NOTES ON THE DELIVERY AND RECEPTION OF DIAGNOSTIC NEWS REGARDING MENTAL DISABILITIES

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Situations in which professionals communicate news of children's mental disabilities to parents have not wanted for attention. Clinically oriented researchers, in assessing parents' point of view and experiences, emphasize the stress they feel and the emotional reactions they exhibit when learning a child is disabled (Wikler, 1981). Suggestions are then made as to how professionals should present such diagnostic news so as to properly deal with parents' stress and reactions (e.g., Rockowitz and Davidson, 1979). From a sociological perspective, informing interviews of this kind are investigated in a literature on "bad news" deliveries, including those where a doctor must report a death to a relative of the deceased (Glaser and Strauss, 1965; Sudnow, 1967), or a U.S. Marshall delivers a summons, takes people into custody, or transfers them to prison (McClenahan and Lofland, 1976).

Whether clinically or sociologically oriented, the literature on bad news presentations uniformly suggests that they are difficult interactional episodes for deliverers and recipients alike. However, the research suffers from two shortcomings which this chapter addresses. First, prior studies are overwhelmingly based on clinical impressions, on interviews in which participants much recall their experiences, or on participant observation, rather than on recorded occurrences of actual interaction. The data for this study were audio-recorded in a diagnostic clinic for children with developmental disabilities; analyses are performed on the tapes and transcripts of them. Second, with the exception of Sudnow (1967), research has focused on the delivery of bad news and neglected how it is received within the conference situation. For one example, while news-recipients' "acceptance" of particular diagnoses may be at issue, it is a phenomenon measured after the interview is over (Svarstad and Lipton, 1977). For another example, McClenahan and Lofland (1976) nicely describe practices involved in preparing to present, and then presenting, bad news, but recipients are considered as targets whose anxiety and depression must be relieved through various "shoring" techniques. A neglected phenomenon is their actual contribution to the interaction, in terms of practices for receiving, and participating in, the delivery of news. The result is that recipients are portrayed as passive rather than active participants in the interview process. This chapter views news delivery interactively. Professionals have patterned ways of presenting diagnoses, to be sure; but the actual course of an interview is co-determined by ways in which parents respond to what is presented. The basic thrust of the paper is to describe how diagnostic news is delivered, how it is received, and to identify relationships between delivery and reception patterns.

The Data And An Initial Problematic Episode

The data were collected in a diagnostic clinic affiliated with a medical school in an urban setting. When children were referred to the clinic, they were evaluated in a variety of ways, which may have included neurological, psychological, and intelligence examinations, and assessments by a pediatrician, social worker, educational psychologist, speech pathologist, and psychiatrist. After team members decided upon a diagnosis and on a treatment plan, parents were referred to the clinic for the "informing interview," during which they were told the findings and recommendations.

The complete corpus includes over 50 conferences between clinicians and parents. Only three interviews are examined here, but they nonetheless represent an array of presentation and response options in talk concerning diagnosis. Following Sacks, Schegloff and Jefferson (1974), and Schegloff and Sacks (1973), the orientation is to preserve the fine points of interaction while describing general patterns of discourse as achieved in identifiable practices of the participants.

The first interview segment is one that stood out in the corpus because it prominently displays the sort of interactional difficulties an-
ticipated by the literature on bad news deliveries. The interview concerns “Donald Roberts” (all names are fictitious).

Dr. “D” begins with what may be roughly termed as an attempt to affiliate with the parents (both mother and father are present). She notes the “extraordinary job” that they had done in dealing with the “hard” situation they face, reminds them of her own status as a “parent” (Dr. D also has a disabled child), and expresses “admiration” for their efforts; see lines 1-9.

