Journal of Multicultural Discourses
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rmmd20

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Published online: 18 Mar 2014.

To cite this article: Juan Eduardo Bonnin (2014): To speak with the other's voice: reducing asymmetry and social distance in professional-client communication, Journal of Multicultural Discourses, DOI: 10.1080/17447143.2014.890207

To link to this article: http://dx.doi.org/10.1080/17447143.2014.890207

Journal of Multicultural Discourses, 2014
http://dx.doi.org/10.1080/17447143.2014.890207

Routledge
Taylor & Francis Group

To speak with the other's voice: reducing asymmetry and social distance in professional–client communication

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(*Received 27 September 2013; accepted 27 January 2014*)

The aim of this article is to examine the case of adoption of characteristic features of the interlocutor's 'voice' in mental health care admission interviews at a public hospital in Buenos Aires, Argentina. We observed ethnographically that 'speaking with the Other's voice' is a strategy adopted by psychoanalysts to achieve clinical goals, though they overlook its wider implications and contradictions as it involves both professionals and patients. We will argue that patients adopt bureaucratic and psychiatric terms in order to decrease asymmetry and reorient the activity conducted between the professional and the client. On the other hand, professionals tend to consider social class, age, ethnicity or religion when adopting the patient's voice in an attempt to decrease social distance. These strategies are employed to accomplish different goals during the interview: to the patient, it is a way to show competence in the activity of medical consultation, indexing the highly valued voices of state institutions and psychiatric knowledge; to the professional, it is a strategy to achieve clinical goals by decreasing social distance and enhancing transference. Analysis will show the unequal distribution of voicing options for participants: while patients attempt to reduce asymmetry despite social distance, psychotherapists try to decrease social distance but maintain asymmetry. In conclusion, wider implications will be discussed for intergroup communication between professionals and clients.

Keywords: communicative competence; interaction; inequality; psychotherapy; voice

Psychotherapy in medical settings: dealing with asymmetry and social distance

This article is a part of a wider research project on language, inequality and access to mental health care in Buenos Aires, Argentina. Here, we will address an empirical issue observed during our ethnographical work in admission interviews at a public hospital: the adoption of characteristic features of the interlocutor's ways of speaking. Although psychoanalysts claim to do so in order to achieve clinical goals, we will explore here the wider implications and contradictions of this voicing strategy as it involves both professionals and patients. In this sense, we attempt to see the potential and the limitations of this other-oriented strategy (Shi-xu 2009, 34–35) regarding actual mental health care practice.

Asymmetry between doctors and patients is one of the most widely acknowledged principles in health communication studies. In the field of Conversation Analysis, structurally asymmetrical roles, defined as 'the sick role' and 'the role of the physician' (Parsons 1975) are a part of the 'organising principles' (Heritage and Clayman 2010, 119)

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of interaction in medical settings. As Ten Have ([1991] 2005) states, the issue of asymmetry has two different aspects: first, regarding topic (it is the patient's health condition, and not the physician's, which is under scrutiny); second, regarding participants' task during the encounter. In the latter, there is a noticeable 'biomedical selectivity in that physicians tend to ignore those aspects of patients' utterances that report on subjective experience, personal circumstances and social conditions' (Ten Have [1991] 2005, 3). The exception which Ten Have (1989) notes is, precisely, when physicians look for psychosomatic aspects of diagnosis and treatment, in which case they usually ask for environmental and subjective reports. This is one of the key differences between biomedical discourse and psychotherapy, whose main topic is precisely subjectivity.

It is possible to locally produce or circumvent (a)symmetrical relationships on the basis of the activities carried out by participants (Ten Have [1991] 2005). In the case of psychotherapy, asymmetry characterises the distribution of roles and tasks – as inherited from biomedical discourse – but on the other hand, needs to be dealt with in order to achieve therapy goals. Bercelli et al. (2006, 44) have noticed 'a uniform asymmetric pattern' regarding turn type distribution and turn order in psychotherapy. Vehilläinen (2006) observes, as a meaningful difference with everyday communication, an asymmetrical relationship regarding participants' knowledge of their own experience. Therefore, the analyst is seen as the only person able to interpret 'the meaning of the client's talk before and beyond the client's awareness of it' (Vehilläinen 2006, 138). In this sense, as Leudar et al. (2006, 154) point out, the therapist uses the client's language and frame of reference and, thus, the degree of asymmetry between therapist and client may vary according to different therapeutic schools. That is, in fact, what many psychoanalysts recommend. In the words of one of the professionals we observed, the challenge is 'to speak with the other's voice' ('*hablar con la voz del otro*') and, in doing so, to understand the other's lifeworld. In clinical terms, reducing asymmetry is important in order to 'enhance transference and remove the barriers between speaker and listener' (Harris 2012, 256).

Asymmetry, however, is not only a local effect of role-identities subject to interactive negotiation. It is also an emergent of social structure and macro patterns of inequality which produce social distance between groups. Granovetter (1983) has demonstrated the role of weak ties between groups in producing and in reproducing social distance, especially between people who occupy the lower and the upper positions in social structure. In Argentina, although public health services can be used by any inhabitant of the country, only around 16 million people (37% of total population), who are not included in private or mixed sectors, go to public hospitals and primary health care centres (De Almeida-Filho and Silva Paim 1999). The neoliberal decade of the 1990s left public health in Argentina as a dismantled, saturated system that lacks basic human and material resources (Belmartino 2002). After decades of privatisation of social rights, the public health care system ceased to be conceived as a human right to which every citizen is entitled and began to be seen as relief for the poor (Comes and Stolkiner 2005; Bonnin 2013a), impacting especially on mental health patients in extremely poor conditions (cfr. Pardo and Buscaglia 2008).

As a consequence, in addition to asymmetry between professionals and patients, there is also a structural social distance between white, Argentine-born, post-graduate middle-class professionals of European descent and patients with partial indigenous ancestry, many of whom have migrated from bordering countries or poor Argentine provinces, with basic education and no steady job. Both components of G. Simmel's 1908 definition

of social distance are present: on the one hand, the interlocutor is perceived as unfamiliar, of a different kind in terms of gender, age, ethnicity or social class. On the other hand, distance is observed in everyday life through the low frequency and intensity of interaction between groups and their members (Ethington 1997). The stereotypical identification of social structure position and sociolect becomes a resource in the management of social distance: as Giles et al. (1991) have demonstrated, intergroup communication is often the result of accommodating to the interlocutors' perceived way of speaking.

