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The categorisation of resistance: Interpreting failure to follow a proposed line of action in the diagnosis of autism amongst young adults.

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Abstract

Many characteristics typical of autism, a neurodevelopmental condition characterised by socio-communicative impairments, are most evident during social interaction. Accordingly, procedures such as the Autism Diagnosis Observation Schedule (ADOS) are interactive and intended to elicit interactional impairments: a diagnosis of autism is given if interactional difficulties are attributed as a persistent quality of the individual undergoing diagnosis. This task is difficult, first, because behaviours can be interpreted in various ways and, second, because conversation breakdown may indicate a disengagement with, or resistance to, a line of conversation. Drawing upon Conversation Analysis, we examine seven ADOS diagnosis sessions and ask how diagnosticians distinguish between interactional resistance as, on the one hand, a diagnostic indicator and, on the other, as a reasonable choice from a range of possible responses. We find evidence of various forms of resistance during ADOS sessions, but it is a resistance to a line of conversational action that is often determined to be indicative of autism. However, and as we show, this attribution of resistance can be ambiguous. We conclude by arguing for reflexive practice during any diagnosis where talk is the problem, and for a commitment to acknowledge the potential impact of diagnostic procedures themselves upon results.

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Introduction

In recent years, there has been an increasing focus in the academic literature on communication between those with autism, and those they interact with. Autism is defined as a neurodevelopmental disability characterised by 'persistent deficits in social communication and social interaction,' and 'restricted, repetitive patterns of behavior, interests, or activities' (American Psychiatric Association 2013: 50). Perhaps unsurprisingly, given this impairment in social communication skills which is seen to underpin a diagnosis of autism, a large proportion of the aforementioned literature has focused on identifying the ways in which the communication patterns of those with a diagnosis of autism differ from those who do not (e.g. Jones and Schwartz 2009; Keen 2003, 2005; Bruinsma et al 2004). An inevitable consequence of this focus has been the development of a range of interaction-based interventions to try and enhance communication in this setting (e.g. Keen et al 2007; Schwartz et al 2004; Kasari et al 2006).

More generally, and alongside these developments, there has been a growing call for a 'sociology of diagnosis' (Brown, 1995; Jutel 2009) which examines the way in which diagnostic labels representing particular conditions or patterns of behaviour come to be applied to individuals.

Critiquing early attempts at understanding diagnosis, Gill and Maynard (1995) have argued that social scientists were prone to evoke what they term 'institutional determinism'. Institutional determinism represents a position wherein diagnosis is '…a straightforward naming activity, where labellers, who are largely naïve to the social and historical contexts in which they operate, decisively attach labels to acquiescent and similarly naïve individuals, and that is that' (Gill & Maynard 1995: 15). In this way, institutional determinism, which Gill and Maynard equate with labelling theory, posits at least two compliant parties in the diagnostic process. First, there are individuals receiving the diagnosis who are taken to be both passive and powerless to resist or shape the diagnostic process. Second, diagnosticians are assumed to be an institution's willing executioners, completing the labelling process in a straightforward, unreflective manner.

These assumptions of naivety and acquiescence have been challenged both theoretically and empirically. Theoretically, those who are often taken to be institutional determinists such as Michel Foucault (Beckett & Campbell 2015: 271) have argued that resistance, on a micro-sociological scale, is inherent to their work (e.g. Foucault 1997: 292). Empirically, a multiplicity of acts have been shown to stop or slow progress during everyday interactions: we sidestep unwanted invitations (Davidson 1984); fail to co-operate with requests we perceive as unreasonable by providing evidence of their unreasonable nature (Backhaus 2010; Heinemann 2006); or avoid committing to follow advice that we have not solicited or do not require (Heritage and Sefi 1992; Pilnick, 1999). There is ample evidence that resistance continues within institutional settings: parties approach a diagnosis with a range of quite different motives and expectations (Singh 2014) and may strongly resist outcomes which they perceive as either unexpected or undesired (Gill et al. 2010; Turowetz & Maynard 2016).

The possibility of resistance to diagnosis does not, however, mean that producing such resistance is easy or straightforward. First, it has been argued that any form of engagement within a diagnostic arena necessitates the taking up of a particular form of subjectivity. While forms of resistance may

offer alternatives, therefore, this is still a form of 'controlled autonomy' (Callon & Rabeharisoa 2002: 13) where engagement ensures that some possibilities arise while others are eliminated (Hacking 1995: 241; Hollin 2017: 617). Second, acts of resistance may be co-opted by those being resisted. So, for example, it has been argued that self-advocacy and the social model of disability, which may be articulated as forms of resistance to the medical model, have been incorporated into governmental policy and diluted or used to support existing positions (Armstrong 2002; Aspis 1997; Buchanan & Walmsley 2006). Third, resistance may be kept off the 'public balance sheet'. Hoffman et al. (2015), for example, note that participants in Stanley Milgram's studies on obedience to authority consistently resisted calls to obey but that these acts were excluded from published reports. Acts which unsettle diagnostic practices in situ may, therefore, ultimately be disregarded. Fourth, and most pertinent to this paper, there may be instances where acts of resistance are themselves interpreted as evidence of clinical pathology. This final point is, we suggest, most likely to be relevant to 'medical problems where talk is the problem' (Garcia 2012), such as autism.

