

Doing Diagnosis: Autism, Interaction Order, and the Use of Narrative in Clinical Talk

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Abstract

This study, with an eye toward the social psychology of diagnosis more generally, is an investigation of how clinicians diagnose children with autism spectrum disorder (ASD). Responding to Hacking's call for a Goffmanian mode of analysis to complement and balance the emphasis on large-scale transformations and discourses, we examine the narrative way in which clinicians provide evidence to support a diagnostic position. Using recordings and transcripts of clinical visits across two eras, our findings about the interaction order of the clinic show distinct story types and components that contribute to diagnostic narratives for ASD. These include stories about concrete "instantiations," stories that propose "tendencies," and "typifications" or generalizations regarding a specific child. This work contributes to interaction order theory, methodology, and other domains of social psychological research.

Keywords

diagnosis, autism, narrative, conversation analysis

This study is an investigation of how clinicians diagnose children with autism spectrum disorder (ASD). Surprisingly, although recent decades have witnessed a dramatic upsurge in the prevalence of ASD and the fields of psychology, anthropology, epidemiology, genetics, neurobiology, and history have all attempted to account for this upsurge, there is no fully developed sociological social psychology of ASD that addresses how clinicians diagnose the disorder in the first place. Our paper aims to fill that gap by explicating the everyday practices that professionals, across a multitude of clinical settings, use in classifying children through testing, discussing results with one another

(called a "pre-staffing"), and presenting diagnoses to families (during the "staffing"). These practices are essentially narrative ones, as clinicians engage in concrete forms of storytelling to rule ASD in or out for a given child.

Studies in the domain of the sociology of diagnosis (Brown 1995:39) emphasize the social and political contexts in which

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“conflicted diagnoses” exhibit manifestations of power and control in the field of medicine. Previous conversation analytic (CA) research about diagnosis (including papers published in this journal) have concerned primary care medicine (Heath 1992; Peräkylä 1998), cancer (Lutfey and Maynard 1998), and developmental disabilities (Gill and Maynard 1995; Maynard 1989, 1992), but all concentrate on the delivery and reception of diagnosis rather than the orderly interactional processes by which clinicians arrive at a diagnosis in the first place. From these two domains of inquiry then, researchers may already know about the institutional milieu of diagnosis, or how clinicians present a diagnosis. In between the larger milieu and the situated delivery of diagnostic news, we find an uncharted social psychological domain of *doing diagnosis*—how, based on their tests and other data, clinicians tell what they have found and what their findings mean. If, as Silverman (2011:194) has said, “the work that constructs autism as a stable population occurs largely at the level of behavioral observations, diagnostic questionnaires, and checklists” (see also Jutel 2009; Singh 2016), then attention needs to be paid to the domain of everyday talk and conduct by which clinicians make sense of such materials.

THE SOCIAL PSYCHOLOGY OF DIAGNOSIS

A variety of investigators have shown that despite efforts to biomedicalize and geneticize ASD, the yield has been disappointing, with no firm results or “tangible benefits” (Bumiller 2009:7; cf. Nadesan 2005; Silverman and Herbert 2003; Singh 2016) in finding a biomarker by which one could directly diagnose the condition. However, it turns out that the diagnosis of biomedical conditions in general—not just developmental disabilities but also

classic disease entities like cancer (Rabe-harisoa and Bourret 2009), Huntington’s disease (Halpin 2011), and cystic fibrosis (Hedgecoe 2003), as well as conditions for which prenatal testing can isolate genetic biomarkers (Timmermans and Buchbinder 2013)—is always far from the Linnaean system of taxonomy for animals, vegetables, or minerals (Hacking 2013). Consequently, the study of ASD shares a place with other medical conditions for which it is recognized that diagnosis is not a point-and-say matter, but rather a contingent, interpretive, temporal process (Balogh, Miller, and Ball 2015). Our research on just one disorder, accordingly, may have implications for understanding the social psychology of many kinds of diagnostic decision-making endeavors and the organization of abstract classification systems (Abbott 1988). By the term social psychology of diagnostic decision making, we mean to uncover, in a way consistent with both ethnomethodology and the pragmatist tradition in Mead’s symbolic interactionism (Emirbayer and Maynard 2011), the taken-for-granted—largely narrative—structures of interaction comprising this process.

We draw on Goffman’s (1983:4) notion of the *interaction order*—the working and enabling practices at the “center” of the social body—without which “our activity, behavioral and verbal, could not be meaningfully organized.” Moreover, we follow Hacking’s (2004) suggestions about how “top-down” approaches to such matters as diagnosis need to be wedded to “bottom-up” analysis of the Goffmanian variety. That is, a question arises about how macro patterns—historically situated “forms of discourse” (cf. Dreyfus and Rabinow 1982; Foucault 1975), movements toward deinstitutionalization (Eyal et al. 2010), the reconfiguration of “networks of expertise” (Eyal 2013), changing jurisdictional claims on diagnosis (Abbott 1988),

and the standardization of such claims (Timmermans and Berg 1997)—“become part of the lives of ordinary people, or even how they become institutionalized and made part of the structure of institutions at work” (Hacking 2004:278). The possibility Hacking raises is that what he calls “discourse in the abstract” can be brought to life through analysis of actual, situated conduct. Accordingly, we show how in two very different eras, professionals in a medical-diagnostic clinic, or what Drew and Heritage (1992) call an “institution at work,” deploy narrative practices that transcend differences in testing, terminology, and theorizing about autism. This means that there is a recondite universality to diagnostic practice—consisting of narrative structure—in the face of terminological and cultural changes across time. Accordingly, a methodological contribution of our paper is to show how social psychologists, through close analysis of recorded, spoken discourse deriving from different times or places, can connect history and talk.

DATA AND METHODS

The data derive from a larger project on the testing and diagnosis of autism spectrum disorder (ASD), which includes audio and/or video recordings collected at a clinic for developmental disabilities—Central Developmental Disabilities Clinic (or CDDC)—located in a medium-sized U.S. city at two points in time: first in 1985 (before the upsurge in ASD diagnosis) and subsequently from 2011 to 2015 (at the then-current peak of ASD’s rise in prevalence). Our cases incorporate video recordings and transcripts taken from a larger corpus: the one from 1985 (out of a corpus of 13) has a larger group of professionals (from the fields of speech and language pathology, psychology, psychiatry, special education, developmental pediatrics, and occupational therapy); the

other, from 2014 (out of a corpus of 49), has fewer clinical participants (usually from psychology, developmental pediatrics, and speech and language) because of the reorganization of the CDDC over the years. Turowetz and Maynard (2016) describe the data more fully.