Asymmetry, on the other hand, is a locally observable phenomenon which depends on the qualification of the individuals to fulfil the requirements of institutionally defined roles. Medical interaction distinguishes between a subject who has a specific knowledge and authority, the *doctor*, and someone who lacks this knowledge about his/her own body, the *patient*. The whole process which begins with a more or less unspecific illness is oriented to the authority which will transform it in a medically validated disease (Heritage and Clayman 2010, 154). Social distance and asymmetry are close, but different. The former is independent, to some extent, of institutionally defined roles. As a consequence, the doctor and the patient may be socially familiar even if, during consultation, they assume asymmetrical roles. On the contrary, institutional roles may be symmetrically distributed – for instance, to the customers in a store – although participants may be socially distant between themselves and do not share any other space of interaction.

In this article, we will argue that the attribution of voice provides patients and professionals with linguistic resources to manage asymmetry and social distance. In the case of the former, patients adopt features of the institutional discourse, which defines the asymmetrically distributed roles, to level the relationship, as an empowerment resource in front of medical authority (Heritage and Clayman 2010, 154 ff.). On the other hand, professionals, especially psychoanalysts, adopt some features of the interlocutor's lect to decrease the perception of social distance and, as a consequence, enhance transference.

Accommodation, voice and social range

Dealing with asymmetry and social distance can be understood in terms of intergroup communication in medical settings as physicians and patients attempt to accommodate to perceived outgroup typicality (Hajek et al. 2007, 294).[1] The Communication Accommodation Theory (CAT) specifically addresses the 'social cognitive processes that mediate a person's perception of the surrounding environment and her/his communicative behaviours' (Nussbaum et al. 2005, 290). The application of CAT in the field of health communication has been extensive since its beginnings (Giles et al. 1991), with special interest in mental health care settings (Stabile et al. 2013) and Ageing Studies (Lagacé et al. 2012; Ota et al. 2007; McCann et al. 2005).

Although we share many interests with CAT, the research we have conducted has not been shaped within its theoretical framework due to a number of reasons. In the first place, the phenomena addressed here have not been identified through a theoretical a priori (i.e. looking for accommodation strategies) but, rather, have emerged as regularities which we reunited in the concept of *voice*. Second, our analytical approach to conversation favours direct observation of interaction in actual contexts. Accommodation research, on the other hand, is mainly experimental, controlling contextual factors and measuring linguistic or attitudinal outcomes (Coupland 2007, 63). Third, as Gasiorek and Giles (2012) have stated, accommodation is a subjective phenomenon, 'the recipient's

perception of a behaviour' (Gasiorek and Giles 2012, 311). In this sense, over- and under-accommodation are 'evaluative assessments made by the recipient of the communication in question' (*id*.), the speaker's actual motive and intent being irrelevant. What CAT takes into account, instead, is the *inferred* motive, i.e. 'the motive that a recipient attributes to a speaker' (*id*.). In this article, in contrast, we will address the speaker's representations of the recipient's social range and thus, of his/her characteristic voice. We have adopted many of CAT's conclusions, especially the observation that convergence and divergence do contribute to achieving closeness (Giles et al. 1987) and distance (Nussbaum et al. 2005) between participants. As both strategies involve the speaker's interpretation of the receiver's needs and comprehension, stereotypes about 'the other' play a fundamental role in (mis)communication between health professionals and patients (Gallois et al. 2005).

In the terms of our research, from the speakers' point of view, we found that one of the most important resources participants use to decrease asymmetry and social distance is related to the adoption of characteristic features associated to the interlocutor's 'voice', that is, 'another's speech in another's language' (Bakhtin [1934–1935] 1981, 324). From this perspective, the speaker can stage two voices as 'two exchanges in a dialogue' (Bakhtin [1934–1935] 1981, 325), evoking different personae engaged in a conversation settled by the speaker. Evoking another's voice does not necessarily mean identifying oneself with it, although it does have impact on the orientation towards the activity being carried on and its participants. Although the voice is attributed to another character, the voicing and contents are provided by the speaker him/herself, who speaks 'as if' she/he were the other. The source of this voice, therefore, is the speaker's experience; his/her own knowledge, beliefs and prejudices about what the other's voice is like. In the terms of Agha (2005, 38), voices are indexed by 'social types of persons, real or imagined, whose voices they take them to be'. Social voices, therefore, are discursive figures that permit characterisation through a metadiscourse of social types of persona attributes. Agha (2005, 39) calls that range of stereotypic social personae performable through characteristic social indexicals *social range*: male, lower-class, a lawyer, a bureaucrat, etc. The group of persons capable of producing and recognising the figures indexed by these voices constitute the *social domain* of enregistered voices.

Consequently, 'speaking with the other's voice' means representing some aspect of the social range of the interlocutor's voice from the point of view of the speaker's own social domain. Specifically within the social domain of register lies a core interest to our work: domains are not just different, but unequal, as they receive different social values on a hierarchically organised scale (Blommaert 2007). Thus, speakers not only recognise the different social voices indexed by (more or less) stereotypical cues but also attribute to them a value within a scale: social voices have the prestige of their speakers. These kinds of voices produce an effect of alignment which has impact not only on the speaker but also on the recipients and, in general terms, on the semiotic activity which involves them both (Goffman 1981). Therefore, adopting the other's voice may work as a way to reorient the activity and thus the relationship between participants.

Now, the questions we will attempt to answer are the following: how do participants identify their interlocutor with a social persona? Which features of the other's attributed identity do they select as relevant for voicing?

Data and methodology

The data analysed in this article was gathered at an outpatient mental health care service at a public hospital in Buenos Aires, Argentina. Throughout years 2011 and 2012, I

attended the service's activities and conferences and discussed preliminary results with the professionals. I ethnographically observed and audio-recorded 41 admission interviews at the outpatient service, in all cases with the written informed consent of patients and professionals. To ensure the confidentiality of data, I do not identify the hospital where interviews took place. I have also replaced the names of patients and professionals with randomly selected letters and, if necessary, names.