Interactional resistance and autism

As we noted at the outset, core symptom clusters in autism manifest themselves most clearly during interaction and conversation. Diagnostic procedures such as the Autism Diagnosis Observation Schedule (ADOS: Lord et al. 1989), which we will consider in more detail in the following section, often involve structured interaction and are intended to elicit such symptoms. A diagnosis of autism is given if interactional difficulties, which diagnosticians are attempting to elicit, are attributed as a persistent quality of the individual undergoing diagnosis[1]. However, and

[1] This premise has been critiqued by self-advocates and those working within disability studies. Milton, for example, argues that 'symptoms' should not be understood as residing within an individual but, rather, should be construed as socially situated. Milton refers to this as the 'double empathy' problem; two individuals occupying different 'lifeworlds' (i.e. 'autistic' and 'neurotypical' lifeworlds) struggle to comprehend each other and, while communication breakdown ensues, neither individual should be understood as impaired (Milton 2012). Such a conclusion is both plausible and valuable but, for present purposes, can be offset in favour of the question of persistence. Any diagnosis of autism, as either difference or deficit, is premised upon *persistent* qualities of interaction rather than any temporary breakdown. It is this distinction which primarily concerns us here.

as others have noted (Turowetz 2015a), interactional difficulty during diagnosis could be located in various other sites which would not presume pathology. Breakdown could, for example, result from the specific interactions between the individual undergoing diagnosis, the diagnostician, and the diagnostic instrument itself. Diagnosticians must, therefore, determine if social or interactional difficulties are specific to *this* moment, interaction, and setting, or if difficulties are a permanent quality of the diagnosed individual's conversations.

This task is made harder for, as several studies have shown, behaviours exhibited during autism diagnosis are frequently underdetermined and can be interpreted in various ways (Muskett et al. 2010; Turowetz 2015b). Turowetz, for example, discusses the example of a child named Tony who, during diagnosis, attempted to drink from a picture of a cup. Tony's actions could variously be interpreted as an example of a confusion between image and reality or as an example of pretend play (Turowetz 2015b: 72-73). The former reading may be indicative of autism while the second, to some schools of thought at least (Hollin 2014: 105), may actually preclude a diagnosis. Interpretation is, thus, in all likelihood a permanent and important feature of autism diagnosis.

When attributing behaviours during autism diagnosis, Turowetz has elsewhere reported that:

> '...clinicians' representations typically attribute responsibility for successes and failures to the child's personal qualities and characteristics, abstracting from the surrounding environment' (Turowetz 2015a: 221).

Clinicians, thus, typically understand behaviours as evidence of fixed traits, rather than responses to the specific environment. Such an attribution is evidently multifaceted, but it becomes even more complex where the interactional behaviour in question is not one that is specific to a diagnosis of autism, but is also found universally. A refusal to make eye contact, for example, may be evidence of autism but it may also indicate a disengagement with, or resistance to, a topic of conversation (Argyle & Dean 1965).

In this paper, we focus on the production of interactional resistance during the actual process of testing for diagnosis. As we have described above, resistance to the ultimately proferred diagnosis, or to the visible building towards such a diagnosis (see Gill et al 2010), is a previously observed feature of healthcare interactions, and is generally treated as an understandable response to unexpected or unwelcome news. Furthermore, previous conversation analytic work begins to identify the range of interactional forms resistance may take. It may be expressed directly, as in the case of the parents explicitly resisting a label of intellectual disabilities for their child (Gill and Maynard 1995), or it may be more indirect or passive, as Heritage and Sefi demonstrate in response to unsolicited advice from Health Visitors and as Stivers (2007) identifies in relation to parents' treatment of doctors' refusal to prescribe desired antibiotics to their children because of a viral diagnosis. The question that guides our analysis here is: how, in the case of autism, do diagnosticians distinguish between interactional resistance as, on the one hand, a diagnostic indicator and, on the other, as a relevant and reasonable choice from a range of possible responses? Put simply, how is it to be judged whether resistance in this setting is to be considered 'mundane' or 'autistic'?

It is important to note here that it is not our contention that autism is purely a social construction (see similar arguments made in relation to intellectual disability, e.g. Rapley (2004)). We do not advocate for institutional determinism, deny the reality of individuals' difficulties with social interaction, seek to undermine the judgement and effort made by diagnosticians or the fact that a diagnosis can provide individuals and families with much needed access to support and resources. Our focus is purely on a specific empirical problem which must be resolved interactionally: by what criteria can everyday interactional practices be distinguished from diagnostic indicators? It is also important to note that we seek to assign no blame, or pass any judgement, on the professionals whose interactions are presented here. We simply seek to shed light on the different ways resistance may manifest itself in these interactions, and the practical problem of categorisation that then

147 arises. In order to unpack this, we focus on the actual delivery of the ADOS test and how it is
148 assessed in the moment, through interactional interpretative work.

149 **The ADOS test**

150 Diagnostic scoring and rating instruments are commonly used across a wide range of medical
151 specialties, from the APGAR scores applied to newborn infants to the Mini Mental State
152 Examination (MMSE) used in the diagnosis of dementia. By their nature, such instruments pre-
153 define specific issues or behaviours as significant. However, as Turowetz has noted, the
154 contribution of these instruments to the production of diagnostic 'facts' is generally minimized;
155 they are 'treated as neutral, autonomous tools of measurement that record data for assessment,
156 rather than contributing to such data' (Turowetz 2015a: 215). The end product of this
157 minimization is the production of test results as though the presenter 'acted in a kind of
158 interactional vacuum'. Such decontextualisation is necessary to maintain the impression of the
159 objectivity of testing. However, as others have ably demonstrated, both within healthcare settings
160 and beyond, what Maynard and Marlaire (1992) call 'the interactional substrate of testing' can have
161 a marked impact on the results that are obtained from it (Antaki, 2001; Maynard and Schaeffer
162 2002).

