Relational work in therapeutic interaction

A comparative conversation analytic study on psychoanalysis, cognitive psychotherapy and resource-centred counselling

Elina Weiste

ACADEMIC DISSERTATION

To be presented, with the permission of the Faculty of Social Sciences of the University of Helsinki, for public examination in lecture room 13, University Main Building, on December 18th 2015, at 13 o’clock.
“Psychotherapy is at root a human relationship”

(Norcross & Wampold 2011: 101)
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Abstract

The quality of the therapeutic relationship is highly significant for treatment outcomes in mental healthcare. While the value of the relationship has been clearly documented, the various aspects of how the relationship is actualized in clinical practice have remained unclear. This dissertation breaks new ground in understanding how the therapeutic relationship is manifested in three forms of therapeutic interaction: psychoanalysis, cognitive psychotherapy and resource-centred counselling. The method of conversation analysis is applied to compare these approaches and reveal how specific aspects of the therapeutic relationship are managed in interaction: 1) how therapists express empathy and respond to clients’ talk on their subjective emotional experiences, 2) how therapists work with experiences that belong to clients’ personal domains of knowledge, and 3) how disagreements are expressed and relational stress managed in therapeutic interaction. The data comprise audio- and video-recorded encounters from each therapeutic approach (86 encounters in total).

The data analysis reveals the fine-grained interactional practices used in the management of the therapeutic relationship. In all the therapeutic approaches, formulating the client’s emotional experience allowed the therapists to display empathic understanding, and prosodic features were important for marking the formulation as either empathic or challenging. In psychoanalysis and cognitive psychotherapy, the client’s emotional experiences were typically validated, interpreted or challenged. In the resource-centred approach, the clinicians sought to focus on successful experiences and praised clients’ agency and competence, while shifting the focus away from their difficult emotional experiences. The data analysis also highlights the complex relationship between emotions and epistemics and describes how a delicate balance between empathic and challenging interventions is manifested in therapists’ supportive and unsupportive moves during extended disagreement sequences.

This dissertation contributes to three areas of research: 1) clinical research, as it underlines the importance of investigating the actions of the therapist and client in a relational way, furthering comprehension of how the processes associated with the therapeutic relationship appear in the context of interaction between therapist and client; 2) sociological studies on mental health, as this study illustrates some important institutional differences between psychotherapy and psychiatric outpatient care; 3) conversation analysis, as this research provides the first broader systematic comparison of interactional practices in different therapeutic approaches.
List of original publications

This thesis is based on the following publications:


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The publications are referred to in the text by their roman numerals.
Abbreviations

Transcription Symbols (Jefferson 2004)

T: Speaker identification: therapist (T), occupational therapist (OT), client (C)
→ Line containing phenomenon discussed in text
[ ] Overlapping talk
= No space between turns
(.) A pause of less than 0.2 seconds
(0.0) Pause: silence measured in seconds and tenths of a second
°word ° Talk lower volume than the surrounding talk
WORD Talk louder volume than the surrounding talk
.hh An in breath
hh An out breath
mt, krhm vocal noises
£word£ Spoken in a smiley voice
@word@ Spoken in an animated voice
#word# Spoken in a creaky voice
wo(h)rd Laugh particle inserted within a word
((word)) Transcriber’s comments
( ) Transcriber could not hear what was said
word Accented sound or syllable
- Abrupt cut-off of preceding sound
: Lengthening of a sound
>word< Talk faster than the surrounding talk
<word> Talk slower than the surrounding talk
↑↓ Rise or fall in pitch
? Final rise intonation
, Final level intonation
. Final falling intonation
Dissertation examines the therapeutic relationship in the psychological treatment of mental health problems, namely in psychotherapy and psychiatric outpatient counselling sessions. The relationship between the therapist and client is crucial in mental healthcare. A large body of research has shown that the quality of the relationship between the therapist and client is highly significant for treatment outcomes irrespective of clients’ problems or the form of therapy (Norcross & Wampold 2011). Fewer studies have explored the clinician-client relationship in mainstream psychiatric settings, but there is increasing evidence that a positive therapeutic relationship also improves outcomes in these settings (Priebe & McCabe 2008). While the value of the therapeutic relationship has been clearly documented, the various aspects of how the relationship is actualized in clinical practice still remained unclear (e.g., Elliott 2010). The prevailing process-outcome paradigm measures the various components of this relationship (such as alliance, empathy or goal consensus) to identify the elements of an effective therapy relationship that predict outcome (Norcross & Lambert 2011). Nevertheless, this paradigm has been strongly criticized for making overly simplistic assumptions about the complex and dynamic nature of the therapy process (e.g., Stiles & Shapiro 1994). Interest has increasingly turned to specifying the nature of the therapeutic process: how it appears in the context of interaction between the therapist and client (e.g., Elliott 2010; Leiman 2012; Merganthaler 1996; Safran & Muran 2006; Stiles 1992). There is a need for qualitative methods to better understand how the therapeutic process really works (Elliott 2012). This dissertation adopts the conversation analytic method to investigate the situated interactional practices through which relational processes are carried out in naturally occurring therapeutic interaction (Pomerantz & Mandelbaum 2005). The starting point for a conversation analytic approach to this question is that the therapeutic relationship is managed in talk-in-interaction largely through the same social actions that people perform to conduct their ordinary social affairs (e.g., Maynard & Zimmerman 1984). In this dissertation, I describe in detail the actualization of the therapeutic relationship in interaction from three perspectives: 1) how do therapists express empathy and respond to clients’ talk on their subjective experiences, 2) how do therapists work with experiences that belong to clients’ personal domains of knowledge, and 3) how are disagreements expressed and relational stress managed in therapeutic interaction.

The field of mental health care consists of various institutions (e.g., psychiatric hospitals, outpatient clinics, community and half way houses and the practices of private psychotherapists), and professionals in these institutions may represent numerous ideological approaches (e.g., biomedical, psychodynamic, cognitive, solution-oriented) that affect the organization of treatment. Consequently, there is likely to be considerable variation in interactional practices (Peräkylä 2013). This dissertation analyses the interactional aspects of the therapeutic relationship in two institutional contexts, occupational therapy encounters in psychiatric outpatient clinics and psychotherapy in the private practices of psychotherapists. Moreover, these institutions represent three
ideologically different therapeutic schools: psychoanalysis, cognitive psychotherapy and resource-centred counselling. The dissertation explores the similarities between these different schools of therapy and investigates how they differ in the interactional management of the therapeutic relationship.

The dissertation consists of four chapters and five original articles. In the introduction, I first provide a general discussion of mental health and its treatment. Second, to contextualise this research, I provide an overview of previous sociological studies concerning mental health and its treatment. Third, I introduce the institutional contexts of the present research: psychiatric outpatient clinics and psychotherapy. Fourth, general descriptions of the therapeutic approaches investigated in this research are provided: psychoanalysis, cognitive psychotherapy and resource-centred counselling. Fifth, I present previous research on the therapeutic relationship from the perspective of psychotherapy research and then from the vantage point of previous conversation analytic research. Lastly, the dissertation’s research questions are introduced. In the second chapter, methods and data, I describe the theoretical and methodological principles of conversation analysis, present the data and discuss the analytic process of this dissertation. In the results, I summarize the research results of the original articles. Lastly, in the discussion, the results are discussed with regard to the previous literature.

1.1 Mental health and its treatment

Mental health can be defined as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO 2013:7). According to this definition, mental health is thus not merely ‘the absence of disease’ but is seen more broadly as an important part of an individual’s general well-being. According to the general psychiatric definition, mental illnesses are then conditions that disrupt an individual’s thinking, feeling, daily functioning, and the ability to relate to others and his/her surroundings (Lönnqvist & Lehtonen 2011:12-13). Symptoms can range from mild to severe and vary in nature according to the type of mental illness, e.g., depression, schizophrenia, bipolar disorder, anxiety disorder or personality disorder. Mental health problems are remarkably common. According to WHO (2014), approximately one third of people experience sufficient symptoms to be diagnosed with a mental illness at some point in their life. According to the same research, 27% of European adults had experienced at least one mental disorder in the past year (WHO 2014). This is also the case in Finland, where Koskinen et al. (2012) showed that approximately one in five adults had experienced some mental disorder, most commonly depression (approximately 13%) or anxiety disorder (approximately 10%) in the past year. Given the prevalence of mental health problems, their financial burden on society is enormous, amounting to between three and four percent of gross national product in Western countries (WHO 2014). For instance, in Finland, the direct cost of treating mental disorders is approximately 692 million euros, 13 percent of the total cost of treating diseases (Sillanpää et al. 2008:171). Moreover, the indirect costs of mental health problems (e.g., disability support and loss of productivity) are calculated to be as high as 2.5 billion euros, or 26 percent of the indirect costs of all diseases. In addition to their economic burden, mental health problems cause
considerable personal suffering, having a significant, long-term impact on the quality of life of both the individual sufferers and whole families (WHO 2014). As a consequence, optimal treatment of mental health problems is extremely important from both an individual and economic perspective.

Despite the enormous burden that mental health problems place on individuals, families and societies, their treatment is insufficient. According to the WHO (2013), 35 to 50 percent of people with severe mental illnesses receive no treatment for their problems in Western countries. In Finland, it is estimated that only one fifth of those suffering from mental health problems receive sufficient psychiatric care, and over half receive no treatment at all (Joukamaa et al. 2011). Treatment of mental health problems can be divided into biologically based treatments (drugs and electroconvulsive therapy) and psychosocial treatments. The focus of this dissertation is psychosocial treatments, specifically counselling and therapeutic treatments that aim to increase the client’s sense of well-being and the ability to better cope with the problems of life (Corey 1991). Common to different counselling and therapeutic treatments is the centrality of talk as an activity and means of healing (Peräkylä 2013). This dissertation studies talk in psychotherapeutic and outpatient counselling encounters. The approach adopted, conversation analysis, is micro-sociological, describing therapeutic encounters as social actions conducted by therapists and clients in their naturally occurring interaction. Next, I will provide a broader description of how mental health and illness are approached in a sociological framework.

1.1.1 Sociology of mental health

Today, research on mental health and illness is a multidisciplinary field; however it has traditionally been the preserve of psychiatry and psychology, whose interest has mainly been the intra-individual aspects of mental illnesses. In contrast, sociological research explores the ‘social patterning’ of mental health, the meanings of illnesses and the organization of their treatments (Watson et al. 2014:125). There is no single sociological style for understanding mental illness. Here, I describe five different angles from which it has been approached. The first three, etiologic research, social constructivism and social consequences, are widely presented in comprehensive text books on the sociology of mental health (e.g., Aneshensel et al. 2013a; Johnson et al. 2014). They are supplemented by professionals and institutions, and micro-sociology, which are also frequently occurring approaches to the sociology of mental health and particularly important for this dissertation.

Etiologic research. The dominant tradition in the sociology of mental health searches for the social causes of mental illnesses (Horwitz 2013). This etiologic research aims to explain why mental disorders are more common among some people in a given society than others. The tradition evolved from Durkheim’s ([1987] 1951) classic study, which investigated the variation in suicide rates among different social groups. Another seminal study was Faris and Dunham’s (1939) exploration of different rates of schizophrenia, alcoholism and organic psychosis across city neighbourhoods, which found higher rates in those patients from poor neighbourhoods. Later on, early community surveys of mental health confirmed the relationship between low socioeconomic status and the prevalence of mental health problems (Pilgrim & Rogers 1993). Since then it has repeatedly been
demonstrated that mental health problems are not randomly distributed throughout society; rather, factors such as gender and socioeconomic and marital status affect a person’s chance of developing a certain disorder (Aneshensel et al. 2013b). Today, there are strong indications that exposure to stress is one of the central ways in which social factors affect mental health (Thoits 2010). Moreover, etiologic research has shown that various forms of social support are significantly associated with mental health and have the most influence on those who are in the most stressful situations (Turner et al. 2014).

**Social constructivism.** In the sociology of mental health, there are also traditions critical of the mainstream psychiatric view of mental illnesses. Social constructivism has focused on the considerable social and cultural variation in how mental illness is understood (Watson et al. 2014:125). For instance, Michel Foucault (1965) argued that mental illnesses exist not in the symptoms displayed by individuals but in changing cultural categorizations of what is considered deviant behaviour. Some commentators have also remarked on the impossibility of designating what constitutes a mental disorder without defining what is ‘normal’ (Horwitz 2013). Social constructivists have raised the question of who has the power to decide what is normal, and whether psychopathology is even on the same continuum as normality (Aneshensel et al. 2013b). The criticism of social constructivists is often directed against the medical model (mainstream model in psychiatry), which views disruptive behaviours and feelings as symptoms of mental illness. They ask whether ‘mental illness’ is a true disease at all or simply a label applied by society to individuals behaving or feeling in a disruptive way (Aneshensel et al. 2013b). Moreover, they highlight that what is considered disruptive varies across time and cultures, as we can see, for instance, in the process of medicalizing and eventually demedicalizing homosexuality (Conrad & Slodden 2013). The process of medicalizing the problematic aspects of life (e.g., sadness or children’s difficulties in concentrating in school classes) has attracted a steady stream of criticism against the medical model. For instance, Furedi (2004) has described how psychiatric terms like stress, anxiety, compulsion, trauma and addiction have become common ways to describe the experiences of daily life. He writes:

*The growth of a therapeutic vocabulary is equally striking. Words that were virtually unknown and unheard by the public in the 1970s would be recognised by most people by the early 1990s. Even in the 1980s, people had never heard of terms like generalised anxiety disorder (being worried), social anxiety disorder (being shy), social phobia (being really shy), or free-floating anxiety (not knowing what you are worried about)* (Furedi 2004:2).

Furedi (2004) argues that pathologizing bad feelings and objectifying the uncertainties of life into risks beyond individual control leads to a profound sense of emotional vulnerability, powerlessness and helplessness. Therapeutic culture, which insists that the management of life requires continuous therapeutic interventions, has become the dominant social force in individuals’ efforts to cope with their fragile sense of self and their perception of vulnerability and risk (Furedi 2004). The expansion of mental health and well-being paradigms to every area of life has also affected the treatment of mental health disorders. If mental health care has traditionally focused on treatment and care, today the emphasis is increasingly on the management of risks and life-skills (Helén et al. 2011). Helén et al. (2011) have analysed, for instance, the development of depression as a
chronic disease in Finland. They claim that the emphasis on symptoms in treatment standards for depression has made anticipatory signs of possible depression the main focus of treatment. Diagnosing depression from early signs, and returning the patient to normality with biomedical and psychosocial treatments are preventive and anticipatory operations. They are primary the vehicles for management of an individual’s life, not health care in a traditional sense (Helén et al. 2011:39).

**Social consequences.** The sociology of mental health also encompasses the study of the social consequences of mental illnesses. The aim of such research is to explore the social processes into which those identified as mentally ill are drawn (Aneshensel et al. 2013b). The most comprehensive research in this area concerns the labelling of individuals as mentally ill and the impact of such a stigma on these psychiatric patients. In labelling theory (Scheff 1966), society considers certain behaviour as deviant, and to be able to understand this behaviour places the label of ‘mentally ill’ on those who exhibit it. Individuals with such a label eventually internalize the expectations that relate to the label and begin to act according to those expectations. Thus, the label becomes a ‘self-fulfilling prophecy’. Later applications of the theory have nevertheless stepped away from the claim that labelling directly causes the mental illness (Link & Phelan 2013). Rather, they highlight people’s own theories about what it means to be mentally ill. If the lay theory is that people with mental illnesses are feared and rejected, those suffering from mental illnesses begin to expect that this is how they will be treated. Eventually, this affects their ability to function in society, harming their chances of employment, social relations and self-esteem (Link & Phelan 2013).

Another major contribution to research on the social consequences of mental illnesses has been Goffman’s (1963a) investigation of stigma: how people manage their stigmatized identity and control information about it. According to Goffman, stigmatization occurs when individuals’ social identity (the social categories and attributes that are related to them) is in contradiction with their virtual identity, i.e. how they are perceived by others in a social situation. There are three types of stigma: ‘abominations of the body’, ‘blemishes of individual character’ inferred from known record (e.g., mental disorders), and the ‘tribal stigma of race, nation, and religion’ (Goffman 1963a:4). Stigmatization causes various forms of discrimination through which the life chances of the stigmatized, for instance a mentally ill person, become remarkable reduced. Goffman was interested in the moral career of the stigmatized person. This career begins at the point when a person learns the standpoint of the normal and becomes aware that he or she is disqualified from it by bearing a stigma (mental disorder). Next, the mentally ill need to learn to cope with the way others treat them. Goffman was especially interested in social situations in which stigmatized and ‘normal’ people meet. His observation was that these encounters cause confusion and uneasiness that need to be managed. The stigmatized mentally ill need to learn a variety of strategies to manage social information about their abiding characteristics. They must constantly evaluate whether to display, tell or share that information, and in each case, to whom, how, when and where. As a consequence, they need to be alive to aspects of social situations which others can treat as uncalculated and unattended, assumedly causing high levels of stress and anxiety (Goffman 1963a).

More recent studies that draw on Goffman’s stigma have placed particular focus on the discrimination process (Link & Phelan 2001). According to Link and Phelan (2001), stigma exists when the following factors come together, mutually influencing each other: First, differences are distinguished and labelled. For instance, psychiatric classification
systems (e.g., DSM) are an example of such labelling. Second, the person with a labelled
difference, for instance schizophrenia, is linked to negative stereotypes, maintained by the
dominant culture (e.g., schizophrenics are dangerous). Third the schizophrenic person is
separated as a substantially different sort of person from the rest of ‘us’. Fourth, emotions
arise: anger, pity and fear are the likely vantage points of a stigmatizer and shame is a
powerful part of the life of the stigmatized schizophrenic. Fourth, the schizophrenic
experiences a loss of status leading to full exclusion, rejection and discrimination. Thus, as
in Goffman’s conceptualization, loss of status and social rejection are prominent features
of stigma. Link and Phelan (2001) have, however, given greater emphasis to social,
cultural, political and economic power relations in the process of stigmatization. Phelan et
al. (2013) have, for instance, discussed the applicability of status characteristics theory to
the problem of stigma for better understanding, and possibly improving, the health of the
population. On basis of the comparison of the concepts of status and stigma, they propose
that stigma is not only an interpersonal but also a macro-level process that may have
similar types of health impacts as socioeconomic status, ethnicity and gender are shown to
have. Phelan et al. (2013) indicate that similar to socioeconomic status, stigma causes a
continuous biological stress reaction that is linked to negative health outcomes, such as
cardiovascular disease and diabetes. For instance, people with schizophrenia are
recognised to have an increased risk for both these diseases compared to the general
population (Hennekens et al. 2005). Moreover, research has shown that for the stigmatized
it is more difficult to get adequate treatment for their health problems compared to the
non-stigmatized. For instance, Druss et al. (2000) showed that individuals with mental
disorders were substantially less likely to receive adequate treatment for heart disease than
those without mental disorders. Hatzenbuehler et al. (2013) have argued that stigmatization is a ‘fundamental cause of disease‘, as the stigmatized person is likely to have poorer resources in terms of money, power and social connections.

The process of stigmatization is also affected by the mass media, which is an important
source of messages stigmatizing mental illness (Wahl 1995). In the mass media, people
with mental illnesses are often portrayed as having negative qualities, such as being
incompetent or dangerous. It has also been demonstrated that there are significant
differences in tackling the stigma of mental illness in different cultures. A study analysing
the visual methods and strategies of anti-stigma campaigns in Europe and China found
that in Europe campaigns focused on the stigma experienced by individuals, while in
China the campaigns mainly stressed the stigma experienced by family members (Prokop
& Ozegalska-Lukasik 2014).

Professionals and institutions. Another important area for research on the sociology of
mental health has been mental health professions and institutions that provide psychiatric
services. Several studies have examined psychiatric hospitals, their organization and
division of labour. In his seminal work, Asylums, Goffman (1961) considered psychiatric
hospitals ‘total institutions’. Based on his ethnographic field work, Goffman described the
characteristics of these institutions as follows:
1. Total institutions are geographically isolated from local communities.
2. Patients have restricted contact with the world outside the institution.
3. The social distance between patients and staff is great and formally prescribed.
4. All aspects of life, such as work, leisure and rest, are conducted in the same place and
   under the surveillance of the same authority, without any privacy.
5. All activities are carried on in the immediate company of other patients.
6. There is no family-life.
7. Daily activities are tightly scheduled from above.
8. Detailed rules that are supported with punishments guide the life of the patients.