Admission interviews have an average duration of 20 minutes and are held at consulting rooms at the hospital once a week. They are usually conducted by two professionals who interview individual patients, who are sometimes accompanied by a relative or a friend. Although there is no explicit distribution of roles, usually one of the professionals (the more experienced, though not necessarily the eldest) takes the lead in interviewing while the other simply takes notes. I have called the former 'psychologist in charge' (PC) and the latter 'assistant psychologist' (AP). Each pair of professionals conducts two or three interviews in a row and, later in the same day, presents each case to the rest of the team in order to decide on the patient's admission or rejection and the specialty that accepted patients should enter (individual therapy, group therapy, addictions, etc.).

Although we have observed directly many of the interactions analysed here, we have not documented them in video due to confidentiality reasons and, therefore, we cannot account for non-verbal contextual connections. This is an actual weakness of the conversation-analytic approach (Shi-xu 2005, 76) even although we situate these observations in a three-year process of ethnographic fieldwork (cfr. Bonnin 2013a, 2013b). In this sense, the sampling criteria have emerged during the research process and the collaborative interpretation of preliminary data analysis. The cases we will discuss here illustrate the diversity of resources deployed by both patients and professionals to deal with asymmetry and social distance by adopting some of the interlocutor's perceived characteristic voice. In the case of patients, indexing upper-level voices (what Giles et al. 1991 would call 'upwards accommodation') is usually achieved by using bureaucratic and psychiatric terms. In the case of professionals, downward accommodation depends on the interlocutors' perceived social range, which varies according to whether the selected feature is age, social class, ethnicity, religious beliefs, etc. We have selected four different examples which illustrate this diversity in actual interaction. Although they are examples of different types of voices which emerge in different interviews, the criteria employed for sampling were theoretical and not statistical.

The patients' point of view: indexing upper-level voices

Outpatients at mental health care admission interviews may develop a strategy to decrease the asymmetry of the situation by displaying knowledge. Relevant knowledge, assumed as a highly valued, potentially empowering voice, appears in our *corpus* either as practical or as theoretical. In the first case, its source is the patient's own experience as a client of the state apparatus and, as such, evokes the bureaucratic voice of institutional talk (Prego Vázquez 2006). In the second case, mass media, Internet and previous treatments help develop folk theoretical knowledge of psychiatric voice which is observable mainly through specialised terminology (Giles and Newbold 2011).

Indexing bureaucratic voice

Although public hospitals are institutions with highly standardised procedures, including communicative ones, mental health care professionals in Buenos Aires tend to react against the impersonal, status-oriented tradition of biomedical discourse (Lakoff 2006). There is a tendency to create informal environments which allow the emergence of biographical, often intimate information, relevant to the diagnostic process (Bonnin 2013a).

Therefore, institutional talk (as described by Heritage and Clayman 2010) appears as an alien voice, the voice of bureaucracy evoked by clients – not by professionals – to index competence in this kind of institutional practices and reorient the activity towards a more formal register. It is usually adopted during the first sequences of admission interviews, designed to gather bureaucratic–administrative information on patients' demographic profiles (such as gender, education, marital status, etc.). As a way of decreasing the level of formality, professionals seldom read aloud the items on the official form, but rather, request the information in a more conversational way:

Excerpt 1[2]

1. PC: deivi vos vivís (.) en capital o vivís en provincia?
2. Patient (PAT): vivo en capital (yo)
3. PC: en capital (1) estás solte::ro casa::do
4. PAT: en pareja (.) °con mi cónyuge°
5. PC: hiciste tratamientos psiquiátricos o psicológicos antes
6. de venir acá?
7. PAT: aquí? sí (.) ya hice dos veces vine
8. PC: viniste dos veces acá al hospital?
9. PAT: sí
10. PC: viniste así a los consultorios o: o: estuviste
11. internado?
12. PAT: no solo vine a los consultorios y estuve internado en:
13. bolivia en la paz
14. PC: ah bien (2) y fueron consultorios de acá de psicología?
15. PAT: salud mental era=
16. PC: =salud mental
17. PAT: salud mental (1.5) en (allá) le dicen así creo

18. PC: sí (.) sí sí=
19. PAT: =igual creo que se llama acá (.) (no es)?
20. PC: sí [sí]
21. AP: [sa]lud mental
22. PC: deivi vos hiciste: la escue:la
23. PAT: sí sí (.) secundario incompleto

Approximate translation[3]

PC: David, do you live in the Capital or in the Provinces?
PAT: I live in the Capital
PC: In the Capital. Are you married, single?
PAT: Cohabiting. With my partner.
PC: Have you had any prior psychiatric treatments before coming here?
PAT: Here? Yes, I've already been here twice.
PC: You've been here twice here, to the hospital?
PAT: Yes.
PC: Did you came to the outpatient service or were you admitted as an inpatient?
PAT: No, I only came to the outpatient service and I was an inpatient in Bolivia, in La Paz.
PC: All right. And was it the outpatient service here, in psychology?
PAT: It was mental healthcare.
PC: Mental healthcare.
PAT: Mental healthcare. That's what they call it there [in Bolivia].
PC: Yes, yes.
AP: Mental healthcare.
PC: David, have you studied at school?
PAT: Yes, yes. Incomplete high school.

In Excerpt 1, the interviewer begins with a casual, conversational style through the informal second-person singular pronoun ('vos', you) and the formulation of questions instead of reading the items in the form. In line 3, she rephrases the original variable ('marital status', *estado civil*) and its options ('*soltero* [single], *casado/en pareja* [married/cohabiting], *separado* [separated], *viudo* [widower]') as a disjunctive indirect question, selecting only the two options which seem to be more adequate to the interviewer's situation. This selection is made not only on the basis of assumptions made by the psychotherapist, probably based on age – wich exclude options such as 'widower' – but also on her own moral prejudices – excluding 'cohabiting' and 'separated'– which may be considered illegitimate options. As the patient actually cohabits (he lives '*en pareja*') with his partner, in line 4, he answers using technical terms which index bureaucratic voice: 'en pareja (.) con mi cónyuge'. Both 'en pareja' [cohabiting] and 'cónyuge' [partner] are technical terms which are present in the form, and the speaker adopts both as an alien voice and as a bureaucratic voice, emphasising this strategy through a short pause and perceptible lowering of volume in line 4.