163 The Autism Diagnostic Observation Schedule (ADOS) was first developed in 1989 (Lord et al.
164 1989), intended for use within both research and clinical settings (Lord et al. 1989: 186), and for
165 those with a verbal age greater than three (Lord et al. 1989: 208). Subsequently, and with the intent
166 of facilitating clinical evaluation in a wider range of individuals, the 'ADOS-generic' (ADOS-G)
167 was developed in 2000 (Lord et al. 2000). This new version of the ADOS has four sub-versions
168 ranging from a 'module 1' version intended for preverbal individuals through to a 'module 4'
169 version intended for adolescents and adults with fluent speech.

170 In all its forms the ADOS is:

171 '...an *interactive* schedule. What is standardized in the ADOS are the contexts that provide
172 the background for all observations and, more specifically, the behaviors of the examiner...'
173 (Lord et al. 1989: 187, italics in original)

174 In the social psychological tradition, therefore, the highly trained practitioners giving the ADOS
175 are understood as stooges or confederates (Lord et al. 1989: 187), standardising activities and their
176 own behaviours in order to prompt a number of 'social occasions' within which 'a range of social
177 initiations and responses is likely to appear' (Lord et al. 2000: 205). These invitations are referred
178 to as 'presses'. Presses on module 4 for the ADOS include: engaging in conversation about a range
179 of 'socioemotional' issues (e.g. friends, loneliness, social difficulties) and everyday functioning
180 (school/work); a construction task (akin to making a simple jigsaw); telling a story from a picture
181 book; physical demonstration of an everyday task (e.g. brushing of teeth); creating a story with the
182 use of physical objects (including, in our sample, a toy car, a sponge, and a cocktail umbrella); the
183 retelling of a cartoon strip; free play with toys; and description of a picture featuring a social scene.
184 Throughout these activities the investigator searches for the social and communicative atypicalities
185 associated with autism. While accounting for the possibility of resistance during these activities
186 does not appear to have been a priority to the creators of the ADOS, measures were put in place
187 to address expected ambiguities. The 0-3 rating scales described below are intended to allow 'room
188 for uncertainty' (Lord et al. 1989: 190) while trained diagnosticians need to 'judge whether factors
189 extraneous to the social demands of the ADOS-G [including 'cultural context'] may have
190 influenced the assessment' (Lord et al. 2000: 222) when making their decisions.

191 Following the ADOS sessions, which are video recorded, examiners watch back the video –
192 sometimes though not always with a colleague – and score participants' behaviour across a range
193 of domains. In some areas the scoring criteria frame this as a quantitative exercise; 'imagination
194 and creativity', for example, is scored from 0 (several instances where imagination is demonstrated)
195 to 3 (no instances where imagination is demonstrated). In other areas, examiners are required to

make a more explicitly qualitative assessment; 'overall rapport' for example is ranked between a 'comfortable' 0 and an 'uncomfortable' 3. Upon conclusion, participant scores are added and a diagnosis of 'autism' is given for particularly high scorers, 'autism spectrum' for those scoring reasonably highly, or 'non-spectrum' for low scorers. While the ADOS has well recognised clinical limitations which prevent its use in isolation – for example, it was designed neither to examine age of onset or the presence of restricted and repetitive behaviours and interests (RRBIs), although some insight into the latter is intended – it has high levels of reliability and validity and has become widely established as a 'gold standard' diagnostic instrument for autism (Fombonne 2009: 592; Norbury & Sparks 2013: 7)

The current sample

The current study examines 7 ADOS sessions, all of which were conducted using the 'module 4' version of the test (Lord et al. 2000). The individuals undertaking the ADOS were all men and aged from late teens to mid-twenties. All had pre-existing diagnoses of either Asperger's Syndrome or autism and, on the basis of these diagnoses, had been invited to take part in a university-based research study for which it was necessary that a further ADOS be completed. In every case a diagnosis of autism or autism spectrum was confirmed. The two examiners conducting the ADOS were both female postgraduate students in their twenties and had been fully trained and qualified to administer the procedure (Lord et al 2002). Although only one examiner acted as 'stooge' in any given session both were involved in the rating of all participants.

In the light of the above information it should be noted that there is a particular dynamic within this sample. Both participants and examiners already knew that an independent diagnosis of autism/autism spectrum had been arrived at previously and there were no clinical consequences following the current sitting (i.e. existing diagnoses could not be questioned). Such uses of the ADOS are intended (Lord et al. 1989: 186) but, as we stress in the analysis and discussion, generalisations to other contexts should be made with caution.

ADOS sessions took place in either the participant's educational setting or at the researchers' university and lasted between 35 and 52 minutes[2]. As is typical (see above) these sessions were recorded in order to facilitate scoring and it is these videos – and the note and scoring sheets made by the examiners – which are utilized in the present study. The note sheets were taken by the examiners either during the ADOS sessions or immediately afterwards. The score sheets contain not only the final diagnostic judgements but also the 'working out' of these scores (so for example noting how many and where instances of 'demonstration of imagination' occurred in order to assign a number from the scale). These written documents therefore provided a significant insight into the diagnostic production process. The present study received ethical approval following University ethical review procedures and all participants gave written permission for their data to be reused for this piece.

