use of speaker voices in discourse presentation, I will provide an example of how the category is put to use in my corpus.

In the overall results for IT, we saw that the category was significantly more frequent in McIntyre et al.'s corpus, whereas the statistical test showed no significance when compared with Semino and Short's corpus. These comparisons suggest that IT is not particularly predominant in my corpus relative to the other two Lancaster-based corpora. However, it still ranks second of all the thought presentation categories, with RTA being the most frequent. This ranking is replicated relative to the two speaker groups, with RTA being the most frequent category in both groups, followed by IT. According to Semino and Short, thought presentation seems to favour the more indirect categories due to its private and non-verbal mode (Semino & Short 2004: 114-118). The predominance of two of the indirect forms in both speaker groups seems to lend quantitative weight to this assumption, only it is the GP group that uses IT significantly more often than the PS group, and vice versa

relative to the even more indirect variant RTA. One of the central differences between the two forms of thought presentation is how much information they present to the audience: structurally, IT projects propositional content in a separate subordinate clause, through which the audience is presented with – if not the ‘wording’ of the thought – then at least some sort of summary (Semino & Short 2004: 127). RTA, in contrast, does not involve a separate propositional clause. This suggests that the distance between the assumed source and the reporting context is greater than is the case in IT. Given both the notion of prototypicality in thought presentation and the contextual variables, such as the serious, professional context in which the thought presentation is produced, the high frequencies of the indirect forms – overall and within the two speaker groups – seem to confirm the existing assumptions regarding thought presentation. The main difference between the two speaker groups is that they manifest the indirectness in different ways. The GPs provide more information by means of the propositional IT category and thereby position themselves closer to the assumed source. This tendency was further confirmed by the significance that we saw in use of FIT by the GP group. In contrast, the PS group choose the summarising RTA, indicating stronger speaker control and thereby less immediate access to the assumed original source.

In their account of thought presentation, Semino and Short note that, unlike RSA and RWA, RTA does not serve the same summary function as the corresponding categories on the other two presentational scales. RTA is instead often used to provide insight into what somebody is thinking at a particular point in time (Semino & Short 2004: 131). In my data material, I found that the vast majority of discourse presentation was realised as non-specific representations, with no significant difference between the two speaker groups. I also found that this tendency is even more prevalent for the summarising categories than in connection with the categories at the direct end of the clines. In the literature, RTA may be characterised as under-described relative to the more well-established thought presentation forms such as DT, FIT, and IT. RTA is the most frequent thought presentation form in my corpus, both overall level and relative to the two speaker groups. Despite its overall prominence, it is significantly more frequent in the PS group. I will thus now show how the category is put to use in this speaker group. This identification of the category’s function in a serious, non-narrative setting will also contribute to redressing the minimal attention the category has received in the literature compared to other thought presentation forms. The following example is an account by a psychiatrist. The account is encouraged by the interviewer, who asks the psychiatrist what kind of condition he considers depression to be:

Example 6.2

Dan:

1INT: så # n:år vi sådan: snakker om depressio:n # øh hv:ad tænker du! så på for en tilstand sådan
2# her hvor # fra hvor du sidder #

3INF: {jamen} for mig at se er det vigtigt a:t skelne melle:m # en depression det er
4behandlingskrævende # på med hospitalsregi <INT: # mm #> # elle:r en depression de:t # øh det
5kan behandles i almen praksis først og fremmest # <INT: # mm # mm> # øh # det opstår ved den
6nye situation her {a:t} øh # for nylig i: {i} regionen # det handler om: # at vi skal lave pakkeforløb

7INT: mm #

8INF: o:g # vi får jo # henvist en masse patienter som vi skal på en eller anden måde filtrere #

9INT: mm

10INF: så # øh det første jeg kigger på er # er! den her patient en patient der skal! behandles her #
11så tager jeg patienten med # <INT: # mm> # som regel! vil jeg sige er det typisk patienter det
12har! # øh # anamnese # med behandlinger # andre steder henne øh # <INT: # mm> øh i forvejen
13# så så typisk tager vi patienten med # <INT: # mm> # øh # når det er så sagt øh o:g # når det er
14den første samtale # øh så gennemgår jeg hele! # historien med patienten med henblik på at
15identificere hvilke faktorer # øh ikke kun de: øh # neurobiologiske faktorer men også <INT: #
16{mm} #> # de psykoterapeutiske faktorer det kan! # medregnes # i: patientens forløb #

17INT: mm #

18INF: øh # [rømmer sig] # en anden situation som er meget tipi- typisk for mig er at kigge på #
19har patienten # fået behandling i forvejen # med S_S_R_I'er # og det er sådan # meget! fokus jeg
20har på det # og patienten får på trods af det # {recidiverende} depressioner # så! tænker jeg på
21hvilke! alternativer jeg skal have øh i: # i baghovedet # med henblik på den farmakologiske
22behandling # <INT: # mm> # [smasker] # øh den tredje ting jeg kigger på # er # øh # sådan en
23timing mellem # farmakologisk behandling # og den psykoterapeutiske behandling # fordi je:g #
24{øh} det er jo det er jo så noget jeg har lært i: # i disse år # o:g # øh # som jeg har læst også:
25forskellige steder # at man skal gøre patienten klar til at modtage # et psykoterapeutisk forløb #
26øh # via den: antidepressive behandling #

27INT: mm # <INF: # [rømmer sig] med>

28INF: medicin # fordi # øh hvis patienten startes # samtidig på psykoterapi og medicin # så går!
det normalt ikke #

29INT: mm #

30INF: så det det er jo så noget jeg # jeg kigger på # så den fjerde! ting jeg ki- tænker på er
31hvordan forebygger jeg # at patienten får {et} tilbagefald # øh # og den tager jeg så i løbet af
32forløbet #

33INT: mm <INF: {øh}> #

34INF: selvfølgelig men: jeg # jeg kigger! jo # med den første samtale hvad er patientens
35beskæftigelse # hvad har patienten af baggrund # uddannelsesmæssig # øh social # øh civil
36status # øh arbejdsrelaterede elementer det kan! bidrage! med # at patienten fik depression #

37INT: mm #

38INF: eller! # det kan bidrage med at patienten ikke! får depression {igen} # <INT: # mm> #

39INT: mm #

40INF: øh # så # stresselementer {der} # øh det <INT: # ja #> kan betyde noget <INT: # ja #> #
41for patientens <INT: # ja # ja #> # øh sygdom # øh # en af de vigtigste ting # når jeg tænker på:
42psykoterapeutisk forløb er # at identificere i hvilken fase patienten er i livet # de:t er # hvis det
43handler om # unge personer der er i gang med a:t # begynde: # universitetsuddannelse <INT: #
44mm> #

45INT: [smasker] #

46INF: er det meget anderledes end at have patienter det har! # levet livet # og kommer # med en
47depression # med gentagne episoder {af} depression # som femogtresårige #

48INT: mm #

49INF: tilgangen er anderledes efter min mening # i <INT: # mm> forhold ti:l # ikke kun medicin
50men også den psykoterapeutiske: # tiltag # så # det er {det er} <INT: # så:> de aspekter jeg
51kigger <INT: # ja #> på # <INT: # ja> # øh når når jeg <INT: # {som:} #> taler første gang med
52patienten # <INT: # ja # ja> #

Example 6.2

Eng:

1INT: so # w:hen we like: talk about depressio:n # eh wh:at do you! then think of of a condition
2sort of # here where # from where you sit #

3INF: {well} in my view it is important t:o discern betwee:n # a depression that is requiring
4treatment # in with hospital <INT: # mm #> # o:r a depression i:t # eh it can be treated in primary
5care first and foremost # <INT: # mm # mm> # eh # it arises with the new situation here {tha:t} eh
6# recently i:n {in} the region # it is about: # that we must make a treatment programme #

7INT: mm #

8INF:a:nd #we get you know # a lot of patients referred who we in some way or other have to filter

9INT: mm

10INF: so # eh the first I look at is # is! this here patient a patient who must! be treated here # then
11I include the patient # <INT: # mm> # usually! I will say it is typically patients who have! # eh #
12a journal # with treatments # in other places eh # <INT: # mm> eh already # then then typically
13we include the patient # <INT: # mm> # eh # when that is said eh a:nd # when it is the first
14conversation # eh then I go through the whole! # history with the patient in order to identify
15which factors # eh not just the: eh # neurobiological factors but also <INT: # {mm} #> # the
16psychotherapeutic factors it can! # be included # i:n the patient's course #

17INT: mm #

18INF: eh # [clears throat] # another situation which is very tipi- typical for me is to look at # has
19the patient # gotten treatment already # with S_S_R_Is # and that is [sort of] # a lot! of focus I
20have on that # and the patient despite it gets # {recurring} depressions # then! I think of which!
21alternatives I must have eh i:n # in the back of my mind # with regards to the pharmacological
22treatment # <INT: # mm> # [smacks] # eh the third thing I look at # is # eh # sort of a timing
23between # pharmacological treatment # and the psychotherapeutic treatment # because I: # {eh}
24that is of course that is then something I have learnt duri:ng # during these years # a:nd # eh #
25which I have read also: different places # that one should make the patient ready to receive # a
26psychotherapeutic course # eh # via the: antidepressive treatment #

27INT: mm # <INF: # [clears throat] with>

28INF: medicine # because # eh if the patient is started # simultaneously on psychotherapy and
29medicine # then normally it does not work out #

30INT: mm #

31INF: so that that is of course something I # I look at # so the fourth! thing I lo- think of is how do
32I prevent # that the patient gets {a} relapse # eh # and that I will then deal with during the course

33INT: mm <INF: {eh}> #

34INF: of course but: I # I look! # with the first conversation what is the patient's occupation #
35what sort of background does the patient have # educationa:l # eh social # eh civil status # eh
36work related elements it can! contribute! with # the patient getting a depression #

37INT: mm #

38INF: or! # it can contribute with the patient not! getting a depression {again} # <INT: # mm> #

39INT: mm #

40INF: eh # so # stress elements {that} # eh it <INT: # yes #> can mean something <INT: # yes #>
41# for the patient's <INT: # yes # yes #> # eh illness # eh # one of the most important things #
42when I think of psychotherapeutic course is # to identify in which phase the patient is in life # i:t
43is # if it is about # young persons who are just # beginni:ng # university education <INT: # mm>
44#

45INT: [smacks] #

46INF: it is very different than having patients that have! # lived life # and come # with a
47depression # with repeated episodes {of} depression # as fifty-six-year olds #

48INT: mm #

49INF: the approach is different in my opinion # in <INT: # mm> relation to: # not only medicine
50but also the psychotherapeuti:c # initiatives # so # it is {it is} <INT: # so:> the aspects I look
51<INT: # yes #> at # <INT: # yes> # eh when when I <INT: # {that:} #> speak first time with the
52patient # <INT: # yes # yes> #

In this lengthy monologue, the psychiatrist describes the steps he takes in the process of identifying and treating depression. Characteristic of the account is that it contains a considerable amount of thought presentation. Apart from employing the more well-established forms (DT and IT), the account also contains several instances of RTA. In general terms, the account serves to identify the different steps the PSs go through when diagnosing and treating depression. As will become evident, all of these steps are conveyed by means of thought presentation.

The psychiatrist initiates the account by making an overall distinction, conveyed by RTA (1.3 'for mig at se er det vigtigt **at skelne**'). He uses this broad divide to distinguish between cases of depression that should be treated at a hospital and cases that are suited for treatment at a clinic. He proceeds by talking about the many patients who are referred to his clinic and about whom he must make a decision whether to treat in his clinic or send to the hospital. Here he employs the thought act *filter* (1.8 'vi får jo # henvist en masse patienter **som vi skal på en eller anden måde filtrere**').

The psychiatrist then begins habitually recounting his diagnostic approach, listing the four steps. The first step, which is a repetition of the overall filtering of patients presented in ll.3-6, is this time rendered as a habitual, iterative report, conveyed by DT (1.10 'så # øh det første jeg kigger på er # **er! den her patient en patient der skal! behandles her**'). He continues this first step by talking

about the initial consultation. Here we also have an instance of thought presentation, realised as IT (ll. 14-15 ‘med henblik på **at identificere** hvilke faktorer...’).

The second step concerns medication and is also initiated by an instance of DT (ll. 18-19 ‘en anden situation som er meget typisk for mig **det er at kigge på har patienten fået behandling i forvejen med SSRI’er**’). This step also comprises an instance of RTA (l.19-20 ‘fokus på’) and an instance of IT, with an embedded instance of RTA with a topic (ll. 20-21 ‘**så! tænker jeg på hvilke! alternativer jeg skal have øh i: # i bagehovedet # med henblik på den farmakologiske behandling**’).

The third step concerns the timing of therapy and medication and is initiated by an instance of RTA with a topic (ll. 22-23 ‘den tredje ting jeg kigger på # er # øh # sådan en timing mellem [...]’) and is also concluded by an instance of RTA (l. 30 ‘så det det er jo så noget jeg # jeg kigger på’). Interestingly, in between these two instances of RTA, the psychiatrist uses an instance of what I have annotated as FIW (ll. 24-26 ‘som jeg har læst også: forskellige steder # at man skal gøre patienten klar til at modtage # et psykoterapeutisk forløb # øh # via den: antidepressive behandling’).¹⁹ By employing writing presentation, the psychiatrist establishes a dialogue with another voice than his own. The written source is thereby treated as an authoritative voice guiding the psychiatrist’s approach to treatment. In 5.3.2, I touched upon how representations of writing are less frequent because the faithfulness claim is easier to validate in connection with presentations of writing. The function that the instance of writing presentation seems to have here is one of substantiation of the psychiatrist’s method. The literature has highlighted the evidence-claiming function of reported discourse in connection with DS (e.g. Holt 1996: 241). Even though the psychiatrist’s instance of writing presentation is not conveyed by the most direct form, I would still argue that it serves as evidence for his argument, especially if we accept Semino and Short’s claim that the epistemic values of speech and writing presentation largely overlap (Semino & Short 2004: 60). Leech and Short have also pointed to the contrastive, sometimes even oppositional, effect that may be invoked by the placing together of presentational modes (Leech & Short 1981: 335). The opposite, however, seems to hold in the present case, in that the psychiatrist’s use of a written source seems to support or validate his thoughts in the decision-making process.

¹⁹ This occurrence of FIW could also be either DW or IW. However, due to the reception perspective conveyed through *læse*, FIW seems a justifiable interpretation (also because *læse* does not count as a reporting clause since the PS is not the producer of the writing, and the free indirect forms often occur without a reporting clause. See Chapter 2.5.2 and 4.2). The fact that the sender is omitted allows for the psychiatrist to place himself at the reception end, by using *læse*. See Chapter 4.2 and 4.7 for a more detailed introduction to such ambiguous instances.

The fourth step is also conveyed by means of thought presentation, realised as another instance of DT (ll. 30-31 'så den fjerde! ting jeg ki- tænker på er hvordan forebygger jeg # at patienten får {et} tilbagefald # øh'). After the fourth step, the psychiatrist resumes talking about the initial screening of the patient, listing the different aspects that he considers (ll. 34-36). This is also conveyed through DT. He then adds another dimension to his account, namely identification of the patient's current life phase, which is conveyed through RT (ll. 41-42 'en af de vigtigste ting # når jeg tænker på: psykoterapeutisk forløb [...]') with an embedded instance of IT, which is conveyed by the reporting verb *identificere* (l. 42). He concludes his account by means of yet another instance of RTA (ll. 50-51).

The RTA category in the psychiatrist's account partly functions as an overall frame, i.e. as a means of opening and closing the account. DT is used to establish headlines in three out of four steps and may be said to have an overall introductory function. In these steps, RTA is mainly used to summarise each step. (By the end of this analysis, I will return to how these uses may be explained relative to the existing literature.) The one step in which DT is not used as an introductory statement is the point at which the account becomes more dialogical, in the form of the instance of FIW (ll. 24-26). Here, RT is used instead, and the psychiatrist may hereby be said to provide space for another, more direct form that does not belong to himself and that is used as an authoritative source, as suggested above. There are two other uses of writing presentation in the account (ll. 8 and 11-12). As we shall see in 6.4.2.3, other speaker voices than one's own often serve to oppose or contradict (see also Leech & Short 1981: 335). These uses of writing presentation are not ascribed to the psychiatrist's voice either and may be said to precede the psychiatrist's interaction with and treatment of the patient. Besides being presented distantly through summarising forms, these are not instances of external discourse that the psychiatrist allows to conflict with his own discourse presentation, which suggests that he maintains a highly authoritative position in his account.

If we turn to the use of speech presentation in this passage, we see that it is used only three times (ll. 11, 13-14 and 51-52), in contrast to the many instances of thought presentation. All three instances refer to consultations in which the psychiatrist interacts with the patient. The first instance is conveyed through the most summarising speech presentation form, RV (l.11). The second instance of speech presentation is also RV (l.13-14), which is embedded within the reporting clause, projecting an instance of DT. The final instance of speech presentation occurs as the final part of the turn (l. 51-52) and is grammatically subordinated to yet another instance of RTA by means of a hypotactical construction. All three instances of speech presentation have the psychiatrist himself as

the speaker, as was the case for all the instances of thought presentation. This means that, even though the three instances of speech presentation refer to his communication with the patient, the psychiatrist employs references that convey matters from his perspective alone. All three instances are also conveyed through the most summarising form (RV). This suggests that we – the audience – are presented with a strong filtering of the speech occurring during the consultation. The embedding and subordination of the presented speech furthermore enhances the distance between the reported content and the reporting context, i.e. the interview. These choices in combination (i.e. the choice of speech presentation form, the choice of speaker voice, and the embedding and subordination) give relatively little prominence to speech presentation and other's voices in the psychiatrist's account, thereby downtoning the communication with the patient in the diagnostic and treatment process and instead foregrounding the psychiatrist's observations and decisions.

In terms of speaker voice, to which I will return in 6.4.2, the analysis shows that the account is presented almost exclusively in the psychiatrist's own voice. The direct quotes that are employed are furthermore all quotes belonging to the psychiatrist himself. The account may be said to become more dialogical in terms of the visibility of the thought presented, achieved through use of DT, which leads to a strong and visible self. Ironically, this dialogical status may in turn be said to be heavily reduced, given that the instance of DT is in fact not somebody else's voice but is instead the psychiatrist's own.²⁰

In relation to writing presentation, the PS employs one other instance (1. 3) apart from the example of FIW discussed above. This instance is realised using passive voice, which functions to impersonalise the voice presented (Biber & Conrad 2009: 161). I will elaborate upon use of passive voice in the two speaker groups in 6.4.2.4, but for now we can conclude that the PS conveys writing presentation in a manner that does not conflict with his own – rather authoritative – voice. We also saw this in the omitted speaker in use of FIW. In Fairclough's terms, the account is heavily reduced with regard to *difference*: “Intertextuality opens up difference, whereas assumptions reduce difference. The most dialogical option would be to explicitly attribute representations to sources, to ‘voices’, and to include much of the range of voices that actually exists” (Fairclough 1992: 46). In

²⁰ As noted in Chapter 2, one branch in particular – represented by Tannen (1989), Clark and Gerrig (1990), Rathje (2009, 2011), etc. – takes a predominantly constructionist approach to discourse presentation. In the case of the psychiatrist's self-quotes, the constructionist approach would claim that the use of DT is not a matter of quoting oneself but of *constructing* oneself by means of the quoted discourse. In this view, it is possible to argue that a self-quote is just as much a type of quote as quoting anyone else, which results in a speech situation, in this case the research interview, being just as dialogical when using self-quotes. However, in the case of the psychiatrist's use of self-quote in DT, I wish to maintain the view that the account becomes less dialogical than if he had quoted another person's thought.

combination with the non-specific mode of the discourse presentation used, the psychiatrist manages to present what resembles a prototype-like procedure claiming a nearly universal position. I return to how the PS group employs this generic approach in the additional studies concerning the two groups of doctors' conceptualisations of depression and of patients with depression in Chapters 7 and 8.

This analysis suggests that the psychiatrist's use of discourse presentation serves to establish a role as a specialist observer. I have shown that these observations are largely established by means of the summarising thought presentation category (RTA), which among other things is used to frame the account. I have also shown that it is to some extent due to the interplay of discourse presentation forms and the category features associated with them – such as speaker voice – that the psychiatrist manages to establish this observational role with such firmness. In their description of RTA, Semino and Short note that this category does not have the same summary function as do the corresponding categories on the other two presentational scales (Semino & Short 2004: 131). I have shown that the psychiatrist uses RTA in part to frame his account of the treatment process. Furthermore, DT is used to exemplify this frame and is at the local level of introducing the steps used as headlines to announce the subsequent discourse. DT may thus be said to function as an overall introductory summary for each step. This function may be regarded as radically different from – almost the reverse of – the general assumption regarding the function of DT in the literature; here it is most often seen as a means of dramatic enhancement at narrative peaks (see Chapter 2).

As far as RTA is concerned, Semino and Short point out that one of the central functions of this category in their corpus is “to provide brief insights into what somebody is thinking at a particular time” (Semino & Short 2004: 131). In the psychiatrist's account, the tendency seems to be toward the opposite. The non-specific account presented is used, by means of iterative or habitual instances of RTA, to establish a notion of general observations, highlighting the procedural – rather than specific – aspects of approaching depression as an illness. The highly iterative mode stakes out a general truth claim, which is applicable to all consultations with patients and thereby underlines the specialist role, drawing upon what the psychiatrist establishes as a well-established ‘recipe’ to follow. This non-specific mode is actually the predominant mode of RTA in my corpus.

In Chapter 5.3.3, I pointed out how the frequency of RTA in my corpus differed from the two Lancaster corpora, in which the category was relatively infrequent compared to other forms of

thought presentation. Semino and Short say of RTA that it “is even less dramatic and immediate than IT, which may explain why it is a relatively infrequent form of thought presentation in our corpus, compared with NRSA(p) and NRWA(p)” (Semino & Short 2004: 131). If we recall my findings on RTA, I found it to be the most frequent thought presentation form overall as well as in both speaker groups and to be significantly more frequent in my corpus than in either of the Lancaster-based corpora. I also found that it is more frequent than both of the categories on the corresponding presentational scales. On the basis of the above analysis of the psychiatrist’s account, I believe that I have shown how the category may be utilised when there are other communicative purposes to fulfil than those suggested by Semino and Short. Semino and Short also found, however, that RTA was slightly more frequent in serious genres than in popular genres (Semino & Short 2004: 123). My data confirms this observation by pointing to RTA as being more frequent than the other thought presentation categories and more frequent in the PS group than in the GP group. The highly serious and almost recipe-like account shows how a highly professional context may embrace use of RTA, apparently for quite different purposes than those suggested by Semino and Short.

