From Engagement to Disengagement in a Psychiatric Assessment Process

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In a longitudinal conversation analytical (CA) case study, we examined patient engagement in a psychiatric assessment process (nine clinical interviews) with a young woman who eventually received the diagnosis of personality disorder. Based on Goffman, we consider engagement in interaction as consisting of three facets: engagement in the action at hand, bodily engagement with the co-participant, and engagement with the local moral order of the encounter. The patient begins the assessment process with high engagement and ends it up in low engagement. Yet, during this process, the patient oscillates between moments of high and low engagement. We show how the Goffmanian idea of engagement can be elaborated by CA. On the other hand, the Goffmanian view enriches CA by bringing to the foreground the interconnectedness of the different facets of engagement. A video abstract is available at https://youtu.be/S7BA7HRFvJ0.
Keywords: engagement, personality disorders, longitudinal conversation analysis, action, bodily orientation, moral order

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INTRODUCTION

Patient involvement is a major theme in the study of mental health care. Involvement is a rather far-reaching concept: in earlier studies, it has been discussed in the context of participation in decision-making, in terms of the patients' experience-based expertise, and in terms of collaboration between patients and professionals (see Tambuyzer et al. 2014). Tambuyzer et al. (2014:142) propose a comprehensive definition: "Patient involvement in [mental health care] means involvement in decision making and active participation in a range of activities (e.g., planning, evaluation, care, research, training, recruitment) starting from the expertise by experience of the person, in collaboration with and as equal partners of professionals."

Involvement means that "patients take up an active role, rather than merely being consulted or receiving information" (Tambuyzer et al. 2014:141). Expertise by experience is part of involvement and it refers to the patient's knowledge of their lived experience. Collaboration with professionals implies that patient involvement is not a patient-controlled initiative (leaving all power to the patient), but a participatory initiative based on partnership (Tambuyzer et al. 2014:141–142). In spite of the fact that the importance of patient involvement has been widely acknowledged, Tambuyzer et al. (2014:142) maintain the "practical ways to shape involvement processes" are not well understood.

Recently, conversation analysis (CA) has offered an interactional perspective to patient involvement in treatment negotiation in psychiatry (Bolden and Angell 2017; Kushida and Yamakawa 2020; Thompson and McCabe 2018; Weiste et al. 2020). CA of mental health care has focused especially on the joint decision-making aspect of patient involvement (Lindholm et al. 2020). Weiste et al. (2020) point out that CA offers a method to examine how different kinds of asymmetries between the participants (e.g., asymmetries in know-how, knowledge, and status) affect patient involvement in decision-making.

In this paper, we will further expand the interactional research on patient involvement in psychiatry. Rather than focusing on one particular action — such as decision-making — we will investigate a particular type of encounter, or more precisely, series of encounters: the assessment of psychiatric patient that takes places in several consecutive interviews. Our key concept is *engagement*: it is in many ways synonymous to "involvement" (Goffman 1963:36, fn3), yet it has a more local and momentary connotation. To be engaged means to show with one's actions and body that one willingly and wholeheartedly takes part in the encounter at hand and focuses one's attention to it and its participants (for a more technical definition, see below). Adopting a longitudinal study design, we will investigate how the patient's engagement in interaction evolves over time in a single case of diagnostic process. In tracing the patient engagement, we will start by examining the sequence where the diagnosis of personality disorder and treatment recommendation for psychotherapy are delivered. Thereafter, we focus on (dis)engagement in patient's answers to clinicians' questions through the assessment process.

Patient engagement in the diagnostic process in psychiatry is pivotal. Unlike perhaps in somatic medicine, the patient's understanding of her problem and motivation to treatment is necessary for successful treatment. Patient engagement in assessment is a particular challenge in personality disorders, because patients with personality disorders often do not recognize problems in themselves (APA 2013).

Personality disorders are relatively permanent patterns of dysregulated emotion and social relations. They are usually diagnosed in early adulthood and their etiology involves both biologically and environmental factors (APA 2013). Due to emotional and relational problems, patients with personality disorders are known to have communication challenges with clinicians (Lawn and McMahon 2015). Furthermore, the personality disorder diagnosis might be problematic for the patient, as personality disorders bring along a particular stigma (Sheehan et al. 2016): to have a personality disorder may mean that one has a difficult character and behaves badly. Therefore, the engagement in diagnostic process can be challenging.

We will present a longitudinal single case analysis of a psychiatric assessment process with a patient who eventually receives a diagnosis of personality disorder. Because the study of assessment in psychiatry, as well as the study of personality disorders in social interaction, is in its infancy, it is meaningful to conduct a case study. Preliminary exploration of a larger database consisting of several video recorded assessment processes suggests that patients with personality disorder typically present not only one but several, mutually inconsistent, stances in their relation to the clinician (Peräkylä forthcoming). Oscillation between engagement and disengagement is particularly pronounced in the patient that we studied.

Because personality disorders are characterized by volatility of emotions and social bonds (cf. Huprich 2018) we have chosen a longitudinal approach (see Pekarek-Doehler et al. 2018). We will investigate how the patient's engagement in interaction evolves over time. Our particular contribution to the longitudinal study of interaction is to show a process, where the relevant interactional patterns do *not* develop into a "normative" or institutionally expected direction, but rather oscillate between what is expected (engagement) and what is not expected (disengagement).

Continuum of Engagement and Disengagement

Engagement is an overarching idea in Erving Goffman's sociology, especially in his early writings (Goffman 1957, 1963). He used alternating terms such as involvement (Goffman 1957, 1963) and engrossment (Goffman 1963, 1974). In this paper, we unpack Goffman's idea of engagement into its empirically analyzable components. We understand engagement as an assemblage of three converging components. (1) Inspired by Goffman's (1963) discussion of participation obligations in "occasioned activity," we consider *collaboration in joint action* as one component of engagement. (2) Inspired by Goffman's (1957, 1964) notion of "conjoint visual attention," we consider *postural and perceptual orientation to the co-participant* as second component

of engagement. Finally, inspired by Goffman's (1963) discussion of "situational proprieties," we consider *sharing of the local moral order* of the encounter as the third component of engagement.

In our data, these facets of momentary interaction — action, bodily orientation, and moral order — hang together, so that they form a "Gestalt." In a more interpretative vein, we could say that through engagement thus understood, the participant displays, through their body and actions, to the co-participant that "I am here with you in this." Disengagement, in turn, means that a participant does *not* show engagement in these three facets in a moment when such engagement has been made relevant.

Goffman (1957) maintained that engagement in interaction is never stable, in spite of the fact that it is considered as primordial sociomoral obligation. There are inherent tendencies for disengagement in interaction and hence, the interaction takes place between tendencies toward what he called alienation and conjoint spontaneous involvement (Goffman 1957:47). This duality between engagement and disengagement is at the heart of this paper.

In the analysis that we present, Goffmanian ideas will be merged with conversation analytical methodology. Using sequential and multimodal analysis, we will seek to show how the engagement and disengagement emerge in the patient's interactions with the clinicians moment by moment. In spite of the well-known tension between Goffman and his students who became conversation analysts (see especially Schegloff 1988, 1992:xxiv) there is also a long history of research where Goffmanian ideas have met CA methods (e.g., Clayman 1992; C. Goodwin 1982; M. H. Goodwin 1990; Manning 1989). Merging Goffmanian ideas with CA methodology will also make it possible for us to discuss pros and cons of such combination at the end of the paper.

DATA AND METHOD

Our data comes from a psychiatric outpatient clinic in Southern Finland. New referrals regularly undergo an extended assessment which consists of five to nine interviews with clinicians, usually with intervals of 1 or 2 weeks. The average length of an interview is about 50 minutes. The goal of the assessment is to establish the diagnosis and to decide about treatment. In this paper, we present a longitudinal analysis of one assessment process consisting of nine interviews. Interviews 1, 2, and 8 were conducted by a psychiatrist and a psychiatric nurse; the rest of the interviews by the nurse alone. In interviews 1 and 8, the patient's mother was also present. The interviews were video recorded; the researcher was not present during them.

In the transcription of multimodal actions, we follow the conventions of Mondada (2018). The frames that we present alongside the verbal transcripts were produced by filtering the original video in *Filmora* video editing software and a professional graphic designer edited the sketches to ensure the anonymity of the participants. The location of frames in relation to the talk is indicated by vertical lines and bolded words (see e.g., Extract 1, line 21 and Frame 1). Through repeated playing

of the videos, transcription, and production of framegraphs, the multimodal analysis of interaction seeks to show how bodily, visual, and verbal aspects of action are coordinated across participants and in time.