Methods

The video-recorded ADOS sessions were fully transcribed using CLAN software, and analysed using conversation analysis (CA). CA is a research method that originates in sociology but draws on insights from other disciplines such as psychology and linguistics (see ten Have, 2007). Its aim is to study the structure and order of naturally occurring talk in interactions. The method has been widely used to study a broad range of healthcare interactions (e.g. Pilnick et al,) as well as the administration of testing instruments where communicative or intellectual competency is potentially an issue (e.g. Antaki (2001), Rapley (2004)). Given the importance of the use of objects for administering the ADOS, it was important also to consider non-verbal and paralinguistic features of the interactions; these were noted alongside the transcriptions. Transcripts were used alongside the original recordings as an analytic aide. The original notes and scoring documents used by the ADOS examiners were analysed alongside the video recordings. Since notes often

[2] One recording failed part way through the session and, thus, only the first portion of this ADOS is considered here.

refer to the specific interactional instances that have occasioned them (e.g. the interviewer recording what has been taken to be an example of a particular phenomenon), this meant that, as far as possible, we could analyse the talk alongside the coding categories that had been assigned to it.

Analysis

Our analysis identifies three different kinds of resistance in our data, which will be considered in turn: resistance to a proposed task; resistance to a behaviour or feeling being characterised in a particular way; and resistance to a proposed line of conversational action.

1) Resistance to a proposed task.

In our data, this kind of resistance is produced in response to requests to participate in specific components of the test, for example a request to act out an action, and a rationale is usually provided for the refusal (e.g. 'not with him watching'). In everyday interaction, resistance to comply with requests is dispreferred, with CA research repeatedly demonstrating that human interaction is organized to favour actions promoting social affiliation (Pillet-Shore forthcoming; Pomerantz and Heritage 2012; Kitzinger and Frith 1999). As a result, a refusal is usually produced with an account or a mitigation; where it is not, it may be seen as accountable by the requesting party (particularly where the request is produced with a high degree of entitlement and a lack of contingency (Curl and Drew 2008)) and so be pursued by the requestor. This pursuit commonly takes the form of reframing. Reframing generally treats the resistance as either a lack of understanding (so the requestor goes on to describe it differently) or a lack of ability (e.g. that someone can't reach something they've been asked to pass). It is not generally treated by the co-participant as a lack of willingness. However, lack of willingness is sometimes specifically demonstrated in these data, as the example below illustrates (INV = interviewer/assessor, PAR= participant, OBV = observer, often a parent):

Extract 1: A13

581 *INV:next thi:ng (0.9) this one you might feel a bit silly doing it
582 *INV:m(h)hm (.) but (.) can you imagine (.) that (.) i::'m just a::
583 *INV:erm (.) we:ll (.) i'm a small child and i don't know how to:
584 *INV:make a cup of tea (.) can you: show and tell me
585 *INV:how to make a cup of tea (.) if say the kettle is he:re
586 *INV:the mug's he:re (.) tea bag is here (.) can you (.) show and tell me?
587 (3.7)
588 *PAR:.hhh::: (.) no (.) no i ⌈can't⌉
589 *INV: ⌊no ⌋ (.) why's that?
590 *PAR:'cos i can't imagine you to be a ch(h)ild
591 *INV:o:r what about (.) erm (.) can you just do it without imagining
592 *INV:that i'm a ⌈child ⌉
593 *PAR: ⌊no (.)⌋ i - (.) no:
594 *INV:no (.) could try a different one?
595 *PAR:he's watching me (.) i can't do it .(h)hhh
596 PAR indicates camera

In this extract, the interviewer introduces a new component of the ADOS test, that of acting out an everyday action. However, she prefaces her description with an acknowledgement that the request which will follow is potentially problematic, and may make the participant 'feel a bit silly' (line 581). While the interactionally preferred response to a request is acceptance or compliance, this request, then, is designed in such a way as to make refusal easier; itself a demonstration that diagnosticians are far from being the cultural dopes assumed within institutional determinism. The extended pause at line 587 signals that straightforward acceptance is unlikely to follow (Pomerantz 1984; Clayman 2002), and the participant does indeed refuse in line 588. This refusal ('no (.) no (.) I can't') does not make explicit the reason behind it, and this is pursued in line 590, prompting the production of a specific difficulty with this specific request by the participant: that he cannot

imagine the researcher as a child. At this point the possibility remains that the participant's unwillingness is linked to this specific manifestation of the activity, rather than the activity itself, and the interviewer first attempts to clarify over lines 591-592 whether a modified version of this specific activity can be attempted which does not require the imaginative leap. When this is also refused, the interviewer produces a more general request to try any activity in this category ('could try a different one?' in line 594). At line 595 it becomes clear that the participant's refusal indexes unwillingness rather than ability; he is not prepared to engage in an activity of this kind with the camera 'watching'.

Extract 2 below shows a further example of resistance to a proposed task, when the interviewer invites the participant to tell a story using the objects on the table; in this instance these include small toys such as a car and a ball, and small household items such as a shoelace and a cocktail umbrella. Immediately prior to this extract, the interviewer has explained the task by telling a short story using these objects herself.

Extract 2: A14 (51:15).

