Disability and Rehabilitation
An international, multidisciplinary journal

http://informahealthcare.com/dre
ISSN 0963-8288 print/ISSN 1464-5165 online

Disabil Rehabil, 2015; 36(17): 1419–1430
DOI: 10.3109/09638288.2013.834987

informa
healthcare

RESEARCH PAPER

Conversational pursuit of medication compliance in a Therapeutic Community for persons diagnosed with mental disorders*

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Abstract

Purpose: In this article, we contribute to the debate on medication compliance by exploring the conversational ''technologies'' entailed in the process of promoting clients' adherence to psychopharmacological prescriptions. Using a case study approach, we explore how medication-related problems are dealt with in conversational interaction between the staff members and the clients of a mental health Therapeutic Community (TC) in Italy. *Method*: Four meetings between two staff members (Barbara and Massimo) and the clients of the TC were audio-recorded. The data were transcribed and analyzed using the method of Conversation Analysis. *Results*: Barbara and Massimo recur to practices of topic articulation to promote talk that references the clients' failure to take the medications. Through these practices they deal with the practical problem of mobilizing the clients' cooperation in courses of action that fit into the institutional agenda of fostering medication adherence. *Conclusions*: Barbara and Massimo's conversational practices appear to reflect the assumption that medication-related problems can be reduced to compliance problems. This assumption works to make the clients accountable for their failure to take the medications while shaping a conversational environment that is unreceptive to their complaints about side effects. Implications for the understanding of mental health rehabilitation practice in TCs are discussed.

Keywords

Communication, compliance, medication, mental health and illness, Therapeutic Community

History

Received 27 December 2012
Revised 6 August 2013
Accepted 12 August 2013
Published online 20 September 2013

➤ Implications of Rehabilitation

- Therapeutic community staff members should be aware of the challenges and blocks in communicating with their clients.
- Therapeutic communities can promote staff members' awareness of communication challenges through reflective workshops in which they can jointly view and comment on interaction with their clients.
- Reflective workshops can be used to raise awareness of the presuppositions underlying therapeutic community staff members' communication practices.

Introduction

Psychotropic drugs are widely used in mental health rehabilitation programs, both in inpatient and outpatient treatment. According to Scheid-Cook [1], ''psychiatric medication provides immediate results, while alternative care strategies can be more costly, time-consuming and may not yield improvement in patient functioning'' (p. 60). At the same time, their use is controversial because of the existence of side effects [2]. Barrett et al. [3] effectively summarize this contradiction:

> Despite side effects, psychotropic medication remains the treatment of choice for psychosis because it is effective in controlling psychotic symptoms. Herein lies the conflict. People with mental illness often have legitimate reasons for refusing medications. Yet mental health practitioners have sufficient evidence that psychotropic medication may be in the best interest of people with mental illness, as it is often the case that noncompliance with medication treatment is the cause of relapse [. . .] The critical issue becomes 'what is more important, individual rights or proper treatment?' (p. 242)

These authors suggest the existence of a dilemma of patient competence regarding pharmacological treatment in mental health rehabilitation. When a patient is not competent to judge her/his own illness and to seek help, it might be unethical not to provide treatment that might improve her/his condition [3]. At the same time, forcing treatment violates the individual right of self-

*An earlier version of this article was presented at the *5th Conversation Analysis Day*, 19 December 2011, in Loughborough, UK.

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determination. Authors who have dealt with these issues in theoretical and legal debates agree that a person should not be deprived of the right to refuse medication, unless a court decides otherwise. At the same time, these studies have attracted accusations of abstractness, insofar as they would fail to capture the multiple and subtle ways in which mental health patients can be forced to take medications [4]. For instance, it has been claimed that psychiatrists often fail to inform their patients about the side effects of psychotropic drugs to encourage their acceptance [5]. It has also been pointed out that practices of subtle coercion extend beyond the psychiatrist's office, into the management of daily routines in rehabilitation programs. For instance, it has been argued that in outpatient services access to housing and money is made contingent on medication compliance [6]. Brodwin [7] has described case managers' technologies, such as the medication cassette, for monitoring the patients' medication compliance in a community treatment program. Using an ethnographic approach, Brodwin conceives compliance as the achievement of practical courses of action which are woven into the organization of patients' and mental health workers' daily routines.

In this article, we contribute to the debate on psychotropic medication in mental health services by taking a similar interest in ''the micropolitics surrounding the acceptance, refusal or negotiation of prescribed medications'' [7, p. 129], as it is scattered through and embedded in the mundane, apparently trivial and unremarkable, activities of mental health workers and patients. However, we focus on an entirely different set of ''technologies'', that is, on practices by which mental health workers and patients engage in talk about medication-related problems. Specifically, we wish to answer the following questions. How do the staff members seek to generate talk about medication-related problems? How do they deal with the interactional difficulties raised by the clients' reluctance to engage in such talk?

Methodology

Research setting and participants

In this inquiry, we take a case study approach to explore how medication-related problems are managed in a residential Therapeutic Community (TC) for people diagnosed with different types of mental illness (schizophrenia for the most part), in Italy. In this particular service, where the second author carried out a year of ethnographic field observations, psychotropic medication is managed in collaboration with external psychiatrists. The clients of the TC periodically go to a mental health centre, where they receive psychiatric consultations and they come back to the TC with pharmacological prescriptions. It is the responsibility of the staff of the TC, composed of nurses, care workers and an educator, to administer the medicines and to monitor the clients' adherence to the pharmacological prescriptions. In this article, we explore the practices of talk that are entailed in this process. The object of our inquiry is a corpus of weekly meetings recorded in the course of our research.

The meetings are attended by two staff members, Barbara and Massimo, and by the clients of the TC (whose number varies between 8 to 10 across the recorded meetings). They sit around a big table for approximately an hour and talk, overwhelmingly by engaging in a *reviewing activity* in which they discuss about events that have recently occurred (usually in the week preceding the meeting). Medication-related problems are addressed in the course of this type of activity.

Data

Data for this study consist of four audio-recorded meetings, each lasting ~1 h (4 h in total). The participants did not authorize video-recording, which was regarded as too intrusive in the therapeutic setting. The participants provided written consent to transcribe and analyze the recordings and to publish the data in anonymized form.

Method of analysis

In this study, we employ Conversation Analysis (CA), an approach for the study of how people accomplish social activities through talk (for an overview, see [8]; for an application of CA to rehabiltiation problems published in this journal, see [9]). In CA, researchers rely on recorded episodes of naturally occurring interactions to conduct detailed analyses of how participants carry out practical courses of action. Understanding *what* the participants do and *how* they do it in interaction is the central commitment of CA studies. This undertaking is pursued through an *emic* (or participant-oriented) approach, in which the analyst seeks to explicate the practices that the participants themselves use to make sense of the activities in which they are involved. This contrasts with an etic (or researcher-oriented) approach, in which pre-formulated categories (such as age, gender, diagnosis and others) are employed to make sense of the participants' actions in a more top-down fashion. In this article, we employ the emic approach to understand medication-related problems from the perspectives of the participants themselves, as they are constructed and made available in the turn-by-turn unfolding of interaction.

We transcribed the recordings by employing the transcription technique commonly used in CA, and originally devised by Gail Jefferson (for an overview see [15], p. 265–269), which allows to capture several aspects of speech production, such as temporality (overlapping speech and silences), intonation, emphasis and others. This level of detail is essential in CA to analyze the *how* of social action, that is, the practical resources (including aspects of speech production and speech delivery) by which the participants accomplish their actions. In the transcripts included in this article, we have altered names and references (such as places) that might lead to identify the participants.

