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THERAPEUTIC MISCONCEPTIONS

When the Voices of Caring and Research Are Miscontrued as the Voice of Curing

Michael Bamberg and Nancy Budwig
Clark University

Research on doctor-patient communication has characterized such interactions as being asymmetrical. The present article tries to shift emphasis away from the different orientations individuals bring to the communicative setting and attempts to highlight the different orientations (“voices”) within a given individual. We draw on an in-depth analysis of discourse between a 21-year-old man who can be ascribed the roles of both patient and potential research subject, and an interviewer who acts in both the role of medical staff and researcher. Focusing our analysis on a limited number of linguistic forms (pronouns and demonstratives), it is argued that the use of the same form for different referents signals a conflation of two voices—the voice of health care (“caring”) and the voice of “research.” Furthermore, we argue that the voice of research is most likely to be interpreted by the patient/

research subject within the framework of curing. As such, the present article promotes a shift in emphasis from different institutional—and as such often assumed to be preexisting—orientations between the communicating parties to differing orientations within the individual that cannot help but be misconstrued in terms of the curing voice. Our conclusion focuses on the ethical and discourse analytic implications of analyzing voices in a discussion.

VOICES AS VALUE ORIENTATIONS IN COMMUNICATIVE CONTEXTS

Employing the terminology of voice or voices, we emphasize that each communicative act is governed by a value orientation. Although it is possible to describe and analyze human actions as narratives (cf. Packer, 1991), traditionally the analysis of voices has taken the language use of particular groups or individuals as displaying an underlying value orientation. For instance, investigations of the moral domain have distinguished two voices demarcating the moral orientation of justice from that of care (cf. Gilligan, 1982, 1987, 1988), and investigations of the health and medical world have differentiated between the voice of the lifeworld and the voice of medicine (Mishler, 1984; Mishler, Clark, Ingelfinger, & Simon, 1989). Taken as prototypes, these voices strive after purification and perfection, and they mutually exclude each other. In most real-life interactions, however, they are not absolutes (i.e., each voice carries residues of the contrasting voice).

In a different article (Bamberg, 1991c), we tried to differentiate between two different value orientations in physicians—the voice of “caring” and the voice of “curing.” Although the voice of caring is somewhat reminiscent of Gilligan’s voice of caring (Gilligan, 1982, 1987, 1988), as well as Mishler’s voice of the lifeworld, its most encompassing component is a view of the individual as functioning within his or her context of personal relationships. Within this perspective, the role of the individual in his or her family and other social relationships becomes relevant in regards to the evaluation of lifestyle habits and the roles of prevention. In contrast, the voice of curing emphasizes the illness and disease aspects of the body. Within this orientation, it is more likely to decontextualize aspects of the individual’s functioning, reduce them to their physical or psychological components, and along this line to deal with them rationally and scientifically. As a consequence, aspects of the institutional and technical context become highlighted. Thus, the voice of curing is one that focuses on the disease and considers rationally and scientifically what steps are optimal in a rather well-defined curing process.

AU: Suggest dropping the cf., if they are simply citations.

Rather than characterizing the voices of curing and caring as clashing in dialogue between some prototypical exemplars of physicians or nurses, and at the same time avoiding the pitfalls of denying the legitimate existence of the voice of curing, we tried to document in two separate studies how the voice of caring and the voice of curing interplay within an individual, resulting in hesitations, ambiguities, and even in straightforward self-contradictions (cf. Bamberg, 1991c; Budwig, 1991). At the center of this line of argument was the recognition that conversational sequences are not to be viewed as following a unidimensional current or an overarching communicative goal that is assumed to preexist in the mind of the speaker, only waiting to be executed in discourse. Rather, communicative actions in real-life situations are probably best understood as expressions of multivoiced individuals (cf. also Bamberg, 1991a).

The case study presented in this article is an offspring from this original point, inasmuch as we are able to document in a similar vein how different communicative orientations come to bear on the actual dialogue between a person who is a representative of a medical staff as well as a member of a research team trying to recruit a patient for a research project on the effectiveness of the medical treatment the patient experiences. The institutional context in which this dialogue is embedded is that of an informed consent negotiation (i.e., the conversation follows to some degree a ritualized format that is imposed by general expectations, the way they are laid out and codified in Constitutional amendments, specific U.S. laws, and a number of previous cases).

INSTITUTIONALIZED CONTEXT OF INFORMED CONSENT AND ITS GROUNDING IN THE CONDUIT METAPHOR

The phrase *informed consent* is used to refer to the ethical principle of respect for persons and is articulated most effectively in the often-quoted passage by Justice Benjamin Cardozo: “The root premise is the concept, fundamental in American jurisprudence, that every human being of adult years and sound mind has a right to determine what shall be done with his own body” (*Schloendorff v. Society of New York Hospital*, 1914). The Nuremberg Code (see “Permissible Medical Experiments”) from the year 1949 explicitly states as its first principle:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to en-

able him to make an understanding, and enlightened decision. (Levine, 1981, Appendix 3, pp. 285–286)

Thus, informed consent as an ethical principle can be viewed as following three different subprinciples: (a) that the decision to partake in medical or experimental treatment is voluntary, (b) that the patient/subject has sufficient information in a comprehensible format, and (c) that the patient/subject has the decision-making capacity to make an informed decision (cf. also the President's Commission, 1982, Vol. 3; also see World Medical Association Declaration of Helsinki, cited in Levine, 1981).