1580:*INV: and (.) your story doesn't have to be as sad as mine

1581:*INV: but if you wanna pick (.) five items that aren't the five I picked

1582:*INV: so out of here ((indicates plastic bag containing items))

1583:*PAR: I'd prefer not to do it ((shakes head vigorously))

1584:*INV: you'd prefer not to do it that's absolutely fine

1585:*INV: ⌈no problem ⌉

1586:*PAR: ⌊it's just a ⌋ bit erm

1587: (2.0)

1588:*PAR: just a bit baby⌈ish ⌉

1589:*INV: ⌊a bit⌋ - that's fine

1560:*PAR: ⌈no offence⌉

1561:*INV: ⌊we try and ⌋ ge- no that's fine (.) we try and get everyone

1562:*INV: to do them regardless of how old they are but if you don't

1563:*INV: want to do it that's no worries at all

1564: (0.8)

This extract begins with the interviewer requesting that the participant select his own five objects from the bag (lines 1580-582). In contrast to extract 1 above, the refusal that occurs here is immediate, and it also embeds an account for the refusal which demonstrates lack of willingness ('I'd prefer not to do it'). Despite the interviewer's lack of pursuit (she immediately accepts the refusal in line 1584), the participant subsequently expands the account to indicate that the lack of willingness is because the activity is 'babyish'; an apology for this (line 1560) is also used to mitigate the refusal. Following the interviewer's response in lines 1561-63 which reiterates acceptance of the refusal, the topic is closed and the interviewer subsequently moves to end the ADOS session (not shown here).

Examination of the records made by the ADOS testers shows that in neither of the examples shown above were the participant responses treated as noteworthy in diagnostic terms. This is also the case for other examples of this type in these data; that this kind of resistance to a proposed task is treated as 'ordinary' or 'normal' resistance. One explanation for this might be linked to the argument that Stokoe (2013) makes in relation to the use of role play more generally: that the 'stakes' in role playing activities may be treated differently (and less seriously) by participants. The knowledge that this is a research rather than clinical setting may also impact on this, and a refusal to participate in a 'babyish' diagnostic activity may be less straightforwardly accepted in a clinical context. In relation to these specific data, however, we note that these refusals show clear orientation to the 'ordinary' rules of interaction; they show delay and/or mitigation and accounting

for the refusal. This is in contrast with other settings where overt refusals are commonly made without this orientation, such as the interactions of people with dementia (O'Brien et al 2016), and where this phenomenon tends to be interpreted as part and parcel of the underlying condition. It appears that what the kind of resistance displayed here does, perhaps paradoxically, is to enable participants to demonstrate interactional competency. We will now turn to examine the second category of resistance emerging from these data.

2.) Resistance to a behaviour or a feeling being characterised in a particular way

The extract below comes from the 'socioemotional' section of the ADOS where the interviewer asks about emotions and feelings. Having asked about feeling annoyed or angry, she moves to ask about sadness:

Extract 3: A13

703: *INV: do you do things if you're feeling kind of sa:d to ma-
704: *INV: to s- to ma- help you feel better ?
705: (1.0)
706: *PAR: well if I'm feeling sad I'd probably like put some music on
707: *INV: mhm
708: *PAR: blank out the world a bit
709: (1.6)
710: *PAR: throw on a game
711: *INV: yeah
712:*PAR: if that doesn't do it watch a funny video
713:*INV: does that help ⌈you -⌉
714:*PAR: ⌊watch⌋ a mo⌈vie ⌉
715:*INV: ⌊yea:h⌋
716:*INV: so relax and ⌈things⌉
717: *PAR: ⌊go to ⌋ bed
718:: (1.1)
719:*PAR: it's pretty (.) normal things to do I think

The interviewer's initial question here asks the participant about how they might manage their feelings of sadness. In response the participant produces first a single item, and then, in the face of minimal acknowledgements or silence from the interviewer, continues with the production of a list of potential activities. At line 713 the interviewer produces a more extended response, and then in 716 a summary of the list which functions as an upshot statement (Robinson 2006), 'So relax and things'. The participant's utterance in line 717 appears to be responsive to the interviewer's use of the word 'relax', so that the final item he produces is 'go to bed' in 718. At line 719 he then produces his own kind of upshot statement, which serves a rather different function than the interviewer's. Rather than providing a category for the kind of activities which references their nature, he instead provides a category which references the way they are to be interpreted: 'normal'. As Sacks (1984) asserts, 'doing being ordinary' takes work and effort, and in order to achieve this it is necessary to have knowledge of what everybody does ordinarily. The participant's response thus references this knowledge and uses it to resist categorisation as 'abnormal' or 'autistic'.

It is worth noting here that this kind of resistance may be particularly associated with the specific characteristics of this population: adolescents or young adults who have previous experience of use of the ADOS as a diagnostic tool. We suggest that this resistance to an 'abnormal' characterisation is not likely to occur in ADOS interactions with younger children, who would be unlikely to have this level of understanding of the process; in addition, the use of this type of resistance also suggests a level of insight into the way in which diagnostic tests such as the ADOS work. This observation feeds in to wider issues around adolescents' participation in health care encounters, where taken for granted assumptions about 'normal adolescence' may be used to justify and normalise behaviours which might otherwise be seen as accountable (Allen, 2013). Interestingly, the body of literature examining interactions between health care professionals and

adolescents also suggests that adolescents' lack of ability to envisage or understand long term effects of behaviour can be consequential; Karnielei-Miller and Eiskivits (2009) use this phenomenon as a justification for arguing that more directive styles of interaction may therefore be appropriate. However, in this instance, the long term effect of presenting something which is seen as an 'abnormal' or 'accountable' way of dealing with feelings of sadness is both anticipated and set aside by this young man's response.

