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# APPLYING LINGUISTICS IN ILLNESS AND HEALTHCARE CONTEXTS

*Edited by Zsófia Demjén*

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# Introduction

ZSÓFIA DEMJÉN

## 1 CONTEXT

Most aspects of illness and healthcare are mediated by language (cf. Sarangi, 2012). This is true of experiences of and beliefs about illness, death and healthcare provision, which are talked and written about; it is true of diagnostic tools and processes as well as treatments, which are (at least partly) conducted, negotiated and discussed verbally; it is true of public health communications and medical education, where communication skills are explicitly honed; and it is, of course, true of interactions between various stakeholders in different healthcare settings, whether they are face-to-face, at a distance or online. These are all inherently linguistic in nature. How we talk about things, people, experiences and how we talk to, about and for each other have consequences for our relationships, our sense of self, our understanding of and reasoning about the subject at hand, our success at achieving our goals and indeed for our health (e.g. Dowell, Jones and Snadde, 2002). Yet linguistic analysis, both as a source of evidence and as a varied toolkit for making sense of the complexities of healthcare and the vast amount of verbal data now available, has been conspicuously absent from the mainstream of medical education, communication training and even medical humanities.

The fact that communication plays a crucial role in healthcare contexts is not controversial and hasn't been so for a long time. The 1950s and 1960s saw a growing number of often interdisciplinary studies explore how language and communication might shed light on the doctor–patient relationship, for example (see Collins, Peters and Watt, 2011 for an overview). While most of these studies did not fall within linguistics, there is also a long tradition of linguists working on communication especially in the context of doctor–patient interactions (e.g. Heritage and Stivers, 1999; Roberts et al., 2005). However,

the impact of this more linguistic work on healthcare practice has at times been somewhat limited (Collins, Peters and Watt, 2011; Roberts and Sarangi, 2003). The chapters in this volume address this disconnect by highlighting the practical implications of a range of linguistic methods and tools applied in different illness and healthcare contexts.

Applied linguistics has as its central mission to connect 'knowledge about language to decision-making in the real world' (Simpson, 2011: 1) and, when appropriate, to investigate 'real-world problems in which language is a central issue' (Brumfit, 1995: 27). Its definition as

> an interdisciplinary field of research and practice dealing with practical problems of language and communication that can be identified, analysed or solved by applying available theories, methods and results of Linguistics or by developing new theoretical and methodological frameworks in Linguistics to work on these problems (AILA, 2017)

embodies these aims. And while these objectives are not uncontroversial (cf. Candlin and Sarangi, 2004; Li Wei, 2014; Roberts and Sarangi, 1999; Sarangi, 2005), its focus on language's role in practical issues and decision making makes it ideally suited for the investigation of healthcare contexts where language and communication can, when they work well, improve information-provision, self-esteem, support and even diagnosis and self-management but, when they work badly, can also be a source of confusion, isolation, anxiety, stigma and even misdiagnosis (Semino et al., 2018).

This volume presents research from different approaches in linguistics and demonstrates how linguistic analyses can

- improve understandings of the lived experience of different illnesses (Demjén, Marszalek, Semino and Varese; Kinloch and Jaworska),
- feed into communications training (Stommel and Lamerichs; Chimbwete-Phiri and Schnurr),
- contribute to illness prevention (Chimbwete-Phiri and Schnurr; Tang and Rundblad),
- improve and illuminate diagnostic categories (Semino, Hardie and Zakrzewska; Demjén, Marszalek, Semino and Varese),
- improve understandings of issues with self-management (Brookes; Thurnherr, Rudolf von Rohr and Locher; Atanasova and Koteyko),
- provide insights into problems with public health messaging (Atanasova and Koteyko; Tang and Rundblad),
- increase access to appropriate care (Sikveland and Stokoe; Loew, Mitchell, Weetman, Millington-Sanders and Dale),

- illuminate issues of professional mobility (Zayts and Lazzaro-Salazar) and
- explain the implications of professional terminology (Galasiński and Ziółkowska; Loew, Mitchell, Weetman, Millington-Sanders and Dale; Semino, Hardie and Zakrzewska).