In February 1966, Surgeon General William Stewart established in the U.S. Public Health Service's Directives on Human Experimentation that the ethical conduct of research involving human subjects was to be regulated more firmly by public agencies (see the "Basic Health and Human Services Policy for Protection of Human Research Subjects" reprinted in Levine, 1981, Appendix 1, pp. 259–268). The legal grounding for informed consent is basically a result of the outcome of litigations and disputes that arose in the context of medical practice. Over the years, courts and legislators have developed two standards to determine whether a decision is actually informed. The predominant standard is "the community of professionals standard" that requires disclosure of information that the committee of health providers would disclose under similar circumstances. The "reasonable person standard" tries to put forth a patient-centered standard, requiring the disclosure of information that reasonable patients in similar contexts would like to know in order to make a sound decision. U.S. research regulations were originally designed to be responsive to the reasonable person's standard. To assist decisions regarding the elements of disclosure, courts and legislatures have spelled out what kinds of information should be disclosed. This information includes aspects such as the content of the procedures, potential risks, possible alternatives to the procedures, and anticipated benefits of the procedures. Although the doctrine of informed consent can by no means lay out specific ways in which information is to be presented, it nevertheless stresses that the disclosure of the information in and of itself is not sufficient. In addition, the process of providing the information has to follow procedures that enable the patient or the research subject to attend to the information, to understand, to accept and remember it, and to be able to reason with it (cf. also the President's Commission, 1982, Vol. 1, p. 71).

Consent is usually given in the form of signing a consent form. However, the fact that a document bears the patient's or research subject's signature is in no way binding if the information the patient received was not sufficient for making an informed choice or if the information was not properly understood. In general, a signed consent form is different from a

commercial contract. As pointed out by Levine (1981, p. 98), the consent form is more like a judiciary, which serves “as an instrument designed to guide the negotiations with the prospective subject.”

Research on the complex issue of ascertaining patients’ or research subjects’ understanding of information has focused on a number of different problems. Silva and Sorrell (1984) analyzed the factors that influence the comprehension of information for informed consent: nature of information (amount, clarity, and complexity), method of presentation, demographic factors (e.g., age, occupation, gender, and education/vocabulary levels), and personal factors (e.g., subjects’ health, patterns of recall, and attitudes toward the informed consent process). Wu and Pearlman (1988) measured information transfer according to four categories of information (rationale of the procedures, the benefits, the risks, and the possible alternatives) and compared their measurement with post hoc interviews of patients and physicians. The President’s Commission report concludes:

Research has identified a number of influences on the success of the communication process and the nature of the message received. These include the particular words used, the structure and the framing of the information, the timing of the disclosure, and the setting in which the discussion takes place. (President’s Commission, 1982, Vol. 1, pp. 89–99)

In spite of the critical orientation that most of the research on informed consent communication as well as the President’s Commission report adopts, there is a central shortcoming in this work regarding the function of informed consent communication. This central shortcoming lies in the reduction of communication to serve the function to convey and transfer information (cf. Budwig, 1991). Unfortunately, this view is being nourished by a number of widely shared folk models (e.g., the conduit metaphor; cf. Bamberg & Lindenberger, 1984, and Reddy, 1979, for a critique of the conduit model) as well as scientific models in linguistics and cognitive psychology. According to these models, language is the means by which thought is transported from the “sending container” to the “receiving container.” To uphold this transportation process, language is viewed as a sign system that refers to items in the world the sending container has picked out to be labeled. This article challenges this basic framework within which the notion of informed consent is situated. To be more specific, we argue that the conduit notion cannot handle particular kinds of understandings or misunderstandings that are grounded in what we like to call “quantity of communication.” In contrast, as long as our understanding of informed consent is guided by the conduit model, and as long as we reduce language to its referential properties only, we end up with an insufficient understanding of informed consent—an understanding that is bound to quantify the factors that lead to understanding or misunderstanding in the search for

AU: No reference for Reddy. Perhaps is it the M.J. 1979 listing, which is missing a last name.

specific reasons rather than to assessments of participants' frameworks that do not mesh in communications between experts and novices.

INVESTIGATION

Data

In our analysis, we used a videotaped interaction between a 21-year-old depressed man and the research coordinator taking place within the medical facility of a large West Coast city in the United States. The research was designed to determine whether the treatment factor (i.e., the therapy program offered within this facility) has any effect on the patients' well-being. The targeted candidate (research subject) for the research project (we named him Jacques) is an outpatient undergoing the treatment program due to his symptoms of depression. Thus, the procedure to obtain the consent of the patient to participate in the study concerns his agreement to undergo additional pretreatment and posttreatment interviews and to allow for the videotaping (and analysis) of the therapy sessions (also called "role play" or "role play sessions"). To obtain the patient's consent, the research coordinator (we named him Peter) has to go over the sequence and function of the normal treatment procedure and also needs to spell out how participating in this research project will subject Jacques to additional procedures. Furthermore, it is the obligation of the researcher to inform the patient/research subject about the overarching goals of the research project (i.e., as to why it is necessary for subjects to participate in the particular research procedures and to inform him or her about aspects of privacy, confidentiality, and the right to withdraw consent at any time during or after the research has been concluded).