However, the employment of RTA for observational and decision-making purposes, as shown in the psychiatrist’s account, does not fully encompass the uses of this highly frequent category in my corpus. In the section on speaker voices in 6.4.2.1, I return to central uses in connection with the first person singular in the GP group and suggest that these seem to be rather different than those in the PS group. Clearly, more research is needed into how thought presentation is used in non-narrative, serious discourse, but I believe that the present analysis, among other things, has shown that we cannot assume the same functions across different contextual settings.

6.3.4 SUMMARISING THE DISCOURSE PRESENTATION FINDINGS

This initial discussion of the overall significant results for discourse presentation as well as central lexical realisations and uses provides initial insights into the two speaker groups’ different means of presenting speech, writing, and thought: from the doctors’ interactions with patients, between actors in the healthcare sector, and in terms of their thoughts, decisions and reflections related to depression.

The two speaker groups show distinctly divergent patterns: they have oppositional placements on the discourse presentation scales; differing lexical choices in speech presentation denoting doctor-patient interaction; different levels of formality in use of reporting verbs in writing presentation; and differing uses of thought presentation, in which the PSs position themselves as observers rather than participants in the consultations. These results provide the first building block in an argument that will be elaborated in the discussion in the subsequent sections. Here, the category features come to play a central role in substantiating and nuancing the overall findings on discourse presentation. I argue that these added linguistic features are able to provide solid, quantitative evidence for patterns that would otherwise have been left unilluminated.

6.4 GP AND PS DISCUSSION: CATEGORY FEATURES

In this section, I discuss the results for use of category features in the two speaker groups. Category features may be perceived as a linguistic framing of the discourse presentation instances. My assumption is that an analysis of these features will be able to anchor and nuance the two groups of doctors' use of the presentational modes and thereby inform understanding of the quantitative results of the discourse presentation categories for the two speaker groups presented in the first part of this chapter.

In Chapter 6.2, I presented the results for the tests for significance for the following five category features:

- 1) Hypotheticality, i.e. whether the instance is presented as real/positive or hypothetical/negated
- 2) Genericity, i.e. whether the instance is presented as a specific occurrence or a general one
- 3) Embedded discourse presentation, i.e. whether a given instance of discourse presentation is layered within another instance of discourse presentation
- 4) Speaker reference, i.e. the sayer, writer, or thinker associated with the presented discourse
- 5) Interactional discourse presentation.

In terms of genericity, the results showed no significant differences between the two speaker groups, and not all speaker voices showed significant differences. In the following sections, I

approach the discussion by focusing on the results that are significant. It should be noted, however, that when combined with other category features, genericity in some cases becomes relevant and will be treated as part of the fine-grained trajectories enabled by the deep-coding of my corpus.

The frequencies for embedded and interactional discourse presentation in my corpus are relatively sparse and produce only little significance. Because of this, I discuss these two phenomena briefly at the end of this chapter. Instead, I give more space to the features with more prominent results.

6.4.1 HYPOTHETICAL DISCOURSE PRESENTATION IN THE TWO SPEAKER GROUPS

Only two tests for hypotheticality showed significant differences: in relation to RWA, the GPs used the sub-variant *hypothetical negated* significantly more often than did the PSs, and in relation to RTA, the GPs employed the sub-variant *hypothetical proper* significantly more often than did the PSs. This sub-categorical approach to hypothetical discourse presentation shows how a more fine-grained annotation of realisations explicitly denoting non-real instances of discourse presentation permits insight into functions of discourse presentation of what was not said, written or thought. In fact, had I only tested the two groups' use of hypotheticality overall, I would have had no significant results to discuss. Thus, I believe to have empirically qualified Semino and Short's suggestion that hypothetical discourse presentation might benefit from a division into different types of hypotheticality, which is something their study does not investigate systematically (Semino & Short 2004: 159ff).

As the statistical tests for hypothetical discourse presentation in the two speaker groups only produce two significant results, an investigation of these two results is manageable and may contribute insight regarding possible differences in the two speaker groups' understandings of depression. In this section, I also investigate how speaker voices are operationalised in connection with the significant hypothetical categories. I have chosen to include the analysis of voices here since the primary discussion of speaker voices in discourse presentation in 6.4.2 will focus mainly on discourse presentation categories rather than category features.

6.4.1.1 Hypothetical negated in RWA

A look at the writing acts associated with the negated use of RWA shows that in the GP group use can be grouped under the following three types of writing acts: prescribing medicine, referring patients, and coding patients on a rating scale:

Example 6.3

Dan:

og der der har vi nok # har vi et godt horn i siden på psykiatrien altså # når de kommer hjem med
<INT: # {det øh} #> med tre forskellige slags: antidepressiver og lidt til natten <INT: # ja #> og lidt
til <INT: # ja> dagen og lidt til # <INT: ja : ha> # det s- det # <INT: # oplever du det> **det skriver
vi ikke ud ja** # <INT: # ja> # (GP6)

Eng:

and there there we probably have # we hold a good grudge against psychiatry you know # when
they come home with <INT: # {it eh} #> with three different kinds: of antidepressants and a bit for
the night <INT: # yes #> and a bit for <INT: # yes> the day and a bit for #INT: yes: ha # it s- it #
<INT: # do you experience that> **we don't prescribe that yes** # <INT: # yes> (GP6)

Example 6.4

Dan:

I_C_D_ti # den s- # siger de her # ting skal være til stede og det skal kun have varet fjorten dage #
så har vi en depression # det holder ikke vand fordi det tit viser sig at det er gået over og så havde
jeg det s- og sådan **det var da godt at jeg ikke henviste her** fordi # så er det fordi det har været
meget så skal det være fordi at depressioner godt kan være så korte # det kan! de måske også <INT:
mm # mm> altså i min gam- min verden der var depression noget der tog tid!

Eng:

I_C_D_ten # it s- # says these # things must be present and it must only have lasted fourteen days #
then we have a depression # it doesn't hold up because it often turns out that it has passed and then I
felt s- and so **it was quite a good thing that I didn't refer here** because # then it is because it has

been a lot then it would be because depressions can be so short # they can! perhaps also <INT: # mm # mm> well in my ol- my world depression was something that took time!

Example 6.5

Dan:

der er da også mange gange hvor jeg ikke bruger det [spørgeskema; HSP] # hvor vi bare har en snak # hvor jeg ikke # og og hvor jeg derfor ikke tager ydelsen så # øh # **så jeg bruger det ikke som fast # øh rutine** men: øh s:- # i stress der synes jeg igen at en en en: øh # indledende øh sådan problemformulering #det synes jeg skelner! meget godt imellem hvad der er stress og hvad der er # er rigtig # depression (GP7)

Eng:

sure there are also many times where I don't use it [questionnaire; HSP] # well where we just have a talk # where I don't and and where I therefore don't charge the service so # **so I don't use it as a fixed routine** but: eh s:- # in stress again I think that one one one: eh # preliminary eh sort of problem statement I think that discerns! quite well between what is stress and what is # is real # depression (GP7)

The writing acts put forward in the GPs' negated use of RWA may be characterised as highly institutionalised writing acts, i.e. standardised routines of written communication in the healthcare sector. The significant use of the negated variant in the GP group indicates that this group of doctors presents these writing acts negatively as something they do not do – and makes such presentations significantly more often than does the PS group. Rather than focusing on what actually does happen in the process of performing these writing acts, the GPs describe the writing acts in terms of absence or non-action. The negated paradigm suggests that the GPs project an image of how they do not wish to be conceptualised and with that an implicit image of how things or people ideally should be. The significant use of negated writing presentation could suggest that the doctors in the GP group use negated presentations of writing acts to project a movement away from the formalised procedures in the healthcare system, for example as indicated in Example 6.3, in which the GP states that he does not use the rating scale as a set routine. To take this argument a step further, it is

interesting that it is precisely the writing *act* category that provides a significant result relative to the negated variant, rather than any of the other writing presentation forms. As noted in 3.1.2, the treatment of patients in general practice is based on criteria formulated in the psychiatric sector. This suggests that the GPs must follow guidelines that they perceive as potentially ill-suited for their context. Choosing to negate the very category that denotes institutionalised writing processes seems to further underline the distance between the GPs and the structural frame in which they conduct their profession.

Any negated use of discourse presentation, though produced by the GP in the interview situation, could of course also refer to other voices than that of the GP himself, thereby indicating that it is other voices that account for the negated use of RWA. However, if we turn to use of voices in the negated variant of RWA, the distribution patterns by the two speaker groups are listed in Table 6.61:

Table 6.61: Voice in RWA, negated.

Category	GP	PS
1 st singular	12	0
1 st plural, doctors – own group reference	5	3
3 plural, patients	0	1
3 plural, doctors, other group	0	1
Noun	1	1
Passive	1	1
Adjective	2	0
Total	N = 21	N = 7

In the PS speaker group, of the seven instances of negated RWA, three are realised as *first person plural, own group reference*, and the remaining four are distributed among other speaker categories, denoting voices that do not involve the PSs themselves. Proceeding to the GPs who are responsible for the significantly more frequent use, we see that all but 4 out of 21 instances refer to the GPs themselves. 12 of these 17 self-referring uses are realised by the first person singular. In the overall

results for use of voices in the two speaker groups, first person singular reference proved significant in the GP group. This predominant use in the GP group is also reflected in the negated variant of RWA. The result for use of voices in the corpus furthermore showed that *first person plural, own group voice* was used significantly more often in the PS group. However, relative to the negated variant of RWA, we see that the GPs actually use this type of reference more often than do the PSs (5 vs 3 instances), adding to the understanding that the GPs predominantly choose references involving themselves. The analysis of voice in connection with the negated variant of RWA thus suggests that the rendering of institutionalised writing acts in negative terms is primarily associated with the GPs themselves. This rather clear pattern may contribute to the argument that the GPs present themselves as possessing reservations with regard to being part of an institutionalised frame that is to some extent defined by the psychiatric sector and that the GPs do not necessarily regard themselves as included within (Davidsen & Fosgerau 2014a). In addition, this result indicates a stance as strong independent subjects vis-à-vis ‘the healthcare system’. These arguments will be elaborated upon in Chapter 7, in which I examine how the two groups of doctors use depression terminology.

6.4.1.2 Hypothetical proper in RTA

The other significant result for hypothetical discourse presentation in the two speaker groups is found in the variant *hypothetical proper* in RTA. As was the case with use of negated RWA, the GP group uses this variant significantly more often than does the PS group. In the overall comparison of RTA, the result for the PS group was highly significant for frequency of use, implying a reversed significance relative to this hypothetical category use. The following examples illustrate use of the variant *hypothetical proper* in RTA in the GP group:

Example 6.6

Dan:

altså jeg kunne godt tænke mig at det var mere enstrenget og så # ud fra de symptomer jeg beskrev så var der nogen der visiterede så man rim- # patienter rimelig hurtigt kom til en eller anden form for forvisitation derude (GP8)

Eng:

well I would like for it to be more uniform and then # from the symptoms I described **then there was someone who assessed so one pre- # patients pretty quickly came to some sort of pre-assessment out there** (GP8)

Example 6.7

Dan:

vi skal ikke sende alle # til psykolog eller vi skal ikke sende alle <INT: mm #> til psykiater og så videre vel <INT: # nej> der er mange som vi har snakket om som vi selv tackler # men der hvor vi synes at # av # der er # de:t der er jeg faktisk noget utryg # **der skal vi have mulighed for at have en hurtig vurdering hos # <INT: # ja> # hos en som # også! kan følge det op #** (GP7)

Eng:

we shall not send everyone # to psychologist or we shall not send everyone <INT: mm #> to psychiatrist and so on right <INT: # no> there are many as we have talked about that we tackle ourselves # but in cases where we think that # ouch # there is # tha:t there I am actually somewhat uncomfortable # **in such cases we must have the opportunity to have a quick evaluation with # <INT: # yes> # with someone who # also! can follow it up #** (GP7)

The *hypothetical, proper* variant is concerned with imagined scenarios, expressed for example as a wish for change in the healthcare system, as in Example 6.6, in which the GP would like to the screening procedures to be handled differently, and in Example 6.7, in which the GP expresses a desire for the opportunity to receive expert advice if in doubt about the diagnostic process. As was the case for negated RWA, I have looked at the voices that are employed to realise the hypothetical instances of RTA. See Table 6.62 below:

Table 6.62: Voices in RTA, hypothetical proper.

Category	GP	PS
1 st singular	2	1
3 rd singular, patient	2	1
3 rd singular, doctor, unspecified	2	0
3 rd singular, GP	2	0
3 rd singular, other voice	1	0
1 st plural, own group	2	0
3 rd plural, patients	1	1
3 rd plural, own group	0	1
3 rd plural, doctors, other group	1	1
3 rd plural doctors, own + other group	1	0
Noun	5	1
Infinitive	0	1
Adjective	1	1
Total	N = 20	N = 8

In negated RWA, we saw a clear tendency in the GP group to use first person, with the majority realised as first person singular, followed by first person plural, own group reference. In relation to *hypothetical, proper* in RTA, the distribution pattern is more diverse in that only 2 out of the 20 occurrences are first person singular, while 2 are first person plural. If we consider third person realisations, 10 out of the 20 occurrences are realised as third person. This means that the heavy first person focus in the negated variant of RWA is replaced by other voices than those including the GP himself in the hypothetical use of RTA. As will become clear in the section on voices, the GPs' use of first person singular is highly significant when compared with the PS group. This makes the very low frequency of first person singular in *hypothetical, proper* seem even more

noteworthy. In short, it seems that, although the negated variant of RWA served as a marker of the GPs' own reservations or resistance, the hypothetical use in RTA does not manifest the GPs' own doubts or wishes; it is instead used to depict how other parties in the healthcare system could – and perhaps should – do things differently. In this light, it could be argued that the GPs do not present themselves as gamechangers, focusing instead on how other actors in the healthcare sector could carry out this function.

Semino and Short only approach hypothetical discourse at an overall level and not in relation to subtypes of hypotheticality (Semino & Short 2004). My analysis has shown that it is possible to increase explanatory potential when hypothetical discourse presentation is broken down into subcategories. This divide has proved particularly fruitful in my analysis because no significant result was found at the overall hypothetical level and because the significant sub-results in *RWA, negated* and in *RTA, proper* proved to be applied for rather different purposes. The added analysis of speaker voices in hypothetical uses of discourse presentation helped bring about this insight, strengthening the argument that a discourse presentation analysis with additional linguistic features is highly useful.

6.4.2 VOICES IN THE TWO SPEAKER GROUPS

Introduction

This parameter, involving whose speaker voice is being presented in the discourse presentation, is thematised neither by Semino and Short (2004) nor by McIntyre et al. (2004). However, it might be useful in a context-specific corpus such as mine because an approach of this kind would allow me to discuss how the two speaker groups assign roles in the doctor-patient relationship, i.e. different patient roles as well as different professional roles. There are accounts that include the analytical dimension of voice, the speaker (Thompson 1996, Møller 1994, Fairclough 2003, Tannen 1989). Apart from Møller, they are, however, not quantitatively operationalised, and they use different – often more abstract – categories that are difficult to apply quantitatively.

I will focus on the categories providing a significant result since the recurrent theme throughout this chapter is the differences between the two speaker groups. There will be four parts, grounded in the significant results:

- The doctors' own voices
- Other professional group voices
- The patients' voices
- The hidden voices: passive and zero voice.

6.4.2.1 The doctors' voices: first person singular and first person plural

I will devote considerable space to use of self-reference, especially first person singular. My motivation for doing so is that first person reference is one of the most frequent categories in my corpus. It is furthermore one of the categories providing the most significant results, also when considering sub-results for specific categories.

The results for the two groups' use of *first person singular* showed that the GPs employ this voice significantly more often than do the PSs. In contrast, the results for *first person plural, own group voice* showed that the PSs use this voice significantly more often than do the GPs. This suggests that, in terms of self-reference, the groups each occupy a particular domain of presenting discourse. I would argue that these different choices of self-reference place the two groups in different positions when speaking about – and thereby expressing understandings of – depression. It is this argument that will be explored in the following discussion of the two groups' uses of self-reference.

On the basis of the results from Chapter 6.2.4, the following table summarises the significant results in the two groups for first person reference:

Table 6.63 Significant results in connection with first person

	GP	PS
1 st person singular overall	x	
1 st person singular + RSA	x	
1 st person singular +	x	

Writing Presentation		
1 st person singular + RWA	x	
1 st person singular + Thought Presentation	x	
1 st person singular + IT	x	
1 st person singular + RTA	x	
1 st person singular + RT	x	
1 st person plural own group voice, overall		x
1 st person plural + Speech Presentation		x
1 st person plural + Thought Presentation		x
1 st person plural + IT		x

In the overall discourse presentation results, we saw that the GPs' use of discourse presentation was significant relative to the categories FIS, FIT, and IT. As far as first person reference is concerned, the GPs' use is not significant relative to either of the two free indirect categories, but the significance of IT is replicated when paired with first person singular. This suggests that the two categories FIS and FIT are used for other purposes than presenting the doctor's own voice. Since the two free indirect categories are not significant for the GP group's use of first person singular, I

will not undertake a deeper discussion of their uses and functions but will simply conclude that these otherwise-significant categories in the GP group are not used with first person voices. Use of speaker voice in FIS and FIT will be discussed in Chapter 6.4.2. The significance of IT in the GP group, which is replicated relative to first person singular, will be discussed below. First, however, I will consider other results relative to first person singular reference in the GP group.

The overall discourse presentation results indicated that the summarising categories RSA and RTA were used significantly more often by the PS group than by the GP group. Interestingly, relative to first person singular, these two categories as well as the third equivalent on the writing presentation scale (RWA) are all used significantly more often by the GP group when it comes to first person singular. These results thus reverse the significances from the overall uses of the summarising categories RSA and RTA. The finding that overall significances in the PS group are reversed when it comes to use of first person singular emphasises the strong presence of an individual or personal voice within the GP group. I will elaborate upon this argument when I have presented the PS group's use of self-reference. If we consider occurrences at the level of the presentational clines, the first person singular relative to the total amount of writing presentation as well as the total amount of thought presentation in the GP group also show significant results. In fact, 8 out of 19 tests (the overall use of first person singular relative to the three discourse presentation clines overall as well as relative to the categories belonging to each cline) show significant results for the GP group when compared with the PS group. Most of the significant results are found relative to thought presentation, which indicates a particularly strong connection between first person and thought presentation in the GP group. In the section below dealing specifically with the GPs' use of first person singular in thought presentation, I will further discuss uses and possible explanation for these uses.

On a more general note, the significance of first person in the GP group could suggest other tendencies: by choosing the voice of first person singular, the GP presents himself as an individual more than as a part of an institutionalised healthcare sector – or at least, his own voice is enhanced within the institutional frame. In addition, first person singular reference conveys a subjective perspective, claiming a particular – rather than a universal – approach: “This is how *I* communicate, this is how *I* think.” In this respect, the GP only speaks and thinks for himself, rather than on behalf of, say, the healthcare system, which incidentally could also open the door for divergent opinions within the GP group as a whole.

If we compare this with the PSs' use of singular self-reference, the contrast is remarkable in that none of the discourse presentation categories or clines (totalling the aforementioned 19 possible significances) are significant in the PS group's use of first person singular. This suggests that the PSs simply do not mark themselves as individuals to the same extent as do the GPs. Taking into account the interview context, the observation that all the significant results for first person singular belong to one speaker group is a rather prominent finding: the interviewer often explicitly states that she is not seeking any particular answers and that there are no right or wrong answers since she is more interested in the doctor's view or opinion on the matter:

Example 6.8

Dan:

1 INT: # for det jeg så gerne vil # snakke lidt med dig om det er hvordan du! overhovedet

2 tænker! om depression hvad du tænker det er for en # tilstand #

3 INF: puha det var sørme! svært <INT: # ja ha> at svare <INT: # ja> på #

4 INT: der er nok ikke noget entydigt svar <INF: # øh #> #

5 INF: øh # jeg tror ikke at øh # altså hvad mener du med depression egentlig!

6 INT: øh j:a men det er jo ogs:å {et} ha **det er du også! velkommen til at sige hvad du! mener**

7 **med depression ikke** {rig-} <ESE: # ja altså {ja}> (PS2)

Eng:

1 INT: # because what I then would like # to talk a bit with you about that is how you! even

2 think! of depression what you think it is of a # condition #

3 INF: phew that was really! difficult <INT: # yes ha> to answer <INT: # yes> #

4 INT: there probably isn't a clear answer <INF: # eh #> #

5 INF: eh # I don't think that eh # well what do you mean by depression actually!

6 INT: eh y:es but it is of course also: {a} ha **you are also! welcome to say what you! mean by**

7 **depression right** {re-} <INF: # yes well {yes}> (PS2)

Example 6.8 is the opening of an interview with a psychiatrist. The interviewer introduces a question concerning the psychiatrist's perception of depression by choosing the verb *tænker* (think), here denoting opinion, as well as emphasising the *du* (*you*) in her elicitation (ll.1-2). The psychiatrist responds by expressing his uncertainty as to how to answer the question (ll. 3 and 5). The interviewer then rephrases the question by encouraging the psychiatrist's personal opinion, again with an emphasis on *du* (ll. 6-7). This interview style, I would argue, explicitly encourages a high degree of subjectivity in the doctors' contributions. Bearing in mind this contextual frame, it seems even more significant that the GPs so consistently excel in use of the first person singular voice and also that this subjective marking displays such great differences between the two speaker groups. I will return to the issue of how the interactional context and the doctors' linguistic choices combine in the chapter dealing with the accounts of a typical patient with depression in Chapter 8 as well as in a broader discussion of interactional aspects related to use of discourse presentation.