The videos were subjected to longitudinal conversation analysis that sought to trace the evolution of patterns of interaction over several encounters. In longitudinal conversation analysis (see Pekarek-Doehler et al. 2018) two temporalities meet: the turn-by-turn temporality of sequences of action and the more macroscopic temporality that extends across interactional occasions (Wagner et al. 2018). In sequential time, we investigated how engagement or disengagement in next actions emerges from what was happening in prior actions. In the time across occasions, we investigated whether, and how, the patient's ways of engaging or disengaging evolved during the whole assessment process consisting of nine interviews. While the organization of (dis)engagement can be studied on sequential temporality without reference to the temporality of the whole process, the latter cannot be studied without knowing about the former. Knowing about the evolution of engagement in the context of the whole process is of primary importance in terms of the institutional goals of the psychiatric assessment. In merging two temporalities, we adopted a methodical pattern that has been developed in earlier longitudinal CA studies in health care and therapeutic settings (see e.g., Heritage and Lindström 2012; Voutilainen et al. 2018).

We have chosen the assessment of this particular patient because in her, the instability of engagement — something that we find also in other patients with diagnosis of personality disorder (Peräkylä forthcoming) — is particularly pronounced. We start our account from the end of that process, the delivery of diagnosis and treatment recommendation.

RESULTS

Disengagement at Diagnosis and Treatment Recommendation

Miia is a 23-year-old student in vocational training. Her main problem (as depicted by the referring primary care doctor and the patient herself) is that she has started to get into physical fights. There are also verbal conflicts, and she is drinking heavily. Miia has nine meetings with the clinicians. In the first, second, and eighth meeting, her mother accompanies her. We will start by examining Miia's interaction with the clinicians at the moment in the eighth interview when the diagnosis is told and the treatment decision is given. At that decisive moment, Miia is very much disengaged from the interaction. In order to illustrate how this interactional disengagement evolves over time, we will then follow up the assessment process step-by-step from its beginning.

In the beginning of Extract 1 below, taken from the eighth interview, the doctor prepares for the actual diagnosis with three presequences (Schegloff 2007): first by asking about the patient's views regarding her personality (lines 10–15), then

by asking about her knowledge regarding "instability" (i.e., emotionally unstable personality disorder; lines 19–21), and then by asserting indirectly that the patient does not have "instability" (by pointing out that the patient does not have symptoms of it: lines 23, 24, 27, 30). The actual diagnosis is then delivered in lines 30–32.

Extract 1 (interview 8)

```
10    D:   ja:, (1.2) ootko koskaan miettinyt, (0.4)
           a:nd, (1.2) have you ever thought about, (0.4)

11         erilaisia persoonallisuustyyppiä. (.)
           different personality types. (.)

12         oot sä ↑koskaan ollu kiinnostunu
           have you ↑ever been interested in

13         mikä persoonallisuus oikeastaan mä oon.
           what personality actually I am.

14         (0.2)

15  P:     en.
           no.

16         (0.2)

17  D:     .jooh,
           .right,

18         (3.0)

19  D:     oot sä kuullut epävakaudesta.
           have you heard about instability.

20         (0.6)
```


Frame 1

```
21  P:     oon?
           I have?

22         (0.4)

23  D:     °jo-° .hh epävakaudessa on aika paljon että sielä on
           °ye-° .hh in instability there is quite a lot
```

```
24        sitä itsen vahingoittamista. (0.4) sitä sulla ei ole.
          that self-injury. (0.4) that's something you do not do.

25        (.)

26  P:    ei oo.
          I do not.

27  D:    sä et viiltelet *ja,*
          you do not cut *and,*
    p:            gazing  D *---*

28  P:    juu en.
          yeah no.

29        (0.2)

30  D:    et sellaista teet ja sulla, .hh on, (0.2) enem*män,
          you do not do that and you, .hh have, (0.2) mor*e,
    p:                                        gazing D *-->
```


Frame 2

```
31        (1.0) ikävää kyllä sanoa* sellaista ↑epäsosiaalisia
          (1.0) I'm sorry to say* but like ↑antisocial
    p:               gazing--> D *

32        piir°teitä°.
          fea°tures°.
```


Frame 3

```
33        (0.4)
```

```
34   D:     ootko sellaista kuullut.
            have you heard of that.

35          (.)

36   P:     en.=
            no.=

37   D:     =epäsosiaalinen. .hhh siihen kuuluu nimenomaan että me,
            =antisocial. .hhh it involves particularly that we,

38          (2.0) käytetään, hh (0.4) aggressio. (.)
            (2.0) use, hh (0.4) aggression. (.)
```


Frame 4

```
39          sanallisesti tai fyysisesti. (1.4) ja siihen kuuluu
            verbal or physical. (1.4) and it involves

40          myös että me, (0.4) tehdään työtä £il(h)man, hh .hh
            also that we, (0.4) work £with(h)out, hh .hh

41          palk(h)kaa. hhh£ tehdään myös pieniä ↑rikoksia jos,
            a sala(h)ry. hhh£ (we) also commit petty ↑crimes if,

42          (0.2) tilanne vaatii. (0.6) ollaan oikeudessa.
            (0.2) the situation requires. (0.6) (we) end up in court.

43          (1.0)

44   D:     ja se, (0.2) on *mahdollista,* (1.2) ↑hoitaa.
            and that, (0.2) is *possible to*, (1.2) ↑treat.
     p:             gazing D *------------*

45          (0.6)

46          mutta se vaatii nimenomaa se mitä
            but exactly that is required

47          sä nyt näytät se sitoutuminen.
            what you now show the commitment.

48          (.)
```

Frame 5

```
49  P:   mm,

50  D:   se vaatii oikeastaan psykoterapian jos haluat siitä,
         actually psychotherapy is required if you want to,

51       (1.4) pääse pois.
         (1.4) get out of it.

52       (0.2)
```


Frame 6

```
53  P:   joo.
         yeah.

54       (0.6)
```

Unlike primary care doctors who usually do not invite patients' comments on diagnosis (Heritage and McArthur 2019), here the doctor seeks to engage the patient in the discussion on diagnosis. She asks perspective elicitation questions (Maynard 1989) before and after the actual diagnosis delivery (lines 10–13, 19, 34). She also offers her statements regarding absence of "instability" symptoms for Miia to confirm (lines 24 and 27). After the actual diagnostic statement (30–32) and a perspective elicitation question (34), the doctor describes the behaviors associated with this diagnosis in lines 37–42. The descriptions are designed as recognizable for Miia as *her* behaviors: these matters have been addressed in this interview and in the preceding ones. The doctor works to engage Miia also in the treatment decision. She stops after a preface where she asserted that there is a possibility for treatment (line

44), thereby creating a place for the patient's "go-ahead" signal. Then she outlines the requirements of treatment (lines 46–47) and in doing that, by referring to the patient (*what you show now*; lines 46–47) she makes patient confirmation relevant. Eventually, she names the required treatment (*psychotherapy*, line 50) and again, she links the suggested treatment to the patient's choices (*if you want to get out of it* [i.e., asocial personality], lines 50–51), thereby inviting patient engagement in discussion. However, Miia remains passive and disengaged.

There are three key facets in Miia's disengagement. They correspond to the Goffman-inspired conceptualization outlined above. The first facet has to do with verbal *action*. Miia does not produce the kind of actions that the clinician is creating relevancies for. While the doctor's perspective elicitation questions make relevant for Miia to tell about her views regarding her personality and about "instability," Miia produces only minimal lexical responses that she utters in a flat, disengaged prosody (see lines 15, 21, 36). Likewise, her confirmations of the (absent) symptom descriptions are minimal and uttered in a matter of fact tone of voice (26 and 28). In response to the actual diagnosis, she remains silent (line 33); as the doctor pursues response with another perspective elicitation question (line 34), Miia responds with a flat *no* (line 36). At treatment proposal, opportunities and expectations are created for Miia to display commitment (lines 45, 48, 52). Yet she remains silent or produces only acknowledgement tokens with flat prosody.

The other facet of disengagement involves Miia's *bodily participation*. For most of the time she gazes away from the doctor, while the doctor quite consistently gazes at her. The only exceptions to Miia's gaze withdrawals are at lines 27, at the completion of doctor's assertion that Miia does not cut herself, in lines 30–31 when the doctor indicates that she is approaching a problematic diagnostic conclusion (Frame 2) and in line 44, when doctor moves on to the treatment recommendation. Miia is engaged in "auto involvements" (Goffman 1963) such as biting her fingernails (Frame 1) or fiddling with them (Frames 3, 4, and 6), or looking at her hand (Frame 5).