Results

We put to use the conceptual tools of CA to analyze how the staff members engage the clients of the TC in talk about medication-related problems. In the first part of this section we argue that, when the staff members deal with medication-related issues in the meetings, they face some practical difficulties, which they seek to solve by establishing medication-issues as conversational topics (for an overview of CA studies on the management of topics in conversation, see [8], chapter 11). Before turning to how the staff members accomplish this task, it is worth illustrating how conversational topics are generated in the TC meetings more generally. This will help to appreciate how the practices used to manage medication-related problems have both commonalities and differences with the practices used by the participants to generate other conversational topics.

Conversational practices of topic generation

The staff members and the clients of the TC do not follow any formal or pre-specified agenda (see, by contrast, [10]), that is, there is not a list of issues, available to them either before or at the beginning of the meetings, from which they can pick topics. Overwhelmingly, topics emerge in the course of the meetings through two sets of practices that researchers in CA have described as a ''stepwise topical movement'' [11], whereby the participants make a topic flow out of a prior topic, and as ''topic initiation'' [12], whereby the participants start a new topic after a prior topic has been discontinued. In this article, we deal with examples of the latter category because, as we will soon make available to the reader, practices of topic initiation are primarily involved in (and

consequential for) the management of medication-related problems. The following three extracts exemplify how the staff members and the clients initiate new topics in the meetings. Massimo and Barbara are the staff members who take part in the meetings; all the other speakers are TC clients. The transcription conventions, illustrated in Appendix, are those employed in CA. The extracts are reproduced in English translation (the original Italian transcripts will be provided by the authors upon request).

Extract 1 (Rg1C)

```
01 Car:  we saw a ho:rror movie
02       yesterda:y.
03       (0.4)
04 ?:    .HHHh
05       (0.4)
06 Bar:  he saw the horror movie?=
07 Car:  =he and I saw a ho:rror
08       movie.
09       (0.6)
10       The Buzy Man Two.
11       (0.4)
12 Bar:  but where?
13       (0.4)
14 Car:  he[re (at home.)
15 Mas:     [at the youth group?
16       (0.2)
17 Car:  no no. here:: (.) on
18       television with the dvd.
19       (0.4)
20 Mas:  rea[lly?
21 Car:     [we went to take the
22       movie.
23       (0.8)
24       it was scary ((he goes on to talk about
         the movie))
```

Extract 2 (Rg4G)

```
01 Mas:  do you wish that we talk
02       about the seaside?
03       (1.3)
04 Giu:  ye:[s.
05 Nad:     [yes come on let's talk
06       about the sea:side.
07 Mas:  how:=and about what?
08       (1.0)
09 Nad:  Franco (              ) to
10       the seaside isn't he? why
11       (doesn't) Franco (     ) to
12       the seaside? >what< happened?
```

Extract 3 (Rg3A1:136)

```
01 Mas:  .hh no because we are
02       al- (0.2) to tell you the
03       truth a little bit worried
04       because:: (0.8) we see you:::
05       a (1.4) a bit absent a bit
06       isolated a bit
07       deta:ched.
08       (4.2)
09 Fra:  °yes because (there are) some
10       times I feel a little ba:d
11       and so:° (5.1)
```

In these three examples, a participant (a client in Extract 1; a staff member in Extracts 2 and 3) employs a practice to initiate a new topic. In Extract 1, a news announcement (lines 1–2) is followed (after some understanding difficulties) by a topicalizer (line 20) and talk on the topic proposed by the announcement (line 24). In Extract 2, the proffering of a topic (lines 1–2) is followed by acceptance of the topic (lines 4–6) and, subsequently, by talk on that topic (lines 9–12). In Extract 3, a ''my side'' telling [13], by which Massimo displays his limited knowledge of a client's personal state (lines 1–7), is at least partially successful in soliciting Franco (a client) to produce talk that expands that knowledge (lines 9–11). There is no room here to specify the distinctive features of these practices, as they are described in the CA literature, but we wish to point to a property that they have in common: they all provide for the *mutual* initiation of a topic in conversation [14]. By displaying availability to engage in talk about the topic proposed through a topic initiating practice, the participants in examples 1–3 make a bid for a topical line to be generated and, thus, make relevant for their interlocutors to either accept or reject the bid. When the bid is accepted and the topic is successfully launched, it can be regarded as the result of a reciprocal display of interest and not as a unilateral imposition by one of the participants.

Conversation analysis researchers have found that the mutual (versus unilateral) initiation of a topic is the preferred procedure to initiate new topics in mundane, non-institutional conversations. In Button and Casey's [14] words, ''topic beginnings done in an environment in which the relevance of more than one trajectory for the conversation can be projected are designed to be interactional and mutual in order to legitimize that as the trajectory which is produced'' (p. 5). Extracts 1–3 illustrate that the staff members and the clients of the TC can and do employ practices for the mutual initiation of conversational topics in ways that are similar to those that can be observed in less institutionalized settings. In a context where a prior topic has been closed and where there is not an official agenda of items from which the participants can choose, the practical problem of selecting a next topic is solved by having one of the participants (either a staff member or a client) make a bid for a new topic. Providing for the mutual initiation of topics can be particularly useful to the staff members (Extracts 2 and 3), because it can allow them to mobilize the clients' cooperation in the initiation a topic, instead of unilaterally imposing one (a point on which we will elaborate later). However, another implication of using practices for the mutual initiation of topics is that the clients' cooperation is needed. In mundane interaction (where practices of mutual topic initiation are overwhelmingly used), it is a common occurrence that the initiation of a topic is not successful. In his analysis of topic proffering sequences, Schegloff [15] observes that when a speaker proffers a topic and the recipient displays reluctance to take up and develop the proffered topic, the first speaker can issue a ''second try'' (p. 173–175). Schegloff also shows that a second display of non-commitment by the recipient to the proffered topic strongly discourages further attempts to pursue that topic. There are two implications. First, topic proffering, like other practices that provide for mutual topic initiation, are vulnerable to rejection. Second, there are limits to how much speakers can ''insist'' in proffering a topic after repeated displays of reluctance by recipients.

By employing practices that provide for the mutual initiation of topics, the staff members rely on the cooperation of the clients to select the objects for the reviewing activity. In Extracts 1–3, the participants display consensus in the initiation of a topical line. By contrast, when the staff members initiate talk about medication-related problems, consensus is always problematic. We argue that in these cases the staff members face the practical problem of obtaining the clients' cooperation in the generation of a topic while, at the same time, trying to steer the talk in a desired direction.

In what follows, we describe three practices that the staff members use to navigate, to circumvent or to avoid the practical

problem of mobilizing the clients' cooperation in talk about medication-related problems. They are: (a) providing for the mutual initiation of talk about medication-related problems, (b) reporting a medication-related problem and (c) embedding the presumption of a medication-related problem.

Providing for the mutual initiation of talk about medication-related problems

Let us start with an example to illustrate the practical problem faced by the Barbara and Massimo when engaging in talk about medication-related problems with the clients and a practice that they use to navigate it. Extract 4 starts at a point where an exchange is already in progress between Massimo (one of the two staff members who attend the meetings) and Franco (a client). In the preceding segment of talk, not reproduced here, Massimo has suggested that Franco has failed to fulfill some duties to which he had previously committed, such as keeping his room clean. Following Franco's disagreement on this matter, the conversation unfolds as follows.