(1) ROBERTS

01 Dr. D: I think you know I’m sure you’re anxious about today and I know this has been a really hard year for you. And I think you’ve really done an extraordinary job in dealing with something that’s very hard for any human being or any parent and you know Mrs. Roberts and I can talk as parents as well as 06 Mrs. R: True
07 Dr. D: uh my being a professional, it’s HARD when there’s something not all right with a child, very hard. And I admire both of 09 you really and, and as hard as it is seeing that there is something that IS the matter with Donald
11 (0.4)
12 Dr. D: He’s NOT like other kids
13 (0.4)
14 Dr. D: He is slow
15 (0.4)
16 Dr. D: He is retarded
17 Mrs. R: HE IS NOT RETARDED
18 Mr. R: Ellen
19 Mrs. R: HE IS NOT RETARDED
20 Mr. R: Ellen, please
21 Mrs. R: No!
22 Mr. R: Hey- look-its their way of- I don’t know
23 Mrs. R: HE IS NOT RETARDED ((sobbing))
24 Dr. D: He can learn and is learning
25 Mr. R: Yes he is learning
26 Dr. R: And he’s making good progress, and he will continue to make good progress
27

Following the attempt at affiliation, Dr. D. provides “person-descriptions” (Maynard, 1983) regarding Donald (lines 9-16), ending with the characterization that “he is retarded.” Then, in a series of turns (lines 17, 19, 21, and 23), Mrs. Roberts loudly disagrees with the description and ends up sobbing. This is followed by Dr. D’s and Mr. Roberts’ more “positive” formulations of Donald, in what appear as efforts to comfort Mrs. Roberts. Clearly, the delivery and reception of diagnosis in this episode exhibits precisely the kind of difficulties adumbrated by previous studies. Beyond these rather intuitive observations, however, the task in this chapter is to provide a structural description of the segment that will locate the observable troubles as achieved outcomes; i.e., as products of the methods by which the involved parties conduct the interaction. Segments of talk from two other interviews will provide an empirical basis for claims regarding alternative patterns of delivering and receiving diagnostic news. After examining these segments, we will return to the Roberts interview for a more technical consideration of its salient features.

A Language Use Problem

The next example is from an interview with a bilingual mother of “Ricardo Alvarez.” Present at the interview are Mrs. Alvarez, Ricardo, and Dr. L, a female pediatrician.

(2) ALVAREZ

01 Dr. L: Okay. Well, now tell us since you’ve been here and through this thing, how do you see Ricardo now 03 Mrs. A: I guess he see him better since he was here...they teach him you know how to say- to TRY you know
05 Dr. L: Uh huh
06 Mrs. A: for him to do it the right way
07 Dr. L: He mm
08 Mrs. A: But I think how he’s doing better because the teacher told me
09 Dr. L: He mm
10 Mrs. A: I asked yesterday and she told me to continue to bring him here cause his doing better ‘n better in speech
12 Dr. L: He mm. Is he getting speech therapy here now? Or you just came in one time and saw the speech therapist
14 Mrs. A: No this is the third time that he came see her
15 Dr. L: Right. Okay, just wanted to make sure that something wasn’t going on that I didn’t know about
17 Mrs. A: "uh"
18 Dr. L: Okay now. Basically um Ricardo is a BRIGHT, NICE little boy 19 who is from everything I can see in my evaluation and from um Miss Seymour’s evaluation, is you know- has real 21 intelligence that is normal
23 (0.6)
24 Dr. L: The there aren’t any real problems with his ability to USE words. The problem is that sometimes that words don’t SOUND quite correct
25 (1.0)
26 Dr. L: And this is a speech problem which can be corrected
29 Dr. L: The thing is it takes a long time to correct, to correct the kind of speech problem that he has, it’s not going to happen in a couple of months. It probably is going to take a couple of years.
31 Mrs. A: Yes, she told me, the last lady that I saw
34 Dr. L: A’ right, Miss Seymour
35 Mrs. A: She told me yes
36 Dr. L: Fine. And this kind of therapy can be done in school. The speech therapist, ALL the schools have speech therapists

There are five features of this segment of interest. First, the interview is started by Dr. L asking how Mrs. A “sees” her son, Ricardo
(lines 1–2). Mrs. A. then provides various indications that he is “better” (lines 3, 8), and particularly in “speech” (line 11). It is after this, and after checking out whether the boy received speech therapy at the clinic (lines 12–16) that Dr. L begins to present her evaluation of Ricardo, which indeed focuses on his speech.