In proposing that narrative structures for accomplishing ASD diagnosis are generic and that these structures accommodate different historical periods, circumstances, people, social environments, and other local matters (Turowetz 2015a), our approach is in accordance with how conversation analysts (Sacks, Schegloff, and Jefferson 1974) discuss the practices of talk as both context-free and context-sensitive. We also draw on Schegloff’s (1987) observations about how, through single-episode analysis, we can bring past work in the field of CA to explicate analytically single fragments of talk.

NARRATIVE AND STORYTELLING IN EVERYDAY AND CLINICAL SETTINGS

In its broadest form, narrative refers to an organized account, spoken or written, of connected events, whether temporally (Labov and Waletzky 1967) or otherwise (Ainsworth-Vaughn 1998; Arminen 2004; Jefferson 1978; Mandelbaum 2013; Maynard 1988). For conversation analysts, storytelling “usually requires extended turns-at-talk on the part of teller” (Mandelbaum 2013:493), although more generally, as Sacks (1972:340) has observed, “if some piece of talk is a possible description it is also, and thereby, a possible story or story part.”

In the present paper, we show how ordinary storytelling competencies and practices are adapted to the institutional aims of the clinic, namely, evaluation and diagnosis. We emphasize the *interactional* telling of stories (e.g., Ainsworth-Vaughn 1998; Atkinson 1995; Gill and

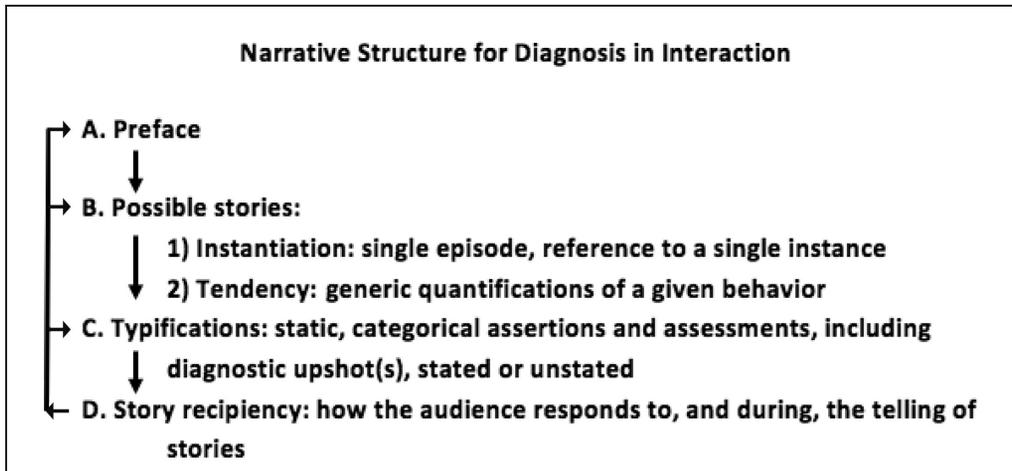


Figure 1.

Maynard 1995; Mandelbaum 2003; Turowetz 2015a, 2015b). This approach distinguishes our analysis from other treatments, particularly in medical contexts, which stress clinicians' private cognitions or patients' personal illness reportage as separate from and competitive with physicians' constructions (e.g., Charon 1989; Frank 1995; Hunter 1991; Mishler 1984). Our investigation probes how tellers and recipients of stories *collaborate* in their production as they assemble specific story components (prefaces, typifying upshots) and types of stories (instantiations, tendencies) into an overall *narrative* in real-time talk *among* clinicians, patients, and/or family members.

The narrative structure for diagnosis is shown in Figure 1. Diagnostic narrative includes the following elements: (A) preface(s) that may introduce an overall narrative or its constituent stories; (B) story types that are either (1) *instantiations*, portraying single episodes of conduct and their particularities, or (2) *tendencies*, which focus on a child's propensities through generic quantifications of a given behavior; (C) typifications, which are relatively static assertions that evaluate or assess behaviors, aligning them either explicitly or tacitly with a diagnostic

category; and (D) reciprocity, consisting of ways that hearers of the story react to the story as it is being told and then as it is completed (Goodwin 1984; Lerner 1992). Note that while recipients often withhold full assessments until the speaker's story is complete, they display reciprocity (e.g., through nods and tokens like "Mhm") throughout the telling as well.

Our two major story types require further definition. With instantiations, clinicians (or others) produce specific observations of a child or deliver a third-party report of a single episode in which the child performed a given behavior. These stories follow the pattern described by Labov (1972), consisting of at least two chronologically ordered clauses about past event(s) that occurred at specific times or places and cannot be reordered without changing the story's meaning. Instantiation stories can also include "reenactments" (cf. Holt 1996; Sidnell 2006; Turowetz 2015a)—embodiment of gesture or other movement—that demonstrate the activity in question.

Tendency stories extend a behavior beyond the single instance; a clinician (or other) describes a class or set of behavior(s) and formulates a child's propensity to do something by way of enumerating

a behavior without reference to specific times or places. Unlike instantiation stories, tendency stories, which Ainsworth-Vaughn (1998:151) and Riessman (1991) call “habitual” stories, do not need to be about past event(s) or ordered chronologically, although the story will have other forms of organization “built into it” (Sacks 1986:132).

The forms of organization built into tendency stories include one or all of the following: (a) modal verbs (*will, would, can, could, may, might*) that suggest a disposition toward certain behaviors (cf. Bruner 1986; Edwards 2006) and adjectives that encode capacities (e.g., “He is able to do x”), (b) quantifiers (e.g., *all, some, every, a lot, etc.*) that specify the frequency or regularity of a behavior, (c) “when” and “if” adverbial clauses that connect specific occasions and/or conditions contingently with a given behavior by locating events at particular places or times, (d) dynamic verb phrases—often with gerund-type suffixes that indicate an ongoing action sequence (e.g., “he is/was struggling”) rather than one that is static or closed, and (e) impressionistic verbs such as *seem, appear, and look*, connected to assessments characterized as likely or probable. Given the enumerative feature of tendency stories, they have a built-in flexibility—they allow the teller to go up or down an evidentiary scale depending on how a recipient responds to the story in its course or upon its completion.

The narrative sequence constitutes the skeletal structure by means of which diagnoses are adumbrated, proffered, and evaluated. We now turn to our case examples from two eras in autism diagnosis, using both documentation (intake reports, medical files) and extracts from recorded interactions in two environments: the pre-staffing, when clinicians meet privately to discuss and determine diagnosis, and the staffing or informing interview, when they see the family and other parties to

relay what they have found. After our case examples, we summarize, address general issues regarding the social psychology of diagnosis, and consider how the structure of narrative in diagnostic decision making operates across contexts.