Extract 4 (Rg1A2)

```
01 Mas:  .hhhhhh because also Franco
02       (l-) (.) (l-) lately
03       doesn't feel very well.=
04       =but (0.7) he might also tell
05       us why if he wants to.
06       (1.7)
07 Fra:  °I don't know.°
08 Mas:  you don't know either?
09 Fra:  tzh
.        ((7 seconds of not discernible talk,
         possibly unrelated to the exchange
         between Massimo and Franco))
10 Mas:  no because we have a bit
11       the doubt that you ha- you
12       haven't taken the medicines
13       for some time.
14       (0.7)
15       ((background talk))/(1.1)
16 Mas:  eh no (.) you can-
17       ((background talk))/(3.0)
18 Mas:  if you say it Franco
19       it's not the
20       ((background talk))/(0.9)
21 Mas:  end of the wo:rld.
22       ((background talk))/(4.8)
23 Mas:  .hh as a matter of fact since
24       this week where
25       ((background talk))/(0.8)
26 Mas:  we make sure a bit more that
27       you take them, it seems to us
28       that you are getting a little
29       calmer I think.
30       (1.5)
31 Fra:  °(but I)/(I) (don't' want to)
32       take the medicines.°
33       (1.6)
```

In the turn in lines 1–5, Massimo solicits Franco to talk about how feels. Like in Extract 3 (lines 1–3), Massimo conveys his limited knowledge of Franco's state, a practice identified in previous CA research as promoting topical talk [13]. Subsequently, Massimo makes explicit the import of this ''my side'' telling by inviting Franco to talk about his alleged negative state (Extract 4, lines 3–5). Massimo's solicitation provides for the mutual generation of topic in two respects. First, it provides for Franco to either accept or reject the topical bid. Second, it gives Franco the opportunity to actively contribute in shaping the topical trajectory by selecting one among several possible reasons for his alleged negative state.

It can be easily noticed that Massimo's solicitation is not successful in mobilizing Franco's participation. Franco produces a type of utterance (''I don't know'' in line 7) that previous research has shown to be involved in resisting solicitations to talk about one's own personal state [16]. In line 8, Massimo presents Franco with an opportunity to revise his response, which, nevertheless, Franco confirms (line 9). Following Franco's displays of non-commitment to the topical trajectory being proffered to him, it becomes available to Massimo that, if a topical line about Franco's personal state has to be launched, it cannot be the result of a mutual display of interest by both of the participants involved (in contrast to what happens in Extracts 1–3). We argue that Massimo has at least two practical alternatives at this point. He can further pursue the orientation to mutuality embodied in his first topic solicitation by acknowledging Franco's reluctance to talk about his own personal state. Massimo could do so by shifting his attention to another client or by selecting a different topic that might result to be more attractive for Franco. Alternatively, he can pursue the topic further, in which case he would have to adopt a more insistent stance, thus modifying the openness to Franco's voluntary participation reflected in his initial topic solicitation (lines 1–5). As we will show in a moment, the unfolding of the conversation shows Massimo to be particularly committed to pursuing the topic of Franco's personal state.

Through the initial solicitation in lines 1–5, Massimo has opened a space where Franco could provide virtually any possible reason for his alleged ''not feeling very well''. However, following Franco's displays of non-commitment to the proffered topical line, Massimo claims that the staff members already suspect that the reason for Franco's alleged negative state is a failure on his part to take the prescribed medication (lines 10–13) (later in the meeting it is made accessible to us that Franco spent some time visiting some relatives in another city, thus escaping the staff members' direct monitoring; see Extract 8, lines 25–29). This turn is prefaced by a ''no because'' component, conveying that it should be understood as an account for Massimo's previous topic solicitation. In other words, despite the relative open-endedness of the initial solicitation, which did not specify what the reason for Franco's negative state might have been, Massimo retrospectively establishes the concern about the client's failure to take the medication as what motivated his solicitous inquiry in the first place. At the same time, by conveying knowledge that is uncertain about the client's behavior (''we have a bit the doubt'', lines 11–12), Massimo opens a space where Franco can relevantly elaborate on the circumstances of his alleged failure to take the medication and, thus, confirm it. Nevertheless, Franco seems to withhold talk altogether (lines 14–15). In lines 16–21, Massimo takes a more directive stance by strongly soliciting Franco to admit that he did not take the medication. He is now well beyond the ''second try'' that speakers recurrently make in mundane conversations to proffer a topic to reluctant recipients [15]. By engaging in repeated attempts to have Franco talk about his failure to take the medication, Massimo displays a strong investment in this topical line.

Why does Massimo accomplish this transition from a mutual to a more directive stance in topic initiation? We argue that, if Massimo had managed to engage Franco in the mutual generation of talk about his own failure to take the medication, he would have been in the favorable position to issue a recommendation to take the medication as a response to an admission of failure to take the medication provided by the client. There is some evidence, in

Extract 4, that Massimo is heading for such a recommendation. Following Franco's persistence in withholding talk (line 22), Massimo goes on to reveal not only what the staff members suspect, but also how they evaluate Franco's situation. Specifically, Massimo conveys the staff members' opinion that the medication is beneficial to Franco and thus, by implication, that he should continue to take it. Franco displays his understanding of this contribution as a recommendation, which he rebuts (lines 31–32). It is arguable that Massimo has delayed the provision of such a recommendation in order to provide Franco with an opportunity to admit his failure to take the medication (see [17] for the description of an interactional pattern, in healthcare interactions, in which the professional delays the provision of her/his view until the client has provided her/his view regarding the matter under discussion).

We are now in a position to appreciate the practical problem faced by Massimo in his attempt to engage in talk about medication-related issues and how he deals with it. Massimo initially employs a practice for the mutual initiation of talk about Franco's personal state. After Franco's repeatedly displayed reluctance to talk, the abandonment of this topical line becomes an available option. Nevertheless, Massimo's conduct seems constrained by his unwillingness to withdraw from the topic of Franco's state, which he subsequently steers in the direction of talk that references Franco's failure to take the prescribed medication. Massimo deals with the problem of Franco's non-cooperation by disclosing what the staff suspect and by putting increasing pressure on the client to provide an admission of failure to take the medication. This is done at the cost of introducing a markedly directive and insistent stance (see lines 16–21), which stands in contrast with the orientation to mutuality in topic initiation initially adopted by Massimo.

Massimo's shift from a more mutual to a more directive stance is consequential for how the sequence unfolds. The sequential relevancies set by the initial topic solicitation, by which Franco has been positioned as the person entitled to fill an information gap regarding his own personal state, have made the advancement of the activity contingent on his willingness to talk. There is evidence that Massimo orients to this impasse in how he designs his solicitations. Although he puts pressure on Franco to talk, thus adopting a directive stance, he also continues to portray the staff members' knowledge about the client's failure to take the medication as uncertain (through the qualifiers ''we have *a bit* the doubt'', lines 10–11, ''we make sure *a bit* more'', lines 26–27, ''it seems to us that you are getting *a little* calmer'', lines 27–29, and the appended evidential ''I think'' in line 29), thus leaving a space open where Franco could relevantly contribute to complete that knowledge by elaborating on the circumstances of such a failure [13]. Massimo, thus, finds himself in the somewhat contradictory position of putting pressure on Franco to engage in a type of activity for which his voluntary participation is needed.

Extract 4 exemplifies how the staff members can employ practices for topic initiation that are commonly used in mundane conversation: they proffer a topic to a client and, by so doing, they make the progression of the activity conditional on his willingness to participate. In mundane conversation, when an interlocutor displays unwillingness to engage in talk about a proffered topic, an available option is to withdraw from the topic in favor of other possible courses of action (another topic, another activity or the termination of the conversation). These resources are, of course, available to the staff members. In Extract 4, Massimo selects a different alternative: the pursuit of the topic, done at the cost of adopting the somewhat contradictory stance of inciting the client to provide something that should have been volunteered in the first place. The staff members employ this alternative for topics in which they have special interest and that they are not willing to drop. Medication-related problems are one of these topics. We turn now to a practice that the staff members can use to circumvent the practical problem that we have illustrated in this section.

Reporting a medication-related problem

In the preceding section we have described how the staff members can seek to deal with a client's unwillingness to participate in talk about medication-related problems. In this section, we illustrate how the staff members can work to prevent it.