Goffman was especially interested in patients’ image of the self in total institutions. Entering the hospital, patients undergo the ‘mortification of self’, a process in which an individual is deprived of his or her previous identity. This involves stripping individuals of their previous affirmation of self, for instance by taking away their personal belongings and making them wear hospital-owned clothes. Eventually, few clues remain which would reveal the social status of the patient in the outside world. The patients are doomed to a ‘total identity’: there is no privacy and no possibility of distancing themselves from the role of the patient.

Although Goffman’s work has later been highly criticized (e.g., Weinstein 1982), it was a key text in the anti-psychiatric movement and the development of deinstitutionalization in the late 1950s and 1960s. Some of his ideas were empirically tested in Rosenhan’s (1973) famous experiment, in which he and his research team, posing as potential patients, asked for admission to various mental hospitals on the basis of claiming to have heard (just once) a voice that said ‘thud’, ‘empty’ or ‘hollow’. All were admitted, and most were diagnosed as schizophrenics. Once they were taken into the ward, they began to behave normally. Most of the other patients, but none of the personnel, realized that they were not real patients. Based on the experiment, Rosenhan concluded that psychiatrists are guided by a readiness to see healthy people as disturbed. He strongly criticized psychiatric hospitals for depersonalising patients and making them invisible, depriving them of the power to affect their circumstances. The behaviour and thoughts of patients were stripped away from their original contexts and connected solely with the medical disorder and its symptoms (Rosenhan 1973).

Moreover, power relations in psychiatric institutions have remained a central field of research in the sociology of mental health (e.g., Rose 1998). For instance, Hook (2003) has discussed ‘governmental psychotherapy’, a complex mode of power in which governmental duties have been extended to include therapists who are qualified and authorized to guide people in how to think, act and interact. As in Parsonian (1951) research on medical interaction, the relationship between the therapist and client is often described as asymmetric, and therapists are presumed to possess professional knowledge and dominance over clients’ experiences and understandings. For instance, the asymmetry between the knowledge of the therapist and the client, which maintains the therapist’s authority at the expense of the patient’s, has been a prominent source of criticism directed at the classical psychoanalytic tradition (e.g., Masson 1992).

Sociologists have also been interested in the ideologies of psychiatric institutions and the knowledge-bases that such ideologies provide mental health professionals. In their seminal ethnographic study on psychiatric hospitals, Strauss et al. (1981) described the complex interplay between institutional, ideological and professional forces that affected the treatment practices of the hospitals they studied. They defined psychiatric ideologies as the shared and collective set of ideas about the etiology and treatment of mental illnesses affecting professionals’ style of operating in psychiatric institutions (Strauss et al. 1981:8). Strauss and colleagues described three ideologies that dominated the psychiatric field in the 1960s: somatic (organically based etiology and treatment procedures), psychotherapeutic (psychological views of etiology and treatment) and sociotherapeutic or ‘milieu therapy’ (emphasis on environmental factors in etiology and treatment). They found great ideological variation between psychiatric institutions, with particular hospitals
characterized as representing certain ideologies. These ideologies affected the organization of treatment and division of labour. In similar institutional conditions, individuals with different ideological positions operated dissimilarly, emphasizing different elements of the treatments available. They also found that professional affiliation strongly influenced professionals’ ideological position; for instance, psychologists and social workers tended strongly towards the sociotherapeutic approach, psychiatrists were consistently either psychotherapeutic or somatic, and nurses adopted all three approaches, lacking clear ideological consistency. Strauss et al. suggested that ideological commitments were built into professional training, and the later circumstances under which a professional worked typically encouraged further development of the position they originally held.

**Micro-sociology.** Micro-sociology shares a common interest with the studies introduced above in investigating mental health professionals and institutions. The perspective, however, is different. Micro-sociology focuses on the language use of professionals and clients in different mental health encounters. The relationship between microsociology and other approaches to the sociology of mental health will be explored in the Discussion section.

The qualitative analysis of recorded therapeutic interaction began with Pittenger et al. (1961), in a study which described the first five minutes of an initial psychiatric interview. This was followed by Scheflen (1973), who presented a microanalysis of a video-recorded segment of family therapy, focusing on the coordination of language use and the non-verbal communication of the participants. Another pioneering work is Labov and Fanshel’s (1977) investigation of a single 15-minute segment of psychotherapy interaction. By examining the actions the therapist performed in his talk, they addressed themes that are still pertinent to the professional understanding of psychotherapy. More recently, conversation analysis has become an increasingly popular method for investigating the social action of participants and the institutional contexts that are created and renewed by these actions (Heritage 1984). For instance, Bergmann (1992) has discussed the veiled moral characteristics of psychiatrists’ talk, analysing how the contradiction between medicine and morality found in psychiatry appears at the level of turns of talk. Davis (1986) analysed a psychiatric interview from a feminist perspective, showing how the problem the client presented (difficulties in her full-time housewife role) was reformulated as a therapy problem (difficulties in expressing emotions). Peräkylä (e.g., 2004; 2008; 2013) has done extensive work in studying the intersubjective nature of psychotherapeutic interaction.

Following this approach, the present dissertation adopts a conversation analytic perspective and studies therapeutic institutions and ideologies as they are constituted by the participants through the composition and placement of their utterances in naturally occurring interaction. This approach is adopted because in most of the mental healthcare professions talking is the key activity through which professionals perform their work. Conversation analysis, as the study of talk-in-interaction, is therefore an apt method for investigating how mental healthcare institutions are ‘talked into being’ through social actions conducted by professionals and their clients in naturally occurring interaction (Heritage 1984). Conversation analysis can offer other sociological approaches to mental health research a detailed perspective on what people do in practice to sustain and renew these institutions. Moreover, the analysis of social actions can reveal the ideologies of professionals. As Strauss et al. (1981:9) have noted, ideologies are best studied when professionals ‘talk of and act out their beliefs’.
Previous conversation analytic studies on psychiatry and psychotherapy will be discussed more closely in the following sections. Prior to that, however, I wish to contextualize the analysis presented in this dissertation by providing a general description of the institutional features of psychiatric outpatient clinics and psychotherapy, the focal contexts of this dissertation.

1.1.2 Psychiatric outpatient clinics

The focus of this dissertation is therapeutic encounters that occur both in private psychotherapy practices and state psychiatric outpatient clinics. I will first discuss outpatient clinics.

Today, the majority of patients in need of psychiatric services are treated in outpatient care, most often in community-based outpatient clinics (Lönnqvist et al. 2011). Generally, mild psychiatric problems are treated in primary care and more severe problems in specialized outpatient clinics. Psychiatric hospitals supplement outpatient services in the most severe cases and in particularly acute crises. In Finland, psychiatric outpatient clinics are part of specialized public sector psychiatric services that provide psychiatric consultation, treatment and rehabilitation for the adult population. They treat a very broad range of mental disorders, which can vary from acute to chronic states. The services are free of charge for the client, but a referral from primary care is needed.

Outpatient treatment is provided by an interdisciplinary treatment team that engages collaboratively with the client to develop a plan of care. The treatment involves periodic visits to a psychiatrist and a key-worker, who can be, depending on the clinic, a psychiatric nurse, psychologist, occupational therapist or social worker. Depending on the client’s problems, the plan of care can also involve, for instance, family-work, psychoeducation or different types of group therapy. Individual counselling sessions, which are the focus of this research, constitute the central part of the treatment. The general aim of the sessions is to review the client’s wellbeing and mental state, offer support, and sustain or increase the client’s functional capacity. In addition, the plan of care may also include individual discussions with a specific professional on designated goals. The treatment process is often open-ended and the meetings are typically every two weeks.

The sub-study on outpatient clinics presented in the present dissertation explores individual counselling sessions between clients and one group of professionals in the interdisciplinary treatment teams: occupational therapists. Occupational therapy is a certified healthcare profession which aims to promote, maintain or restore clients’ wellbeing and functional independence through meaningful activities (WFOT 2012). The primary goal is to enable clients to participate in the activities of everyday life: taking care of themselves, managing domestic life, coping at school and work, societal participation, spending leisure time and resting. This goal is achieved by working with clients to enhance their ability to engage in the activities they want to, need to, or are expected to perform, or by modifying the activities or the environment to better support their engagement (WFOT 2012). Occupational therapists often use different types of activities meaningful to the client as therapeutic tools for precipitating changes in the client’s function and performance (Creek 2014). Clients are actively involved in the therapeutic process, and the general goal of the interventions is to increase the client’s functional performance and develop skills to support health, wellbeing and life satisfaction.
1.1.3 Psychotherapy

Psychotherapy is a general term for the treatment of mental disorders by psychological means. Psychotherapeutic treatment often takes place between an individual client and a therapist, but it may also be provided for couples, families or a group of people. Wampold (2001:3) provides the following definition of psychotherapy:

*Psychotherapy is a primary interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client’s disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint.*

According to this definition, psychotherapy always involves an interpersonal, communicative relationship between therapist and client (Wampold 2001:3). Accordingly, psychotherapy has often been called ‘the talking cure’. Interaction between the therapist and client is intended to promote change in the client’s thoughts, emotions, behaviour or social relationships (Peräkylä et al. 2008).

Psychotherapists are healthcare or social work professionals who obtain a certified clinical degree in psychotherapy (the certification system varies between countries). In Finland, approximately half of trained psychotherapists work in public healthcare (Knekt et al. 2010). However, because, for adults especially, long periods of psychotherapy are rarely provided by public healthcare, the private sector, which provides services for a fee to clients and municipalities, is also very important (Knekt et al. 2010). The most significant public funder for long periods of psychotherapy is KELA (the Social Insurance Institution of Finland), which can reimburse the costs of rehabilitative psychotherapy (KELA 2015). The client must be 16 to 67 years old and psychotherapy must be deemed necessary in order to maintain or enhance the client’s ability to cope at school or work.

Mainstream psychiatric outpatient services share some features with psychotherapy, while also having some distinct features. For instance, in both settings, the therapeutic relationship is the central element of the treatment process (Priebe & McCabe 2006). In both psychotherapy and individual psychiatric counselling sessions, the general purpose is to explore the thoughts, feelings and behaviour of clients in order to maintain or increase well-being and functional capacity. However, in psychiatry, the focus is often on medical intervention and practical support, and treatment strives more for stability than change in the client’s cognitive and emotional processes (Priebe & McCabe 2006). Psychotherapy typically takes place for a fixed period of time, but in psychiatry the treatment processes are often open ended and may last for several years. In psychiatric outpatient care, the treatment is delivered in interdisciplinary teams, and clients are often simultaneously engaged in relationships with other professionals (Priebe & McCabe 2006). Moreover, professionals in both of these institutionalized contexts may follow a range of theoretical models and therapeutic ideologies that affect what is treated and how. It is estimated that there are more than 400 different therapeutic schools, and professionals often integrate aspects and interventions from different approaches (e.g., Lindfors 1997). Consequently, there is likely to be considerable variation in interactional practices between different therapeutic settings.
In previous conversation analytic studies on therapeutic interaction, the data have typically come from one particular type of therapeutic school. The present dissertation adopts a comparative perspective and discusses the interactional similarities and differences of three ideologically divergent therapeutic schools: psychoanalysis, cognitive psychotherapy and resource-centred counselling. The basic principles of these theoretical frameworks are presented next.

1.2 Therapeutic approaches

In this dissertation three types of ideological approaches to therapeutic treatment are discussed: psychoanalysis, cognitive psychotherapy and resource-centred counselling. These approaches are not, as such, connected to any particular psychiatric institution or mental health professional. For instance, a psychiatrist working in an outpatient clinic can be psychoanalytically oriented and a private psychotherapist can apply resource-centred thinking. In Finland, as a whole, the psychoanalytic and cognitive approaches have dominated the field (Knekt et al. 2010), but recently solution focused and resource-centred approaches have also gained a greater foothold (Riikonen & Vataja 2011).

The three approaches studied in this dissertation can be located on a continuum from expressive to supportive therapies. According to Hellerstein et al. (1994), in expressive therapies the focus is on making clients increasingly aware of the emotions hidden in their unconscious mind. Because the unconscious must be made conscious, the free flow of unconscious material is important: clients are encouraged to say whatever comes into their mind. The therapist listens and offers clarifications, confrontations and interpretations. The therapeutic relationship is crucially important. The focus is on exploring transference, the process in which clients unconsciously redirect their feelings for a significant person to the therapist. In supportive therapies the focus is on supporting and enhancing the client’s strengths, coping skills, self-esteem and capacity to use environmental support. A positive therapeutic relationship is of utmost importance. The therapist is responsive, and therapy-related anxiety is avoided. The emphasis is on understanding and reducing the client’s distress and behavioural dysfunctions. Problematic patterns in the client’s current or past relationships may be explored, but no effort is made to encourage the replication of these patterns in the therapeutic relationship. Interpretations of transference and unconscious conflicts are avoided (Hellerstein et al. 1994).

Supportiveness and expressiveness can be characterized as ‘shell of techniques’ used by therapists of different theoretic approaches (Hellerstein et al. 1994). In everyday practice, however, most therapies involve both supportive and expressive elements, with their relative weighting defining the therapy’s location on the continuum. The three particular approaches studied in this dissertation were chosen because of their different locations on the expressive-supportive continuum, with psychoanalysis being at the expressive end, resource-centred therapy at the supportive end and cognitive psychotherapy somewhere around the middle. In the following sections I will briefly describe the basic ideas of each approach.
1.2.1 Psychoanalysis

The roots of psychoanalytic psychotherapies are in the theory of the development of personality and psychological disorders, developed by Sigmund Freud in the late 1890s (Corey 1991). In psychoanalytic therapy, childhood experiences have an essential meaning in the birth of psychological disorders. The psychological organization of childhood is considered to remain in adulthood, when the past is repeated (often unconsciously) in the present (Tähkä 1993). The general purpose of psychoanalytic therapy is to increase clients’ self-knowledge of their unconscious conflicts, eventually making symptom formation unnecessary (Tähkä 1993). There are three key concepts concerning the therapeutic relationship in psychoanalytic theory: transference, counter-transference and resistance. Transference means that the client unconsciously experiences the therapist as a central figure from his or her own past and transfers the emotions associated with that figure to the therapist (Greenson 1967). It is thought that transference allows the client to bring developmentally crucial past relations to the therapy, and thus working with it and making the client conscious of it is one of the cornerstones of psychoanalytical therapy. Another central term related to transference work is counter-transference, meaning the emotions and images awakened in the therapist by the client (Hayes et al. 2011). The reactions aroused in the therapist through counter-transference can be the only key to understanding the client’s mental world. With its help, wordless communication can arise, helping interaction between the therapist and client. In a therapeutic relationship, the resistance of the client is also central. Resistance is thought to be an attempt to maintain a symptom image, possibly as the only way for the client to maintain some kind of psychological balance (Tähkä 1993). Discussing resistance, exploring its meaning and allowing expressions of the emotions related to it are essential in psychoanalytic therapy (Tähkä 1993).

Psychoanalytic techniques are divided into four different but often overlapping techniques: confrontation, clarification, interpretation and working through (Greenson 1967). The most central of these is interpretation, and its significance is considered to be a factor distinguishing it from other schools of psychotherapy (Greenson 1967). Interpretation refers to a statement made by the analyst claiming that the client’s dream, symptom or chain of free associations is the result of something below the client’s conscious awareness (Rycroft [1995]1968). In interpretation, the unconscious meaning, its history and relevance to the client’s other experiences are made increasingly conscious (Greenson 1967). In resistance interpretation the therapist reveals the client’s resistance to the therapeutic relationship, and the interpretation is intended to find the unconscious reasons behind this resistance (Greenson 1967). Such reasons might be associated with the client’s unconscious opposition to change and factors disrupting the existing balance. The client unconsciously desires to prevent the exposure of these reasons through resistance. Nevertheless, with the help of interpretation it is possible for clients to become aware of the reasons for their resistance, enabling them to be worked on during the therapeutic process (Greenson 1967). Well-timed and apt interpretations may allow clients to access their inner world and better understand themselves (Tähkä 1993).
1.2.2 Cognitive psychotherapy

Cognitive psychotherapy is a general title for a theoretical approach, and the therapies developed from it (mainly in the 1970s), in which the input of cognitive factors is determinative (Beck et al. 1979). Cognitive psychotherapy is based on the background assumption that individuals’ affects and behaviour are mainly determined by their way of perceiving the world. Individuals’ cognitions (thoughts, information processing, inner images and memories) are based on attitudes and assumptions formed by earlier experiences (Beck et al. 1979). In cognitive psychotherapy, these cognitions are explored. The therapeutic process aims to allow clients to find an alternative, less problematic way of constructing their experiences and relating to the world. The premise of traditional cognitive psychotherapy is that by changing the substance of cognition, the client’s feelings, behavioural problems or symptoms change (Beck et al. 1979). The construction of alternative thinking in relation to the client’s beliefs is an essential goal for effecting this change.

Central to the therapeutic relationship is collaborative empiricism, which means that the therapist and the client work together to identify and test the client’s automatic and dysfunctional thoughts (Wills & Sanders 1997). The emphasis is on the equal and reciprocal nature of the relationship. Both therapist and client are active, collaboratively exploring the client’s experience (Beck et al. 1979). The techniques are devised to identify, test and correct the distorted conceptualization and dysfunctional beliefs behind clients’ cognitions. The aim of therapy techniques is to teach the client to recognize negative, automatic thoughts and their relation to the client’s feelings. Once automatic thoughts have been identified, their accuracy can be tested and challenged. There are three main techniques for testing and challenging dysfunctional thoughts: guided discovery (aided by Socratic questioning), thought diaries and behavioural tests (Wills & Sanders 1997).

The data for this dissertation come from a cognitive-constructive strand of cognitive therapy. Compared to traditional cognitive therapy, it places greater emphasis on the process of how each individual creates personal representations of self and the world (Toskala & Hartikainen 2005). It is also less instructive and challenging, and attending to the interaction between the therapist and client is seen as essential (Kuusinen 2003). Moreover, the emotional experiences awakened in the therapist by the client and the client’s resistance are considered central factors of the therapeutic relationship. Exploring disturbances in the therapeutic relationship (so called alliance ruptures) is also seen to reveal something of the client’s central problems in interacting with people outside therapy (Leahy 2001). Thus, discussing ruptures provides the possibility of new understanding and change. While ‘classical’ cognitive therapy is seen as contrasting strongly with psychoanalysis, some of the features of cognitive-constructive therapy (e.g., the focus on emotions, transference and counter-transference) suggest a convergence with psychoanalysis (e.g., Guidano 1991; Safran 1998).
1.2.3 Resource-centred counselling

Resource-centred client-work, counselling and therapy all refer to practices with an emphasis on locating and enabling the client’s resources and possibilities (Riikonen & Vataja 2011). Resource-centred practices are connected to empowerment, client centeredness and solution-focused forms of counselling and therapy. However, resource centeredness is a broader perspective connected to a rehabilitational paradigm where the main goal is to locate means of strengthening clients and their social resources with the focus on wellbeing, motivation and factors increasing functionality (Riikonen & Vataja 2011). Typically these factors are found in situations connected to the client’s everyday life, in which only the client can be the best possible expert. In terms of their ideological foundations, resource-centred ideas are close to the basic principles of occupational therapy (e.g., Creek 2014; Sumsion 2006).

Resource centeredness is based on the client’s own goal setting. Because the client’s goals and purposes are central and the professional’s role is close to that of a mentor, the approach has been considered close to coaching in its basic principles (Riikonen & Vataja 2011). The view that relieving mental health problems requires analysis and understanding of their causes has been partially abandoned in resource-centred counselling (Riikonen & Vataja 2011). The emphasis is rather on locating and supporting already well-functioning issues and existing motivation. However, such factors as clients’ perceptions of the causes of their problems are a point of interest, as they play a role in how clients define their problems and set goals. The focus of the therapeutic process is on positive development, success and the analysis of positive periods. Therapy aims to identify clients’ values and motivations and strengthen the activities in their lives that support these values and motivations (Riikonen & Vataja 2011). The relationship between the therapist and the client is seen as that of equal companionship (e.g., Sumsion 2006). Clients’ active involvement in the therapeutic processes is supported and they are encouraged to take the role of experts in their own lives. In the therapeutic relationship, the significance of positive, respectful interaction and listening to the client is emphasized (Sumsion 2006).
1.3 Clinical research on the therapeutic relationship

The previous sections presented some general ideas on the aspects of the therapeutic relationship emphasized in different schools of therapy. Next I will continue to discuss these clinical theories by introducing in more detail some empirical research on the therapeutic relationship. This research mostly comes from the process-outcome paradigm, which is predominant in psychotherapy research. In this paradigm, the basic idea is to measure process variables (e.g., interactional factors such as expressed empathy) and test whether they relate to the overall outcome of the therapy (Timulak 2008). Process-outcome studies have shown that the therapeutic relationship plays a significant role in producing the beneficial effect of psychotherapy: over half its general effectiveness is explained by the quality of the therapeutic relationship (e.g., Horvath 2001; Norcross & Wampold 2011). Moreover, the significance of the therapeutic relationship has been shown to be independent of the therapeutic school or the methods used by the therapist (Norcross & Wampold 2011). According to the common factors theory, the effects of different forms of psychotherapy are largely explained by the same factors: a good working alliance, the ability of the therapist to facilitate this alliance, and the therapist’s trust in his or her own ability to help the client (Wampold 2001). Today, all schools of therapy consider the therapeutic relationship important, although slightly different aspects are often highlighted (Kuusinen & Wahlström 2012).