The lack of relevant and expected next actions and the bodily disengagement results in yet another facet of disengagement in Miia's comportment, which has to do with *moral order*. First of all, expected next actions and bodily and perceptual involvement are in themselves moral obligations (Goffman 1957) that Miia in Extract 1 fails to fulfill. Yet, the moral order has also to do with commitments and obligations that are shown in the interaction but anchored in the world outside the encounter. This "extra-interactional" morality has two aspects: general civic morality (pertaining to norms about good behavior), and the moral obligations of a patient (what the patient should do or aim at in psychiatric care). The doctor displays a moral stance that emerges in the diagnosis preface *I'm sorry to say* (line 31), and in the oblique person reference *we* when describing the patient's symptomatic behaviors (lines 37–42). By these means, she marks the diagnosis as delicate and problematic (cf. Bergmann 1992). The behaviors she describes (physical and verbal

aggression, work without salary, petty crimes) are hearably bad in terms of civic morality ("work without salary" means here the patient's illegal blackwork), and the doctor also depicts their adverse consequences (*we end up in court*). The treatment recommendation involves an orientation to the patient's moral obligations: the doctor depicts the possibility of the treatment as dependent on the patient's *commitment*. Additionally, the very beginning of the diagnostic sequence — the doctor's perspective elicitation question whether Miia has thought about what kind of personality she is (lines 10–13) — also conveys an orientation to the patient's moral obligations, as it makes relevant for Miia to *reflect about herself*. By sticking to mere minimal acknowledgments instead of elaborated responses, by her flat prosody, postural withdrawal, and auto-involvements, Miia avoids reciprocation of the clinician's moral stances: She does not show that she would be interested in herself or concerned about her behaviors, and she does not display commitment.

In this paper, we ask: how did the assessment process, consisting of many interviews, anticipate or produce this massive disengagement that emerged at the conclusion of the assessment. We will track Miia's assessment process in terms of engagement and disengagement.

Our analysis focuses on action sequences and topics that are particularly central in the psychiatric assessment: clinicians' questions and patients' answers that deal with Miia's impulsive behaviors, her diagnosis and possible treatment. Focusing on a particular action sequence is typical and even necessary in CA studies (e.g., Sidnell 2013). The sequences that we have chosen as target of analysis are, as we understand it, at the heart of the institutional activity of assessment interview. The clinicians' questions create the expectation that the patient would account for and/or reflect upon her behaviors. Thereby, the questions incorporate a local moral order as it is understood by the clinician. We will not present sequences other than clinician-initiated adjacency pairs, such as Miia's unsolicited tellings or her questions to the clinicians. In them, engagement and disengagement take somewhat different shape. Particularly, the dynamics of collaboration in action are different in them: as the initiator of action, the patient is inviting the clinician's collaboration rather than vice versa.

The extracts to be shown below demonstrate that at the beginning of the assessment process, there was strong engagement, in the middle part of the process, there was oscillation between engagement and disengagement, and toward the end of the process, there was an important episode of strong disengagement. Eventually at the very end of the process, Miia returned to oscillation between engagement and disengagement.

We should emphasize that the difference between engagement and disengagement is not binary but a matter of gradation: there is a continuum from disengagement to engagement. Yet, in presenting our cases, we have organized them as moments of engagement and moments of disengagement.

Moments of Engagement

At the beginning of the assessment process, and repeatedly during its course, Miia is engaged in the interaction with the clinicians. One key environment where engagement was particularly pronounced is in the enquiries regarding the reason for Miia's visit: her answers convey her reasons and goals, and Miia is engaged in giving them. In Extract 2 below, the doctor first formulates the just prior discussion on Miia's motivation to come to the clinic (lines 01 and 03). The formulation is affiliative, acknowledging Miia's motivation, even though there is also a qualification (*some kind* of motivation: line 1). The doctor then (lines 03–04) asks Miia to name her goals. In her response, Miia is engaged in the interaction: she produces the expected action, is posturally oriented to the co-interactant, and displays moral stance that is relevant to the site.

```
Extract 2 (interview 1)

01  D:  eli sulla on jonkunlaista .hh motivaatio nyt et nyt,
        so you have some kind of .hh motivation now so that now,
    d:  ≫gazing P -->
    p:  ≫gazing D -->

02  P:  m[m,

03  D:  [pitäis tulla (0.4) joku muuto*s .hhh% mikä
        [there should be (0.4) a change .hhh% what
    p:                              *nods
    d:                                      %gazing at papers-->

04      olis *sun tavoite.
        would be *your goal.
    p:       *gazing at D's papers-->

05      (3.0)
```
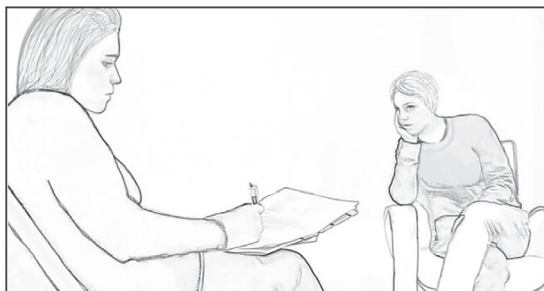

Frame 7

```
06  P:  &.mt *päästä %eroon (.) no&ist *kaikista. (1.0)
        .tch *to get rid of (.) all those thi*ngs. (1.0)
```

```
     d:   &gazing P-----------------&gazing papers ==>
     p:       *gaze up%gaze down-->.    *gazing D-->
```


Frame 8

```
07      aggres&siivisuu*des&ta ja saada nukutt&uu (.) uni (.)
        the aggression and to be able to sleep (.) the (.)
     d:            &------------&gazing P.    &gazing P==>
     p:   --gazing D-----*gazing at hand and middle distance==>

08      ongel*mat pois ja,
        insomnia away and,
     d:        *gazing papers-->

09      (.)

10  D:  m*m-m?
     p:   *gaze at D
```


Frame 9

```
11  P:  *jaksais käydä &kouluu.&
        *to have energy to go to school.
     p:  *middle distance gaze-->
     d:                  &------&gazing P
```

```
                                          Frame 10

12        (0.2)*(0.2)
   p:        *gaze at D-->

13  D:  mm-m? (.) .h mihin kouluun (0.2) toivosit,
        mm-m? (.) .h which school (0.2) do you wish to go to,

14        (1.2)

15  P:  mä oon koulus koko ajan,
        I'm at school right now,
```

In response to the doctor's question, Miia in lines 06–08 and 11 enumerates her goals. Her answer involves the expected second position action not only because she is listing culturally and medically relevant goals for treatment, but also because she builds her answer turn as one that complies with the question format and is grammatically dependent on that (cf. Raymond 2003). By naming her goals, Miia also displays her negative stance toward the problematic behaviors (see especially the answer preface in line 06: *to get rid of all those things*). Thereby, she shows her involvement in the local moral order — both in terms of the civic morality, and the moral obligations of the patient. Posturally, Miia displays attention and involvement by being oriented toward the doctor through the segment. During the formulation (lines 01, 03) the participants are in mutual gaze. At the end of the formulation, the doctor shifts her gaze in her notes; at the beginning of the doctor's question (line 04) Miia also starts to look at them. Thereafter, Miia's gaze direction alternates between the doctor, doctor's notepad and a middle distance (i.e., looking to front of her but apparently not focusing on any particular object; Heath 1988); at one moment (line 07, Frame 8) she briefly gazes at her hand. The doctor mostly looks at the notes that she is writing yet gazes occasionally at Miia. At key points of the answer where she enumerates her goals — lines 06–07, *of that all, of aggressivity* — Miia is gazing at the doctor (Frame 7). She also gazes at the doctor after having completed the enumeration (line 12; Frame 10) which probably works as a signal for closing of the answer and turn transition (Stivers and Rossano 2010). Even when Miia is not gazing at the

doctor, she maintains the postural orientation to her (see line 11, Frame 9) — thereby still bodily engaged with the co-participant.

Extract 2 that demonstrated Miia's engagement was from the initial interview. Such moments of engagement were not, however, confined to the first interview but occurred also in the later ones. During the course of the assessment process, there emerged moments where Miia was disengaged. We will now turn to such moments.

Moments of Disengagement

During the assessment process, there were frequent moments during which Miia did not show engagement on the planes of action, bodily participation, and orientation to a normative order. We should point out that in our data, there is no total disengagement. Thus, in the extracts to be shown below, Miia *does* answer even if her answers are unexpected; she remains in the visual co-presence with the clinicians even if she turns her body away, and she even acknowledges the local moral order even when she resists it. Still, the contrast between moments of disengagement and moments of engagement is stark.

Consider Extract 3 below. Miia has just told about repeated incidents when she says bad things to her friends (being engaged while telling), and the nurse has started to ask her questions that explored further these conflicts. Extract 3 shows a one moment in this interrogative series. In lines 23 and 24, the nurse asks Miia to think about why she directs her angry bouts at her friends, suggesting thereafter (line 25) that she could quite as well express her anger without directing it to anybody. The question invites Miia to explore her motivations and to rethink her actions.