AUTISM IN 1985: RONNIE

At the time of his evaluation at CDDC, Ronnie Martin was four years old. According to the intake report, Ronnie’s teachers were concerned “about some unusual behaviors and difficulty in playing with peers” and, together with his parents, were seeking clarification of diagnosis and recommendations for his academic program. A team of clinicians, including a psychologist, psychiatrist, pediatrician, special education specialist, occupational therapist, and speech and language pathologist, conducted individual evaluations of Ronnie over a period of two days, using tests that included the Brigance Inventory of Early Development, the Ongoing Developmental Assessment Tool, the Psychoeducational Profile, and Leiter Scale, along with informal interviews with the parents. Afterward, during a meeting about Ronnie, team members contributed to a narrative that substantiated a diagnosis of atypical pervasive developmental disorder (APDD), in line with the operative *Diagnostic and Statistical Manual-III* (American Psychiatric Association [APA] 1980), which listed both infantile autism (IA) and APDD under the category of Pervasive Developmental Disorders.

Backstage: The Pre-staffing

In Goffmanian (1959:106) terms, this gathering occurs “backstage,” a “region” (i.e., a clinic room) to which the family has not yet been invited. In contrast with Goffman’s focus on self-presentation, clinicians who have tested a child are not

(1a) RM pre-staffing:290/01 (5:04)

1 Debbie: Anyways Bill ↑every↓thing I did with him on the: (0.2) rea:diness
 2 types of things that I do with four fi:- ↓five year olds? .h
 3 [He] ↓did all at age level.
 4 Bill: [Mm]
 5 Bill: °Yeah.° (0.3) .hh yeah=
 6 Debbie: =It's jus:t (uh)- (.) from talk↓ing to the ↑tea:↓chers it sounds like
 7 when he has to take those skills and ↑apply: it=
 8 Bill: =Mm hmm=
 9 Debbie: =to something, that's where he [falls] ↓down and he doesn't=
 10 ? : [Mm hmm]
 11 Debbie: =have the generali[zation] skills, and-
 12 Bill: [Mm hmm]

preparing for the presentation of “self” per se, except in a collective way, as they both determine the diagnosis and prepare to deliver their findings to the family in a coherent, unified way that represents the clinic’s jointly determined diagnosis (cf. Anspach 1993:92).

As the pre-staffing for Ronnie begins, the clinicians discuss the school’s referral, suggesting that the school had “in effect” already made a diagnosis of autism.

The case coordinator, a psychologist whom we call Bill Pender, says, “And even some of the school people are sophisticated enough to know, you know, things like the DSM-three criteria for autism because they were structuring some of the reports . . . along the kind of symptoms that one would look for.” However, Debbie Jones, the special education clinician, noted that although someone “along the way” had stated that Ronnie “was autistic,” the school did not “give him that label.” This was, she further stated, “because the family is gonna have a lot of problems with the label,” adding about her own experience with the parents, “they seemed kind of vulnerable.” In fact, throughout their discussions, the clinicians anticipated resistance from the parents regarding an autism diagnosis.

After these preliminary discussions, Debbie, the special education clinician, starts diagnostic considerations with a prefacing

claim about the “readiness tests” she does with four- and five-year-olds. On these tests, Ronnie performed “at age level” (extract 1a, lines 1–3).¹

Bill responds with “yeah” tokens (line 5), and Debbie proceeds to extend and qualify her preface: Ronnie is testing at age level, which can suggest no intellectual impairment. However, according to his teachers (line 6), “when he has to take those skills and apply” them (line 7), he “falls down” (line 9). This is a tendency story that culminates in an upshot: “he doesn’t have the generalization skills” (lines 9, 11; she appears to begin another component to this utterance but cuts it off at line 11).

Debbie immediately takes an in-breath (extract 1b, line 13) and, by way of a specific instance of literalism, goes on to produce support for her claim that Ronnie lacks generalization skills. She begins with a story preface (“Did they tell you about . . .,” lines 13–14) indicating “reported speech” (Clift and Holt 2007:4) and moves immediately into the story proper (lines 16–17), describing the indicated movie and formulating its message.

Debbie then depicts the focal action of the narrative, which is introduced by a “well” preface (line 20) that can forecast

¹See online appendix, which can be found with the online version of the paper, for transcription conventions.

(1b) RM pre-staffing:302/14

13 Debbie: .hhh Did they >tell you about< how they showed a (0.6) a: child
 14 abu[se ↑mo:vie] and that (0.5)
 15 Bill: [O:h]
 16 Debbie: =and that he wasn't supposed to: y- (.) you're s'pposed to say no:
 17 (.)↑run ↓away and tell two friends.
 18 (0.4)
 19 Bill: Mm hmm=
 20 Debbie: =Well: ↑he: ↓viewed his dad telling him to pick up his toys as
 21 ch[ild abu]se, [(0.2) and] so he told his dad, ↑I can say no=
 22 Bill: [()] []
 23 ?: [hhh hhh]
 24 Debbie: =and I'm going to run ↓away and [tell two friends. (0.6)]
 25 All: [(General laughter)]]
 26 Debbie: [You know? And he <could:n't distinguish>]=
 27 All: [(laughter)]]
 28 Debbie: [that it [\$wasn't really child] abuse\$
 29 Bill: [huh heh huh That's funny .hh]
 30 Debbie: It's [interesting] that=
 31 Bill: [That's good.]
 32 Debbie: =He's ↑very lit↓eral, [(y'know)]
 33 Barb: [Yeah,] that comes out.

a discrepancy between what Ronnie was “supposed to say” and what he actually did (cf. Schegloff and Lerner 2009). She recounts how Ronnie reacted to his father disciplining him by repeating what he had been told at school (lines 20–21, 24). The story elicits overlapping laughter from others in the room (lines 25, 27) as Debbie proposes the upshot that Ronnie could not “distinguish” his father’s actions from “child abuse” (lines 26, 28). After Bill produces appreciative commentary on the story (lines 29, 31), Debbie suggests a typification: Ronnie is “very literal” (line 32), which she emphasizes with stress and rising-falling intonation. As Debbie completes her turn, Barb (speech and language) aligns with an agreeing upshot, “Yeah that comes out” (line 33), which also operates as a preface to her own diagnostic stories.

Having shown narrative practices by drawing on Debbie’s presentation, for space reasons we will summarize further discussion in the pre-staffing.