In the second example of this type shown here, the interviewer has just concluded the telling of her story using the everyday objects that are available (this process is detailed in the discussion of extract 2). Before she began, she informed the participant that after she had completed her story, she would ask him to tell one. At the conclusion of her story there is shared laughter, before she invites the participant to begin by way of referring to the quality of her own story:

Extract 4: A28

1128 *INV:⌈(laughs)⌉
1129 *PAR:⌊(laughs)⌋
1130 *INV:erm
1131 (1.5)
1132 *INV:as you can tell it doesn't have to be a great work of fiction .(h)hh
1133 *INV:.(h)hhh
1134 *PAR:all the things that I'm bad at you're asking m(h)e to d⌈(h)o (h)ha⌉
1135 *INV: ⌊(laughs) ⌋
1136 *PAR:which I guess is the point
1137 (0.8)
1138 *PAR:erm (.) okay

Following the interviewer's self-deprecating assessment in line 1132, the participant's response is not, however, to immediately begin the story. Instead he offers initial resistance (1134), produced as humorous, and interviewer aligns with the humour. However, his continuation in 1136 orients

to a wider understanding of the activity- that the specific purpose of the ADOS tasks are to elicit areas where he may have difficulties. The interviewer does not produce a response to this, and after a short pause (line 1137) the participant does embark on the telling of a story. In this case then the resistance is more subtle than in Extract 3, and is only temporary.

In both of the extracts shown here, the resistance which is displayed moves beyond the interaction. In so doing, it orients to the fact that this is not simply a conversation where regular conversational actions have to be attended to (responding to a question, listening to a story etc) but also one where both the quality and content of these actions are being assessed through a particular framework. As with the first type of resistance identified above, in our data this type of resistance is likely to be treated as a reasonable, 'normal' response. In neither of the examples above do testers score this resistance as problematic.

We now turn to examine our third category of resistance: resistance to a line of conversational action. As analysis will show, this category is both more complex and more consequential than those considered previously.

3.) Resistance to a line of conversational action

As we have already described, those administering the ADOS attempt to prompt a number of 'social occasions' within which 'a range of social initiations and responses is likely to appear' (Lord et al. 2000: 205). Practically, this may include the interviewer telling their own story which relates to a topic raised by the respondent, sharing their own fears when a participant has described something they are afraid of, or offering their own experience of an event or happening when a participant has shared theirs. All of these 'social occasions' also potentially occur within mundane conversation, where an individual has the ability to align or otherwise, and where a lack of alignment may potentially be treated as accountable (see for example Jefferson's (1988) work on troubles telling and the requirement for one party to align as a 'troubles-recipient' for the activity to continue). There are a number of examples in our data where participants in the ADOS do not

align in this way. Extract 5 begins following a discussion of things that make the participant anxious:

Extract 5: A12 (18:30)

619:*INV: yeah hey (.) that's really good that you're working to it

620:*INV: I'm only just starting to work on my anxieties as well

621:*INV: I had something really bad happen to me

622: (4.2)

623:*INV: so (.) I was (.) cycling into work (.) and a car

624:*INV: came at me (.) like this to the side

625:*PAR: [.hhh]

626:*INV: [and I went] into the tram tracks and fell over

627:*INV: and I got really really (.) scared cycling for a while

628:*INV: but (.) I had to be you know (.) had to be strong

629:*INV: and now I'm cycling into work again and I'm just (.) i -

630:*INV: I act safer on the road now

631:*PAR: [mmm]

632:*INV: [like] instead of me going into the side of the road

633:*INV: I take the whole road like a car

634:*OBS: [(laughs)]

635:*INV: [much better plan]

636: (1.0)

637:*INV: alright

After acknowledging the participant's discussion of anxiety in the preceding section (not shown here) the interviewer begins, at line 620, to tell a story relating to her own anxiety. In line 621 this

is concretised into a 'really bad experience'. There is a significant pause but the participant does not align here either as a recipient of the story, or of the expressed trouble. Instead, the interviewer continues with the specifics of this story- a cycling accident- over lines 623-35. While the participant does offer some minimal acknowledgements/continuation markers (lines 625 and 631), and the video shows some eye contact, he does not acknowledge or respond to the completion of the story in line 636. Instead, following the pause, the interviewer moves to a different topic. This resistance to assuming the role of story or troubles recipient is noted by the assessors, and scored as indicative of autism.

An example of a similar phenomenon can be found in Extract 6 below. In this extract the prior discussion has been about work and careers:

Extract 6: A16 (13:20)

370:*INV: but I'm guessing - (.) have you got one of those integrated
371:*INV: masters ⌈things yeah (.) er::m⌉
372:*PAR: ⌊yeah (.) it's a undergrad masters⌋
373:*INV: undergrad masters yeah yeah that's what (.) my fiance did
374:INV: but he didn't do it in physics
375: (3.4)
376:INV: cool (.) okay
377: (1.2)

In this instance, the interviewer already knows that the respondent is a physics graduate, and they have been talking about a third party who has recently completed their Masters degree. The interviewer makes a proposal as to the kind of qualification in physics the respondent has, which he affirms in line 372. The interviewer responds by relating that this is the same qualification as

her fiancé has, but stating that 'he didn't do it in physics'. There is a lengthy pause, during which there is eye contact and a small head movement in acknowledgement by the participant. However, no verbal response is produced to either acknowledge the story or to seek further details. Again, this failure to respond is categorised as problematic, with the notes identifying a failure to follow up the interactional 'press'.