This is applied linguistics at its best. Importantly, all insights are based on authentic data from actual language, interactions and practice, rather than hypothetical scenarios, role play or simulations (cf. Sarangi, 1994).

The collection sets itself apart from other texts on this topic (e.g. de Silva Joyce, 2016; Galasiński, 2013; Gygax and Locher, 2015; Hamilton and Chou, 2014; Harvey and Koteyko, 2013; Pickering, Friginal and Staples, 2017; Locher, 2017; Rudolf von Rohr, 2018; Semino et al., 2018) in its range of linguistic approaches, in its focus on different healthcare contexts and, most importantly, in its emphasis of the practical implications of the current research included in each chapter. A number of chapters are also co-authored by healthcare practitioners, who, along with Tomlinson in the Epilogue, add much needed insights and understandings regarding the settings, pressures, constraints and practical considerations of contemporary healthcare. I completely agree with Tomlinson when he says that for linguistic health research to have the biggest impact, it needs to be grounded in such intimate knowledge of what is already known, what is assumed and what the immediate needs and issues are at a particular point in time. This is the difference between applying theoretical and methodological tools to a real-world setting and focusing on exactly how such a study will be practically relevant to professionals in that setting (Roberts and Sarangi, 2003). Finally, the volume also covers a range of international settings: United Kingdom, Netherlands, Hong Kong, Chile, Malawi and United States.

## 2 APPLYING LINGUISTICS

It is a recurring theme of internet memes that a linguist, upon declaring their discipline, is asked: 'So, how many languages do you speak?' (see also Li Wei, 2014). There is often an assumption that communication is simple, transparent and neutral, if people know how to do it 'properly', and that therefore there isn't anything much beyond additional languages to study. It takes quite some explanation to convince people that there is more to language use than immediately meets the eye (or ear). The analysis that linguists do, particularly those focusing on how language is used in real-world texts and interactions, is designed to get below the surface of what is said by focusing on *how* people choose to put things into words. As Chafe explains,

> …think of linguistic form as if it were located in a pane of glass through which ideas are transmitted from speaker to listener. Under ordinary

> circumstances language users are not conscious of the glass itself, but only the ideas that pass through it. The form of language [seems] transparent, and it takes a special act of will to focus on the glass and not the ideas. Linguists undergo a training that teaches them how to focus on the glass, but fluent users of a language focus their consciousness only on what they are saying. People use language to organise and communicate ideas without being at all conscious of how their language does it. It is undoubtedly this [apparent] transparency of language that makes it so difficult for more people to understand why language should have a science devoted to it. Still, there are many aspects of language a person can learn to be conscious of. Linguists do that professionally, and the experience of becoming conscious of previously unconscious phenomena is one of the principal joys of linguistic work. (1994: 38, my additions in square brackets)

While this explanation somewhat simplifies the communicative process, relying on the so-called conduit model (cf. Reddy, 1979), it nevertheless makes clear that linguistic analysis is very different from simply analysing content or themes (*what* is said). To a linguist, language is never simple or transparent or neutral, and the theoretical, methodological and analytical tools they use surface and deconstruct this complexity. Linguistic analysis relies on systematic, replicable and theoretically based methods of looking at what choices (e.g. in pronouns, metaphors, grammatical form, etc.) are made (consciously or not) in contrast with other choices that could have been made, how such choices pattern systematically, and what the implications might be. In short, linguistic analysis encourages us to think about the seemingly obvious and rediscover it as profound (cf. Skelton, 2002); it exposes 'beliefs and practices that might be taken for granted or overlooked altogether' (Harvey and Koteyko, 2013: 2). As such, it has a particularly important role to play in exploring, understanding and improving what goes on in healthcare contexts (cf. Hunt and Carter, 2011; Sarangi, 2005).