Extract 5 (Rg4C)

```
01 Mas:   now i:::f=m:::h I must tell
02        you one thing. Di:na, (0.7)
03        is a bi:t in::: (.) tch in
04        conflict with the medication
05        that [she's taking?
06 ?:          [(mh)
07        (.)
08 Mas:   right?
09        (.)
10 Din:   ye:s.
11        (0.2)
12 Mas:   but she talked about this to
13        doctor Pilla.
14        (0.5)
15        to our director.
16        (0.8)
17        tch
18        (0.4)
19        and so he:::: (0.6)
20        advised her (1.5) anyway
21        not to make a fuss with the
22        workers. (.) about the
23        medication.
24 Din:   al[right.
25 Mas:     [a:::nd her medication
26        to discuss it with
27        her doctor [((curante)).
28 ?:                [e:h. (      ).
29        (0.9)
30 Mas:   and so to accept, (1.3)
31        what i::s (0.2) prescribed
32        her by the doctors.
33        (0.9)
34        to tru:st ((them)) °I mean°.
35        (0.4)
36 Din:   alri:ght.
37        (0.3)
```

Massimo's announcement in lines 1–5 initiates talk about medication by referencing Dina's resistance toward the pharmacological regime prescribed to her. After soliciting (line 8) and obtaining (line 10) Dina's confirmation, Massimo goes on to develop the topic in the form of a narrative about Dina's contact with the service director (lines 12–23). Embedded in the narrative is a recommendation (or possibly a command) ''not to make a fuss [. . .] about the medication'' (lines 21–23), reportedly made to Dina by the coordinator (a psychiatrist). Dina receives it as a recommendation not to oppose the administration of medications, made relevant in the interaction here and now, which she accepts (line 24). Massimo recompletes the already uttered recommendation three times (lines 27, 32 and 34), the latter of which is again followed by Dina's acceptance (line 36). In contrast to Extract 4, Massimo does not provide for the client to talk about

her personal state or her alleged ''conflict with the medication'' (line 4), but he takes full responsibility in reporting it. This practice might present Massimo with some payoffs. First, Massimo presents a medication-related problem as something certain, thereby exerting considerable pressure on Dina to confirm it. Second, restricting Dina's participation to confirming an already known state of affairs can discourage her to produce talk that does not fit into Massimo's interactional project (again, in contrast to Extract 4).

Why might it be important for Massimo to have his recommendation preceded by talk that exposes the client's opposition to the pharmacological regime? One clue might be that these exchanges take place in the presence of the other clients of the TC. An explicit orientation to this over-hearing audience is displayed in Massimo's announcement and subsequent narrative, where he talks about Dina in the third person (see also Extract 4, lines 1–5). In announcing Dina's failure to adhere to the pharmacological prescriptions, Massimo appears to orient to the accountability of issuing a recommendation that is justified by a publicly accessible warrant. The practice employed here is effective in providing such a warrant, but it does so at the cost of reducing the space for the client's participation in the activity. We argue that the practice of reporting a medication-related issue does not enable Massimo to solve the practical problem illustrated in the previous section (generating talk about medication while, at the same time, mobilizing the client's cooperation in such talk), but only to circumvent it. The recommendation ends being based on an analysis of the client's opposition to the pharmacological prescription that is primarily produced by the staff member, with no commitment to it by the client (with the exception of the minimal confirmation in line 10). However different the sequential trajectories in Extracts 4 and 5 might be, they share a common outcome: the staff member ends providing an analysis of the client's medication-related problem with no active cooperation by the client to the production of that analysis. To support this claim, we show that, later in the same meeting, Massimo displays an orientation to this missing element. The following exchange occurs ~1 min and 30 s after the one illustrated in Extract 5.

Extract 6 (Rg4C)

```
01 Mas:  .hh so i::f also you Dina
02       who (0.5) would like to
03       go home to live etcetera.=
04 Din:  =e:[:h.
05 Mas:     [m- (0.3) [that if here at=
06 Din:              [sure?
07 Mas:  =the community you make a fuss
08       =>to take the medication,<
09       when you are home alone will
10       you ↑take it the medication?=
11 Din:  =e:::h. (0.2) I don't know.
12 Mas:  eh you ↑see?
13       (1.2)
14       and s[o this- ]
15 Din:       [I feel a ] bit
16       drugged Massimo?
17       (1.3)
18       anyway I believe eh in- I
19       believe in the medicines, I
20       think that they have helped me
21       too the medicines?
22       (1.1)
23 Mas:  the important thing is not to
24       abuse them right?
25       (0.2)
26 Din:  exa:ctly.
27       (9.6)
```

In this segment, Massimo provides for Dina to formulate an aspect of her own experience (lines 1–10). The ''also'' component in line 1 can be understood as signaling that the reference to Dina's experience is being introduced as an ''Nth'' element in a series. In the segment of talk preceding Extract 6 (not reproduced here) Barbara and Massimo have provided some reasons to further support the recommendation already uttered in Extract 5. In this light, the invocation of Dina's experience can be heard as another argument in that series. However, whereas the other arguments have been unilaterally introduced by the staff members, Massimo now provides for Dina to articulate an aspect of her experience as an ex post demonstration of the validity of the recommendation. As we will show in a moment, such a demonstration consists in exposing a contradiction in Dina's stance regarding the pharmacological treatment, by pointing to the fact that her refusal to take the prescribed medications contrasts with (and even undermines) her otherwise legitimate project to terminate the TC program and to go home. In lines 9–10 Massimo invites Dina to anticipate whether or not she will take the medication when she will have concluded her TC program and gone home. Given that the inquiry is preceded by a reference to Dina's willingness to go home (lines 1–3; confirmed by Dina at line 6) and by a reference to Dina's present reluctance to take the medication (lines 5–8), this inquiry accomplishes two things. First, it conveys the assumption that Dina will have to carry on her pharmacological regime after concluding the TC program (the implication is also delivered that, if she cannot be trusted to take the medication, she cannot be considered ready to go home). Second, the inquiry in lines 5 and 7–10 can be heard as challenging Dina to promise that she will take the medication, while providing elements that would make such a promise hard to believe, even if it was uttered [18]. Massimo receives Dina's answer (line 11) as an admission of reluctance to adhere to the pharmacological prescription (line 12). There follows a silence (line 13) in which Dina could respond to Massimo's solicitation in line 12 by formulating the upshot of the now exposed contradiction between the client's willingness to go home and her lack of adherence to the pharmacological regime. Nevertheless, it is Massimo who starts speaking (possibly to reissue the recommendation to take the medication), only to find himself in overlapping talk with Dina who now discloses another, unsolicited aspect of her experience with the medication (lines 15–16). Why does this happen here? Recall that, in Extract 5, Dina was invited to confirm an already known state of affairs. In Extract 6, she is put in the position of sharing an aspect of her experience, specifically her intentions for the future, to which Massimo does not have access. It is this upgraded epistemic position that she exploits to produce more, unsolicited talk. Dina provides a motivation for the bewilderment already expressed in line 11 and ends producing a complaint about the medication. This disclosure has the potential to strongly revise the import of her previous displays of acceptance of Massimo's recommendation (see Extract 5). Those displays can now be heard as having been strongly encouraged by Massimo's directive stance, not as grounded in Dina's belief that the medication is beneficial for her. Furthermore, the complaint does not fit into the staff member's interactional project, which is to demonstrate the validity of an already issued recommendation to take the medication without protesting. Massimo's silence embodies a hostile reception, received as such by Dina, who modifies her stance in lines 18–21, now claiming adherence to the pharmacological prescription, a stance subsequently reinforced by Massimo (lines 23–24) and reconfirmed by Dina (line 26).