These kinds of 'presses' are included in the ADOS precisely because a failure to respond appropriately to them is seen as characteristic of autism. An inability to engage in social communication and a lack of awareness of another's feelings or emotions are diagnostic criteria of autism, and so the failure to respond to presses like these is taken as the interactional manifestation of autism. The diagnostic importance of these instances for the ADOS means that it is critical that they can be accurately and appropriately identified. However, given the messiness of talk-in-interaction in general, we suggest that this task may be more challenging than is generally acknowledged. Extract 7 below shows another example of a 'press' which is not responded to, which we argue is much more ambiguous than the two we have seen so far:

Extract 7: A10 (15:00)

488 *INV: do you like rollercoasters and - and fairs and -
489 *PAR: I don't like big rollercoasters
490 *INV: yeah
491 *PAR: yeah (.) I know it seems a little bit silly but
492 *PAR: I only like the little roller⌈coasters⌉
493 *INV: ⌊yeah ⌋
494 *PAR: the little kiddy ones
495 *INV: do you feel scared on the big ones
496 *PPP: (1.3)
497 *PAR: I (.) haven't even been on one yet
498 *INV: okay ⌈does the thought⌉
499 *PAR: ⌊??xxx?? ??xxx?? ⌋
500 *INV: of it

501 *PAR: yeah
502 *INV: [yeah]
503 *PAR: [the thought] of it s- scared me
504 *INV: yeah (.) me too (.) can you describe that feeling
505 (2.1)
506 *PAR: I-
507 (1.1)
508 *PAR: (h) (h) (h)it's scaring me even thinking [of one]
509 *INV: [oh really]
510 *INV: okay we'll move on ye- I don't like them either
511 *INV: I used to like them but then last year I went on one and since then
512 (4.5)
513 *INV: okay (.) er::m (.) so::
514 *INV: so you're at college at the moment

In this extract, the interviewer and participant are talking about rollercoasters, prompted by the participant having revealed that he is about to make a trip to Blackpool, an English town with a famous funfair (talk not shown here). The interviewer attempts to use this topic to discuss the feeling of being scared (line 504), but the participant resists this, initially delaying and eventually explicitly producing an account that even thinking about this is scary (line 508). At line 510 the interviewer acknowledges this by producing a topic closure indicative statement- 'we'll move on' - before immediately embarking on a story about her own trip on a rollercoaster last year. There is a lengthy pause, before the interviewer does move to a new topic at 513.

The notes suggest that this introduction of the interviewer's story about a rollercoaster was intended as a press, and the lack of response is rated by one of the two scorers as problematic for that reason. However, we would argue that a judgement about whether this instance is to be considered consequential is very delicate, and complicated by the fact that there is an arguably mixed message sent by the tester. The participant's response could be read as a lack of orientation

to the story, and a resistance to occupying the role of story recipient. Equally, however, it could be read as a competent orientation to the signalled closing of a topic; the 'we'll move on' produced by the interviewer in line 510. Another ambiguity is introduced by the fact that the interviewer's turn to continue the topic in line 511 is grammatically incomplete, so the participant could simply be waiting for the completion of this utterance. The fact that only one of the two scorers scores it as problematic highlights these ambiguities.

This kind of ambiguity over how an utterance's appropriateness is to be interpreted is evident in other locations in our data, demonstrating how much the actions of the tester contribute to the 'interactional substrate' of the ADOS. The example below is taken from earlier in session A10.

Extract 8: A10 (10:07)

329 *INV: yea::h (.) did you go swimming
330 *PAR: yeah
331 *INV: did you like it
332 *PAR: yeah
333 (1.5)
334 *INV: I used to like swimming in the sea but I don't like it anymore
335 (1.0)
336 *PAR: yeah
337 (1.0)
338 *PAR: ??one of my?? (.) dogs is terrified of sand

In this instance, the topic of conversation is holidays; having established that the participant went swimming on their recent holiday (329-30), and that they enjoyed it, (331-32) the interviewer then offers the beginning of a story or trouble in line 334. There is a minimal acknowledgement of this from the participant before he then begins to talk on a different topic in line 338. This exchange is scored by both scorers as a failure to respond to the press, indicative of autism. However, we

would argue that just as there is ambiguity in Extract 8 above over whether the respondent is actually orienting to a different interactional contingency, there is also potential ambiguity here. In ordinary interaction, participants may sometimes respond to a story by producing a story of their own, rather than by continuing to inhabit the role of story recipient. Second stories are generally built to show that they are picking up the point of the previous story, or are "touched off" by them (Sacks 1992: 771). In this instance, then, it is possible that the participant's response in line 338, which continues with the broad theme of anxiety at the seaside, is designed as a relevant contribution in this way.

Analysing the scoring notes alongside the three categories of resistance we have identified in these data shows that it is this third category of resistance, resistance to a line of conversational action, that is the most consequential in terms of its likely diagnostic implications. It appears, however, that this is also the most interactionally complex category, so that the potential for ambiguity of interpretation is greater. We argue that this ambiguity is related to the fact that any resistance displayed in response to an ADOS interactional 'press' is inherently likely to be much more indirect than that displayed in response to a request for action, or as a pre-emptive strike against categorisation. Direct requests, for example, fit an adjacency pair format and conditional relevance of the response is a normative requirement, so that pursuit of a request is both expected and accepted where a relevant response does not occur. A failure to align as a troubles recipient in response to someone else's expressed difficulties is both less straightforwardly accountable and more likely to be done indirectly.