With its range of methodologies, applied linguistics straddles the humanities and (social) sciences and can operate in the paradigms and frameworks of both – in fact, it can often be used to bridge the gap (Crawford, Brown and Harvey, 2014). This is particularly important in illness and healthcare contexts, where intensely subjective, personal, human experiences co-exist, and sometimes collide, with the more abstract, impersonal and scientific world of biomedicine. The emergence of fields such as medical humanities and narrative medicine (e.g. Charon, 2006; Greenhalgh and Hurwitz, 1999) speak to this disconnect, as well as to the recognition that both are essential for improvement and progress (Greenhalgh, 2016). However, even the medical humanities and narrative medicine, while adopted and appreciated by many, have a hard time bringing the human and the biomedical together on a large scale. The chapters in this volume demonstrate that linguistics is a useful partner in this endeavour:

it has robust and reliable tools that allow it to make sense of data on a large, statistically significant, scale (cf. Crawford, Brown and Harvey, 2014), while also treating people as individuals and taking their words and stories seriously. Thus, it provides the conceptual and methodological glue to connect lived experiences, practices and texts with medical science.

### *2.1 Methods and tools*

All chapters in this volume focus on how language is used in particular real-world texts or interactions, to what end and why (always bearing the specifics of the context in mind). This broadly falls within the discourse analytic tradition of applied linguistic analysis. In fact, a number of chapters refer to their approach as a type of discourse analysis. 'Discourse analysis' (DA) in this sense refers to a collection of different tools and techniques to make sense of social life through language (Potter and Wetherell, 1987). The chapters in this volume, for example, explore different types of language data (face-to-face, telephone, email and online conversations, technical definitions, research interviews, media articles, diagnostic tools, open-ended responses to questionnaires), using a range of specific methods:

- General, cognitive or critical discourse analysis: these focus on the content and form of stretches of text (semantics, syntax and function) and look at the social actions that are accomplished (general DA); the relationship with power and ideology (critical DA); the mental representations of information and experience formed or triggered by language (cognitive DA).
- Conversation analysis (CA), micro-analysis of online data: these focus on how the organization of talk (CA) or online or mediated interactions (micro-analysis of online data) help to achieve social goals.
- Interactional sociolinguistics: focuses on the micro details of an interaction as well as contextual background in which the encounter takes place to examine how social goals are achieved.
- Narrative analysis: focuses on how narratives are constructed and performed to achieve interpersonal and discourse goals.
- Rapport management, relational work and (im)politeness theory: these focus on how people use language to manage competing wants and needs among each other while maintaining (or disrupting) social harmony.
- Critical metaphor analysis: focuses on metaphorically used words or expressions to raise awareness of their underlying or implied meanings and their implications with regard to ideology and power.
- Corpus analysis: this is in itself is a collection of tools for making sense of large quantities of data.

Although not an exhaustive toolkit, the variety of methods used in this volume showcases the possibilities that linguistics can offer,[1] including several quantitative techniques, which can speed up different kinds of analyses, cope with large amounts of data and increase systematicity, replicability and reliability – a particular advantage in the age of big (and ever increasing) data. At the same time, the methods are not mutually exclusive and none of them are applicable only to the contexts in which they are demonstrated. A number of chapters draw on more than one analytical tool to make the most of their data and all tools are applicable to other healthcare contexts as well.

## 3 OVERVIEW OF THE BOOK

The volume is organized into four parts, representing crucial roles language can play in healthcare contexts.

Part I, 'The Experience of Illness', focuses on how patients use language (or how they do *not* use it, in the case of Chapter 4) to describe their symptoms and experiences of illness among themselves or to researchers and healthcare professionals.

