New Perspectives on Goffman in Language and Interaction

Body, Participation and the Self

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10 Bad behaviours, spoiled identities

Face in personality disorders

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1. Introduction

Especially in his earlier works, Goffman developed the idea that *self* – how I see and present myself, and how others see me – is an omnipresent concern for participants in social interaction. The idea was first encapsulated in his theory of *face* (Goffman, 1955). The image of self that our actions project is for us a source for gratification and anxiety (Goffman, 1955, 1959, 1963). In conversation analysis, there are persistent differences regarding the relevancy of Goffman's theory about self. Schegloff (1988) suggests not only that Goffman's idea regarding the omni-presence of the concern for self in interaction is wrong, but also that such an idea is harmful for the analysis of interaction because it blocks the analyst from seeing the actual organisation of the action. On the other hand, some conversation analytical studies have located the concern for the self or face in specific interactional practices (see Maynard & Zimmerman, 1984; Lerner, 1996; Heritage & Raymond, 2005). Such argument is developed further by Heritage and Clayman in this collection.

This chapter presents an analysis of a rather specific interactional setting – the assessment interview in psychiatry. I will demonstrate that within this setting, a patient's concern for the self is pervasive in the interaction. The patients in my data suffer from personality disorders. I will show how they alternate between different evaluative perspectives (that I refer to as stances) in their talk. I argue that all these stances involve a solution to a problem of the self when a patient's propensity to behaviours that damage their self-image has been acknowledged. While I present evidence that supports Goffman's theory of self, my chapter also highlights that the detailed method of CA can deepen and elaborate on the rather general claims made by Goffman.

In his writings on self, Goffman contributed to a long tradition of social psychological research. Others before him, such as James (1891), Mead (1934/1962), and Cooley (1922), pointed out that an individual

experiences of self arises from an understanding of how others in different social contexts see them and recognise them. Recently, Rochat (2009) conceptualised the same dynamics. For Rochat, the self can be experienced from the perspective of the first or third person. The first-person perspective occurs developmentally earlier, and it involves the perception of the integrity and agency of one's body. The first-person perspective on the self is usually positive. However, rather early in an individual's development, the third-person perspective emerges. In it, the self is constructed as an object of external evaluation. The third-person perspective implicates the judgement of the other and it is anchored in a moral space in which the self can be more or less valuable. Rochat suggests that an inherent and unsolvable tension exists between the first-person and third-person perspectives of the self. The practices and strategies of self-presentation involve (never fully successful) attempts to reconcile these perspectives.

Yet the most influential analysis of the interactional ramifications of self is by Goffman. Years before Rochat, Goffman conceived of the self as existing in an evaluative matrix. He argued that through their verbal and non-verbal actions, the participants of social interaction express "[their] view of the situation, and through this [their] evaluation of the participants, especially [themselves]" (Goffman, 1955, p. 213). While the evaluation of the self (resulting in what Goffman referred to as *face*) is primarily local, occurring in the here and now of the social encounters, what is beyond that situation also matters. To maintain one's face, the participant must "take into consideration his place in the social world" (Goffman, 1955, p. 214). These are the issues that I focus on in this chapter: how the participants in psychiatric assessment interviews deal with information that potentially damages their face or self-image.

During a psychiatric assessment interview, patients disclose aspects about themselves – such as their proneness to impulsive behaviours – that depending on the cultural and social context, can be considered to be against the norm. Goffman's (1963) theory of stigma suggests that in social interactions, an individual's bodily, mental, or social attributes can *spoil* his or her identity, making the person of lesser social value in the eyes of others than they would otherwise be. Goffman alternated the wording of his key concepts in his different works, but in hindsight, we can say that the existence of a stigma (a concept from the early sixties) potentially involves a major threat to one's face and self-image (concepts from the fifties). "Blemishes of individual character" (Goffman, 1963, p. 4) are one type of stigma. As examples, Goffman (1963, p. 4) lists "weak will, domineering or unnatural passions, treacherous or rigid beliefs, and dishonesty", inferred from a known record.

The management of stigma involves the control of the information about the stigma, and the ways to relate to one's own or another's stigma when it becomes visible. Stigmatised persons have three basic lines of action to manage their stigma. The first is to show that they support the norm while acknowledging that they cannot fulfill it. The second is to reject the norm and consequently become alienated from the community that supports the norm (Goffman, 1963, p. 129). Somewhere in between these lies the third solution, which is based on information control and collaborative impression management. This involves the art of regulating the disclosure of the stigmatising attributes and of negotiating the meaning and salience of what is there to be seen (Goffman, 1963, pp. 129–130).

This analysis examines psychiatric assessment interviews with patients who exhibit symptoms of personality disorders. A personality disorder can be oriented to as a stigma: as a "blemish of individual character" (Goffman, 1963, p. 4). Indeed, personality disorders are understood as disturbances in social relations and social behaviour (see APA, 2013). In particular, I focus on the discussions on *impulsivity*, which is a central aspect of behavioural disturbances in personality disorders (especially in what is referred to as an *emotionally unstable personality disorder*, see WHO, 2018). The excerpts demonstrate the patients' means of managing the disclosure of their impulsive, non-normative behaviours.

Personality disorders also involve problems with self-experience: enhanced vulnerability or instability of the self (APA, 2013). It can be assumed that assessment interviews are particularly stressful situations for patients who have personality disorders because they are invited to disclose their "bad", impulsive behaviours. Disclosing these types of behaviours can threaten the face of the speaker. A threat to the self can be experienced all the more intensively when speakers are inherently vulnerable or unstable in their self-experiences, as individuals with personality disorders are understood to be.

Psychiatric assessment interviews with patients who have personality disorders can be considered as a "magnifying glass" that reveals the self-related social processes that otherwise might be difficult to observe. These interviews highlight the issues related to the face and self. In this chapter, I examine the ways in which patient impulsivity – potentially a stigmatising "blemish of character" – is discussed during assessment interviews. As I will demonstrate, patients employ different strategies to manage stigma. These strategies concern the patients' stance displays regarding their own impulsive actions. At the end of the analysis, I argue that the three lines of the stance display that I have discovered correspond to the three basic solutions in stigma management that were outlined by Goffman.