Barb, referencing her speech and language exam, goes on to produce tendency components deriving from her own

observations and knowledge of the family, which depicts Ronnie’s literalness in terms of how he plays with toys. Following displays of alignment from Bill and Debbie both, Barb extends the narrative by means of further tendency components. “The only way,” Barb suggests, that Ronnie is “able to pick up other ways” of playing is when “his little sister” does “other things,” which implies imitative learning. Bill then tells a story by reporting a teacher’s assessment that Ronnie does not do “creatively . . . new things with toys,” adding the teacher’s tendency story about how, if they “show” Ronnie how to do such things as use a puppet, “then he can sort of imitate it.” With a typifying upshot that aligns to Bill’s turn and the overall narrative that she had initiated, Debbie agrees: “He’s a real good person for imitating and modeling.”

As the deliberation of Ronnie’s case continues, a psychiatric resident reports that Molly (the supervising psychiatrist, who was not at the pre-staffing because of a scheduling conflict) had mentioned APDD to the parents.

Then, the occupational therapist gives her findings, followed by the speech and language clinician. Each clinician systematically alternates between tendency and instantiation stories on behalf of typifications that in turn aligned to APDD as a diagnosis. As the pre-staffing comes to closing, Bill raises the issue of how the family was “coping” with the potential autism-related diagnosis. Debbie says, “I think they’re really afraid that he’s gonna be labeled,” an assertion with which the other clinicians agree and which (in line with what was said at the outset) further suggests an anticipatory stance regarding how to deliver the diagnosis—delicately.

Frontstage “Staffing:” Telling the Parents

As indicated, the pre-staffing is, in part, a backstage preparation for the clinicians’ subsequent meeting with Ronnie’s family and school teacher, where they deliver the now solidified diagnosis.

The overall pattern is that each of the clinicians straightforwardly prefaces a delivery of findings and then gives a report using the various narrative components to replay for the parents what they had told one another during the pre-staffing.

Subsequently, parents regularly show alignment—tokens of acknowledgment or acceptance—or produce “second” stories that reinforce themes in the clinical reports but draw on their own experience regarding Ronnie. That is, parents match the straightforward manner of clinical presentation regarding test results by regularly and unhesitatingly producing relatively parallel observations and experiences, which also facilitates clinicians’ recommendations on how Ronnie should be taught. In other words, during or following clinicians’ stories, parents produce what conversation analysts call “preferred” responses, characterized as

lacking in hesitation, showing agreement, allowing for progression in the talk, and other features (Pomerantz and Heritage 2013). At a relatively late stage in the staffing, Bill captures this co-aligning dynamic by referencing the “open discussions” and “back and forth” and “brainstorming” quality of the staffing up until this point.

By contrast, having (in the pre-staffing) anticipated resistance to the specific labels, clinicians become cautious (see the following) with typifying and diagnostic talk, which occasions “dispreferred” responses, including hesitations, withholding, questioning, and other such features (Turowetz and Maynard 2016). This pattern begins inadvertently when the clinicians raise the possibility of brain damage. Bill lists Ronnie’s problems (difficulties with thinking, being “real hung up on getting things exactly right,” language problems), then typifies them as “real up and down development,” and goes on to say, “It’s not because you are bad parents or just because he was premature but that something about *the way his brain is functioning . . . some damage* [italics added] . . . that isn’t allowing him to make sense of the world in the way that a normal child might.” In an era when the possibility of parent-blaming and parental guilt about a child’s disability could still be prominent (Eyal et al. 2010), Bill’s statement is potentially offering release from any such culpability.

The parents are both silent at this point. Later, after she works to explicate the matter of brain damage and the parents remain silent, Molly asks, “Is that scary?” Mrs. M nods, says, “Yeah,” grabs a tissue from the table in front of her, asks, “Why does any kid have a problem?,” sobbing quietly for over 20 seconds, after which she intones, “Okay whata we do now?” As Bill begins to elaborate on what Molly means by “brain damage,” Mr. M, having sat impassively, simply

says, "To me it doesn't seem that severe," and Mrs. M immediately agrees: "Yeah." From this point, Bill, Molly, and Debbie work to put an optimistic cast on things with various formulations about Ronnie's "positive things," such as "good language," "pre-academic skills," "showing affection," and the like. Already (i.e., before pronouncing diagnosis as such), then, the clinicians, by their good news exit from the "brain damage" formulations, show an orientation to this having been received as bad news (Maynard 2003).

Subsequently, Bill proposes a "one, two, three" closure to the interview, offers to "start" things off (extract 1c, line 1), and recaps his earlier formulation about the "back and forth" discussions they have had until this point (lines 2–5). In a regular way of leading into diagnostic terminology, he goes on to suggest the relevance of "helpful . . . organizations" (lines 5–6). In mentioning "some" and "other parents" (lines 5–6), Bill alludes to the diagnosis with a vague and euphemistic, or mitigating, reference (Bergmann 1992) to their "kids who have this

kind of a handicapping condition" (lines 6–7). In a sense, the psychologist is syllogistically delivering information about an organization (Gill and Maynard 1995) rather than a diagnosis. At line 8, the parents show no uptake, either through their talk or body movement. Bill then suggests contrasting stances toward such organizations ("feel queasy" vs. "love," line 10) as, in a clarification of the earlier, vague reference to "organizations" (line 6), he leads into naming "the autistic society" (line 11), after which the parents remain mostly silent and still (line 12) except for a whispered token on Mrs. M's part (line 13). Bill goes on to refer to his colleague, Dr. Rinehart (Molly), and quotes her as using "a term called pervasive atypical developmental disorder" (lines 14–15), for which he offers a tendency story ("what we really mean . . . is he shows many of the signs," lines 16–17), invoking the diagnosis (line 17) by way of anonymous quotation (it's what "other people call autism").

Again, the parents are silent (line 18), and Bill utilizes a feature of tendency

(1c) RM Staffing: 3328/29

1 Bill: Uh: let me start and then >I'll go around<.=.h >I think< .h in
2 addition to wanting to see ya ba:ck .hh to continue:: these kinds of
3 ya know kinda open discussions where it goes back and forth between
4 your feelings: (.) brainstorming about ideas, hearing what
5 professionals say .hhh so:me parents also find it helpful to hook up
6 with organizations: .hhh uh:: composed of other parents who have
7 ki::ds who have this kind of a handicapping condition.
8 (1.2) ((Parents sit rigidly, gazing at Bill))
9 Bill: .hhh uh::m (.) Some people feel that that's- you know you can feel a
10 little queasy about it, others lov:e the opportunity.= =so there's
11 something called the autistic society,
12 (1.0) ((Parents remain in rigid postures, gazing at Bill))
13 Mrs. M: °Ya°
14 Bill: .hh When doctor Rinehart ((Bill gestures toward Molly) uses a term
15 called >pervasive atypical developmental disorder,< .hh >what by- <
16 I think what we really mean by that is he shows m:any of the signs
17 (0.9) that other people call autism
18 (0.4)
19 Bill: But maybe not all of the signs and maybe to a (.) somewhat milder
20 degree.
21 (0.6) ((Mrs. M nods slightly))