Something equivalent happens in line 16, when discussing the designation 'mental health care' ('*salud mental*') in which the nominal phrase is followed by a noticeable pause which introduces a metalinguistic commentary on the expression modalised through the verb '[I] think' (line 17). In this case, the psychotherapist had introduced the issue in line 13 with a non-technical expression, 'outpatient service here, in psychology' ('*consultorios de acá de psicología*') which can be seen as the 'voice of the lifeworld' which prevents the emergence of the 'voice of medicine' (Mishler 1984, 63). However, the patient has experience in the domain of clinical mental health care, and this experience is displayed as he adopts the bureaucratic voice which technically refers to 'mental health care', at first with some hesitations – as we saw in line 16 – but then seeking confirmation on his metalinguistic competence at line 18.

Finally, in line 22, the patient answers 'more than the question' (Stivers and Heritage 2001) by providing information on the 'level of completion' of education. Although the professional asks an indirect polar question, the patient adopts the bureaucratic voice, adding information typically requested by statistical forms when asking for levels of education. Although the question on 'level of completion' had not yet been enunciated, the patient is able to anticipate it as a part of the routine activity of gathering demographic information at social security institutions (as analysed by Pantaleón 2005). Facing this activity, the speaker answers to the bureaucratic voice of the statistical form in the same terms, even if they are not adopted by the professional.

The psychiatric voice

The predominance of the 'voice of the lifeworld' (Mishler 1984) in psychotherapeutic interviews is often resisted by patients. They evoke psychiatric voice through technical terminology designed to name symptoms and diagnostic labels. In other terms, something too close to an ordinary conversation (as shown by Bartesaghi 2009) is driven to the medical field in order to meet the patients' expectations about medical settings and medical discourse. In such a context, evoking the psychiatric voice is a way of showing competence in medical discourse and, rejecting the voice of the lifeworld, reorienting the activity.

What patients do not know is that psychoanalysts usually reject medical discourse as an illegitimate biologisation of the psyche (Lakoff 2006); therefore, instead of achieving better empathy, psychiatric voice creates more distance as is rejected by professionals. The conflict between psychiatric and psychoanalytical discourse in admission interviews has been shown in a different context (Bonnin 2013b). Here we can observe its emergence as a voicing issue, evoking psychiatric voice and dismissing it:

Excerpt 2

1. PC: dígame: hizo::: e: (.) qué nivel de educación tiene?
2. [secundario?] terciario?
3. PAT: [e:::] universitario:: (1)
4. PC: completo?

5. PAT: no incompleto (.5) no porque me agarró ataques de
6. pánico y tenía que dar dos finales obligatorios y no me
7. siento a leer dos reglones (.5) mirá que me encanta leer ↑
8. por miedo de (.) e igual me agarró de nuevo (…)
9. PC: cuéntenos por qué vino ahora?
10. PAT: y porque me parece que otra vez me agarraba ataques de
11. pánico (.) viste? esto:y cansa:da (.) no tengo ganas de
12. hacer na:da (.) tristona (.) viste? ahora desde el lunes a
13. la tarde estoy con opresión y palpitaciones (.) pero
14. continuamente
15. PC: ah sí? desde el lunes?
16. PAT- desde el lunes a la tarde (1) igual yo ya venía pero
17. no tanto (.) me agarra viste?
18. PC: pasó algo últimamente? algo que pueda [relacionarlo
19. con eso?]
20. PAT: [no no] nunca puedo enganchar qué es lo que:: (2)
21. (…) oy (.5) tengo ganas de llorar (.) mirá que yo (.) no
22. sé qué se me mueve te juro
23. PC: a ver (.) vamos a hablar un poquito (.) usted dice que
24. esto empezó en el 2002 (.) cómo empezó? usted dice ataque
25. de pánico pero vamos a ver qué: a qué:=
26. PAT: =qué eran los síntomas?
27. PC: claro
28. PAT: bueno estaba tri:ste (.) deprimida: (.) tenía
29. palpitaciones (.) sudoración (.) me quedaba (.) viste?
30. eh::: dura (.5) eh: tenía:: (2)

Approximate translation

PC: Tell me, have you… What is your level of education? Secondary, higher?

PAT: Higher.

PC: Complete?

PAT: No, incomplete, because I suffered these panic attacks and I had to take these exams and I couldn't even read two lines. And I love reading!

PC: Tell us, why have you come here now?

PAT: Because I felt I was suffering these panic attacks again, you know? I'm tired, I don't want to do anything, I feel gloomy, you know? Now since Monday afternoon I feel oppression and palpitations, continuously.

PC: Hmm. Since Monday?

PAT: Since Monday afternoon. Anyway, I was already feeling this way but not that much. It just happens, you know?

PC: Has anything happened lately? Something that you can relate to that?

PAT: No, no. I can never identify what it is. Oh. I feel like crying. And I'm not a crying person.

PC: Hmm. Let's see. Let's chat a little. You say it began in 2002. How did it begin? You say panic attack but let's see what… what

PAT: What are the symptoms?

PC: Right

PAT: Well, I was sad, depressed, I suffered palpitations, sweating. I was like, you know, rigid, I had…

Excerpt 2 shows one of the most common self-diagnosis among patients in the outpatient service, *panic attack* (lines 5–6, 11–12), which has had extensive media coverage in recent years. Professionals usually reject patients' engaging in self-diagnosis (Broom 2005; Giles and Newbold 2011; Bonnin 2013b), dismissing psychiatric terminology either explicitly or implicitly. As in Excerpt 1, line 4, the patient answers more than the question in 5, adding information to explain the reason why she had not finished her higher level education. However, the professional does not acknowledge this information, which included the 'panic attack' self-diagnosis, ignoring the digression and moving forward to inquire, paradoxically, about the reason for the visit (the 'problem presentation' described by Heritage and Clayman 2010, 104 ff). The answer in lines 10–14 offers an elaboration of the previous turn, omitting circumstantial information. After the self-diagnostic formulation of lines 10–11, there is a first attempt to describe the symptoms in everyday, non-technical terms. Therefore, the patient uses informal second-person forms ('*viste?*', 'you know?') in lines 11 and 12, and a diminutive in line 12 ('*tristona*', 'gloomy'), indexing affective meanings which contrast in line 13 with technical nominalisations, which mitigate the subjective position provided earlier, 'palpitations' and 'oppression'.