Method of Analysis

Although previous investigations of the expression of value orientations have paid particular attention to the lexical devices chosen, we focus solely on the use of pronouns and demonstratives, especially the use of *it*, *this*, *that*, *we*, *you*, and *I*. Obviously, these forms refer to aspects of the situational context (i.e., items that are specified elsewhere and therefore are open to interpretation and miscommunication). We picked the personal pronouns *I*, *you*, and *we*, because their use indicates the alliances of speaker and hearer as researcher and research subject in the one role system and as a member of the health or medical staff and the patient in the other role system. *It*, *this*, and *that* were originally chosen as linguistic forms that potentially

refer to the consent form or the act of signing the consent form, which constituted the overarching goal of the informed consent conversation. In the course of our analyses, however, these forms turned out to be extremely useful indexes for speaker and hearer in terms of signaling devices of what is assumed to be shared between them. Even more so, these forms became very useful when a speaker wanted to set up something he or she considered to be new versus something that had been referred to in previous passages of the discourse (cf. the following for similar ways of analyzing discourse: Bamberg, 1987, 1990, 1991b; Bamberg, Budwig, & Kaplan, 1991; Bamberg & Damrad-Frye, 1991; Budwig, 1986, 1989, 1990a, 1990b). Thus, not only with regard to the distinction between new versus old information, but at the same time in terms of spelling out more clearly where one is within an ongoing conversation and where the conversation might be heading, these highly ambiguous forms function pragmatically as “shifters” (cf. Jakobson, 1957/1971; Silverstein, 1987). That is, in the broadest sense, they contribute to the process of mutual understanding as pragmatic indexes, signaling how the speaker meant to be understood.

Turning to a detailed analysis of one interaction between the researcher and the patient/subject, we emphasize the following three related points:

1. We demonstrate how the use of the shifters *I, we, you, it, this, and that* indexes the topical segmentation of the discourse, resulting in the final outcome of the interaction, namely, obtaining the patient/subject’s consent to participate in the research procedure.
2. In using this method for the analysis of informed consent processes, we aim to contribute to a better determination of the quality of information that is provided in informed consent. (cf. Benson, Roth, Appelbaum, & Lidz, 1988)
3. We also address the phenomenon termed *therapeutic misconception*, which explains how patients/subjects in psychiatric and medical research are led to the understanding (misconception) that there are direct benefits to them from participating in research. (cf. Appelbaum, Roth, & Lidz, 1982)

Analysis

Our analysis starts with the end point (goal) of the interaction, where Peter says:

277: alright—basically that’s what’s in the paper

278: okay

279: what I’d like you to do

- 280: is—is read this over . . .
 284: and then when you're finished reading
 285: and you think you understand
 286: you can just sign on the last page

That in Line 277 of the transcript refers to the whole of the previous conversation (i.e., what Peter and Jacques talked about in the previous 276 lines or clauses). *This* in Line 280 refers (deictically) to the consent form Peter held on his lap during this conversation. *That* and *this* are related insofar as the actual word *this* (i.e., the consent form) forms the basis for the law to which the patient/subject actually consented with his or her signature; *that* (i.e., an elaboration of the actual procedures within the overarching research question with the intent to provide optimal information and supposedly an optimal understanding), although not irrelevant to the law, is basically left up to the researcher's or interviewer's subjective assessment.

It is commonly assumed that the consent form should enlighten the subject sufficiently about the goals of the research as well as of the subject's role in participating in the concrete research procedures. Signing a consent form should, under normal circumstances, imply that the subject understands his or her participation and is aware of potential risks and benefits for self and for others. However, it may be in the best interest of all participants in a research project to have some prior understanding, especially of the larger framework within which the specific procedures operate. Particularly, in that participation in research presupposes trusting the expert researcher, any conversation regarding the informed consent process is to be considered as constitutive of the trust-building framework within which researcher and research participant (i.e., the subject) are supposed to cooperate. Consequently, at least according to our Western folk belief, the acquisition of information leads to better understanding, and understanding appears to be the basis of trust (cf. Patenaude, Rapoport, & Smith, 1986).

To assess the notions of quality of information and how the information may have been understood (including the potential therapeutic misconception), let us follow Peter's course of argumentation, that is, how he got to Lines 277–286 (cf. with earlier argumentation), namely, finally asking Jacques to sign the consent form.

In Lines 17–18, Peter establishes the topic for the subsequent conversation (i.e., the therapy program):

- 17: well—what I wanted to talk to you about
 18: was like I told you earlier today about the therapy program
 19: that we have in this facility

In the subsequent lines, Peter grounds his role as research coordinator within the particular facility (including the therapy program), although he seems to try to hint at the fact that the research project, of which he is coordinator, and the therapy program are not the same. The difference between the two is indexed by the use of *they* in Line 22 and *we* in Lines 25–28 and 36–38; although, from this perspective, the use of *we* in Lines 19, 27, and 37 becomes somewhat blurred (does *we* refer to the research group or to the therapeutic staff?):

- 21: okay—my job is
- 22: really I am what they call research coordinator . . .
- 25: what we are trying to find out is
- 26: we're trying to find out first
- 27: whether or not the medical facility we have here
- 28: is helping people . . .
- 36: and the second part of what we're trying to find out
- 37: is in particular whether or not the therapy program we have
- 38: is helping people.