Second, this presentation, which occupies lines 18–25, is formatted in a particular way. Positive descriptions of the boy occur initially (lines 18–21), and then Dr. L produces a formulation of his problem (lines 23–25). Thus, there is *good-news/bad-news* structure to the delivery.

Third, the characterizations of Ricardo’s intelligence and his speech abilities are grounded in Dr. L’s and Miss Seymour’s “evaluations” (lines 19–20).

Fourth, the course of news delivery is striking for the absent or minimal responses from Mrs. A., resulting in an elongated turn by Dr. L, which contains slight shifts of topic. That is, according to the turn taking system described by Sacks, Schegloff and Jefferson (1974), when a speaker has arrived at turn completion (as at line 21), a co-participant may produce the next unit of talk. When she does not, speaker may initiate another utterance (line 23), thereby extending her own turn of talk. This phenomenon may occur more than once (see the silences at line 26 and 28, and the added utterances at lines 27 and 29–32) before recipient takes a turn (as at line 33). Thus, multi-utterance turns such as Dr. L’s in line 18–32 are not designed unilaterally by a speaker but result from an interactional sensitivity. Furthermore, shifting a topic in the added utterances may be a means of eliciting a demonstration of the news’ implicativeness (Jefferson, 1978). Given that the positive characterizations of Ricardo obtain no remark from Mrs. A., Dr. L moves to the delivery of diagnostic “bad” news. When this meets with a minimal response, she returns to some “good” news which is that the “speech problem CAN be corrected” (line 27), although it will take a “long time” (line 29). Clearly, although a variety of opportunities for recipient’s verbal acknowledgment, assessment, or comment occur during Dr. L’s talk, none is taken up.

Finally, when recipient does take a turn at talk, she reports (lines 33) that the “last lady” she saw (Miss Seymour) has already “told” her something of what Dr. L has just stated. Thus, by way of her not talking during the diagnosis delivery, and then quoting another clinic official when the topic of the “correctability” of the problem is broached, Mrs. A’s own position regarding the delivered diagnosis is not visible. This may reflect a discrepancy between the parent’s and clinic’s views of Ricardo: recall that Mrs. Alvarez stated that Ricardo was doing “better and better in speech.” Then, when Dr. L delivers a characterization of Ricardo’s problem as related to the “sound” of his words, it may contradict Mrs. Alvarez’s evaluation. However, since Mrs. Alvarez’s position is not articulated after delivery of diagnosis, nor during the rest of the interview, it is speculation to conclude that a discrepancy in points of view actually existed. We can say, minimally, this appears to be an instance of a parent, whatever the state of her own attitude in the matter, “going along” with what the doctor says.

### A Child With Two Problems

With “David Hamilton,” the clinic found two problems. Each diagnosis is discussed separately and delivered very delicately. Close inspection of the discourse reveals considerable trouble, especially regarding how the parents view the first diagnosis. The interview included a male pediatrician, Dr. R, a social worker (SW), and both parents of the involved child. The interview began in a manner similar to the last, with the pediatrician asking Mr. and Mrs. Hamilton for their views of David.

Dr. R: Have you noticed any improvement since I saw him last, which was over three, four months ago.

The parents, with the father doing most of the talking, reply that David appears more “controlled” now, and less “wild.” But the mother says that “he won’t listen,” and the father adds that “you really have to yell at him, repeat, repeat, repeat.” Then:

(3a) Hamilton

01 Mr. H: You know I think basically the problem is as I also said to
02 Dr. R: Uh, when you reach the age of about...
03 Dr. R: A half you more or less stop maturing right there
04 Dr. R: Okay. Well that kind of leads into what we found uh,
05 Mr. H: Essentially what we have found in David is that at a certain
06 point his development HAD stopped
07 Dr. R: Right.
08 Dr. R: and uh, when tested he tends to look at us like a kid
09 with retarded development.
10 Mr. H: Hm.
11 Mr. H: Hm.
12 Dr. R: This is a kid who's reached a certain point and then he
13 Mr. H: stopped.
14 Mr. H: Right.