Chapter 1: Focusing on (im)politeness phenomena in reported interactions between people who hear voices and their voices, Demjén, Marszalek, Semino and Varese examine the relationship between voice and hearer, including relative power, as constructed through language. They link different patterns of (im)politeness, especially on the part of the voice, to different levels of distress experienced by voice-hearers. The authors argue that impoliteness in particular can be one of the ways in which the voices exercise control over the hearers, thereby limiting how they can live their lives. Demjén et al. propose that it might be possible to alter distressing, antagonistic relationships between voices and hearers by changing the way voice and hearer relate to each other linguistically.

Chapter 2: Given the number of chapters in this volume that use quantitative corpus methods to make sense of large data sets, Brookes provides a step-by-step introduction to how such an analysis might be conducted and what researchers must consider in the process. Analytic steps and decisions are demonstrated on a data set of online forum contributions around the topic of diabulimia, a contested eating disorder. Brookes uses three standard corpus techniques (keywords, collocations and concordances) to explore how diabulimia, in particular the restriction of insulin intake, is constructed by those with the condition. He shows that insulin restriction is mostly negatively evaluated in responses from other group members, even in a diabulimia support group. This, however, means that most of the contributors who describe restricting their insulin do so in relatively non-specific ways, making their practices more difficult the challenge.

Chapter 3: Examining and comparing the collocates of 'PND' (i.e. postnatal depression) across three data sets, Kinloch and Jaworska discuss the ways in which mothers on Mumsnet manage and justify experiences of perinatal mental distress and/or PND. They show how distress as well as the diagnosed disease itself are associated with internalized stigma, which needs to be discursively managed, or mitigated. They track where this stigma might stem from by comparing Mumsnet data to media reports and patient information documents on PND. They suggest that healthcare practitioners need to be more aware of the social pressures and aetiological uncertainties that stop mothers recognizing or accepting they may have PND and from seeking help.

Chapter 4: Semino, Hardie and Zakrzewska use corpus linguistic tools differently to other chapters in this volume. Their focus is on the linguistic descriptors included in the McGill Pain Questionnaire (MPQ), but rather than analysing their data text (i.e. the questionnaire) with corpus tools, they instead use these tools to explore the usage of the linguistic descriptors in general English. In this way, they are able to show that the seventy-eight descriptors in the MPQ vary greatly in terms of frequency in everyday English (some also being associated with specialist genres). They are therefore not equally likely to be familiar to the patients responding to the questionnaire. Other descriptors are only rarely, if at all, used in the context of pain and may therefore be avoided by patients. By way of a pilot, the authors test whether these aspects might correlate with patient choices of descriptors and finds that this is in fact the case.

Part II, 'Relating to Each Other', focuses on how the rapport and relationships so crucial for health and effective healthcare are built and negotiated in different healthcare contexts.

Chapter 5: Using interactional sociolinguistics, Chimbwete-Phiri and Schnurr unpick the language used by HIV/AIDS counsellors in a prevention clinic in Malawi that has particularly high adherence/attendance rates. They show that the particular ways in which advice and questions are phrased – how the counsellors say what they say – are likely to be contributing factors to the clinic's success. They draw out the discourse strategies that are most successful – using questions, drawing on local knowledge, metaphors and narratives – and suggest that these could form the basis of a kind of best practice in similar group counselling settings.

Chapter 6: Stommel and Lamerichs use a micro-analytic process to document the different strategies that counsellors use in online chat counselling for displaying empathy, to better understand the ways in which such interactions work. They contrast the actual practice of online counselling, with guidelines that advise explicit empathy displays, showing that these might be less important in themselves in the online context. They argue that empathy has to be performed in a way that is appropriate to the affordances of the medium in

which counselling takes place and that guidelines therefore need to draw more from current successful counselling practice.