Next, I will focus on research concerning alliance, empathy and ruptures in the therapeutic relationship, which are issues related to the themes investigated in this dissertation. I will also outline some research findings especially concerned with psychiatric settings and occupational therapy.

1.3.1 Alliance

In several meta-analyses, the therapeutic alliance has been shown to be a significant factor in explaining the efficiency of psychotherapy, regardless of the therapeutic approach (Horvath et al. 2011). Alliance refers to the shared idea of the goals of the therapy as well as the tasks advancing them (Bordin 1979). Mutual trust and the quality and strength of the emotional bond between the therapist and client are also essential. A strong emotional bond between the therapist and client facilitates discussion on goals and tasks, and a shared view strengthens the emotional bond (Kuusinen & Wahlström 2012).

Within psychotherapy research, many different instruments have been developed to measure alliance, where it is assessed on certain scale by the therapist, client and/or an outside observer (Horvath et al. 2011). One example is the Working Alliance Inventory, which assesses the mutual bond between the therapist and client, collaboration on therapeutic tasks and agreement concerning the goals of the therapeutic process (Horvath & Greenberg 1989). Meta-analyses have found that creating a good alliance at the beginning of the therapy process is essential, as it decreases the risk of premature termination of therapy and creates room for therapeutic work (Horvath et al. 2011). A good therapeutic alliance can be considered a precondition for using therapeutic techniques or interventions. It has also been shown that the experiences of therapists and clients on the quality of the alliance can be strikingly different, especially at the beginning of therapy. However as the therapeutic process progresses, the perspectives of the client
and therapist tend to coincide more, and often agree by the end of the process (Horvath et al. 2011). Most often, therapists rate the quality of the alliance higher than do clients, possibly decreasing the favourable outcome of therapeutic interventions. Moreover, the strength of the alliance has been found to vary significantly from one session to another. Thus, it is considered important for therapists to observe changes within the alliance and discuss them when necessary (Horvath et al. 2011).

1.3.2. Empathy

Empathy has been shown to be another central factor explaining the efficiency of psychotherapy (e.g., Horvath 2001; Lambert & Barley 2001; Marziali et al. 1981). Empathy is typically studied by rating its different aspects from recorded therapy sessions. Ratings can be conducted by observers, clients or therapists themselves. In particular, the client’s experience of the therapist’s empathy has been observed to relate to the effectiveness of therapy (Horvath 2001). Due to the multidimensional nature of empathy, there are a number of different rating measurements (e.g., Barkham & Shapiro 1986; Elliott et al. 2011). Interest has also focused on the congruence between the ratings of the therapist and the client (Elliott et al. 2011).

In psychotherapy research, empathy has been conceptualized in different ways. However, in his widely quoted definition, Carl Rogers (1980:86) conceptualized empathy thus: “the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings and struggles from the client’s point of view. It is this ability to see completely through the client’s eyes, to adopt his frame of reference”.

Empathy is often divided into two aspects: cognitive empathy, related to understanding the client’s experiences, and emotional empathy, related to experiencing the client’s feelings (e.g., Bohart & Greenberg 1997; Rogers 1975). Cognitive empathy is often related to ‘person empathy’: the therapist’s effort to understand the client’s experiences, both historical and present, in the context of the client’s current experiences (Elliott et al. 2011). Emotional empathy is linked to communicative attunement, an active, on-going effort to stay attuned to the client’s affective experiences (Elliott et al. 2011). Furthermore, empathy can be considered from different perspectives, for instance, how the therapist resonates with the client’s feelings, how the therapist communicates empathy and how the client experiences the therapist’s empathic communication (Barret-Lennard 1981). The client’s received empathy is further divided into cognitive empathy, emotional empathy, sharing empathy (the therapist shares his/her personal experiences relevant to the client’s ongoing communication) and nurturing empathy (the therapist’s attentive, supportive, secure presence) (Bachelor 1988). The last aspect of empathy is linked to empathic rapport, the therapist’s compassionate and understanding attitude towards the client, which is often seen as general condition necessary for effective treatment (Elliott et al. 2011).

Different schools of therapy nevertheless emphasize slightly different sides of empathy. Psychoanalytic therapy emphasizes ‘person empathy’, the empathy of the therapist towards the client’s whole person (Eagle & Wolitzky 1997). Through empathic understanding it is considered to be possible for the therapist to understand the dynamics of the client’s unconscious. In addition, empathy is thought to be curative in itself, especially if the client failed to receive empathic understanding in childhood (Eagle & Wolitzky 1997). The latter view has also been emphasized within cognitive therapy. The therapists’ empathic understanding is considered to help clients relate to the self and their
own experiences in a new way (Greenberg & Elliott 1997). The importance of empathic reflection, the wording of the client’s inner experience, has also been emphasized. Resource centred therapies highlight the significance of empathic rapport, positive emotional experiences and the support offered by the therapist (SUMSion 2006).

1.3.3 Ruptures in the therapeutic relationship

Psychotherapy research has also studied how problems in the therapeutic relationship occur and how they are solved during the therapy process (Safran et al. 2011). Safran & Muran (2006) highlight the therapeutic alliance as an ongoing negotiation where the strength of the cooperative relationship depends on identifying and solving the ruptures that have occurred. Alliance ruptures can be associated with disagreements about the goals or tasks of the therapy or tensions in the emotional bond between the therapist and client (Safran & Muran 2006). In newer forms of cognitive therapy, ruptures have also been approached from the perspective of the interaction models internalized by the client in childhood (Kuusinen 2003). Such interaction models may become activated during the therapy process and complicate the emergence of the therapeutic relationship. Alliance ruptures can be taken to the level of meta-communication, in which both the interaction and how the client and therapist experience the situation are discussed together (Kuusinen & Wahlström 2012). In psychoanalytic psychotherapy, ruptures are typically understood from the perspective of transference: how client expectations and disappointments in early relationships are redirected to the therapeutic relationship (Tähkä 1993). The therapeutic relationship is considered to be curative, as it can offer a healing interactional experience for the client (Lilja 2011).

1.3.4 The therapeutic relationship in psychiatry and occupational therapy

Although the therapeutic relationship is studied less in mainstream psychiatry than in psychotherapy, it has also been shown to predict treatment outcome in various psychiatric settings (Priebe & McCabe 2008). For instance, a positive relationship between the key-worker and client is shown to be significantly associated with better treatment outcomes for schizophrenic patients (Tattan & Tarrier 2000). A strong working alliance between chronic psychiatric patients and key-workers has also been found to decrease patients’ symptoms, improve functional capacity, social skills and medication compliance, and increase patients’ general quality of life (De Leeuw et al. 2012). Reviews of the research findings (e.g., De Leeuw et al. 2012; McCabe & Priebe 2004) demonstrate that similar factors, such as rapport, empathy and goal consensus, seem to be related to a positive therapeutic relationship in both psychotherapy and psychiatry. There are, however, also differences. For instance, in key-worker consultations the impact of practical help (e.g., providing support for activities in daily life) on the working alliance is reported to be important (De Leeuw et al. 2012; Calsyn et al. 2006). Another specific feature of the therapeutic relationship in psychiatric settings is the fact that it is rarely initiated by the client but instead by clinical personnel (McCabe & Priebe 2004). Consequently, there is often no shared understanding of what is treated and why. Thus, while in psychotherapy the client’s and therapist’s perception of alliance converge during the therapeutic process
(Horvath et al. 2011), in a psychiatric setting this type of concordance is often not achieved (Svensson & Hansson 1999, see McCabe & Priebe 2004). Moreover, setting boundaries and assisting in the management of patients’ finances have noted to have a negative impact on the working alliance (De Leeuw et al. 2012).

A significant relationship between the therapeutic alliance and treatment outcome has also been found in occupational therapy (e.g., Eklund 1996; Morrison & Smith 2013). For instance, Eklund (1996) studied the role of the therapeutic relationship in the treatment outcomes of long-term psychiatric patients receiving occupational therapy in a psychiatric day care unit. She found that patients who had positive relationships with the main therapist showed greater improvement in global mental health criteria and occupational functioning. It has also been shown that a good therapeutic alliance is correlated to increased changes in occupational performance and a decreased level of psychiatric symptoms (Gunnarsson & Eklund 2009). Some scholars have argued that a collaborative, client-centred relationship leads to improved outcomes (e.g., Ayres-Rosa & Hasselkus 1996; Hinojosa et al. 2002; Townsend 2003), while others have placed greater emphasis on empathy and a caring relationship (e.g., Cole & McLean 2003; Peloquin 2005). Overall, both clients and occupational therapists nevertheless consider the therapeutic relationship the most important factor affecting outcome (Hanna & Rodger 2002; Holmqvist et al. 2009; Taylor et al. 2011; Wressle & Samuelsson 2004).

**1.3.5 The gap between outcome correlates and interactional processes**

As noted in the previous sections, process-outcome studies measure various aspects of the therapeutic relationship to identify the elements that predict outcome (Norcross & Lambert 2011). However, this approach has been criticized for making overly simplistic assumptions about the complex and dynamic nature of the therapy process (e.g., Stiles & Shapiro 1994). Moreover, the approach views the therapeutic relationship as one of the elements affecting outcome, rather than as an integral part of the interactive process occurring between therapist and client (Lilja 2011). It is claimed that in order to better understand the therapeutic process the role of interactional factors in the client’s process of change and how the processes associated with the therapeutic relationship appear in the interactional context between therapist and client must be comprehended (Safran & Muran 2006).

Recently, many researchers have turned to qualitative methods for a better understanding of how the therapeutic process really works (Elliott 2010). Conversation analysis has proved to be one valuable means of describing how the therapeutic relationship is conducted in and through the interaction between therapist and client (Elliott 2010; 2012; Lilja 2011).
1.4 Research on therapeutic elements in naturally occurring interaction

In this section I describe how the interactional elements important to the therapeutic relationship are studied in conversation analytic research. Some of this research comes from mundane conversations and some from psychotherapy or other institutional contexts. Conversation analysis posits that the same practices found in ordinary conversations can be employed in institutional contexts like psychotherapy or psychiatric outpatient consultations.

In conversation analysis, relationship is conceptualized differently from the psychotherapeutic research tradition. Conversation analysis describes the situated interactional practices through which relational processes take place in naturally occurring social interaction (Pomerantz & Mandelbaum 2005). Moreover, alliance and communication can be seen as different but interrelated terms (Priebe & McCabe 2006): alliance being a psychological construction held by the therapist and client, and communication referring to components of the behavioural exchange that are observable and describable for an outside observer. Alliance and communication are thus inherently intertwined: the therapeutic alliance can be influenced by communication and communication can be informed by the alliance (Priebe & McCabe 2006). The conversation analytic view on relationship adopted in the present dissertation does not deny the existence of alliance as a psychological construction. However, the analysis is targeted at what is observable: communication. As Maynard and Zimmerman (1984:305) write, “Rather than approaching relationships as a reality lying behind and influencing members’ face-to-face behaviour, we can investigate them for how, in the course of time, they are accomplished within everyday interaction by various speaking practices”. According to this view, relationship is something that is subject to on-going management within talk between individuals, and is embodied in sequentially organized interactional practices (Maynard & Zimmerman 1984; Peräkylä 2013). Next, I will discuss three different themes that are relevant to the management of relationship in interaction and are central to this dissertation: 1) affiliation and empathy, 2) management of epistemic relations and 3) disagreement, resistance and repair of mutual affiliation.

1.4.1 Affiliation and empathy

Research on affiliation and empathy builds upon conversation analytic studies of emotions (Peräkylä & Sorjonen 2012; Ruusuvuori 2013). In conversation analysis, displays of emotion are understood in the context of the actions in which participants in interaction are involved (Peräkylä & Sorjonen 2012). Thus, the resources to display affiliation and empathy are also assumed to be context sensitive and situated at specific sequential positions within interaction (Couper-Kuhlen 2009). Affiliation is used to describe actions in which a recipient displays support for the affective stance expressed by the speaker (Lindström & Sorjonen 2013; Stivers 2008). Stance refers to the speakers’ affective treatment of the event they are talking about (Stivers 2008). It is noted that affiliative responses are made relevant in a range of sequential positions when different types of epistemic, evaluative or affective stances are negotiated (Kupetz 2014). In a therapeutic
context, researchers such as Muntigl et al. (2012) have studied the verbal (formulations) and non-verbal (therapists’ use of nods) practices used by therapists to affiliate themselves with clients’ positions.

Empathic responses are made relevant in more specific sequential contexts when one participant’s personal, often affective, experiences are dealt with (Kupetz 2014). A range of different interactional practices to display empathy have been described: facial expressions, response cries, parallel and subjunctive assessments, follow-up questions, candidate understandings, observer responses, expressions with mental verbs, formulations and second stories (Couper-Kuhlen 2012; Heritage 2011; Kupetz 2014). All these can display understanding of the other person's emotional situation, although they vary widely with regard to their mode (verbal, vocal, kinetic), frame of reference (display of the teller’s or recipient’s side) and orientation to affectivity or understanding (Kupetz 2014). All these practices require some type of orientation to an asymmetry between the teller’s and recipient’s experiential rights and/or emotive involvement (Heritage 2011). The recipient often lacks direct access to the experience the teller is describing, and even if the recipient has independent access to it, he or she needs to decide how to respond without disattending to the specifics of the teller’s description (Heritage 2011). Kupetz (2014) has suggested that it might be useful to conceptualize empathy as displays that range from more affect-oriented (apprehension) to more cognition-oriented (comprehension) (these would be the interactional correlates to emotional empathy and cognitive empathy discussed in psychotherapy research).

In addition to kinetic and verbal means, the prosodic delivery of an utterance is also crucial in empathic displays (Couper-Kuhlen 2012; Selting 1994). Couper-Kuhlen (2012) investigated the prosodic resources used by participants in mundane conversations for conveying empathy in response to displays of anger and indignation. She showed that in verbal expressions of empathy, the speaker either mirrored the prosodic features of the previous speaker’s utterance (prosodic matching) or increased the intensity of the rise in pitch compared to the previous speaker’s utterance (prosodic upgrade). Less empathic verbal responses were produced with less intensity or with a lower pitch than the previous speaker’s utterance (prosodic downgrade).

Empathy displays have also been studied in different institutional contexts. For instance, Ruusuvuori (2007) has investigated how professionals in general practice and homeopathic consultations manage talk on patients’ emotional experiences. In these contexts, empathic practices included displaying understanding of the possible consequences of the problematic situation, describing the patient’s situation as sharable but still owned by the patient, and treating the patient’s experience as relevant and possible. Moreover, Ruusuvuori & Voutilainen (2009) have shown that empathy displays serve remarkably different functions in general practice and homeopathy compared to psychotherapy. In the first two settings, empathic responses provided a quick way of returning to the medical business at hand, whereas in psychotherapy they were used to generate the client’s self-reflection.

Previous CA studies have shown that formulations are repeatedly used for delivering empathetic responses (e.g., Beach & Dixson 2001; Fitzgerald 2001; Hepburn & Potter 2007; Pudlinski 2005). Heritage and Watson (1979) have defined formulations as conversational action in which a speaker proposes a rephrased version of the previous speaker’s utterance, displaying his or her understanding of it. Formulations may present either the gist of the talk thus far or an upshot of some of its unexplained implications (Heritage & Watson 1979). Formulations are often framed with initiating particles and
expressions like so/so that/you mean and designed to mirror the content and form of the client’s previous turn, preserving the client’s perspective (Bercelli et al. 2008). In psychotherapy, at least three different tasks are achieved through formulations. First, formulations can transform the client’s talk into therapeutically relevant issues suitable for closer psychotherapeutic work (Antaki 2008). Davis (1986) was the first to notice how formulations serve to redefine clients’ problems. Vehviläinen (2003) has noted that formulations may prepare the client’s talk for interpretation by verbalising its unconscious layers. Second, formulations can also be used to manage the agenda of the therapy session by closing topics that are not therapeutically interesting (Antaki et al. 2005). Furthermore, Hutchby (2005) has noticed that formulations are used for topicalizing issues and focusing the talk on the client’s own experiences. Third, formulations are used to preparing the client’s talk for the therapist’s subsequent actions. Antaki et al. (2005) have described how this is done by moulding the client’s account into a shape more suitable for later therapeutic work. Thompson (2013) found a positive correlation between the frequency of the use of formulations by psychiatrists in psychiatric outpatient care and better client adherence and more favourable perceptions of the therapeutic relationship by the clinician. She suggested that by formulating the implicit emotional and psychological meanings of the client’s talk, psychiatrists displayed understanding, thereby improving the therapeutic relationship.

Expressions of empathy can also be in the service of other interactional agendas. In the context of cognitive psychotherapy, Voutilainen et al. (2010a) have suggested that empathy is a prerequisite for more interpretive actions that imply access to the client’s experience. They show how empathy and interpretation are combined in specific ways in the therapist’s turns at talk. Sometimes, recognition of the client’s experience (empathic utterance) precedes interpretation as a separate act. Recognition invites agreement from the client, and in this way it can also build the ground for the therapist’s next interpretative action. However, recognition can also be performed through the same utterance that also conveys interpretation. Affective prosody in an interpretative utterance is one way of doing this (Voutilainen et al. 2010a).

In therapeutic contexts the prosody of empathic utterances has not, however, been systematically investigated. Furthermore, research on prosody in emotional situations other than those involving expressions of anger and indignation (the context of Couper-Kuhlen’s study) is needed. As Ruusuvuori and Voutilainen’s (2009) study shows, displays of empathy may take different forms and serve different purposes in various institutional contexts. Because empathy is a crucial element in therapeutic interaction, it would be important to study its appearance across different therapeutic institutions and ideological approaches.
1.4.2 Epistemic relations

In different types of therapy and counselling encounters, asymmetry always exist between participants (Drew 1991). Clients come for help with their problems to a therapist with expert knowledge on the treatment of the human mind and more experience of how such problems can be solved (Fitzgerald 2013). Conversation analytic studies are interested in how therapists and clients enact asymmetries of knowledge through their situational interactions (Drew 1991).

In therapeutic encounters the relationship between the therapist and client involves a specific kind of asymmetry: the talk mainly addresses the client’s experience, which, as such, is unavailable to the therapist (Peräkylä & Silverman 1991; Vehviläinen 2003). However, in order for it to be worked upon in therapy, the therapist needs to have some form of access to the client’s experience, as it is the institutional task of therapists not only to respond to clients’ descriptions but also to reshape them in various ways. This problem of how to respond and describe the experience of others is not unique to therapeutic encounters but is faced in all kinds of conversational situations in which people talk about their personal experiences. It has been observed that in everyday conversation people expect their thoughts, feelings and experiences to be treated as their own to know and describe (Heritage 2011; Sacks 1984). Sacks (1995) discusses this in terms of experiential rights, pointing out that in conversational situations participants’ entitlement to experiences is often asymmetric. Participants have different rights and constraints in respect to describing experiences and expressing the feelings which may be related to those experiences (Sacks 1995). More recently, Heritage (2011) has concluded that because respondents to the reported experiences of others conceive those experiences as owned by the teller, it is difficult to respond to the experience of another without access to that experience. This becomes especially relevant in stretches of talk where one participant reports and displays affectivity to personal experiences and the other is expected to respond in an empathic way (e.g., Couper-Kuhlen 2009; 2012; Stivers 2008).

Recently, Heritage has addressed the question of experiential rights in terms of epistemicity (e.g., Heritage 2013). The idea is that any two speakers in conversation have their own domains of information. In the course of the interaction, specific elements of knowledge can fall within one or other domain, or more often, to differing degrees, within both domains (Heritage 2012). The concept of epistemic status involves this relative epistemic access to a domain of knowledge, stratified between participants in interaction so that they employ a more knowledgeable or less knowledgeable position (Heritage 2013). Epistemic stance, then, involves moment by moment expressions of epistemic status as indexed through the design of turns at talk (Heritage 2013).