The professional does not provide any feedback on the psychiatric voice. On the contrary, in lines 24–25, there is an attempt to dismiss self-diagnosis by opposing the patient's reported speech ('you say panic attack') to direct observation ('let's see') through the contrastive conjunction 'but'. Since this is a face-threatening act which diminishes the degree of evidentiality that sustains the patient's self-diagnosis – in other words, it diminishes her credibility or reliability – she answers by evoking the psychiatric voice again. Thus, in line 26, the patient interrupts the professional with emphasis and repairs the hesitations of line 25 with the technical term 'symptoms' and enumerating technical and non-technical terms: 'deprimida' (depressed), 'palpitaciones' (palpitations), 'sudoración' (sweating) among the former; 'triste' (sad), 'me quedaba dura' (I was like rigid) among the latter.

In this excerpt, the patient uses the psychiatric voice in those cases which require levelling up the situation among participants: in the first case, at the beginning of the interview, we can see an attempt to negotiate the activity by showing technical knowledge on her condition. In the second case, as a reaction to a potential face threat, the patient fills the professional's hesitations and, again, evokes the psychiatric voice to enumerate her symptoms technically.

The professionals' point of view: speaking 'at the patients' level'

In the previous section, we observed the strategies displayed by patients to orient the activity by adopting/evoking two well-situated voices: the bureaucratic and the psychiatric. The relevant feature of the interlocutor's identity is his/her role in the actual interaction: as a bureaucrat and as a doctor, specific vocabulary and degree of formality are adopted to show competence and, thus, level up the patient's asymmetrical position.

In the case of professionals, on the contrary, we observe an adoption of the interlocutor's voice, not in terms of the locally defined role of 'patient', but in terms of demographic–social structure. Thus, the position of patients within the social structure becomes the dominant feature which professionals select in order to attribute to them a social range and thus a voice to adopt. As a consequence, social distance is emphasised even when an attempt is made to reduce it.

That is what one of the professionals once meant by saying that '*tenés que hablarles a su nivel*' ('you have to speak to them at their own level'). By adopting these stereotyped, 'lower' voices, professionals attempt to decrease social distance, levelling down their position to the patient's supposed range. When this strategy is successful, patients recognise their attributed voice as legitimate and use it to elaborate further on the topic of the interaction.

The young, middle-class voice

The following example is taken from an interview with a 19-year-old male, who is currently studying software engineering and, despite having access to private health care, is interviewed by a psychotherapist who is a friend of his mother. This information is relevant because the professional belongs to the same social class and, therefore, tries to adopt the young man's chronolect as the other's voice:

Excerpt 3

1. PC: =ah. (3) hubo una diferencia para vos=
2. PAT:= sí, sí,[totalmente]
3. PC: [eso estás] diciendo (.5) hubo una
4. diferencia cuando (.) tu novia- charlaste con tu novia
5. profundamente=
6. PAT: =claro (.) sí (.) sí=

7. PC: =*como se dice ahora tehizo un click*
8. PAT: >sí, sí, sí, sí, sí<=
9. PC: ahá
10. PAT: y me siento- cada día me siento diferente y con
11. ganas de::- o sea (.) siempre me juntaba con- antes de
12. juntaba con (buena) gente este:: (2) siempre salía con
13. chicas mas chicas también
14. PC: esta: (.) novia (que edad tiene)?
15. PAT: la misma edad que yo
16. PC: me pareció que igual me dijiste que se había:- que
17. te habías peleado?
18. PAT: cla::ro (.) sí porque::: salía con mi ex que:::
19. con esta chica (ya llevo) hace tres meses (.) ¯o
20. cuatro meses¯ (1) con mi ex la vi un par de veces,
21. después de saliendo con ella este:: (.) pero sí tengo:
22. así *contacto corporal* digamos a veces no? (inaudible)
23. y yo le decía que no (.) bueno por esa mentira
24. ella se enojó mucho porque es mu::y de *ir de frente*
25. (2) y creo que también eso fue una inmadurez de
26. no: haber (encarado las cosas *de una)*
27. PC: *uno m*ás
28. PAT: *cla:ro, una (cosa m*ás, sí)
29. PC: *una m*ás
30. PAT: sí (.) sí (.) totalmente=

Approximate translation

PC: So there was a difference to you?

PAT: Yes, yes, absolutely.

PC: That is what you are saying: there was a difference when you talk seriously to your girlfriend

PAT: Right, yes, yes.

PC: 'Something clicked', as they say nowadays [untranslatable: '*como se dice ahora, hiciste un click*')

PAT: Yes, yes, yes, yes, yes.

PC: Hmm.

PAT: And I feel different every day and willing to… I mean, I used to hang out with… I used to hang out with nice people. I used to go out with younger girlfriends, too.

PC: This girlfriend you mention, what is her age?

PAT: The same as mine.

PC: I thought you said that you had broken up with her?

PAT: Yes, right, because I was going out with an ex-girlfriend of mine. I have been going out with this girl three months, already, or may be four. Then I have been with my ex-girlfriend a couple of times, after beginning to go out with her, and I had… body contact, so to speak, a few times, right? And I said I did not. Well, she got really upset about that lie, because she is very 'confrontational' [untranslatable: 'ir de frente'] and I think that was an immature thing I did, not facing things 'right away' [untranslatable: 'de una'].

PC: The right way.

PAT: Right, right away.

PC: The way right away.

Pat: Yes, yes, absolutely. (The last four turns are freely translated in order to preserve the effect of wordplay of the original in Spanish).