Extract 3 (interview 5)

```
23  N:   no ↑minkä *takii sen
         well why *does it
    p:   ≫middle distance gaze-->
                   *-->yawning
```
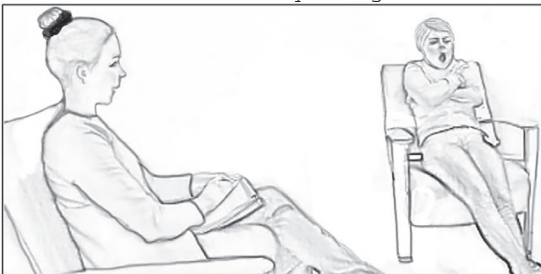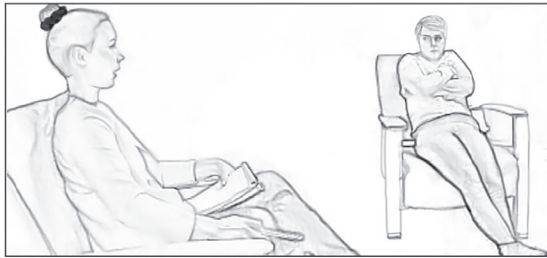

Frame 11

```
24       pitää kohdistu&u heihin et sul menee hermo*
         have to be directed at them that you lose your nerves*
    p:                               yawning-->*
```

```
n:                    &-->gazing P
```


Frame 12

```
25      voisithan sä nyt &kirota vaan niinku *ylei&[sel* tasol.
        you could just curse at like a general [level.
   p:           middle distance gaze --> *-------* gazing N
                                                  *--> mid.dist g.
   n:      gazing P -->  & gazing right-----------&--> gazing P
```


Frame 13

```
26  P:                      [↑no jos ne ärsyttää muah.
                            [↑well if they irritate me h.

27      (0.6)

28  N:  minkälaiset asiat sua är[syttää.
        what kinds of things ir[ritate you.
```
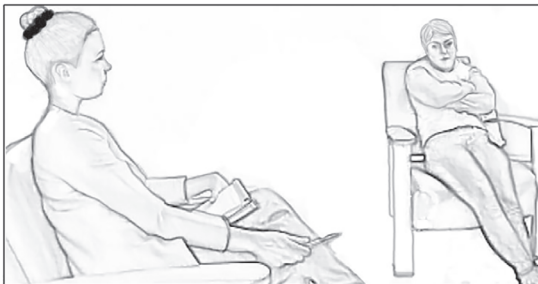

Frame 14

```
29  P:                      [m:ua ärsyttää kaikki
                            [I:'m irritated by everything
```

```
30      tänää £thhhh.£
        today £thhhh.£
```

Miia's answer fails to collaborate in the action that the nurse made relevant: rather than reflecting upon her own motivation (what was invited by the nurse), she gives, as a reason for her behavior, that the friends irritate her (line 26). The nurse takes another route that would make relevant self-reflective accounting and asks what kind of things irritate Miia (line 28); rather than reflecting and naming something (as the question would make relevant), Miia claims that she is irritated by everything today (lines 29 and 30). Both answers are given in overlap with the nurse's talk which seems to convey some agitation, rather than stepping back and exploring her mind.

Through her answers, Miia also distances herself from the local moral order of the encounter: the critical evaluation of self. The nurse's "why" (or, literally, *what for, minkä vuoksi*) question in lines 23 and 24 adopts a formula that is often used in the context in criticizing, to communicate that the asked-about matter is "possibly inappropriate or unwarranted" (Bolden and Robinson 2011). Miia's answers (26 and 29) are defensive. While not accepting her culpability, she does orient herself to the implicit blame. Yet, she disengages from the situational moral order where her task would be to reflect upon her mind and to consider her irritability as inappropriate.

In bodily participation, Miia is mostly disengaged. The nurse shifts her gaze to Miia at the point where the direction of her question becomes clear (line 24 *to them*; Frame 11); in line 25, when she suggests the alternative way of acting, she gazes away for a while, until at the end of her turn (line 25), she gazes again at Miia (Frame 12), and keeps her gaze on her through her answer. The nurse's question in lines 23 and 24 is first met by Miia's yawn (Frame 11). Miia shortly gazes at the nurse at the end of her question (line 25; Frame 12), only to withdraw into middle distance gaze (Heath 1988) as soon as her answer begins (line 25; Frame 13). The middle distance gaze persisting though the nurse's follow-up question (line 28; Frame 13) and Miia's answer to it (lines 29 and 30; Frame 14). Through the sequence, Miia holds her arms crossed in front of her, creating an impression of defensive withdrawal.

For another moment of disengagement, consider Extract 4 below. The nurse has just asked about things that Miia wants to raise in her meeting with the social worker. Miia has answered that there are none, and after that, the nurse in line 1 reminds Miia about "the contact to the student counsellor." The turn design (how about X) and the placement of the question constitute it as a reminder of a plan that has been spoken about earlier. The question invokes an expectation that Miia will tell how she has dealt with, or intends to deal with, this plan.

Extract 4 (interview 6)
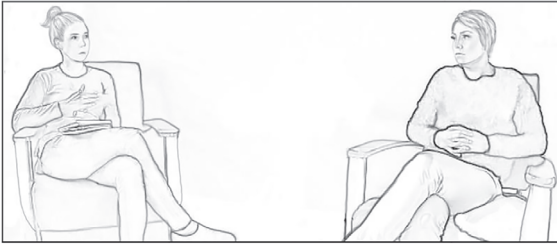

```
                                                     Frame 15
```

```
01  N:   mites se [opo*n ko*n[takti.
         what about th*e [co*ntact to the student [counsellor.
    p:               *----* gazing N
    p:                  *-->middle distance gaze
```
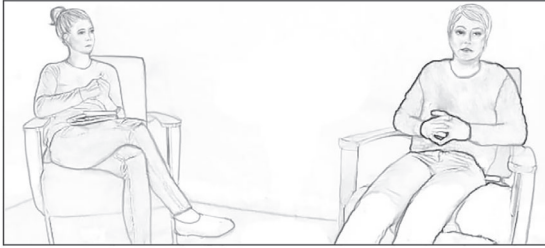


```
                                                     Frame 16
```

```
02  P:                [.ffff.   [en:: o nähny en oo ottanu
                      [.ffff.   [Haven::t seen her have not contacted
```



```
                                                     Frame 17
```

```
03       yhteyttä *en oo kerenny en oo *muistanu eikä
         her haven'*t had the time have not *remembered and
    p:             *-------------------*gazing further away from N
    p:                                  *-->middle distance gaze
```

Frame 18

```
04      oo kiinnostanu.
        have not been interested.
```


Frame 19

```
05  N:  *↑nmitä sä ajattelet siitä jos sä [siihen
        *↑what do you think about taking [it
06  P:                                    [hhhhh.
    p:  *--> gaze down
07  N:  tarttuisit Elinan kans si[ihe asiaa.
           up with Elina.
08  P:                           [nii varmaan täytyy
                                 [that's what I probably need to do
09      °koska ei nyt tuu muutem mitää.°
        °because otherwise nothing's going to work.°
10  N:  mm.
```

In lines 02, in overlap with the nurse's question, Miia gives an answer. She offers first two answers in the negative (*Haven't seen her have not contacted her*), and then gives three accounts (*have not had the time have not remembered and have not been interested*). The chain of three accounts, ending with claim of lack of interest, conveys irritation and defiance, as does the flat prosody and voice quality. Miia's noncollaboration in joint action does not involve lack of response: she does give answers and treats herself accountable. Yet, the "dramatized" repetition of accounts, and the irritation and defiance in them, makes the answer recognizably uncollaborative. By displaying her noncollaboration with the action initiated by the nurse, Miia also conveys disengagement with the local moral order, where responsibility in sorting out things, for example with the student counselor, would be important. Miia's turn challenges the local moral order also in terms of conversational norms

as she produces a dispreferred action as not delayed but in overlap (Pomerantz and Heritage 2012).

Miia shows visually her disengagement. She glances at the nurse at the moment when the key referent of the question (*student counsellor*) has transpired (line 1; Frame 15). Before beginning her answer, however, she withdraws her gaze, adopting first a middle-distance position gazing forwards (lines 1–3; Frame 16). At the beginning of the third part of her answer (which is the first account; line 03) she shifts her gaze further away from the nurse (Frame 17), to return to the gaze to front (still away from the nurse) toward the end of the second account (lines 03 and 04; Frame 18). As the nurse in the third position starts her suggestion to pursue the matter (line 05), Miia drops her gaze (Frame 19) and it remains there till the end of the segment.

In this section, we showed question-answer sequences where Miia was disengaged from the interaction. The questions made relevant responses where Miia would have reflected upon her behaviors (Extract 3) and accounted for her doings (Extract 4). Instead of expected second pair parts, Miia's actions incorporated defiance. Through the unexpected next actions, she also displayed disengagement with the local moral order. Through her gaze and body position, she withdrew from orientation to the co-participant.

After the disengagement that Miia displayed in the sequences shown in this segment, the participants collaboratively made moves that resulted in the re-engagement of the patient. Consider Extract 5 below, which is the direct continuation of Extract 3 shown earlier.