When Dr. R provides descriptions of David (beginning in lines 4–6), they are specifically fitted to the father’s foregoing remarks. First, there
is a topic shifting utterance that formulates a "lead in" connection between the father's utterance and Dr. R's own turn (line 4). This moves the focus from the parents' view of David to what the clinicians "have found," line 4. Second, at lines 5–6, the characterization of David that "his development HAS stopped" is produced as an assessment agreeing with the father's (line 3), the stress on "has" marking the agreement.

The utterance of Dr. R is followed by an agreement-token by Mr. H ("right," line 7); subsequently Dr. R produces another description of the child, as a "kid with retarded development" (lines 8–9). We will see shortly that the use of this particular description (as opposed to something like "he is retarded") is significant. A further feature of this utterance (lines 8–9) is that, like the Dr's prior turn (lines 4–6), and like Dr. L's presentation in example 2, the characterization of the child is grounded. That is, not only is he described as having a "stopped" and a "retarded" development, but these are what the clinicians "found" (line 4) and "tested" (line 8), respectively.

The "retarded development" characterization is met with ambiguous utterances by both Mr. and Mrs. Hamilton (lines 10–11). The ambiguity derives from the multiple use terms such as "mm hmmm" and "mhm" can be put to. At times, they are used to indicate agreement, or understanding, but they more regularly operate as "continuers," merely signalling a party who has the floor to resume talking (Schegloff, 1981). They are evidently troublesome for Dr. R, because upon their production, he returns to an assessment of the child's development as "stopped" (line 12). Thus, this, is dealt with by a less ambiguous agreement token, the "right" (line 14) that Mr. Hamilton had also provided (line 7) when this assessment was first produced (lines 5–6).

Thus, the "retarded development" diagnosis is precariously managed as a bit of news. It is provided only after Dr. R asks for the parents' view of David's progress; it follows a potentially less troublesome characterization ("stopped development") of the doctor, which is fitted to the father's assessment; it is provided not as a matter of opinion, but as a finding; and, in terms of the sequential organization of utterances, Dr. R retreats from the diagnosis when it meets ambiguous responses from Mr. and Mrs. Hamilton.

In addition, there is evidence that the "mm hmmm" responses referred to above may be suppressing active disagreement by the parents with the clinic's diagnosis. As a general phenomenon, disagreement is exhibited as a dispreferred activity in adult talk (Pomerantz, 1975). For example, second assessments, which run counter to first evaluations, are often delayed within a single utterance by the prior use of acknowledgements, tokens of agreement, and other prefeces such as "well."

Example

01 A: That was a great movie
    (first assessment)

02 B: Well I thought it was a bit maudlin
    (second assessment)

In contrast, turns which agree with a foregoing utterance have the agreement components placed in the initial part of the turn.

In this interview, it becomes clear that the parents do not view David as "retarded," but an opposed characterization occurs only when it can be locally occasioned by other topical talk. Thus (about three minutes later in the interview):

(3b) Hamilton

01 Dr. R: This is not necessarily a total thing. And there are certain
times where some of these kids will function in an area
very well. Uh some of these kinds can be very very bright
03 Mr. H: Well David has to be a very bright child
05 Mrs. H: He- you know he can sit through a classroom, in the class and
06 he' ll be oblivious you know by appearance, but yet he'll come
07 home and tell me just what went on in the classroom
08 Mr. H: [Right
09 Mrs. H: Now he'll memorize songs, and he's not paying attention at all
10 Dr. R:
11 Dr. R: Mm hmmm
12 S.W.K: So you don't think he's retarded
13 Mrs. H: No
14 Mr. H: I wouldn't say- No, no I wouldn't say he's retarded at all
15 Mrs. H: I talked to the principal in fact the other day and she said
16 S.W.K: Yeah
17 Mrs. H: he improved so much since September
18 Dr. R: Right. But this is all right, this is the area where we
don't know right? As I said this is a very muddy field

Here, the father, in a standard topical move, uses the categorical statement by Dr. R, "some of these kids can be very bright," to formulate David as a specific instance (line 4). Then, the mother provides biographical items that heuristically substantiate the father's assessment (lines 5–9). Finally, the Social Worker asks if they "don't think" David is retarded. The form of the question expects confirmation by a negative; both parents supply it (lines 13–14). Clearly, then, the earlier tokens, "mm hmmm" and "mhm" were avoiding the production of conversational disagreement regarding David's intellectual capacities, despite the parents' holding views contrary to the clinician's diagnosis. Notice here that the opposing characterization is still not produced as a disagreement per se which Pomerantz (1975) defines as the display of discrepant positions in adjacent turns. Rather, the parents produce talk about how 'bright' David is, which leads to the Social Worker's inference that they don't think he's retarded. The primary work of the
parents' characterization of David as not retarded, therefore, is to confirm the correctness of that inference.