A question that inevitably arises from the finding that the GP group uses the subjective voice significantly more often than does the PS group is: What do the PSs do instead to bring their own voices into play? In the annotation of plural voices, I chose to distinguish between whether the reference is exclusive to one's own group or whether it includes other participants as well. This distinction was upheld in order to pinpoint uses presenting the doctor's own professional group and thereby capturing plural renderings of a purely professional voice. This also made possible a comparison with use of singular self-references. The results for the annotation of the category *first person plural, own group* showed that the PS group employs this speaker voice significantly more often than does the GP group. Of the 19 tests for significance, 4 provide a significant result, all in favour of the PS group, whereas none of the tests for the individual categories are significant in favour of the GP group. This pattern suggests a similar tendency as in the GP group's use of first person singular, namely that it is on the thought presentation cline that we find many of the significant results in the PS group's use of *first person plural, own voice*: three of the four significant results are found relative to this presentational cline. From a distributional perspective,

the GPs may be said to consistently prefer first person singular voice, whereas the PS group prefers the category *first person plural, own group voice*. The study in Chapter 7, in which I examine the two speaker groups' uses of depression terminology, confirms this speaker voice pattern.

Category-specific uses in connection with first person reference

Because use of first person singular and plural carry so much significance, I will consider how the significant results at category level relative to first person reference are put to use. This is also motivated by the finding that a number of the significant results found in the overall comparison of the two speaker groups are reversed relative to first person. I expect this fine-grained approach to the findings at category level to illuminate in even greater detail how the two groups of doctors choose to present themselves and, by means of discourse presentation, position themselves in the healthcare system and toward their patients.

RSA: first person singular and first person plural

I have already noted that the PS group's significant use of RSA in the overall comparison of the two speaker groups is reversed in use of first person singular, now being significantly more frequent in the GP group. The question arising from this reversal is thus: What do the GPs use this speech presentation category for when rendering their own voice? To approach this question, I have considered the actual speech acts employed by the GP group:

Table 6.64: GP speech acts in first person singular.

Speech act	Number of occurrences	Context of communication: Doctor-patient relationship	Context of communication: Communication with other parties
Spørge / Ask	9	x	
Tilbyde / Offer	6	x	
Bud på / Suggestion	2	x	
Foreslå/foreslag	3	x	

/Propose/suggestion			
Anbefale / Recommend	1	x	
Sende videre /Send forward	4	x	
Ønske /Wish	1	x	
Gå ind I /Go into	1	x	
Lykkes at få nogen til at / Succeed in making someone	1	x	
Ikke presse på / Not insist	1	x	
Ikke insisterende /Not insisting	1	x	
Sige nej til/ Say no to	1	x	
Følge op/follow up	1	x	
Konferere med / Confer with	1		x
Total	33		

This table shows the lexical realisations of RSA. I have distinguished between whether the represented speech act refers to doctor-patient communication or whether it refers to other communication contexts. What becomes clear from this analysis is that 32 out of 33 instances denote contexts of doctor-patient communication. The use is here exemplified by a GP who speaks about using a questionnaire in his consultations:

Example 6.9

Dan:

jeg ved godt Hamilton egentlig først skal bruges længere henne men nogle gange så bruger jeg den jo også for <INT: mm #> # om ikke andet så får jeg spurgt om de ting jeg skal spørge om (GP8)

Eng:

I do know Hamilton actually should first be used further along but sometimes I use it also to <INT: mm #> # **if nothing else then I get to ask about some of the things I must ask about** (GP8)

The finding that all but one of the instances refer to the consultation setting establishes a GP role that is highly focused on interaction with the patient. The lexical choices made in first person singular realisations of RSA match another result in the GP group, namely use of the shared doctor-patient perspective, realised by the category *first person plural, shared voice*. In 6.4.2.1, I argue that this shared voice substantiates the tendency for the GP group to convey a patient-oriented understanding of depression.

These findings for the GP group contrast with the choices made by the PSs when presenting their own voices. The plural *we*, which is significantly more frequent in the PS group, suggests that the PSs choose grammatical categories presenting them as representatives of a professional group rather than as a singular person interacting with the patient. The predominance of *we* may be said to enhance the distance in the interaction between doctor and patient since it is the individual PS does not speak as a person but instead as a group of professionals. Let us turn to how the PS group employs its significant self-referential voice, *first person plural, own group reference* in connection with RSA. As noted above, the test for use of RSA in connection with first person plural did not provide a significant result in the PS group. The significance is instead found at the overall level of speech presentation, which suggests that the significance is distributed across the different speech presentation categories. However, in order to compare with the GPs' use of RSA, I have extracted the speech acts employed in connection with *first person plural, own group reference* for the PS group. The speech acts are listed in Table 6.65 below:

Table 6.65: PS speech acts in first person plural, own group reference.

Speech Act	Number of occurrences	Context of communication: Doctor-patient relationship	Context of communication: Communication with other parties
------------	-----------------------	--	---

Kalde ind / Call in	1	x	
Ikke bare sende ud i ingenting / Not just send away into nothing	1	x	
Spørge / Ask	1	x	
Rådgivende kontakt / Advisory contact	2		x
Rådgive / Advice	2		x
Udspørge / Question	1	x	
Spørgsmål / Question	1	x	
Tilbud / Offer	4	x	
Afslutte / End	2	x	
Total	15	11	4

Of the 15 instances, 11 refer to the PSs' communication with their patients, and 4 refer to other communicative contexts, mainly with other professionals, such as GPs or fellow PSs. A Fisher Exact test for the two groups' uses of RSA in those denoting patient interactions vs those not denoting patient interactions shows a significant difference (p -value: 0.0281). This significant finding adds strength to the finding that the GP group displays a highly patient-centric focus. And if we compare the two groups' uses of first person singular, the tendency is the same: the PS group produces a total of 16 instances, and over a third of these refer to communication with other parties than the patient (6 instances). One of the PS groups' typical uses of RSA in first person plural portrays this group of doctors as giving advice and providing guidance to other professional groups:

Example 6.10

Dan:

INT: for jeg tænker har I no: get samarbejde! me:d er der noget samarbejde med de # praktiserende læger eller med de praktiserende psykiatere eller #

INF: øh ja! altså det er der jo der er jo masser a:f telefonisk kontakt # <INT: # ja> #

INT: ja #

INF: altså **vi har jo masser af rådgivning!** #

INT: ja #

INF: altså hvor både de praktiserende læger og de praktiserende psykiatere # ringer ind #

Eng:

INT: because I am thinking have you any collaboration! with is there any collaboration with the # general practitioners or with the practising psychiatrists or #

INF: eh yes! well there is of course there is of course plenty of telephone contact # <INT: # yes> #

INT: yes #

INF: well **we do have lots of guidance!** #

INT: yes #

INF: well where both the general practitioners and the practising psychiatrists # call in #

The tendency in the PS group's use of RSA to refer to communicative contexts involving doctors alone – especially those concerning communication with GPs – could be said to enhance the specialist position characteristic of the PS group.

To strengthen the argument that self-reference in RSA is used rather differently in the two speaker groups, it may be useful to consider the actual speech acts presented. One of the most common speech acts is *ask*, indicating a search for information. This speech act is used in 9 out of 33 instances by the GP group when using the significant self-referential voice, first person singular. All 9 instances are verbal realisations, indicating a focus on the process of asking. In the PS group, the same speech act realised as a verb is only used in 1 instance out of 15 in its preferred voice category, first person plural. One further occurrence is realised as a noun (*spørgsmålene*/Eng: *the questions*), and in one instance the stronger verb *udspørge* (Eng: *question*) is used. What these very different patterns in the speaker groups may tell us is that the two groups of doctors seem to have

different approaches to the patient. The relative prevalence of *ask* in the GP group compared to the PS group suggests a focus in the GP group on the patient's own contribution in the consultation, whereas this focus is less visible in the PS group.

Another interesting difference is found relative to the speech act *tilbyde* (Eng: *to offer*) and the nominal variant *tilbud* (Eng: *an offer*): in the GP group, the verbal realisation is used in 6 out of the total of 33 instances of RSA in first person singular. In the PS group, the nominal variant *tilbud* occurs 4 times out of the total of 16. The fact that the PS group chooses the static nominal realisation results in a less dynamic rendering of the speech act. This may be an expression of the established treatment provided by the psychiatric sector (also indicated by the plural *we*), rather than a more dynamic process of offering, as established by the GPs' verbal use of the speech act. The PSs possess a specialist function, and their linguistic choices seem to maintain a great degree of certainty in their approach to patients.

In addition, the PS group employs speech acts such as *indkalde* (*call in*) and *afslutte* (*finalise/complete*). These speech acts are associated with structural aspects of handling patients, rather than denoting actual interactional speech acts. If we return to the remaining speech acts in the GP group's use of first person singular, these are *foreslå* (*suggest*), *anbefale* (*recommend*), and *ikke insistere* (*not insist*). The illocutionary force of these speech acts seems more tentative than the ones used by the psychiatrists. Moreover, all of them refer to the actual interactional patient-doctor setting rather than being speech acts referring to more institutional or structural communicative aspects.

These different lexical choices in RSA for the two speaker groups may be explained in terms of the different structural levels from which they carry out their profession: the psychiatric sector may be said to be a specialised and more established system, with set procedures when it comes to dealing with patients suffering from depression, whereas this is much less the case in general practice (Daviden & Fosgerau 2014a). The two groups' different uses of RSA echo the overall finding that, when presenting their own voice, the PS group chooses to do so at a professional group level and significantly more often than do the GPs, who present themselves as individual entities rather than as professional representatives of the healthcare sector.

In the following section, I will consider another significant result in the GP group, which is use of first person singular in connection with RWA.

First person singular and RWA

The overall results showed that the GPs produce 96 instances of RWA, and the PSs produce 76 instances, with no significant difference between the two speaker groups. In terms of first person, the results did, however, show a significant difference, with the GPs again employing this variant significantly more often than do the PSs (33 vs 9 instances). The test for the negated variant of RWA also showed a significant difference between the two speaker groups, with the GPs employing this form significantly more often than do the PSs. The GP group produced 21 instances of the negated variant, whereas only 7 instances occurred in the PS group. Of the 21 negated instances in the GP group, 12 are realised by first person singular marking. In contrast, none of the negated occurrences in the PS group are found in connection with first person singular. Considering use of voice seems to substantiate the argument proposed in relation to the significant use of the negated variant of RWA, that the GPs present themselves as independent of a well-defined institutionalised healthcare context: the self that the GPs present may be said to be negatively defined in terms of not necessarily being part of an established healthcare sector involving set writing procedures for the doctors to follow.

First person singular and plural in thought presentation

The tests for significance for use of first person singular and first person plural showed that a considerable amount of the significance is found relative to thought presentation. As was the case with speech presentation, the GPs have a significantly higher frequency of first person *singular*, and the PSs have a correspondingly high frequency of first person *plural*. One of the major differences between uses of first person in speech presentation and thought presentation is the number of tests showing significant differences: in the GP group, the categories IT, RTA and RT as well as the total amount of thought presentation provide a significant difference relative to first person singular when compared with the PSs' use. In relation to first person *plural*, the results are almost mirrored (the test for RT does not show a significant result), with the difference being that it is the PS group

that prefers this category. None of the thought presentation categories relative to the PS group's use of first person singular provide a significant result – and vice versa. This consistency in terms of attribution of significance by voice strengthens the argument that the GPs speak from a personal standpoint, whereas the professional group voice is consistently maintained in the PS group. The results for the GPs' use of Representation Speech Act showed that the significance from the overall results was reversed relative to first person singular. The same tendency is found relative to RTA. Similarly, the overall significance found in the GPs' use of IT is reversed when paired with first person plural, now being significantly more frequent in the PS group. The fact that use of certain voices manages to reverse an overall significant result strongly cements the predominance of the voice in the speaker group: the first person singular voice in the GP group and the first person plural professional group voice in the PS group.

On the basis of an analysis of a single psychiatrist's use of discourse presentation in Example 6.2, I argued that his use of thought presentation was highly observational and procedural, conveying his determined focus on his approach to diagnosing and treating his patients. The result for first person singular in IT proved highly significant in the GP group. The following example of IT conveys a GP's habitual thoughts through first person perspective:

Example 6.11

Dan:

jeg kan godt blive i tvivl om det er lige så godt som det for eksempel en god psykolog kan (GP9)

Eng:

I can begin to doubt whether it is as good as what for example a good psychologist can (GP9)

In this example, the general practitioner uses IT to express his doubts about the quality of his treatment, as opposed to a psychologist's treatment. This use is radically different from the psychiatrist's use of thought presentation, claiming almost another epistemological status for the

treatment than was the case presented by the psychiatrist. Through the GP's use of IT, we are thus presented with a much more private account as well as with the actual propositional content, which in terms of the direct-indirect parameter bears witness to a GP who allows his doubt to be exposed to a greater extent than if a more summarising form had been chosen.

RTA is the most frequent thought presentation category in the corpus overall and in the PS group. However, this significance is reversed relative to first person singular. If we look more closely at how the two speaker groups use RTA in connection with first person singular, apart from the significance in the GP group, there seems to be a difference in terms of category use: use in the PS group to a great extent seems to match the tendency I noted in the analysis of Example 6.2. Generally speaking, the PS group employs RT to express choices, decisions, and observations. In contrast, the GP group generally uses RTA to express wonder, tentativeness and doubts, as illustrated by the three examples below:

Example 6.12

Dan:

nogle gange så undrer jeg mig over hvis jeg oplever en der virker s- # ret så syg # og jeg opfatter som deprimeret hvor så skemaet det viser faktisk noget andet # (GP7)

Eng:

sometimes then I wonder about if I experience someone who seems s- # quite sick # and I perceive as depressed where then the chart it actually shows something different # (GP7)

Example 6.13

Dan:

jeg øh det k- det kan være v- jeg i hver fald mere forsigtig med **at stille depressionsdiagnoser**
<INT: # mm> # på # unge (GP2)

Eng:

I wh it c- it might be v- I at least more cautious about **giving depression diagnoses** <INT: # mm> #
to # young (GP2)

Example 6.14

Dan:

INT: og når du så siger at det er # det der spektrum og du taler også om krisetilstande og så noget #

INF: ja # <INT: # hvad skal der>

INT: til før du # kalder det en depression #

INF: jamen jeg prøver **at score dem efter det der** der hedder I_C_D_ti- # -skemaet # (GP9)

Eng:

INT: and when you then say that it is # that spectrum and you also talk about states of crisis and
such #

INF: yes # <INT: # what does it >

INT: take before you # call it a depression #

INF: well I try **to score them by what is** called the I_C_D_ten # -sheet # (GP9)

In Chapter 7, I investigate how the category Report of Language Use is used by the two speaker groups, and I argue that the patterns support the two speaker groups' differing realisation patterns of thought presentation.

First person plural – the shared perspective

The statistical test for the speaker category *first person plural, shared voice* showed significantly more frequent use in the GP group. This result suggests that the GPs choose a speaker category that allows the patient's voice to be aligned with the doctor's voice. The vast majority of the instances within this speaker category convey speech, as in the following example, in which where the interviewer and the GP discuss certain topics that he avoids in the initial clarification stage of diagnosing the condition:

Example 6.15

Dan:

jamen je:g øh # j:eg undlader i hver fald i starten! af sådan en samtale at al for brask og bram # a:t # øh tale om: # depressioner o:g så videre **vi taler om symptomer # øh og meget lidt om diagnoser** og jeg taler slet ikke om medicin og sådan # ting altså jeg <INT: # mm #> # det holder jeg # øh # lav! profil med

Eng:

well I: eh # I: omit at least in the beginning! of such a conversation that too # t:o # eh talk about: # depressions a:nd so on **we talk about symptoms # eh and very little about diagnoses** and I don't at all talk about medicine and such # things well I <INT: # mm #> # I keep # eh # a low! profile with that

The GP presents the shared voice (bolded), conveyed through RV. This form of speech presentation is the category providing the least source information and is thus the most filtered form of speech presentation. The distribution pattern of *first person plural, shared voice* shows that the vast majority of the speech presentation instances are conveyed through RV, with 21 out of 40 instances in the GP group taking this form and with IS being a rather distant second at 10 instances. Interestingly, only 3 out of 40 occurrences of *first person plural, shared voice* in speech presentation are realised as RSA. The speech act is characterised by having a specific purpose (Searle 1976: 2-3). This need not be the case with the less specific RV. As noted in connection with the two groups' uses of RV in 6.3.1.1, this category is often semantically light and may be regarded as more informal since it lacks the semantic density characteristic of e.g. RSA. Bearing in mind these traits of RV, this speech presentation combined with the shared perspective may be said to establish an informal doctor-patient relationship that also includes the patient's perspective. It could be argued that the predominance of RV in the shared doctor-patient perspective places focus on the importance of communication as an *activity*, rather than focusing on content or wording in the

exchange – or on actual speech acts performed by one of the parties in the communication. In this manner, the GPs may be said to actually enhance focus on the *joint* effort in the consultation, acknowledging that the explorative dimension of the consultation is a central component in the diagnostic process. This is particularly relevant in the light of depression being an illness that cannot otherwise be measured but that must be established through conversation (often in combination with a rating scale).

6.4.2.2 Third person plural, doctors' own and other groups

The category *third person plural, own group* denotes instances in which the doctors refer to their own professional group but without the self-referential function found in *first person plural, own group*. *Third person plural, own group* is very sparsely represented in the corpus. In the results, we saw that the GPs do not use this voice at all, while the PS group employs it 19 times. The other type of group voice in third person plural concerns references that capture the other professional group's voice. The figures indicated that this category is more frequent than *third person plural, own group*, occurring 30 times in the GP group and 55 times in the PS group. The test for significance showed that this difference is significant.

The pattern of these two group voices relative to the three presentational scales indicates that the PS barely use writing presentation in connection with *third person plural, own group*, with only 2 of the 17 instances being found on the writing presentation scale. In contrast, apart from being significant at an overall level, we see a significant result in use of *third person plural, other group* relative to writing presentation, of which 7 instances are realised as RWA. In relation to the GPs' significant use of the negated variant of RWA, we saw that the majority of instances were realised using first person singular and that all the instances concerned formalised, institutional writing acts rooted in the healthcare system. Interestingly, six out of the seven instances of the PS group's use of the GP group's voices in *third person plural* are either references to referrals or prescriptions. This co-occurrence in the GPs' own voice in the negated variant of RN with the PS group's presentation of the GP group's voice indicates that both groups present writing concerned with the GP group's handling of and attitude toward formalised writing acts in the healthcare system. I will provide an example of how this is achieved by a psychiatrist, and in connection with this, it may be useful to draw upon Tannen's account of the evaluative dimension of constructed dialogue. Tannen highlights one of the functions of this feature as evaluating non-present third parties, serving an

immediate interactional goal (Tannen 1989: 108). She is only concerned with Direct Speech, but I would argue that presenting other people's voices by means of any discourse presentation form may have an evaluative function:

Example 6.16

Dan:

INT: kunne du forestille dig at det <INF: # praktiserende #> kunne være et # bedre samarbejde #
<INF: # det undrer mig>

INF: de ikke ringer! oftere det vil jeg så si:ge øh <INT: # ja #> # så # at de ikke ringe:r om # råd og vejledning kan man sige <INT: # ja #> ved nogle af deres <INT: # ja #> de- deprimerede patienter

INT: ja #

INF: og så undrer det mig at **de ikke # skriver nogle bedre henvisninger** hvis de gerne vi have deres patienter ind i: en <INT: # ja #> visitation

Eng:

INT: could you imagine that the <INF: # general #> could be a # better collaboration # <INF: # it baffles me >

INF: they don't call! more often I will sa:y eh <INT: # yes #> # so # that they don't ca:ll for # advice and guidance one can say <INT: # yes #> by some of their <INT: # yes #> de- depressed patients

INT: yes #

INF: and then it baffles me that **they don't # write some better referrals** if they want to have their patients into: an <INT: # yes #> assessment

In Example 6.16, the PS is asked about cooperation between the two groups of doctors. Part of his answer concerns his dissatisfaction with the GPs' referral skills. In this manner, he evaluates the GPs as one group and makes them responsible for faulty or insufficient cooperation between the two groups.

If we return to the results for first person plural, own group voice, we saw that this group voice was also significantly more frequent in the PS group, which could indicate that the PSs position themselves as having a clear specialist identity. The singular self-reference, in contrast, was significant in the GP group. The results for the third person group voices suggest that the PS group generally uses group references when presenting professional voices. This result, I would argue, actually substantiates the pattern that the GPs do not act out a strong professional group identity, whereas this is more the case in the PS group. The GPs do not project themselves as a group, but my results suggest that the PSs first and foremost choose to identify doctors as belonging to a professional group. By enhancing their own individual voices, the GPs seem to focus instead on their own practice rather than on being part of a wider institutional system. It could be argued that the marked difference in use of professional group voices in the two groups enhances the divide between the two medical professions and that the PSs' significant choice to voice the different medical professions in distinct groupings is yet another means of manifesting that their professional identity differs from that of the GPs.

In addition, we have seen that the GPs use the lexical discourse presentation choices as well as the shared plural voice that includes the patient to establish a professional identity with a more symmetrical relationship to the patient.

6.4.2.3 The patients' voices: third person singular and third person plural

Now that we have seen how the voices of the two groups of doctors are put to use in different ways in the presentation of discourse, I will discuss how patient voices are operationalised by the two groups of doctors.

The results for use of patient voices (singular and plural) in the corpus showed that these make up only 16% of all the voices in the corpus. Given the contextual circumstances of the research interview, in which the interviewer aims to elicit the doctors' understandings of depression, the relatively low proportion of patient voices may seem unsurprising. But the results for singular and plural patient voices showed that the PS group employs the category *third person singular, patient's voice* significantly more often than does the GP group (92 vs 75 instances). Conversely, the GP group employs the plural counterpart significantly more often than does the PS group (139 vs 94 instances). This distribution pattern suggests that each group of doctors owns a

patient category, which echoes the tendency that was found relative to the singular-plural dimension related to self-reference: here I suggested that the GPs own the singular self-reference, and the PSs own the plural self-reference. In contrast, here, the PSs prefer the singular scale and the GPs the plural scale. Let us first consider the PS group's use of the singular voice.