2.   Participants and data analysis

My data are video recordings of the assessment interviews of three patients in a psychiatric outpatient clinic in Southern Finland. At the beginning of a psychiatric contact, a key task of clinicians is to gain an understanding of the patient's possible problems. This is achieved in psychiatric assessment interviews. In the three cases examined here, the assessment processes consisted of four to nine interviews, and at end of that process, all three patients were diagnosed as having a personality disorder. The patients are *Milla*, a woman in her early twenties in vocational training, who was referred to the clinic by the school psychologist and primary care doctor due to her problems related to her anxiety, mood, and impulsive behaviours; *Sanni*, who was also in her early twenties and in vocational training, referred by her primary health care doctor predominantly due to her problems with violence; and *Sinikka*, a middle-aged woman who was referred to this clinic by a youth and adolescent psychiatry clinic that was treating her daughter for behavioural problems. Milla's assessment process consisted of eight interviews, Sanni's of nine interviews, and Sinikka's of four interviews. With each patient, the first and last interview was conducted by a psychiatrist and a nurse together, while the interviews in between were usually conducted solely by a nurse. The clinicians gathered information on the patient's symptoms and circumstances, provided information to the patients regarding the possible disorders, and conducted joint reflection on the patient's emotions, behaviours, and problems.

Two cameras were used to video record the interviews and these were transcribed in conversation analytical notation. The participants granted their informed consent to the recording and the use of the data for research. For this chapter, I analysed all the discussions on impulsive behaviours (topics such as losing one's temper, physical violence, and self-harm). My data analysis reveals the different ways that the patients in assessment interviews manage the threats to their face that arise when exploring their impulsive behaviours. Through this empirical analysis, I contribute to the Goffman-CA debate concerning the place of the self in social interaction.

3.   Results

The participants in the assessment interviews regularly *display an evaluative stance* toward the behaviours that they describe (for stance displays in interaction, see Goodwin et al., 2012; Du Bois, 2007). In other words, the patients do not "merely" or "technically" describe their impulsive behaviours, but they show what their evaluative relation to these behaviours is. I argue that the stance displays entail solutions to the problem of the

self: each stance, in a different manner, defends the patient's self when the patient's potentially identity-damaging behaviours are being acknowledged.

The patients' stance displays are made locally relevant by the clinicians' questions. These questions are designed so that they – even if not openly displaying the clinicians' own stance – still invoke something that might be called *an evaluative space*: the questions make it relevant for the answerers to display their stance. In what follows, I present some of the clinicians' questions. However, as the data also demonstrate, the patients orient to the relevancy of the display of their stance even in extended turns (such as narratives) that are not immediately prompted by the clinicians' questions.

The patients display three different types of stance when they describe their impulsive behaviours: (1) *self-reproach*, (2) *lessening the reproach*, and (3) *defying the reproach*. By using the term *reproach* here, I wish to convey that the stance displays of the patients orient to a third-person evaluative perspective to their bad behaviours, and thus to their selves. Some examples from each stance are presented below.

3.1   Self-reproach

All three patients display a negative stance toward their impulsive behaviours. They convey to the co-interactant that they consider what they do as bad. This self-reproach occurs on the patients' own initiative: during their turns, the patients engage in stronger or more explicit stance marking than was there in the clinician's questions that the patients' turns are answers to. The practices of self-reproach include evaluations, marking of the exceptionality of their own behaviours as well as non-verbal displays of a negative stance.

3.1.1   Evaluations

Evaluations are perhaps the most straightforward means for the patients to express that they consider what they do as bad behaviour. Evaluations can consist of assessments, that is, utterances the primary task of which is to assess the patient's behaviour (see Pomerantz, 1984), but evaluation can also be conveyed by including evaluative terms in the behaviour descriptions (see Edwards & Potter, 1992). Let us consider excerpt 1 below.

Excerpt 1 (#11; P1K5 s. 18–19) NUR=Nurse, SAN=Sanni (the patient)

```
01 NUR:    onks sul i↓telläs jotain toiveita tai mi̲stä
           do you your↓self have some wishes or what would
02         sä niinkun haluaisit hhhh (0.9) lähteä
           you would like to like hhhh (0.9) begin
```

```
03          liikkeelle itsesi (0.5) £hoitamisessahh£
            with in treating (0.5) £yourself hh£
04 SAN:     m näist her↓moromahuksis.
            m these ner↓veous breakdowns.
05          (0.5)
06 NUR:     mt tää on niinku vakavinta.=
            tch this is like the most serious thing.=
07 SAN:     =joo mua ärsyttää itteekii ku mul on pinna
            =yeah I myself get annoyed too when I'm
08          kireel.
            nervy.
09 NUR:     °mm-m.°
10          (1.0)
11 SAN:     ja mä saatan sanoo tosi pahasti niinku (.)
            and I might say really bad things even like (.)
12          mun kavereillekki sillon ku mul menee
            to my friends when I lose
13          her:mo (0.6) vaik mä en tar:kota.
            my ner:ves (0.6) even though I don't me:an to.
```

In her question (lines 1–3), the nurse asks which issue Sanni would like to focus on first in the upcoming treatment. Sanni names "these nervous breakdowns". This is readily understandable as a reference to the irritability that Sanni displayed at the beginning of the session. In line 6, the nurse reformulates Sanni's answer. The formulation characterises "this" (referring to the nervous breakdowns) as *the most serious thing*, thus shifting the focus from the treatment to the problem (that needs to be treated). The formulation also orients to an evaluative space where behaviours can be serious or non-serious. However, the nurse displays caution in her own evaluative expression. Her formulation mirrors, rather than intensifies, the negative stance that was inherent in Sanni's description in line 4.