It is here that the earlier use of "retarded development" becomes crucial, because it permits Dr. R to exhibit a further pliability of position.

(3c) Hamilton

01 Dr. R: ...we have to be very wary about what we say about David's intelligence, I purposely used the word retarded DEVELOPMENT
02 Mr. H: Right
03 Dr. R: Because I don't know whether he IS retarded per se

Thus, it is clear the "retarded development" in (3a), line 9, is carefully chosen and further exhibits the precariousness of the diagnostic news delivery there.

The last two segments, (3b) and (3c), were taken from later in the conversation than (3a). To return to the immediate context of (3a), what follows is the presentation of the second diagnosis regarding David.

(3d) Hamilton

01 Dr. R: And- and there are a lot of things that we don't know about. But beyond just his way of functioning, per se, I mean the ability to function at an age appropriate level is the WAY he functions
02 Mrs. H: Mn hmm
03 Dr. R: That is he seems to be very oriented inwardly in himself
04 Mrs. H: Right
05 Dr. R: His functioning seems to really come from inside of him rather than from well, you or I perceive something out there and react to it. He seems to do alot of his-
06 Mr. H: In his own world more or less
07 Dr. R: Right, in his own world. And um for that reason and for other reasons that we found, uh we tend to call that- that sort of sits in the emotional realm, what we call an emotional problem or psychiatric problem
08 Mr. H: Right
09 Dr. R: And once we get into that realm its very hard to be very specific about what it is. That could be what we call a childhood psychosis
10 (0.6)
11 Dr. R: Or it could be what we call childhood autism
12 (1.0)
13 Dr. R: A lot of people wouldn't distinguish between those two
14 (0.6)
15 Mr. H: Well it's like what Bill Smith said, actually he noticed right away that there was a problem with his thought process
16 Dr. R: Right

In this segment, Dr. R shifts the talk from David's "age appropriate" abilities (lines 2–3), which had been the topic in segment (3a), to the "way he functions" (line 3).

Following Mrs. H's continuus (line 4), Dr. R. moves, in a step-by-step fashion, to provide a formal diagnosis. Each step, however, is taken after the parents provide demonstrations of agreement or understanding (lines 6–7, 11, 16), until Dr. R produces relatively technical terms, including childhood psychosis and childhood autism (lines 19, 21), which obtain no response. Thus, the delivery of news involves movement from vernacular characterizations ("oriented inwardly") to more official and potentially stigmatizing terms ("emotional problem," psychiatric problem," "psychosis," "autism"). And again, Dr. R not only provides the diagnosis, but emphasizes found "reasons," including the clinicians' and Mr. H's observation of David being "in his own world" (lines 12–13).

The lack of turn transition (at lines 20, 22 and 24) apparently foreshadows a later discussion of the diagnostic terms, which were not adequately understood by Mr. and Mrs. H.

(3e) Hamilton

01 Mrs H: There were two terms you mentioned that I didn't understand,
02 psychosis and something else
03 Dr. R: and autism
04 Mrs H: Now what are these terms
05 Dr. R: Well those are terms basically applied to children who have a certain problem with reality as we see reality...
06

However, in (3d), Mr. H does provide some display of understanding by quoting another person (lines 25–26), and using a less technical phrase, with which Dr. R agrees (line 27).

To summarize: The doctor in this interview carefully delivers each diagnosis. He first leads up to, and then backs off from the "retarded development" phrase. The parents, while not approving of this diagnosis, withhold active disagreement when it is first delivered, and exhibit contrary views 'in later talk, in a different sequential environment from the news delivery. The doctor also progresses, step-by-step, to the announcement of psychosis and autism, using both the clinic's findings and characterizations provided by the father to substantiate the diagnosis.