The majority of the PS group's instances denoting singular patient voices are found at the indirect ends of the scales, primarily conveyed as either speech or thought. The following example renders a patient's thought:

Example 6.17 (extract from Example 6.2)

Dan:

så går man et trin op hvor man sætter patientens initiativ på spil [...] **og hvor patienten designer sin egen behandlingsplan # det er patienten selv der bestemmer hvad han eller hun skal lave # i forhold til motion # i forhold til kontakt til andre mennesker** (PS8)

Eng:

then you go one step up where one puts the patient's initiative on the line [...] **and where the patient designs his own treatment plan # it is the patient himself who decides what he or she should do # with regards to exercise # with regards to contact to other people** (PS8)

In Example 6.17, the PS employs the patient's voice twice, first by means of RTA ('patienten designer sin egen behandlingsplan'), then by means of IT ('det er patienten selv der bestemmer hvad han eller hun skal lave'). Interestingly, the PS's use of thought presentation here does not provide insight into the patient's inner world as such, i.e. the patient's worries or private thoughts. The patient's thought is instead employed by the PS to encompass habitual processes in the treatment in which the patient's decision-making skills are trained, based on the psychiatrist's initiative ('hvor man sætter patientens initiativ på spil'). Other uses of patient voice relative to thought presentation encompass symptomatic uses:

Example 6.18

Dan:

det kan man sagtens <INT: # mm #> være hvis man er deprimeret eller angst at **man kan have svært ved at <INT: # mm #> koncentrere sig** (PS6)

Eng:

one can very likely <INT: # mm #> be if one is depressed or anxious that **one can have trouble with <INT: # mm #> concentrating** (PS6)

Of the 92 instances of singular patient voice in the PS group, 48 are realised as thought presentation. In terms of presentational mode, the difference between the two speaker groups is found relative to thought presentation. Of the 48 instances of thought presentation, 32 instances are realised as either RTA or RT, and the significance between the two speaker groups at category level is found in RT. This suggests that, in the majority of instances, none of the propositional content is presented. Thus, even though the PS group chooses to depict singular patients significantly more often than does the GP group, it chooses the forms that are the most distanced from the imagined source (the patient), whose voice does not appear as visibly in the accounts as if another, more direct form had been chosen. The indirectness in the PSs' use of thought presentation in connection with patient voices is reminiscent of the group's overall tendency toward indirectness.

The finding that the PS group employs the singular patient's perspective significantly more often than does the GP group could suggest a PS focus on the individual patient, rather than perceiving patients as a plural group consisting of people who all think and speak the same way. However, I have also previously noted that the majority of the discourse presentation in the corpus is realised as non-specific representations, with no significant difference between the two speaker groups. This suggests that only a small portion of the discourse presentation highlights specific instances of discourse (see Chapter 6.2.2). Considering the instances relative to the specific/non-specific distinction in connection with singular patient voice, the figures are as follows:

Table 6.66: Specific and non-specific singular patient voices.

Patient's voice	Third person singular, specific	Third person singular, non-specific	P-value
GP	45	30	0.000037
PS	26	66	0.000037
Total	71	96	

When tested for significance, we see that the GPs use specific representation in the singular patient voice significantly more often than do the PSs and that the result is highly significant (p-value: 0.000037). Examples of the specific (Example 6.19) and non-specific (Example 6.20) variants are provided below:

Example 6.19

Dan:

jeg spurgte ham: øh # øh # øh jeg prøvede at formulere det på en facon så øh det ikke var lige sådan at s- # ligge ordene i munden på ham men # spurgte # måske om jeg kan ikke huske det hel! nøjagtig sætningen! men øh # om han havde tænkt på selvmord eller noget i den stil <INT: mm #> # **nej** sagde han så <INT: # mm #> **ja det er jeg sgu for fej til** # (GP7)

Eng:

I asked him: eh # eh # eh I tried to word it in a manner so eh it wasn't like s- # putting the words into his mouth but # asked # maybe if I can't remember it just! exactly the sentence! but eh # if he had considered suicide or something like that <INT: mm #> # **no** he said <INT: # mm #> **I am sure too cowardly for that** # (GP7)

Example 6.20

Dan:

øh v- # [stønner] nej men det har jeg det har jeg set ret meget af altså at <INT: # ja> # **patienten påstår at jeg er i hvert fald ikke deprimeret** # og E_C_T er det eneste som hjælper # (PS2)

Eng:

eh v- # [moans] no but I have I have seen quite a lot of that well that <INT: # yes> # **the patient claims that I am definitely not depressed** # and E_C_T is the only thing that helps # (PS2)

Example 6.19 shows how the GP presents a third person singular voice of a specific patient who talks about lacking the courage to commit suicide. Example 6.20, produced by a PS, also conveys the voice of a patient in the third person singular. However, in this case, the singular voice is non-specific and does not refer to a particular patient ('det har jeg set ret meget af at patienten påstår...'). In this use, the singular voice seems to function as an exemplification of the *type* of patient who refuses to acknowledge the condition. In her treatment of voice in constructed dialogue, Tannen introduces the term *dialogue as instantiation*, which she employs to encompass instances that are "occurring repeatedly" and are "offered as an instantiation of a general phenomenon" (Tannen 1989: 111). The generic pronoun 'man' in Example 6.18, the present tense use in Example 6.20 and the quantifying 'det har jeg set ret meget af' are all linguistic markers that suggest that the majority of singular patient voice uses in the PS group function as instantiation rather than as a means of conveying individual patients' actual specific voices. Use of specific and non-specific representation relative to third person singular indicates that, even though the PS group employs the third person singular patient perspective significantly more often than does the GP group, the sub-analysis of specificity suggests that the PSs' singular voice is used to *typify* patients' voices rather than to highlight individuals. We have also seen that the majority of the singular renderings are conveyed by summarising forms, which is particularly prevalent in the presentation of the singular patient's thought. These features – the highly non-specific presentation in combination with the predominance of the most summarising forms – suggest that, when the PS group presents singular patient voices, these voices are not in fact used to enhance the visibility of the patient's voice in the PSs' discourse about them. In other words, the PSs' choices seem to bleach the dialogical status of their discourse.

In the analysis of a psychiatrist's use of RTA, which I showed was highly generic and iterative, the few uses of the patient's voice were correspondingly generic and in the singular voice

(see Example 6.2). As we shall see in Chapter 8, in a separate study on the topic of *the typical patient*, this tendency to use the patient as a generic example rather than as a specific one reverberates into the generic use of patient singular voices.

If we turn the plural use of patient voices, the results showed that this type of speaker reference was significantly more frequent in the GP group. Interestingly, the GPs' use of this voice shows no significant results when tested at category level, and no significant results appear when tested relative to the three presentational modes. The finding that the significance only occurs at the overall level indicates that the GPs' presentation of patients' voices is not related specifically to a particular mode of presentation or to any certain type of discourse presentation category, suggesting a more diverse representation of the patients' voices. In the PS group's use of patients' plural voices, however, we find a significance at category level in use of IT. This finding is remarkable in at least two respects: first, because the overall significance of the plural patient voices is associated with the GP group and, second, because the PS group reverses the GPs' overall significantly more frequent use of IT. In relation to third person singular, we also saw that this was connected to the presentation of thought. This pattern is replicated in the PS group's use of patients' plural voices relative to IT. If we make a similar comparison in reverse, no significant results were found in the GP group at category level in the singular use of patients' voices. Here, the singular category may be said to be fully owned by the PS group.

In order to explain how the significance in the GP group's use of patients' plural voice works in the corpus, I will turn to the two categories with the most realisations (RV and FIS).

RV is the most employed discourse presentation category in the GPs' presentations of patients' plural voice:

Example 6.21

Dan:

det at man har kendt dem i tyve år at der har man selv en enorm! terapeutisk # effekt **de behøver bare at komme ned og snakke** så er det # så så er de sådan lidt på s- # noget! på sporet igen (GP6)

Eng:

the fact that one has known them for twenty years that there one oneself has an enormous!
therapeutic #effect **they only need to come down to talk** then it is # then then they are kind of back
o- # well! back on track (GP6)

Example 6.21 shows that the patients' voice is used to refer to the consultation with the GP. This use actually seems to present a distinct pattern in the GP group: a count for which communication situation RV refers to shows that 26 out of 27 instances refer to the consultation with the GP. By comparison, the PS group produces 14 instances of RV, and only 8 of these refer to patient voices in the actual consultation. This analysis of the reported communicative context suggests that the GPs use RV to allow the patients' voices be heard in the actual consultation to a greater extent than do the PSs. Returning to the PSs' significant result in the frequency of singular use of patient voices, in which the two speaker groups produced roughly the same amount of RV (GP: 12, PS: 10), it is not possible to detect a similar tendency in that only approximately half of the instances in each speaker group were used to denote communication in the consultation setting. This comparison with the singular use of patient voices does not clash with the finding that the GPs choose to focus on communication with their patients when presenting their voices. The focus on the doctor-patient interaction in GPs' use of patients' plural voices is reminiscent of the overall analysis of lexis in RV, in which I suggested that the GPs' use of *snakke* presented a different doctor-patient focus than in the PS group, which used RV to present asymmetrical speech events, creating a less aligned doctor-patient relation.

FIS is the second-most employed category for presenting patients' plural voices in the GP group. In contrast, in the overall results, FIS came last. When turning to the results for the patients' plural voice, we see that 21 out of the total 78 instances of FIS in the GP group occur in connection with the category of voices. This result indicates that the patients' plural voice is the category with the greatest occurrence of FIS in the GP group. In addition, more than a quarter of all plural patient voices are instances of FIS (21 out of 81). Example 6.22 illustrates a use of FIS:

Example 6.22

Dan:

et # her og nu # øh altså nogle gange kommer folk med noget de har printet ud fra s:- fra: internettet de har siddet og udfyldt ikke **og så er de jo øh enormt syge** men så snakker jeg {lidt} med dem og så finder man ud af det er de altså ikke (GP8)

Eng:

a # here and now # eh well sometimes people come with something they have printet out from s:- from the internet they have sat and filled out right **and then they sure are eh tremendously ill** but then I talk {a bit} to them and then one finds out that they are really not (GP8)

In Chapter 2.5.2 I introduced the concepts of *foregrounding* and *backgrounding*. These phenomena encompass the positioning of speaker roles and content, achieved by contrasting different discourse presentation forms, such as direct vs indirect forms, or by contrasting presentational modes, e.g. speech and thought. Leech and Short also discuss an example of FIS and conclude that “the contrast between the modes of speech presentation put one, so to speak, in the shadow of the other, and allows us to infer different characters’ attitudes towards the information presented” (Leech & Short 1981: 335). FIS is the most direct discourse presentation form employed in Example 6.22 above. By employing one of the most direct forms (FIS), the GPs minimise the distance between the reported and the reporting context and allow the voices of the patients to appear with minimum filtering. At the same time, the instance of FIS occurs in a cluster of discourse presentation: the first instance of discourse presentation is realised as RN, which also belongs to the patients (‘de har siddet og udfyldt’), and which refers to the self-testing that anybody can do, filling out an online form at home. This is followed by the instance of FIS, denoting the patients’ self-diagnosed condition derived from the online test (‘og så er de jo enormt syge’). FIS seems to be used to encompass what the GP considers to be the patients’ rather unsubstantiated layman’s diagnosis. Use of FIS may be said to foreground the patients’ often mistaken conclusion, with RN serving as the background for this. By contrasting the two forms of discourse presentation conveying different degrees of directness, the patients’ voice is foregrounded, and the preceding RN is backgrounded. The instance of FIS is followed by an instance of the summarising RV, which belongs to the GP (‘så snakker jeg lidt med dem’). By using the most summarising form (RV), the GP may be said to dissolve or take a

step back from the drama of the situation, achieved by the summarising category itself, as well as the informal lexis *snakke*. The cluster is finalised by an instance of FIT with the generic pronoun *man* ('så finder man ud af at det er de altså ikke'). The GP's use of *man* could either refer to the GP's own thought process or to a joint recognition between doctor and patient. Regardless of the pronominal interpretation, use of FIT may be said to be foregrounded, partly by its direct form and partly by setting up an inner-outer world contrast with summarising talk with the patient, thereby conveying the conclusion of the consultation, in which the outcome is different from the patient's initial assumptions. This relatively short stretch produced by the GP contains a total of four instances of discourse presentation, which I would argue may be paired in sub-clusters of two and two, thereby achieving a backgrounding/foregrounding effect (RN vs FIS and RV vs FIT). I would also argue that the entire cluster achieves a wave-like movement by interspersing indirect and direct discourse presentation forms from all three presentational modes, ending with the GP's conclusion, conveyed by thought presentation, which turns out to be radically different from the diagnosis first introduced by the patient. This sets up a contrastive 'loop' in the cluster in that the conclusion reached by the GP goes back and modifies the assumption first set forth by the patient. If we return to use of FIS, one of the traits characteristic of the discourse presentation form is evaluative lexis, here realised by the degree adverb *enormt* (Eng: *tremendously*). Clearly, this evaluative flavour in use of FIS is – as with any other linguistic feature – added by the GP, and because the utterances are presented as habitual occurrences, these evaluative markers have most likely never been uttered. Tannen discusses the function of presenting discourse belonging to non-present third parties, which are often evaluations of these non-present parties (Tannen 1989: 108). As with her approach to discourse presentation in general, Tannen's main line of thought is that such uses first and foremost serve an interactional purpose (Tannen: 1989: 108). If we consider the participant structure of the research interviews that comprise my corpus, the interviewer is not an 'outsider' interviewing an 'insider'; the interviewer instead has extensive medical background herself, having worked for several years as a general practitioner. As I have shown in the stretch of presented discourse, the outcome of the interaction with the patient is quite the opposite of the diagnosis first suggested by the patient. Taking into account the similar professional backgrounds of the participants, the GP could be said to use the rather evaluative FIS to construct a joint venture with the interviewer, creating an opposition to the layman, the patient. FIS thus seems to serve an interactional purpose between two like-minded professionals.

The ambiguity of FIS suggests a certain level of creativity on behalf of the reporter, enhancing the dialogical status of the text. Even though the discourse of the research interviews is non-narrative, the finding that the GPs use two of the free indirect forms significantly more often than do the PSs suggests that the GP group creates discourse that is more heterogeneous, positioning it as a less authoritative group of doctors than the PS group, which, as we have seen, makes rather different choices when presenting discourse.

In the discussion of singular patient voices in 6.4.2.3, I showed a use of speaker voice as an example of what Tannen terms *instantiation*, i.e. speech that is presented as recurring repeatedly. Another central term in Tannen's account is *choral dialogue*, which denotes speech that is attributed to a group of speakers (Tannen 1989: 111-114).

The use of FIS in Example 6.22 encompasses both of these phenomena due to the habitual presentation and use of *de* (Eng: *they*). In fact, all of the 21 instances of FIS used to denote patients' plural voice are presented as non-specific. In addition, the vast majority of these instances occur in combination with other discourse presentation forms, which could indicate that the patients' plural voice is often used to achieve the backgrounding/foregrounding effect exemplified above. This also means that the patients' voice is seldom presented alone but mostly occurs alongside other voices. This is yet another indication that the dialogue with the patient is central.

We have seen above how the GPs' lexical choices often involve the patients. The clustering of patients' voices in FIS with other presentations of discourse indicates that the dialogue with the patient occurs not only at a lexical level but also at the level of reported sequencing. The exact functions and mechanisms in all these cluster occurrences would, of course, need to undergo a more detailed analysis to be fully illuminated. Nevertheless, it seems that – even though the representation of the GP's use of patients' plural voice in FIS is non-specific – use of the form approaches Leech and Short's literary concept of foregrounding and backgrounding. I would argue that this finding encourages a dual conclusion:

- 1) that a central concept in a literary stylistic context may be applicable to an entirely different context, that of the serious, predominantly non-narrative research interview
- 2) that the GPs, by means of significant uses of FIS and FIT, draw upon a greater span of discourse presentation forms, which includes allowing the patients' voice be presented in a less filtered manner than is the case in the PS group. This suggests both that the GPs' discourse is more

dialogical and that this group of doctors approaches a style that is more specific – and perhaps even more narrative – than that of the PS group.

6.4.2.4 The hidden voices – passive and zero voice

The final two speaker voice categories showing significant results are passive voice and zero voice. Common for these two types of voices is that the speaker is omitted from the presentation. I argue, however, that the two forms result in rather different functions, implying different approaches to presenting discourse – and that these varying approaches may be linked to wider tendencies within the two speaker groups.

The results for the two speaker groups showed that passive voice is more frequent and highly significant in the PS group, whereas zero voice is more frequent and is significant in the GP group. I will begin by discussing the PS group's use of passive voice and then proceed to the GP group's use of zero marking, which will lead to the tying together of these two significant categories.

Passive voice

In formal terms, passive voice is defined by the omission of an agent (Heltoft & Falster Jakobsen 1996, Hestbæk Andersen 2006). When passive voice is employed with representation of discourse, we are not presented with a speaker (or writer or thinker) responsible for it. This omission of the agent may fulfil a number of functions: the agent may be obvious from the context, it may be unimportant, or it agent may be omitted for strategic purposes (Hestbæk Andersen 2006: 92). There are a number of interesting observations to be made concerning use of passive voice in my corpus: first, there seems to be a correlation in terms of frequency between use of passive voice and the discourse presentation categories at the summarising end of the scales. In fact, 84 out of the 102 instances of passive voice in the PS group and 53 out of 59 in the GP group are used with discourse presentation forms that do not project propositional content.²¹ As established above, the PS group uses the summarising forms RSA and RTA significantly more often than does the GP group. Second, in terms of distance between the reported and the reporting, we have also already

²¹ There may be topological reasons for making a passive construction less likely in a separate reporting clause than in the one-unit constructions in the summarising categories, which do not project propositional content. However, a grammatical discussion and clarification of this issue is beyond the scope of this thesis.

established that, by using the summarising forms, the distance between the two is maximised, due to the filtering of the reporter in the reported discourse. This reduces, in Bakhtinian terms, the dialogical imprint in the conversation, in this case the research interview. In terms of passive voice, because the voice of the ‘source’ utterance is omitted, we are not given direct access to the voice of the original utterer of the discourse. This clearly is a result of the reporter’s choice. This frequent co-occurrence of passive and summarising forms, I would argue, results in a double distancing effect between the reported discourse and the reporting context.

If we turn to Biber and Conrad’s account of register and genre and consider how they treat passive voice by genre, the index contains several listings of passive voice (Biber & Conrad 2009: 342). However, in their account, passive voice is only described in connection with written genres, particularly academic writing (e.g. Biber & Conrad 2009: 122-123, 128-131). Central to Biber and Conrad’s account is *impersonalisation*, which is achieved by placing the object as the point of focus when omitting the agent (Biber & Conrad 2009: 161). As I have suggested in relation to e.g. use of speech events in RV and reporting verbs in IW, the PS group seems to make linguistic choices that suggest a more formal, institutionalised, and perhaps written style than does the GP group. For example, in the analysis of RV, I showed how some speech events conveying an asymmetrical relationship between the doctor and the patient were significant in the PS group. I also suggested that the PSs’ use of first person plural establishes a strong institutional group voice. I would argue that the significant use of passive voice adds to this notion: the PSs treat roles within the institutional frame as given, as seems to be the case in the following example:

Example 6.23

Dan:

INT: ja # så # hvordan # hvis du sådan skal beskrive! en # typisk depression- # {-billed-} eller det kan være du kan huske en # speciel patient! du måske kan #

INF: jamen altså vi har jo en hel hel <INT: # nævne #> fast øh hel fast kuty:- kan man sige **de vil blive indkaldt til en forsamtale** # <INT: # mm> nu har vi lige ændret det til de faktisk skal ind til to! forsamtaler (PS6)

Eng:

INT: yes # so # how # if you kind of were to describe! a # typical depression- # {-image-} or it might be you can remember a # special patient! you perhaps can #

INF: well we have a completely completely <INT: # mention #> fixed eh completely fixed cust- one can say **they will be summoned to a pre-conversation** # <INT: # mm> now we have just changed it to they actually must come in for two! pre-conversations (PS6)

From a broader perspective, the PSs hold a specialist function in a healthcare system with clearly defined roles. By omitting the agent, as in Ex. 6.23 above, the focus can instead be placed on the procedural aspects as well as on the object (in this case, the patient) rather than on the agent (i.e. the psychiatrist or her secretary), who, due to these established roles, is presented as implicit. In much the same way, the omission of the agent also conveys a stronger implicit understanding of the communication processes in the healthcare system. Along the same lines, it is worth noting that, of the 76 instances of RWA in the PS group, 20 are realised with passive voice. This is the largest single frequency of RWA in a voice category. As presented in 6.3.2, RWA in my corpus seems to be used predominantly for institutionalised writing procedures. The finding that the writing presentation category is relatively predominant in connection with passive voice may substantiate the argument that the PS group presents a highly institutionalised professional identity.

Fairclough uses the terms *activated/passivated* to show qualitatively how power and suppression may be established using passive voice (Fairclough 2003: 145-150). He also discusses other ways of presenting participants, using different parameters than I have chosen for my investigation of speaker voices in my analysis of discourse presentation. However, what his textbook example may tell us is that the study of what Fairclough terms *social actors* is actually a fruitful way of illuminating a chosen area of investigation. Unlike Fairclough, I have carried out a quantitative analysis of voice in discourse presentation, which I would argue is capable of providing a more solid argument when seeking to substantially illuminate a given context. I will return to a broader

discussion of the advantages and disadvantages of my quantitative approach in Chapter 9. Specifically in relation to the annotation of passive voice, I should mention, however, that what I do not manage to encompass by means of the quantitative approach is the contextual inference analysis that passive voice requires in order to pinpoint the omitted agent. My corpus is too large to undertake a systematic qualitative investigation of the instances of passive voice. In my findings on the significant use of this category in the PS group, I instead rely on the built-in explanatory potential that this grammatical form possesses: that choosing passive suggests the power to choose not to present a given voice and that passive voice is often associated with discourse that upholds a certain level of formality. In short, the structure of the grammar conveys an understanding of the structure of the system and the roles of its actors.