Chapter 7: Thurnherr, Rudolf von Rohr and Locher explore the functions that narratives perform in three healthcare contexts. Their chapter emphasizes that narratives always fulfil multiple functions simultaneously and cannot therefore be taken at face value. There is no question that narratives play a crucial role in how patients organize, understand and communicate their experiences and that these have clinical value, but the authors argue that the multiple other functions that narratives serve in any given social context influence what is being said and how. In particular, the authors focus on the relational work that narratives do, that is, the interpersonal goals they are used to achieve (e.g. positioning oneself and one's audiences in particular ways). These goals influence how narratives are told and therefore how they should be understood.

Part III, 'Illness in the Mass Media', explores language in the context of public communications, where the diffuse nature of the target audience and the framing function of language make getting the message right particularly difficult, and particularly important.

Chapter 8: Using critical metaphor analysis, Atanasova and Koteyko expose how news reporting on obesity typically uses War metaphors and show that the ways in which these metaphors frame the issue can contribute to stigma and unfavourable views of obese individuals. For example, War metaphors typically require that there is an enemy to be fought. However, in the case of obesity (as with other chronic conditions), there is no obvious external entity such as a virus: the enemy to be fought are the patients themselves. This leads to a kind of othering that may explain why obese individuals increasingly report feeling stigmatized and receiving unequal treatment in clinical encounters.

Chapter 9: Tang and Rundblad use cognitive DA to explore media reporting on the presence and risks of contaminants in drinking water as an example of a 'health scare'. They show how the media represented the health risks differently from official sources (water industry, governments) and how such skewed representations – in particular of who is responsible for what kinds of actions and what uncertainties exist – can prompt behaviours that have unfavourable outcomes. In the case of potential contaminants in drinking water this may simply be undue anxiety, but in other cases such as the MMR vaccine controversy, it could lead to an increase in measles outbreaks. While their recommendations – for greater explicitness about what exactly is uncertain and who is responsible for different actions – are particularly important for public health communication (with its wide audience) about health risks, it also applies on the more micro level of healthcare professional to patient communication.

Finally, Part IV, 'Professional Practices and Concerns', deals with the impact that language used by professionals working in healthcare contexts can have on their own practices as well as on their patients.

Chapter 10: Sikveland and Stokoe show how CA can be used to demonstrate and train a more patient-centred approach to triaging in General Practice surgeries. They analyse telephone interactions between patients and receptionists and show clearly that when an institutionally relevant category such as 'routine appointment' (and in some cases 'urgent') is presented explicitly to patients calling for appointments, it tends to elicit resistance on the part of the patient and results in a more fraught triaging process. Instead, they suggest that in most cases patients automatically give clues about the urgency of their request in their opening turns and therefore do not require an institutionally prescribed and worded triage process.

Chapter 11: Zayts and Lazzaro-Salazar use the tools of interactional sociolinguistics to examine how migrant medical professionals reflect on the intersections of healthcare systems, cultures and practices, and the challenges they face when transitioning to work in a country other than the one they trained in. Their chapter touches on issues of professional mobility as well as multicultural communication and provides a more nuanced understanding of (cultural and linguistic) adjustment and adaptation processes. The authors show that, contrary to much discourse-oriented research, semi-structured interviews can be useful data for linguistic analysis as long as they are treated not as de facto representations of the interviewee's thoughts, but as social processes in their own right, in which social actions are accomplished, and stances and identities are negotiated.

Chapter 12: Loew, Mitchell, Weetman, Millington-Sanders and Dale outline known barriers to the provision of good end of life care such as fractured continuity of care and inadequate support for patients and their families. Using corpus-based DA, they re-analyse existing data to show that there is a lack of clarity around key terminology such as 'end of life', 'palliative' and 'hospice' and that this may contribute to fractured continuity of care. In addition, they find that GPs construct barriers to good PEOLC in terms of an absence (what there is not) of various abstract entities such as resources and time. In this way, they (a) emphasize the importance of these (they maintain focus on absences and do not discuss enablers) and (b) construct barriers in a way that often backgrounds any agency, including their own. Yet, while structural issues are undoubtedly important, the authors argue that more could be done on the part of GPs too, especially when it comes to preparing patients and their families for the end of life.