The practice of reporting a medication-related problem avoids the impasse possibly generated by providing for a client to volunteer such talk (see Extract 4). The price paid for this solution is to drastically reduce the client's participation to either confirming or disconfirming information to which the staff members already have (or to which they can legitimately claim) access. As we have argued in the analysis of Extract 6, this practice does not allow Massimo to solve, but merely to circumvent the practical problem of pursuing talk about the clients' medication-related problems. As a matter of fact, in Extract 6 he displays an orientation to a missing ingredient to support his recommendation to take the medication: Dina's participation in (and commitment to) an analysis of her alleged medication-related problem. The pursuit of it leads Massimo to the same outcome observed in Extract 4: when he utters a recommendation, it is grounded on an analysis of the medication-related problem that remains the staff member's responsibility, with no commitment to it by the client. When given the opportunity to take a more active role in the management of the conversational topic, the clients in Extracts 4 and 6 volunteer materials that do not support the staff member's interactional project.

Embedding the presumption of a medication-related problem

In our analysis so far we have suggested that the staff members promote or engage in talk that is focused on the clients' medication-related problems as a preliminary step to issue a recommendation to take the prescribed medications. We have also argued that the staff members rely on practices of mutual topic generation because these practices enable them to solve the problem of topic selection in an environment where the participants do not follow a formal agenda of items to be discussed. Another reason for relying on practices of topic generation might be the following: topical talk has been described in the literature as having a sequence structure capable of receiving *extended talk* on a topic [14], that is, talk that is designed to provide an expanded (versus minimal) articulation of the topic. In Extract 4, Massimo solicits Franco to produce such extended talk; in Extract 5, Massimo engages in such talk himself. In the sequential environment of expanded topical talk, the circumstances of the clients' medication-related problems can be fully articulated and provide the staff members with the warrant for a recommendation to adhere to the pharmacological prescriptions. Nevertheless, there is one case in our data set where a staff member does not employ topic generation practices as a vehicle to warrant a course of action that deals with a medication-related problem.

In the following extract, staff member Barbara does not provide for talk about a medication-related problem, neither does she report a medication-related problem. She simply takes for granted that a client failed to take the medication and embeds this presumption in a turn designed to perform other interactional work. Prior to the Extract 7, Franco has told Barbara that sometimes he feels bad because he has some ''strange thoughts''. However, he has also declined Barbara's invitation to tell more on that subject. Having accepted Franco's reluctance to elaborate on that issue, Barbara has asked Franco whether he has talked to his psychiatrist about his personal state and Franco has responded affirmatively. We enter at a point where this topic is being brought to a point of possible closure. We focus on the action performed by the turn starting in line 9, however it is useful for the analysis to show some of the immediately preceding context.

Extract 7 (Rg3A)

```
01 Bar:   and have you
02        calmed down a ↑bi:t?
03 Fra:   yes: yes °yes.°
04        (0.4)
05 Bar:   m:h?
06        (0.2)
07        °ok fine°.
08        (0.4)
09 Bar:   .hhhh (0.4) and so how come
10        you don't always take the
11        medicines Franco?
12        (0.2)
13 Fra:   .hhh because this medication
14        is not ri:ght:.
15        (.)
16        because it causes me
17        that problem and so:: (0.2)
18        I don't want::: to risk.
19        (2.3)
```

The inquiry in lines 1–2 comes after a stretch of talk occupied by the topic of Franco's negative mental state. By shifting the focus to an improvement in Franco's state, the inquiry makes a move toward possible topic closure. Franco's positive response is followed by a token produced with upward intonation (line 5), which makes it sound as a confirmation request. Barbara seems to take the ensuing silence as testifying to Franco's lack of interest in introducing new topical material and she moves to bound the topic with an ''ok fine'' produced with lowered volume (line 7). Following another silence in which Franco does not volunteer other material, Barbara issues a wh-question, which makes relevant an account for Franco's alleged failure to take the medication (lines 9–11). Treating such a failure as an already established matter exempts Barbara from relying on his cooperation to confirm or to admit that he actually failed to take the prescribed medication.

It could be argued that the practice employed by Barbara is a way of simply offering Franco an opportunity to voice his concerns about the medication and not a vehicle to foster his adherence to the pharmacological prescription. Nevertheless, closer examination of the extract does not support this interpretation. Barbara starts the turn in line 9 with an ''and'' component, a practice recurrently used in institutional interaction to index that the upcoming question is part of an institutional agenda [19]. Furthermore, the ''so'' component signals that the turn will be occupied with drawing some kind of unstated upshot of the preceding talk [20]. The preceding talk has been occupied with the description of Franco's negative mental state. Being connected to this talk through the ''and'' component and being indexed as introducing some kind of upshot through the ''so'' component, Barbara's inquiry in lines 9–11 can be heard as pointing to a contradiction in Franco's position. In the light of his alleged ''not feeling well'' and having ''strange thoughts'', his refusal to take the medication prescribed to him is exposed as an unmotivated and illogical behavior. This analysis suggests that Barbara's question is a vehicle to make Franco accountable for his failure to take the medication. In this respect, it pursues the same institutional agenda of the practices analyzed in the two preceding sections: encouraging adherence to the pharmacological prescription. The difference is that the staff member does not employ practices to establish a medication-related problem as a conversational topic before taking some action to deal with it. The practice of embedding the presumption of a medication-related issue in an account solicitation exempts the staff member from the practical problem illustrated in the previous sections, because the progression of the activity is not made contingent on the client's participation in and commitment to an articulation of the medication-related issue. Nevertheless, the account solicitation

is not preceded by any preliminary talk that could mitigate its adversarial character. The adversarialness of Barbara's move seems mirrored in Franco's outright complaint about medication in lines 13–18.

Summary

The staff members employ practices of topic generation that can be observed in less institutionalized and more mundane settings. We have argued that, by doing so, they try to solve different practical problems entailed in talking about medication-related problems. (a) They try to solve the problem of topic selection in a setting where there is no formal of pre-specified topical agenda to follow. (b) They provide for the topic to be the result of a reciprocal display of interest by a staff member and a client. (c) They pursue an admission of failure to take the medication as warrant for a recommendation to take the medication.

Topical talk offers a sequential structure that possibly solve these problems: it provides for extended talk on a topic as the result of a mutual display of interest by the parties involved [11]. The latter feature can also account for the difficulties that the staff members face. Because the topic initiation practices employed in mundane interaction provide for conversational topics to be mutually generated, reluctance to talk on a topic by one of the parties can undermine the other party's attempt to pursue talk on that topic. Extract 4 exemplifies the impasse that can stem from these interactional contingencies: Massimo pursues the mutual generation of a topic that appears to be specified in advance and that fits into his own agenda (not the client's). Extract 4 illustrates one way of dealing with this practical problem: pursuing the topic across the client's repeatedly displayed reluctance. Extracts 5 and 6 illustrate a different scenario, in which the staff member selects to unilaterally reference the client's failure to take the medication. This practice has the consequence of only circumventing the difficulties observed in Extract 4, because it does not solve the problem of promoting the client's participation in an analysis of her own medication-related problem, which the staff member pursues as a warrant for a recommendation. Finally, we have illustrated an alternative to topical talk as a way of dealing with medication problems: in Extract 7, a staff member embeds the presumption of a medication-related problem in an account solicitation.

In the preceding analysis, we have suggested that the staff members' goal is not to provide the clients with a forum where they can voice their concerns about the medication, but to foster the clients' adherence to the pharmacological regimes prescribed to them. If this is the case, the clients' complaints about the medications should be seen not as a desired outcome of the activity in progress, but as an emergent obstacle, which the staff members seek to overcome in the pursuit of pharmacological adherence. In the remainder of this article, we examine two instances of the staff members' reception of the clients' complaints regarding the medications. Through this analysis, we wish to argue that a fundamental mismatch can be observed between the staff members' and the clients' ways of framing medication-related problems in the meetings and that this mismatch might account for the interactional difficulties that the participants face when they engage in talk about medication-related problems.