In her response to the formulation, Sanni engages in an evaluative description of her "nervous breakdowns". In lines 7–8, she depicts being agitated as something that *I myself get annoyed* with. While this evaluation can be understood as self-attentive (she finds nervous breakdowns to be annoying), after the nurse's acknowledgement token (line 09), Sanni continues with an evaluation by stating that she regrets saying *really bad things* to her friends (line 11–12). In this manner, Sanni conveys that she considers her behaviours to also be problematic for others, implying her own responsibility. She expresses this self-reproach on her own initiative, but it also occurs in an environment in which the speakers have collaboratively adopted an evaluative perspective concerning Sanni's behaviour.

For other evaluations, let us examine excerpts 2 and 3. Sometime before excerpt 2, Milla identified one of her character traits as "short-temperedness". In line 1, the nurse invites Milla to "tell about" her short-temperedness. After no uptake (the 1.0 sec pause in line 2), the nurse reformulates her question in lines 2–3 and 5–6. The specified questions are designed to elicit a factual description of Milla's character and behaviour, without

engaging in an overt moral evaluation of her behaviour. Nevertheless, by inquiring about details linked to a potentially problematic character trait (short-temperedness), the nurse is also maintaining an evaluative space for the upcoming talk.

During her long answer, Milla first claims that "this" was "much worse" (lines 9–10) when she was younger. She thus evaluates her behaviours literally as "bad". Thereafter (data not shown), she first mentions conflicts with her sister, and then, in line 34, returns to depict the course of her conflicts with others.

Excerpt 2 (#4) NUR=Nurse, MIL=Milla (the patient)

```
01 NUR:     .mthhh kerro mulle sul lyhytpinnasuudesta.
            .mthhh tell me about your short-temperedness.
02          (1.0) minkälaisista asioista sä (0.2)
            (1.0) what kind of things make you (0.2)
03          menetät (0.2) maltin (0.2) pinnasi.
            lose (0.2) composure (0.2) your temper.
04 MIL:     .nh[hhh
05 NUR:        [miten sä käyttäydyt kun näin
               [how do you behave when this
06          tapah[tuu.
            happe[ns.
07 MIL:          [hhhh
08          (2.0)
09 MIL:     no: (.) tää oli siis nuorempana paljo
            well (.) when I was younger this was much
10          pahempaa siis< (1.0) mä saatoi suuttua
            worse so< (1.0) I could get angry
11          niinku (1.0) i- ihan niinkun (1.0)
            like (1.0) q- really like (1.0)
12          *mitättömistäkin asioista? .hhh >tai
            *for insignificant things? .hhh >or
   mil      *----------------------*lateral headshakes
((22 lines omitted))
34 MIL:     eka rupeen huutaa. (0.2) mul on paha
            first I start to shout. (0.2) I have a bad
35          tapa heitellä asioita, (0.4) tavaroita,
            habit of throwing things, (0.4) objects,
36          (0.2)
37 NUR:     m[m:?
38 MIL:      [yleensä sitä ihmistä päin joka mua ärsyttää,
             [usually at the person who irritates me,
39          (0.2)
40 NUR:     mm:?
41 MIL:     yleensä mä en osu kyllä. (0.4)
            usually I don't hit the target though. (0.4)
42          mikä on hirvee hyvä. .hhh[h
            which is really good. .hhh[h
43 NUR:                              [.mt joo:?
                                     [.tch yeah:?
```

When describing her behaviour, Milla not only discloses that she throws things, but she embeds the assertion about throwing things in the evaluative clause *I have a bad habit of*. In short, she shows that she considers what she tends to do as unacceptable. In line 41, Milla states that she

usually misses the person she intends to hit; this is followed by a positive assessment in line 42. Through the two assessments (lines 9–10 and 42) and the evaluative description in lines 34–35, Milla indicates that she is keenly aware of the morality concerning her bad behaviour.

In excerpt 3 below, Sinikka recounts her conflicts with her 11-year-old daughter regarding her excessive computer use. In lines 1–3, she asserts that during one of these conflicts, she asked the daughter to kill herself. After this self-disclosure, she continues her narration by shifting the focus from her own actions to her daughter's problems (see lines 3, 6, 7, 10, 12, 14). In a follow up question, the psychiatrist (in lines 11, 15, and 16) nonetheless shifts the focus back to Sinikka, inviting her to reflect upon what she said to her daughter. The doctor's question does not explicitly convey moral assessment, but it does establish an evaluative space for the upcoming talk. By shifting the focus back to the patient, by highlighting the difference between the time of action and the time of reflection (*what do you think now*, line 15), and by characterising the action to be reflected upon by using the marker *even* (line 16), the doctor communicates a need to rethink what has happened. Even so, the doctor is also cautious to avoid making an independent moral assessment: for example, in using the marker *even* (line 16) she actually recycles the wording of Sinikka's self-disclosure (line 1).

Excerpt 3 (#18) SIN=Sinikka (the patient), PSY=Psychiatrist, NUR=Nurse.
The first interview, which is conducted by two clinicians.

```
01 SIN:     ja, (.) mä jopa *sanoin sille et, (.)
            and, (.) I even said to her that, (.)
   SIN                      *lateral headshakes->
02          tapa ittes
            kill yourself
03          ku se oikee raivos ja huus hulluna, hh
            as she was really raging and shouting mad, hh
04 PSY:     aija[a,
            o[h,
05 NUR:         [.mmh *
   SIN           --->*lateral headshakes
06 SIN:     et ku se on nii riippuvai siit koneesta. hh
            as she is so dependent on that computer. hh
07          sill_[o addiktio siihe,
            she'[s addicted to it,
08 PSY:          [.joo
                 [.yeah
09          joo. (.) joo, (.) jo[o,
            yeah. (.) yeah, (.) yea[h,
10 SIN:                          [et se:,
                                 [so she:,
11 PSY:     mitä sä a[jattelet,
            what do you t[think,
12 SIN:              [kokee tuskaa ku [se joutuu siit
                     [feels pain when [she has to part
13 PSY:                               [.nii
                                      [.yeah
```

```
14 SIN:    eroo. h
           from it. h
15 PSY:    joo. (.) mitä sä ajattelet nyt, h (0.4) että
           yes. (.) what do you think now, h (0.4) that
16         jopa sanoit hänelle tän,
           you even said this to her,
17         (.)
18 SIN:    hirveelt tuntuu.
           feels awful.
19 PSY:    mm,
20 NUR:    mm,
21         (.)
22 SIN:    miten voi äiti sanoo omal lapselle tollee,
           how can a mother say something like this
           to her own child,
23         (1.0)
24 PSY:    .hjust (.) joo,
           .right, (.) yes,
           (3.0)
```