Zero voice

The zero quotative is a phenomenon associated with the categories at the direct end of the discourse presentation cline. In her investigation of *constructed dialogue*, Tannen states of reporting signals in conversation that “At one pole there is no introducer at all, used in informal conversational narrative because of the great expressive power of the human voice” (Tannen 1986: 323). What is notable here is that Tannen places the ‘no introducer’ (which is what I call *zero voice*) in the context of ‘informal conversational narrative’. Macaulay notes that zero voice often occurs in sequences of reported dialogue, forming part of an adjacency pair (Macaulay 2005: 146). In Chapter 5.3, I argued that the differences in my results when compared with Semino and Short and McIntyre et al.’s corpora was partly due to the non-narrative and serious mode of the interviews in my corpus. Nevertheless, this zero voice – which Tannen, Macaulay, and others argue is used in informal conversational narrative – is used significantly more often by the GP speakers than the PS speakers (p-value 0.014039). The vast majority of the instances realised with zero voice are found at the direct end of the presentational clines: in the GP group, 77 out of 84 instances are realised using either a direct or a free indirect form. Of course, the hypotactic structure of IS, writing, and thought makes zero voice much less obvious here, leaving only two instances of these two categories realised using zero voice.

One of the functions of zero voice involves closeness to the events being reported: the omission of the reporting clause – and thus the reporting voice – suggests minimal interference by the reporter, who lets the report stand alone, unfiltered. This suggests a reduction in the distance between the

reported discourse and the reporting context. Below is an example of how zero voice occurs in a GP's criticism of how the psychiatric system works:

Example 6.24

Dan:

- 1 INF: øh {alt det der psykiatri og m-} # øh # øh med {aminer} og # <INT: # nej> #
- 2 INT: så det bliver to forskellige systemer der ikke #
- 3 INF: ja #
- 4 INT: hænger sammen xxx # <INF: # og jeg synes psykiatrien>
- 5 INF: de øh altså # jeg har så nogle # sætninger fra nogle udskrivningskort **da patienten ikke**
- 6 passer ind i vores terapeutiske miljø udskrives patienten** ikke # <INT: # mm> #
- 7 INT: mm # <INF: # **altså hvem**>
- 8 INF: hvem skal pas- tilpasse sig** #
- 9 INT: ja # ja ha # <INF: # ha øh ha> #
- 10 INF: **til til hvem** ikke # (GP6)

Eng:

- 1 INF: eh {all this psychiatry and m-} # eh # eh with {aminer} and # <INT: # no> #
 - 2 INT: so it becomes two different systems that don't #
 - 3 INF: yes #
 - 4 INT: connect xxx # <INF: # and I think psychiatry >
 - 5 INF: they eh well # I then have some # sentences from some release charts **since the patient**
 - does not**
 - 6 fit into our therapeutic milieu the patient is discharged** right # <INT: # mm> #
 - 7 INT: mm # <INF: # **well who**>
 - 8 INF: who shall fi- adapt** #
 - 9 INT: yes # yes ha # <INF: # ha eh ha> #
 - 10 INF: **to to whom** right # (GP6)
-

In lines 5-6, the GP presents an instance of DW referring to a number of written documents from psychiatric hospitals stating that they cannot treat the patients due to a mismatch between the treatment offered and the patients' condition. The GP then responds to these statements using an instance of what I have termed DT (ll. 7-8, 10). This instance is, however, highly inference-rich and potentially ambiguous in terms of whether it should be regarded as thought, speech, or writing. This ambiguity arises because the GP chooses the zero quotative: essentially, we do not know whether she has phoned the hospital, sent them a reply by e-mail, or has thought this thought to herself. The lack of a reporting clause also means that the quote is not anchored in terms of tense. As such, her thought might as well be a present tense thought, functioning as a generic thought. Labov has highlighted how DS and thought may have an evaluative function (Labov & Waltetzky 1967: 35). It therefore seems plausible that the GP's inference-rich answer may be seen as an evaluation of the hospitals' statements. I have already noted the GP group's tendency to use discourse presentation and speaker voices as means of speaking out against or opposing the healthcare system. What the GP manages to do here by employing zero voice in response to instances of institutional writing is to create an oppositional voice against the established system. By omitting the speaker voice, the voice may be said to function not only as a generic voice, as suggested above, but as an unidentifiable, 'free' voice, one that will not be subjected to the voice of official, institutionalised writing.

It should also be noted that because zero voice is particularly inference-rich, it holds an interactional potential in the reporting context for the listener to co-construct the evaluation (Tannen 1989). This is what occurs as the GP utters her instance of DT, with the interviewer backchannelling and laughing at the GP's report to demonstrate her understanding of the irony of the GP's account (l. 9). As suggested in the discussion of the example of FIS relative to patients' voices, I would argue that what is taking place relative to the GP's use of zero voice is a similar joint venture, suggesting that zero voice requires a certain amount of interactional cooperation to succeed. I will return to some interactional dimensions related to the results for the discourse presentation in the doctors' interviews in 6.4.4.

In the overall results for the two speaker groups, the two free indirect forms (FIS and FIT) were significantly more frequent in the GP group. In the literature, the free indirect forms are often described as occurring without any reporting clause (e.g. Semino & Short 2004: 84, see also Chapter 2.5.2). Again, these descriptions are based on the premise that we are dealing with literary

– or at the very least, narrative – language rather than scientific research interviews. Nevertheless, the GP dominance in the free indirect forms may at least partly explain the significant use of zero voice in the GP group.

In the discussion of the GP results so far, I have suggested that – relative to the significant use of discourse presentation forms, certain lexical choices, and voices – the GPs choose markers that suggest a more conversational, direct, and inclusive approach when presenting discourse than does the PS group. The significant use of zero voice supports the argument that the GPs actually lean toward a more conversational – and perhaps narrative – style than do the PSs. If we accept the premise that the omission of the reporting clause reduces the distance between the reported discourse and the reporting context, what the GPs seem to be doing significantly more often than the PSs is allowing the presented voices (i.e. *within* the reported direct and free indirect discourse) to come alive without the reporter’s authoritative filtering. In Bakhtinian terms, this is yet another way in which the GPs enhance the dialogicality of their discourse. This argument may also be used to contrast the significant use of passive voice that we have just seen relative to the PS group, in which I argued that the PSs’ choices lean more toward a written, institutionalised discourse. Interestingly, both passive voice and zero voice are ways of omitting the represented voice and thereby depending on context and shared knowledge to identify the speaker. However, based on the existing literature on passive voice and zero voice, in combination with the other proven significances relative to the two speaker groups, these two means of excluding the speaker voice seem to manifest two rather different discursal styles.

6.4.2.5 Summarising speaker voices

- The deep coding of discourse presentation and speaker voices has shown a replication of certain overall significant discourse presentation results, whereas other results have shown a reversal in significance when tested relative to speaker voices. The integration of speaker voices has demonstrated the potential for the discourse presentation categories to be analysed in greater depth than had the analysis been confined to category level. I would argue that this fine-grained coding approach is particularly useful in a context-specific corpus such as mine since, as we have seen, it has the potential to reveal roles and positionings of these by means of speaker

voices. Other accounts of discourse presentation do acknowledge and in some form integrate the dimension of speaker voices (Thompson 1996, Fairclough 2003, Møller 1994). However, my account is, to the best of my knowledge, the first to systematically apply speaker voices to the Lancaster discourse presentation framework within a quantitative frame. As has hopefully become evident from the analysis at the level of speaker voice, this systematic, quantitative approach to speaker voice has enabled me to uncover patterns that would otherwise have been overlooked.

6.4.3 Embedded discourse presentation

The results for embedded discourse presentation showed two significant results, Direct Speech and Report of Writing. Both were at category level and both were significant in the PS group. The two significant results are based on very low figures, so the result should be taken with precaution. The significance for embedded Direct Speech is actually the only significant result for Direct Speech in the corpus. As noted throughout, it is the GP group who provides significance at the direct end of the clines. The embedding implies that the instance of discourse presentation is subsumed within another discourse presentation category. Interestingly, now that we have the PS group providing the significance for a category at the direct end of a cline, the directness is made distant by the embedded layers. Also 4 of the 7 instances of embedded Direct Speech are realised with what I called *hidden voices* (i.e. the passive or zero voice, cf. 6.4.2.4):

Example 6.25

Dan:

så er der også rigtig mange netop hvor det er det der med at de # altså hvor det ligesom arbejdspladsen der får øh der får skylden for for syge- <INT: # mm #> for for stressen # altså # stress på arbejde og # <INT: # ja> # <INT: ja #> mobning af kollegaer o:g # <INT: ja #> **ny chef der ikke forstår mig** o:g <INT: # yes> hvor jeg nogle gange sådan ikke kan lade være med at tænke # hvad nu hvis man lige skiftede et arbejde ville man så fungere meget bedre (PS5)

Eng:

then there is also a lot where this thing about that they # well it is kind of the workplace who is eh blamed for for the ill- <INT: # mm #> for the stress # well # stress at work and # <INT: # yes> #

<INT: yes #> bullying by colleagues a:nd # <INT: ja #> **new boss who don't understand me**
a:nd <INT: # yes> sometimes I just can't help thinking # what if one just got a new job would one
then function much better (PS5)

This use of speaker voice of the embedded Direct Speech – it could be argued – adds to the distance between the reported and the reporting. As noted in 6.4.2.4, zero voice, is often used as part of reported dialogical sequences, which is one of the typical uses of zero voice in connection with Direct Speech (Macaulay 2005: 146). Due to the embedding, this sequencing is not possible here and the zero voice is not used as a narrative trait by the PS. as I have shown was the case with the GPs' use of zero voice in 6.4.2.4. Thus it could be argued that the significant use of embedding confirms the tendency in the PS group to favour distance in its use of discourse presentation.

6.4.4 Interactional discourse presentation and second person singular

One test for significance for interactional discourse presentation provided a significant result. This was the use of elicited thought presentation in the PS group:

Example 6.26

Dan:

INT: ja # **hvordan vælger du dem ud** du selv vil have i terapi øh #

INF: **det er meget tilfældigt** # kan man sige <INT: ja #> der er ikke noget formelt tilbud om
individuel terapi det er en ekstra ting de får #

Eng:

INT: yes # **how do you select the ones** you want to do therapy with yourself eh #

INF: **it is very random** # so to speak <INT: yes #> there is no formal arrangement regarding
individual # therapy it is an extra thing they get #

In Example 6.26 the interviewer is asking about how the psychiatrist decides who to accept for therapy carried out by himself. It is interesting that it is the use of elicited thought presentation that is significant in the PS group. We have also seen how the overall significance for RTA in the PS group, which was a highly significant result, shifts to the GP group in the use of first person. This

lack first person thoughts together with the significant result for *elicited* thought presentation could be indication that the PS speakers do not display their personal thoughts in the interview.

I have also saved one of the significant uses of speaker voice for this section, which is the use of second person singular. This speaker voice is also significantly more frequent in the PS group:

Example 6.27

Dan:

og når **du** så udreder <INT: ja #> dem så kan **du** jo også se mønstret at # det falder <INT: # ja #> på plads <INT: # ja> #

Eng:

and then when **you** analyse <INT: ja #> them then **you** can see the pattern that # <INT: # ja #> it makes sense <INT: # ja> #

Du, as opposed to *man* (Eng: *one*), has the potential of including the listener (Jensen & Gregersen 2016). In Example 6.27 the psychiatrist's use of *du* is part of explaining how he makes diagnoses. Thus, the use of *du* could be coined as a 'didactic' use in the interview context (also note the use of *jo*, which is used to mark evidentiality in Danish). I return to this topic in Chapter 9, in which I analyse how the two groups of doctors handle a specific request from the interviewer.

Of course, my arguments concerning interactional features and suggested uses would have to be substantiated by more extensive qualitative analyses. However, the quantitative analyses of such features may provide us with indications as to where to direct our attention (see also Semino & Short 2004: 8).

6.4.5 SUMMARY OF DISCUSSION

In this section, I will sum up the findings and discussions for the two groups of doctors, the general practitioners and the psychiatrists. Rather consistently, the results have shown that the two groups place themselves opposite each other in the analytical distinctions offered by the discourse presentation framework and not least in the trajectories enabled by the deep-coding. I have argued these realisation patterns and associated uses indicate relatively sharp divisions in the health care system, in which the general practitioners conceptualise the doctor-patient relationship as symmetrical and themselves as critical towards and to some extent detached from the established system, but with minimal distance to ‘real life’. In contrast, the psychiatrists’ discourse presentation use indicates conceptualisations as specialists, with a larger degree of asymmetry in the doctor-patient relationship and a general tendency to express ownership of the treatment and the health care system.

PART 3 PERSPECTIVES

This last part of thesis is intended to shed light on my findings and discussions so far, both relative to the discourse presentation patterns found in the corpus and relative to conceptualisations of depression derived from these findings.

CHAPTER 7: REPORT OF LANGUAGE USE

In this chapter, I move a step away from the corpus investigation of discourse presentation in order to examine a specific phenomenon that occurs frequently in my data and which is what McIntyre et al. call *Report of Language Use*.²² This phenomenon is used to describe the report of habitual language use, as in their example below:

Example 7.1

What they called the tacklers were over the weavers (McIntyre et al. 2004: 63)

With inspiration from McIntyre et al., I have found it useful to examine how the two groups of physicians use this phenomenon in reports of language use concerning depression:

Example 7.2

INF: I think depression is many things **those old {endogenic} # as they were named in the old days** one doesn't see a lot of those, # right

INT: # no

INF: I don't think (PL8)

²² This chapter is a modified version of my article 'Grammatisk talesproganalyse som tilgang til at studere forståelser af depression' in NyS 54 (Pedersen 2018).

In my encounter with the general practitioners and psychiatrists' reflections on depression in the interviews, I noted a tendency among both groups of physicians to report habitual language use, and it is this variant of reported language use that will be described on the following pages.

I believe that it will be useful to apply this phenomenon to the study of the verbalisation of specialist terminology by general practitioners and psychiatrists, because it can give insight into how the two groups of doctors use a jargon that is related to their professional identities and their conceptualisations of depression. *Report of Language Use* can be described as a supplement to the original spectrum of speech presentation categories, but must be classed as under-described compared to the other categories, since the only available study of the phenomenon is that of McIntyre et al., in the form of a quantitative count (McIntyre et al 2004). In order to apply Report of Language Use as the access to examining understandings of depression, it is therefore necessary to specify the phenomenon's realisation and function: Which linguistic choices do the doctors make, when they apply the phenomenon, and which interpretations do these choices indicate? In order to frame the phenomenon, I make use of Systemic Functional Linguistics. Here, language is viewed as a resource whereby the grammatical choices made in conjunction with the realisation of an utterance are in themselves bearers of meaning: "This makes it important to keep the *choice* in mind when we consider use of language. Language use is created by the sender choosing to instantiate one part of their resource, rather than other parts. The language use received by the recipient must therefore not only be understood in the light of the choice made, but also in the light of everything which the sender could have chosen to instantiate." (Andersen and Holsting 2015: 16) (my translation). In this way, it is not only the thematics in the reported language use that are central and meaningful, but just as much the linguistic structures whereby speech about the language of depression is realised. This is the perspective that I apply to the instances of reported language use produced by the two groups of doctors. My study will therefore also form the basis for a discussion of the explanation potential of this category to shed light on conceptualisations of depression in a professional healthcare context.

Report of Language Use (RU)

McIntyre et al. describe reported language use as follows: "RU [Report of Language Use; HSP] captures metalinguistic mentions of language use, such as the words or expressions habitually used to refer to things, or the ways words were spelled or pronounced" (McIntyre et al. 2004: 519). As

pointed out in the introduction, reported language use is only superficially described in McIntyre et al.'s study of speech and thought presentation in spoken discourse, and their definition comprises the citation given above; just as they add elsewhere that the use is often idiosyncratic and often appears in connection with statements about the past (McIntyre et al. 2004: 517). The delineation criteria are therefore rather unclear. My way of delineating reported language use may therefore affect the comparability with the study by McIntyre et al. The superficial report does open up a dual perspective, however: First of all, it gives an opportunity for a more comprehensive description of the category, towards which this study is a contribution. Secondly, it gives an opportunity to make the category operational within a grammatical framework for the investigation of understandings of depression. Besides typifying the realisations of reported language use, on the basis of my data, I have therefore found it useful to involve more classical, linguistic investigation parameters, such as modality and use of pronouns, in the operationalisation of reported language use as a methodological framework for the investigation of understandings of depression. The following section presents an identification of reported language use, as well as my annotation principles, after which I will present the survey results.

Annotation of Report of Language Use

In the annotation, I counted all instances of Report of Language Use in the interviews, which means that there is no actual delineation of the individual occurrence in relation to the theme of 'depression'. The argument for my annotation of all occurrences of Report of Language Use has been that the thematics of the conversation have been set by the purpose of the interview, which is to investigate understandings of depression (see Chapter 3.1). After annotation, all occurrences were reviewed to ensure that there are no digressions, for example, that are not related to the interview's overall topic of conversation, i.e. depression. I will return to the methodological implications of this approach – and of my approach to coining conceptualisations of depression in the thesis more generally – in Chapter 9. My approach to studying understandings of depression is data-driven, since I have counted instances of reported language use and the grammatical realisations related thereto, and then tested the results for significance by using either a chi²-test, or a Fischer exact test in the cases where the number of occurrences is below five. The grammatical categories on which my investigation of Report of Language Use is based were selected by

reviewing the collection of occurrences and on that basis identifying obvious grammatical features, such as modality.

Name (hedde) and call (kalde)

Example 7.2 above ('those old endogenic as they were named in the old days') illustrates a prototypical occurrence of Report of Language Use, where the speaker uses the copular verb *name* to report language use concerning depression. Another frequently occurring use is the causative construction *call*:

Example 7.3

INF: as a psychiatrist one sees # those # that # the # heaviest share
or [breathes] uh, something like that #
INT: # mm
INF: # of what **one calls depression** (PS4)

The two types of Report of Language Use in Example 7.2 and 7.3 cover by far the majority of the realisations in my data, and these two variants will therefore constitute the focal point for the further investigation of the phenomenon. The difference between the two constructions is agency: The copular construction with *name* in Example 7.2 requires no agent. This agentless construction implies a high degree of objectivity, so that reported language use in this realisation can be presented as a fact that appears to be verifiable. Within Systemic Functional Linguistics, *name* is an example of a relational process that denotes state, rather than e.g. action (Halliday & Matthiessen 2004: 210 ff.). The type of process or verb, and the absence of an agent, makes this variant more static in its semantics. In contrast, the example with *call* in Example 7.3 is a causative construction (Hansen and Heltoft 2011: 866-7, Andersen and Holsting 2015: 166). In contrast to *name*, the causative construction is realised with an agent and thereby a visible (and for passive constructions an implied) agent. By using *call* in connection with Report of Language Use, and depending on the choice of subject, the speaker can, for example, mark a distance from or relationship to the terminology introduced. While Example 7.2 has no explicit agent, Example 7.3 is realised with the agent *man* (Eng: *one*). In the following sections I will present the results of the use of *name* and *call*, and discuss the implications of these two realisations of Report of Language Use in relation to

understandings of depression. Before that, I will review the criteria I have applied to the delineation of the category.

Delineation of Report of Language Use

The data material presents examples that have a certain similarity with the use of *name* presented in Example 7.2, but which fulfil another function in the interviews, namely to recall words or phrases:

Example 7.4

but it's actually stated in our **what's the name in: # in our referral:- uh # what's the name of that # -procedure** that # it must actually be done by the patient's own doctor #before they refer (PS6)

In Example 7.4 the speaker does not seem to be able to remember the name of the guidelines he wishes to refer to. He produces hesitance ('in:', 'referral:-'), several pauses (#) and self-interruptions, which occur at the start on the introduction of the preposition phrase ('in our what's the name in:') and as interposed word search for the compound noun he is attempting to recall. This gives the utterance a recollection function that is realised by an interrogative structure ('what's the name', 'what's the name of that'). This type of metalinguistic modification is related to word search and repair. In this context, the use of *name* has no referential value as such and is therefore not included in the count. Other borderline cases that are not included comprise occurrences where entire sentences appear as citation-like presentations:

Example 7.5

well # the entrance ticket to get into psychiatric # hospital in [name of hospital] ! # **to name it, I have suicidal thoughts** # (PS2)

In Example 7.5 the speaker presents a generic exemplification of the admission requirements for hospital treatment, where the occurrence of *name* is used to introduce a general statement. The use of *name* makes the statement resemble reported language use. I believe, however, that since a full sentence, 'I have suicidal thoughts', is used, this does not constitute the use of a term, but rather direct speech in generic form (e.g. Clark and Gerrig 1990, Tannen 1989 and Rathje 2009).

In the process of identifying occurrences of Report of Language Use I encountered two types that are immediately related to the interaction between interviewer and informant, and where both participants in the conversation, although to differing degrees, contribute to the construction of Report of Language Use. The motivation for mentioning these rarer occurrences is to point to the versatility in the realisation of the phenomenon, not least in relation to McIntyre et al.'s sparse account. This introductory description can hopefully serve as a basis for a more comprehensive description of Report of Language Use. I believe that such finely-meshed interactional analyses would be of significance to further studies aimed at investigating contextual factors such as the interviewer's influence on the informant's speech in the production of specific linguistic phenomena, in this case reported language use. In this study, my count solely includes the occurrences where the informant produces the actual concept that is reported. In Example 7.6, by proposing the *depression* label, the interviewer produces an occurrence of Report of Language Use. However, the respondent's answer does not contain any word material, so that I have chosen not to include such occurrences:

Example 7.6

INT: no # so # these are conditions **you would actually call depression** #
based on the criteria or #
INF: # yes they could - they fit the criteria (PL11)

Another variant of interactionally prompted Report of Language Use is the following:

Example 7.7

INT: **so would you call it a certain type of conversational therapy**
INF: I don't know, well **then it must be supportive**
INT: yes
INF: # supportive! mainly psychoanalytical uh based but with elements of # of
cognitive therapy (PS7)

In contrast to the example in 7.6, in 7.7 it is the informant who produces the word materials (*supportive*). Both Example 7.6 and Example 7.7 are thus examples of interactionally generated and co-constructed occurrences, but where the use of word materials is placed differently. Even though, from an interaction perspective, it can be argued that all occurrences are interactionally generated to a greater or lesser degree, examples such as 7.6 are not included. On the other hand, I have chosen to consider examples such as 7.7 to be Report of Language Use, as the part with word material is

produced by the informant, and the focus of this study is the informant's use of the phenomenon. A third variant of Report of Language Use is a realisation in nominal form:

Example 7.8

INF: but think! about what the word **smoker's lungs** #
 INT: yes #
 INF: uh did! # to put the clampdown on smoking # right
 INT: yes # yes #
 INF: it # and think about what- **the word happy pill** #
 INT: yes #
 INF: has done # (PL6)

This nominal realisation is relatively rare in my data. An adjectival variant that is realised with *so-called* only occurs once. The variant that I call *mentally reported language use*, in which Report of Language Use is realised with *teach*, also only occurs once:

Example 7.9

and uh # and uh # the problem is # that uh # that it is difficult to distinguish # # uh # what i:s # what is # uh is what **we were taught to be an endogenic depression** and # and what is more # stress and # and uh # and uh existential # conditions (PL4)

RESULTS

Table 7.1 presents occurrences and percentages of Report of Language Use in the two groups of doctors.