To conclude, the organization of epistemicity is recognized to be crucial for working with clients’ experiences in psychotherapy. Nevertheless, therapeutic ideologies seem to differ in what therapists are expected to know about their client’s mind and how they should communicate this knowledge to the client. For instance, in psychoanalysis therapists strive to interpret the psychic events and emotions hidden in the client’s unconscious mind (Greenson 1967). In contrast, cognitive psychotherapy is more focused on here-and-now problems, and therapists make no reference to unconscious mental processes (Beck et al. 1979). Due to these differences it would be important to compare the interactional realizations of epistemicity in different approaches.
Expressing disagreement is an everyday phenomenon. The ways in which disagreement is expressed have an impact how it is perceived and enacted in further interaction (Angouri & Locher 2012). Maynard (1985; 1986) has shown how arguments generally consist of three phases: 1) a disputable event whose status is made partly visibly, 2) an oppositional, argumentative action and 3) a reaction phase in which the opposition is handled, for instance, by accounting, insisting or substitution. Muntigl and Turnbull (1998) found that in everyday interaction participants in interaction disagreed by making irrelevancy claims, challenging the other’s positions, pointing out contradictions and using counterclaims. Each of these disagreement types differed in how face-threatening they were to the other person (Muntigl & Turnbull 1998). Due to their face-threatening nature, it is often claimed that disagreements are avoided in conversations (e.g., Labov & Fanshel 1977). Nevertheless, Goodwin (1983) has shown that in the everyday conversations of children, there is no attempt to avoid disagreement. Instead, heated disagreements are worked towards in their own right, and the interactional practices associated with them display rather than mask the expression of opposition. In addition, there are some institutional contexts in which disagreements are looked for and even encouraged. For instance, Hutchby (1996) has shown how argumentation is constructed in British radio-call-in-programmes, and recently Pomerantz and Sanders (2013) have studied jury deliberations and discussed interactional circumstances that engender or avert acrimonious disagreements in courtrooms.

In therapeutic encounters disagreement is an inevitable feature of interaction, and several conversation analytic studies have described clients’ disagreement and resistance to therapists’ actions. In the context of narrative and solution-focused therapies, MacMartin (2008) studied those client responses that resisted alignment with the optimistic assumptions in therapists questions and found several strategies that clients used to avoid or mitigate the optimism in the question (e.g., optimistic downgrading, refocusing responses, joking and sarcastic responses). Moreover, Vehviläinen (2008) has studied resistance in psychoanalytic interaction by exploring sequences in which the therapist focuses on the client’s prior action to invoke a ‘puzzle’, i.e. a noteworthy enigmatic issue requiring explanation and exploration. Such therapist turns, which topicalized or characterized the client’s action, were challenging or even critical, and they often invited argumentative and defensive talk.

Several studies have focused on therapists’ strategies for dealing with client resistance. In MacMartin’s (2008) study, therapists reissued or recycled their optimistic questions to invite clients to produce aligned responses. Muntigl et al. (2013) have examined how emotion-focused therapists re-affiliate with clients after clients have disagreed with their formulations of clients’ personal experiences. Therapists recurrently affiliated with clients’ contrasting positions through non-verbal (mainly nods) and verbal practices. In some cases, therapists oriented to clients’ disagreements primarily as problems in understanding that needed repair. Therapists’ repair initiations did not, however, lead to successful re-affiliation but fostered further separation by contesting the clients’ perspectives. Nevertheless, Voutilainen et al. (2010b) have observed that misalignment between participants can be turned into a resource for therapeutic work. They described a single session of cognitive psychotherapy in which the therapist pursued an exploratory orientation to the client’s experience while the client oriented to complaining and ‘trouble-telling’. These different projects led to a misalignment which was managed during the
session. Eventually, the therapist brought the therapeutic relationship into the conversation, which recast the misalignment as a resource of therapeutic work and restored alignment between the participants.

Previous research has mainly focused on clients’ disagreement with therapists’ interventions. Therapists’ disagreements have gained less attention (except for the research by Vehviläinen 2008). In addition, the findings of Vehviläinen (2008) and Muntigl et al. (2013) indicate that there are differences between therapeutic approaches in how disagreements are dealt with. Vehviläinen (2008) found that in psychoanalysis therapists engaged themselves in openly challenging sequences. In contrast, Muntigl and colleagues (2013) found that when disagreement arose, therapists in emotion-focused therapy retreated from their own positions, maintaining affiliation with the client. Consequently, comparative research between different approaches is needed. Furthermore, research is lacking into what interactional moves in disagreement sequences engender or avert conflicting talk in therapeutic interaction. In the management of the therapeutic relationship this would be important to know.

1.5 Research questions

In this study, I examine the situated interactional practices through which relational processes are performed in therapeutic interaction. I explore the subject in three therapeutic approaches: psychoanalysis, cognitive psychotherapy and resource-centred counselling. My research questions in this dissertation are as follows:

1. How do therapists and clients manage and negotiate the therapeutic relationship in the moment-by-moment, sequential unfolding of interaction?
   - How do therapists express empathy and respond to clients’ talk on their subjective emotional experiences? (Articles I, II, III)
   - How do therapists work with experiences that belong to clients’ personal domains of knowledge? (Article IV)
   - How are disagreements expressed and relational stress managed in therapeutic interaction? (Article V)

2. How do the interactional practices through which the relationship is managed differ or converge in psychoanalysis, cognitive psychotherapy and resource-centred counselling?

By answering these questions, I will provide a detailed description of the practices through which the therapist actualizes the therapeutic relationship in moment-by-moment interaction.
2 Methods and data

In this chapter I present the method, conversation analysis (CA), and data used in the study. First, I begin with an overview of the theoretical background of conversation analysis. Then I discuss some basic methodological principles and the particular approaches within CA that are relevant for this research. Lastly, I introduce the data and describe the research process for this dissertation.

2.1 Theoretical background of conversational analysis

Conversation analysis is based on a theory of the organization of social interaction developed by Harley Sacks in the 1960s. Moreover, it is inspired by Erving Goffman’s (1983) idea of human interaction constituting an autonomous order of social organization. Conversation analysis is also related to Harold Garfinkel’s (1967) ethnomethodology, which seeks to investigate the processes and practical reasoning upon which the social order of everyday life is based. What is common to all these micro-sociological approaches is that they study social interaction and the organization of everyday life and are interested in how participants themselves orient to the social situations in which they are involved (Heritage & Stivers 2013).

2.1.1 Erving Goffman and interaction order

One of the founding principles of conversation analysis, as we now know it, is Goffman’s idea of ‘interaction order’, according to which, face-to-face interaction is a distinct social institution that can be studied in its own right (Goffman 1983). Consequently, social interaction is not reducible to individuals, other institutions or macro-social structures. For Goffman, all arenas of human interaction are meaningful and highly ordered (Rawls 1987). According to Goffman (1983), people engage in the order of interactive situations because of the nature of their social self, to maintain the self. Goffman also emphasizes the normative aspect of engaging in the obligations of interaction, which are the basic rules of interaction. The significance of interactive situations is not determined by those exterior structures in which the situation is located. Actions do not receive their significance primarily through a relation to external ends, but through shared single-mindedness about how the interaction is maintained (Goffman 1983). Meaning, or social reality, is therefore constructed through an interactive relationship with others involved in the situation (Goffman 1983; Rawls 1987).
Goffman (1963b) defines all moments of simultaneous presence as social situations. They can be characterized as ‘gatherings’ where two or more individuals are present in the same space and situation. Social situations can also become ‘encounters’, where individuals acknowledge each other as the focus of the same visual and cognitive attention. The parties in this case have some shared focus. Gatherings do not necessarily include encounters, in which case the interaction is unfocused in nature. Situations of unfocused interaction are not, however, insignificant in terms of societal life; rather they include numerous normatively regulated codes of conduct on the involvement of individuals and its regulation (Goffman 1963b). CA research, including the present dissertation, typically studies encounters, an interactional situation in which participants have some shared focus. Unfocused interaction is studied less (however, see e.g., Mondada 2009 for sequences taking place before the actual opening of a social encounter).

According to Goffman (1955), interaction between people is necessary to create and maintain a social self. The social self does not exist without the continuous acknowledgement of one’s existence through interaction. The self’s dependence on interaction becomes a fundamental imperative. Consequently, one of the basic principles of social life is that one should save both one’s own face and that of other people (Goffman 1955). By face, Goffman is referring to individuals’ view of the impression they have given to others and the picture of the self constructed through this impression. According to Goffman, interaction has a strong ritual component because it requires continuous work to save one’s own face and that of others. It is important for each person to represent themselves in a consistent way. Blunders must be corrected, for example by offering an explanation, making a joke or by pointing out that the ‘mistake’ was out of character. Others must also participate in this face-work by helping the person recover from the situation without it affecting the roles the participants have defined for themselves in the situation (Goffman 1955).

2.1.2 Harold Garfinkel and ethnomethodology

In addition to Goffman’s ideas on interaction order, conversation analysis has also been inspired by the ethnomethodological tradition of studying the practical reasoning of social actors. Ethnomethodology was developed by Harold Garfinkel in the late 1950s and early 1960s. Similar to Goffman, Garfinkel was also interested in everyday life, especially the taken-for-granted and routinized practices we conduct in our daily lives (Heritage 1984). The starting point of ethnomethodology is that all social organizations are emergent achievements of members in society who act in their local, everyday situations (Maynard & Clayman 2003). Central to these achievements are the various methods social actors use to produce and reorganize patterns of social activity and the local contexts in which they are embedded.

Ethnomethodology studies the common sense reasoning social actors apply and collaboratively construct in their everyday affairs. This reasoning is embodied in their use of language, which became a topic of research in its own right (Maynard 2013). For Garfinkel, language is indexical, i.e. the meaning of expressions is tied to the particular contexts in which they emerge (Heritage 1984). The key for understanding language is not understanding sentences per se but understanding the social actions that particular utterances convey in relation to their context.

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Garfinkel was interested in the complex interpretative processes social actors use when making sense of these social actions (Heritage 1984). The documentary method of interpretation is a method which lay people (as well as sociologists) utilize in common sense reasoning when attempting to understand their social world. According to Garfinkel (1967:78), the method consists of “treating an actual appearance as the ‘document of’, ‘as pointing to’, as ‘standing on behalf of’ a presupposed underlying pattern”. In other words the process of recognizing everyday objects and events is a mutually elaborative process between objects and their context (Heritage & Stivers 2013).

This can be applied to the understanding of the relationship between rules and situated actions (Maynard & Clayman 2003). As social actors orient to relevant aspects of the situation at hand (e.g., the institutional situation in which they are present), they use and apply the norms, rules and other ordering practices they know about the given situation to interpret and explain their own and others’ activities (Maynard & Clayman 2003). In sense-making processes, both normal and deviant actions are of interest: the analysis of situations in which the common sense method breaks down can reveal how normal circumstances are constituted. Garfinkel used his famous breaching experiments to examine the reactions of social actors to situations where commonly accepted social rules or norms were violated (Garfinkel 1967). The reactions were dramatic, even hostile, which suggested that the sense-making procedures of everyday life are morally obligatory to members of society. Deviations from conventionalized practices incur sanctions, and those violating norms must account for their actions. In this way, members of society produce and maintain a shared sense of social order (Garfinkel 1967).

2.1.3 Sacks, Schegloff, Jefferson and science of social action

Goffmanian sociology and Garfinkel’s ethnomethodology opened the ‘sociological doors’ for Harvey Sacks, Emmanuel Schegloff and Gail Jefferson to develop conversation analysis (Maynard 2013). Garfinkel placed everyday affairs and common sense reasoning within the domain of sociological research, and Goffman showed that interaction constitutes a normative and highly structured institution that can be studied in its own right (Maynard 2013). However, neither offered a precise research methodology. In the 1960s and 1970s, Sacks, Schegloff and Jefferson developed a unified theory of social action and a distinctive methodology that would enable the systematic and detailed analysis of the organisation of interaction (Heritage & Stivers 2013).

The theoretical and methodological principals of conversation analysis will be discussed in the following section.
2.2 Conversation analysis as a method

The key idea of CA is to study the structural organization of naturally occurring interaction (Sacks et al. 1974; Schegloff 2007). The basic arguments of CA are talk is action, actions are structurally organized and actions create the intersubjective, shared world (Peräkylä 2014).

The first argument, talk is action, means that turns of talk are not primarily examined with respect to topicality (what the turn of talk is about) but with respect to what the turn of talk is doing in the given moment of social interaction (Schegloff 2007). Thus, every turn of talk is seen as implementing social actions (such as offering, asking, inviting, proposing, requesting, asserting or agreeing) (Sacks et al. 1974). The aim of conversation analysis is to examine the ‘main job’ that turns perform by analysing “what the response must deal with in order to count as an adequate next turn” (Levinson 2013:107). This dissertation studies several types of actions that therapists and clients perform in their turns of talk during therapy sessions. All the articles discuss instances where clients describe their personal experiences. Articles I, II and III demonstrate how therapists formulate clients’ descriptions, i.e. they show that they understand what the client is describing by proposing an altered version of the client’s talk (Heritage & Watson 1979). In article IV therapists formulate and interpret the client’s talk by delivering their understandings of the significance of their clients’ inner experiences. Each article also deals with client turns that agree or disagree with the therapist’s interventions. Article V examines arguments between therapists and clients, instances where therapists challenge clients by disagreeing with their descriptions of their personal experience and clients perform counter-arguing and withdrawing actions.

The second argument, actions are structurally organized, concerns the conversation analytic theory of the sequentiality of talk (Schegloff 2007). Sequentiality means that a single utterance is intrinsically related to the utterances that precede and succeed it. Thus, adjacent utterances and actions are closely connected: “next turns are understood by co-participants to display their speaker’s understanding of the just-prior turn and to embody an action responsive to the just-prior turn so understood” (Schegloff 2007:15).

The basic sequence of talk is termed an adjacency pair, which is a sequence of two adjacency placed turns produced by different speakers in a way that the first pair part of the sequence specifies a range of possible types of actions performed in the second pair part (Maynard & Peräkylä 2003; Schegloff 2007; Schegloff & Sacks 1973; Stivers 2013). In this dissertation, formulation-decision pairs are one example of this type of adjacency paired structure. According to Heritage & Watson (1979:141-142), formulations (first pair-part) that offer a candidate reading for the sense established in the previous speaker’s turn have profound implications for the development of subsequent talk: their reception is constrained to confirmation or disconfirmation (second pair-part) of the formulation. Of course, a first pair part is not always followed by a relevant second pair part and the second pair-part may also be totally absent. The adjacency pair structure is normative in the sense that participants in interaction hold one another accountable for deviations from that structure (Maynard & Peräkylä 2003; Schegloff 2007; Sidnell 2010; Stivers 2013). The basic adjacency pair sequence may also be expanded in various ways. Participants in interaction may want to lay the ground for the first-pair part or they may need to repair the first pair-part before they are able to provide the second pair-part (Schegloff 2007). Adjacent sequences may also be further expanded following the second pair-part in so
called third-position turns (Peräkylä 2011a; Schegloff 2007; Stivers 2013). Articles II and III analyse therapists’ turns following the client’s response to their formulations. These turns shows how therapists deal with clients’ responses, but they also reveal important aspects of therapists’ actions in the first position (the direction the therapist was heading in the first turn).

In addition to adjacency pairs, extended telling is another type of sequential organization that is important in this dissertation (Schegloff 2007; Stivers 2013). Therapists’ actions are responsive to clients’ extended telling sequences, which convey a certain stance (affective treatment of the event the client is describing, Stivers 2008:37) towards the experiences in their lives. During these telling sequences, therapists provide different forms of acknowledgement tokens (e.g., the discourse particles mm, mm-hm, and head nods) that indicate therapists’ active involvement and often affiliation with the client’s stance (Muntigl et al. 2013). Completion of the telling sequence typically involves some type of uptake by the therapist, and that uptake often initiates the adjacency paired sequence described above.

The third argument, actions create the intersubjective world, is based on the claim that linked actions are the basic building-blocks of intersubjectivity (Heritage 1984:256). Each utterance brings forth some aspect of its speaker’s momentary experience for co-interactants to observe (Peräkylä 2014). In adjacent utterances, the latter utterance brings forth its speaker’s understanding of the former speaker’s momentary experience. In consequence, interactants inevitably orient to each other’s experiences (Peräkylä 2014). The sequential structure of talk allows then for a framework of intersubjective understanding that is constantly constructed and updated in every turn of talk (Heritage 1984; Peräkylä 2014; Sidnell 2010). Through adjacent actions, the therapists and clients in the present dissertation constantly construct and negotiate their shared understanding of the client’s experiences, therapeutic processes and the client-therapist relationship. This negotiation becomes explicit in article V, where disagreement between the participants leads to momentary ruptures of shared understanding and thus to talk on the therapeutic relationship.

Conversation analysis is concerned with empirical data. It aims to describe the organization of social actions that are achieved in conversation by participants mobilizing a range of verbal, vocal and embodied resources (Mondada 2013). Even the finest details of interaction (such as silences, stammers or sighs) are considered important in how the participants in interaction interpret and orient to each other’s actions. According to Heritage (1984:241), “no order of detail in interaction can be dismissed a priori as disorderly, accidental or irrelevant”. Audio and video recordings of naturally occurring interactions provide the data that enable the detailed analysis of the events in interaction (Sidnell 2010). Recordings provide the opportunity to examine the events of interaction repeatedly, extending the exactness of the observations (Heritage 1984; Mondada 2013; Sidnell 2010). Detailed conversation analytic transcripts help analysts detect and describe the orderly practices of interaction (Hepburn & Bolden 2013). Thus, the analytic process usually begins with transcribing the data. Depending on the phenomenon of interest, the transcription of intonation is sometimes supplemented by acoustic software, such as PRAAT (Boersma & Weenink 2015). The original audio/video recordings are always used alongside the transcripts and acoustic measurements.

In conversation analytic research, the analysis is inductive and data-driven (Sidnell 2010). The analytic procedure begins with ‘unmotivated’ listening and observation of the data. The next stage is to identify interesting reoccurring phenomena. Specific research
questions are not decided in advance; rather, they are formulated on the basis of early observations of the data (Sidnell 2010). When a phenomenon of interest is identified, all cases related to it are collected from the data. The each case is qualitatively analysed to determine the nature and variation of the phenomenon in question. The focus is on interactional practices in specific sequential environments, that are used to accomplish particular social actions (Sidnell 2013). CA research provides detailed descriptions of interactional practices that participants in interaction orient to as relevant (Sidnell 2013). In the last stage of the analytic procedure, the findings are discussed in the context of their wider implications, for example for social relations or professional practices (Peräkylä & Vehviläinen 2003; Sidnell 2010).

In conversation analytic studies, the validity of the analysis is controlled by providing other researchers (as well as the readers of research reports) the resources to check the accuracy of the analysis being reported (Peräkylä 2011b). Holding data sessions with trained CA researchers and providing extracts of the data-analysis in research reports makes the analysis subject to public examination and helps minimize the influence of researchers’ personal preconceptions (Peräkylä 2011b). Another important means of assuring the validity of CA research is the so called ‘next-turn proof procedure’ (Heritage 1984; Sidnell 2013). Participants in conversation look to a next turn to see if and how they have been understood. CA analysts exploit the same resource by seeking evidence for their analysis from how the participants in interaction interpret the meaning of the preceding talk (Peräkylä 2011b; Sacks et al. 1974; Sidnell 2013).

The core of CA research has been the analysis of everyday, mundane conversations (Heritage 1984). Mundane conversations have been seen as the primordial form of interaction into which children are first socialized (Heritage 1984). However, CA has also been widely applied to research on institutional interaction (e.g., Drew & Heritage 1992), such as therapeutic treatment discussions. CA research on institutional interaction is discussed next.

2.2.1 Institutional interaction

According to the theoretical principles of CA, social interaction is an institution in its own right (Goffman 1983; Heritage 1984). Moreover, the institution of social interaction is seen to underlie the functions of all other institutions in society, such as the family, education, medicine, and therapeutic institutions, etc. (Heritage 1984). Conversation analysis provides a method for investigating how various social institutions (such as psychotherapy) are ‘talked into being’ through the local sequences of the participants’ talk (Heritage 1984:290). CA research on institutional interaction aims to describe the ways in which institutional goal-oriented tasks are accomplished by participants through the composition and placement of their utterances (Arminen 2005). The institutional context is understood as both “a project and product of the participants’ actions”: it sets special constraints on participants’ social actions, and it is created and renewed by those actions (Heritage 2004:224). The specific goal oriented tasks, identities, constraints, frameworks and procedures that participants orient to in interaction create a unique ‘fingerprint’ for each institution (Heritage 1984; 2004).