Chapter 13: Galasiński and Ziółkowska use the tools of critical DA to critique standard definitions of suicide used in research and healthcare practice. Examining thirty definitions, they show how these systematically construct suicide as an abstract act, without temporality, and exclude or background those who take their lives. The authors argue that these patterns have implications for how suicide is researched (e.g. prioritizing measurables rather than the lived

experience), how policies are established and indeed how people are treated. They propose an alternative template for formulating definitions of suicide.

The final chapter of the book, the Epilogue, reflects on the role of language in context of primary care in the UK. It highlights some of the points raised, insights gained and questions yet to be explored in the preceding research chapters from the perspective of a general practitioner.

### *3.1 Intersections*

While the organization of the volume imposes one particular order on its chapters, there are a number of intersections between different parts and chapters and the collection covers a multitude of illnesses and settings, as well as types of language data. This reflects the increasingly dynamic, complex and interacting contexts within which illness and healthcare are situated and the different communicative practices among and between its range of stakeholders – healthcare professionals, patients, families/carers, medical researchers, journalists and more. These communicative practices go well beyond doctor–patient encounters and include mass media reporting, public communications and increasingly interactions in online patient communities (e.g. Harvey and Koteyko, 2013). As Tomlinson argues in the Epilogue, face-to-face consultations are being displaced and speech is being replaced by text with online forms, forums and emails.

For this reason, the chapters in this volume similarly move beyond a focus on healthcare professional–patient interactions, which has traditionally been the staple of health communications research (Ong et al., 1995; Sarangi and Roberts, 1999). Such interactions are clearly important and are the focus of Chapter 3. Equally important, however, are chapters on dialogic communication between healthcare practitioners and patients mediated by technology (Chapter 6) and chapters on mediated communication involving less prototypical professionals such as receptionists (Chapter 10), or not involving healthcare professionals at all, but taking place between peers (Chapters 2, 3 and 7). There are chapters looking at research interviews with healthcare practitioners (Chapter 11) or patients (Chapter 1) and ones focusing on questionnaire responses from doctors (Chapter 12). Several chapters explore monologic communication with the public (Chapters 8 and 9), or with healthcare practitioners and academics (Chapters 4 and 13). This reflects the increasingly diverse contexts and settings within which communication related to health and illness takes place and the wider range of participants playing important roles in healthcare interactions.

As noted above, interactions taking place in computer or telecommunications mediated environments, in particular, are increasingly used in healthcare (Harvey and Koteyko, 2013), and this kind of data in large quantities is also more readily available for linguistic analysis (Lupton, 2017). This explains

the prevalence quantitative corpus methods applied in various chapters of this volume, whether used alone or in combination with general DA. On the one hand, such 'big data' represents a fantastic opportunity and with more data comes more reliability and generalizability. On the other hand, manual, qualitative linguistic analysis is extremely time consuming and therefore difficult to use with extensive data sets. The techniques of corpus linguistics enable researchers to combine the two: statistical reliability and in-depth analysis. Chapter 2 provides an introduction to corpus analysis, which Chapters 3, 4 and 12 build on while also each introducing the specific corpus tools they use.

In addition to the above, there is an even split between chapters looking at mental health (Chapters 1, 2, 3, 6, 13) and physical health (Chapters 4, 5, 8, 12, 13), in so far as the two can be considered separate. There are chapters on General Practice (Chapters 10 and 12), specialist clinics (Chapters 4 and 5) and general health and well-being (Chapters 7, 8, 9, 11). There are chapters on treatment or management of illness (Chapters 1, 2, 3, 6, 7, 12), prevention of illness (Chapters 5, 9), and also on the processes surround these such as professional (Chapter 11 and 13) or public attitudes (Chapter 8), gaining access to care (Chapter 10), and diagnostic processes (Chapter 4).