In Line 51, Peter uses the same form *we*, although this time just referring to Jacques and himself (the deictic plural: you and I). At the same time, the use of *it* in the same line refers to the previous conversation, signaling that some information (and consequently some understanding) has been established between the two of them previously. Thus, the subsequent discourse (up to a point) does no more and no less than to elaborate and, it is hoped, deepen the understanding reached thus far:

- 50: well—let me back up
- 51: and we'll go through it slowly
- 52: and see what we're all about . . .
- 55: what we have
- 56: we have a—a program
- 57: that's called the therapy program

Subsequent discourse (Lines 59–134) elaborates and explains what this therapy program, as part of this particular medical facility, is all about. In going over the different aspects of this program, the researcher points out the possible merits of the program for the participating patients. Without going into a detailed analysis of this part, Peter does not seem to speak in this stretch as the research coordinator but, rather, as someone else would who knows the program well enough. At the same time, the first guess from Line 51, namely, that *it* (in “and we'll go through it slowly”) refers to the therapy program, gets further substantiated from the subsequent stretch of

discourse (Lines 59–134). This interpretation is furthermore confirming that the topic of the overall conversation is really the therapy program (cf. with Lines 17–19), whereas the actual role of Peter as the research coordinator as well as Jacques’s role as participant in the research project (Lines 25–28 and 36–38) become more and more backgrounded.

This discourse orientation changes drastically from Line 143 on. In his discursive orientation, however, Peter introduces this change by making use of Jacques’s former agreement that, in his opinion, this particular medical facility is actually good for him (Lines 29–32, not quoted here):

135: okay

136: so—now—like you said

137: you think

138: this particular medical facility here is helping you . . .

143: another way we can find this out

144: is by looking at you

145: now that you’re beginning at this facility . . .

156: and when you’re finished

157: when you’re ready to be discharged from this facility

158: we just want to look at you again . . .

177: okay—so—now—how do we do this

Peter begins to describe the actual research procedure (i.e., what kind of testing the patient has to undergo as a research participant). Thus, retrospectively, it becomes clear that *we* in Lines 143, 158, and 177 is not referring any longer to Peter and others in their role as staff in the therapy program. Rather, *we* refers to Peter (in his role as research coordinator) and the research team. Within this reading, the topic has shifted with Line 143 from the contents and potential merits of the therapy program to an elaboration of Lines 36–38, namely, “We’re trying to find out . . . whether or not the therapy program . . . is helping people.”

The gist of the information in the stretch of discourse following Line 143 is that there are two parts to the research project. The first part consists of the two interviews at the beginning and at the end of the participation of the therapy program (cf. Lines 143–145 and 156–158); the other part of the research project supposedly consists of the analysis of videotaped group sessions in which the patients engage in role play. Again, for this part of the research, Peter as the research coordinator needs Jacques’s consent to videotape him and to analyze the videotaped interactions with others. Accordingly, Jacques needs to be informed that his participation is voluntary and that the information obtained will be kept confidential.

This second part of the research is introduced in Lines 202–203:

202: the other part of what we're going to do

203: is the role playing—okay

And its importance for the research team is underscored in the following excerpts:

218: it's actually the best way

219: we have

220: of finding out about your interaction skills...

236: and it's important

237: like I said

238: that we get that information...

265: we put it on videotape

266: and we erase it

267: as soon as we're finished...

272: and that's it

273: and I'll put your name on it

274: and no one sees the videotape except myself and my two research assistants

275: okay

276: Jacques: yeah

278: alright—basically that's what's in the paper

It in Line 218 refers to *role play*, whereas *it* in Line 236 points forward to Line 238. *It* in Line 265 refers back to *information*, *it* in Lines 266 and 273 refers back to *videotape*, whereas *it* in Line 272 may refer to either the whole research project or the conversational goal (i.e., to inform Jacques about the procedural aspects of his participation in the research project and to get his consent). In regard to the use of *we* in Lines 238, 265, 266, and 267, it becomes clear with Line 274 that the research team consists of Peter and two research assistants.

Before engaging in a more fine-grained analysis of Lines 240–263, let us pause and summarize how the flow of the conversation is segmented. Having a clearer notion of the topical segmentation, we can more clearly determine the overall orientation of the discourse and how the different parts contribute to this orientation. At the outset of the conversation (see Line 18), Peter establishes the discourse topic (i.e., the therapy program). When he presents this program in more detail (Lines 61–134), he can be understood as part of this program that is designed to help patients. Thus, by creating the discourse topic (i.e., therapy program) and presenting it using the pronoun *we*, Peter speaks the “voice of health care.” In other segments of the discourse, Peter speaks of a different *we*, namely, the “voice of research.” This voice briefly surfaces in Lines 26–28 and 36–38 and then,

later on, becomes the dominant voice starting with Line 143, finally culminating in the research coordinator's encouragement to sign the consent form in Lines 277–288. (Lines 240–263 cannot be integrated into the voice of research, but they are discussed in more detail later.)