Implementing and maintaining a compliance assumption

The preceding extracts allow to illustrate that, when the clients are provided with an opportunity to deliver their views regarding the medications, they produce information that does not fit into the staff members' interactional project, and possibly undermines it (Extract 4, lines 31–32; Extract 6, lines 15–16). We argue that the clients' complaints have the potential to challenge an assumption of compliance embodied in the staff members' conversational practices and that an orientation to this potential is reflected in the staff members' hostile reception of those complaints. According to the compliance assumption, medication-related issues can be interpreted as compliance problems. Two presuppositions related to this assumption are that: (a) the pharmacological regimes prescribed by the service psychiatrists are in the clients' best interest and that the clients should always respect those regimes and (b) if problems with the medication arise, they can ultimately be attributed to clients' faults. In Extract 5, Massimo's actions rest on the first presupposition: he treats medication as a necessary treatment for Dina, not only in the present but also in the future, after the completion of her TC program. In Extract 7, lines 9–11, Barbara's account solicitation also rests on the presupposition that, if the client does not feel well (Franco has reported to have ''some strange thoughts''), he should accept pharmacological treatment. In Extract 4, Massimo's topic solicitations rest on the second presupposition: he suggests that the deterioration of Franco's mental state is caused by his own failure to take the medicines as prescribed (lines 23–29). Also in Extract 6, lines 23–24, in response to Dina's complaint about the medication, Massimo suggests that the medicines can only do harm if a patient does not follow the medical prescription.

The compliance assumption and its related presuppositions are incompatible with alternative explanations for the clients' medication-related problems, such as the idea that psychotropic drugs can be harmful because of their side effects. This idea is, nevertheless, consistently reflected in the clients' actions. Through the examination of two additional extracts, we provide further evidence for the claim that the staff members work on the assumption that medication-related problems should be framed as compliance problems. We also show that the staff members receive the clients' expressed concerns about the medications as challenges to the compliance assumption, which they seek to maintain. The following instance is a continuation of the exchange shown in Extract 4. Because of space limitations, we enter some lines later into the transcript, at a point where Franco is answering an invitation issued by Barbara to account for the refusal to take the medicines uttered in lines 31–32 of Extract 4.

Extract 8 (Rg1A2)

```
01 Fra:  °(because) it::::: (1.5) makes
02       me see strange °al:- (0.7)
03       all thins:::°
04       ((background talk))/(1.5)
05       °badly.°
06       ((background talk))/(1.4)
07 Bar:  does it make you see badly?
08       ((background talk))/(.)
09       does it hurt your eyes?
10       ((background talk))/(0.4)
11 Fra:  °no it makes me see things
12       badly.°
13       (0.6)
14 Bar:  it makes you see things badly.
15       (0.7)
16       but what thi- make us an
17       example come on.=because
18       [I find it a bit hard-
19 Fra:  [all things.
20       (0.8)
21       e:h?
22       (0.6)
23 Fra:  all things.
```

```
24          (4.8)
25 Bar:     but e::::h (0.3) when
26          you were::::::: in ((city
27          name)) though
28          ((background talk))/(0.6)
29 Bar:     you didn't take it ri[ght?
30 Fra:                          [yes
31          I took it.
32          (0.2)
33 Bar:     eh.
34          (1.1)
35          ↑you said that you din't
36          [always take it.
37 Fra:     [no I took it.
38          (0.5)
39 Bar:     have you changed your mind?
40          (0.4)
41 Fra:     no I took it.
42          (2.8)
43 Bar:     and have you tried to talk to
44          the doctor about it?
45          (1.0)
46 Fra:     she said that she will be
47          there on next Wednesday, she
48          said that:: she- will reduce
49          them.
50          (0.6)
51          ((background talk))/(1.1)
52 Bar      m:h!
53          ((background talk))/(1.9)
54 Bar:     oka:y then if- you have been
55          good if you managed to talk to
56          the doctor about it.
57          (0.7)
58          and she said that she will
59          reduce it on
60          Wednesday?
61          ((background talk))/(2.4)
62 Bar:     fine then we'll watch and see
63          what happens.
```

Across lines 7–21 Barbara repeatedly invites Franco to clarify his position regarding the medication. Barbara and Massimo recurrently use this practice to expose the clients' misjudgments concerning different states of affairs (including medication) and to subsequently correct them (this is not to claim that Franco's contributions constitute evidence of ''actual'' misjudgments about the medication but that they are so treated by the staff members). As in Extract 7, Barbara does not seem to pursue the goal of providing Franco with an opportunity to voice his concerns. The practice of soliciting him to articulate his view regarding the medication appears to be instrumental to advance the institutional agenda of recommending medication adherence. This interpretation is supported by the observation that Barbara does not seem to take seriously Franco's assessments of the medication. At lines 1–5 Franco complains about some perceptual side effects of the medication. At lines 7–9 Barbara offers a candidate understanding of Franco's turn as a complaint about physical pain that the medication would cause to his eyes. At lines 11–12 Franco engages in third position repair [21] and clarifies that the problem is not physical, but perceptual (notice the stress on ''things'', which contrasts with Barbara's stress on ''see'', conveying that the complaint does not involve Franco's eyes as physical organs, but his ability to perceive external objects). In her next turn (lines 14–18), Barbara treats this clarification as unsatisfactory. Given that Franco does not offer many details to Barbara, it is possible that her repeated displays of non-understanding reflect an actual difficulty in grasping the client's problem. However, it is also possible that Barbara is resisting the construction of the medication as a complainable matter. This interpretation is reinforced by what happens next.

Having failed to obtain a more elaborated account from Franco (see the extended silence in line 24), Barbara prompts him to confirm that he failed to take his medicines in the course of a recent trip (lines 25–29). The turn initial ''but'' sets a contrast between this information and the preceding talk. Because in the preceding talk the possibility of medication side effects has been raised, Barbara's confirmation-request can be heard as making available an alternative explanation for the problems that Franco has been attributing to the medication. Barbara seems to be suggesting that the reported disorders were not caused by the medication, but by Franco's mental illness, which manifested its symptoms because he failed to take the medication. The second of the compliance-related presuppositions appears to be at work here: the idea that, if the client experiences problems with the medication, it is not because of the medication itself, but because of his failure to take the medication as prescribed. Barbara's action in lines 25–29 can, thus, be understood as an attempt to reframe Franco's problem as a compliance problem. This move is also revealing with respect to the import of Barbara's actions in lines 1–18. Because she now displays, albeit indirectly, that she has understood Franco's complaint as regarding psychiatric (not physical) side effects, there are now stronger warrants to interpret her previous displays of non-understanding (e.g. lines 16–18) as attempts to resist the construction of the medication as a complainable matter. After Franco refuses to produce the required admission (lines 30–31 and 37), Barbara takes a different tack. In lines 43–44, she refers back to Franco's complaint about the medication, this time by designating ''the doctor'' as the most appropriate interlocutor for such a matter. Coming at this point, this can be understood as an exit strategy, bringing the topic of medication to closure after repeated attempts to frame it as a compliance problem (lines 35–36 and 39) have met the client's non-cooperation.

Extract 8 exemplifies the staff members' commitment to frame medication talk under the auspices of the compliance assumption in two ways. First, Barbara prompts Franco to admit noncompliance at a sequential place where negotiations about the causes of his reported perceptual disorders are under way. Second, when Franco resists this attempt, Barbara moves to close the topic by indicating Franco's psychiatrist as the appropriate recipient for complaints about medication. The next exchange, extracted from a different meeting, exemplifies the same phenomenon.