### *3.2 How to read this volume*

The collection has been put together with different audiences in mind: (applied) linguists, medical humanities scholars, as well as medical practitioners and educators.

To cater for our non-linguistic audiences, authors have provided introductions to the various methods they use in a way that does not assume any previous knowledge. There are clearly marked summaries of the key implications of their findings for healthcare practice at the end of their chapters, which might be most interesting to healthcare practitioners and educators. Medical humanities scholars may find the chapters on lived-experience accounts and illness narratives most enriching, while perhaps also being interested in the range of methods linguistics can offer. Finally, students and practitioners of linguistics will likely want to focus on the overviews of the healthcare contexts and details of the original research showcased in each chapter, perhaps skipping introductions to methods with which they are already familiar.

## 4 CONCLUDING REMARKS

As some of our most significant interactions will take place in a healthcare context, the importance of better communication cannot be overstated. Better communication means not just using different words to say the same things but better understanding how language functions in different contexts.

Linguistics is a psychosocially aware, yet empirical method, with an appreciation for the cultural, contextual and personal pluralities of experience at its core. Of course, as Collins, Peters and Watt (2011) point out, linguistics can learn a lot from healthcare research, and Tomlinson's Epilogue offers pointers in this vein for future research. They also point out, however, that linguistics has a huge amount to offer healthcare – something that this volume makes explicit in the range of insights it provides.

## NOTE

1. The range of approaches is limited to verbal communication: not because other modes of communication, such as the visual or kinetic, are considered unimportant, but because such approaches, to be taken seriously, deserve volumes in their own right.

## REFERENCES

AILA (Association Internationale de Linguistique Appliquée). Available online: http://www.aila.info/en/about.html (Accessed December 2017).

Brumfit, C. J. (1995), 'Teacher professionalism and research', in G. Cook and B. Seidlhofer (eds), *Principle and Practice in Applied Linguistics*, Oxford: Oxford University Press.

Candlin, C. N. and Sarangi, S. (2004), 'Making applied linguistics matter', *Journal of Applied Linguistics*, 1 (1): 1–8.

Chafe, W. (1994), *Discourse, Consciousness, and Time: The Flow and Displacement of Conscious Experience in Speaking and Writing*, Chicago: University of Chicago Press.

Charon, R. (2006), *Narrative Medicine: Honoring the Stories of Illness*, Oxford: Oxford University Press.

Collins, S., Peters, S. and Watt, I. (2011), 'Medical communication', in J. Simpson (ed.), *The Routledge Handbook of Applied Linguistics*, 97–110, Abingdon: Routledge.

Crawford, P., Brown, B. and Harvey, K. (2014), 'Corpus linguistics and evidence-based health communication', in H. Hamilton and W. S. Chou (eds), *Routledge Handbook of Language and Health Communication*, 75–90, New York: Routledge.

de Silva Joyce, H. (2016), *Language at Work: Analysing Language Use in Work, Education, Medical and Museum Contexts*, Newcastle: Cambridge Scholars Publishing.

Dowell, J., Jones, A. and Snadden, D. (2002), 'Exploring medication use to seek concordance with "non-adherent" patients: A qualitative study', *British Journal of General Practice*, 52: 24–32.

Galasiński, D. (2013), *Fathers, Fatherhood and Mental Illness: A Discourse Analysis of Rejection*, Basingstoke: Palgrave.

Greenhalgh, T. (2016), 'Cultural contexts of health: The use of narrative research in the health sector', *Health Evidence Network (HEN) Synthesis Report 49*, Copenhagen: WHO Regional Office for Europe.