Extract 5 (interview 5; continuation of Extract 3)

```
28  N:   minkälaiset asiat sua är[syttää.
         what kinds of things ir[ritate you.
     p:  ≫middle distance gaze

29  P:                           [m:ua ärsyttää kaikki
                                 [I:'m irritated by everything

30       tänää £thhhh.£
         today £thhhh.£
```
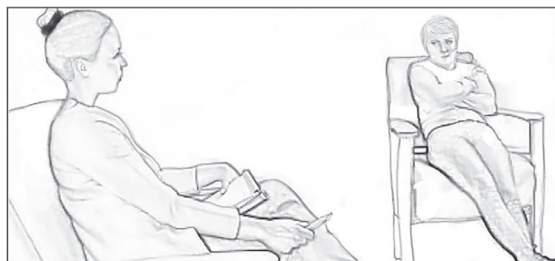

Frame 20

```
31       (0.6)*(0.6)
     p:       *--> gazing N
```

```
32  N:  °m*m.°
    p:  -->*-->gazing N
           *-->blinking, middle distance gaze
33      (2.4)

34  P:  must tulee hirveen äkkipikane.
        I become horribly short-tempered.
```

Having adopted a position of disengagement, Miia produced a laugh particle after her answer *I am irritated by everything today* (lines 29 and 30). A silence ensued (line 31) during which Miia shifted her gaze to the nurse (see Frame 20). Thereby, she seemingly sought for a response from the nurse (Stivers and Rossano 2010) and opened the way for sequence expansion (Rossano 2013). Accordingly, the nurse uttered a softly spoken *mm* (line 32), which in turn was followed by Miia's assertion *I become horribly short-tempered* (line 34). Through this utterance, Miia shifts the focus on herself, taking a step toward the kind of self-reflective stance that the nurse was inviting her to. A corresponding shift occurs in prosody. In line 26 (see Extract 3 above), Miia speaks quick and in high pitch; the pitch becomes lower and the rhythm slower first in line 29 and then even more in line 34. An impression is created of agitation giving way to momentary sadness. Thus, in Extract 5, Miia re-engaged after the disengagement shown earlier in Extract 3.

In Extract 4 also shown above, the nurse meets Miia's defiant answers by a suggestion to deal with the neglected matter in the coming meeting with the social worker (see lines 05–07). Miia eventually agrees with this plan, showing that she considers it important (lines 08–09)—thereby engaging in terms of action and moral order. So, it seems that Miia's disengagements during the assessment process were, after all, short lived, and after it, she returned to engagement.

Intensification of the Disengagement

Concluding discussion on diagnosis and treatment (Extract 1 above) took place in the penultimate interview. The psychiatrist and the mother were also present. At the beginning of this interview, Miia is engaged in the interaction, for example when the participants talk about her achievement in staying abstinent. Then, in mid part of the interview, a "rupture" in her engagement occurs. Unlike in earlier interviews, no collaborative move toward re-engagement follows the disengagement. We will now focus on this moment. The delivery of diagnosis and treatment recommendations shown in Extract 1 above followed some minutes after the extract that will be shown below.

In Extract 6 below, Miia "gets caught" having lied to the clinicians. The participants are talking about Miia's habitual weekend work in a pizzeria owned by her friend. Earlier in the interviews, it has transpired that Miia has no formal work con-

tract, nor regular salary; rather, she gets paid through gifts such as a package tour. The clinicians have treated this as problematic. Miia has, however, maintained that she does not anymore do this "black" work.

Eventually (see line 01) Miia's mother rebuts her claim (*you have been working there all along*). In line 02, the mother continues her turns with a reproachful assessment. The doctor takes the turn in lines 04 and 05: first formulating what has been transpired (*so you are still working there*) and thereafter, in the same prosodic unit, asking *do you then also go drinking in the evening?* The question challenges Miia's earlier reports (that were celebrated by the clinicians) about abstinence. In line 06 Miia however rejects the doctor's inference; this is confirmed by the mother in line 09 and reconfirmed by the patient in line 10. We will now focus on Miia's response to the nurse's question (lines 14 and 15), whereby she invites Miia's self-reflection regarding the reasons that lead her hide the unpaid work.

Extract 6 (interview 8)

```
01  M:  #mm# (.) ootsä ollut siellä koko aika töissä
        #mm# (.) you have been working there all along

02      se on must niinku niin .hhhh (.) järkyttävä se,
        to me it's like so .hhhh (.) shocking that,

03      (.) mhh[hh

04  D:         [et sä oot edelleen siellä töissä menetkö
               [so you are still working there do you then also go

05      sitten illalla vielä juomaan?
        drinking in the evening?

06  P:  en mene, h
        no I do not, h

07  D:  sitä et:,
        that you do not:,

08      (.)

09  M:  s sitä ei oo kyl [tehny kyllä [että;
        th- that (she) has not surely [done indeed [so;

10  P:                                [en,
                                      [no,

11  D:                                                [(mm)

12      (.)

13  M:  [varmaan siis (--)
        [so probably (--)
```
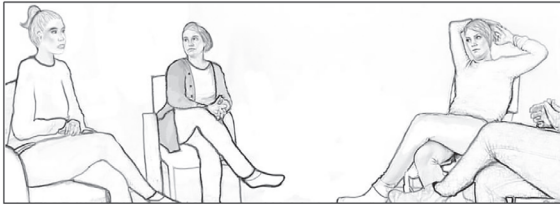
Frame 21

```
14  N:   [miks tää on ollu vaikee sanoo *mm täällä et sä
        [why has this been difficult for you to say mm here that you
    p:                                    *-->gazing N


15       käyt [koska,
        go [because,
```
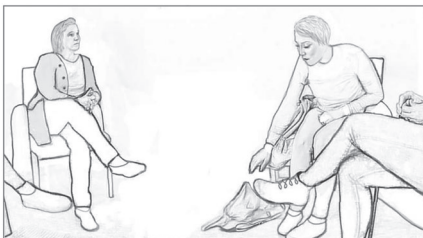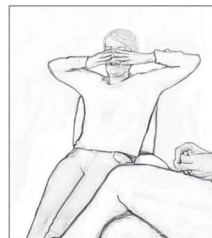

Frame 22

```
16  P:   [noku *hirvee kitinä siit oli
        ['cos there was such terrible whining about it
    p:       -->*gazing N
                  *-->hands down, leaning forwards, taking bag


17       alunperinki:,
        in the first place:,
```
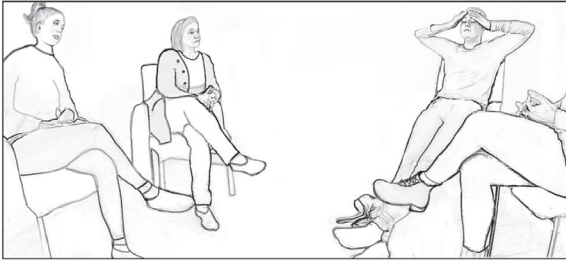

Frame 23   Frame 24

```
18       (.) *mä en jak*sa. hh (.) %ai vittu mul menee hermo, h
        (.) *I'm fed *up. hh (.)%oh fuck I'm losing my nerves, h
    p:       *-------*throwing bag to floor
                            %-->leaning back, covering face


19       (2.0)
```

Frame 25

```
20  N:   .hh oliks siit hirvee *kitinä. Hh
         .hh was there such terrible whining. Hh
    p:                         *-->hands on forehead, temples, cheeks
```


Frame 26

```
21  P:   oli, hh (.) *ku ei saa käydä koulussa tai: jos
         there was, hh (.) 'cos I'm not allowed to go to school or: if
    P:              *-->folded arms
22       ei käy koulussa nii ei jaksa käydä
         I do not go to school then there's no strength to go
23       *töissäkää mitä sit *sanot
         *to work either so what do you *say
    p:   *crossed fingers----*
24       yhelle et mä en o käyny
         to someone that I have't been to
```


Frame 27

```
25       töis.sä *.ja .vittu .mä .en .jaksa
         wo.rk *.and .I'm .fucking .fed .up
    p:          *-->leaning forwards
```

```
26        *hhhhhh mul menee hermo, h
          *hhhhhh I'm losing my nerves. h
     p:   *-->gazing floor, hands on temples
```


Frame 28

```
27        (2.0)
```

The nurse's question about Miia's reasons for not telling about her work (lines 14 and 15) is a why-interrogative, implying that what Miia did was not appropriate (Bolden and Robinson 2011). It is also designed to be a bid for understanding: by asking *why has this been difficult to say mm here* the nurse presupposes that Miia would have wanted to tell, but something prevented her from that. The turn is left unfinished as Miia takes the turn in line 16; in the aborted continuation of the turn the nurse might have been heading toward a claim that withholding the information was unnecessary.

An expected answer would be an account of Miia's "difficulty" in telling about the matter. On one level, Miia produces such an answer, as she in lines 16 and 17 gives a reason not to tell: *'cos there was such terrible whining about it in the first place*. Yet, in relational and emotional aspects, Miia is *not* involved in the action that the nurse initiated: the bid for understanding is met by complaint about the clinicians' ways of dealing with the matter. The complaint is delivered in an agitated voice: quick pace, high volume, and emphasis on the key words, in contrast with the nurse's question (line 14) delivered in a slower pace and peaceful tone. Miia continues after the complaint with an exclamation of anger and irritation in line 18 (*I'm fed up. hh (.) oh fuck I'm losing my nerves, h*).