(1d) RM Staffing (continues 1c)

22 Bill: But .hhh uh other ↓parents (1.0) will be going through what
 23 you're going through.
 24 (0.4)
 25 Bill: And those parents will have .hhh uh come up with their own ideas
 26 of things that work, [things that don't work. .hh uh how to=
 27 Mrs. M: [(nods slightly)]
 28 Bill: =become good advocates to fight for your kid's rights:
 29 (0.5)
 30 Mrs. M: °Mm hm.°
 31 Bill: You know how ta cope when: grandma says:
 32 (1.2)
 33 Bill: [you're not doing something ri[:ght,]
 34 Mrs. M: [(slight smile) []
 35 Mr. M: [Work it in-] work it into a-
 36 uh:: daily routine of [working an:d (.) and: (.) of:=
 37 Mrs. M: [Yeah. ((reaches for a tissue))
 38 Mr. M: =[maintaining a house[hold, and-
 39 Bill: =[.hhh hh [Yeah. Yeah, yeah.
 40 Mrs. M: [(two hands put tissue over nose)]
 41 Bill: What you're [struggling with many parents also are struggling=
 42 Mrs. M: [(blows nose)]
 43 Bill: =with.

stories, which is that in their quantifying of behavior, they can be used—as at lines 19–20—to retreat from initially stronger forms of the evidence they provide on behalf of diagnosis. This occasions a small nod from Mrs. M (line 21).

Both Bill, as clinician and deliverer of the news, and the parents, as recipients, show the dispreferred status of the diagnosis. As defined previously, *dispreferred* refers not to their attitude toward the diagnosis but rather to the practices for delivering and receiving the news. Bill's lead-in to pronouncing “pervasive atypical developmental disorder” and “autism” have features of “forecasting” while also “shrouding” the diagnostic terms (Maynard 2003) by encapsulating them in a tendency story rather than a typification (which we will see used in our next case). That is, he hedges on the application of the diagnosis to Ronnie. By their stoicism and minimalism, the parents resist the diagnosis, and they continue to do so as Bill goes on to mention “other parents” in the Martins' situation (extract 1d, lines

22–23) having “ideas of things that work” in terms of advocacy (lines 25–26, 28) and ways of dealing with family members (“grandma,” lines 31, 33). This generates a small smile from Mrs. M (line 34).

However, Mr. M takes a practical stance, neither showing acceptance nor agreement with the diagnosis as such but only with the advice about working “it” into household maintenance (lines 35–36, 38)—thereby sidestepping the diagnostic news, however tacitly it has been conveyed. Mrs. M, showing a more emotional reaction, takes a tissue and blows her nose (lines 40, 42). At lines 41 and 43, Bill aligns to Mr. M's response and again offers a kind of palliative as a way of exiting from the news, proposing their experience to be like that of other parents. In subsequent talk (not included here), Bill addresses Mr. M's concerns with income and costs by proposing that with the diagnosis, state funding for treatment may be available. Further discussion concerns schooling for Ronnie, and the interview is brought to a close.

AUTISM IN 2014: SARA

We now move forward in time, from 1985 to 2014. In the *DSM-5* (APA 2013), autism is conceptualized as a linear spectrum disorder, with symptoms varying in frequency and intensity, rather than as a family of discrete “pervasive developmental disorders.” Other disorders on the spectrum, including Asperger’s, have been collapsed into this single autism continuum. Also different in the contemporary era is that autism “increasingly appears in the everyday life of American families” (Liu, King, and Bearman 2010:1390), such that “a person with autism is no longer an oddity” (Grinker 2007:14). Further, because of the resources that are known to accrue for a family, parents are more likely to expect and even seek out a diagnosis of autism (Liu et al. 2010). At the same time, such changes operate within the interaction order of the clinic and the narrative way that clinicians decide on and present a diagnosis to parents.

We investigate these matters using the case of “Sara Brenan” as representative. The case is also instructive because her autism spectrum disorder (ASD) diagnosis was very tentative and thereby shows how, using the current diagnostic tools by way of instantiation, tendency, and typifying components, clinicians can resolve any impasse over diagnosis. Further, when we examine the staffing, we will see how the parents participate in both similar and subtly different ways than in 1985. After exploring the Brenan case, we shall be able to generalize about the relations among the various story types as part of overall diagnostic narratives.

Sara Brenan was three years old when her family doctor requested an evaluation for “developmental delay and concern for social interaction.” Previously, Sara had been found to have language and gross motor delays and had received remedial

services through a “birth-to-three” intervention program. When the family was seen at CDDC in 2014, the team that evaluated Sara consisted mainly of a developmental pediatrician, who interviewed the parents, and a psychologist, who administered the now “gold standard” for diagnosis, the Autism Diagnostic Observation Schedule, or ADOS (Lord et al. 2012). A speech and language clinician observed the ADOS to assess Sara’s language difficulties but, due to scheduling conflicts, did not perform a separate interview. We focus on pre-staffing talks between the developmental pediatrician, Leah Grant, and the psychologist, Ruth McCain.

Sara’s visit begins with Leah interviewing the parents and examining Sara. Subsequently, in a brief meeting, Leah informally reports a number of findings to Ruth. Although Leah says, “You know I think what I’m hearing is a lot of red flags,” indicating the possibility of ASD, she proposes that Ruth would be able “to get more of that information when you do the ADOS,” thus deferring a firm stance on the diagnosis until the testing could be done.

Accordingly, the next step in Sara’s evaluation involves Ruth’s administration of the ADOS. Immediately afterward, Ruth meets again with Leah. Ruth still has not had a chance to score the ADOS, so the discussions center on more informal observations made in the context of administering the test. Ruth pages through her ADOS test booklet, consulting her notes. As she narrates her observations to Leah through different story types, diagnostic ambivalence is evinced by her use of *contrastive* elements (cf. Goldknopf 2002:74–77). A pattern is that Ruth produces positive assessments, then a contrast term (*but*), followed with a negative assessment that, by naming a behavior or assessment associated with ASD, diminishes the positive assessment and potentially aligns to an ASD diagnosis.

I can just tell you quick that she had some nice strengths still [typifying], but she was pretty rigid in her play [tendency].

So with the balloon play especially, she did a really nice requesting with gestures [typifying], but it wasn't really with eye contact, and she would look right at the balloon instead of at me [tendency].

The way that we code with this, she has a lot of the skills that you would see [tendency]; they're just not great [typifying component].