In institutional interaction, people deploy the same generic patterns of talk-in-interaction as they do in mundane conversations, but in institutional interaction they are
modified to serve specific goal-oriented purposes (Heritage 1984). According to Drew and Heritage (1992:22), the basic elements of institutional talk are:

1. Participants are involved in specific goal oriented tasks and identities (e.g., therapist and client).
2. The institutional context sets constraints on what will be treated as ‘acceptable’ contributions to the business at hand (e.g., therapists do not complain about their own problems).
3. The interaction involves inferential frameworks and procedures specific to the institutional context (e.g., the therapist can interpret the client’s inner experiences, whereas in everyday conversations this type of turn could be considered intrusive).

Participants’ orientation to the presence of the institution can be detected in many aspects of interaction, for example in lexical choices, turn design, the structure of specific action sequences and interactional asymmetries between the participants (Drew & Heritage 1992; Heritage & Maynard 2006). Some types of institutional interactions also have a special turn-taking organization: the meetings of Alcoholics Anonymous, for instance, have a very formal turn-taking system (Arminen 1999). Institutional interactions can also have an overall structural organization involving different phases or activities. In acute care doctor-patient interaction (e.g., Robinson 2003) and 911 emergency calls (Zimmerman 1992), this organization is highly structured, whereas in psychotherapy the structure is rather loose (Bercelli et al. 2013).

In institutional interaction the recognizability of participants’ actions often depends on expert knowledge or specific sense-making processes that are unknown to outsiders (Drew & Heritage 1992). From the researcher, this requires sensitivity to the context and sufficient knowledge of the institution in question (Arminen 2000; 2005). Some institutions also involve professional theories and ideologies concerning the interaction between professionals and their clients, known as professional stocks of interactional knowledge (Peräkylä & Vehviläinen 2003). Research on institutional interaction is interested in the relationship between professional theories and the actual practices of interaction (Peräkylä et al. 2005). Conversation analytic findings can correct, specify and add new dimensions to the understanding of interactional practices derived from often very abstract professional theories (Peräkylä & Vehviläinen 2003).

2.2.2 Comparative research

Conversation analysis is essentially a comparative method (Haakana et al. 2009:15). According to the basic methodological principal of CA, individual instances are compared to identify the sense and variation of the practice in question (Arminen 2009). In this internal comparative analysis, the similarities and differences between cases in a collection are qualitatively analysed. This detailed, qualitative, case-by-case analysis forms the basis for all conversation analytic investigations (Arminen 2009).

However, when research aims to compare different practices, or the same practice across different data-sets, some quantitative evidence is needed to complement the qualitative analysis (Arminen 2009; Robinson 2007). Typically this means that the frequency of instances within and between datasets is provided, sometimes testing the differences between groups using statistical methods. Examples of studies that compare
different interactional practices include Peräkylä’s (1998) research on utterances used by primary care doctors for delivering diagnostic news and Stivers’s (2001) study on speaker selection for the presentation of problems in paediatric encounters. In these studies the outcome of the interaction is observable in participants’ orientation in the on-going interaction. Audio/video-recordings can also be supplemented with other outcome data, such as questionnaires or interviews. For example, in Robinson and Heritage’s (2006) comparative study on the different types of opening question that begin medical encounters, the patient’s satisfaction was measured after the encounter with a questionnaire. McCabe et al. (2013) compared the different types of repair practices of psychiatrists and clients, developing a CA-informed standardized coding protocol to examine the association between repair categories and clinician-rated patient adherence. In a similar vein, Thompson (2013) compared the different question types used by psychiatrists and investigated their association with the therapeutic relationship and treatment adherence measured with specific scales.

In CA, the quantitative research approach has become increasingly popular, especially in studies of different types of health care settings (Robinson 2007). However, the problem of several CA studies, including my own, is that the data is collected for qualitative research purposes, often resulting in low sample sizes and non-random sampling (Robinson 2007). In these cases statistical results can only provide some very general guidelines that complement the qualitative analysis (Arminen 2009; Robinson 2007). In this dissertation the core of the analysis is qualitative and quantification is only used in order to provide a general view of the frequencies of the interactional patterns that are analysed qualitatively. A qualitative, case-by-case analysis has preceded all the quantitative operations: a detailed qualitative analysis ensured that the interactional practices studied shared the same features and belonged to the same phenomenon; thus, they were “qualified for quantitative treatment” (Schegloff 1993:115).

Research that compares the same interactional phenomenon across different data-sets can explore similarities and differences between mundane and institutional contexts. This type of research is ideal for uncovering how the resources of everyday talk are modified for institutional purposes (Haakana et al. 2009). Participants in interaction generally orient to the same basic structures of interaction (e.g., sequence organization or turn-taking) and they perform similar types of actions (e.g., describing, agreeing or arguing) in both ordinary and institutional interaction (Haakana et al. 2009). The comparative perspective is interested in similarities and differences in the way participants perform these actions. An excellent example of this type research is Maynard’s (2003) study on good and bad news, where he explored how good news and bad news were delivered and responded to in everyday talk and in different clinical settings.

Comparative research can also investigate how a particular action is accomplished in two (or more) different institutional contexts (Haakana et al. 2009). This type of research aims to uncover the specific features of the institutions in question. For instance, Drew (2003) has compared the use of formulations in different institutional settings and shown how participants in interaction manage a range of different tasks through formulations: in news interviews formulations were used to make the interviewee’s speech more newsworthy, in radio call-in programmes to challenge the caller’s position and in industrial negotiations to construct a compromise to settle the matter under negotiation. In a similar vein, Hak and de Boer (1996) have analysed the use of formulations in respect to different interview styles in medical, psychiatric and psychotherapeutic settings. They concluded that formulations were absent from investigatory medical interviews, but they
were frequently used in psychiatric interviews to explore the client’s experience and in psychotherapy to translate the client’s talk into a problem that could be worked on later in the therapy. Ruusuvuori and Voutilainen (2009) also compared different healthcare encounters (general practice, homeopathy and psychotherapy). They aimed to reveal responses to clients’ ‘trouble telling’ in these institutions, concluding that in general practice and homeopathy affiliating responses were used to provide a smooth way of continuing the medical task at hand, whereas in psychotherapy they were used to recast the client’s self-reflection. Therapeutic counselling also provided a context for comparison in Vehviläinen’s (2001a; 2001b) studies on delivering advice in student and healthcare counselling settings. Although the sequences were quite similar in both contexts, in healthcare settings the preferred response to advice was agreement, whereas in educational settings argumentation and exploration of the student’s own ideas were expected. In all these studies, comparison was used to gauge the institution-specific nature of the interactional practices found in a particular setting and how the findings illuminated the characteristic nature of the institutions in question (Drew 2003).

2.2.3 Applications in psychotherapy

The therapeutic settings studied in this dissertation are particular kinds of institutions. Thus, this dissertation continues the CA tradition of investigating institutional interaction. Psychotherapy is made possible by therapists and clients using their everyday skills in social interaction: taking turns, repairing their talk, making claims, assessing, responding etc. (Peräkylä et al. 2008). CA research on psychotherapy, including my own, is interested in how these different types of everyday practice are modified for accomplishing the specific tasks that are central to therapeutic work (Peräkylä et al. 2008).

Psychotherapy is a specific type of institution because of the number of professional models and theories that explain and guide professional interaction (Peräkylä et al. 2008). CA research that aims to describe the actual interactional practices of therapeutic communication can use these professionals’ stocks of interactional knowledge as a resource to gain understanding of the goals and motivations of the participants (Peräkylä & Vehviläinen 2003). Conversely, the findings of CA research can be a resource for practitioners to view their work at a detailed level and help them understand and develop their practice.

In this study’s analysis, Peräkylä’s (2014) template for analysing psychotherapeutic interaction (Figure 1) is used as a guide for observing the data.
In CA research on psychotherapy, the basic methodological approach is similar to any other context: investigation of the ways in which actions arise from prior actions and how they control subsequent actions (Peräkylä et al. 2008; Peräkylä 2013). *Third position turns*, turns that come after the response to the ‘target’ action, are also important in revealing the uptake to the response and indicating its institution-specific nature (Peräkylä 2011a). Psychotherapy makes systematic use of this basic sequential structure of interaction: therapists can invite particular experiences from their clients by utilizing different types of social action (e.g., formulations, interpretations, questions etc.) and then respond to their clients’ experiences in their third position turns (Peräkylä et al. 2008). CA studies have indeed provided detailed descriptions of a variety of actions that therapists and clients engage in during the therapeutic process (Peräkylä 2013).

Although the starting point of CA is action, not topics (Schegloff 2007), the *referents* of the participants talk and the processes through which they are transformed during the turns of talk are important for understanding therapeutic interaction (Peräkylä 2014). In therapeutic interaction, talk is often about the client’s *emotions* and emotional experiences (Peräkylä 2014). Talking about clients’ emotional experiences is viewed as a central part of the institutional task of psychotherapy (Ruusuvuori & Voutilainen 2009). In CA, displays of emotions are studied in the context of the sequential actions in which participants in interaction are involved (Peräkylä & Sorjonen 2012). CA research on psychotherapy has described how different actions, such as extensions and interpretations, can be geared to emotion work (Peräkylä 2008; Vehviläinen 2003; Voutilainen et al. 2010a). Moreover, the different verbal and non-verbal resources used by participants for conveying emotional involvement have also been investigated. Rae (2008), for instance, describes one type of verbal resource, *lexical substitution*, in which the therapist replaces a word in the client’s utterance with a word that heightens its emotional involvement. Muntigl et al. (2012) have, in turn, studied a non-vocal resource, therapists’ use of nods, as affiliative advice in sequences where therapists work to remain aligned with their
clients’ positions. Emotion-related work is important in all of the articles presented in this dissertation.

Another aspect that is crucial for therapeutic interaction is the therapist-client relationship. CA research aims to explore how that relationship is transformed in and through sequences of actions (Peräkylä 2014). Such relational work is the central theme of this dissertation and is closely related to emotional work.

The last aspect discussed here, which is inevitably present in research on psychotherapy interaction, is the longitudinal nature of therapeutic projects, which are the larger interactional projects the therapists are involved in (Peräkylä 2014). In longitudinal studies on change and the cross-session continuity of actions and thematic threads, Bercelli et al. (2013), Muntigl et al. (2013), Peräkylä (2011a) and Voutilainen et al. (2012) describe therapists’ projects that unfold across several sessions. In this dissertation, article V examines disagreements that are essential parts of therapists’ overall project, continued across sequences of talk, to increase clients’ awareness of their distorted emotional patterns and challenge their dysfunctional thoughts.

One methodological disadvantage of CA research on psychotherapy has been the lack of comparative research between different schools of therapy (Peräkylä 2013; Vehviläinen et al. 2008). In psychotherapy, such comparison is sorely required because the field consists of numerous schools of thought, leading to considerable variation in therapists’ larger interactional projects as well as the practices they use (Peräkylä 2013). Thus, due to the lack of comparative research into different therapeutic approaches, it is unclear if the findings of previous research are restricted to the approaches they investigate (Vehviläinen et al. 2008). Only in one previous CA study has a comparative approach been adopted. In Kondratyuk and Peräkylä’s (2011) study, therapeutic work with the present moment in existential therapy was compared to a similar type of practice in cognitive therapy. Although the research data came from one teaching video of each of approach, it showed the richness of the comparative approach: both existential and cognitive therapists work with a focus on the present, but the interactional structures of their practices, as well as their therapeutic aims, were markedly different. The present dissertation contributes to the research on psychotherapy interaction by providing the first broader and systematic comparison of therapists’ interactional practices in different therapeutic approaches. Next, I will describe more closely the data used in this research.

2.3 Data

The data used in this dissertation consist of three different datasets:
The first dataset consists of 41 audio-recorded sessions of psychoanalysis. As each session lasts 45 minutes the data cover approximately 30 hours of interaction (one of the recordings failed). The data come from two different dyads: one therapist with two different clients. The data were collected in Finland between 1999 and 2000 in the research project Psychoanalysis as Social Interaction, led by Anssi Peräkylä at the University of Tampere. The whole dataset was transcribed. The psychoanalyst is a highly experienced private practitioner (male and in his sixties). He represents an object relations oriented, neo-Freudian psychoanalytic school. The first client was a man in his forties. There is no background information on the client, but based on the tapes he was suffering
from depression and work-related burn-out problems. At the time of the recordings, KELA (the Social Insurance Institution of Finland) was reimbursing the costs of his rehabilitative psychotherapy. For this therapist-client dyad, 20 sessions were recorded, during a period beginning approximately three years from the start of therapy. The second client was a woman in her sixties. 21 sessions were recorded for this second dyad, during a period beginning approximately two and a half years from commencement of therapy. In Finland psychoanalysis typically lasts 5 to 6 years, so these recordings took place during the middle of the therapy process. In both therapies the frequency of the sessions was approximately three times a week. The whole dataset is used in this dissertation.

The second dataset consists of 170 audio-recorded sessions of long-term cognitive psychotherapy. As each of the sessions lasts 60 minutes, the data consist of 170 hours of interaction. The data, again, come from two different dyads: one therapist with two different clients. The data were collected in Finland between 2004 and 2009 in the research project Interaction, Emotion and Institutions, led by Anssi Peräkylä at the University of Helsinki. The data-set is partially transcribed (46 entire sessions and some partly transcribed sessions). The therapist is a well-trained, experienced private practitioner (female, in her fifties). She represents a cognitive-constructivist strand of cognitive therapy, and she has also long experience in training cognitive therapists. Both of the clients in cognitive therapy were young women (in their twenties) suffering from depression and anxiety. In addition, one also suffered from panic attacks and the other from a personality disorder. Both of the therapies were rehabilitative and reimbursed by KELA. In the case of the first client, the recordings of 57 sessions cover a period during the last 18 months of a two-year therapy process. The second client’s therapy process lasted three years, and 113 sessions were recorded (covering the whole therapy, excluding the very first sessions). The meetings in both cognitive therapies were approximately once a week. For comparative purposes, the same amount of recorded interaction was used from the cognitive psychotherapy dataset as from the psychoanalysis data. The sessions were selected on the basis of the phase of the therapy process: as the psychoanalytic data were from the middle part of the therapy process, cognitive psychotherapy data from the middle part of the therapy were also selected.

The third dataset consists of 15 video-recorded sessions of resource-centred counselling conducted by occupational therapists. The lengths of the sessions vary from 45 minutes to two hours and comprise approximately 16 hours of interaction. The data come from three different dyads: three therapists with three different clients. The data were collected in Finland as a part of my doctoral studies between 2012 and 2013. The whole dataset is transcribed. The therapists are professionally trained occupational therapists working in two different public sector outpatient clinics in Finland (women, age varying from 30 to 50). The first client (two recordings) was a woman in her fifties suffering from schizophrenia and depression. Due to her mental health problems, the client was retired, and she had a long history of using psychiatric services. The second client (nine recordings) was a young woman in her twenties suffering from depression and anorexia. Her treatment had also lasted for several years, and she was receiving a rehabilitation allowance from KELA. The third client (four recordings) was a woman in her forties suffering from schizoaffective disorder and a personality disorder. At the moment of data collection, all the therapists and their clients were engaged in ongoing relationships that had lasted from 6 months to two years. As is typical for this type of psychiatric service (in
contrast to psychotherapies), the treatment processes were open-ended. Regular meetings were held approximately every two weeks. This third dataset differs from the other two in several respects, including the institutional context and goals of the sessions, the severity of the clients’ problems and the treatment process. Thus, these data are not included in the comparative analyses in articles I, II, IV and V. Article III, however, explores the specific nature of this therapeutic approach, and here the findings are discussed in comparison to the results for two other approaches.

The therapists in all three datasets were recruited on the basis of their positive attitude to research and their connections to the academic world. The therapists then recruited clients whose treatment processes would not be disrupted by the therapy sessions being recorded. The therapists informed the clients of the research, both verbally and in writing, and informed consent was obtained from all the participants. They also had the possibility of withdrawing their consent at any point in the recordings. The researchers were not present in any of the therapy encounters; recording devices were given to the therapists, who were responsible for turning them on. In the case of the third dataset, permission to collect the data was obtained from the municipal health authority and the ethical board of the University Central Hospital. As therapy processes are very private occurrences where clients discuss extremely delicate issues, the anonymity of the participants has been carefully ensured in the research reports. The names of all the people and places, professions, hobbies and other details which could enable their identification have been altered in the text and data excerpts. Furthermore, dialect words that might connect the participants to certain regions of Finland have been changed to more standard language.

Before moving on to describing the research process and summarizing the results, a broad description of the structure of the interaction in the datasets is due. In psychoanalysis, clients typically initiate the session by describing what has been on their mind. The client produces long narratives while the therapist remains silent. When the client reaches the end of a narrative, the therapist typically make a statement (e.g., a formulation or interpretation) about the events described or invites the client to continue. Cognitive therapy sessions typically begin with greetings and informal chat, after which the therapist asks a question focusing on the present situation in the client’s life. During the session, the therapist is actively involved in the interaction, e.g., by frequently asking questions and formulating the client’s talk (the structure is quite similar to that described by Bercelli et al. 2008). In occupational therapy, the sessions also begin with greetings and chat before moving on to questions concerning the client’s daily life. Generally, the structure of interaction in the sessions is quite similar to cognitive therapy: therapists are active, frequently ask questions and formulate the client’s talk. A particular feature of occupational therapy encounters is that participants frequently engage in certain goal oriented activities. In my data-collection, there are four such activity oriented sessions (where the clients cook and practise different types of art).

To illustrate the general difference between the approaches, I randomly chose one session from each approach (from the occupational therapy data a session from those solely involving talk) and counted the different therapist turns and the duration of instances in which both therapist and client were silent. The results are shown in Table 1.
Table 1. Frequency of therapist turns in one hour of each approach

<table>
<thead>
<tr>
<th>Type of therapist's turn</th>
<th>Psychoanalysis</th>
<th>Cognitive psychotherapy</th>
<th>Resource-centred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Minimal response</td>
<td>19</td>
<td>53</td>
<td>38</td>
</tr>
<tr>
<td>Question</td>
<td>5</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Formulation</td>
<td>7</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100</td>
<td>69</td>
</tr>
</tbody>
</table>

| Silence in min | 23 | 7 | 4 |

Table 1. Frequency of therapist turns in one hour of each approach

The difference between the approaches is exhibited most clearly in the prevalence of therapist turns at talk (the resource-centred and cognitive therapists were far more active than the psychoanalytic therapist). The other aspect that seems crucially different is acceptance of silence (in psychoanalysis, there is much more silence). The difference between the approaches is less prominent in the therapists’ use of formulations: they appear as an interactional resource in all three types of therapeutic encounter. Formulations and other turns that are responsive to clients’ descriptions of their personal experiences will be discussed more closely in the results section.

2.4 Research process

In the previous section on the methodological approach of CA, I provided a general description of the CA analytic process. I will now report on the analytic process of this particular research.

My involvement with the present research originates from my longstanding interest in mental health and its treatment. Before starting my doctoral studies, I worked for ten years as an occupational therapist in a psychiatric hospital, during which time I began to ponder issues relating to social interaction and the therapeutic relationship between staff and patients. Consequently, in 2010 I was thrilled to be given the opportunity to begin my doctoral thesis under the supervision of professor Anssi Peräkylä and utilize the data his research team had previously collected on psychoanalysis and cognitive psychotherapy. The findings of Peräkylä’s previous projects provided an excellent starting point for comparing practices in those two types of therapy.

I began the research process by acquainting myself with the data, listening to all the tapes and making notes on issues of potential interest. During that process I utilized Transana software, which has been developed by David Woods to manage and analyse video- or auditory data (www.transana.org). With the help of Transana, I identified
analytically interesting portions of the recordings and created ‘clips’ that I then categorized into thematic collections. At the end of the process, I was left with 57 different collections, most of which have never seen the light of day (collections with titles such as ‘what happens in these ones’, ‘assorted B-events’ or ‘the moment of insight’). In the early phases of the research process, regular data sessions with professor Peräkylä and other members of the research team were most valuable for gaining ideas and testing them. At the end of the first six months, I became interested in formulations, of which I already had a large collection. Formulations also seemed to be a good starting point for comparison, because, as Antaki (2008) notes, they have been one of the central topics in earlier CA studies on psychotherapy. By the time I began work on the first article on formulations, I had systematically investigated about 23 hours of interaction from both approaches. This explains why the quantity of data is smaller in the first article than in the following ones: it was simply the volume of data I had processed at that point. In the first collection, I gathered all the turns of talk in which therapists paraphrased clients’ utterances. Then I excluded the utterances that were transparently ‘innocent’ repair initiations – turns that checked the correctness of the therapist’s understanding of some specific aspect of the previous turn, for example its intended referents (Lilja 2010:138; Kurhila 2006:153). Because my interest was primarily the relational work to which formulations might be geared, my analysis focused on the interactional functions of formulations that were responsive to clients’ descriptions of their personal experiences. Thus, other interactional aspects of formulations, for instance their role in agenda management (Antaki 2008), were less central to my analysis. During the publication process, the reviewers of my manuscript suggested a quantitative analysis of the central findings. Nevertheless, the data we have clearly fail to meet the criteria for statistical analysis. My intention during the whole process was to provide a detailed qualitative description of the similarities and differences in therapist-client interaction in different therapeutic approaches, and I still feel uncomfortable with some of the quantitative solutions in this dissertation. On the other hand, regardless of its defects, quantification has strengthened and validated the study’s qualitative analysis. The decisions made concerning quantification are a compromise: quantification (coding the cases in a collection based on qualitatively formed categories and comparing their frequencies across different types of therapies) is used at a descriptive level in articles I, II and IV and less so in articles III and V, the main focus remaining, however, on the qualitative research.