In line 18, Sinikka asserts that she *feels awful*. After the acknowledgments by the clinicians (lines 19 and 20), she continues in line 22 by a self-reproaching exclamation that takes the form of a rhetorical question. Sinikka refers to herself through the category of "mother". By using this categorical (rather than pronominal) self-reference, Sinikka sets up a contrast between commonsense understandings of how mothers should act and how she actually acted. Nevertheless, by her formulating "the mother" as the target of the evaluation rather than "I", Sinikka also distances herself as a speaker from the target of the evaluation, adopting rather an external evaluator's perspective to herself.

In excerpts 1–3, the patients performed explicit negative evaluations of their own behaviours. In each case, the clinician's question cautiously created or maintained an evaluative space for the patient's answer (cf. Bergmann, 1992 on cautious morality in psychiatry). The patients inserted evaluative elements in their accounts: the clinicians offered the space that the patients filled with their own evaluations that conveyed self-reproach. The patients displayed recognition that their behaviours are non-normative and that this awareness is relevant for them.

3.1.2 *Marking the exceptionality*

The patients also display their stance towards their impulsive behaviours by marking it as exceptional through *extreme case formulations* (Pomerantz, 1986). If we consider excerpt 2 shown earlier, in lines 10–13, when the patient describes her "short temperedness", she observes that when younger, she could get angry about *really like (1.0) insignificant things*. Getting angry about insignificant matters is something out of the ordinary and therefore unjustified.

Let us turn to examine excerpt 4 below. The nurse just asked Milla whether she has been involved in "problem behaviour", meaning self-harm, during the past week. Milla states that she did not engage in problem behaviour

even though she had several really bad days. The nurse then asks "what does a bad day mean in your case" (data not shown). In face of silence, the nurse rephrases her question in lines 1 and 2. Similar to excerpts 1–3, the nurse's questioning creates an evaluative space, yet using non-evaluative descriptive language and consequently avoiding making explicit evaluations.

Excerpt 4 (P4K3 s. 7–8) NUR=Nurse, MIL=Milla (the patient)

```
01 NUR:    miten sä oot sillom muuttunut, .hhhh
           what has changed in you then, .hhh
02         miten to[iminnat on muuttunu. h
           how have your a[ctions changed. h
03 MIL:         [no mä, #yy# öö hh
                [well I, #erm# eh hh
04         (1.0)
05 MIL:    siis mä oov vaa niinkun (0.4) ↑tiuskinu,
           so I've just been (0.4) ↑snapping,
06         (0.4) kaikille,=paitsi totta kai töissä
           (0.4) at everybody,=except of course at work
07         nyt ei oo voinu. (.) se om pitäny
           it's not been possible. (.) it's been necessary
08         pitää sillai erillää (ku) siis niinku, .h[hhh
           to keep that like separate (as) like, .h[hhh
09 NUR:                                              [mm:?
10 MIL:    yksityiselämäs mä oov vaa tiuskinu
           in private life I have just been snapping
11         kaikile, hh kaikki ärsyttäny,
           at everybody, hh been irritated by everything,
12         hh
13         (1.0)
14 NUR:    mm↑m,
```

Milla replies by describing her "bad day" behaviours. She uses extreme case formulations (lines 5–6 and 10–11: *just been (0.4) snapping at everybody (. . .) been irritated by everything*). By invoking "everybody" as her targets, and "everything" as affecting her, she depicts her behaviours as out of the ordinary and unjustified.

Extreme case formulations are typically used in actions that defend or support the self against its antagonists – "in complaining, accusing, justifying, and defending" (Pomerantz, 1986, p. 219). The usage in our data is reversed: the extreme case formulations serve as a critique of the self, as the patients reveal just how out of the ordinary their *own* behaviours are. By describing their own behaviour in this manner, the speakers take the side of the critical evaluative "other" and assess themselves from that perspective. In Rochat's (2009) terms, the patient's talk documents a third-person perspective to the self.

3.1.3   *Bodily displays of negative stances*

Negative stance can also be conveyed through bodily displays. In our data, lateral headshakes do this work (see Kendon, 2002). In excerpt 2 above, Milla shakes her head when she utters the extreme case formulation *for*

insignificant things (line 12), and in excerpt 3 above, Sinikka shakes her head when she recounts how she told her daughter to kill herself, continuing her headshake through the clinician's acknowledgement tokens (lines 1–5). These headshakes convey a negative evaluation by speakers of their own behaviours and in excerpt 3, of the daughter's behaviours as well. Headshaking can also convey an evaluation when it emerges on its own without overlapping talk. Let us consider excerpt 5 below. This is a continuation of excerpt 4 shown above.

Excerpt 5 (Continuation of except 4; P4K3 s. 7–8) NUR=Nurse, MIL=Milla (the patient)

```
10 MIL:      yksityiselämäs mä oov vaa tiuskinu
             in private life I have just been snapping
11           kaikile, hh kaikki ärsyttäny, hh
             at everybody, hh been irritated by everything,
12           hh
13           (1.0)
14 NUR:      mm↑m,
15           (1.0)* (1.0) #
   mil            *shaking head-->
   fig                   #fig 9.1
```
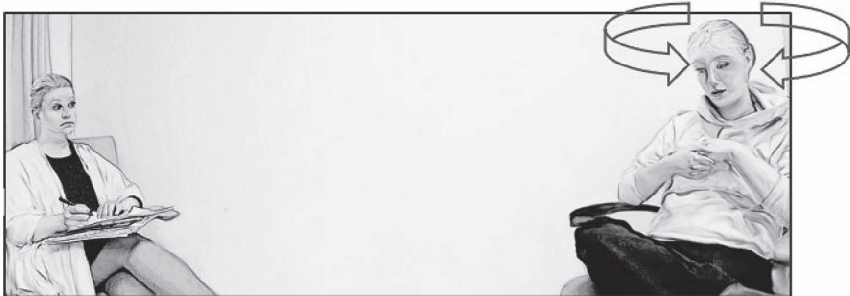