In line 20, the nurse pursues her bid of understanding by questioning whether there was the *terrible whining* that Miia spoke about. Miia responds by reasserting this (line 21), and then goes on with a complaining account of what the clinicians have told her about work and school (21–25); seemingly pointing out that they have given conflicting advice. Again, Miia in one respect gives an expected answer to the nurse's bid of understanding (giving her reasons for considering the clinician's earlier talk as "terrible whining"), but still her answer is in contrast to the nurse's first pair part: the bid for understanding is, again, met by complaint. Like in the prior sequence, the complaint is followed by exclamation of anger (lines 25 and

26). In sum, in Extract 6, the nurse's bids of understanding were met by complaints and exclamations of anger. In spite of answering nurse's question with grammatically fitted answers, Miia does not collaborate in the action that the nurse initiated: she does not offer descriptions of her mind, but rather, complains about the questioner.

Miia also distances herself from the local moral order of the encounter. The clinicians treat the "black work" as a problem, and Miia's responses play down that (civic morality). The nurse's actions invoke the value of moderation and self-reflection, and by her emotionally intensive complaints, Miia rejects that (patient's moral obligations).

Miia's disengagement is particularly pronounced in her bodily orientation. She withdraws her gaze from other participants at the beginning of the mother's utterance (data not shown) in which she eventually discloses (line 1) Miia's lie. During the nurse's first bid for understanding (lines 14–15), Miia briefly shifts her gaze to her (Frame 21) only to withdraw it at the beginning of her answer (lines 16–17). This remains the only moment in the segment when Miia looks at her co-participants. Intensive body movements ensue. During the angry complaint (lines 16–17) Miia brings her hands forcefully down (Frame 22) and leans forward. During the following exclamation, at the word *fed up* (line 18), she throws her bag to the floor (Frame 23). Thereafter she leans back again and covers her eyes with her hands at the word *fuck* (line 18), remaining in this position till the end of her turn and through the silence that follows (line 19; Frame 24). Miia moves her hands from covering her eyes to her temples during the nurse's question (line 20, Frame 25), still leaning back. During her complaining answer (line 21), she folds her arms (Frame 26). At the beginning of the ensuing exclamation (line 25) she again leans forwards (Frame 27), and then covers her face with her hands (Frame 28) and remains in that position through the silence that follows.

Extract 6 makes visible two facets of disengagement: opposing and withdrawing. The opposing disengagement involves that Miia actively resists the nurse's line of questioning in her answers (lines 16 and 17 and 21–25). It also involves the agitated body movements accompanying her talk. In the withdrawing disengagement, on the other hand, Miia claims that she is not able to interact (lines 18 and 24–26), then stops talking and withdraws from visual contact with the co-participants by leaning back (Frames 24 and 25) or forward (Frames 28). The two facets of disengagement are intertwined in the other extracts that we have shown, yet in Extract 6, they are more pronounced and take place in different moments in time.

After Extract 6, the participants continue the discussion about Miia's black work and her friends. Questions to the patient alternate with advice and assessments. Miia remains mostly disengaged. After six and a half minutes, the therapist starts to deliver the diagnosis. Diagnosis was introduced as a topic linked to this prior discussion. The interactional environment for the conclusion of the assessment

process was unfavorable if not unfortunate. In spite of the fact that the prior assessment interviews included moments of both engagement and disengagement, at the moment of the diagnosis delivery, the participants had already adopted positions where the patient was strongly disengaged. As we saw in Extract 1, this disengagement persisted through the delivery of diagnosis and treatment recommendation.

## Corrective Work: Looking Back at the Diagnosis

On the basis of the assessment process, Miia was referred to group treatment within the clinic. Before joining the group, she met the nurse once more. In lines 01–06 in Extract 7 below, the nurse invokes as topic "*what Katariina* (i.e., the doctor) *said last time*" and "*that thing about personality that we spoke about,*" which is recognizable as reference to the discussion on the personality disorder diagnosis in the prior interview (Extract 1). She asks whether that discussion has left Miia pondering (lines 03–04), and whether she has looked for information on it (lines 04–06). In her response, Miia is disengaged in terms of action, bodily participation, and moral order. Yet, the participants also accomplish moments of re-engagement. Apparently, they work toward repairing their relation that was strained in the prior interview.

Extract 7 (interview 9)
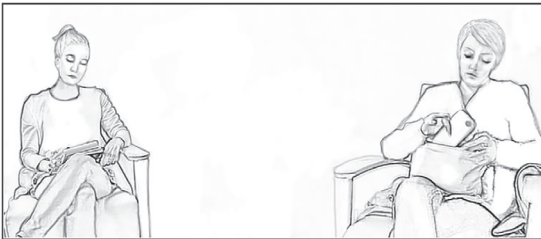
Frame 29

```
01  N:  o[kei, h .hhh no mites *sitte se mitä
        o[kay, h .hhh well *then how about what
    p:                      *-->gazing & tapping mobile phone

02  P:  [nii. h
        [yeah. h

03  N:  Katriina sano viimeks et, (.) jäiks
        Katriina said last time that, (.) did that

04      se sua *mietityttämään tai tutustuik_sä
        leave you *pondering or did you familiarize yourself
    n:         *-->gazing at P
```
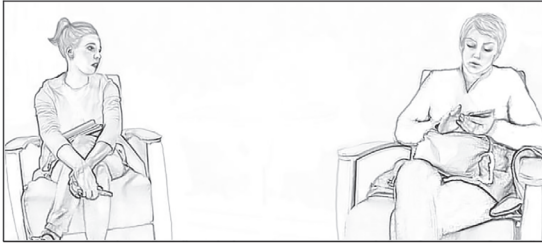
Frame 30

```
05      siihen, h asiaa siit, .hhh
        with, h that thing about the, .hhh
06      persoonallisuudesta mistä puhuttii.
        personality that we spoke about.
07  P:  .hh luim mä siit netis mut em_mä viel
        .hh I did read about it on the internet but so far
```
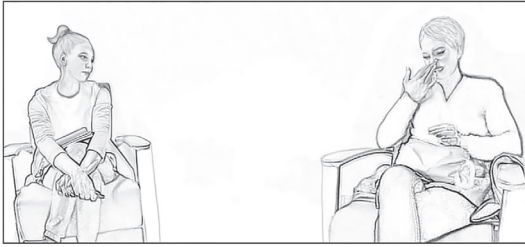

Frame 31

```
08      oo linnas ollu ni ei täs oo mitää *hätää,
        I have not been to jail so there's nothing to worry about,
    p:              puts mobile phone in bag *-->

09      (1.0)*(1.0)%
    p:  --> * puts mobile phone in bag
                %--> gaze at N-
```
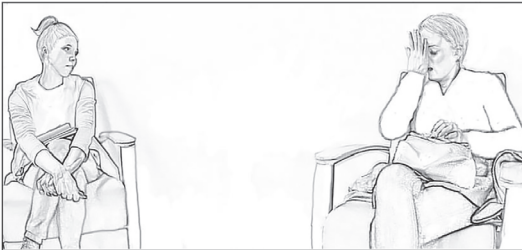

Frame 32

```
10  P:  hehehe*he % (0.4)€.thh
        hehehe*he % (0.4)€ .chh
    n:          *-->smile
    p:            %-->smile
                       €-->gazing down

11      (1.0)%(0.5)*(0.5)
    p:    -->%smile*--> pressing nose
```

Frame 33

```
12   P:   .hh (.) äiti sano et se täsmää muhu,
          .hh (.) mom said that it matches up with me,
13        (2.0)
```
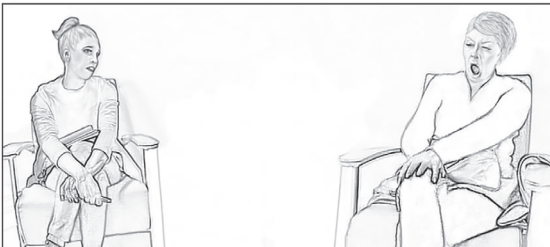

Frame 34

```
14   N:   mm;
```


Frame 35

```
15        *(1.0)%(3.0)
     p:   *looking at hand
               %-->yawning
```


Frame 36

```
16   N:   .hhh on olemas aika *harvoja* sella%sia
          .hhh there are very *few* such
     p:                       *------* gazing N
                              yawning-->%
```

```
17       psykiatrisia määri*telmiä tai *di[agnooseja
         psychiatric defin*itions or *di[agnoses
         p:                       gazing N*------------*

18  P:                            [h *heh heh
    p:                               *-->smiling
```



```
                                                    Frame 37
```

```
19  N:   mit#kä tiedät&kö, .h&hh *täsmäis, (.)
         th#at you &know, .h&hh would *match up, (.)
         p:       gazing N &-----&   *-->fiddling and looking at hands
                                     smiling-->*

20       täysij johonki ihmisees niinku#; hh
         completely with some person like#; hh
```



```
                                                    Frame 38
```

```
21  P:   nii:,
         yeah;,

22       (.)

23  N:   #joku muotti päälle että#, hh
         #like some kind of mould that#, hh

         ((five lines omitted))

29  N:   niihin ei kannata sen takii niinku
         that's why it's not worth it to like

30       itse liikaa jäädä.
         you sticking to them too much.
```