"He Is Not Retarded"

Let us now return to segment (1) which is reproduced here:
1. ROBERTS

01 Dr. D: I think— you know I'm sure you're anxious about today and I
02 know this has been a really hard year for you, and I think
03 you've really done an extraordinary job in dealing with some
04 thing that's very hard for any human being or any parent— and
05 you know Mrs. Roberts and I can talk as parents as well as
06 Mrs. R: True
07 Dr. D: uh my being a professional. It's hard when there's something
08 not all right with a child, very hard. And I admire both of
09 you really and, as hard as it is seeing that there IS
10 something that IS the matter with Donald
11 (0.4)
12 Dr. D: He's NOT like other kids
13 (0.4)
14 Dr. D: He is slow
15 (0.4)
16 Dr. D: He is retarded
17 Mrs. R: HE IS NOT RETARDED!
18 Mrs. R: Ellen
19 Mrs. R: HE IS NOT RETARDED!
20 Mr. R: Ellen, please
21 Mrs. R: No!
22 Mr. R: May—look—its their way of- I don't know
23 Mrs. R: HE'S NOT RETARDED ((sobbing))
24 Dr. D: He can learn and is learning
25 Mr. R: Yes he is learning
26 Dr. R: And he's making good progress, and he will continue to make
27 good progress

The task now is to provide a structural description of this segment that will locate the visible troubles as achieved outcomes, i.e., as products of devices by which parties conduct diagnosis delivery and reception. This analysis will depend, in part, on what we have learned from the prior examples.

To focus on Dr. D’s presentation from lines 9–16, it contrasts with deliveries of diagnosis in both (2) and (3). The characterizations of Donald are done not after asking the parents what their view of the child is, but as a first piece of business. Providing diagnosis second to parents' discussion of the problem allows the clinician to anticipate their receptivity, and/or to tailor descriptions to the parents’ announced perspective. In (2) it was after the mother had discussed the improvements in “speech” that Dr. L. characterized Ricardo’s problem as his words not sounding correctly (2, lines 24, 25). In (3a), Dr. R used the father’s “stop maturing” formulation to “lead into” describing David’s development as “stopped” (3a, lines 4–6).

Thus, Dr. D does not solicit the parents’ view of Donald. Nor does she obtain any indication of their perspective as she delivers the diagnosis, unlike Dr. R in (3d). That is, Dr. D does produce a set of characterizations in a step-by-step fashion (compare to segment 3d); there is “something the matter with Donald” (line 10), “he’s not like other kids” (line 12), “he is slow” (line 14), “he is retarded” (line 16). The turn in which she does this is interactionally accomplished (see the discussion of segment 2, lines 18–32); i.e., the components follow silences (lines 11, 13, 15) which occur at points where Mr. or Mrs. Roberts could have provided demonstrations of understanding or agreement. Dr. D simply progresses to the formal diagnosis without these. By the time she arrives at “he’s retarded,” then, two resources for involving the parents in the delivery of diagnosis (asking their view; obtaining demonstrations of understanding/agreement with preliminary formulations) have either not been exploited or have failed.

One thing this means is that when Mrs. Roberts resists the diagnosis, there is no avenue for backing down. For example, in (3a), when Dr. R’s “retarded development” characterization was greeted with ambiguous responses, he could “retreat” to the “stopped development” description in which the parents had been co-implicated. Obviously, the term “retarded” also lends itself to retreat less well than “retarded development.”

Finally, again in contrast to examples (2) and (3), note that the characterizations of Donald which Dr. D provides are not grounded. There is no invoking of findings that would warrant the descriptions and diagnosis; they are presented as simple predicates.

To summarize regarding diagnosis delivery: it is done directly, without garnering the parents’ view, without collaboration from the parents on preliminary formulations, without room for retreat, without appealing to grounds for the diagnosis. In a word, and speaking comparatively, we can consider Dr. D’s approach not only as direct, but, perhaps as blunt.