Figure 10.1 patient's head shakes

```
16 MIL:      *(>niinku<)
             *(>like<)
   mil       *eyes closed->
17           (0.7) *% (0.3)*
   Mil            -->*
   mil                    *shaking head->
   nur            %nodding->
18 MIL:      (ihan) sellasta.
             (quite) like that.
19           (1.0)
20 NUR:      mm ↑hm,
```

Milla reaches the possible grammatical and pragmatic point of completion of her description in line 11–12. Through her use of flat prosody, however, she rather indicates a prospect of continuation. The nurse in line 14 produces an acknowledgement token while writing her notes. Midway

through the two-second silence after the acknowledgement token, the nurse gazes at the patient, and at the same time, Milla begins to shake her head (line 15). Her headshake continues through an aborted turn continuation >*like*< (line 16) and the subsequent silence (line 17), until she starts a summarising sentence (*(quite) like that*; line 18) that eventually brings the description of her snapping to an end. Milla closes her eyes during her headshake. The nurse begins to nod in line 17, just before Milla stops her headshake.

Milla's headshake is associated to her search for words to further the description of the "bad days" that remains prosodically uncompleted. As she attaches strong negative stance markers to the behaviours she describes, a conclusion or assessment might be relevant. Her headshake expresses a negative assessment which she, at the time of her headshake, may be trying to find words for. The headshaking could even convey that there was something "unspeakably" negative in the behaviours that she was describing. Her closing her eyes adds a dramatic dimension to the headshake, displaying that Milla is momentarily immersed in her self-reproach.

Through self-reproach, the patients display a negative stance to the behaviours they are describing. During these sequences, the past and current self are momentarily dissociated (see Deppermann et al., 2020): the current self disapproves of behaviours that the past self has engaged in. It appears that by displaying their disapproval, the speakers identify themselves with the evaluative perspective of another person. In Rochat's (2009) terms, during moments of self-reproach, the continuous ongoing negotiation between the first-person perspective and the third-person perspectives on the self is momentarily resolved in favour of the third person's moral evaluation. This predominance of the third-person perspective on the self is to be expected in assessment interviews because the institutional goal is to examine patients, and the patients' collaboration in this can require that they look at themselves through another person's eyes.

The unequivocally moral tones that the patients engage in while describing their impulsive behaviours suggest that in the context of the assessment interview, these behaviours are treated as stigma, as an attribute that discredits the patient's identity. There is an important interactional and moral benefit for a person to engage in self-reproach. The patients collaborate with the clinicians and communicate that they actually know, think, and feel that their behaviours should not be there. In Goffman's (1963, p. 129) terms, they show that they "support the norm" and that they belong to "the community that upholds the norm", even though that they do not conform with the norm. The benefit of self-reproach is to claim membership in the moral community. The detailed conversation analysis reveals that the community is oriented to the then and there, in and through the interaction, where the addressee, the clinician, is treated as its representative.

3.2   *Lessening the reproach*

Self-reproach not the only means that the patients orient to their impulsive behaviours while describing them. They also often moderate their descriptions of their behaviour so that the image of their self that they convey becomes less damaged. They communicate that certain aspects of their conduct do *not* deviate from the norm, or that when they do deviate from the norm, they are not responsible for that deviation. Let us now turn to examine these practices.

3.2.1   *Displaying residual responsibility*

Patients repeatedly add elements to their descriptions that convey that their problematic behaviours are only limited to certain contexts or conditions. For example, if we turn again to excerpt 4, we see that while Milla is engaged in self-reproach (conveyed by her extreme case formulations and bodily displays), she also adds a parenthetical specification to her account of her snapping (see lines 6–8): *except of course at work it's not been possible. (.) it's been necessary to keep that like separate*. Through this specification, Milla presents another side of herself in that she has controlled her behaviour at the workplace. This is something that might be called *residual responsibility*: in the midst of presenting scenes of impulsivity, there is a residual of behaviour that this not impulsive but responsible. In other words, she can control her behaviours if she must.

   A residual responsibility is also conveyed in excerpt 6 below. During her first interview, Sinikka told about her daughter cutting herself and about their visits to the youth and adolescent psychiatry centre. The story ends with an indirect telling of the parents' violent behaviours toward their daughter (lines 13–23) and the custody decision that followed (lines 26, 29).

Excerpt 6 (P7K1 s. 8–9) SIN=Sinikka (the patient), PSY=Psychiatrist, NUR=Nurse

```
01 SIN:    siel sitt#e ö#; käytiin, (.) yks kerta siin
           then we erm went there, (.) once to the
02         psykiatri[ses, (.) [poliklinikalla [Hanna
           psychiat[ric, (.) out patient clinic [Hanna
03 PSY:           [(e)-     [joo?            [joo,
                  [(e)-     [yeah?           [yeah,
04 SIN:    kävi [juttelemas siel
           went there [to have a chat there
05 PSY:         [.joo
                [.yeah
06 SIN:    mä sanoin et nyt saat
           I told her that now you can
07         kertoo kaikki? .hhh
           tell everything? .hhh
08 PSY:    joo.
           yes.
09         (.)
```

```
10 SIN:     miltä sust tuntuu? hh (.) ja [m- (.)
            what you feel like? hh ().) and [a- (.)
11 PSY:                               [mm,
12          meistä kaikki. h
            about us everything. h
13          (.)
14 SIN:     ja sehän sitte kerto et, (1.0) hhh kuinka me
            and then she told, (1.0) hhh how we
15          ollaan sitte, (.) tukisteltu sitä ja (.) .NFF
            have then, (.) pulled her hair and, (.) .NFF
16          (.)
17 PSY:     m[m,
18 SIN:       [mä oon lyöny kerran henkarilla
              [I have once hit her with dress hanger on
19          takapuoleen ku se ei lopeta *£si(h)t
            the buttocks as she does not stop £th(h)at
   sin                                  *smiling-->
20          PELAAmista£, (.) et se on ihan hirveetä,
            playing£, (.) so it is totally awful,
21          (.)
22 PSY:     mm:?*
   Sin        -->*
23          (1.0)
24 SIN:     ja: (.) kuulemma potkittu sitä ja tätä on
            and: (.) supposedly kicked her and this has
25          kestäny niin kauan ku se muistaa.
            lasted as long as she remembers.
26          (1.0)
27 PSY:     oke[:i.
            oka[:y.
28 SIN:        [nii seuraavan päivän se otettii huostaa.
               [so the next day she was taken into custody.
29          (.)
30 PSY:     jo[o.
            ye[s.
31 SIN:       [kiireellises[ti.
              [as an urgent [case.
32 PSY:                    [just, (.) [.joo
                           [right,(.) [.yeah
33 NUR:                               [mm:,
34 PSY:     joo.
            yes.
35 SIN:     .mt
            .tch
36 PSY:     joo,
            yes,
37          (.)
38 SIN:     mikä oli ihan hyvä?
            which was quite good?
```