The only point at which the two voices are distinguished and somewhat set against each other is when Peter introduces himself: “*They call me the research coordinator.*” However, this crucial point in the conversation, where Peter stages his identity for Jacques and the future course of the conversation, by no means clarifies his role as part of the research team. Rather, his appeal to them, meaning those who gave him the name research coordinator, may also signal that he does not feel happy in this role and that his “real” identity lies somewhere else. Again, the possibility of this interpretation further suggests that Peter would like to be understood as someone who speaks the voice of health care and helping.

In sum, Peter speaks in two different voices: that of the healthcare profession and that of the research team. Both are not differentiated enough for a clear understanding of the two different underlying perspectives. In spite of the fact that nothing really changes from Jacques's viewpoint (e.g., he may have been videotaped anyway, and he most likely will undergo repeated interviews regarding his progress in the program), the fact that a research perspective is added to the healthcare perspective makes it necessary to keep them apart, because they have different origins and they pursue different goals. Both perspectives, and thus both voices through which they are established, operate optimally within a trust-building framework. However, borrowing trust that already has been established within one framework and carrying it over to establish trust for another framework may turn out to be counterproductive, because this generates hopes and illusions the research project ultimately may not be able to meet.

We are not arguing that Peter is picking this undifferentiated perspective as a strategy to improve his chances of getting Jacques's consent to participate in the research project. Actually, we are convinced of the contrary, namely, that this is the last thing on his mind. Rather, and there is some evidence for this line of thought, it is Peter's deeper identification with the voice of the healthcare profession that makes it difficult for him in his presentation of the therapy program to differentiate between the two voices that need to be kept apart in this kind of discourse. In a fine-grained analysis of Lines 240–263, we further develop this particular argument.

In the following part of the conversation (after Peter has clarified why the research team needs the information from the role-playing sessions for assessing the effectiveness of the program but before Peter informs Jacques that the sessions will be videotaped), he slips back into the healthcare profession voice:

- 236: and it's important
 237: like I said
 238: that we get that information
 239: Jacques: okay
 240: because what we do with it then
 241: is we use it to help you in group
 242: okay—like if we find out
 243: umm—you're doing something
 244: like some people have nervous habits
 245: when they talk to people
 246: when they play with their hair
 247: they bounce their knee
 248: or something like that
 249: Jacques: mhm
 250: quite distracting
 251: if you're trying to have a conversation with somebody
 252: sitting there
 253: going like this the whole time
 254: you know
 255: Jacques: right
 256: if we see things like that
 257: we can help you
 258: learn to do something else with your hands
 259: okay
 260: so that you don't have that
 261: Jacques: right
 262: alright
 263: that's the kind of stuff we do with it
 264: like I said
 265: We put it on videotape
 266: and we erase it
 267: as soon as we're finished

It in Lines 240, 241, and 263 refers back to *that information* (Line 238), which later on is specified as videotaped data (Lines 264–267). Because data from videotaped therapy sessions can be reviewed and used effectively for individual treatment, we have no quarrels with the message Peter is trying to convey in this passage. Considering the previous and subsequent context of this passage, however, we wonder whose voice is speaking, that of the researcher or the person conducting the therapy sessions.

Jacques has already agreed to undergo treatment in this particular medical facility. Thus, to hear “we . . . help you in group” (Line 241) must sound encouraging. However, when he hears this from Peter, the research

coordinator, whose goal is to “get that information” (Line 238), to “put it on videotape” (Line 265), and to have Jacques “sign the last page” (of the consent form; Line 286), Jacques is likely to misconceive the treatment of his illness and the research project as being the same thing. One may argue that the research project ultimately will feed back into better therapy programs (or their replacement by better procedures), but Jacques himself will most likely not profit from the insights that come out of the conducted research.

Peter seems to be aware of the potential misconception, and he avoids using *you* as the addressee who potentially benefits from using the more impersonal third-person plural; “some people have nervous habits when they talk to people” (Lines 244–245). In Lines 257–260, however, Peter returns to the use of *you*, supposedly in an effort to become more personal. Again, one may argue that *you* in this passage, especially because it is used interchangeably with the third-person plural, is not addressing Jacques, but rather any patient participating in the therapy program. This is correct, although our point here is that he is the research coordinator and not the therapist. The voice he is speaking in, however, is that of the nurse or the therapist and not that of the researcher.

If *it* in the lines previous to the passage in question, and subsequent to it, were referring to the therapy program, the declared topic of the interaction, we would have no quarrel with Peter’s wording. Because *it*, however, refers to the videotaped data that are of relevance for the research project, treatment and research project become totally undifferentiated, leading Jacques to misconstrue research and treatment as being one and the same. This is a typical case of what is called “therapeutic misconception” (cf. Appelbaum et al., 1982; Appelbaum, Roth, Lidz, Benson, & Winslade, 1987).