TABLE 7.1: FREQUENCY AND DISTRIBUTION PATTERNS OF REPORTED LANGUAGE USE FOR THE TWO GROUPS OF PHYSICIANS

Variant	General practitioners	General practitioners	Psychiatrists	Psychiatrists
	N	%	N	%
Name	38	51%	20	42%
Call	31	41%	21	44%
Interactional	0	0%	2	4%
Nominal	5	7%	4	8%
Adjectival	0	0%	1	2%
Mental	1	1%	0	0%
Total	n = 75	100%	n = 48	100%

The frequency of Report of Language Use in the two groups shows that the general practitioners make use of this resource to a greater extent than the psychiatrists (75 versus 48 occurrences). The total number of words in the group of general practitioners is 96,854, while the figure for the psychiatrist group is 82,104. An index calculation shows that the occurrence of Report of Language Use per 1,000 words for the general practitioners is 0.77, while the figure for the psychiatrist group is 0.58. This difference indicates that the general practitioners more often use Report of Language Use for depression terminology, which may be due to the guidelines and diagnostic criteria for the treatment of depression being formulated in psychiatry (Davidsen & Fosgerau 2014a: 1). The general practitioners may therefore view the depression disorder as unknown or foreign territory, and the employment of Report of Language Use thus comes to function as a way in which this group of doctors annexes this relatively unknown territory, compared to psychiatrists. I will further develop this assumption in the coming sections by making the association that the two groups' linguistic choices indicate different understandings of depression. The following analysis section considers how *name* and *call* are used by the two speaker groups.

Name (hedde) and call (kalde)

A chi² test for the overall use of *name* versus *call* shows no significant difference for the two groups (p=0.4085). This result indicates that the use of *name* and *call*, respectively, does not belong to a specific professional group. Does this almost equal distribution of both variants in the two groups mean, however, that the two types of doctors introduce and use depression concepts in the same way and thereby relate to depression concepts as given and objectively verifiable entities, as the *name* variant can be said to imply? In order to answer this question, I examined another phenomenon in the two groups' use of Report of Language Use, namely which grammatical subjects, i.e. speaker voices, are attached to the presentation of Report of Language Use.

Who does the report belong to?

In my analysis I found it useful to investigate to whom Report of Language Use belongs, i.e. who is stated to be the referent of the language use. As pointed out, the difference between the two main variants of Report of Language Use is agency: *Name* is a copular construction that is realised without agent:

Example 7.10

INF: and then there is **something named mindfulness** that is

INT: yes

INF: # is becoming popular now # so (PS4)

Call, on the other hand, is a causative construction that is agent-determined:

Example 7.11

we see very! few # of well what **I** would call # classic depressions (PL6)

The agentless construction in *name* means that an analysis of the referent in this variant of the reported language use is not possible. For *call*, the affiliation is indicated by the use of pronouns, which fall into the following four groups: first person singular, third person singular, and first and third person plural. The occurrences of *call* distributed on the various types of pronouns are presented in Table 7.2:

TABLE 7.2: OCCURRENCES OF PRONOUNS IN *CALL*

	General practitioners		Psychiatrists	
	N	%	N	%
I	11	35.4%	2	9.5%
One	7	22.5%	11	52.3%
We	11	35.4%	7	33.3%
They	2	6.4%	1	4.7%
Total	n = 31	99.7%	n = 21	99.8%

I

Eleven of the general practitioners' occurrences of Report of Language Use were realised with *I*. In Example 12 a general practitioner uses this subjective marking in connection with *call*:

Example 7.12

uh # well: # I do carry out something **I** myself call cognitive therapy (GP2)

Among psychiatrists, on the other hand, *I* only occurs twice. Example 13 illustrates a psychiatrist's use of *I*:

Example 7.13

I carry out – something – **I** call talk therapy (PS7)

A chi² test shows a significant difference in the use of *I* between the two physician groups ($p=0.0339$) and thereby indicates that, to a greater extent than the psychiatrists, the general practitioners speak from a personal perspective in the use of depression terminology. I will elaborate on this tendency for subjective marking in the analysis of the first person plural, *we*.

One

The generic pronoun *one* is used when a speaker wishes to generalise a given utterance:

By using a generic pronoun the speaker is instructing the addressee to see the referent from a “structural” point of view: Even though it may in principle be possible to determine the pronoun’s precise extension, the whole point is that the predication illustrates how the world works in general, not the properties of specific persons or events. (Jensen & Gregersen 2016: 6)²³

The pronoun *you* can also function as generic pronoun, but is not nearly as frequent as *one* (in Danish) (Jensen & Gregersen 2016: 1). In their article, Jensen and Gregersen discuss semantic and interactional differences between *one* and *you* and emphasise *you* as a stylistic lever that can be used to show, rather than tell, a given point, just as they emphasise that the use of *you* appears to be context-sensitive (Jensen & Gregersen 2016: 5). Only *one* serves as generic pronoun in my

²³ Oversættelse her

occurrences of Report of Language Use. The context of my study is the research interview, of which the purpose is to collect specialised knowledge within a field, in this case depression (see Chapter 3.1.2). As suggested throughout the thesis, the context for the two groups of doctors' production of Report of Language Use can thereby be described as institutional and professional, and with a high degree of seriousness, which could explain why both groups prefer *one* to *you* as the generic pronoun. The frequency of *one* in the two groups of doctors, however: less than a quarter (7 of 31) of the occurrences of *call* among the general practitioners are realised with the help of *one*, while this accounts for more than half among the psychiatrists (11 out of 21). The trend for different use of generic marking is confirmed by a chi² test, which shows a significant difference between the two physician groups' use of *one* ($p=0.026668$). In Example 14 the psychiatrist refers implicitly to previous use of depression jargon:

Example 7.14

no **one** doesn't call it diagnostic any more (PS5)

The psychiatrist also expresses how this use is no longer correct. Instead of, for example, subjectively marking which terminology he prefers instead of *diagnostic*, he uses *one* instead to emphasise this shift in the use of terminology. This use of *one* is related to a generic truth value (Jensen & Gregersen 2016), which thereby supports the psychiatrist's argument. In this context, it is once again interesting to note that the diagnostic criteria for depression are formulated by psychiatry (Davidsen & Fosgerau 2014a: 1). Psychiatrists' tendency to refer to depression terminology with a high degree of generic truth value could indicate that this group is to a greater extent oriented towards this, in psychiatry, well-defined understanding of depression. Psychiatrists' significant choice of *one* will be considered further in the later section on the use of modality in reported language use. Where the general practitioners appear to be more inclined towards the personal, rather than the generic, marking in reported language use concerning depression, as we saw in the result for the use of *I*, psychiatrists seem to show the opposite tendency.

We

The use of *we* is characterised by including more voices and other voices than just the speaker's own. The pronoun is used, for example, to mark affiliation, which can take place by including persons who are not necessarily present in the utterance situation:

Example 7.15

I think that # w- what what I perhaps # use the most # that is what **we** call # psychoeducation # (PS4)

We can also be used to include the listener:

Example 7.16

well in this case **we** can call them strain repair-# uh # r- reactions with depressive symptoms (PS2)

Counting of the use of the first person plural shows equal distribution of this variant in the two physician groups, and a χ^2 test shows no significant difference in the frequency of use of the phenomenon by general practitioners versus psychiatrists ($p=0.872926$). A closer look at the use of *we* reveals that the referents in the two groups of doctors differ in nature, however: In five out of seven cases among the psychiatrists, *we* refers to psychiatrists as a medical profession, such as in Example 15. The remaining two occurrences may possibly include the listener, as in Example 16, where *we* seems to denote agreement. In only two out of 11 cases among the general practitioners can we see that *we* occurs as a unique reference to the general practitioners as a professional group. Example 17 is an example of this use of *we* by the general practitioners:

Example 7.17

I find it hard to # uh I wouldn't say accept uh but like relate! # the psychiatric way of viewing depression that I can remember from the: from psychiatric wards # to! how we view depression # or what **we** call depression uh out here in practice (GP7)

Seven out of 11 occurrences of *we* among the general practitioners have a potentially inclusive function for roles other than the general practitioners themselves, such as in Example 18, where *we* refers to the doctor-patient relationship:

Example 7.18

so we will all have to choose! whether # whether **we** call it anxiety or depression (GP4)

Based on this more detailed investigation of the use of the first person plural, it can be seen that the general practitioners make more varied use of *we* than the psychiatrists to include a number of different affiliations and relationships, whereby a broad spectrum of speaker voices and roles are put into play. Among the psychiatrists, *we* is used primarily as a reference to the psychiatrists' profession. This group of doctors thus to a greater extent than the general practitioners presents a uniquely identifiable voice, which could indicate a more established professional identity.

In summary, the results for the use of pronouns show that the first person singular form is more common among the general practitioners than among the psychiatrists, while the opposite is the case for the use of the third person singular form, *one*. The first person plural is distributed evenly between the two groups; yet an analysis of the referents indicates a significant difference in use. I discuss these different patterns use in Chapter 9 in relation to understandings of depression among the two physician groups. Now, I will present the results of the marking of modality in Report of Language Use.

Modality in Report of Language Use

In order to nuance the use of Report of Language Use, I have investigated the use of modality among the two groups of doctors. *Modality* denotes the uncertainty lying in the spread between

solely positive (affirmative) and solely negative (negating) utterances: “Modality designates the sender’s attitude in relation to the propositional/proposal significance in the sent utterance [...] the sender can then graduate the statement or question by specifying degrees of possibilities and probabilities and/or frequency.” (Andersen and Smedegaard 2005: 63, my translation). Analysis of modality thus makes it possible to examine *the extent to which* the speaker either endorses or questions the reported language use. Example 19 illustrates *name* with modality that here marks probability with the help of the modal particle *I guess*:

Example 7.19

well I guess that’s what’s named depression now, isn’t it # (GP7)

Another example of modality appears in Example 20, where the psychiatrist expresses uncertainty about the correct term *character-neurotic*:

Example 7.20

INF: and I think # if I s- think {with life} of that psychiatric
ward that they had per- they were perhaps a little neurotic or # what
were {they} named, character- # character.neurotic! **wasn’t that the name name for them #**
INT: # yes # yes
INF: # **uh back then #** (PL6)

In Example 20 uncertainty is marked through the interrogative structure, which serves as an enquiry to the interviewer. In addition, the preterite form assigns referential value (‘wasn’t that the name for it back then?’). Example 20 has certain similarities with Example 4, where the informant used *name* for reproduction and word search (‘but it actually says in **what’s the name in: # in our referral:- uh # what’s the name for that # -procedure** there’). Here, I argued that the use of *name* was without referential value. In Example 20, the enquiry to the interviewer is of a more direct nature, since *not* is used as a marker that assumes the other party’s confirmation. The use of *name* in Example 20 therefore to a greater degree than the example in Example 4 functions as a question and thereby falls under the Systemic Functional definition of modality. The results for Report of Language USE with modality are shown in Table 7.3:

TABLE 7.3: MODALITY IN REPORTED LANGUAGE USE

	General practitioners		Psychiatrists	
	N	%	N	%
With modality	36	52%	10	24%
Total	n = 69	100%	n = 41	100%

A χ^2 test for Report of Language Use with and without modality shows a significant difference between the two physician groups ($p=0.004283$). The general practitioners thus seem to mark modality in Report of Language Use to a far greater extent than the psychiatrists. One explanation might be found in the psychiatrists' specialist function, in that by presenting markers without modality they emphasise a more specialised and clearer professional identity than the general practitioner. In addition, as stated, the psychiatrists have the right of definition with regard to depression (Davidsen & Fosgerau 2014: 1). The certainty that is marked by the psychiatrists' deselection of modality supports Davidsen and Fosgerau's interpretation of the psychiatrists' position. On the other hand, the significant use of modality by the general practitioners can be said to create a distance or hesitance towards psychiatry's specialised terminology. In connection with *name*, modality is distributed as follows in the two groups of doctors:

TABLE 7.4: MODALITY IN NAME

Speaker group	General practitioners		Psychiatrists	
	N	%	N	%
With modality	13	34%	5	25%
Without modality	25	66%	15	75%
Total	38	100%	20	100%

Example 2 showed how *name* is used without modality to introduce a term as a well-established phenomenon ('those old endogenic as they were named in the old days'). A χ^2 test for the use of modality in connection with *name* shows no significant difference between the two groups of

doctors ($p=0.47111$). *Name* without modality is used more frequently in both groups, which may be due to the actual copular construction's semantics, which, without built-in agency, can be said to express a more static and thereby objective relationship than is the case, for example, with the semantics of *call*, which, as stated, implies an agent, to whom the language use is attributed. The results for modality in connection with *call* are presented in Table 7.5:

TABLE 7.5: MODALITY IN *CALL*

Speaker group	General practitioners		Psychiatrists	
	N	%	N	%
With modality	23	74%	5	24%
Without modality	8	26%	16	76%
Total	N = 31	100%	N = 21	100%

In the presentation of the results for *call*, for which the agent is key, we saw an almost identical distribution in the two speaker groups, whereby the variant amounted to around half of the occurrences of Report of Language Use in each speaker group. If we distinguish between *call* with and without modality, we can see, however, that the general practitioners use modality to a greater extent than the psychiatrists. A χ^2 test confirms this significant difference ($p=0.000349$). Example 21 illustrates psychiatrists' use of the variant without modality:

Example 7.21

INF: because sometimes **what one: calls depression** is al:so uh # bad

marriages, a bad workplace an:d

INT: # yes # yes #

INF: # difficulties with the children and

INT: # yes #

INF: # I mean, # then it's also important! for one to see which illness

INT: yes

INF: and which circumstances in life (PS5)

In Example 21 the psychiatrist talks about general practitioners' approach to the treatment of patients with depression. The psychiatrist introduces the term *depression* without any form of modality ('what one calls depression'). The use of the generic pronoun *one*, which I interpret as a reference to the general practitioners, could indicate that the psychiatrist finds that depression is viewed incorrectly by the general practitioners, who too often, according to the psychiatrist, have a misguided approach to diagnosis. In this way, *call* without modality serves as the psychiatrist's evaluation of the general practitioners' approach to the diagnosis and treatment of depression, where the psychiatrist, by using *one*, makes the general practitioners responsible for a misguided use of the diagnosis. *One* thus seems to be used here to create distance from a certain kind language use, which in combination with the psychiatrist's rejection of modality appears to emphasise the general practitioners' uncritical use of the term. An example of *call* with modality is the material from Example 18, which is reproduced below:

Example 7.22

then together we have to decide! **whether # whether we want to call it anxiety or depression**
(GP4)

The example expresses the modality of *opportunity*, which is marked with the conjunction *whether*. This articulation of opportunity could be an indication of an inclusive and flexible understanding of the terminology and diagnosis of depression; and even with a high degree of patient involvement, which is expressed by how the general practitioner presents the diagnostic process as a joint decision between physician and patient. It may be argued that the modality equates the patient's own opinion with the physician's professional expertise in the decision-making process, and also plays down the significance of the correct specialist terminology.

Different use of Report of Language Use as an expression of different understandings of depression

In this study I have attempted to illuminate a discourse presentation phenomenon which is almost undescribed in the Lancaster framework. The study has shown that Report of Language Use is realised in a number of different ways, and that the different realisation patterns in the two groups of doctors manifest different conceptualisations of depression. The frequency of Report of

Language Use was higher among the general practitioners. More detailed analysis indicated, however, that the general practitioners do not relate to depression terminology as a defining entity; instead, the frequent occurrences of modality and subjectivity indicate that depression terminology is an entity that can be personified, negotiated and questioned. This observation can be compared with psychiatry's use of Report of Language Use as a generic phenomenon and with far less modality. Broadly speaking, the psychiatrists' use can be viewed as an authority-directed top-down understanding of depression. Among the general practitioners, the understanding is materialised as a bottom-up approach, which to a lesser degree takes account of norms and the fixed standard found in e.g. psychiatry's diagnosis criteria. In their study of the two groups' perceptions of depression, Davidsen and Fosgerau conclude the following: "Psychiatrists considered the diagnosis of depression as a pragmatic and agreed construct and they did not question its validity", while the general practitioners "... thought depression was a 'gray area' and questioned the clinical utility in general practice" (Davidsen and Fosgerau 2014:1). The significant difference in the use of modality in *call* in the two groups of doctors can be said to constitute structural evidence of Davidsen and Fosgerau's observed differences in the two physician groups' perceptions of depression, as either a well-defined phenomenon or a less well-delineated entity.

One of the main conclusions of the pronoun analysis was that the general practitioners' starting point is a personal or subjective understanding through the use of *I*, while the psychiatrists' marking is to a greater extent generic, which is reflected in the group's frequent use of *one*, both in relation to the group's own use of *I* and the general practitioners' use of *one*. In the first person plural, the psychiatrists' uniform use of the pronoun seems to emphasise their professional affiliation, while among the general practitioners, the pronoun linguistically manifests a wider range of potential actors and resources that can be incorporated in the assessment of the treatment of the depressive patient. This wider range of actors can also be viewed as an expression of a patient view that considers the patient as a whole person in a socially rooted context, in which background and circumstances in life are considered to be decisive factors in the doctor's assessment of the patient's condition (e.g. Armstrong and Earnshaw 2004, Schumann et al. 2012). The psychiatrists' more diagnostic focus, which among other things is manifested in depersonalised genericity, can be said to take the place of the diversity and negotiation that is linguistically identifiable among the general practitioners.

On the basis of their results, Davidsen and Fosgerau discuss possible implications for coordinated treatment in the healthcare sector and conclude, among other things, that "GPs feel that

psychiatrists have the right of definition, which could possibly lead to a clash of interests” (Davidsen and Fogtmann 2014: 8). This study is a contribution to identifying how variations in the realisation of terminology use in the two groups of doctors can be seen as an expression of the handling of this right of definition. The analysis has shown a need to distinguish between a number of different realisations of reported, habitual language use. It thereby constitutes an important contribution to the further development of the theory of speech presentation and to applied healthcare communication research. I return to this discussion in Chapter 9.3 in which I discuss the perspectives for a linguistically anchored approach to representations, and thereby conceptualisations, in health care communication.

CHAPTER 8 THE TYPICAL PATIENT WITH DEPRESSION

8.1 A narrative approach to examining conceptualisations of depression

In this chapter, I move one step further away from the corpus approach to examining the two groups of doctors' conceptualisations of depression. This supplementary qualitative study, which includes all 23 interviews, examines how the doctors conceptualise patients by means of narrative genres.²⁴ This study should be seen as a product of my original motivation for choosing the representational interview setting as my research object. I wanted to examine the two groups of doctors' narratives and how discourse presentation was employed in these narratives. I soon realised, however, that my data did not comprise enough narrative material for a fully-fledged corpus study. Instead, I focused on a question which recurred frequently across the interviews. The question was designed to elicit a story about a patient and is worded along the lines of: 'Do you remember a typical patient with depression?' or 'Do you remember a patient story?' The question occurs in all the interviews except for two, making the speech situation comparable across the interviews (see also Gregersen & Barner-Rasmussen 2011). Apart from identifying different narrative genres as possible manifestations of such conceptualisations, I argue that interactional phenomena must be taken into consideration to provide a full picture of the two groups' productions of patient narratives in the interviews.

The current interviews are one-on-one interviews, which means that there is no competition for the right to the floor. The interviewee is therefore relatively free to elaborate on the answers as she wishes (e.g. Møller 1993: 294-5). This uncompetitive setting often results in rather long, monologic stretches of speech. Some of these stretches of speech often take the form of a narrative in that they present chronologically ordered past events (Eggins & Slade 1997, Gregersen & Barner-Rasmussen 2011). It is such narrative stretches prompted by the elicitation question that this study is concerned with: what do the two groups of doctors do when they are presented with such a question in an uncompetitive setting?

²⁴ This study is a modified version of an article that has been accepted by the journal *Sygdом & Samfund*. The article is at the time of writing in review (Pedersen & Davidsen, in press).

One of the leading figures in depression research, Professor of Primary Medical Care Chris Dowrick (2009), emphasises the value and importance of language in working with depressed patients, as it forms a vital part of an open doctor-patient dialogue, ultimately leading to empowerment of the patient (Dowrick 2009: 214). Dowrick represents a constructionist view of language and sees narratives as a tool which has the capacity to shape our own and others' selves (Dowrick 2009: 219). Within the sciences more generally, *the narrative turn* marks the incorporation of narrative conceptualisations into a broad variety of fields, qualified by narrative scholars such as Bamberg (e.g. 2010), Bruner (e.g. 1986, 2002) and White (e.g. 2007). Building on these widely accepted notions of narratives as a means of shaping reality and selves, this additional study shows that language is not only central to the interaction with and treatment of the patients, as it can, for example, encourage patients to tell positive stories about themselves. Language also plays a central role in reflecting on and shaping the reality of the professionals treating the patients. Therefore, I apply this perspective in this qualitative study of the two groups of doctors talking about their patients.

8.2 Narrative genres

Departing from classic sociolinguistic narrative theory (Labov & Waletzky 1967), the present study claims that a linguistically founded narrative framework can provide a fine-grained approach to narrative investigations to shed light on how speakers understand patients with depression. According to this view, speakers' linguistic choices play a determining role in their conceptualisation of patients with depression.