In sequential terms, moreover, this contrastive device positions the final, downgrading phrase as strongly "implicative" for further discourse (Schegloff and Sacks 1973:296), enabling interactional progressivity toward diagnosis. A coherent narrative in Sara's case comes together in the front stage when Leah and Ruth meet with the family—mother, father, Sara, and her younger sister—during the staffing interview.

The Staffing: "Rigidity and Repetitiveness"

While the clinicians' talk evinces structural similarities to that from 1985, particularly with respect to how narrative is used to gradually build an evidentiary basis for diagnosis, there are also contextual differences. These include the parents' reaction to the diagnosis—a mix of distress and relief, in contrast to the strongly resistive reactions seen in 1985—and the knowledge of autism the parents, particularly the mother, can mobilize in making sense of the diagnosis.

As the staffing begins, Leah turns the floor over to Ruth, who recalls the reasons the family visited the clinic—including the possibility of ASD—and explains the "play-based assessment" (i.e., the ADOS) that she did with Sara. Ruth starts on an optimistic note, producing a preface

about Sara's "strengths" and introducing brief tendency stories (e.g., doing "a lot of gesturing" and not having "unusual . . . sensory interests, spinning and things")—evaluations that derive from the *DSM-5* criteria for ASD, which are calibrated with the ADOS.

Having produced positive assessments, Ruth describes troublesome aspects of the clinical picture, following the familiar pattern of marking her delivery with the contrast term ("But," extract 2a, line 1).

She also emphasizes the auxiliary verb ("did") in a way that can be suggesting a contrast between the previous positive assessments and the forthcoming "concerning" issues (Raymond 2017). She may also be asserting her epistemic rights as a consulting psychologist to notice troublesome behaviors (cf. Stivers 2005). This utterance at lines 1–2 works as a story preface, and Ruth goes on to produce a tendency story depicting a habitual or recurrent behavior (lines 2–3).

Ruth's "over and over and over" utterance (line 2) has a performative, mimetic quality: it enacts the very sort of repetitiveness it describes. In lines 3 through 5, she initially projects instantiation ("for example") but proceeds with a further tendency story, recounting how Sara "did a . . . nice job" giving her a (toy) phone to talk on (line 4) while Sara had a different phone (Ruth points to a phone in the room, to which "that phone" at lines 4–5 refers). With the modal "would" (Edwards 2006), Ruth is suggesting a tendency in Sara's initiations that she next assesses as not "really . . . typical" (line 6) and depicting her resulting difficulty with knowing how to start playing (lines 6–7). Mr. B acknowledges this (line 8), and the clinician continues to suggest, contrastively, that even when she and the child managed to play successfully (lines 10–12), the theme was "very repetitive" (line 12). Ruth concludes the story with an upshot ("So it was always about

(2a) Case 34:p1:35

1 Ruth: But what I did see that's concerning is (.) a lot of repetition in
 2 her plays? of the same theme over and over and over?, she's gonna get
 3 stuck on? .hh and um: (.) so: for example we were playing with- she
 4 did a really nice job of getting me a phone? an:d then she: had that
 5 phone and she would (.) to initiate (.) that interaction wasn't
 6 really a typical way of inter- I didn't always know that I was
 7 supposed to start playing with her?=
 8 Mr. B: =Uh huh.
 9 (.)
 10 Ruth: Uh but through some gesturing and her being persistent, I could
 11 figure out that she wanted me (.) to: (.) start (.) uh playing with
 12 her. But the theme was very repetitive. So it was always about a
 13 bunny and her saying help .hh and it never went uhm (.) anywhere
 14 else?

a bunny . . .”, lines 12–13). The frequency adverbials *always* and *never* also work as “extreme case formulations,” which, among other things, can tacitly establish the “wrongness” of a practice (Pomerantz 1986:229).

After Ruth completes her story about Sara's play, she produces another tendency story (not shown) about how Sara “got pretty stuck in the birthday party theme”—referring to a portion of the ADOS where the child is encouraged to have an imaginary birthday party for a toy baby. She says that when Sara did include her in play, there “was rigidity,” and it was “all on her terms.” At this point, Mr. B responds with a “Yeah,” Mrs. B nods, and Ruth proceeds to tell an instantiation story. The story anecdotally builds on its predecessors in making the case that Sara's play, in addition to being repetitive, is also rigid. The story is about how Sara initiated a pretend picnic by putting out a blanket (intended for use with a baby doll) on the floor. Although she assesses the picnic play positively, calling it “nice” and “creative,” Ruth describes how, as the game progressed, she felt increasingly excluded. She enlivens the story by quoting the child's speech, using a tendency story to the effect that Sara “does a lot of the direction” and “she doesn't take

a lot of direction.” With head nods, both parents align to this suggestion, after which Ruth produces a tendency story as an upshot, “So she has some rigidity in her play and also some repetitive play.”

From here, Ruth proceeds to establish Sara's lack of interest in social communication. She starts with a prefacing claim: “She's also not really interested in conversation,” produces tendency stories in support of this claim, and concludes with an upshot, “She just doesn't understand the back and forth nature of conversation,” followed by a further (brief) tendency story as a second upshot, “A lot of times it's difficult to know . . . who she's talking to.”

Delivering the Diagnosis: “She Did Meet the Cutoff . . .”

Having established Sara's symptoms on two key diagnostic dimensions of autism, repetitive behavior and social communication, Ruth delivers the diagnosis. In extract 2b, her so-prefaced turn at line 1 proposes a typifying upshot to preceding talk. Then, after a 1.6-second pause (line 1), she goes on to pronounce the diagnosis (lines 2–3); following this pronouncement and another brief pause (line 2), she appends an evidential reference (cf.

Maynard 2004; Peräkylä 1998), citing her “assessment today” (line 3). In suggesting a tendency by indexing the ADOS measurement (i.e., Sara “did meet the cutoff,” lines 1–2), Ruth’s delivery is euphemistic as it delays the typifying diagnostic upshot, “for an autism spectrum disorder” (line 2). Nevertheless, Ruth’s approach differs starkly from that used in the 1985 informing interview, when Bill initially referred to “this kind of handicapping condition” and “the autistic society” rather than Ronnie as such. At line 5, Mr. B appears to display understanding, if not acceptance, while at line 6, Mrs. B asks, “So what does that mean” (cf. Maynard 2006).

In response (lines 8–9), Ruth renders the diagnosis more explicit—she “predicates the diagnosis as an attribute” of Sara (Maynard 2004). This is in contrast to how in case 1 the psychologist and case coordinator, Bill, was more hedging with whether or how autism and a pervasive developmental disorder characterized Ronnie. Here, Mrs. B immediately puts

her hands over the lower part of her face (line 10) and produces muffled sobbing sounds (Hepburn 2004), as Mr. B again nods (line 12). The display on Mrs. B’s part is a classic example of an “empathic opportunity” (Suchman et al. 1997), and Ruth follows with an “empathic receipt” (line 13) insofar as it proposes an understanding of her co-participant’s mental state (Hepburn and Potter 2007:104; Heritage 2011; Ruusuvuori 2005) and, with its “I know” preface, does so in a strong epistemic way (Heritage 2013). Again, by contrast, Bill displayed a distanced response to the emotional display of Ronnie’s parents, although this possibly also reflected their resistive postures.