But if Dr. D’s delivery is blunt, so is Mrs. Roberts’ protest. Disagreement in adult conversation is a dispreferred activity, and is often “held off” or suppressed by various mechanisms, as example (3) showed (cf. Pomerantz, 1975). There are, however, procedures for accomplishing disagreement as an “exposed” activity (Goodwin, 1978). Here, Mrs. Roberts repeats Dr. D’s utterance “he is retarded” with a negative and thereby produces disagreement as an immediate and principle activity in the talk. Moreover, the opposition is maintained across three appeals by her husband (lines 18, 20, and 22).

By Mrs. Roberts’ last protest (line 23), she is also sobbing. Dr. D’s and Mr. R’s formulation of Donald’s “learning” and “progress” shifts from the “bad news” to good or better news, perhaps as a form of comfort for Mrs. Roberts. But they also thereby focus off the protest and disagreement, leaving these, for the moment, unresolved.

For our purposes, the important point is that a confrontation occurs
between the doctor and the parent, and can be described in systemic terms. It is not just that Dr. D and Mrs. Roberts oppose each other in their assessments of Donald, but that their opposition, interactionally, is the outcome of devices for doing "direct" delivery of diagnosis and "direct" disagreement in the reception of the diagnostic news.

Conclusion

This chapter is an initial, interactional investigation of the delivery and reception of diagnostic news concerning disabled children. Clinicians deliver diagnostic news in a variety of ways which include providing diagnosis as a "second" activity to hearing parents' own formulations of their child, using a good news/bad news format, invoking "findings" as grounds for the diagnosis, and so forth. Parents receive diagnostic news by using various forms of acknowledgment, agreement or disagreement, demonstrations of understanding, or, in some instances, by withholding any audible response. One segment was analyzed for its obvious bluntness and opposition, and it was found to include various forms of doing direct diagnosis delivery and exposed disagreement in receiving the news. This contrasted with other segments, in which clinicians sought parents' collaboration in eventually providing a diagnosis, and parents went along with the clinician, by, at least in one case, suppressing active disagreement.

Studies of diagnostic news deliveries have emphasized clinicians' styles of communication on the one hand, and parents' emotional reactions, on the other. But the delivery of diagnosis, including its smoothness or difficulty, is not just a function of professionals' ways of communicating and parents' experienced stress as separate entities. It is an outcome of professional and client interaction. Clinicians display a more or less highly tuned sensitivity to how parents regard diagnostic categories. Parents, for their part, have a range of devices for accepting, going along with, resisting, or countering the news they receive, these devices affecting the course of actual delivery. A better understanding of the informing interview can be gained from less emphasis on professional or client styles and psychologies, and more attention to properties of their interaction, including its "difficulty," as emergent products of discourse practices.

An issue for further research is how social control is exerted in the relation between professionals and clients (Daniels, 1975), because it is clear that parental resistance is a salient theme in the interviews, whatever the exhibited degree of interactional difficulty. This resistance is a phenomenon which is largely overcome in favor of the clinical perspective (Silverman, 1981). More understanding is needed regarding how this is accomplished within discrete occurrences of interview talk.

NOTES

1. The data were originally collected under Grant No. HD 01799 from the National Institutes of Health, Stephan A. Richardson principal investigator. Helen Levens Lipton and Bonnie L. Svarstad analyzed the data and reported their findings in Lipton and Svarstad (1977) and Svarstad and Lipton (1977). Professor Svarstad generously made tapes and early transcripts available to the present author.
2. News delivery segments were excerpted from the Svarstad and Lipton "normal" transcripts, and transcribed in further detail according to the system devised by Gail Jefferson (Schenken, 1978: xi). Pam Schnafl and Gary Mejchar aided in this work. The segments appearing in the paper preserve as much information from the detailed transcripts as is necessary to make analytic points. See the appendix for transcribing conventions used in this chapter.
3. There may be nonverbal cues (such as head nods) occurring at the identified points of silence. But these can still be considered as minimal responses, in comparison with some demonstration that the news is agreed with or understood.
4. Local occasionedness refers to a preferred way of getting a potential topic or utterance into a conversation, which is to hold it off until it can be made to fit with another utterance "naturally." That is, another utterance is used as the sufficient source for the mentioning of the topic or the producing of the utterance in question. See Scheglof and Sacks (1973).

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