The four formulation practices described in the first article, highlighting, rephrasing, relocating and exaggerating, form a general description of the practices used by therapists to respond to clients’ descriptions of their personal experiences that is deepened in the following articles. Article II continues to explore therapists’ rephrasing formulative utterances from the perspective of prosody. When I was working on the first article, it became clear that some formulations ‘sounded’ different from others. In fact, in the very first drafts of the article I had already included analysis of some of the prosodic features of the formulations. However, it was decided that an analysis of prosody warranted an article of its own, as it is rarely studied in psychotherapy interaction. In the process of writing the second article, the invaluable help came from Melisa Stevanovic and Mikko Kahri, who were working on their own paper on the relationship between prosody and agency in responsive turns (Stevanovic & Kahri 2011). The first two articles are co-authored by professor Anssi Peräkylä, who significantly contributed to the analysis of the data and edited both manuscripts, which I had first written alone.
Article IV broadens the view on rephrasing and relocating formulations, exploring the practices therapists use for performing interpretative work in psychoanalysis and cognitive psychotherapy. This article builds on previous work by Sanna Vehviläinen (2003; 2008) and Anssi Peräkylä (2004; 2005; 2008; 2010; 2011a) on interpretations in psychoanalysis and Liisa Voutilainen (Voutilainen et al. 2010a) on recognition and interpretation in cognitive psychotherapy. Article IV is co-authored with Liisa Voutilainen and Anssi Peräkylä. The analysis on which the article is based was conducted in co-operation with Voutilainen, who also edited the manuscript. Anssi Peräkylä’s contribution was especially important for the formulation of the final arguments. This article was written during my exchange period at the University of Loughborough. During that time, supervision discussions with professor Charles Antaki were invaluable in developing the analysis of the article.

Article V also continues the themes embarked upon in the first article by exploring therapists’ challenging projects in a more detailed way. The early ideas for this article were developed during my time at Loughborough, and data sessions with professor Paul Drew and professor Jeffrey Robinson’s medical interaction workshop were most helpful in constructing my analysis. Liisa Voutilainen has also made a significant contribution to developing my early ideas on therapists’ challenging projects.

The data for article III were gathered during my maternity leave in 2010 and 2011, and these data were transcribed while I was working on articles IV and V. Although my primary idea was exclusively to compare the practices of psychoanalysis and cognitive psychotherapy, it became important for me to collect these data and include them in my dissertation for several reasons. Firstly, I wanted to gain experience of the whole data collection process. The process of committing clinicians to the project, applying for permission from the ethical board, all the practical arrangements and finally transcribing and analysing the data have all been a valuable learning experience. Secondly, I also have a strong interest in studying therapeutic conversations outside psychotherapeutic encounters. This interest evolved from my previous career in municipal psychiatric services. In Finland at least, these are the primary services for clients with mental health problems, and it would be important to better understand therapist-client interaction in these settings. Thirdly, the third dataset provides an interesting point of comparison for the other two approaches (although it is not systematically used in comparative articles I, II, IV and V). As was stated in the introduction, the resource-centred approach, which is essential to occupational therapy, is very different from psychoanalysis in terms of supportiveness versus expressiveness. In the light of the common factors theory, which proposes that all psychotherapeutic approaches share important common components that mostly relate to the therapeutic relationship (Wampold 2001), it is interesting to investigate whether the actual practices through which the therapeutic relationship is managed are similar or different in approaches associated with very different clinical theories and stocks of interactional knowledge (Peräkylä & Vehviläinen 2003). I was able to include only one article concerning the third dataset in my dissertation. Article III continues the theme of articles I and II by exploring the use formulations in this particular type of therapeutic interaction. The focus of articles II and III is similar: both investigate therapists’ turns that shift the discussion of clients’ emotional experiences in a certain direction. Thus, combined, these two individual articles illuminate important aspects of the differences between psychoanalytic, cognitive and resource-oriented approaches. There would be, however, much more to say about the interactional practices that characterize resource-centred occupational therapy, but that remains a task for the future.
3 Results of the sub-studies

In this section I will summarize the results of the original articles. The results for the first main research question (How do therapists and clients manage and negotiate the therapeutic relationship in the moment-by-moment, sequential unfolding of interaction?) are organized according to two themes: emotion work and epistemic work. As working with clients’ emotions and emotional experiences is an important part of all therapeutic work, the first three articles focus on interactional work that is related to reshaping and managing talk on clients’ emotional experiences. The two latter articles concentrate on epistemic work: interactional practices that are related to the management of knowledge relations between the therapist and client. The findings pertaining to the second main research question (How do the interactional practices through which the relationship is managed differ or converge in psychoanalysis, cognitive psychotherapy and resource-centred counselling?) are discussed in respect to both emotions and epistemics, and the similarities and differences are summarized in the last section of the results.

3.1 Emotion work

The feeling of understanding and being understood is an integral part of human relationships (Antikainen & Ranta 2008). In a therapeutic relationship, however, mutual understanding is critically important. Formulations are one interactional practice that makes displays of understanding explicit and thus available to the researcher. The first three articles in this dissertation describe therapists’ use of formulations: how they reshape, transform, validate, and challenge the clients’ talk. The focus is on client talk that describes personal and emotional experiences, for instance, how they feel about somebody or something. The articles analyse how therapists orient to and work with clients’ emotional experiences. They respond to the first sub-question (How do therapists express empathy and respond to clients’ talk on their subjective emotional experiences?). The first article provides a general outline of how formulations are used in cognitive psychotherapy and psychoanalysis to reshape clients’ descriptions of their personal experiences and display understanding and empathy. The second article focuses on the nonverbal, prosodic aspects of therapists’ empathic formulations and explores how their prosodic design anticipates the direction of the sequences. The third article concentrates on resource centred encounters and investigates the use of formulations in managing talk on clients’ emotional experiences.
3.1.1 Formulations in reshaping the client’s personal descriptions

Article I describes how therapists use formulations for reshaping talk on clients’ personal experiences. These personal descriptions are most often related to clients’ emotional experiences: how they feel toward something or someone. Formulations are one commonly used way for therapists to attend to clients’ descriptions of their emotional experiences in a way that enables their reshaping for specific therapeutically relevant purposes. The article compares the use of formulations in cognitive psychotherapy and psychoanalysis. Based on a collection of 224 formulations, the article describes four kinds of formulation in which therapists deal with clients’ descriptions of their personal experiences.

In a highlighting formulation, the therapist underlines some part of the client’s description by providing a version of it that remains close to the client’s original description. These formulations are lexically designed to recycle elements from the client’s prior talk. The elements that are selected from the client’s talk typically contain some therapeutically dense material, such as emotionally heightened descriptions of the client’s narration. As these formulations are strongly sequentially contingent on the client’s prior turn, they make relevant the client’s confirming response. The clients in our data typically responded to these formulations with a minimal confirmation and continued their narrations. Highlighting formulations are used to display understanding of the client’s description. By formulating the key descriptions in the client’s talk, therapists can show that they are actively listening to the client’s talk and have recognised the client’s experience.

In the second type of formulation, therapists rephrase the client’s description. Rather than using the same lexical items as the client, the therapist renames the client’s descriptions in generic and often somewhat abstract psychological terms. Rephrasing formulations are used for directing clients’ attention to their subjective (often emotional) experiences and inviting the client’s self-reflection. In our data, client responses that merely indicated confirmation were most often oriented to as insufficient, and agreements (or disagreements) extended with personal descriptions were invited.

In the third, relocating formulations, therapists still expand on clients’ descriptions of their experiences by proposing that they are connected to experiences at other times or places. Thus, these formulations transform the content of the client’s descriptions in a radical way. Sequentially, these formulations are quite similar to rephrasing formulations: they too invite extended elaboration of the client’s own experience. The fourth type of formulation is designed to exaggerate the client’s previous descriptions. These formulations recast the client’s talk as something that is apparently implausible or even absurd. Sequentially, exaggerating formulations recast the client’s description in such a way as to create an expectation of disagreement with the formulation. In our data, highlighting and rephrasing formulations occurred with comparable frequency in both psychoanalysis and cognitive psychotherapy. The other two types of formulation were exclusive to one or other approach: relocating formulations to psychoanalysis and exaggerating formulations to cognitive psychotherapy.

Article I suggests that highlighting and rephrasing formulations might be interactional practices that are related to the common factors of psychotherapy: highlighting formulations by displaying understanding and rephrasing formulations by guiding clients to focus on their subjective experience. Both formulations may also deliver empathic
responses, as they show understanding of the client’s experience. Thus, they seem to be one important interational means of conducting emotion-related work in therapeutic interaction. Relocating and exaggerating formulations appear, on the other hand, to be interactional practices related to approach-specific therapeutic techniques. Relocating formulations are used to prepare the ground for an interpretative statement by providing the material on which the subsequent interpretation is built (also Vehviläinen 2003). Sometimes, these formulations were also used as vehicles for delivering the whole interpretation. Exaggerating formulations are used, in turn, for challenging the client’s maladaptive or dysfunctional thinking by recasting the client’s talk as apparently implausible. However, the suggestion is not that there is no interpretative work in cognitive psychotherapy or challenging in psychoanalysis. Article IV describes other types of practices that therapists use for delivering interpretative utterances, and article V explores other practices of challenging in both cognitive psychotherapy and psychoanalysis. Before discussing these articles in more detail, I will summarize the findings in articles II and III on the ways formulations are used in therapeutic interaction.

3.1.2 Prosody of formulations in empathic and challenging sequences

Article II more closely describes therapists’ use of rephrasing formulations in cognitive psychotherapy and psychoanalysis. The article analyses the prosodic aspects of 59 formulations in sequences where clients describe their emotional experiences and therapists rephrase that emotional description, thereby displaying their understanding of the client’s experience. Two alternative interactional trajectories were found to follow from therapists’ formulations. In the first trajectory, the client confirmed the therapist’s formulation and, subsequently, the therapist validated the client’s emotional experience. The first example in the article shows how the client orients to the therapist’s formulation as a validating formulation by remaining in the emotional state and expressing it through tears. After the client’s emotional display, the therapist remains focused on the client’s feeling, demonstrating that it is legitimate and understandable. The article suggests that in such sequences therapists deliver empathic responses.

In the second type of trajectory, the therapist’s focus is different. As in the validating trajectory, the therapist first receives the client’s description by rephrasing the emotion the client has described. However, here clients orient to the therapist’s formulations as more problematic than in the validating trajectory, often disagreeing with them or only partially confirming them. After the client’s response, the therapist then goes on to evaluate or even challenge the client’s description. The analysis indicates that the difference between these validating and challenging trajectories is not yet evident in the lexical design of the formulations: in both trajectories, the formulations rename the client’s descriptions in generic psychological terms. However, the prosodic design of the initial formulation already anticipates the direction toward a validating or challenging trajectory. The article describes in detail the prosodic features of these formulations.

The prosodic pattern that characterizes formulations with a validating trajectory is termed prosodic continuity, as the therapist’s turns continue the intonation of the client’s preceding turn. The therapist’s turns are also produced in a lower and/or quieter voice than the client’s preceding turn. A prominent feature is also a narrower pitch span than in the client’s previous turn. The article suggests that these features constitute ‘the therapist’s empathic tone of voice’. In contrast, the prosodic pattern that characterized formulations
leading to a challenging trajectory is termed *prosodic disjuncture*. There is a discontinuation in intonation from the client’s previous turn. In addition, the therapist’s voice is higher and/or louder, and the pitch span is wider than in the client’s previous turn.

Article II suggests that the choice between prosodic continuity and prosodic disjuncture is an essential resource for therapists in designing their formulations as either empathic or challenging. Moreover, these prosodic resources of expression seem to be similarly used in both psychoanalysis and cognitive psychotherapy. The article highlights the centrality of reciprocal and mutual aspects of psychotherapy interaction by considering the prosody of the therapist in relation to the prosody of the client’s prior turn.

### 3.1.3 Formulations in managing talk on the client’s emotional experiences

Article III also describes the interactional trajectories that follow formulations that focus on clients’ descriptions of their emotional experiences. The data for this research come from resource-centred occupational therapy encounters in psychiatric outpatient clinics. Based on 34 formulation sequences, the article describes two interactional trajectories that differ from the previous validating and challenging trajectories.

In the first trajectory, clients take a positive stance towards their own experience, highlighting their agency, competence or personal resources. Occupational therapists then select the positive aspect of the client’s description to be formulated, and in their following turn endorse the client’s positive description and preserve the client’s agency and competence as the topic of the talk. The article suggests that this is one sequential place where positive empathy, optimism and accentuating the client’s strengths, all critical values in the resource-centred approach, occur.

In the second trajectory, clients provide trouble-talk without accentuating the positive. In their formulations, occupational therapists recognize and topicalize the clients’ difficult emotional experience but proceed, in their following turn, to guide the discussion towards less affective aspects of the experience or towards another agenda for the session. For instance, example four in the article describes how the therapist initiates sequence closure and orientation towards another activity by shifting her gaze from the client to the calendar on her desk while the client is still in the middle of her emotional description. These topic or activity shifts were not resisted by the clients and they rarely moved back to their trouble-talk.

The article suggests that these formulations are similar to those found in cognitive psychotherapy and psychoanalysis in that they provide understanding of the client’s emotional experience. However, in the resource-centred approach the occupational therapist turns that followed these formulations were very different from the validating or challenging turns of the therapists in article II. In validating and challenging trajectories, the client’s emotional experiences were still the focus of the following interaction, which aimed to encourage self-reflection within the client. In contrast, the formulation trajectories in resource-centred counselling come closer to those in medical settings, where empathic recognition of the client’s trouble-talk is utilized to provide a smooth return to the main activities of the encounter (Ruusuvuori 2007).
3.2 Epistemic work

In conversation analysis, epistemics refers to the knowledge claims that participants in interaction assert and contest in their sequences of talk (Heritage 2013). It has been noted that individuals have a privileged epistemic status relative to their privately acquired experiences (Heritage 2013). This becomes crucially important in therapeutic work where therapists are required to make interventions that are directed towards the client’s private mental experiences. Two articles in this dissertation describe this phenomenon. The first of these (article IV) responds to the sub-question how do therapists work with experiences that belong to clients’ personal domains of knowledge? The second (article V) analyses therapist interventions that directly disagree with clients’ descriptions of their personal experiences. The results of article V answer the sub-question how are disagreements expressed and relational stress managed in therapeutic interaction?

3.2.1 Interactional practices for displaying access to clients’ experiences

Article IV describes the interactional practices therapists use for displaying access to clients’ personal domain of knowledge. The focus is on therapists’ formulations and interpretations dealing with clients’ inner experiences. It further develops the idea of the functions of rephrasing and relocating formulations and discusses how interpretative content is similarly or differently delivered in psychoanalysis and cognitive psychotherapy. The basic idea in the article is that in order to be understood and accepted by the client, therapists need to do interactional work to show that their interventions are based on something that has been previously said by the client. The article describes the practices therapists use for linking their interventions to the client’s previous talk.

The article is based on 121 therapist interventions, including both formulations and interpretations, that have the client’s inner experience as their referent. Two types of epistemic work for displaying access to the client’s experience were identified. In the first, therapists co-described the client’s inner experience with the client, demonstrating access to the experience on the basis of the client’s here and now description. Therapists tied their interventions to the client’s previous turn, thereby showing that the turns were closely related and that the therapist’s intervention was a continuation of the client’s turn. The practices for doing this were turn initial particles, which framed the content of the intervention as something derived from the client’s talk, and syntactic continuity between client’s and therapist’s turns. The therapists also used zero-person constructions to frame the client’s feeling as generally understandably, as something that everyone would feel in a similar situation. In this way they moderated their claims to know how the clients actually felt. Continuity between the client and therapist’s turn was also achieved by non-verbal means, namely by prosodic continuity, as described in article II. In this way, it could be argued that the therapists attuned themselves to the client’s affective experiences, demonstrating that the experience was available to them on the basis of empathetic understanding. This type of co-describing was most often found in therapists’ formulations.

The second type of epistemic work used by therapists for displaying access to the client’s experience was the construction of evidential grounding for the intervention. This was achieved, for instance, by summarizing the client’s talk as proof of the therapist’s own
conclusion and using the same descriptive terms as the client. Therapists mitigated their access to clients’ personal domains by using framing expressions and hypothetical turn construction features. These practices were used in interpretations which went beyond the clients’ immediate experiences, providing explanations, connections and the origins of those experiences. The therapists manifested epistemic asymmetry by marking the interpretation as based on their own reasoning and thus unavailable here and now to the client.

The article also provides an example of how participants may orient to missing epistemic work. In the case described in the article, the referents of the interpretation are outside the prior discussion and are thus sequentially unexpected for the client. The therapist fails to design the interpretation in such a way as to show its grounding in the client’s prior talk, and consequently the client explicitly calls into question the therapist’s epistemic rights to know what is (or is not) on her mind. The article suggests that cases without common grounding may provide clients an opportunity to resist the content of the therapist’s intervention by treating the therapist as accountable for the epistemic claims that the intervention conveys.

The article concludes that cognitive psychotherapy and psychoanalysis seem to be different in terms of participants’ orientation to epistemic relations. In the cognitive psychotherapy data, the therapist’s interventions were carefully tied to the client’s prior talk, and they mainly addressed the client’s immediate experience. Interventions beyond the client’s immediate experience were rare, and in those few cases the therapist marked her utterances as interactionally problematic. Conversely, in psychoanalysis, the therapist commonly used interventions that went beyond the client’s immediate experience by providing new meanings and connections over and above what was readily observable in the client’s talk. However, the majority of these interventions involved evidential grounding, intended to demonstrate that they were based on the client’s previous talk.

3.2.2 Disagreeing with clients’ descriptions of their personal experiences

Article V analyses sequences of talk in which therapists from psychoanalysis and cognitive psychotherapy disagree with clients’ descriptions of their personal experiences. Therapists’ disagreeing turns are an essential part of their overall project, continued across sequences of talk, to challenge clients’ maladaptive emotional or cognitive patterns. The article describes how therapists balance between supportive and challenging interventions and illustrates the different ways disagreements are performed. The disagreeing turns in the data highlight problematic elements in the clients’ descriptions of their experiences. These turns prompt the clients to defend their view, maintain their positions and sometimes withdraw from further conversation. In the data analysis of 24 extended disagreement sequences, two different disagreement types were found. In supportive disagreement, therapists actively work to find congruence between their perspectives and those of the client, validate the client’s emotional experience and display only partial access to the client’s domain of knowledge. As an example of supportive disagreement, the article describes a long segment of talk from cognitive psychotherapy in which the

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1 The term supportive is used in here to describe the interactional features of the sequences in question. It does not refer to the supportive-expressive continuum used to describe the overall differences between therapeutic approaches.

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therapist directly challenges the intensity of the client’s emotional experience in a rather unmitigated way, resulting in the client’s withdrawal. This is followed by the active modification of the therapist’s arguments to include the client’s perspective, so as to demonstrate the client’s maladaptive thinking pattern while validating her feeling. The therapist also respects the client’s epistemic primacy by displaying that she can only imagine how the client feels. These interactional moves were successful in engaging the client to continue to work with the problematic experience.

In unsupportive disagreement, divergent perspectives are maintained and the therapist implies that the client’s view is unrealistic and/or fails to respect the client’s epistemic domain. In our data, these moves provoked irritation or anger in the client, leading the participants to abandon the original topic that led to the disagreement and initiate a talk on their mutual relationship. In the article, an example from psychoanalysis is provided in which the therapist strongly confronts the client’s position and rejects the concession the client attempts to offer. The therapist also indicates that the client’s view is unrealistic, while his counter view represents reality. Moreover, the therapist claims that the client knows the veracity of his assertion but is unwilling to admit it because she is repressing the painful truth. This leads the client to express irritation and the relationship between the participants becomes the topic of the following discussion.