Previous CA work suggests that one way in which resistance may be indirectly expressed in healthcare is by clients withholding a response to an expressed perspective (Heritage and Sefi 2002, Stivers 2007), but such withholding in these contexts is not necessarily treated as accountable or pursued. ADOS examiners, then, are required to make two sets of incredibly complex interactional judgements as part of their categorisation process: firstly whether what they have observed is

indicative of resistance (in the sense that it acts to stop the progress of an interactional trajectory); and second whether that resistance is significant for the diagnostic process. Given the complexities involved, it is no surprise that this is not always a clear-cut judgement. As our examples above have shown, in some cases where resistance is categorised there are other, plausible interpretations; these would in fact display different kinds of 'normal' interactional competencies on the part of the participants.

Discussion

Our analysis of ADOS examinations has noted several prominent features of diagnostic interactions. First, neither participant nor diagnostician is 'institutionally determined' (Gill & Maynard 1995: 15); both parties behave reflexively and in response to the local particularities of the interaction. In the case of participants, these situated responses include a range of resistances to the 'substrate of the testing' (Maynard and Marlaire 1992) including the filming of sessions, tests that are perceived to be 'too babyish', and the conversational actions of the examiner.

Given that autism is a condition 'where talk is the problem' (Garcia 2012) these resistances to conversational flow pose a particular problem for diagnosticians. We have shown that testers are engaged in constant judgments about the kinds of resistance they are experiencing, determining which kinds of resistance are to be considered consequential for diagnosis. Our findings demonstrate that not all kinds of resistance are considered equal in the ADOS. Resisting a proposed task as inappropriate, or resisting the characterisation of a particular behaviour as 'autistic', is likely to pass unremarked. Resistance to a line of conversational action – a failure to respond appropriately to a conversational 'press' from an examiner – is, however, often determined to be consequential and indicative of autism. This is despite the fact that firstly, similar forms of resistance can be evident and deemed purposive in other healthcare settings (Gill & Maynard 1995; Stivers 2007) and, secondly, they can be difficult to identify with absolute clarity given the degree of interpretation that is required.

630 It is however important to note that our sample is both small and particular. Participants were
631 intellectually able and demonstrated a degree of insight that may not be common across the
632 population with whom the ADOS is used. Participants also had a pre-existing diagnosis of
633 autism/autism spectrum and no clinical consequences followed from this particular encounter. As
634 we stress in the analysis, these factors limit the extent to which generalisation to clinical settings or
635 other populations is appropriate. Also noteworthy is the significant contrast between some of the
636 standard ADOS processes and the general norms of wider healthcare interaction; for example, it
637 is not usual in healthcare encounters for the professional to initiate stories about their own
638 difficulties. What little evidence there is for the impact of other departures from the interactional
639 norm in healthcare suggests that, unsurprisingly, this can cause significant difficulty for both parties
640 in assimilating the new interactional 'rules'. Previous CA work on genetic counselling, for instance,
641 shows the difficulties clients experience where a non-directive ethos means that they are expected
642 to set their own agendas and understand that practitioners will not make testing recommendations
643 for them (Pilnick 2002a, 2002b). From a practitioner perspective, CA work to shed light on the
644 unease caused by patients complimenting surgeons in pre-surgery consultations shows that
645 compliments offered before treatment recommendations can engender resistance from surgeons
646 concerned with patient motivation (Hudak et al 2010). Though these studies are from very
647 different contexts, their findings highlight expectations of how healthcare encounters 'normally'
648 work, and the consequences of deviations.

649 Despite the above notes of caution, we do feel some generalisable claims are possible. As a CA
650 analyst, one has the benefit of repeated detailed viewings of an interaction, and the ability to unpack
651 an unfolding interaction sequentially, before arriving at an interpretation. Even with the capacity
652 to re-watch diagnostic encounters on video, time pressures ensure that these luxuries are not
653 routinely available to ADOS practitioners. Nonetheless, interpretation is crucial given the
654 consequences – positive, negative, and uncertain – of a diagnosis of autism. We began by noting
655 that it was not our intention to be critical of practitioners, and our analysis has shown the complex

interactional judgments that are required of them. It is in this context that we offer the following two conclusions.

First, it is crucial that ADOS practitioners have a firm grounding in how 'ordinary' conversation works, including an understanding of the everyday forms of resistance which occur in everyday talk. To make judgements on what constitutes 'interactional abnormality' without a nuanced understanding of what constitutes 'interactional normality' seems, to us, problematic. Second, our analysis highlights that, rather than framing practitioners as 'stooges' in the traditional sense, reflexive practice for those using the ADOS, or indeed any diagnostic tool where 'talk is the problem', is essential. We suggest this reflexive practice needs to sit alongside an increased and sustained commitment to acknowledging the potential impact of the substrate of interaction-based testing upon results. This chimes with Stokoe's (2013) call to consider the ways in which the interactional 'stakes' of a manufactured activity may be seen to differ from 'ordinary' interaction, and the impact this may have on interactional practices. In this specific context, failure to acknowledge the need for reflexive practice may have an impact on the security with which an autism diagnosis can be viewed, but more pervasively, it may deny individuals undergoing these kinds of tests the mundane opportunities for interactional resistance that are ordinarily open to others.

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