The nurse's question in lines 01–06 creates an expectation of more than a yes or no as answer: it invites Miia's reflections regarding the diagnosis of "asocial personality." Miia's response can be considered in three parts. The first part in one sense meets the expectations (she asserts that she has read about the diagnosis and tells what she thinks about it) but yet does not collaborate with the line of action that the nurse initiated: rather than reflecting upon the meaning of the personality diagnosis, she claims that its implications are not relevant for her (*so far I have not been to jail so there's nothing to worry about*). The answer is uttered in "no-news" prosody (initial pitch high, then going down) which conveys a sense of disinterest. The second part of the response is nonlexical. Miia turns toward the nurse and laughs (line 10). The nurse reciprocates the humorous stance by smiling, and a moment of affiliation and mutual amusement ensues. The defiance and disengagement in action of the first part of the answer becomes, as it were, detoxicated, as the participants redefine the initial answer as humorous. Finally, in line 12, Miia expands her initial answer by telling that *mom said that it matches me*. In and through this expansion, she moves closer to engagement in action that the nurse initiated: indirectly (by citing her mother) she asserts the possibility that the diagnosis would indeed be relevant for her. So here, as earlier in the assessment process, we can observe the oscillation between engagement and disengagement in Miia.

Miia's oscillation in engagement in action has implications for the engagement with the local moral order. The first part of the answer conveys indifference and defiance toward both the civic morality (her wrongdoings are not a problem) and the patient moral obligations (she is not evaluating her own actions critically), while the third part of the answer in effect assumes the relevancy of such orders.

In terms of her bodily orientation to the co-participant, Miia is mostly disengaged, while there are also moments of re-engagement. At the beginning of the nurse's question, she picks up her mobile phone from her bag (line 01; Frame 29), and then remains oriented to that through the question and the first part of her answer, until line 09 (Frames 30 and 31), while the nurse is gazing at her at the key word of the question (line 4: *pondering*) and thereafter. Through the involvement with the phone, Miia contributes to the impression of indifference toward the nurse's question. However, during the silence following Miia's laughter after her answer (line 10, Frame 32), she turns to the nurse and both smile in mutual orientation, achieving re-engagement also in participation. Miia then again withdraws her gaze (line 10) and starts pressing and massaging her nose (from line 11; Frame 33) and produces the third part of her response (lines 12) in this postural orientation. The auto involvement with the nose continues over the silence that follows the answer and the nurse's acknowledgment token (line 14; Frame 34). In sum, Miia's side involvements (phone and nose; Goffman 1963) during the nurse's question and her multi-unit answer convey disengagement, which is interrupted with the moment of re-engagement in the midst of the answer.

The nurse's third position response (lines 16–30) to Miia's answer is of interest. Rather than pursuing her question (as she did in Extracts 3, 4, and 6), she gives her

own view which, in effect, plays down the relevance of the diagnosis. She affiliates with the patient by pointing out that psychiatric diagnoses tend to be imprecise and usually do not fully match with individuals (lines 16–23). She concludes (lines 29–30, that it is not worth "sticking" to them. This is hearable almost as an encouragement to forget the diagnosis delivered in the previous session (Extract 1).

By presenting her view, the nurse also engages in what Goffman (1955) called corrective face work: canceling the negative social attributes that the diagnosis implied. Miia, however, remains mostly disengaged during the nurse's turn. She glances at the nurse three times — at the beginning of her turn (line 16), at a key term (*definitions or diagnoses*; line 17), and at the entry to the key argument (line 19; Frame 37) — but otherwise she is occupied with yawning (lines 15 and 16; Frame 36), fiddling with her hands (lines 19–23; Frame 38) and other auto involvements (lines 24–30, data not shown).

In Extract 7, the nurse's project seemed to be to minimize the relational damage that occurred in the prior interview where the diagnosis was delivered (Extracts 1 and 6). She did not pursue her questions but offered her affiliation instead. Alongside her disengagement, Miia enacted a moment of engagement. It appears that the nurse, successfully, prioritized momentary emotional relation rather than further invitations for reflection. After this meeting, Miia left the assessment team and continued in group treatment.

From Engagement to Disengagement and Re-Engagement

Unlike in some other longitudinal CA studies (e.g., Heritage and Lindström 2012; Pekarek-Doehler et al. 2018; Voutilainen et al. 2018), we did not find a unilateral developmental trajectory in our longitudinal data. Yet, there was a process. It consisted of (1) initial engagement in the first interview; (2) oscillation between engagement, disengagement, and re-engagement in the middle phase; (3) intensification of disengagement in the penultimate interview where diagnosis and treatment decisions were discussed; and (4) return to oscillation between engagement and disengagement in the last interview.

The aim of the first interview for the clinicians to learn about Miia's problems and her goals. Largely, Miia was engaged in discussions on these matters. Affectively, the first interview was perhaps more reserved than the others — understandable given that the participants are meeting for the first time.

Most of the oscillation between engagement and disengagement took place in interviews 2–7. Interviews 3–7 are conducted by the nurse on her own. Miia was more spontaneous, and emotional rapport developed between them. The oscillation between disengagement and engagement may be made possible by this: more than in the first interview, Miia was "free" to disengage and return to engagement.

The intensification of Miia's disengagement in the penultimate interview was prompted by a face-threatening situation as she was caught of a lie. Her

disengagement was more intensive than in the middle phase and she made no moves toward re-engagement. The delivery of diagnosis and treatment recommendation occurred soon after these moments of intensive disengagement. The patient's disengagement in diagnosis and treatment discussion can thus be understood as a carryover from them. The timing of the diagnosis delivery was thus problematic. The middle phase oscillation between engagement and disengagement suggests however that the clinician-patient dyad had a long-lasting propensity for patient disengagement, which then was actualized in the penultimate interview.

In the last interview, after moments of disengagement, Miia made moves toward engagement, and they were reciprocated by the nurse. The re-engagement involved mutual positive affect, giving an impression of repair of the emotional rapport. The nurse also distanced herself from the ideational content of the talk on diagnosis in the penultimate interview, thus orienting herself to the interactional problems in the earlier talk about diagnosis. Miia, however, returned to her disengagement.

DISCUSSION

In a longitudinal case study of nine assessment interviews with a patient who eventually received a diagnosis of personality disorder, we described the evolvement of patient engagement. We conceptualized engagement as an assemblage consisting of collaboration in joint action, physical and perceptual orientation to the co-participant, and sharing of the local moral order of the encounter. With multimodal conversation analysis, we examined patient engagement in clinician-initiated adjacency pairs where the clinician's question invited the patient to account for and/or reflect upon her behaviors. In the recurrent moments of disengagement, Miia's responsive utterances ran against the expectations created by the clinician's initiatory utterances, and they embodied disaffiliation from the moral order invoked by the clinician's turns and known-in-common for the participants.

Our key contribution to longitudinal analysis of interaction is to show a nonlinear process. We showed oscillation between engagement and disengagement. Yet in this oscillation, there was a continuity and recognizable linkages between different moments of interaction: the gradually growing "ease" in which Miia moved between engagement and disengagement in the middle part of the process, the continuity of strong disengagement between different moments and actions in the penultimate interview (shown in Extracts 6 and 1) and the corrective move from disengagement toward engagement occurring between Extracts 6 and 7. Such linkages could be characterized as *interactional memory*: continuity of (dis)engagement behaviors in spates of talk longer than sequence, also across sessions.

For Goffman, social encounters involve inevitably dual tendencies toward engagement and disengagement: "spontaneous 'normal' involvement seems to be the exception and alienation of some kind the statistical rule" (Goffman 1957:134). Miia's disengagement behaviors might in themselves be neither exceptional, nor

direct expressions of personality pathology. All interactants occasionally, or even rather often, produce responses that run against the expectations of the prior talk, withdraw posturally, engage themselves in side involvements, and fail to engage with the relevant moral orders. Yet the amount and density of such behaviors in Miia's interactions with the clinicians is exceptional.

According to the established psychiatric view, emotional dysregulation and interpersonal dysregulation are at the heart of personality disorders (APA 2013). Conversation analysts usually keep apart the analysis of interaction and clinical theories in order to avoid using psychological assumptions as causal explanations of interactive behaviors. Yet, with data and phenomena as ours, a dialogue between CA and clinical understandings seems necessary. Importantly, we believe that such dialogue is possible without assuming that internal states or traits would *cause* the interactional phenomena.