CONCLUSIONS

Analyzing Voices in Discourse: Implications for Discourse Analysis

The assumption of different voices in speech is not a new discovery that emerged from the analysis of speech data we chose to present in this article. Rather, it is a theoretical construct that explains certain phenomena. The phenomena explained in the speech sample we analyzed were of a peculiar heterogeneity and vagueness regarding the correspondences between speech forms and what these speech forms symbolize. The fact that something was wrong or at least not clear became obvious to us in our first reading of the transcript. Not knowing at that time what we were up to, we had sensed a tension between two seemingly contrasting communicative

orientations. On the one hand, we realized that the researcher intended to disclose information that was pertinent to the potential research subject's voluntary decision to partake in the research project (as a research subject). In other words, the researcher wanted to enlist an informed subject, who not only gives consent but, at the same time, cooperates meaningfully in the research procedures. On the other hand, however, there were indicators in the researcher's interactions that gave us the impression that the researcher was not clear about the role of the research program; it seemed as if the researcher tried to disassociate and distance himself from the research program. On closer examination of particular linguistic forms, we tried out the construct of two communicative orientations (voices) that interact and as such create the tension that originated in our first encounter with the transcript.

However, the two interacting orientations we were able to differentiate in terms of a voice of caring and a voice of research are not a priori mutually exclusive. Research can be (or should be) a trust-building, cooperative experience between researcher and subject. Within the institutional constraints in which research takes place, however, there is a general conception of research as being a means to the end of publishing and of research subjects as providing a way to quantify and generalize across a given number of exemplars. As long as research subjects cooperate within this framework, they represent good means. The interpersonal relationship between researcher and research subject within this framework presents an interfering contextual variable that usually is not in the interest of an objective research design and therefore—within this framework—should be reduced to a minimum.

It is exactly this institutionalized framework against which young students and professionals of health care institutions often rebel, because, as we believe, this framework is diametrically opposed to the caring orientation that originally led students to choose a career in the healthcare profession. Furthermore, both orientations—the voice of curing and the voice of research—share at their bottom line the same decontextualization of the role of the individual person and as such potentially clash with the voice of caring. The curing orientation reduces the individual person to the object or carrier of illness and disease, whereas the research orientation reduces the individual person to his or her participatory role in the research project as the object.

In our discourse analysis of the use of particular linguistic forms, we have identified and exposed two contrasting orientations within the same speaker. In the interaction piece we chose for analysis, the researcher is torn between two different value orientations—the voice of caring and the voice of research. Although we do not have any independent measures to confirm how the tension between these two voices was actually understood

by the potential research subject, we nevertheless speculate that they could be construed as one voice, namely, as the voice of curing. Two factors support our interpretation. First, the remarks and questions of the potential research subject stood out primarily as indexes of his patient orientation. At no time during the informed consent negotiation did Jacques seem to fully accept the role of the potential research subject and orient the communication toward this goal. Second, the specialty of the situation of doing research in a healthcare setting promotes a tendency to construe research as a component of curing, that is, as part of the institutionalized sequencing of finding out what is wrong (anamnesis) in order to cure (treatment).

Our discourse analytic point of view produced two important achievements. First, this article documents the multivoiced speaker or, in Bakhtin's (1986, p. 78) terms, exemplifies the fact that "we speak in diverse genres without suspecting that they exist." As such, we added to previous assumptions regarding the "social language" of different social groups or strata and to the assumption that individual persons have different social languages "within a given social system at a given time" (Holquist & Emerson, 1981, p. 430). It is also important to note that different cultural and institutional contexts may be expressed in the same situation by the same speaker. In other words, individual persons have more than one value orientation, which at times is difficult to integrate into an overarching system. Moreover, these different value orientations can be analyzed and exposed by discourse analytic means.

The second achievement of this article is a more general orientation away from the imposition of unidimensional goals onto human motivations in interactions and toward an analysis of different value orientations in interaction. Thus, we propose to give up the 1 Person = 1 Value equation in favor of a detailed analysis of how values emerge and change in human interactions. Discourse analysis understood along those lines would automatically be understood in terms of a critical analysis of the "ideological formulation, the communicative reproduction, the social and political decision procedures and the institutional management and representation of such issues as inequality, class differences, sexism, racism, power, and dominance" (van Dijk, 1985, p. 7; cf. also Lavandera, 1988).

Analyzing Voices in Discourse: Ethical Implications

It is the ultimate aim of the doctrine of informed consent to protect the autonomy of the citizen. Consequently, the information given should be adequate so that the subject/patient can make an informed choice. Further, the information must be comprehensible for the subject/patient. The expert not only has to avoid unnecessary jargon but, more important, has

to tune his or her language use according to his or her patient's social or ethnic background and to his or her particular mental or folk models that also may affect the patient's conception of treatment options (cf. Budwig, 1991; Cicourel, 1985). Finally, the consent of the subject/patient has to be voluntary. Although it may be difficult to define in concrete situations how adequate the information really was, whether it was really understood, and whether the ultimate choice may have possibly been influenced by the information that was withheld (in contrast to information actually given) or by the way the information was broken down and sequenced, adequate information, sufficient comprehension, and voluntary decision-making are nevertheless the general ethical principles that each physician and experimenter must uphold in informed consent discussions.