The article indicates that while openly challenging sequences are found in both psychoanalysis and cognitive psychotherapy, there were also significant differences, especially in terms of the epistemic primacy of the client. In the cognitive psychotherapy data, the client’s epistemic primacy was respected in challenging sequences, whereas in some of the disagreement segments in psychoanalysis, epistemic incongruence was strong.

3.3 Summary: similarities and differences between therapeutic approaches

In the datasets for each therapeutic approach (psychoanalytic, cognitive and resource-centred), formulations were a central interactional practice for working with the client’s emotional experiences. Moreover, all the therapists, irrespective of the approach, used formulations of the client’s emotional experience to display understanding of that experience. In this respect, formulations can be considered a vehicle for empathic responses. In our data from psychoanalysis and cognitive psychotherapy, two types of formulations were similarly used: highlighting formulations, which remained close to the client’s previous talk and focused on therapeutically dense material, and rephrasing formulations, which renamed the client’s feelings and centred on the client’s subjective experiences. The tasks of demonstrating that the client’s talk had been heard and understood and guiding the talk towards the client’s subjective experience were found to be common to both these approaches. In both the psychoanalytic and cognitive psychotherapy data, prosody was also similarly used to mark a formulation as either empathic or challenging. Prosodic continuity was found to be a central resource used by therapists for delivering empathic responses. Moreover, in both psychoanalysis and cognitive psychotherapy, therapists faced a challenge in balancing between supportive and more challenging responses. In our data, the therapists engaged in challenging sequences in which they openly disagreed with the clients’ descriptions of their personal experiences.
Supportive and unsupportive disagreement sequences were found in both datasets. In unsupportive disagreement, the topic of conversation invariably turned to the therapeutic relationship itself. In addition to challenging interventions, the therapists in our data also used interpretative interventions in both approaches. In these turns of talk, the therapists delivered their understanding of the client’s inner experience. This type of intervention required epistemic work, i.e. practices that displayed the therapist’s access to the client’s private experience. A commonly used practice in both approaches was to co-describe the client’s experience: tie the intervention closely to the client’s previous talk and downgrade its ‘firstness’ in relation to the client’s previous turn.

Although challenging and interpretative interventions were found in both the cognitive psychotherapy and psychoanalytic datasets, there were several differences in how they were used. In the cognitive psychotherapy data, challenging interventions often took the form of exaggerating formulations. Interpretations merely paraphrased the client’s immediate experiences and stayed close to the client’s prior talk. In the cognitive psychotherapy data, interpretative content was typically delivered in and through empathic reflections, i.e. the therapist attuned herself to the client’s emotional experience, thereby allowing claims that were not directly based on the client’s prior talk. The few cases in which the cognitive therapist moved further from the client’s prior talk, by providing, for instance, explanations of the client’s experience, were marked as interactionally problematic. In contrast, psychoanalytic interpretations were more distanced from the client’s prior talk. Moreover, a specific formulation practice, the use of relocating formulation, was employed in interpretative work in psychoanalytic data. Through these formulations, the therapist was able to make far-reaching interpretations and frame them as something based on the client’s previous talk. Differences in epistemic relations between the two approaches were noticeable in our data in extended challenging sequences, where epistemic incongruence was much stronger in psychoanalysis than in cognitive psychotherapy. Thus, cognitive psychotherapy and psychoanalysis seem to differ in terms of epistemic relations.

Last, the data from the resource-centred approach differed from the psychoanalytic and cognitive psychotherapy data in its orientation to the client’s emotional experiences. In our data from psychoanalysis and cognitive psychotherapy, the client’s emotional experiences were typically validated, interpreted or challenged. The therapists performed interactional work in order to ‘be with’ the clients’ feelings and face their difficult emotional experiences, even when the clients resisted their exploration. In contrast, in the resource-centred dataset, the clinicians focused on positive, successful experiences and praised their clients’ agency, competence and personal strength. In this approach, the clinicians’ talk tended to focus away from the client’s difficult emotional experiences.
4 Discussion

The overall findings and contributions of this dissertation, as presented in the original articles, can now be considered. Next, I will discuss the findings of my five articles in the light of previous studies in three research fields: conversation analysis, clinical research and sociological research on mental health. Before detailing these, some methodological strengths and limitations will be discussed.

4.1 The benefits and limitations of CA in therapy research

Conversation analysis has distinct methodological strengths when conducting research on therapeutic interaction. As psychotherapy primarily occurs through talking, conversation analysis, as the study of talk-in-interaction, is an ideal method for its investigation. Process-outcome research on psychotherapy has traditionally focused on the psychological effects of the therapy during the therapeutic process (Elliott 2012). Although this research has been successful in identifying specific ingredients related to successful outcomes, relatively little is still known about how the therapeutic process actually occurs (Elliott 2012). Moreover, the traditional methods used in process research have ignored the process through which the client and therapist together, moment by moment, create therapeutic sessions (Peräkylä et al. 2008). The novelty of conversation analysis lies in its efforts to study, in a relational way, the actions performed by the therapist and client during therapy sessions. Thus, CA investigates the therapist’s turns of talk in relation to the turns of the client and vice versa. Consequently, the focus is neither solely on the psychological process that takes place in client nor on the interventions made by the therapist. Instead, the analysis centres on the joint management of conversational actions and the consequent transformation of the description of experience (Peräkylä 2014).

The other notable strength of conversation analysis is its grounding in general social scientific theory on human social interaction, rather than it being anchored in any psychotherapeutic school of thought. CA is a strongly data-driven approach, and its focus is on what really happens in naturally occurring, ordinary therapeutic encounters. This differentiates CA from several other qualitative approaches that have been developed in the field of psychotherapy research. Freedom from the theoretical assumptions of any specific psychotherapeutic approach is especially important when comparing different therapeutic approaches; this is the strength of CA and the strength of this dissertation’s analysis. Previous conversation analytic research on psychotherapy has failed to provide a systematic investigation of different therapeutic approaches. By comparing three therapeutic approaches that can be characterized as representing opposite ends of the expressive-supportive continuum, I hope to have offered a novel methodological contribution to the field of conversation analysis and psychotherapy research.
Demonstrating how ordinary interactional practices are employed in therapeutic interaction for these three approaches will further our understanding of how therapeutic work is performed.

As with any piece of scientific work, this dissertation has its limitations, the first being the small number of participants in the datasets. In the case of cognitive psychotherapy and psychoanalysis, the data came from just one therapist from either approach, while the resource-centred data came from three occupational therapists. Moreover, the clinicians who consented to participate were not randomly chosen; rather, they were particularly open to the idea of their work being recorded, and thus probably more interested in unravelling and developing their working practices than clinicians on average. Due to the limited number of participants, the interactional differences found between these representatives of different therapeutic approaches might be a result of their ‘personal styles’ rather than the therapeutic tradition to which they belonged. On the other hand, the interactional differences found were in line with differences between the clinical theories of the different approaches, which supports the idea that the findings reflect interactional differences between these therapeutic approaches at a more general level.

The clients, moreover, were not randomly chosen; rather, the clinicians themselves selected clients they considered appropriate for participation in the study. Thus, the clients were not chosen on the basis of diagnostic criteria or any other measured attribute. The background information on the clients is also very limited. For these reasons, the findings of this research, especially the quantitative results, should be interpreted with caution, and it would be important to establish the generalizability of the findings with more data involving several practitioners.

The other limitation of this dissertation is the lack of video-recorded data from cognitive psychotherapy and psychoanalysis. In the analysis of participants’ expression of emotion, visual data would have provided invaluable detailed information on the momentary expressions of the participants. The analysis particularly suffered from the lack of such data in moments of silence. The highly confidential nature of therapy, especially in the case of psychoanalysis (psychoanalysts have not been particularly open to the idea of recording analytic sessions), made the acquisition of video-recorded data unfeasible. As non-verbal expressions are a crucial part of the expression of emotion, my solution in this dissertation was to complement the analysis of verbal actions with an analysis of prosody.

A further limitation of this dissertation is the lack of outcome measurements for the overall therapeutic processes. Because the focus of the analysis was on interactional manifestations of the therapeutic relationship, an assessment of the participants’ perceptions of the therapeutic relationship would have been advantageous. Combining conversation analytic investigations and outcome measurements would have provided important information on how well the interactional practices studied in this research work outside their immediate local contexts.
4.2 Social actions and continuities with mundane conversations

In this section I will discuss the findings of this dissertation in relation to previous conversation analytical research. I will begin with formulations, which have been one of the central topics of earlier CA studies on psychotherapy. In previous CA research, formulations are discussed from two perspectives. First, discussion has centred on the elements that differentiate formulations from other actions, most importantly interpretations (or reinterpretations). A clear distinction between formulations and interpretations has been made in many earlier studies (e.g., Antaki 2008; Bercelli et al. 2008). The basic idea is that formulations paraphrase what the client has said, thereby preserving the client’s perspective and inviting a minimally confirming or disconfirming response (Bercelli et al. 2008). In contrast to formulations, interpretations (or reinterpretations) deliver the therapist’s own reasoning, inviting an extended agreement. According to this definition, the highlighting formulations in our analysis seem close to what are generally referred to as formulations. However, as already noted in Heritage & Watson’s (1979) seminal paper, formulations are devices capable of initiating or performing a range of activities. Heritage & Watson (1979:156) write:

*Formulations may be located in utterances which achieve considerably more conversational work than formulating per se. Once again, it is clear that analysing utterances into conversational activities is not an either/or matter. We have sought to show in this paper that it is precisely through their particular fixative conversational work that formulations may provide valuable in achieving larger conversational undertakings.*

Although formulations are designed to be based on the client’s previous talk, it does not mean that they are mere repetitions of that talk. Formulations are capable of delivering therapists own reasoning, while masquerading as a rephrased version of the client’s prior talk. In this way, formulations can even function as interpretations. This is the case, for instance, in relocating formulations, which transform the content of the client’s description in a radical way: in an example presented in article I, (extract 5) the client’s criticism of his father was transformed into criticism of the therapist (*So that I am a bad analyst*). Although the turn was designed as a formulation, in terms of action it was an interpretation aimed at making the client aware of his (at least partially) unconscious feelings towards the therapist. The same complexity applies to the formulations discussed in article IV. Although these turns are designed as summaries of clients’ prior talk, they do more than demonstrate the therapist’s attention to and recognition of the client’s experiences. As Voutilainen et al. (2010a:89) observe, these utterances “combine characteristics of statements, extensions and formulations with subtle shifts towards the client’s inner experiences”.

In earlier CA research, formulations have also been discussed in terms of their use for different interactional purposes. In psychotherapy, at least three different functions have been found for formulations: they can transform the client’s talk into therapeutically relevant issues, manage the agenda of the session and prepare the client’s talk for the therapist’s subsequent actions (Antaki 2008). The findings of my dissertation complement previous research in this area by investigating exaggerating formulations and addressing their role in challenging the client’s talk in cognitive psychotherapy. The challenging
function of formulations has been observed in radio-talk-in-shows (Hutchby 1996) but not previously in psychotherapy. Thus, my results indicate the presence of interesting connections in the use of formulations between different institutional contexts. Even though formulations can perform rather specific tasks (such as exaggerating formulations challenging the client’s maladaptive thoughts), it also appears that similar types of formulations can be found in surprisingly different settings (such as challenging a caller’s position in a radio-call-in-show).

My dissertation also contributes to previous CA research on emotion in naturally occurring spoken interaction (see Peräkylä & Sorjonen 2012) by analysing the meaning of the prosodic aspects of therapists’ empathic and challenging formulations. In CA research on psychotherapy, prosody has not previously been the subject of systematic analysis. However, in an everyday context the prosodic features of empathic responses have indeed been studied. Couper-Kuhlen (2012) has analysed responses to complaint stories, finding that empathic responses were delivered with prosodic matching and upgrading. In contrast, responses that were considered less empathic were produced with prosodic downgrading. The results of our research are partially consistent with the findings of Couper-Kuhlen. In our data, the mirroring of clients’ intonation was an important aspect of empathic formulations that initiated a validating trajectory. However, this study’s findings differ from Couper-Kuhlen’s in that the empathic formulations in our data were delivered with prosodic downgrading and the challenging formulations with an upgrade. It is possible that this difference stems from the different emotions expressed in our own and Couper-Kuhlen’s datasets: anger and indignation in Couper-Kuhlen’s study and sadness in our research. On the other hand, Hepburn & Potter (2012) have studied responses to crying in mundane conversations and help-line calls and proposed that sympathetic responses are mainly realized by such prosodic means as high or rising-falling pitch, or a stretched, breathy and creaky voice. However, while Hepburn and Potter’s crying sequences seem to involve some form of response to sorrow or sadness, the high or rising-falling pitch employed in these responses was not found in our data (the pitch was low and level in our data). This could indicate that psychotherapy interaction involves a reflexive dimension that favours the downgrading of pitch and volume as a means of displaying empathy. Support for this idea can be found in Fitzgerald and Leudar’s (2010) findings on person-centred psychotherapy, in which the therapist’s empathic continuers were prosodically produced with a low pitch, matching with the client’s previous talk. Also Xiao et al. (2014) found that high pitch and energy of the therapist was negatively correlated with empathy.

Attuning to the client’s affective experience may also be related to the epistemic work therapists perform when working with the client’s inner experiences. Heritage (2011) observes (while discussing mundane conversation) that in moments when another person is describing his or her affective experiences, the other participants are obligated to join in the evaluation of the experience and affiliate with the stance taken by the teller towards the experience in question. The recipients, however, face a dilemma, for as Heritage (2011:161) notes, they are “required to affiliate with the experiences reported, even as they lack the experiences, epistemic rights, and sometimes even the subjective resources from which emotionally congruent stances can be constructed”. The analyses of articles II and IV suggest that through continuous prosody therapists can attune themselves to the client’s affective experiences, and in this way display a more congruent emotional stance. Article IV discusses therapists’ formulations that co-describe the client’s inner experience. In these formulations the therapist’s orientation toward sharing the emotional stance of the

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client was maintained through syntactic and prosodic continuity. In this way, the therapists demonstrated that the clients’ experience was available to them on the basis of empathetic understanding (Voutilainen et al. 2010a). Stevanovic and Peräkylä (2014) have proposed that relationship negotiations in interaction involve a complex interface between knowledge, power and emotions. Our analysis in article IV supports this idea by showing how sharing an emotion can moderate epistemic asymmetries in psychotherapeutic interaction, as attuning to the client’s emotional experience enables the therapist to display some knowledge of the client’s personal experiences. The idea that ‘affective attunement’ can be used as a ‘ticket’ for a formulation on a co-participant’s mental state is also theoretically interesting: here the emotional order and the epistemic order (Stevanovic & Peräkylä 2014) meet, and the emotional stance display modulates the epistemic relationship.

Similar to mundane interaction, clinicians in psychotherapeutic interaction systematically take into account clients’ privileged access to their own experiences (e.g., Peräkylä & Silverman 1991). Therapists need to perform constant epistemic work to justify their claims (e.g., formulations and interpretations) about the client’s personal domain of knowledge. Of course, some interventions that are regularly used in psychotherapy are very rare (or non-existing) in mundane conversations: responding to the trouble-telling of a friend with an interpretation of his or her unconscious processes would rarely be acceptable. On the other hand, due to the asymmetric relationship between the therapist and client (the conversation is about the client’s experience and therapists’ disclosures of their own perspectives are more restricted than in everyday talk), many of the strategies used in everyday interaction for responding to the experience of others are unusual in therapy data. For instance, responses that mark the recipient’s lack of epistemic access (like that sounds wonderful or lucky you!), second stories based on the recipient’s own related experience, or response cries (e.g., Heritage 2011) are very rare in our data. The therapist’s contributions to interaction seek to facilitate joint understanding of the client’s inner experiences, but because that understanding is often achieved in a painfully gradual way, knowing and not-knowing are often very obscure. Due to the ‘epistemically fuzzy’ nature of therapeutic conversation, when analysing the data it is difficult to determine whose knowledge forms the primary basis for shared understanding, or whose knowledge is more certain.

CA research on epistemics (e.g., Heritage & Raymond 2005; Raymond & Heritage 2006) has mostly focused on agreements, for instance on how second speakers can qualify their agreements in a way that reduces the responsiveness of their second assessment to the first assessment. Much less attention has been paid to direct disagreements, especially to disagreements in first position turns. Article V of this dissertation explores the strong oppositional statements used by therapists for disagreeing with clients’ descriptions of their personal experiences. Previous conversation analytic literature has shown that in everyday interaction expressions of direct disagreement (or other discordant actions) are often avoided and different sequential arrangements are employed to suppress their occurrence (e.g., Clayman 2002; Pomerantz & Sanders 2013; Pomerantz 1984). However, other studies have observed that there are contexts (both in everyday and institutional settings) in which disagreements are not avoided but are actively pursued (e.g., Goodwin 1983; Hutchby 1996; Pomerantz & Sanders 2013). Moreover, it has been shown that disagreement may not necessary result in conflict, instead being more of a sign of an intimate social relationship (e.g., Corsano & Maynard 1996). Article V contributes to this body of knowledge by demonstrating how, rather than retreating from situations of
potential conflict (cf. Muntigl et al. 2013), the therapists in our data sometimes engaged in openly confrontational argumentation. Article V expands Pomerantz and Sanders’ (2013) perspective on conflicting interaction in courtroom situations by describing practices for averting and engendering acrimony in psychotherapy interaction. One important feature of argumentation in psychotherapy (and a possibly difference between psychotherapy and other contexts) is that heated arguments can be dealt with by taking up the therapeutic relationship as the topic of the conversation. As suggested by Voutilainen et al. (2010b), disagreeing interventions and the topicalization of the relationship may be a resource for therapeutic work and thus indeed a sign of a social relationship that is intimate and yet professional. Article V also contributes to CA research on therapeutic relations and longitudinal projects (e.g., Bercelli et al. 2013; Muntigl et al. 2013; Peräkylä 2011a; Voutilainen et al. 2012) by describing longer disagreeing sequences in which emotions and therapeutic relations are worked with.

I would lastly like to discuss topicality in CA research on psychotherapy interaction. CA has traditionally held that talk-in-interaction is better examined with respect to action (what the utterance does) than topicality (what the utterance is about) (Schegloff 2007:1). Orientation to action is the corner-stone of any conversation analytical work, but in the CA of psychotherapy, it appears that we also need to address topic, and thereby the referentiality of talk, in a particular way. The question of topics and actions becomes especially important when identifying and including cases in a collection during data analysis. Cases in a collection are typically identified on the basis of the actions or practices the target utterance conveys. For instance, in my core collection on formulations, cases were identified on two bases: 1) therapists’ utterances paraphrased what the client had said and 2) different types of tying practices were used to show the relatedness of the therapist and client’s turns. However, the topic of talk might also be crucially important for therapists’ actions. For instance, article II describes the prosodic aspects of therapists’ empathic formulations. In order to identify ‘empathic sequences’ in our data, we first collected sequences in which the client described an emotional experience or expressed emotions in situ. We then made a sub-collection of cases in which the therapist formulated those emotional experiences. Thus, the content of the formulation (it is about the client’s emotional experiences) was crucial. Moreover, these formulations are considered empathic actions precisely because of their content; because they choose to focus on the client’s emotional experience rather than any other aspects of the preceding talk. In a similar vein, the analysis in article III, which describes practices for managing talk on clients’ emotional experience, requires identification of the emotional content of the client’s talk. Article IV is the most interesting in this respect. In a general sense, therapists’ interpretations are actions that deliver the therapist’s reasoning for the client’s personal experiences (Bercelli et al. 2008). Because the delivery of the interpretation may take several forms (Bercelli et al. 2008; Vehviläinen 2003), especially between therapeutic approaches, the collection for article IV was gathered by first focusing on content: therapists’ turns of talk that were about the client’s inner experiences were collected. In this way, we were able to identify the different practices used by the therapists for delivering interpretations (be they interrogatives, statements, formulations etc.) This focus on content is perhaps ill-fitting with CA’s traditional emphasis on practices and actions, but I suggest that action and content are not always mutually exclusive categories. At least in therapeutic interaction, topic, in a broad sense (e.g., about the client’s feelings or inner experiences), seems to be integral part of what therapists and clients do, and what they themselves orient to, and thus it should not be excluded from the analysis of social actions.
4.3 Managing the therapeutic relationship in interaction

I will now move to discuss the results of this dissertation in relation to previous clinical research and other ‘non-CA’ studies on psychotherapy, psychiatry and occupational therapy.