While this account conveys damaging material about Sinikka, she also includes a report of herself encouraging the daughter to openly talk about her problems and those of her family (lines 6–7). In this manner, Sinikka depicts herself as a "facilitator" of the daughter's revelations – as a responsible parent. Sinikka also portrays herself as reasonable and responsible at the end of the segment (line 38) where she offers her evaluation of the care order.

By using descriptive elements that convey their residual responsibility, the patients communicate that even during impulsive scenes, they also harbour traits other than impulsiveness – aspects of selves that are unspoiled.

3.2.2 *Attributing the blame to others*

Alongside their displaying residual responsibility, patients have other means of moderating their behaviour descriptions. They also account for their problematic behaviour as a response to others' inadequate behaviours. In this manner, the patients recognise the norms of appropriate (that is, non-impulsive) behaviour but lessen their own culpability. Attributing the blame to others is one of the paradigmatic "accounts" described by Scott and Lyman (1968).

Returning to excerpt 3, after Sinikka discloses that she told her daughter to kill herself (line 1–2), she proffers a string of descriptions of her *daughter's* problematic behaviours (lines 3, 6, 7, 10, 12, and 14). Through the placement of these descriptions, and the use of the connectors *ku* and *et ku* (both translated *as*; lines 3 and 6) and *et/so* (line 10), the daughter's behaviours are offered as explanations for what Sinikka said to her daughter.

In a similar vein, Sinikka's self-disclosure in excerpt 6 concerns her having hit her daughter with a clothes hanger (line 18–19) is connected, with *ku/as*, to a description of the daughter's problematic behaviour (line 19–20) and this serves as an explanation for hitting her daughter. The depiction of the daughter's behaviour (*she does not stop that playing*) is followed by a strong negative assessment (*so it is totally awful*). In other words, Sinikka attributes the blame to her daughter and thus mitigates Sinikka's own culpability.

Through their practices of lessening their reproach, the patients, who in assessment interviews are expected to describe their impulsive behaviours, mitigate the extension in which impulsivity spoils their identity. This is achieved by presenting and momentarily foregrounding an other, relatively unspoiled aspect of the self or the self-other relations. These practices resemble what Goffman (1963) characterised as the "third main solution to the problem of unsustained norms" in stigma management (Goffman, 1963, p. 129). Through displays of residual responsibility and attribution of blame, the individual "exerts strategic control over the image of himself and his products that others glean from him" (Goffman, 1963, p. 130). Yet, by lessening the reproach, the patients also display their orientation to there being something to be reproached for: they indicate that, in the first place, they consider their impulsive conduct as questionable. In this manner, they also show their membership in the community that upholds the norm.

3.3 *Defying the reproach*

The following analysis focuses on moments when the patients momentarily do *not* strive to display their membership in the normative community.

During these moments, the patients reject or counter the relevancy of a negative moral evaluation of their impulsive behaviours. This can be accomplished through their stance displays that are in contrast to the negative evaluation that the context and participants' prior actions make relevant. What could be expected to be marked with a negative stance is marked differently, with a stance that is difficult to define exactly, one that also has positive markers. This stance, displayed through turn design, prosody, and/or facial expression, can convey defiance toward the clinician.

Consider excerpt 7 below. The nurse is conducting a structured interview to detect personality disorders (SCID-2) with Milla. When exploring self-harm, Milla has replied "yes" to the questions on cutting, burning, and scuffing herself. The nurse subsequently asked Milla when she last self-harmed. After Milla gives a rather recent point in time, the nurse (lines 1 and 3) inquires further as to what happened.

Excerpt 7 (P4K7 s. 40–41; 47:28-) NUR=Nurse, MIL=Milla (the patient)

```
01 NUR:    Mitäs sillon tapahtu. Mitä sä teit. Miten sä
           What happened then What did you do How did you
02 MIL:    a[a.
           o[h.
03 NUR:     [vahingoitit.
            [harm yourself.
04         (1.0)
05 MIL:    (ei se nyt,) seiveri kätee ja menoks.
           (no it isn't,) shaver in hand and off we go.
06         *(0.2)#(0.2) mhh ## tk niin sano*tusti.
           *(0.2)#(0.2) mhh ## tch so to sa*y.
   mil     *--- smiling -------------------*
   fig          #fig 9.2.1, 9.2.2
   fig                      ##fig 9.3.1, 9.3.2
07         siis viiltelin.
           meaning I cut myself.
08 NUR:    mm. °mm.°
```


Figure 10.2.1   *Figure 10.2.2*

Figure 10.3.1

Figure 10.3.2

Milla describes the events in lines 5–6. After a hesitation (*no it isn't*), she restarts her utterance and describes her self-harm in a markedly light manner: *Shaver in hand and off we go*. This echoes an optimistic situation such as when someone sets off on a trip. By using that expression in the context of cutting her skin, Milla adopts an ironic stance toward her self-harm. Given that the nurse's question maintained the evaluative space, Milla's conduct also expresses defiance toward her. Milla's light-hearted and defiant stance is further displayed through her facial expression: turning her gaze to the nurse, Milla smiles after her assertion (line 6; Figure 10.2.2); Milla's smile widens as she shifts her gaze slightly away from nurse (line 6, Figure 10.3.2). The nurse does not mirror Milla's smile, but remains neutral, or serious while gazing at her (Figures 10.2.1 and 10.3.1).