A further comparison with the informing interview from 1985 is that here, the parents’ reaction is less resistive. For one thing, Mr. B nods in what is ordinarily an affirmative, aligning gesture (Stivers 2008), and at the very least can be seen to acknowledge the diagnostic news. And despite clearly being upset,

(2b) Case 34:p3:108

- 1 Ruth: So ↑having said all (of) that (1.6) She di:d (.) she did meet the
 2 ↓cutoff fo:r an autism spectrum disorder (0.4) in terms of (0.8) .h
 3 what I saw in the: uh (.) in the assessment today.
 4 (0.2)
 5 Mr. B: [((Head nodding))]
 6 Mrs. B: [So what does that mean.]
 7 (0.2)
 8 Ruth: It ↑means ↓tha:t we ca:n go ahead and give her a diagnosis (.) of
 9 aut[ism].
 10 Mrs. B: [((Looks down; puts hands over lower face and cries))
 11 [(2.4)
 12 Mr. B: [((Head nodding))
 13 Ruth: I n- I know that’s really a difficult thing to hear.
 14 (1.8)
 15 Mrs. B: It just- ((muffled; crying voice)) In a way it’s a relief but at the
 16 same time it’s not. .h ((removes hands from face))
 17 Ruth: Yeah ((nodding))
 18 Dr. G: Mm hmm ((nodding))
 19 (1.0)
 20 Ruth: Uh::m:
 21 Dr. G: ((Standing and offering tissue box to Mrs. B)) Would you like a
 22 tissue
 23 Mrs. B: °Yes:° ((Takes tissue; sniffles))

Mrs. B quickly follows Ruth's display of empathy with a measured expression of relief (lines 15–16).

A Provisional Diagnosis and Tendency Story by Sara's Mother

The topic of differences between autism diagnoses in 1985 and 2014 cannot be fully considered here (see a companion paper: Maynard and Turowetz 2017). However, given the importance of reciprocity to narrative structure, one comparative facet of our two cases is important to explore. After delivering Sara's diagnosis, Leah exits the delivery in a prototypical way, with various "good news exits" (Maynard 2003). First, she qualifies the diagnosis, saying, "because she's so young and because she has so many strengths," they are "gonna call it a provisional diagnosis," and recommends that Sara be reassessed when she enters kindergarten. Leah also notes that Sara is a "really bright little girl, . . . and happy . . . and . . . all these really nice strengths." Then, Leah returns to "supports" for Sara and articulates a "hope" that they will help her be "successful," regardless of the "ultimate diagnosis" (not on transcript).

Following this, we can observe, in summary fashion, a distinct, inferentially era-specific and relatively sanguine stance on the mother's part. After Leah's assurances, Mrs. B starts a story that draws on her personal experience with a "gentleman" who visits her at work (in extract 2c).

In telling this story, Mrs. B demonstrates firsthand knowledge of autism. Just after she reaches the climax of the story ("I think he's autistic," lines 6–7), Leah, who has been nodding and smiling throughout the story but had ceased nodding, produces a bigger smile and more dramatic series of nods (not on transcript). Ruth also smiles, then nods her head (also not on transcript). Thus, both clinicians show agreement with Mrs. B's assessment in ways that are also strongly affiliative (Stivers 2008). At line 10, following Leah's overlapping acknowledgment (line 9), Mrs. B asserts understanding of the syndrome, although she qualifies that assertion with "kinda" and "a little bit." Subsequently (not on transcript), Mrs. B offers a positive characterization of the "gentleman's" parents (they "have done well with him") and says, "I can see that there're gonna be challenges, but she [Sara] is happy so . . ." This statement affirms from her own stance the optimistic outlook the clinicians have been offering.

Historical Context: Changing Attitudes toward Autism

Although a more sanguine outlook is inferentially era-specific, we are confident about it representing a pattern for several reasons. First, as recently as the 1970s, autism was not a separate category in the *Diagnostic and Statistical Manual* but rather a feature of childhood psychosis. If our data from that era are representative, parents could and would *refuse* such

(2c) Case 34:p4:191

1 Mrs. B: I: have a: gentleman that- he's probably in his forties he lives down
2 the street from my work 'n stuff, and everyday he talks to me, and
3 it's just like one-sided conversation him talking just for: .hh split
4 like three minutes and then he walks out and everybody's like (0.2)
5 .h I don't understand, and like, my coworker's like I don't
6 understand and we're:- other customers. I was like, I ↑think he's
7 au:tistic. Y'know like- it's just- we're part of his routine so he's
8 like coming in to say [hi to] me.=
9 Leah: [Uh huh]
10 Mrs. B: =And it's- Yeah. So I kinda understand a little bit.

a diagnosis, withdrawing from the clinic and getting another, less stigmatizing opinion (Maynard and Turowetz 2017). In the 1980s, when autism *was* listed in the *DSM*, it was still unfamiliar, and (as the Ronnie Martin case indicates) parents were resistive but not refusing, as they indicated that it could be beneficial for obtaining services. In the current period, parents are accustomed to the term (Grinker 2007; Liu et al. 2010); indeed, when there was a contraction of the spectrum associated with the development of *DSM-5* in 2012, many engaged in what Barker and Galardi (2015:129) call “diagnostic domain defense.” Because the diagnosis confirmed their own sense of things and rendered difficulties with their children meaningful, parents argued for keeping the diagnostic criteria as they were. In short, both the familiarity and acceptability of the diagnosis has increased over time. Another reason for inferring an era-specific, optimistic reaction is that it is found in other cases of autism from our current data but not in those from our earlier (1970s or 1980s) data.