In process-outcome research, various rating systems for therapists’ empathic communication have been developed (e.g., Elliott et al. 1987). Even though earlier research has clearly shown the importance of prosody in empathic communication, prosodic aspects have been difficult to code and rate reliably (Elliott et al. 1987). The CA approach provides a detailed qualitative method for analysing the prosody of the therapist in relation to the client’s prior talk. Article II provides a novel contribution to the field of psychotherapy research by showing how prosody contributes to the accomplishment of psychotherapeutic acts and revealing one way in which prosody is a central part of relational work. The article also contributes to our understanding of the concept of emotional empathy (e.g., Bohart & Greenberg 1997; Greenson 1960; Rogers 1975) by describing the practices of vocal matching (together with other prosodic features). Vocal matching practices have been identified as crucial vehicles for bonding, attachment and intimacy between babies and their caretakers, but they have largely been neglected by researchers of adult psychotherapy interaction (Beebe et al. 2003:810).

Article V contributes to the field of psychotherapy research by highlighting the importance of disagreements in therapeutic work, and by describing the challenge therapists face in balancing between supportive and challenging interventions. According to the so called balance hypothesis (Bänninger-Huber & Widmer 1999), therapists are required to fulfil a double function: they must engender a sense of trust in the client in order create the required sense of security in the therapeutic relationship, but they also need to sustain a certain level of conflictive tension in order to work on the client’s problems and achieve change. The challenge for the therapist is to identify the adequate level of tension; the sensitivity to know when to retreat and when to push is needed (Ribeiro et al. 2014). Article V describes how this balancing is manifested in situated supportive and unsupportive moves during extended disagreement sequences. It describes the dynamic process of how understanding between the participants diverges and convergences through sequences of actions, making visible the intersubjective nature of therapeutic talk.

In process-outcome psychotherapy research, there have been myriad studies on the similarities and differences between various therapeutic approaches. Earlier studies have uncovered, for instance, differences in theoretical conceptualizations (e.g., Ziegler 2002), the frequency of different verbal activities (e.g., Elliott et al. 1987; Stiles 1992) and general process characteristics (e.g., Hilsenroth et al. 2005; Watzke et al. 2008). Moreover, there are number of studies comparing manualized treatment processes (e.g., Luborsky & DeRubeis 1982; Malik et al. 2003). In the present dissertation, the focus is, nevertheless, different: it concentrates not on the frequency of verbal practices or the techniques therapists use (although it does address these issues); rather, the focus is on describing how practices are used similarly or differently between schools of therapy. Article I contributes to comparative psychotherapy research by indicating which interactional practices for delivering formulations are similar in psychoanalysis and cognitive psychotherapy and which are distinct to each approach. By describing the use of formulations, the article distances itself from therapeutic theories, choosing rather to focus
on the attributes that make these approaches interactionally similar and/or different. The study suggests that despite some recent convergence of theories in psychoanalysis and cognitive psychotherapy (cognitions have become more of an issue in psychoanalysis, as have unrecognized emotional conflicts in cognitive therapy, e.g., Guidano 1991; Fonagy et al. 2002; Safran 1998; Sandler 1994), interactional differences still exist between these two main approaches. Article IV describes the similarities and differences between cognitive psychotherapy and psychoanalysis in participants’ orientation to epistemic relations. By describing the similarities and differences in the ways epistemic practices are accomplished in psychoanalysis and cognitive psychotherapy, the findings illustrate the approach-specific features of the relational work conducted in these two schools of therapy.

Article III contributes to clinical research on psychiatry and occupational therapy by emphasizing the importance of emotion-related work. Although the role of the therapeutic relationship is recognized in mainstream psychiatry and occupational therapy, several studies have shown that clinicians feel that they receive little specific instructions and training in the interactional skills required in relationship work (Dibbelt et al. 2009; Hanna & Rodger 2002; Priebe & McCabe 2008; Taylor et al. 2009). It is generally accepted that in order to understand better the nature of clinician-client interaction, more research on interactional processes is needed (e.g., Dowling et al. 2004; Hanna & Rodger 2002; Harra 2014; McAnuff et al. 2013). Article III describes how positive empathy (e.g., Abreu 2011; Peloquin 2005), a feature characteristic to occupational therapy and resource centred therapies more generally, is manifested in interaction. As positive empathy is an important part of relational interaction in occupational therapy, it is essential to know how it is conveyed to the client in real-time clinical practice. This would specify the stock of interactional knowledge of occupational therapy, providing tools for clinical training and supervision and enabling identification of further observable actions performed by clinicians that are associated with successful therapy processes. The sequences presented in the article illustrate the interactional practices occupational therapists use when focusing on optimism and clients’ strengths in order to verify their understanding of the client’s emotional experiences. By describing in detail the actual practices used by occupational therapists for accentuating the positive, the present study expands current knowledge of relational interaction in occupational therapy. To my knowledge, this is the first conversation analytic study that specifically explores occupational therapy encounters.
4.4 Interaction order in therapeutic encounters

In this section I will discuss the findings of this dissertation in relation to previous sociological studies on the treatment of mental illnesses. In particular, I will discuss the institutional differences between psychotherapy and psychiatric outpatient clinics.

Erving Goffman’s micro-sociological approach has been important for this dissertation in two ways. Firstly, this study is theoretically and methodologically based on conversation analytic theory on the organization of human social interaction. That theory is strongly influenced by Goffman’s (1983) idea that interaction comprises an autonomous order of social organization. Thus, Goffman’s notion of interaction order has also been highly influential in this research. Secondly, Goffman was especially interested in psychiatric institutions. Goffman’s *Asylums* (1961) was one of the first sociological studies of the social situation of patients in psychiatric hospitals. It has been one of the most cited sociological texts, and its contribution to the formulation of mental health policy decisions has been highly influential (Weinstein 1982). Nevertheless, although Goffman’s work focuses heavily on psychiatry and psychiatric institutions (how psychiatry interprets breaches of interaction norms as a sign of mental disorders), he did not study the therapeutic process itself – let alone mental hospitals – in terms of the interactional situations where clinical treatment practices are created and maintained. In this sense, the present dissertation continues the ‘Goffmanian’ research tradition by combining these two themes of research, interaction order and psychiatric institutions, and investigating the organization of treatment discussions in two psychiatric institutions: psychotherapy and psychiatric outpatient care.

Based on the findings of this dissertation, some preliminary conclusions on the similarities and differences in the use of conversational practices between these two institutional contexts can be made. I will use formulations as a window through which to compare and contrast relational work in the two contexts. In both contexts, formulations proved to have a significant role in reshaping the client’s talk in an institutionally relevant direction (articles I, II and III, see also Antaki 2008). Very often these formulations contained references to the client’s emotional states. By formulating the client’s emotional states and their natural implications, the clinicians were able to display understanding and empathy. Previous research has shown that recognizing the client’s emotional experience and displaying understanding are important functions of formulations in both psychiatric outpatient care (Thompson 2013) and psychotherapy (e.g., Fitzgerald & Leudar 2010; Voutilainen et al. 2010a). As far as formulations as concerned, active listening (Fitzgerald & Leudar 2010; Hutchby 2005), focusing on clients’ psychological perspectives (Vehviläinen 2003), displaying understanding (Beach & Dixson 2001; Depperman & Spranz-Fogasy 2011) and expressing empathy (Hepburn & Potter 2007; Pudlinski 2005; Ruusuvuori 2005; Voutilainen et al. 2010a) seem to be important functions irrespective of the mental health setting.

However, the sequential implications of clinicians’ formulations seem to be significantly different in psychiatric outpatient consultations and psychotherapy. When clients described difficult emotional experiences in our data from outpatient consultations, the formulation topicalized the client’s emotional stance, but it was immediately followed by a clinician-initiated shift towards less affective content in the experience or towards another agenda for the session. Previous research supports the idea that this might be a more general feature of outpatient consultations. Thompson (2013) found that
psychiatrists’ formulations in outpatient consultations were geared towards sensitively closing particular trouble-telling trajectories and managing topic transitions. In her data, clients largely responded to formulations of this kind with minimal confirming/disconfirming tokens and psychiatrists rarely expanded beyond these basic formulation–confirmation sequences. Thus, while such formulations displayed understanding of the client’s account, sequentially they simultaneously edited and deleted the client’s contribution, focusing instead on the psychiatrist’s agenda (such as reviewing the client’s overall state) (Thompson 2013). This sequential pattern is close to what Beach and Dixson (2001) found in medical appraisal interviews: formulations provided a psychologically sensitive way to orient to the client’s talk while closing the topic and moving on in the interview agenda. The findings are also close to those from primary care consultations, where general practitioners have been observed to affiliate with patients’ trouble-telling descriptions but then produce a quick closure to the sequence and return to the main activity of the session (Ruusuvuori 2007). However, it is important to note that psychiatric outpatient clinics are complex institutions involving several groups of professionals, and these findings do not necessary apply to all such groups.

Although formulations may also manage the agendas of the session in psychotherapeutic encounters (Antaki et al. 2005; Antaki 2008), formulations focusing on clients’ personal or emotional experiences are often employed to invite self-reflection from the client. With the exception of highlighting formulations (close to Bercelli et al.’s (2008) definition of formulations), all the formulations in this dissertation invited extended elaborations from the clients. Thus, rather than closing the topic, these formulations invited more talk on it. This sequential feature was also realized in the therapist turns that followed the clients’ responses. In the data from cognitive psychotherapy and psychoanalysis, the therapists stayed with the client’s emotional states, either validating them or continuing to work with the client’s experiences by challenging or interpreting them (article II). In previous studies on psychotherapy interaction, formulations have also been observed to invite self-reflection from the client (e.g., Vehviläinen 2003; Voutilainen et al. 2010a). In their comparative research on medical, homeopathic and psychotherapeutic encounters, Ruusuvuori and Voutilainen (2009) suggest that the reflective dimensions of psychotherapy, in which the client’s experiences and emotions are the primary material to work with, are central its institutional task. Thus, there appears to be an important difference between psychotherapy and psychiatric outpatient consultation in this respect.

To conclude, occupational therapy encounters in psychiatric outpatient clinics seem to fall somewhere between medical and psychotherapeutic encounters, at least in respect to management of talk on emotions. To develop these preliminary ideas, further investigation of ‘psychotherapy-like’ practices in institutions close to psychotherapy, such as different types of psychiatric consultation and counselling sessions, is warranted. The focus could then be widened to include new forms of counselling professions in the wellbeing and life-management markets as well other settings such as religious meetings, education and voluntary work. This type of analysis could contribute to research on social constructivism in the sociology of mental health by offering detailed descriptions of how the ‘therapisation’ of postmodern society is realised in the ways people interact in different social situations. Therapy culture, shortly referred to in the Introduction, basically means that in postmodern societies different spheres of the life-world, such as education, healthcare or religion, have gained a psychology-based therapeutic character (e.g., Giddens 1991; Rose 1998). At the core of therapy culture is the experiential perspective of
the individual and his/her inner growth and change. This constant process of personal development becomes a subtle and persuasive means of social control. From a critical perspective this means that social problems derived from social inequality are attributed to individuals, who are considered solely responsible for their causes and resolutions (e.g., Furedi 2004). Because in therapy culture an individual’s ‘self’ is a constant process that requires observation, modification and interpretation, the ability to conduct a conversation about one’s ‘self’ in different social contexts is a necessary skill. Interactional practices for self-related talk are learned in every walk of life, for instance in women’s magazines and other cultural products, but especially in institutions of education and therapy (Vehviläinen & Lindfors 2005). It has been proposed that self-reflective talk (Vehviläinen & Lindfors 2005), especially concerning one’s own emotions (Vehviläinen 2004), is an interactional phenomenon in which the ethos of personal development is made visible. Psychiatry offers an interesting avenue for investigating how reflective talk on emotions is oriented to in therapeutic situations where the client lacks some of the abilities required in such talk. In my data from psychiatric outpatient clinics, the occupational therapists orient towards helping the clients recognise and express their feelings, but they also manage the appropriate ways of expressing these feelings in this institutional context. Clients are encouraged to develop reflectivity regarding their own emotions, but the level of this reflectivity is different from that observed in our data from cognitive psychotherapy and psychoanalysis. In the data from psychiatric outpatient clinics, feelings are recognised, but the experiences behind those feelings are rarely explored in the manner seen in our psychotherapeutic data. This type of comparative conversation analytic research could empirically investigate the cultural similarities and differences of self-reflective talk-patterns and other interactional phenomenon, possibly related to therapy culture in different social contexts. This would help reveal cultural features that have largely become taken for granted and thus invisible and clarify institutional processes and practices in which responsibilities over social/individual problems are attributed (see Vehviläinen 2015).

Understanding the similarities and differences between psychotherapy and psychiatric outpatient consultations is also important from a socio-political perspective. Today, most psychiatric treatment discussions occur during routine appointments in outpatient clinics, or, increasingly, in primary care (e.g., Lönnqvist et al. 2011). In particular, clients with severe mental illnesses receive mental health treatment from key-workers rather than psychotherapists (Klinkenberg et al. 1998). Although the discussions in outpatient clinics and primary care are not psychotherapy, it is important that they are therapeutic, as the evidence shows that the presence of a therapeutic relationship also leads to more favourable outcomes in mainstream psychiatric settings (McCabe & Priebe 2004; Priebe & McCabe 2006; 2008). Moreover, clients have repeatedly listed the therapeutic relationship as the most important component of care (Johansson & Eklund 2003). Clients in psychiatric outpatient clinics would often benefit from psychotherapy, but the waiting lists are long, the clients are not seen as suitable for psychotherapeutic work and/or the client cannot afford private psychotherapy (McCabe 2014). For many clients, counselling discussions in psychiatric (or primary care) clinics are the only therapeutic service they have. As the therapeutic relationship is managed and influenced by communication between clinician and client (Priebe & McCabe 2006; 2008), it would be important to identify the therapeutic practices used in these discussions.

The findings in article III are also interesting in terms of how far they reflect resource-centred treatment ideology. I suggest that the way clinicians focused away from clients’
difficult emotional experiences (which would have traditionally been the subject of psychotherapeutic work) and focused towards clients’ agency, competences, strengths and life-management skills, might demonstrate the coaching-like orientation characteristic of resource-centred work (Riikonen & Vataja 2011). In a broader sociological sense, this orientation could be seen as reflecting a more general change in the treatment of mental health problems from traditional care towards life-management and enhancement (Hélen et al. 2011). As previously noted, mental healthcare has spread to all sectors of welfare and healthcare, such as schools, child health clinics, occupational health services and eldercare. Although the orientation towards life management, the normalization of individuals and the improvement of their functional capacities mainly concerns individuals outside traditional psychiatric care, presumably it also affects the treatment ideologies of those with severe mental illnesses. If, for instance, the traditional psychoanalytic view has been that mental disorders are impairments in the psychological organization of the person, curable by psychotherapeutic means (Tähkä 1993), the starting point of resource-centred therapies is different. The focus of treatment is not the client’s ‘mind’; rather, it is the different types of life-management skills practised as a central part of treatment programmes in psychiatric outpatient care.

Furthermore, it would be interesting to discuss these and other patterns for understanding mental illnesses (for the changing medical understanding of mental illness see, e.g., Armstrong 1984) in relation to ‘client-centeredness’ and ‘client empowerment’ in the interactional ideologies of several therapy-related professions. Today, client-centeredness has been posited as the primary method of mental health service delivery (O’Donovan 2007). The core idea of this model is to elicit and understand clients’ experiential perspectives, feelings, concerns, expectations, needs, and functioning in order to reach a shared understanding of the problem and its treatment and help clients share power and responsibility by involving them in choices to the degree that they wish (Epstein et al. 2005:1517). These ideas represent a marked shift from the traditional asymmetric doctor-patient relationship, involving a passive patient and a dominant clinician (Roter 2000). However, the main difficulty in understanding the client-centred ethos in the clinician-client relationship is the dearth of evidence on how it (as an abstract concept) is transformed into therapeutic practices (e.g., Dowling et al. 2004; Harra 2014). To understand the constituents of client-centeredness, the actual practices that clinicians and clients use in naturally occurring talk need to be examined.

Overall it seems that conversation analytic research on psychotherapy and psychiatry has most often been conducted in dialogue with professional theories concerning social interaction (see Peräkylä & Vehviläinen 2003), and this dissertation has also largely adopted this approach. In contrast, the dialogue between conversation analysis studies and sociological research on mental health, especially research on etiologic and social consequences has been rather limited. However, taking the social actions of clinicians and clients as the unit of the analysis opens up fruitful avenues for sociological research on mental health. Sensitivity to local contexts and participants’ own orientation to the meaning of their action would provide new perspectives on the study of social consequences, for instance the process of stigmatization as it is produced and manifested in naturally occurring interaction (see e.g. Gill and Maynard 1995 on labelling in delivering and receiving a diagnosis of developmental disabilities). For instance, Druss et al. (2000) showed how individuals with mental disorders were substantially less likely to receive adequate treatment for heart disease than those without mental disorders. Following their argument, treatment negotiations between doctors and patients suffering
from physical or mental health problems would provide a possible context for studying stigmatization as it is generated in real-time encounters. There is already a large body of conversation analytic research on negotiating and delivering treatment decisions in medical encounters that would provide an interesting starting point for comparison (e.g., Landmark et al. 2014; Toerien et al. 2013). Another sociologically interesting area would be diagnostic interviews and the discussions between medical personal in which diagnostic decisions are negotiated and determined. Analysis of professionals’ reasoning would open up an interesting avenue for exploring how the line between normality and mental disorder (e.g., Aneshensel et al. 2013b) is manufactured in talk-in-interaction.

4.5 Concluding remarks

To conclude the discussion, I would like to consider the clinical implications of my findings. First, there seems to be local, interactional evidence that formulations lexically designed to display understanding of the client’s feelings and show prosodic continuity with the client’s talk are oriented to by the client as utterances expressing empathy. This orientation is manifested in the clients’ following turns of talk, where they agree with the formulation and allow themselves to remain in the emotional state expressed, for instance, by crying. In contrast, when the formulation is conveyed with prosodic disjuncture, the clients in our data often only partially agreed, or even disagreed, with the formulation, indicating their orientation towards something more problematic: a challenging rather than validating stance. From a clinical perspective, this finding emphasizes the meaning of prosodic communication in the therapeutic process. However, the difficulty of prosody is that unlike verbal actions, which can be referred to using widely-shared concepts (like questions, agreements, invitations and so on), our common sense understanding does not offer us concepts to describe what we do with prosody (Szczepek Reed 2011:12). The detailed description of prosodic continuity and prosodic disjuncture provided in this dissertation conceptualizes the prosodic features of therapists’ empathic and challenging communication, specifying the clinical theories that underlie this communication and providing tools for clinical training and supervision.

The second clinically interesting finding is practices related to disagreements and the resolution of relational stress. Safran and Muran (2006) have argued that better understanding of how relational stress is negotiated is of primary interest in clinical psychotherapy. My findings concerning supportive and unsupportive disagreement provide one description of how this negotiation is conducted at the level of actual interactional practices. If, in the case of a client’s withdrawal, therapists worked at finding congruence between their perspective and that of the client, validated the client’s emotional experience and respected the client’s epistemic primacy, the therapist succeeded in re-engaging the client in the exploration of his or her experience. However, unsupportive disagreements are also clinically interesting: these sequences prompted the clients’ aggravation and withdrawal, leading eventually to the topicalization of the therapeutic relationship. Safran and colleagues (2001) have observed that moments where the therapist tropicalizes the client’s resistance and moves to a ‘metadiscursive’ talk on the therapeutic relationship are clinically important for resolving relational stress.
Thirdly, the findings of this dissertation emphasize the importance of recognizing and respecting the client’s epistemic primacy. Strong epistemic claims in disagreement sequences were an interactional move which invoked aggravation in clients. Furthermore, in therapists’ interpretative interventions, epistemic work was crucial. Failure to demonstrate that the intervention was based on the client’s previous talk provided the client an opportunity to focus on epistemics as a means of resisting the intervention. Questions of epistemics are also clinically important because they seem to involve clinicians’ tacit knowledge, which is discussed in clinical theories at a rather abstract level. Thus, the findings of this dissertation provide a fresh perspective on how epistemic relations are managed in on-going interaction between the therapist and client.

All these findings indicate that clinicians’ specific interactional moves can produce strong effects on local interactional outcomes; i.e. they have sequential consequences for how clients interpret the therapist’s turns of talk and how they act in their following turns (Heritage & Maynard 2006:365). In this dissertation, these local outcomes were not linked to the global measures of the therapeutic relationship or to the efficiency of the overall therapeutic process. How these local outcomes combine to affect outcome in the longer term is an interesting question for further research.

Last, it is my hope that the detailed descriptions of therapists’ verbal, prosodic and other communicative practices offered in this dissertation will provide clinicians with a useful perspective on their relationships with clients in terms of the dynamic dialogical processes occurring in and through interaction.
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