The study is based on an analysis of three different speech genres which in different ways are narrative in their structure and function: *the personal narrative*, *the specific account* and *the general account*. These three types of narrative genres are based on findings from studies of language change at the LANCHART Centre at the University of Copenhagen, where a large corpus study of *so-called* sociolinguistic interviews has suggested that *the narrative field* is covered by these three genres (Gregersen & Barner-Rasmussen 2011:15). The assumption for the present study is that the doctors' selections from the narrative field will indicate how the two groups conceptualise patients with depression. By covering all three genres, I aim to ensure the broadest possible understanding of the ways GPs and PSs construct patient identities. The three genres are replicated below:

The personal narrative

The most well-established of the three genres is the personal narrative as defined by the sociolinguist William Labov (e.g. Labov & Waletzky 1967, Labov 1972). Through a study of New Yorker narratives about the informants' experiences of life-threatening situations, Labov discovered a recurrent structure in the way informants told stories (Labov & Waletzky 1967: 26). Labov views the overall narrative structure “[...] as a series of answers to underlying questions [...]”:

- a. Abstract: what was this about?
- b. Orientation: who, when, what, where?
- c. Complicating action: then what happened?
- d. Evaluation: so what?
- e. Result: what finally happened?

(Labov 1972: 370).

A sixth element, which is absent from the list above, is *coda*, which closes the narrative by bridging the narrative world and the current speech situation (Labov 1972: 370). Of the six elements, Complicating Action and Evaluation are obligatory elements (Eggins & Slade 1997: 237). Further, for the story to qualify as a personal narrative, it must be rendered as reportable, centred on one unique event implying a climax and subsequent resolution, and the narrator must have been a participant in the narrated events (Labov 1972: 355, Labov 1997: 7-8).

The specific account

The specific account is similar to the personal narrative in focusing on a specific event in the past. As with the personal narrative, the narrator must have been a participant in, or at least a witness to, the events in the past. The mode differs from that of the personal narrative, however, in treating the event in a descriptive rather than performed mode, and the focus is on the process rather than on one central event. This mode is typically realised as listing events, using ‘and then... and then... and then...’, and the amount of detail is less than in a personal narrative (Eggins & Slade 1997: 259). The specific account may contain elements similar to those described in the personal

narrative, but the only obligatory element is the chronological rendering of a sequence of events (Eggins & Slade 1997: 259).

The general account

The general account is a rendering of recurrent past events, routines or habits or general processes and sequences and thus differs from the other two narrative genres in terms of specificity (Gregersen & Barner-Rasmussen (2011: 15-16). As in the specific account, the narrative mode is descriptive rather than performed. In contrast to the two other narrative genres, the general account need not be self-experienced (LANCHART, 2011: 44).

Summary of narrative speech genres

The characteristics of the three narrative genres, which differ in degrees of specificity and detail, reportability and evaluation, are summarised in the table below:

Table 8.1: Characteristics of the three narrative genres

Narrative genres	Personal narrative	Specific account	General account
Participation	Central role	Central role	No requirement
Narrative mode	Specific, performed	Specific, descriptive	General, descriptive
Reportability	Reportable	Non-reportable	Reportable or non-reportable
Obligatory elements	Complicating action and evaluation	Chronological rendering of events	N/A

8.3 Results

8.4.1 Narrative genres

A count of the different speech genres produced by the GPs and PSs provides the following results:

Table 8.2: Distribution of narrative genres in the GP and PS group

GENRE	Personal narrative	Specific account	General account
11 GPs	4	4	3
9 PSs	2	3	4

Of the 12 GPs, 11 produced a narrative genre when asked the elicitation question, whereas 1 attempt was unsuccessful. Of the 11 PSs, 2 were not presented with the elicitation question, which makes a total of 9 PS speech genres.

The most notable difference between the two groups is the production of personal narratives (4 vs. 2). Even though the doctors were encouraged to tell a story about a typical patient, relatively few doctors produced a fully-fledged story, i.e. a personal narrative. Regarding the number of accounts, the two groups showed similar trends, the GPs producing slightly more specific accounts (4 versus 3) and the PSs slightly more general accounts (4 versus 3). If we combine the genres that per se are specific, i.e. the personal narrative and the specific account, and compare these with the general genre, the general account, we see clearer differences between the two groups' preferences: in the GP group, 8 of 11 genres are specific, whereas this is only the case in 5 of 9 instances in the PS group. Example 8.1 is a personal narrative produced by a GP:

Example 8.1 Personal narrative²⁵

Element	Personal narrative
Elicitation	<p>INT: do you remember any patients?</p> <p>INF: well I think # I have already # we have already #</p> <p>INT: you just said burning <INF: # yes #> on the tongue {is} it was {n-} is it a patient who #</p> <p>INF: yes! it is a it # <INT: # has had {these symptoms}></p> <p>INT: {or} # yes <INF: # yes: it ehm> #</p> <p>INF: well she! is not that good an example it {it} is just because ehm # it was</p>

²⁵ Danish language examples can be found in Appendix 3

	<p>more because #{yes she} I just mentioned Lyr- # la- la- Lyrca and ehm # <INT: # mm> # there were some who had suggested</p> <p>INT: yes #</p> <p>INF: suggested it #</p> <p>INT: yes #</p>
Abstract	<p>INF: but but I think # no what can we I don't know if I can think of any examples but sometimes there are <INT: # no #> some patients where I think # yes it may well! be that it is what is called somatisation but I think that is also very much down the # <XAD: # yes> # depressive anxie- # <XAD: # yes> alley right #</p> <p>INT: yes</p>
Orientation	<p>INF: ehm that ehm # oh I have I have a young Tunisian: ehm man ma- a man of Tun: ehm Tunisian origin</p>
Complicating Action	<p>who # first said that he had a # fever # fever he said and then he did like that and then <INT: # yes # yes> # I completely misunderstood and then I showed him a thermometer and then he was completely terrified # about it # about about <INT: # yes # yes #> the way we measure! ha <INT: # mm> the temperature <INT: yes ha> #</p>
Result	<p>but it turned {out} that he had a pricking sensation #</p> <p>INT: yes #</p>
Evaluation	<p>INF: and # of course there is something: # ethnical and cultural to that! # but # he is co:mpletely # out of his wits because of th- <INT: # mm> because of- of- of- this thing #</p> <p>INT: yes #</p> <p>INF: a- a- and th- # I am thinking it i:t # these are symptoms where you: # must be aware if # if there are men- # me:ntal conditions and if it could be <INT: # yes #> anxiety <INT: # yes #> #</p> <p>INT: yes</p>
Coda	<p>INF: anxiety depression are ehm as such <INT: # yes yes #> # in the medical field I think they have been mixed # <INT: # yes> # maybe a bit too much together (GP6)</p>

In the personal narrative in Example 8.1, the GP talks about a patient whose cultural background led to a misunderstanding in the consultation. The GP suspected that the patient's somatic symptoms could be related to a mental condition. By means of this personal narrative, the GP exemplifies partly how somatic symptoms – in this case combined with a different cultural and ethnic schism – may be rooted in an underlying mental condition, and partly the importance of differentiating between various mental conditions, such as anxiety and depression.

Example 8.2 is a general account produced by a PS:

Example 8.2

INT: so # how # if you are to paint! a # typical depression- # {-picture-} or perhaps you can remember a # certain patient! you perhaps can #

INF: well we have a completely <INT: # mention #> fixed proce:- so to speak they are called in to a pre-interview # <XAD: # mm> now we have just changed it so that they actually must come to two! pre-interviews #

INT: right #

INF: but often most of it we are able # to clarify in the first pre-interview <INT: # yes #> where I <INT: # yes #> participate and then there's also a district nurse # <INT: # yes> # and then we make a completely! standard anamnesis recording it takes # just under an hour #

INT: mm

INF: # mm mostly # and go through just like when you make any # other medical record # {with dispositions and} allergies and <INT: # yes> previous: # go through all these other organ systems systematically how do you say it to: mm # partly to find out if: # they have! some kind of illness they have forgotten to tell about: # there can be side effects # or to # also typically to be able to describe! if there is # for example if they mention that they have a headache regularly so if they come back a:nd # complain about headache in connection with start-up of medication! then we can kind of look back and say well they # actually also had this before is it <INT: # mm #> congestion! or <INT: # mm #>

INT: # yes #

INF: whatever it may be # (PS6)

In Example 8.2 the PS describes the diagnostic process related to depression. The focus is on bodily/somatic symptoms in the screening procedure and the subsequent medical treatment, rather than e.g. a specific patient's life story potentially shedding light on the causes of the patient's depression, as was the case in the GP narrative in Example 8.1.

The thematic focus, along with the general mode, provides interesting information about the PS's focus, and perhaps also infers something about his conceptualisation of depression, which conveys a much stronger medical and diagnostic focus than e.g. the GP narrative in Example 8.1. I will return to differences in thematic foci in 8.3.2. Further, the PS's choice of genre is interesting in relation to the interviewer's question, which ends with an invitation to talk about a specific patient: "perhaps you remember a certain patient you can tell me about". However, the psychiatrist seems to overrule this invitation by maintaining a general focus. This phenomenon will be treated in detail in 8.3.3. These results suggest that the GPs choose to highlight individual patients, whereas the PSs conceptualise the patients in general terms, leaving out the reference to individual patients' stories and outcomes.

8.3.2 Thematic focus in the speech genres

The thematic focus in the speech genres also reveals a difference between the two groups. In all the GPs' elicitations, the patient's psychosocial background forms part of the storyline. The GPs tend to highlight the causes of or explanations for depression by referring to family relations, life-changing events or – as is the case in Example 8.1 – cultural and ethnic aspects. This focus is only found in 5 of 9 PS elicitations. In 3 of these 5 instances, a general account is chosen as the narrative mode, indicating that when the PSs choose to thematise patient backgrounds, they tend to paint a general picture of psychosocial causes and circumstances instead of highlighting specific patients. In this way, the predominant picture established by the PS group is one of generality, which yet again supports the argument that this group of doctors conceptualise the psychosocial aspect of depression as a dimension that can be categorised, which is less the case with the GPs.

8.3.3 Singular/plural phrasing of elicitation question in relation to narrative genres

In examining the doctors' genres as a response to the elicitation question, a systematic analysis of the interviewer's wording of the question held up against the genres can be useful in supporting the

argument of the two groups of doctors' different takes on constructing depression. Consider the following elicitations:

Example 8.3

if you were to mention a typical patient with depression who do you think of? (PS1)

Example 8.4

do you remember any stories as examples of some of those different types? (GP9)

In Example 8.3, the interviewer's question is posed using the singular, whereas in Example 8.4 the interviewer employs the plural form. The hypothesis behind the singular-plural distinction is that a question posed in the singular will evoke a story about a single patient, realised as a specific genre, either a narrative or a specific account, and conversely that a question in the plural will result in a general account. In cases of ambiguity as regards the singular/plural distinction, it is the last part of the question – i.e. how the interviewer *ends up* phrasing the question – that has been included in the count.

The table below displays the correlations between the phrasing of the elicitation question and production of genres in the two groups:

Table 8.3: Singular/plural distinction in questions and answers in the GP and PS groups

	GP group	PS group
Total production of genres	11	9
Singular elicitation>specific genre	6	4
Singular elicitation>general genre	3	3
Plural elicitation>specific genre	2	1
Plural elicitation>general	0	1

genre		
-------	--	--

A comparison of the two groups' production of genres in relation to the singular/plural distinction points to two conclusions: firstly, in the GP speaker group, both questions that are phrased in the plural prompt a specific genre (i.e. personal narrative or specific account). Even though a question in the plural would be expected to elicit a general genre, the GPs choose to contradict this expectation and adapt the question for their own purposes, talking about a single patient through a specific genre. This count supports the idea that the GPs tend to view their patients as individuals and that the emphasis on single fates is paramount to e.g. diagnostic processes and categorising the patient. Secondly, in 3 of 9 PS interviews, a specific question is responded to with a general genre. The elicitation question in the plural is also responded to with a plural genre, in contrast to the way in which the GP group handled questions in the plural. The GPs do produce general genres following elicitation questions in the singular, but only in a few cases (3 of 11) as they predominantly seek the specific genre no matter how the question is phrased.

8.4 Taking on the task?

In many of the interviews, the speakers produce a genre immediately after the interviewer's elicitation question. However, in some of the interviews the doctors negotiate the elicitation question before producing a genre. This negotiation may take the form of any inserted talk between the elicitation question and the start of the narrative genre, such as clarifying questions from the interviewees. Example 8.5 shows an instance of negotiation:

Example 8.5

-
- 1 INT: Do you remember like a # typical # patient with the: unipolar depression #
 - 2 INF: yes I have just had one ehm here oh with a unipolar! are you asking for now here <INT:
 - 3 # yes ehm> # right # <INT: # yes>
 - 4 INT: it can also be the other type
 - 5 INF: oh it was {just because} the other <INT: # ehm yes #> I was thinking about the other
 - 6 <INT: # yes yes yes>
 - 7 INT: but you #
 - 8 INF: ehm # <INT: # can also tell about that > # ehm well what now what what now then

9 {then} now I have just lost the thread because now now now s- you asked xxx <INT: no yes I
10 was asking if>
11 INT: you could remember a # like a # patient you thought was typical with regard and there I
12 was actually thinking about the un- unipolar but I would <INF: #unipolar yes #> also like to
13 hear about the other one #
14 INF: yes
15 INT: yes #
16 INF: : ehm but it is more I actually think the unipolar is the most interesting to you because
17 <INT: # yes yes> because it is the one that i:s most # it is that type tha:t comes into general
18 practice <INT: # yes #> typically right <INT: # yes #> # ehm yes # we:ll I remember a lot so
19 what is it that you would like to know then I can # <INT: # yes but I would like to know>
20 INT: kind of ehm it it ehm and of course that is probably not the typical kind but ha well
21 when I am asking for a typical patient then it is <INF: # yes #> a kind of a picture that # that
22 mirrors #
23 INF: yes # <INT: what>
24 INT: you would # think it is # it is what you often see right # yes <INF: # okay #> # PS5

Counting the instances of negotiation after the elicitation question in the interviews reveals another difference between the two groups: whereas 7 of 11 GPs produce a genre immediately after the elicitation question, this is only the case in 4 of the 9 possible PS genres. Example 8.5 is taken from a PS interview and shows an extended negotiation, consisting of an insertion of nine turns before the actual genre is produced. This negotiation could be regarded as a desire to provide precise information, fulfilling the purpose of the speech event, the interview, and ultimately the research project by ensuring the interviewer's take-away from the interview. This is also supported by the PS's counter question: 'what is it that you would like to know?' (l. 19), along with the extensive use of meta-language throughout the sequence, underlining the PS's focus on identifying the task that he is given by the interviewer. Further, the story is realised as a general account, which supports the assumption that the PSs tend to conceptualise patients in categorical terms rather than in specific encounters. The predominance of the negotiation in the PS group could also be seen as an affirmation of the specialist professional identity that the PSs, as opposed to the GPs, possess. In Example 8.5 the PS even decides what the most valuable information for the interviewer is (ll. 16-18).

The different interactional structures that are found between the interviewer and the two groups, both in the negotiation of the elicitation and in relation to correlations between the singular/plural distinction in questions and answers described in 8.3.3, may be illuminated further by looking at the context: the research interview. Kvale argues that: “The research interview is an inter-view where knowledge is constructed in the inter-action between two people. The interviewer and the subject act in relation to each other and reciprocally influence each other. The knowledge produced in a research interview is constituted by the interaction itself, in the specific situation created between an interviewer and an interviewee. With another interviewer, a different interaction may be created and a different knowledge produced.” (Kvale 2007:11-13). The differences between the two groups, not only in terms of representation, but also how the representations are fuelled in the interaction, would seem to be supported by Kvale’s observation. The relation between the interviewer, who has a long history as a GP, and the two groups of doctors could be the result of a local, contextually motivated realisation of broader professional and not least cultural differences between the two groups of doctors and their conceptualisations of depression and patients with depression.

8.5 Discussion

The investigation into the two groups’ representations of patients, in combination with interactional phenomena in the interviews, has suggested differences in the ways the GPs and the PSs conceptualise patient identities, and indeed how they conceptualise their own professional identities. The divide between specific and non-specific narrative genres was particularly prevalent. The result that the GPs tend to conceptualise specific patients indicates that the GPs take a more individual approach to the patients, in which dimensions such as specific life-circumstances, critical events and causes etc. are central in establishing a helpful and complete picture of the patient. In the PS group, the patient is to a greater extent construed as generic, which suggests that to the psychiatrists the patient is a category more than a product of psycho-social circumstances. The study has also revealed differences in interactional patterns between the two groups of doctors. These differences were manifested in varying approaches to the interviewer and the interview situation, just as subtle variations in the interviewer’s interview technique may have contributed to slightly different results within the two groups. These interactional observations, I would argue, add to the notion that the two groups have diverging professional identities. I return to these differences between the two groups of doctors in the discussion in Chapter 9.

CHAPTER 9 DISCUSSION

The discussion consists of three parts: the stylistic perspective (9.1), which focuses on the theoretical framework as a basis for a corpus stylistic discipline as well as its explanatory potential in a context-specific corpus investigation; the sociolinguistic perspective (9.2), where I seek and discuss explanations for the differences in linguistic patterns between the GP and PS groups; and finally, the applied perspective (9.3), where I discuss how adopting a discourse presentation framework may enhance health care communication and the potential for combining the framework with other approaches to health care communication.

9.1 The stylistic perspective

One of the two main objectives of my thesis has been to apply the Lancaster discourse presentation framework to a corpus of spoken, institutional, predominantly non-narrative interview discourse. The scalar approach to examining discourse presentation, as opposed to the widespread focus on direct speech, has proven highly useful, for example by capturing the high frequencies of the summarising categories noted in the three presentational clines. Comparing the two speaker groups has also provided highly significant results, again with regard to the summarising categories. Such distinct differences, both when comparing my corpus with existing corpus investigations, and from the comparison of the two groups of health care professionals, would not have come to light had the focus been on the widely described Direct Speech, even contrasted with Indirect Speech. I would argue that one of the advantages of the scalar approach is the meaning potential that lies in selecting a specific category, thereby deselecting the rest. The scalar paradigm is in line with the idea behind Systemic Functional Linguistics, where linguistic structures are seen as a resource and where the actual choice made carries meaning in itself (Andersen & Holsting 2015: 16). Continuing on this theme, I would argue that another strength of the scalar approach is the ability to capture meaning from locally paired and/or contrasted discourse presentation categories and scales. This is supported by, for example, Buchstaller (2002), who demonstrated the usefulness of systematic analyses of co-occurrences, i.e. cluster analyses, of quotatives. Semino and Short also briefly introduce the concept of co-occurrence, but do not back this up with any systematic analysis or figures (Semino & Short

2004: 29). In future research, I expect that carrying out more systematic cluster analyses may be able to expand the description of the clines and associated categories.

In terms of my use of category features, these additions, intended to illuminate uses of the discourse presentation categories, are by no means a new take on the Lancaster discourse presentation framework (Semino & Short 2004, McIntyre et al. 2004). However, the features that were most prevalent and provided the most encouraging results in my corpus were not examined by Semino and Short at all (McIntyre et al. do not provide results at feature level): for genericity, I found that the corpus is dominated by non-specific presentation, and in relation to speaker group, the annotation of voice provided several significant results between the two speaker groups.

In their discussions on discourse presentation examples, Semino and Short occasionally mention who is responsible for a given utterance, and how roles are construed in represented dialogic passages by contrasting discourse presentation categories, including assigned speaker roles. They also point out that plural voices may be applied with certain categories (e.g. Semino & Short 2014: 72, 76). However, the mark-up of their corpus does not include a systematic annotation of speaker voices. Based on my quantitative results, I would argue that speaker voice has been the most rewarding coding addition in my study. I would also argue that corpora constructed to illuminate a specific context may benefit from incorporating a systematic annotation of speaker voice. More generally, even though the investigation at the level of discourse presentation categories showed several significant differences between the two speaker groups, we have also seen how the trajectories of the deep coding have annulled or reversed overall results. Thus, deep coding enables us to get a fuller and more fine-grained picture of patterns which would otherwise have been overlooked.

I have argued that the quantitative corpus approach, combined with deep-coding and its trajectories, is an extremely useful one. In the light of these findings, it seems relevant to ask how far a quantitative approach can take us in extracting meaning from a context-specific corpus like mine. I have provided examples of how category use may vary according to speaker group. In some cases, this was due to different uses of category features. In other cases, however, I have identified variations between speaker groups in lexical realisations, e.g. for Representation of Voice, Representation of Thought Act and reporting clauses in Indirect Writing. Showing this variation in lexical choices would not have been possible from consulting quantitative results only.

Nevertheless, the quantitative results have made it possible to identify prevalent structures and patterns on which we can carry out qualitative analyses. In fact, the quantitative approach to stylistics is a relatively recent trend in this field, which is known to be inherently qualitative in its approach to text (Semino & Short 2004: 4). And I believe I have demonstrated, just as Semino and Short and McIntyre et al. did, the validity of a corpus-based approach. As suggested by Semino and Short, among many others, quantitative and qualitative analyses seem to be an ideal combination (Semino & Short 2004: 201). Another central dimension when working with spoken interaction is the context in which the discourse presentation is produced. In my corpus, I have attempted to incorporate the annotation of basic interactional patterns. A description of such patterns can clearly be taken much further in future research, but for the purposes of this thesis, I will return to a discussion of interactional aspects in 9.3. My supplementary studies in Chapter 7 and 8, one more grammatically detailed, one based on narrative genres and interaction have shown confirmed the two groups patterns of use in the corpus with regard to different conceptualisations of doctor-patient relationship and professional authority, also towards the interviewer in the study in Chapter 8. Apart from being studies in their own right, I would argue that these supplementary perspectives actually validate the corpus approach and the explanatory potential of such an approach.

Even though discourse presentation has a long tradition as a literary phenomenon, subsequent studies have shown that discourse presentation is also common in other types of written text than literary, just as several studies have explored especially direct speech in spoken discourse. However, the scalar approach to discourse presentation in spoken language is underexplored, even though McIntyre et al. (2004) and Pedersen (2009) make contributions to right this imbalance. However, McIntyre et al. do not provide any examples of use and function, let alone category features. The present thesis has confirmed that discourse presentation is a phenomenon far from exclusive to written, literary text. It has also shown that language need not necessarily be narrative to include a high density of discourse presentation, contrary to what by Semino and Short and McIntyre et al. suggested. The insights gained from looking at other types of discourse are merely different in nature and therefore contribute to expanding and qualifying the existing discourse framework. This observation leads me to highlighting one particular result in my corpus, which, I would argue, makes applying a discourse framework to other discourse types – and languages – even more relevant: the use of Free Indirect Speech in my corpus.