If we were to take each of the principles separately and examine the discussion between Peter and Jacques according to whether or not the principles were upheld, Peter would rate very highly. The information given was sufficient, the examples came from the patient's realm of personal experiences, and as such illuminated the points very well. Thus, all in all, the information was comprehensible, and Jacques's final decision to partake in the research project seemed to be a voluntary decision—resulting in what on good grounds could be called informed consent. In light of our analyses, however, we maintain that the informed consent negotiation resulted in a miscommunication, one that is commonly called therapeutic misconception (cf. Appelbaum, Roth, & Lidz, 1982; Appelbaum, Roth, Lidz, Benson, & Winslade, 1987; Benson, Roth, Applebaum, & Lidz, 1988). In addition, we claim that what is misconceived cannot be explained in terms of the actual information that was disclosed. Rather, the misconception takes place on both ends of the negotiation—the nurse/researcher and the patient/subject. Put differently, the misconception emerges in and out of the informed consent discussion. As such, the misconception is not grounded at the level of information disclosure but, rather, at the level of prior conceptions or beliefs about the different roles of research and health care—beliefs that are more deeply seated in conceptualizations about the modern self (cf. Taylor, 1989). Consequently, it is neither Jacques, who misconstrued the message, nor Peter, who coded the message inappropriately, but their understandings of who they are and whose voices they speak with that is at issue.

Rather than stopping at this point, where miscommunications are viewed as accidentally happening and where nobody is to blame, we nevertheless want to discuss two messages that can be learned from our analysis of the interaction. Both remain rather general and, of course, do not extend to the level of actual wordings, although that was the level of our previous analysis.

First, it seems to be most expedient for both parties to become clear about (a) the different goals that are pursued by the treatment of the patient

and (b) the research treatment of the research subject. Only if these different goals are separated can the two roles or personae that go along with these goals be kept apart: The researcher needs to be differentiated from the nurse/health care person, and the patient needs to be differentiated from the research subject. If the two orientations—which we identified as different value orientations—can be separated, healthcare personnel and patient can form one communicative alliance, and researcher and research subject can form another. Without being able to give specific advice about how these differentiations in both parties can be achieved, we nevertheless believe that it may be helpful to reserve a part of the discussion for the topic of both parties' general expectations regarding the different goals of research and treatment. This discussion should most likely take place near the beginning of the interaction and could also be used to initiate the patient/research subject's active involvement in the discussion, which would help in ascertaining his or her basic beliefs and concerns regarding the topic under consideration.

Second, to defuse the situation even more, it may be advisable to have personnel who have no healthcare responsibilities conduct the interview and run the research project. This is at least a possible reading of the Declaration of Helsinki, Principle 1.10, which says:

When obtaining informed consent for the research project the doctor should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is not engaged in the investigation and who is completely independent of the official relationship. (Levine, 1981, p. 288)

However, the introduction of a neutral person, originally designed to play a disambiguating role “in informing subjects of their rights and of the details of protocols, assuring that there is continuing willingness to participate, determining the advisability of continued participation, receiving complaints from subjects, and bringing grievances to the attention of the IRB” (Levine, 1981, p. 92) does not speak to the core of the problem. On the contrary, it overpersonalizes the problem, as suggested by Beecher (1970) and Spiro (1975). If the core of the matter lies with the identification of two different value orientations, then it is the perspective from which the process is directed that matters and not who is directing the process. Consequently, one way of clarifying potential differences in value orientations is a joint discussion of both parties' beliefs and hopes. This discussion should include generally held beliefs about research and being a patient and should move from there to specifics of the research goals in question and the specific assessment and hopes of the patient regarding his or her illness, the research treatment, and potential connections. Having highlighted the fact that these different value orientations can be found

within one person, we believe that a more basic discussion of the values of these issues not just between patient/subject and physician/researcher but for laypeople and experts in general is essential—possibly in the form of a general public education process.

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REFERENCES

- Appelbaum, P. S., Roth, L. H., & Lidz, C. W. (1982). The therapeutic misconception: Informed consent in psychiatric research. *International Journal of Law and Psychiatry*, 5, 319–329.
- Appelbaum, P. S., Roth, L. H., Lidz, C. W., Benson, P. R., & Winslade, W. (1987). False hopes and best data: Consent to research and the therapeutic misconception. *Haslinger Center Report*, 17(2), 20–24.
- Bakhtin, M. M. (1986). *Speech genres and other late essays*. Austin, TX: University of Texas Press.
- Bamberg, M. (1987). *The acquisition of narratives*. Berlin, Germany: Mouton de Gruyter.
- Bamberg, M. (1990). The German perfekt: Form and function of tense alternations. *Studies in Language*, 14, 253–290.
- Bamberg, M. (1991a). Conceptualization via narrative. *Journal of Narrative and Life History*, 1, 155–167.
- Bamberg, M. (1991b). Narrative as perspective taking: The role of emotionals, negations, and voice in the reconstruction of the story realm. *Journal of Cognitive Psychotherapy*, 5, 275–290.
- Bamberg, M. (1991c). Voices of curing and caring: The role of vagueness and ambiguity in informed consent discussions. *Family Systems Medicine*, 9, 329–342.
- Bamberg, M., Budwig, N., & Kaplan, B. (1991). A developmental approach to language acquisition: Two case studies. *First Language*, 11, 121–141.
- Bamberg, M., & Damrad-Frye, R. (1991). On the ability to provide evaluative comments: Further explorations of children's narrative competencies. *Journal of Child Language*, 13, 689–710.