Extract 9 (Rg3A2)

```
01 Bar: 1   it is necessary to ta:ke it
02          for some time it is not that
03          one (0.4) takes a pill, (.)
04          [and immediately (.) has the effect.
05 Fra:     [(but) if I take ( ) e- every
06          day I'm in hospital
07          you tell me?
08          (1.4)
09 Bar:     yes this:: look today Sara
10          wasn't there this morning.
11          (.hh) but we have
12          already::: (0.2) mentioned it
13          to doctor Pilla.
```

In lines 1–4 Barbara issues a recommendation to take the medication and suggests, this time more explicitly (compare

Extract 8, lines 25–29), that a failure to adhere to the pharmacological prescription might be the cause of the side effects suffered by Franco. Franco responds with a fully-fledged complaint (lines 5–6) and a challenge (line 7). As in Extract 8, after Franco has displayed unwillingness to align to Barbara's assessment (which is informed by the compliance assumption), Barbara moves to close the topic, again by indicating the psychiatrists (Sara and doctor Pilla) as the proper recipients of complaints about side effects (lines 9–13).

Extracts 8 and 9 provide further evidence for the claim that the staff members frame medication-related problems as compliance problems and that they actively work to maintain this assumption. When he is provided with opportunities to voice his view about the medication, Franco complains about medication side effects. These complaints have the potential to undermine the compliance assumption, because they attribute some experienced disorders to the medication. Barbara receives Franco's concerns by trying to reframe them in the terms provided by the compliance assumption (for another example see Extract 6, lines 23–24). When this strategy does not work, she seeks to bound and close the topic. There is now evidence to support the claim that not only the staff members do not pursue the goal of providing the clients with a forum where they can voice their medication-related concerns; such complaints are simply not compatible with the interpretive framework that underlies the staff members' interactional conduct. While the clients point to the side effects of the medication as a complainable matter, the staff members point to the clients' noncompliance as a complainable behavior. These two perspectives make available opposing and reciprocally incompatible explanations for the same set of problems: the clients' experienced difficulties with the medications.

Discussion

Although a single TC has been studied here, the findings from this inquiry are suggestive of the challenges that can characterize rehabilitation practice in a mental health residential service. It is, thus, worth discussing some of the implications of this study for the understanding of mental health rehabilitation practice. In this article, we have argued that the staff members of a mental health TC in Italy rely on practices of topic initiation, which can be observed in mundane, non-institutional interactions, to generate talk about medication-related problems. Such practices can provide for the mutual generation of extended talk referencing the clients' failure to take psychotropic medication as prescribed by the service psychiatrists. Such talk, we have argued, is pursued by the staff members to expose the clients' failure to take the prescribed medications and, hence, as a warrant for issuing recommendations to adhere to the pharmacological prescriptions. The implication is that the staff members recur to very informal practices, otherwise used in everyday, non-specialized interactions, and which are not designed to secure the achievement of institutional goals. These practices make the success of the activity contingent on the clients' willingness to take part in an analysis of their own medication-related problems. The fact that the staff members depend on the clients to admit their own failure to take the medications might reflect the precarious nature of their institutional role in at least two respects. First, the examples in this article suggest that monitoring the clients' behaviors is a recurrent practical concern for the staff members. The staff members are responsible for the clients' health and safety and are accountable for ensuring that the clients do not run unnecessary risks or harm themselves. Nevertheless, as Extracts 4 and 8 exemplify, the staff members do not have the means to constantly monitor the clients' behaviors and have to rely on their willingness to report medication-related problems. A second and related aspect is that the staff members act as institutional intermediaries: they are expected to monitor the clients' adherence to the pharmacological regimes prescribed to them, however they are not entitled to discuss other medication-related issues with the clients, because they are not psychiatrists (see Extracts 8 and 9). This might account for why the staff members confine themselves to treating medication-related problems as behavioral management problems and display reluctance to engage in other types of medication-related talk (such as talk about side effects). It might also account for why the staff members seek to establish the clients' medication-related problems as conversational topics before issuing a recommendation (see Extracts 4 and 5): because the staff members are not fully entitled to discuss medication-related issues, it would be easier for them to issue a recommendation in response to a client's admission of medication non-adherence.

We have also suggested that a mismatch between two different interpretive frameworks, which the staff members and the clients, respectively, bring to bear on talk about medication-related problems, might account for the staff members' failure to obtain the clients' cooperation. We have argued that the staff members' interactional conduct reflects the assumption that medication-related problems can be framed as compliance problems. Two presuppositions, which are related to this assumption, are that psychotropic drugs always constitute a suitable treatment for the clients and that problems with the medication can be reduced to compliance problems (and, hence, that they can be attributed to the clients' responsibility). Discussions about the presuppositions undergirding the management of medication-related problems can be found in the literature. For instance, Glick and Applbaum [22] point to a compliance assumption in media discourse about mental illness, which conflates elements of the biomedical model of recovery, where pharmacological therapies are deemed to be the best solution for the management of mental illness, and the moral model of recovery, where the individual is made normatively accountable for managing her/his own illness. As a result, pharmacological noncompliance is construed as a reprehensible behavior which needs to be identified and corrected. In his analysis of the Assertive Community Treatment model, Gomory [6] found the same mix of biomedical and moral presuppositions, according to which patients are held morally accountable for accepting what is deemed to be the most suitable solution for the management of mental illness: psychotropic medication. Scheid-Cook's [1] findings from interviews with primary clinicians are consistent with this scenario; she found that clinicians tended to disregard their patients' concerns with side effects and that they were primarily concerned with patient compliance. These studies illustrate that the discourses and practices entailed in the management of medication-related problems in mental health treatment reflect attributions of limited awareness and limited commitment to one's own recovery. These attributions resonate with the presuppositions undergirding the staff members' interactional practices analyzed in this article. For instance, in Extract 6, lines 1–10, Massimo suggests that the successful outcome of Dina's TC program is contingent on her willingness to accept psychopharmacological treatment. His conduct implies the presupposition that pharmacological treatment is (and will be) the most suitable solution for the client and that the client's failure to adhere to the pharmacological prescription can be treated as evidence of limited commitment to her own recovery. In Extract 8, lines 126–130, Barbara provides Franco with an alternative explanation for his disorders: she suggests that the side effects suffered by Franco (''seeing things badly'') might not be caused by the side effects of psychotropic drugs (as he claims), but by Franco's mental illness, which is out of control because of his failure to adhere to the pharmacological prescription (see also the

analysis of Extract 5). In this respect, Barbara's conduct implies the presupposition that Franco's medication-related problems can be reduced to a compliance problem and it also reflects an attribution of limited awareness, according to which the client might not be aware of his own illness and of its effects.

These examples illustrate that the staff members hold the clients responsible for taking the medication as prescribed (see also Extracts 4 and 7), but they do not treat them as competent judges of their own mental condition. When the clients express concerns about the medication, the staff members suggest alternative explanations for their reported negative symptoms, which they attribute not to the pharmacological side effects, but to the clients' failure to take the medication as prescribed. Our analysis of Extracts 8 and 9 shows that the staff members can engage in active work to reframe the clients' reported problems in the terms provided by the compliance assumption. Under the auspices of this assumption, the staff members can treat the clients' concerns about medication side effects as misjudgments and, hence, they can avoid taking them seriously. As a result, when the clients voice their concerns, they end up doing so in a hostile environment, already shaped by the assumption that the relevant thing about medication is compliance. At the same time, it should be noted that working under the compliance assumption also constrains the staff members' opportunities of action. The practices that they use to initiate talk about medication-related problems recurrently elicit complaints (see Extracts 6–9) but they also shape an environment that is not receptive to such complaints. Herein lies the contradiction: the staff members recurrently provide for the clients to deliver their concerns about the medication but they systematically withhold from taking those concerns seriously. This leads to a deadlock where the staff members struggle to foster pharmacological adherence, which is more or less openly resisted by the clients, and where the clients struggle to communicate concerns about medication, which are not taken into account by the staff members.