Greenhalgh, T. and Hurwitz, B. (1999), 'Why study narrative?' *British Medical Journal*, 318: 48–50.
Gygax, F. and Locher, M. (2015), *Narrative Matters in Medical Contexts across Disciplines*, Amsterdam: Benjamins.
Hamilton, H. and Chou, W. S. (2014), *The Routledge Handbook of Language and Health Communication*, Abingdon: Routledge.
Harvey, K. and Koteyko, N., eds (2013), *Exploring Health Communication Language in Action*, Abingdon: Routledge.
Heritage, J. and Stivers, T. (1999), 'Online commentary in acute medical visits: A method of shaping patient expectations', *Social Science and Medicine*, 49: 1501–17.
Hunt, D. and Carter, R. (2011), 'Seeing through The Bell Jar: Investigating linguistic patterns of psychological disorder', *Journal of Medical Humanities Journal of Medical Humanities*, 33 (1): 27–39.
Locher, M. A. (2017), *Reflective Writing in Medical Practice: A Linguistic Perspective*, Bristol: Multilingual Matters.
Lupton, D. (2017), *Digital Health: Critical and Cross-Disciplinary Perspectives*, London: Routledge.
Ong, L. M. L., de Haesa, C. J. M., Hoosa, A. M. and Lammes, F. B. (1995), 'Doctor-patient communication: A review of the literature', *Social Science and Medicine*, 40 (7): 903–18.
Pickering, L., Friginal, E. and Staples, S. (2017), *Talking at Work: Corpus-based Explorations of Workplace Discourse*, Basingstoke: Palgrave.
Potter, J. and Wetherell, M. (1987), *Discourse and Social Psychology: Beyond Attitudes and Behaviour*, London: Sage.
Reddy, M. J. (1979), 'The conduit metaphor: A case of frame conflict in our language about language', in A. Ortony (ed.), *Metaphor and Thought*, 284–310, Cambridge: Cambridge University Press.
Roberts, C. and Sarangi, S. (1999), 'Hybridity in gatekeeping discourse: Issues of practical relevance for the researcher', in S. Sarangi and C. Roberts (eds), *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings*, 363–90, Berlin: Mouton de Gruyter.
Roberts, C. and Sarangi, S. (2003), 'Uptake of discourse research in interprofessional settings: Reporting from medical consultancy', *Applied Linguistics*, 24 (3): 338–59.
Roberts, C., Moss, B., Wass, V., Sarangi, S. and Jones, R. (2005), 'Misunderstandings: A qualitative study of primary care consultations in multilingual settings, and educational implications', *Medical Education*, 39 (5): 465–75.
Rudolf von Rohr, M.-T. (2018), *Persuasion in Smoking Cessation Online: An Interpersonal Pragmatics Perspective*, Freiburg i. Br.: Albrecht-Ludwigs-Universität Freiburg. Available online: https://freidok.uni-freiburg.de/fedora/objects/freidok:16755/datastreams/FILE1/content.
Sarangi, S. (1994), 'Intercultural or not? Beyond celebration of cultural differences in miscommunication analysis', *Pragmatics*, 4 (3): 409–27.
Sarangi, S. (2005), 'The conditions and consequences of professional discourse studies', *Journal of Applied Linguistics*, 2 (3): 371–94.
Sarangi, S. (2012), 'Practising discourse analysis in healthcare settings', in I. Bourgeault, R. Dingwall and R. De Vries (eds), *The SAGE Handbook of Qualitative Methods in Health Research*, 397–416, London: Sage.

Sarangi, S. and Roberts, C. (1999), 'Introduction: Discursive hybridity in medical work', in S. Sarangi and C. Roberts (eds), *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings*, 61–74, Berlin: Mouton de Gruyter.

Semino, E., Demjén, Z. Hardie, A., Payne, S. and Rayson, P. (2018), *Metaphor, Cancer, and the End of Life: A Corpus-Based Study*, New York: Routledge.

Simpson, J. (2011), *The Routledge Handbook of Applied Linguistics*, Abingdon: Routledge.

Skelton, J. (2002), 'Commentary: Understanding conversation', *BMJ*, 325: 1151.

Wei, Li (2014), 'Introducing applied linguistics', in Li Wei (ed.), *Applied Linguistics*, Chichester: Wiley-Blackwell.