It is important to note that Milla's defiant stance was associated with her *self-directed* impulsive behaviours. By comparison, in excerpt 8, Sanni moves from self-reproach to a positive stance when talking about her impulsive behaviours toward others. In lines 1–3 she volunteers her concern for her violent behaviours. Sanni's use of the extreme case formulation *seriously scared*, she conveys that her tendency for violent behaviours is out of the ordinary. In line 5, the nurse invites Sanni to divulge more by asking an open-ended question; Sanni's answer begins in line 7. She first talks about the "return" of her aggressive behaviours (see lines 7–12). Her face and voice quality also convey seriousness (see Figure 10.4). In lines 13–16, she expands her answer by telling about a recent violent episode.

Excerpt 8 (P1K3) SAN=Sanni (the patient), NUR=Nurse

```
01 SAN:    .thh mut sit taas nyt on alkanu menee
           .thh but then again now I've started to lose
02         hermot ja mua pelottaa tosissaa et mä
           my composure and I'm seriously scared I'll
03         humautaj jotai vielä. hhhh
           yet thump someone. hhhh
04         (1.0)
```

```
05 NUR:     mm hm? hh mihis tää nyt liittyy.
            mm hm? hh what's this got to do with then.
06          (.)
07 SAN:     .khh siis just ku on nyt, (.) em_mä
            .chh like now that it's just, (.) I
08          tiedä mist se on tullu takas mun
            dunno how it's come back my
09 SAN:     agressiivisu#us ku sehän oli pitkän
            aggressiveness 'cos it was gone
   fig                    #fig 9.4
```


Figure 10.4

```
10          aikaa poissa. (.) et mull_ei ollu
            for a long time. (.) so I didn't have
11          minkään näköst agressiivist
            any kind of aggressive
12          käytöstä ni nyt on ollu just ku,
            behaviour and now there's been as,
13          .hh.nhh mts h (.) no sillon ku
            .hh.nhh tch h (.) so it was
14          oli itsenäisyys#päivä?# h (0.5)*(0.5)#
            the Independence Day? h (1.0)
   san                                    *smile->
   fig            fig.9.5#    #fig.9.6      #fig.9.7
15          £ni mä löin sit yht jätkää sillei
            I punched that one guy so that
16          et sil tuli veret suusta, h £
            blood came from his mouth, h £
17 NUR:     nii tää oli se [mikä,
            yeah this was the one [that,
18 SAN:                   [joo?
                          [yeah?
```


Figure 10.5   *Figure 10.6*   *Figure 10.7*

The temporal orientation of *so it was the Independence day* (lines 13–14) is followed by a depiction of the actual violent act, *I punched that one guy* (line 15), and then proceeds to describe its consequences as *so that blood came from his mouth* (lines 15–16). Sanni's choice to present graphic detail may in itself convey a stance, as if it were demonstrating the power of her action.

When approaching the description of the violent act, Sanni's speech changes so that at the temporal orientation (line 14), the pitch drops and her pace becomes slower, creating something similar to an effect of suspense. Her facial expression also remains neutral (Figures 10.5 and 10.6). During the pause in line 14, before launching into a description of the event, Sanni begins to smile (Figure 10.7); this smile is understandable as a projective emotional transition that creates a shift to a positive or light stance (Kaukomaa et al., 2013). The nurse does not reciprocate Sanni's smile. As Sanni offers a detailed description of her violent act (lines 15–16), she continues smiling and her voice is smiley. The design of her description, changes in her voice, and the facial expression all create an impression of the excitement and positive affect that is associated with that event. This stance contrasts with the worry and concern for violent behaviours that the participants otherwise maintain during their interaction.

In excerpts 7 and 8, the patients retreated from the expected negative evaluation of their impulsive behaviours. By verbal and non-verbal means, they display a stance to their behaviours that has positive markers. This means that they defy the negative evaluation that the participants otherwise maintain. By doing this, the patients distance themselves from the clinicians who maintain the evaluative space. The mismatch between the evaluative orientations of the clinicians and the patients is encapsulated in the lack of reciprocity of the patients' smiles. Restated in Goffman's terms, the patients "alienate [themselves] from the community that upholds the norm" (Goffman, 1963, p. 129). In Rochat's (2009) terms, during these moments, the patients do *not* prioritise the third-person evaluative perspective but instead claim a priority for their first-person perspective to the self.

The clinicians in our data leave defiant displays unattended. By not responding, this may facilitate the patients' smooth return to the normative community in the subsequent interaction. Clinically, the lack of interactional attention can be understood in two ways. On the one hand, as the primary goal of the interviews is diagnosis (and not to give therapy), it may be sensible not to attend to the patient's stance displays. On the other hand, however, when patients defy a reproach, these moments might bring to surface something related to the gratification that they experience by engaging in their impulsive behaviours. When the clinicians do not topicalise or otherwise interactionally attend to their patients' defiant displays, the opportunity for this understanding may be lost.

4.   Individual variation in the stigma management

Above, I have described the patients' practices of evaluative stance display in depicting their impulsive behaviours during assessment interviews. I showed practices of self-reproach, as well as practices that lessen the reproach or defy the reproach. There is no single predominant way for the patients to express their relation to their impulsive behaviours, but there are many.