In lines 1 and 3–5, the professional attempts to locate what psychoanalysts call a 'turning point' (Böhm 1992, 675), that is, 'the sudden change of quality that plays the part of a forerunner or a prerequisite to the slow structural change in psychoanalytic treatment'. In order to emphasise the relevance of the fact, for the third time, she refers to it in line 7, adopting explicitly the young people's voice through the metalinguistic commentary: '*como se dice ahora*' ('as they say nowadays'). The term '[*hubo una*] *diferencia*' ('[there was a] difference'), which is named as the turning point in lines 1 and 4, is now rephrased in the chronolect of the interlocutor as '[*te hizo*] *un click*' ('something clicked'), emphasising its relevance through the metalinguistic commentary and the emphatic tone. The adoption of the patient's voice helps to decrease the distance even in the formal context of the interaction. As a consequence, the patient also moves towards the young enregistered voice proposed as his own, using chronolectal expressions such as 'ir de frente' (line 24, 'being confrontational') and 'de una' (line 26, 'right away'). In both cases, there is some sort of prosodic mark which, similarly to other metalinguistic devices shown previously, indexes voice changes: a hesitation ('*mu::y*', 've::ry') followed by a medium pause of two seconds in the first case and a noticeable volume decrease in the second. The competence in the young man's voice, however, seems to be insufficient to decode every chronolectal expression he uses. Hence, the psychotherapist says '*uno más*' in line 27 (freely translated as 'the right way', in order to preserve the wordplay) as a recall of the patient's last turn, which had employed the expression '*de una*' ('right away') which probably was not understood by the psychotherapist. The patient, in line 28, apparently confirms line 27 but, instead, provides a repair cohesive with the item 'cosas' in line 26. Rather than dismissing the misinterpretation of his voice by the psychoanalyst, the patient offers a productive 'mishearing' in order to contribute to the interaction, recalled by the psychotherapist in line 29 ('*una más*', 'the way right away') and confirmed by the patient in line 30.

The echoes of what the professional considers the young patient's voice, manifested in phrastic units considered characteristic of the other's lect, allow her to reach clinical

goals. Even if her competence is limited, it enabled the patient to adopt his own voice and elaborate on the topic under discussion.

The voice of lower-class youth

When social distance is perceived as greater, a more complex voice is embodied by the professional. In Excerpt 3, as the patient was considerably younger than the PC, but belonged to the same social class, only chronolectal terms were adopted. But the usual population at the hospital comes from lower classes and requires a more elaborate strategy. In the following case, the interlocutor is a 21-year-old young woman who lives in a *villa* (an extremely poor neighbourhood, equivalent to 'shanty town', including a pejorative meaning) and has basic education and no steady job. In this case, in order to decrease social distance, the psychotherapist adopts the patient's chronolect in addition to meaningful aspects of lower-class phonology, dropping voiceless sibilants and dental consonants in word-final position:

Excerpt 4

1. PC: =pero viste esa frase que dice la procesión va por dentro?
2. se- conocés esa frase? (1.2) que parece que está todo
3. bien, pero lo que uno le pasa va por adentro y a veces ni uno
4. mismo se entera (1) se entera (.) porque a veces de repente (.)
5. le a[garra]
6. PAT: [porque, por ej-] sí::: ya sé porque yo a lo
7. primero no caía que mi hijo había fallecido (1) o sea (.) no es
8. que no caía (.) era que yo estaba bien, (1) [este]
9. PC: [claro] triste pero: [máh o menoh andabah] (…)
10. AP:[siempre viviste con él?]
11. PAT: sí (.) desde chica
12. PC: o sea vivías vos y tu hermano más grande y este::
13. PAT: y este pibe (.) que es <u>más</u> chico que mi hermano más grande
14. PC: este pibe qué edaØ tiene?
15. PAT: tiene y:: (.) e:: trein treinta
16. PC: ah::! es bastante más grande digamos: o sea:
17. PAT: sí sí sí (.) un tirón me lleva (a mí):)

18. PC: está bien (.) o sea esto trajo muchos conflictos a nivel
19. familiar y te hago una pregunta Mariela?

Approximate translation

PC: But, you know that phrase that says 'still waters run deep'? Do you know that phrase? It seems that everything is OK ['está todo bien'], but important things are going on deep inside you and sometimes you do not even notice. Because is happens all of a sudden.

PAT: Because, like. Yes, I know, because at first it didn't really sink in that my son had died. I mean, it did sink in, but I felt fine.

PC: Right, sad but… More or less you kept going (…)

AP: You always lived with him?

PAT: Yes. Since I was a girl.

PC: So it was you and your elder brother and this…

PAT: This guy ['pibe'] who is younger than my elder brother.

PC: And this guy ['pibe'], what age ['edaØ'] is he?

PAT: He is… thirty years old.

PC: Oh, he's quite a bit older than you.

PAT: Yes, yes, yes; he's much older than me ['un tirón me lleva']

PC: Right. So this brought a lot of conflicts in your family. Tell me, Mariela…

Excerpt 4 begins with a traditional idiomatic expression, '*la procesión va por dentro*', whose meaning is metalinguistically topicalised by the professional in lines 1 and 2. As there is a 1.2 seconds gap, the professional repairs the idiom rephrasing it with a chronolectal voicing '*está todo bien*' (lines 2–3, 'everything is OK') and elaborates until the overlap in line 4. In this overlap the patient shows understanding, confirming with '*sí::: ya sé*' (l. 6, 'yes, I know') and further elaborating with her own particular case, related to the death of her child. As a one-second gap preludes a hesitation in line 8, the professional overlaps again and repairs the patient's turn in line 9. In doing so, she drops three consecutive sibilants in word-final position (line 9), either by aspiration ('*mah*', 'more') or elision ('*menoØ*', 'less'; '*andabaØ*', 'you kept going'). Although aspiration is an extended phenomenon in Buenos Aires, elision is not; indeed, it is a stigmatised variant identified with lower classes (Aleza Izquierdo 2010, 64). In lines 13–17 we can observe a similar phenomenon. The patient uses the item '*pibe*' (line 13, 'guy'), which can be identified as chronolectal, and, as an identity marker, is repeated by the psychotherapist in line 14, combined with a lower-class variant: omitting the voiced dental fricative [ð] in final position at '*edaØ*' ('age'). The adoption of the other's voice, young and poor, proves successful in decreasing social distance, encouraging the patient to adopt other terms and expressions characteristic of lower-class young people, as shown in the rephrasing of '*bastante más grande*' (line 16, 'quite a bit older than you') as '*un tirón me lleva*' (line 17, untranslatable, 'much older than me').

The ethnical voice

Although there is no statistical information on the subject, 19 out of the 41 cases we have studied involve people born in Bolivia, Peru or Paraguay. As these are countries with a strong indigenous component and a wide variety of contact between Spanish and indigenous languages (mainly, Quechua, Aymara and Guarani), the 'ethnical voice' appears as a way to decrease social distance, especially with migrants who show traces of language contact.