STORY TYPES AND DISTRIBUTIONS

Rather than following previous research that has either examined social and political structures surrounding diagnosis or focused on the delivery and reception of diagnostic news, we have examined how clinicians arrive at a diagnosis, showing that the process is a narrative and collaborative one in which diagnostic stances become progressively realized through telling stories about and assessing test performances. As clinicians build a narrative case that can rule a diagnosis in or out, these stories are evidentiary or probative for the particular case. Furthermore, story types play distinct roles in the building of a narrative. For example, there is progressive abstraction as clinicians go from instantiation to tendency to typifying components and upshots

of an overall narrative. Thus, in the deliberations over Ronnie, clinicians discussed a concrete instance of literalism, adduced tendencies in this regard by reporting other such observations, and typified Ronnie as literalistic and imitative rather than creative in play—all features that fit with an autism diagnosis. A similar pattern is evident in the discussions about Sara, whose diagnosis was less clear-cut but in which there was movement from acknowledging strengths to a contrastive instantiation story about a pretend picnic that excluded Ruth, the psychologist, from entering in; then, to citing tendencies toward control (directing others but not taking directions); and, finally, to typifying her as rigid and repetitive in her play. Although storytelling about children can support *either* the category of ASD or that of a typically developing child—where ASD is ruled out (Turowetz and Maynard 2016)—in this case, Sara’s narrated characteristics support an autism diagnosis.

A feature of the increasing abstraction that marks clinicians’ ASD narratives is that as we count story types in the two cases involving Ronnie Martin and Sara Brenan—and indeed in our larger corpus of data—the large majority of stories that clinicians use during both pre-staffing conferences and staffing interviews are ones that embody tendencies of a given child. Instantiation stories, and the particularity and concreteness of conduct that they convey, are very few. In the two cases we have examined, which are from very different eras and in which the criteria for diagnosing, the number of professionals, and the length of discussions vary, the proportions of stories are remarkably similar and reflective of the wider corpus: about 20 percent are instantiation stories, and 80 percent are tendency stories. Whereas both instantiation and tendency stories provide evidence for typifying components, including diagnostic conclusions themselves, clinicians

mostly rely on generic quantifications of behaviors rather than telling about such behaviors in discrete or particular terms.

In the staffing or informing interview, clinicians again predominantly tell tendency stories, with very few instantiations. Parents also tell more tendency rather than instantiation stories, but the latter are a larger proportion of their contributions to diagnostic narrative. Clinicians produce proportionately more stories (in the range of 75 percent to 90 percent) and typifying components compared with parents overall. Moreover, stories from parents are regularly in second position—that is, they follow a clinician’s report, usually in an aligning way. In our 1985 case, for example, Bill, the psychologist, told about the difficulties Ronnie had matching pictured items based on their being fruits: “So he doesn’t put the pear with the apple, he puts the yellow pear with something else that’s yellow.” Mrs. H aligned to that with an agreeing tendency story, “Well right now, he’s still kinda more on the colors than the basics.” These two stories lent to Bill’s upshot: “He had a hard time on his own knowing when to make sense of the world based on colors and when that’s not the way you think.” These patterns, in which clinicians tell more stories and use them in first rather than responsive positions, reflect an asymmetry in epistemic status (Heritage 2013), wherein parents, having less access to the specialized knowledge that clinicians embody, are recipients rather than deliverers of diagnosis, although being authoritative about behavioral particularities and tendencies in the household.

SOCIAL PSYCHOLOGY AND THE INTERACTION ORDER OF THE CLINIC

Given what we reviewed about the essentially interpretive work of diagnosis in many clinical settings—even those where there may be distinct biological or

neurological markers of disease (Balogh et al. 2015; Feinstein 1973; Hunter 1991)—we suggest that comparative research be done on other disabilities and diseases. These include those relatively mild conditions that are the focus in primary care and would involve moving beyond earlier, important studies of “online commentary” and the delivery of diagnoses (Heath 1992; Peräkylä 1998; Stivers 2007) to analyze the role of narrative and the distribution of story types and components among involved parties in the progression toward ruling a diagnosis in or out. This may permit a better understanding of the *social organization* of abstraction that all diagnosis involves (Maynard and Turowetz 2017), and it implies an important role for sociological social psychology in specifying the mechanisms by which clinicians order and organize the challenging interpretive process that diagnosis of many medical conditions comprises.

Most of the sociological understanding of ASD has been top-down, starting conceptually from the diagnosis and attempting to explain rates, especially for immediately recent decades in which prevalence has climbed dramatically. Indeed, we have learned much from approaches (e.g., Eyal 2013; Eyal et al. 2010; Liu et al. 2010) that show how large-scale institutional changes, evolving networks of expertise, relations among community members, and alterations in definition have affected the quantities and spread of diagnosis.

Complementary to these studies, and recognizing the importance of shared behavioral observations (e.g., Bumiller 2009; Nadesan 2005; Silverman and Herbert 2003; Singh 2012), our approach puts flesh on the bones of Hacking’s (2004:238) call for the discourse of “concrete conversation.” This entails specifying the interactional practices through which clinicians assign diagnoses to persons—or, per Hacking’s (2004) formulation,

elaborating the Goffmanian bases of Foucauldian or other types of abstract discourse analysis. Accordingly, one of our key theoretical contributions is to show precisely *how*, through narrative, individuals are made to embody the historically shifting discourses constitutive of autistic personhood. That is, we have seen the ways in which clinicians, given the contexts in which they operate, actually *do diagnosis* and position themselves in terms of adducing evidence for telling the diagnosis to parents and other recipients. Drawing on ethnomethodology and pragmatism, as Emirbayer and Maynard (2011:256) suggest, means that our study helps to define the social psychology of diagnostic decision making by bringing to life “social life as it is lived in its member-produced practices.” The practices our analysis identifies include the inhabited clinical experience of narrating diagnosis in probative ways. Such practices in turn constitute the largely uncharted terrain of psychiatric diagnoses in the making—as opposed to those that have already been determined and need only be delivered to recipients.

As a methodological contribution to social psychology, we suggest that close analysis of recorded, spoken discourse from different eras can aid in connecting history to the social and institutional organization of diagnostic interaction. As we earlier noted, narrative structures are like turn-taking in conversation insofar as they are both “context-free” and “context-sensitive” (Sacks et al. 1974:699; cf. Stivers et al. 2009). Along these lines, where most CA research has stressed the context-“free” part of this relationship, a further contribution of our study is to address the balance between context transcendence and adaptation by specifying the circumstances—including changing “professional stocks of interactional knowledge” (Peräkylä and Vehviläinen 2003) as embodied in diagnostic manuals and clinical “gazes”

(Singh 2012)—to which, in our case, the practices of narrative in diagnosis are “sensitive.” As clinicians work to do diagnosis, they adapt narrative practices to individual children, their families, and their social environments and experiences, thereby reconciling generic diagnostic criteria and the specifics of history and biography.

SUPPLEMENTAL MATERIAL

Supplemental material can be found with the online version of the paper.

FUNDING

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was made possible by a grant from the National Science Foundation (#1257065) and the National Institutes of Health (#17803). We are also grateful for support from the Waisman Center at the University of Wisconsin and its University Center for Excellence in Developmental Disabilities grant (NICHD #P30 HD03352).

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