Mis-taking turns: Conversing with a patient with schizophrenia

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The *collaborative model* of communication states that conversation is a collaborative process (Clark 1996) where speakers and listeners produce information together, continuously coordinating and collaborating to establish each other's understanding and incrementally co-constructing the evolving content. Smooth turn exchange is achieved through tight coordination of interlocutors' verbal and non-verbal communication (Bavelas et al., 2002). Turn exchange becomes problematic when this tightly coordinated communication deviates from expectations. Under these circumstances, turn exchange processes, and the strategies that people use to overcome them, become more overt.

Patients with a diagnosis of schizophrenia are one of the most socially excluded in society (Addington & Addington, 2008). A central and debilitating feature of schizophrenia, which may contribute to patients' social exclusion, is patients' difficulty interacting with others, including the ability to 'mesh' their turns appropriately (Mueser et al., 1991). Interactions involving patients with a diagnosis of schizophrenia therefore offer an opportunity to observe the strategies that people employ when turn exchange is problematic, and shed light on how 'normal' turn exchanges are managed.

We use data from a corpus of triadic conversations originally collected to investigate only non-verbal behaviour (Lavelle et al., 2013). The corpus contains 20 dialogues involving one patient with a diagnosis of schizophrenia and two healthy controls (unaware of the patient's diagnosis) and 20 dialogues involving three healthy participants. We hypothesise that turn exchange will not be as smooth in dialogues including a patient with schizophrenia. This should be evident both in patients' lack of uptake of the turn when their interacting partners expect it and uncertainty regarding the cues speakers give in indicating that they have finished their turn or in selecting the next speaker (Schegloff et al., 1974).

Results show greater within turn pauses in patients' partners, when they leave space for a turn exchange that the patient does not take up (Howes et al., 2017) as well as greater delay before the patients' partners take the floor (see figure 1). Following McCabe & Lavelle (2012), we identify the increasingly explicit strategies that participants employ in offering the floor to the patient from nonverbal cues to explicit direct questioning. Initially, speakers invite the patient to take their turn through use of gaze and pauses, which the patient may decline by avoiding speaker gaze. Following failed attempts to offer the floor nonverbally to the patient, we see participants employ more explicit strategies such as verbal invitations for the patient to speak (e.g. 'what do you think?'), which are more likely to result in patients' taking their turn, but are rarely seen in the control group dialogues.

This shows how, despite the lack of clarity about who should take the floor in patient interactions, and patients' problematic floor change cues, their interlocutors can nevertheless adapt the strategies they use to manage the coordination of smooth turn exchanges.

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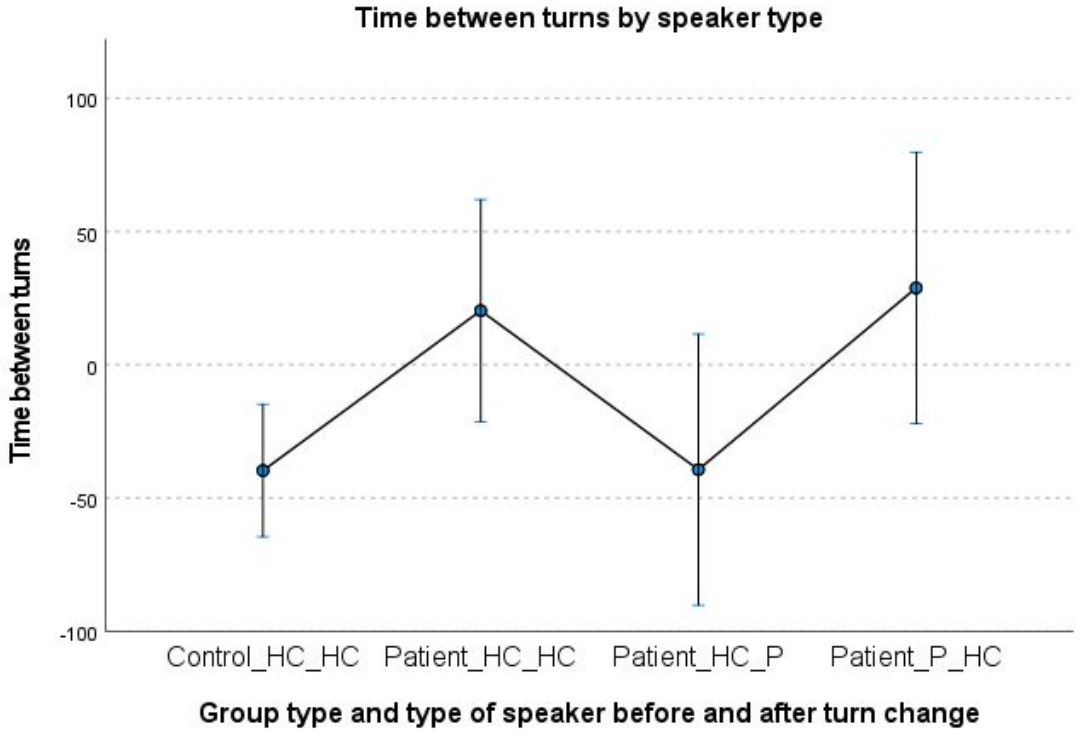

Figure 1: Time between speaker turns in milliseconds by group type and speaker and next speaker type (HC = Healthy Control; P = Patient)