While the stance displays are embedded in their local contexts, no direct relation was detected between the direction of the patient's stance display and the way in which the clinician's question invokes the evaluative space. On a general level, each patient was engaged in all three types of practices. However, a global examination of the interviews suggests that there are distinctive individual differences between them. For example, Milla engages most consistently in the practices of self-reproach. The other practices of stigma management (displaying residual responsibility, shifting the blame, and defiant stance displays) are less prominent in her interactions with the clinicians and the talk that is related to them is short-lived, especially so in the case of defiant stance displays.

For Sinikka, her dominant stance was to lessen a reproach, which was evident in particular through her practice of shifting blame. Sinikka typically attributes blame to others not only in her descriptions of her own impulsive behaviours (which have been the focal theme in this paper) but also more generally in her narration on her life and circumstances. Her self-reproaching practices, in contrast, are rather rare and short-lived. It is interesting that when she does engage in self-reproach, she is particularly strong and "totalistic", as was evident in excerpt 3. In contrast to Sinikka, Sanni's management of stigma is different. She seems not to have one dominant stance, but she rather oscillates between two: self-reproach and defiance of it (see also Peräkylä et al., 2021). This type of oscillation can occur within a short time span and within the same topical segments.

Goffman was aware of the individual differences in managing the self. In *Face work* (Goffman, 1955), he observed that *each person* seems to have their "own characteristic repertoire of face-saving practices" (Goffman, 1955, p. 216). While this repertoire is drawn from a limited matrix of possibilities that society makes available, it is nonetheless understood as a hallmark of what a person "is 'really' like" (Goffman, 1955, p. 216). In the context of psychiatric assessment, this means that the clinicians' professional evaluation of patients, including the diagnosis attributed to them, is probably informed not only by the "content" of their accounts of impulsive behaviours, but also by the ways in which the patients manage stigma and strive to save their face in interviews. During their backstage discussions (Goffman, 1959) before and after the actual interviews, the professionals indeed assessed Milla – whose dominant stance was

self-reproach – in highly positive terms, playing down her personality pathology, while Sinikka was the target of the most negative evaluations; her dominant voice was to lessen a reproach through shifting her blame.

5. Discussion

In his book *Stigma*, Goffman (1963, pp. 129–130) outlined three ideal typical solutions that persons with a discrediting attribute can resort to in managing their normative predicament. The first is to show their support for the norm while acknowledging their own deviation from it. The second is to alienate themselves from the normative community by claiming that the norm is irrelevant. The third solution is to navigate between those two other solutions through self-presentation and impression management. This chapter applied the method of conversation analysis to examine how patients who are prone to impulsive behaviours manage their normative predicament in a particular institutional setting, the psychiatric assessment interview.

Using CA, we detected three basic stances that the patients display towards their impulsive behaviours: a self-reproach, a lessening of reproach, and a defying of reproach. While these stances were discovered through inductive analysis, they correspond to the three solutions for normative predicament that Goffman (1963) outlined: in self-reproach, patients express their support of the norm that their own conduct does not meet; in defying the reproach, they reject the norm and alienate themselves from the normative community; and in lessening the reproach, in a particular manner, they engage in impression management.

The important question at this point is whether conversation analysis contributed anything to Goffman's observations. While Goffman can be understood to speak about the life strategies of persons with stigma, our observations concerned momentary choices in a highly specific interactional context. Yet, the observations that we made on the differences between the three patients, regarding their choices of stance display practices, likewise point to the more life-historical perspective that Goffman adopted in his seminal work.

The difference between CA and the Goffmanian approach also arises in the conceptualisation of what Goffman referred to as "the community that supports the norm" (Goffman, 1963, p. 129). For Goffman, this was a generic moral community that the persons with stigma can either retain their membership in or alienate themselves from. Conversation Analysis does not reject the concept of this type of community, but it also offers a far more local perspective. The patients' stance displays were directed to the matters that they talked about – their own impulsive behaviours – but at the same time, they implicated something about their own relation to the addressee, the clinician conducting the interview. The clinicians,

in collaboration with the patients, maintained the evaluative space in which the patients' impulsive behaviours were considered to be problematic. In their self-reproaches and in their lessening of their reproaches, the patients *approached* the clinicians, claimed that they are in the same world with them, and by defying reproaches, they momentarily *distanced* themselves from the clinicians and that world. This means that the community that supports the norm referred to by Goffman appears in the micro-perspective of conversation analysis to be represented by the clinician.

In his essay on face-work, Goffman argued that the two basic facets of self are "the self as an image pieced together from a full flow of events in an undertaking" and "the self as a kind of player in ritual game" (Goffman, 1955, p. 225). He illustrated this distinction with a metaphor from card games: the former facet involves "the value of a hand drawn at cards" and the latter, "the capacity of the person who plays" this hand (ibid.). It is important to clarify that both the "hand" and the "capacity to play" are socially defined, not given. During assessment interviews, that distinction takes a special meaning. The potentially stigmatising aspect of impulsive behaviours is part of the "hand" that the patient brings to the interview. The practices of stigma management involve the play with that hand. For the present analysis, conversational analysis helped elucidate these practices. It is important to note that during assessment interviews, *both* the hand *and* the player are under evaluation: the clinicians glean information not only from their patients' reports of their impulsive behaviours, but they also base their assessment of the patients' personality on how the patients relate their behaviours to the clinicians, that is, on the basis of the patients' stigma management.

This study analyses the interactional management of the self in one particular institutional setting: psychiatric interviews, a situation that involves assessing patients. Even so, in reading Goffman, one could expect such management – in different forms – to be a part of virtually all interaction. In his paper titled "Insanity of Place", Goffman (1969, p. 360) suggested that while the actions of a person and their co-interactant define their self, "some of his minor gestures will convey what he feels about having a self that his defined in this way". In this chapter, CA helped to explicate these "minor gestures" as the verbal and non-verbal practices of stance display toward an individual's reported behaviours. Goffman (ibid.) goes on to suggest that "these gestures in turn will be taken as part of his enacted self by himself and others, which fact can in turn be taken into consideration in the assessment he or others make of him". If Goffman is right, then the assessment that occurs in a psychiatric interview might be a specific, explicit, and elaborate instance of an assessment of the self and other that implicitly occurs during all interactions.

Acknowledgements

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