Implications for future research and intervention

Previous research has outlined that the therapeutic relationship (TR) with the psychiatrist is associated with schizophrenic patients' adherence to treatment [23]. Nevertheless, our study is the first, to our knowledge, to examine in detail how issues pertaining to medication and compliance materialize in actual episodes of conversational interaction. Instead of measuring patients' adherence retrospectively [23] we have sought to track the sense-making practices by which the participants invoke non-compliance as an explanatory category in order to account for reported medication-related problems. Our most significant finding is that the staff members' practices contribute to an interactional environment that is unfavorable to the recognition of patients' concerns regarding medication side effects. This finding resonates with earlier CA studies on interactions between caregivers and people with intellectual disabilities in residential settings, which demonstrated that the caregivers avoid recognition of the residents' preferences and complaints [24]. A related relevant finding of our research is that the staff members' conversational practices reflect and enact presuppositions about the clients' incompetence and limited awareness about their own mental states and health condition. In this respect, our study contributes to a strand of research about how attributions of client (in)competence are achieved in interaction [25].

Future research should compare how issues of compliance and client competence are tackled across different healthcare settings. From previous research, we know that physiotherapists can use delicate and indirect practices when correcting clients' performance, so as not to overtly expose their incompetence [26]. Likewise, home health visitors can design advice in cautious ways, so as to avoid attributions of incompetence or lack of knowledge in interaction with first time mothers [27]. Future comparative research should analyze how the same types of social action (such as fostering compliance, correcting client performance and others) are delivered across different settings and how observed differences in the design of these practices might be associated with features of the institutional settings (such as type of clientele and institutional mandate).

Another possible extension of our study is to compare how TC staff members and psychiatrists deal with issues of treatment adherence and patient competence in interaction. We have argued that the staff members work under the constraint to avoid discussing medication-related issues (such as side effects) with the TC clients. Psychiatrists, on the other hand, are fully entitled to discuss these issues with patients. This does not imply that the psychiatric consultation is a forum where patient concerns are always taken seriously and acted upon. Previous CA research shows that psychiatrists can display reluctance to engage in discussions regarding psychotic patients' concerns regarding their own symptoms [28]. Research is needed to understand how psychiatrists respond to patients' concerns regarding pharmacological treatment in the course of consultations.

Finally, the results of our study make relevant applied work aimed at raising TC staff members' awareness of the conversational practices that they employ to deal with medication-related problems. This might be done in workshops with the aim of involving TC staff members in jointly reflecting on the interactional implications of the practices described in this article, and of the presuppositions that they seem to embody.

Acknowledgements

We are grateful to Charles Antaki for his input during the early development of the article, and to the editor and reviewers for their comments.

Declaration of interest

The authors report no declarations of interest. This research received no grant from any funding agency in the public, commercial or not-for-profit sectors.

References

1. Scheid-Cook TL. The validity of social control critiques: psychiatric medication, side effects and outpatient commitment. Sociol Focus 1991;24:59–77.
2. National Institute of Mental Health. Mental Health Medications. U.S. Department of Health and Human Services; 2010.
3. Barrett KE, Taylor DW, Pullo RE, Dunlap DA. The right to refuse medication: navigating the ambiguity. Psychiatr Rehabil J 1998;21: 241–9.
4. Fisher DB. Comments on the article, ''The right to refuse medication: navigating the ambiguity''. Psychiatr Rehabil J 1998; 21:250–1.
5. Gottstein JB. Psychiatrists' failure to inform: Is there substantial financial exposure? Ethic Human Psychol Psychiatry 2007;9: 117–25.
6. Gomory T. The origins of coercion in assertive community treatment: a review of early publications from the special treatment unit of Mendota State Hospital. Ethic Human Sci Serv 2002;4:3–16.
7. Brodwin P. The assemblage of compliance in psychiatric case management. Anthropol Med 2010;17:129–43.
8. Sidnell J. Conversation analysis: an introduction. Malden (MA): Wiley-Blackwell; 2010.
9. Denman A, Wilkinson R. Applying conversation analysis to traumatic brain injury: investigating touching another person in everyday social interaction. Disabil Rehabil 2011;33:243–52.
10. Svennevig J. The agenda as resource for topic introduction in workplace meetings. Discourse Stud 2012;14:53–66.

11. Jefferson G. On stepwise transition from talk about a trouble to inappropriately next-positioned matters. In: Atkinson JM, Heritage J, eds. Structures of social action: studies of conversation analysis. Cambridge: Cambridge University Press; 1984:191–222.
12. Button G, Casey N. Generating topic: the use of topic initial elicitors. In: Atkinson JM, Heritage J, eds. Structures of social action: studies of conversation analysis. Cambridge: Cambridge University Press; 1984:167–90.
13. Pomerantz A. Telling my side: ''limited access'' as a ''fishing'' device. Sociol Inq 1980;3–4:186–98.
14. Button G, Casey N. Topic nomination and topic pursuit. Human Stud 1985;8:3–55.
15. Schegloff EA. Sequence organization in interaction: a primer in conversation analysis I. Cambridge: Cambridge University Press; 2007.
16. Hutchby I. Resisting the incitement to talk in child counselling: aspects of the utterance 'I don't know'. Discourse Stud 2002;4: 147–68.
17. Maynard DW. On clinicians co-implicating recipients' perspective in the delivery of diagnostic news. In: Drew P, Heritage J, eds. Talk at work: interaction in institutional settings. Cambridge: Cambridge University Press; 1992:331–58.
18. Koshik I. Wh-questions used as challenges. Discourse Stud 2003;5: 51–77.
19. Heritage J, Sorjonen ML. Constituting and maintaining activities across sequences: and-prefacing as a feature of question design. Lang Soc 1994;23:1–29.
20. Raymond G. Prompting action: the stand-alone ''So'' in ordinary conversation. Res Lang Soc Interact 2004;37:185–218.
21. Schegloff EA. Repair after next turn: the last structurally provided defense of intersubjectivity in conversation. Am J Sociol 1992;97: 1295–345.
22. Glick D, Applbaum K. Dangerous noncompliance: a narrative analysis of a CNN special investigation of mental illness. Anthropol Med 2010;17:229–44.
23. McCabe R, Bullenkamp J, Hansson L, et al. The therapeutic relationship and adherence to antipsychotic medication in schizophrenia. PLoS One 2012;7:1–5.
24. Jingree T, Finlay WML, Antaki C. Empowering words, disempowering actions: an analysis of interactions between staff members and people with learning disabilities in residents' meetings. J Intellect Disabil Res 2006;50:212–26.
25. Maynard DW, Marlaire CL. Good reasons for bad testing performance: the interactional substrate of educational testing. Qual Sociol 1992;15:177–202.
26. Parry R. A video analysis of how physiotherapists communicate with patients about errors of performance: insights for practice and policy. Physiotherapy 2005;91:204–14.
27. Heritage J, Sefi S. Dilemmas of advice: aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In: Drew P, Heritage J, eds. Talk at work. Cambridge: Cambridge University Press; 1992:359–417.
28. McCabe R, Heath C, Burns T, Priebe S. Engagement of patients with psychosis in the consultation: conversation analytic study. Br Med J 2002;325:1148–51.

Appendix

Conversation analysis symbols

[word	overlapping talk (onset)
word]	overlapping talk (offset)
(0.4)	silence in tenth of seconds
(.)	silence less than 0.2 seconds
=	connects continuous parts of an utterance with no break or pause
wo::rd	sound extension
word.	falling intonation
word?	rising intonation
word,	continuing intonation
↑word	talk higher than the prior talk
↓word	talk lower than the prior talk
°word°	talk quieter than the surrounding talk
WORD	talk louder than the surrounding talk
<u>word</u>	emphasis
word-	cut-off word
hh	outbreath
.hh	inbreath
(word)	word in doubt
( )	unclear word
((text))	non-verbal features of the interaction