In the following example, we will see an interview with a Bolivian patient who speaks a typical Andean-Pacific variety of Spanish. The psychotherapist will adopt an anti-normative expression used by her interlocutor in an attempt of downward accommodation to the other's lect:

Excerpt 5

1. PAT: teníamos () pero:: (.) después ya no él (2) se iba a la calle
2. de la: de la casa salía y: (nosotros) teníamos que ir a buscar =
3. PC: = y no lo acompañaban?
4. PAT: no (1) se perdía
5. PC: y pero no (.) por qué iba solo?
6. PAT: **no se perd**ía de la casa digamos (.) estaba la puerta abierta
7. del hospital se sale y: =
8. AP: = a:: se iba del hospital? (1) eso es lo que,
9. PC: a:: lo acompañaban al hospital y **se perd**ía del hospital?
10. PAT: (1) a: veces pero no: más no (.) pero en la casa ya (.) en la
11. casa ya o sea (.) e:: antes que mejore (.) antes que ahora está
12. mejor (.) cuando no cuando no estaba mejor se i:ba a la calle se
13. sal:ía por (.) o sea (.) sin pedir pedir permiso y se perdía =
14. PC: = no pero lo que yo le pregunto es lo siguiente (.) él estuvo
15. internado en el Borda (.) salió del Borda
16. PAT: sí sí salió (2012-11-15 3)

Approximate translation

PAT: We had, but… After that, he used to go out to the street of the house and we had to look for

PC: Didn't you go with him?

PAT: No, he used to get lost.

PC: And why didn't you… Why did he go out by himself?

PAT: No, he didn't get lost out of the house ['no se perdía de la casa'], so to speak. There was this open door at the hospital and he went out…

AP: Hmm. He left the hospital, that is what you…

PC: You used to go with him to the hospital and he used to get lost out of the hospital ['se perdía del hospital']?

PAT: Sometimes, but no. In the house, he… Before getting better, because now he is better, when he, when he was not better he used to go out to the street and, I mean, without any authorization, he used to get lost.

PC: No, but what I am trying to ask is this: he was admitted to the [hospital] Borda, he left the Borda

PAT: Yes, yes, he left.

In line 6, the preposition '*de*' seems to be dependent of the verb '*perderse*' ('to get lost'). Although it is not 'normative', the professional assumes this relationship as a trace of language contact, proper to the patient's variety of Spanish. It is noticeable that the patient used a hedge, '*digamos*' ('so to speak'), which can be associated with the processes of idiomatisation and fixation (Grande Alija 2010) and, therefore, can be interpreted as a trace of language contact. Although the AP does not fully understand, and asks for a repair in line 8, the PC repeats the expression in line 9 in order to decrease social distance based on language variety, here associated with nationality and ethnicity. The patient's turn, in lines 10–13, is a confusing attempt to answer both questions, formulated by AP in line 8 and PC in line 9. At the end of line 13, the verb '*perderse*' ('to get lost') is used by the patient in its standard form, without the preposition. After the confusion is disentangled, the psychotherapist rephrases '*se perdía del hospital*' ('he used to get lost out of the hospital') as '*salió del* [*hospital*] *Borda*' (line 15, 'he left the [hospital] Borda'). Then, the patient finally confirms emphatically in line 16.

As in Excerpt 3, the professional's attempt to adopt the interlocutor's voice is based on a limited competence and, although it deals with social distance in order to decrease it, does not favour comprehension. In this case, the voice of the migrant is identified with the anti-normative Spanish and the feature selected to evoke it is, precisely, the non-standard relationship between verb and preposition. As 'Bolivian', in social range, is both a combination of ethnicity and nationality (Dreidemie 2013), and ethnicity is associated with language contact, the non-standard becomes a symbol of voice.

The voice of popular religion

Religion, as a widespread cultural phenomenon, is linked to social structure in Argentina, not only regarding demographic distribution of beliefs and institutions but also social representations of them (Heaton 2013; Mallimaci 2013). In this sense, the association of lower classes with folk beliefs and popular religious practices is prevalent in common sense, even among social scientists (cfr. Martín 2009). As Semán (2004) points out, popular religion becomes a cultural logic that assumes the immanence and super-ordination of the sacred in the world. Hence, facts which would be considered 'miraculous' or 'impossible' by a middle-class Catholic or a non-believer are seen as regular (not extraordinary) events for lower-class, 'popular' believers (Martín 2009, 279). Popular beliefs and practices, therefore, are perceived as distinctive of lower classes. Specific religious voicings are typically associated with specific social ranges, especially when seen from a different social domain.

Excerpt 6

1. PC: entiendo pero me (.) volviendo a esto de: (1) las cuestiones
2. que te pasaron en el cuer:po y que por ahí vos ubicás a esta
3. religión (.) específicamente vos qué pensás de eso? porque como

4. que no me queda: (2) no no sé (.) no quedó muy claro en relación
5. a ver (.) si vos (.) sentís como que que hicieron al:go como un
6. gualicho no sé cómo se llaman igual (.) esas, =
7. PAT: no no (.) no sé ni idea (.) e: (.) no que me hicieron a mí
8. sino que había quedado algo en la casa (1) y me lo agarré yo
9. PC: (1) algo qué es? (.) porque la verdad que:
10. PAT: (1) no: una: (.) es que yo no sé cómo hablar de la religión en
11. realidad (.) porque no la conozco (.) no me gusta me da miedo ?
12. aparte ? (1) no:: (.) no sé cómo es (.) pero: viste que traen
13. mucha (1) las malas lenguas dicen que trae mucha mala on:da malas
14. energí:as co (.) te (traen) cosas malas (.) si vos no limpiás la
15. casa (2) yo creo que eso me lo agarré yo

Approximate translation

PC: I understand. Now, going back to these things you experienced in your body which you seem to relate to this religion. What do you think of it? I didn't… I didn't fully understand if you feel like… somebody cast a spell ['*gualicho*'] on you, I don't know what these things are called.

PAT: No, no, I don't know, no idea. It's not something that someone cast on me, but something in the house which I suffer.

PC: What do you mean by 'something'. Because I really…

PAT: I don't know how to speak about religion, really, because I don't know, it scares me. Besides, I… They bring a lot of, you know, people say they bring a lot of bad vibes ['*mala onda*'], bad energy ['*malas energías*']. It brings bad things to you if you don't clean up ['limpiás'] the house. That's what I think I'm suffering.