There has been an assumption that Free Indirect Speech is a stylistic phenomenon characteristic of – and somewhat exclusive to – written, literary discourse (e.g. Chafe 1994, Semino & Short 2004, McIntyre et al. 2004). However, Brøndum-Nielsen (1953) finds that Free Indirect Speech has a long tradition in spoken Danish – a conclusion which is reiterated by both Møller (1995) and Pedersen (2009). My corpus investigation adds quantitative weight to these observations. Since the English language literature about discourse presentation in spoken language consistently avoids dealing with this speech presentation form²⁶, it seems relevant to ask whether Free Indirect Speech is a trait that is language specific – or perhaps even culturally bound. To take this argument a step further, in relation to the speaker groups, we saw that the incidence of Free Indirect Speech was most significant in the GP group who, I have argued, both in terms of discourse presentation choices and lexicality use language that approximates to what we may call ‘vernacular’ or ‘layman’ language. Could this higher incidence be an indication that Free Indirect Speech is indeed a trait of common language use (in spoken Danish) rather than exclusively a stylistic phenomenon characteristic of crafted prose?

9.2 The sociolinguistic perspective

The second main objective of my PhD was to investigate general practitioners’ and psychiatrists’ uses of discourse presentation and associated features as indications of conceptualisations of depression. The motivation for this second objective was the need for new evidence about the respective understandings of depression in the two sectors, with the perspective of investigating the possibilities for shared care between general practice and psychiatry in terms of shared discourse. It is therefore relevant to ask if there are covert barriers between the two groups (Gask 2005). The notion of understandings and conceptualisations has been prominent throughout my study and may be regarded as a language psychological approach to investigating speaker groups in a sociolinguistic context: The corpus results revealed several significant differences between the two groups of professionals in their uses of discourse presentation, as well as in the deep-coding of category features. Because the corpus is controlled, both with regard to discourse presentation categories and in terms of immediate context, viz the research interview (see Chapter 3), I have argued that there is a high degree of comparability between the two speaker groups. Hence, there is reason to assume that at least part of the explanation for the differences is to be found in two

²⁶ Semino and Short point out that most literature use the term Free Indirect Discourse (or the like), suggesting that it fails to acknowledge distinct differences between the two free indirect categories (Semino & Short 2004: 9, 124).

differing background variables: one, the circumstances under which the doctors meet their patients, and two, their medical training. GP-patient relations are often very long-standing, which could explain why the GPs in my study use discourse presentation to describe their dialogues with patients, and generally incorporate speech and thought in ways which are more dialogical and with less reporter control than is the case with the psychiatrists. By contrast, the psychiatrists treat patients specifically for their mental condition, which implies that they do not have the same long-term relationship with their patients as do the GPs. This may at least partly explain why the PS group is less focused on the dialogical aspects of doctor-patient relations and are instead generally more authoritative in their linguistic choices.

As regards medical background, the GPs' training encompasses a wide range of different disciplines. In contrast, psychiatrists' training focuses on achieving competences in diagnoses and prescribing appropriate medication (Stange 2009). I have argued that the GPs' use of discourse presentation indicates a strong individual position and a tendency not to consider themselves as aligned with the system, as opposed to the PS groups' specialist, authoritative stance, which positions them very differently in the health care system. Thus, the two groups' different linguistic patterns both confirm and accentuate the fact that they are representatives of different sectors in the health care system and that they fulfil different roles. A central issue is to what degree the GPs' mindset and their approach to their patients can be integrated into shared care between the two sectors (Overbeck, Kousgaard & Davidsen 2018a). The current situation is that GPs have to refer to diagnostic criteria formulated in the psychiatric sector (Gask, Klinkman, Fortes & Dowrick 2008); criteria that they do not always consider relevant in general practice (e.g. Davidsen & Fogtmann 2014a). This discussion about the relevance of diagnoses also had a prominent position in the Danish Collaborative Care study (Brinck-Claussen 2017). The GPs thought that the criteria for patients to be included in the project were too rigid and did not mirror the clinical reality in general practice (Overbeck, Kousgaard & Davidsen 2018a). This result, seen together with the different levels of specialisation in the two groups with regard to treating mental illness, seems to suggest an asymmetrical relation between them, which could pose a challenge to future cooperation. In the Collaborative Care study, psychiatric nurses employed in psychiatry treated patients in general practice (Brinck-Claussen et al. 2017). Communication between the two sectors was mostly monologic with the psychiatric nurses simply making their reports; only rarely was it dialogical to include contributions from GPs and care managers as well (Overbeck, Kousgaard & Davidsen

2018b). These observations seem to confirm the lack of integration of understanding between psychiatry and general practice.

Two studies have been carried out on the same 23 doctors interacting with their patients²⁷. Based on video recordings of consultations, the studies show that GPs and PSs have different approaches to their patients (Davidsen and Fosgerau 2014a, Fosgerau and Davidsen 2014). One of the studies, which looked at differences between how the two groups of doctors handled patients' emotional disclosures, concluded that: "the differences between GPs and psychiatrists might mirror deeper differences in the conceptualization of depression as a biomedical disease or a condition caused by life circumstances [...] A lack of consensus might affect fruitful interdisciplinary work." (Davidsen & Fogtmann 2014a: 66).

The evidence from the current study, which shows that the two groups display differences in terms of discourse presentation use and in the grammatical and interactional patterns employed, indicates that practical and structural factors in the two health care sectors do not provide a full explanation for the findings of the Davidsen & Fogtmann studies. Instead, we might view the differences between the two groups as being indicative of more fundamental cultural differences between the two sectors of psychiatry and general practice, partly caused by the different roles they have and the conditions under which they work in the health care system (Stange 2009, Stange & Ferrer 2009, McWhinney 1996).

9.3 The applied perspective

As stated in the introduction to this thesis, my motivation for using interview data has been to investigate health care communication from a representational rather than an interactional perspective, i.e. to study how doctors talk *about* patients, their profession and depression as a condition. The thesis can therefore be regarded as a supplementary approach to the established tradition within health care communication research of examining doctor-patient interaction (refs. Peräkylä). Semino & Short's corpus investigation may be seen as a strong argument for carrying out a sustainable corpus analysis of discourse presentation. By identifying clear patterns of discourse

²⁷ As pointed out in Chapter 3, my corpus consists of interviews with 12 of the 23 doctors, and the two studies in Chapter 7 and 8 are based on all 23 interviews.

presentation use, I have provided linguistic evidence for the doctors' conceptualisations of doctor-patient interactions, their own professional identities, and how they view depression as a condition. In studies of interaction we examine how participants *act*. In thematic analyses, which will be treated below, we look at *what* the participants talk *about*. The structural approach taken here can be regarded as an attempt to uncover the less obvious meanings that lie in such structural patterns – patterns which the participants may not pay attention to or be aware of when being 'research objects', whereas it may be easier for participants to control thematisations in interviews and behaviour in interactions.

One of the studies by Davidsen and Fosgerau (2014) is based on the same interview data as mine and considers how the two groups of physicians experience the depression diagnosis and the diagnostic process. Davidsen and Fosgerau apply the Interpretative Phenomenological Analysis (IPA) method, which can be used to identify key issues at an overall thematic level (Smith et al. 2009). Where the IPA method is in principle explorative, my approach is more deductive, since I have sought to identify a set of pre-defined, structural phenomena. Both methods can handle large amounts of data, but examine the object of investigation in different ways and through magnifying glasses of different strengths. Concerning the language employed by the psychiatrists and general practitioners, Davidsen and Fosgerau point out that:

The two groups differed completely in their use of language when talking about depression and patients with depression. Psychiatrists used medical language and focused almost solely upon symptoms of depression and the agreed diagnostic criteria for the diagnosis. They talked in general terms about groups of patients and GPs' focus was specifically on individual depressed patients. Psychiatrists sometimes used a depersonalizing language and designated patients with depressions as "depressions". (Davidsen & Fosgerau 2014a:4)

This citation is a predominantly thematic description of the two groups of doctors' language use and is analytically consistent with other professions' approaches to investigating health care issues in representation contexts in which the structural, grammatically-based approach is under-represented. The specific linguistic structures that I have identified in my analysis support Davidsen and Fosgerau's thematically-based statements, but also provide structural evidence to support claimed

understandings of depression. These two approaches can be advantageously combined by first identifying passages with a required theme using the IPA method, and then analysing them in more detail with the help of a grammatical discourse presentation analysis. Abildgaard et al. provide a recent example showing how it is possible to integrate IPA into a linguistic framework in a study of health care communication. They combined IPA and Systemic Functional Linguistics, thereby enabling them to describe how patients with stress express their identities (Abildgaard et al. 2018). Abildgaard et al. may thus be considered to have a cross-disciplinary approach to investigating mental conditions. In a broader perspective, I believe that the potential for methods from linguistics and social psychology to be combined makes it possible for different professions across sectors to meet in a description of the same domain.

In the beginning of the thesis, I stressed that my use of the term discourse *presentation* does not reflect a certain standpoint on the relation between the reporting and the reported. The debate about whether to regard discourse presentation as a situated phenomenon concerns the very ontology of discourse presentation: is it a rendering of a previous instance of discourse or is it, to use Tannen's term, a *constructed* phenomenon serving an interactional purpose in the reporting context? Within many areas of linguistics and in the social and human sciences more generally, the constructionist view has gained considerable ground over the last few decades, the field of discourse presentation being no exception. The ontological status of discourse presentation also reverberates at a more concrete level, namely in the approach to analysing discourse presentation. For example, the premise for the predominantly conversation-analytic *Reporting Talk* (Clift & Holt 2006) is that discourse presentation constitutes an interactional resource (see also e.g. Beck Nielsen 2007). Following Tannen (1989), Clift and Holt only deal with Direct Speech (with the exception of one chapter about Direct Thought). In Short's review of *Reporting Talk*, he notes the predominant focus on analysing Direct Speech and thus advocates integrating the scalar approach (Short 2009: 209). Semino and Short also discuss the possibility of testing their discourse framework on spoken, interactional discourse (Semino and Short 2004: 9, 230-231). I have made an initial attempt to incorporate interactional phenomena in my annotation, and have suggested how the interaction may influence the participants' use of discourse presentation. Taking into consideration the well-established position conversation analysis has in health care communication, the potential for combining an interaction-analytic approach and discourse presentation seems considerable.

Another established method in health care research is administering post-consultation questionnaires and so-called *recall sheets* in order to capture how patients and doctors experienced the consultation (e.g. Skinner et al. 2007, Goodchild et al. 2005). A questionnaire is a relatively easy and low-cost method of gaining such information. At the same time, however, the pre-defined structure of such documents poses some methodological problems in terms of controlling the outcome, viz my discussion above of the potential of a structural rather than a thematic or interactional approach. A way of overcoming this may be to employ discourse presentation analyses as a method of recalling consultations. I would argue that by focusing on presentations of speech, writing and thought, the discourse presentation framework has the potential to be extremely useful and precise when applied to such post-consultational contexts. In 9.2, I argued that my results, at least to some extent, correlate with the analyses of the same doctors' interactional patterns in consultations. This suggests that there are links between talking *with* and talking *about* – and lines between interaction and (re)presentation to be drawn. Consider this thesis a first tentative line, please!

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APPENDIX 1

Interviewguide - depression

Hvad tænker du, depression er for en tilstand?

Hvordan oplever du, depression viser sig hos patienterne?

Hvad plejer du at gøre for at finde ud af, om det er en depression?

Synes du, det er nemt at stille diagnosen?

Er det nemt at afgrænse depression fra andre tilstande?

Kan du fortælle om en depressionspatient, du har haft?

Hvad tænker du, der kan give depression?

Tænker du, at biologiske eller psykologiske forhold har størst betydning?

Hvordan plejer du at behandle depression?

Tilbyder du samtaleterapi/psykoterapi?

Hvordan synes du det er at tale med patienter med depression?

Er samtalen anderledes end med andre patienter?

Er der nogle bestemte ting, du er opmærksom på?

Hvordan tænker du, at samarbejdet bedst kan fungere mellem praktiserende læger og psykiatere?

Har du oplevet ændringer i, hvordan man ser på depression gennem årene?

APPENDIX 2

Danish examples from the study *Report of Language Use*

Example 7.1

Example 7.1 is an English language example

Example 7.2

INF: jeg tror depression er mange ting **de der gamle**
{**endogene**} # **som det hed i gamle dage** dem ser man
jo ikke så mange af # vel
INT: # nej
INF: synes jeg ikke(GP8)

Example 7.3

INF: som psykiater så ser man så # de sådan # det
den # tungeste halvdel eller[puster] øh
noget i den stil #
INT: # mm
INF: # af det **man kalder depression** (PS4)

Example 7.4

men der står faktisk så i i **hvad hedder det i: # i vores henvisnings:-**
øh # hvad hedder så noget # -procedure der at # det
faktisk skal være foretaget hos egen læge # før de henviser (PS6)

Example 7.5

altså # indgangsbilletten til at komme ind på psykiatrisk # sygehus
i [navn på hospital] ! # **det hedder jeg har selvmordstanker**
(PS2)

Example 7.6

INT: nej # så # så det er nogle tilstande **du egentlig**
ville kalde depression # ud fra kriterierne eller
hvordan #
INF: # ja de kunne sa- altså de passer på kriterierne
(GP11)

Example 7.7

INT: så vil du kalde det en bestemt form for samtaleterapi
INF: det ved jeg ikke lige jamen så må det jo være
støttende
INT: ja
INF: # **støttende!** primært psykoanalytisk øh baseret
men med træk a:f # a:f kognitiv terapi (PS7)

Example 7.8

INF: jamen tænk! hvad **ordet rygerlunger** #
INT: ja #
INF: øh gjorde! # for at få skovlen under rygningen
ikke
INT: ja # ja #
INF: det # og tænk hvad lyk- ordet **lykkepiller** #
INT: ja #
INF: var har gjort altså # (GP6)

Example 7.9

og øh # og øh # problemet er jo lidt # at øh # at det er svært at
skelne # # øh # hvad der er: # hvad der er # øh er det **vi lærte**
som en endogen depression og # og hvad der mere er # stress
og # og øh # og øh eksistentielle # vilkår (GP4)

Example 7.10

INF: og så er der **noget der hedder mindfulness** som er
INT: ja
INF: # ved at komme på mode nu # altså (PS4)

Example 7.11

vi ser meget! få # sådan hvad **jeg** vil kalde # klassiske depressioner
(GP6)

Example 7.12

øh # jamen: # jeg laver da noget ha **jeg** selv kalder kognitiv
terapi (GP2)

Example 7.13

jeg laver – det – **jeg** kalder det samtaleterapi (PS7)

Example 7.14

ej diagnostisk kalder **man** det ikke mere (PS5)

Example 7.15

jeg tror at at altså # d- det det jeg sådan måske # bruger allermest
det er det **vi** kalde:r # psykoedukation # (PS4)

Example 7.16

så i så fald kan **vi** kalde dem belastningsreparatio- # øh # d- reaktioner
med depressive symptomer (PS2)

Example 7.17

jeg har svært ved at # øh jeg vil ikke sige acceptere øh men men
sådan ligesom forbinde! # den psykiatriske måde at se depression
på som jeg kan huske fra de: fra psykiatriske afdelinger # til den!
måde vi ser depressioner # eller det **vi** kalder depression øh herude
i praksis (PL7)

Example 7.18

så skal vi jo sammen vælge! om # om **vi** kalder det angst eller
depression (GP4)

Example 7.19

jamen det er **vel** det der hedder depression nu ikke # (GP7)

Example 7.20

INF: og jeg tror # hvis jeg s- tænker {med livet} på
den der psykiatriske afdeling der havde de måsvar
de måske lidt neurotiske eller # hvad hed
{de} karakter- # karakterneurotiske! **hed hed det
ikke så nogle #**
INT: # ja # ja
INF: # øh dengang # (GP6)

Example 7.21

INF: fordi nogle gange er **det man: kalder depression**
jo også øh # dårlig ægteskab og dårlig arbejdsplads
o:g
INT: # ja # ja #
INF: # vanskeligheder med børnene og
INT: # ja #
INF: # altså # så det er jo også vigtigt! man får set
på hvad sygdom
INT: ja
INF: og hvad er livsomstændigheder (PS5)

Example 7.22

så skal vi jo sammen vælge! **om # om vi kalder det angst eller
depression** (GP4)

APPENDIX 3

Danish examples from the study *The Typical Patient with Depression*

Example 8.1

INT: ja # har du: # kan du huske! så nogle # patienter øh #

INF : jamen dem synes jeg da # dem # dem har vi da #

INT: nu sagde du brænden <INF : # ja #> på tungen {er} det var {n-} er det en patient der #

INF : ja! det er en det # <INT: # har haft {det symptomer}>

INT: {eller} # ja <INF : # ja: det øh> #

INF : ej hun! er ikke så godt et eksempel det {er} bare fordi øh # det var nu fordi # {ja hun} lige nævnede Lyr- # la- la- Lyrica og øh # <INT: # mm> # der var nogle der havde foreslået

INT: ja #

INF : foreslået det #

INT: ja #

INF : men men jeg synes # nej hvad kan vi jeg ved ikke om jeg lige kan komme i tanke om nogle eksempler men der er nogle gange nogle <INT: # nej #> # nogle patienter hvor jeg tænker # ja det kan også! godt være det bare er det der hedder somatisering men det synes jeg også er meget ovre i den # <INT: # ja> # depressive angst- # <INT: # ja> -gade ikke #

INT: ja #

INF : øh at øh # jo jeg har jeg har en ung tyrkisk: øh mand ma- en mand af tyr: øh tyrkisk herkomst som # som først sagde at han havde # feber # feber sagde han og så gjorde han sådan der og så <INT: # ja # ja> # jeg misforstod det helt og så viste jeg ham et termometer og så blev han fuldstændig rædselsslagen # på den # for for <INT: # ja # ja #> den måde man målte! ha <INT: # ja> temperatur på <INT: ja ha> # men det viste {sig} så at han havde stikken og prikken #

INT: ja #

INF : og # der er selvfølgelig noget: # etnisk og kulturelt i det! # men # han er f:uldstændig # skræmt! fra vid og sans af d- <INT: # mm> af d- af d- af d- af det der #

INT: ja #

INF : o- o- og d- # det da tænker jeg det de:t # det er så nogle symptomer hvor man: # må være opmærksom på om # om der ligger ps- # p:sykelige lidelser og hvad skulle det <INT: # ja #> være angst <INT: # ja #> #

INT: ja

INF : angstdepression jo som jo også sådan <INT: # ja ja #> # i lægeverdenen synes jeg har flydt # <INT: # ja #> # måske lige # lovlig meget sammen men det er jo meget almindeligt det der med at # at vi måske er begyndt at stille diagnoser omvendt altså # det som den medicin # virker på det hedder så <INT: # mm> det ikke altså <INT: # mm> det astmamedicin virker på <INT: # mm #> det hedder astma ha <INT: # ja # ha #>

Example 8.2

INT: ja # så # hvordan # hvis du sådan skal beskrive! en # typisk depressions- # {-billed-} eller det kan være du kan huske en # speciel patient! du måske kan #

INF: jamen altså vi har jo en hel hel <INT: # nævne #> fast øh hel fast kuty:- kan man sige de vil blive indkaldt til en forsamtale # <INT: # mm> nu har vi lige ændret det til de faktisk skal ind til to! forsamtaler #

INT: ja #

INF: øh men ofte så kan man # afklare det meste ved første forsamtale <INT: # ja #> hvo:r hvor jeg <INT: # ja #> deltager og så deltager der en distriktssygeplejerske # <INT: # ja #> # og så laver vi en fuldstændig! normalt anamneseoptagelse det tager # en lille time #

INT: mm

INF: # øh for det meste # o:g øh gennemgår ligesom når man laver en # hver anden journal # me:d # {diskussion og} allergier og <INT: # ja> tidligere: <INT: # ja #> # går igennem alle de her øvrige organsystemer systematisk hvad hedder de:t øh # for at dels for at se om: # de fejler! et eller andet de lige har glemt at fortælle eller om: # der kan være bivirkninger # eller for at # også typisk for at kunne beskrive! om der er # for eksempel hvis de beskriver de har jævnligt hovedpine så hvis de kommer o:g # klager over hovedpine i forbindelse med opstart af medicin! så kan vi ligesom kigge tilbage og sige jamen det # havde de faktisk også før er det <INT: # mm #> forstoppelse! eller <INT: # mm #> #

INT: ja #

INF: hvad det nu kan være #

INT: ja #

Example 8.3

INT: hvis du skulle nævne en typisk patient med depression hvem tænker du så på (PS1)

Example 8.4

INT: kan du huske nogle # historier sådan som eksempler på nogle af de der # (GP9)

Example 8.5

INT: ja # ja # kan du huske sådan en # typisk # patient med den: unipolare depression #

INF: ja # sad lige med en altså her nå med en unipolar! spørger du om nu her # <INT: # ja øh> # okay #
<INT: # ja>

INT: det må også godt være den anden

INF: nå det var {lige fordi} den anden <INT: # øh ja #> hvor jeg <INT: # ja #> tænkte på # <INT: # ja ja ja>

INT: men det #

INF: øh # <INT: # må du gerne fortælle om > # øh jamen hvad nu hvad hvad så nu {nu} har jeg lige tabt
tråden for nu nu nu s- du spurgte xxx <INT: ej ja jeg spurgte om>

INT: du kunne huske en # sådan en # patient som du syntes var typisk i i forhold og der tænkte jeg egentlig
på den un- unipolare jeg vil <INF: # unipolare ja #> da også godt høre om den anden #

INF: ja

INT: ja #

INF: øh men det mere jeg tror det faktisk unipolar mest interessant for jer fordi at <INT: # ja ja #> det at det
er den at der e:r mest # det er jo den de:r # der også kommer i almen praksis <INT: # ja #> typisk ikke

<INT: # ja #> # øh ja # altså de:t jeg kan huske mange så hvad er det du gerne vil høre så kan # <INT: # ja
men jeg vil høre>

INT: sådan øh det det øh og det er selvfølgelig ikke sikkert det typiske men ha altså når jeg spørger om en
typisk patient så er det <INF: # ja #> sådan et billede der # der svarer til #

INF: ja # <INT: # det>

INT: du vil # tænke det er # det er det du ofte ser ikke # ja <INF: # okay #> #