We suggest that Miia's disengagement behaviors were not caused by emotion dysregulation, but that what we see in the data is how they *incorporate* the emotion dysregulation. On a more general level, we consider a distinction between "internal" emotional processes (be they experiential or physiological) and "external" behavior unnecessary: internal regulation (or dysregulation) and interactive behavior are parts of the same system (Beebe and Lachmann 2002). The diagnostic interview focuses on the patient's weaknesses and bad behaviors, entailing a threat to self-experience. Questions that invite accounts and reflections on behavior invoke such threat. Disengagement can involve an effort to manage that self-threat (cf. Hopwood and Back 2018:510). Engagement incorporates another, socially more adaptive way to regulate emotions. The oscillation between engagement and disengagement can be understood as an alternation between emotional regulation and dysregulation. Furthermore, we should emphasize that in an interactional setting (such as diagnostic interview), emotion regulation is an interpersonal, rather than individual, process (cf. Beebe and Lachmann 2002). The clinicians are also part of this process. So, we suggest that in moments of engagement, the participants co-regulate their emotions, conjointly making bearable the focus on painful, self-threatening experiences. In moments of disengagement, the mutual emotional regulation fails, and each participant resorts to their own regulation strategies. Miia resorts to withdrawal and/or opposition. The clinicians' categorical descriptions (as in the diagnosis delivery) or questions invoking accountability and reflection may help them to regulate their own situational emotions, but they do not facilitate, in the moments that we investigated, the co-regulation of emotions.

We conceptualized engagement as an assemblage consisting of collaboration in joint action, physical and perceptual orientation to the co-participant, and sharing of the local moral order of the encounter. Of these three facets, sharing of the local moral order is conceptually and empirically the most complex one. One aspect of the complexity is the duality of general civic morality (pertaining to norms about good behavior), and the moral obligations of a patient (what the patient should do or aim at in psychiatric care). Engagement and disengagement could involve

orientation to one or the other, or both. But there is even more to the complexity of the morality and engagement. As Goffman (1957) points out, being engaged is in itself a moral obligation. He talks about "the individual's obligation to maintain spontaneous involvement in the conversation" (p. 48). Thus, we might say, that a failure to collaborate in joint action and in maintaining the perceptual orientation to the co-participant involves, in itself, a failure to share the local moral order of the encounter. Drawing upon Bergmann (1998) we could say that showing deference to the general civic morality and the moral obligations of a patient has to do with morality *in* interaction, whereas the collaboration in joint action and perceptual orientation to the co-interactant have to do with the morality *of* interaction. Both are at play in the (dis)engagement examined in this paper. They are also in a reflexive relation to each other, so that disengagement in the planes of action and participation (morality *of* interaction) can index the patient's disengagement regarding the civic or clinical moral expectations (morality *in* interaction).

Our analysis focused on the clinicians' questions and Miia's answers. It is of importance to note that questions that create an expectation the recipient would account for and/or reflect upon their behaviors are potentially "toxic": they can convey that there is something wrong or unclear in the recipient's behaviors (cf. Bolden and Robinson 2011). So, Miia's disengagement in segments shown in this paper did not occur "spontaneously" or in a "neutral" sequential environment, but rather, in moments that could constitute a threat to her self-presentation (cf. Goffman 1959).

We should also look at the interactional history beyond the very questions that Miia was answering (cf. Peräkylä 2019). The talk before the clinician's question could also contribute to Miia's choices in responding to the questions. In the example of engagement (Extract 2), there was an element of affiliation in the prior talk (the doctors' formulation of Miia's motivation), whereas in the strongest example of disengagement (Extract 6), the nurse's questions were preceded by a moment of stark disaffiliation between Miia and the other participants. Perhaps the prior interaction (before the question-answer sequence) "primes" Miia toward engagement or disengagement in answering the actual question. Yet, in some other examples of disengagement (Extracts 4; 7), the clinician's question involved a shift of topic and action which made it partially independent of the prior talk. It would be a topic for further studies to follow the emergence of (dis)engagement through a continuum of turns that is longer than the question-answer sequence.

The participation structures in the data at hand are complex. In three interviews, there were two clinicians, doctor and nurse. Our global impression is that Miia established closer emotional alliance with the nurse, which enabled her to move between engagement and disengagement more freely in the middle phase of the assessment. Yet it is impossible to know whether Miia would have been more engaged in the delivery of diagnosis (see Extract 1) if it were done by the nurse in a dyadic setting. The difference between Miia's engagement behaviors when interacting with different clinicians would deserve more attention in future studies. Furthermore, Miia's

mother is central in the emergent conflict (Extract 6): she reveals Miia's unpaid work and teams up with the clinicians. The mother's contribution to Miia's engagement behaviors would also deserve further research.

CONCLUSION

Our paper brought together Goffman's ideas regarding engagement, and contemporary methodology of multimodal conversation analysis. In pursuing the linkages between Goffman and conversation analysis, we followed a line of research associated, for example, to the work of C. Goodwin (1982) and M. H. Goodwin (1990). In their work, Goffman's ideas of co-presence, focused encounter, and participation are elaborated by using CA methods. Yet, the relation between CA and Goffman is far from simple. In a widely cited text, Schegloff (1988) lays out conceptual CA critique of Goffman, pointing out that Goffman's focus on self and ritual entails a psychological and motivational account of interaction, one that occludes the analytical view to the primordial structures of social action, pertaining to turn-taking and sequences.

One methodological contribution of our paper was to unpack Goffman's idea of engagement into its empirically analyzable components, and to trace them through sequential and longitudinal analysis. Our results showed that this works. But did Goffman's concept bring anything new and helpful to our empirical method, conversation analysis? CA concept of *alignment* (Stivers 2008) comes close to what we referred to as action plane of engagement. Engagement in local moral order, on the other hand, touches upon (but does not overlap) with what conversation analysts recently have conceptualized as *affiliation* (Stivers et al. 2011). Why not stick to these concepts? In our data, the three planes of engagement — action, bodily participation, and moral order — usually go together, and even more, they seem to index each other. If you disengage from one, you may, through the same behaviors, show your disengagement from the others as well. This is particularly the case in disengagement with the moral order: in our data, it is accomplished in and through the other two facets of disengagement. Engagement and disengagement seem to be, as it were, a Gestalt for the participants. Goffman's holistic conceptualization may help us to see that.

The place and significance of self in social interaction is one key target of Schegloff's (1988) critique of Goffman. The analysis presented in this paper has focused on interactional engagement rather than on self, thus taking up aspects of Goffman's work that were not the primary target of Schegloff's critique. Yet, the analysis that we have presented in this paper could be linked to the concept of role distance (Goffman 1961) which is part of Goffmanian sociology of self. The oscillation between engagement and disengagement involves also oscillation between what Goffman called role embracement and role distance. Goffman showed how persons in social interaction can relate to the roles that they perform, making a distinction between the actual role performance, and the self that such performance implies. In what he called *role embracement*, the performer, as it were, takes over the self-implicated by the role, whereas in role distance the performer acts according to

the role, but is not assuming the self that the role performance implies. In Goffman's words: role embracement means "to disappear completely to the virtual self available in the situation, to be fully seen in terms of the image, and to confirm expressively one's acceptance of it" (Goffman 1961:94). In role distance, "the individual is actually not denying the role but the virtual self that is implied in the role for all accepting performers" (p. 95). Thus, role distance is realized by "actions which effectively convey some disdainful detachment of the performer from a role he is performing" (p. 98).

Goffman associated roles to what he called "situated activity systems." Psychiatric diagnostic interview is one such system. In the moments of disengagement, Miia did perform her role: she was there in the interview, answering questions and listening when she was given a diagnosis. Yet her disengagement showed that her heart was not in this. Her actions "effectively convey[ed] some disdainful detachment of the performer from a role [s]he [was] performing" (Goffman 1961:98). In the moments of engagement, on the other hand, she conveyed her acceptance of the momentary image of self that the diagnostic interview allocated to her. It appears that engagement and disengagement behaviors on the one hand, and role embracement and role distance behaviors on the other, largely implicate each other, at least in our data.

In the light of Schegloff's (1988) critique of Goffman, we should ask whether the analysis of engagement and disengagement behaviors, and the role distance and role embracement achieved through them, has confined the analysis "in the psychology" (p. 94), obstructing the view to the actual organization of action. Rather than maintaining the boundary between psychology and sociology, we advocate radical lowering of it (cf. Potter 2012). Even though it has not been our research topic, it is, in our view, obvious that Miia's behaviors explicated in this paper are associated with momentary emotional states (for example, arousal in Extract 6) and that they probably reflect more enduring personality traits (such as emotion dysregulation). Yet, whatever these psychological states and traits are, in the moments that we have examined, they exist in and through the actions that we have been analyzed. The psychological states and traits are not behind the actions, they do not explain or motivate the actions, but rather, they are in the actions. In this paper, we hope to have explicated some facets of the organization of actions constituting interactional engagement, in one particular social setting, the assessment interview.

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