In Excerpt 6, the professional explicitly attempts to clarify the terms of the interaction through metalinguistic activity by pointing out that she did not fully understand what the patient had said before (lines 3–4). Then she rephrases the patient's previous words, evoking the religious voice in the lexical item '*gualicho*' (line 6, 'spell'), a popular term which designates an activity of witchcraft. As in the previous examples, there are traces of the adoption of the other's voice, as the lengthening in '*al:go*' (line 5, 'something', cohesive with '*gualicho*', 'spell'), the hedge '*como*' (line 5, 'like') to introduce the term, a prosodic emphasis when pronouncing the word (line 6) and the metalinguistic commentary '*no sé cómo se llaman igual (.) esas*' (line 6, 'I don't know what these things are called'). As the voice of popular religion is not prestigious – rather, it is stigmatised – the patient's first reaction is to reject it, showing a lack of competence in this field through metalinguistic activity: '*no sé ni idea*' (line 7, 'I don't know, no idea') and then '*yo no sé como hablar de la religión*' (line 10, 'I don't know how to speak about religion'). However, the effect of adopting the other's voice, thus generating confidence,

proves to be effective and the patient elaborates further on the topic, using herself – once religious voice is accepted as legitimate – technical terms of the field such as '*mala on: da*' ('bad vibes'), '*malas energí:as*' ('bad energies') and '*limpiar*' ('clean up'). In this case, the identification of the patient with the voice of popular religion becomes useful to decrease social distance, thus increasing confidence and encouraging storytelling, which will eventually lead to formulating a diagnosis.

Conclusion: voice, asymmetry and social distance

Although the examples analysed differ widely from each other, they all share two features: (1) they involve the adoption, by the speaker, of a voice which is frequently marked as alien but attributed as proper to the recipient; (2) this attribution is a consequence of identifying the interlocutor with a social persona and its characteristic ways of speaking.

The analysis allows us to distinguish two distinct strategies: from the patients' point of view, the professional is identified as a representative of institutionalised medicine. Therefore, patients adopt features of bureaucratic and medical voice. In both cases, we can recognise some aspects of 'institutional talk', especially regarding participants' involvement 'in specific goal orientations which are tied to their institution-relevant identities' (Heritage and Clayman 2010, 34). In this sense, patients tend to identify psychotherapists as bureaucrats (as long as they request demographic–epidemiological information) and doctors (as long as they work in a hospital). Thus, patients adopt these voices in order to reduce asymmetry, displaying what they consider some kind of acquaintance with the other's role identity.

On the other hand, professionals index lower range voices as they identify their interlocutor with lower levels of social range, either as young middle-class (Excerpt 3), young and poor (Excerpt 4), Bolivian (Excerpt 5), believer in popular religion (Excerpt 6), etc. Speaking 'at the patients' own level' means decreasing the perceived social distance by adopting some feature of the interlocutor's attributed lect. Several metalinguistic markings show, at the same time, an acquaintance with the interlocutor's social range but not an identification with it. Examples in Excerpts 3 and 4 show the impact of social distance in perceiving the 'otherness' of the other's social position and range. In Excerpt 3, belonging to the same social class, the professional adopts the voice of 'youth' as her interlocutor's main characteristic. In Excerpt 4, on the other hand, as there is also a social class difference, the other's voice is identified through age and social class to manage the distance between a middle-aged professional and a young working-class woman.

To sum up, while patients index locally defined roles to adopt the voice of the interlocutor and negotiate the activity, professionals index out-of-context identities to decrease social distance and better develop the psychotherapeutic conversation. However, structural positions are not abandoned. We observed in Excerpt 2 how a patient's attempt to adopt psychiatric voice was dismissed by the professional as inadequate, thus reinforcing asymmetry based on roles and knowledge. On the contrary, Excerpts 3 and 5 show that professionals who fail to adopt the patient's voice are not sanctioned because, despite local procedures to decrease social distance, structural factors still act to reproduce an unequal relationship between participants. Inequality, therefore, conditions the voicing options of participants: patients attempt to reduce asymmetry despite social distance; psychotherapists try to decrease social distance but maintaining asymmetry.

These results have consequences in the field of mental health care practice. Research in terms of voice and inequality allows us to better understand professional–patient interaction in terms of inter-group communication (as seen when summarising CAT). In this sense, there is still a lot of work to do in order to understand the intercultural dimension of psychotherapeutic interviews in the field of public health care in Argentina. However limited, the analysis presented here has impact on the actual practice of admission interviews as long as representations of the interlocutors' identities and voices are involved. On the part of the professionals, we have already argued the need to negotiate with biomedical discourse (Bonnin 2013b), at least until the establishment of a common ground regarding the participants' roles in psychotherapeutic interviews, the relevance of diagnosis, etc. Therefore, it might be preferable for professionals to temporarily accept patients' attribution of a bureaucratic and medical position (which is directly linked to the activity being carried on) than to adopt the informal voice of the lifeworld. This dialogue with the other's own cultural representations and beliefs is necessary as it allows social distance to be decreased without reifying cultural differences. Professionals seem to understand this need and, therefore, evoke the interlocutor's voice without identifying with it, as repeatedly is shown by metalinguistic comments. These results show an attempt of adopting 'the other's own, local, historical terms' (Shi-xu 2005, 107), although in contradiction with the professionals' own asymmetrical, dominant position.

Future research should be oriented towards facilitating this intercultural dialogue by recognising cultural diversity and negotiating the professionals' dominant position. In this sense, it will be necessary to confront interactional data with patients' and professionals' own perceptions. This will contribute to avoid one-dimensional stereotypes and to recognise the singularity and complexity of 'the other's' voice.

Acknowledgements

I would like to thank professionals and patients at the hospital for their help in collecting and in interpreting the data analysed here. I would also like to thank Virginia Unamuno, the anonymous referees and Dr Shi-xu for their helpful suggestions to a prior version of this article.

Notes

1. This relation has been appropriately pointed out by one of the anonymous reviewers of this article.
2. We have adopted the transcription symbols proposed by Richards and Seedhouse (2005).
3. As many idioms, hesitations and word separations are idiosyncratic of Spanish, we have decided not to translate word by word but to offer an orthographically and syntactically normalised version in English. We always offer both versions in the analysis.

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