- Bamberg, M., & Lindenberger, U. (1984). Zur Metaphorik des Sprechens. Mit der Metapher zu einer Alltagstheorie der Sprache [Metaphoricity of speaking: Using metaphors to develop an everyday theory of language]. *Sprache und Literatur in Wissenschaft und Unterricht*, 53, 18–33.
- Beecher, H. K. (1970). *Research and the individual: Human studies*. Boston, MA: Little, Brown.
- Benson, P. R., Roth, L. H., Appelbaum, P. S., & Lidz, C. W. (1988). Information disclosure, subject understanding, and informed consent in psychiatric research. *Law and Human Behavior*, 12, 455–475.
- Budwig, N. (1986). *Agentivity and control in early child language*. (Unpublished doctoral dissertation). University of California, Berkeley, CA.
- Budwig, N. (1989). The linguistic marking of agentivity and control in child language. *Journal of Child Language*, 16, 263–284.
- Budwig, N. (1990a). A functional approach to the acquisition of personal pronouns. In G. Conti-Ramsden & C. Snow (Eds.), *Children's language* (Vol. 7, pp. 121–145). Hillsdale, NJ: Erlbaum.
- Budwig, N. (1990b). The linguistic marking of nonprototypical agency: An exploration into children's use of passives. *Linguistics*, 28, 1221–1252.
- Budwig, N. (1991). The conduit metaphor: Language and informed consent. *Family Systems Medicine*, 9, 313–327.
- Cicourel, A. V. (1985). Doctor-patient discourse. In T. A. van Dijk (Ed.), *Handbook of discourse analysis: Vol. 4, Discourse analysis in society* (pp. 193–202). London, England: Academic.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Gilligan, C. (1987). Moral orientation and moral development. In E. F. Kittay & D. T. Meyers (Eds.), *Women and moral theory* (pp. 15–51). Totowa, NJ: Rowman & Littlefield.
- Gilligan, C. (1988). Two moral orientations: Gender differences and similarities. *Merrill-Palmer Quarterly*, 34, 223–237.
- Holquist, M., & Emerson, C. (1981). *The dialogic imagination: Four essays by M. M. Bakhtin* (Glossary, pp. 423–434). Austin, TX: University of Texas Press.
- Jakobson, R. (1971). Shifters, verbal categories, and the Russian verb. In R. Jakobson (Ed.), *Selected writings 2*. The Hague, the Netherlands: Mouton. (Original work published 1957)
- Lavandera, B. R. (1988). The study of language in its socio-cultural context. In F. J. Newmeyer (ECL), *Linguistics: The Cambridge survey: Vol. 4, Language: The socio-cultural context* (pp. 1–13), Cambridge, England: Cambridge University Press.
- Levine, R. J. (1981). *Ethics and regulation of clinical research*. Baltimore, MD: Urban & Schwarzenberg.
- Mishler, E. G. (1984). *The discourse of medicine. Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Mishler, E. G., Clark, J. A., Ingelfinger, J., & Simon, M. P. (1989). The language of attentive patient care: A comparison of two medical interviews. *Journal of General Internal Medicine*, 4, 325–335.

- Packer, M. J. (1991, April). *Human activity and interpretation: Action, text, and narrative*. Paper presented at the biennial meeting of the Society for Research in Child Development, Seattle, WA.
- Patenaude, A. F., Rappoport, J. M., & Smith, B. R. (1986). The physician's influence on informed consent for bone marrow transplantation. *Theoretical Medicine*, 7, 165–179.
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. (1982). *Making health care decisions. The ethical and legal implications of informed consent in the patient-practitioner relationship* (Vols. 1–3). Washington, DC: U.S. Government Printing Office.
- M. J. (1979). The conduit metaphor—A case of frame conflict in our language about language. In A. Ortony (Ed.), *Metaphor and thought* (pp. 284–324). Cambridge, England: Cambridge University Press.
- Schloendorff v. Society of New York Hospital, 211 N.Y. 125 (1914).
- Silva, M. C., & Sorrell, J. M. (1984). Factors influencing comprehension of information for informed consent: Ethical implications for nursing research. *International Journal of Nursing Studies*, 21, 233–240.
- Silverstein, M. (1987). The three faces of “function”: Preliminaries to a psychology of language. In M. Hickmann (Ed.), *Social and functional approaches to language and thought* (pp. 17–38). Orlando, FL: Academic.
- Spiro, H. M. (1975). Constraint and consent: On being a patient and a subject. *New England Journal of Medicine*, 293, 1134–1135.
- Taylor, C. (1989). *Sources of the self. The making of the modern identity*. Cambridge, MA: Harvard University Press.
- Van Dijk, T. A. (1985). Introduction: The role of discourse analysis in society. In T. A. van Dijk (Ed.), *Handbook of discourse analysis: Vol. 4, Discourse analysis in society* (pp. 1–8). London, England: Academic.
- Wu, W. C., & Pearlman, R. A. (1988). Consent in medical decision making: The role of communication. *Journal of General Internal Medicine*, 3, 9–14.

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