Tampere University

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The Management of Experience as a Platform for Social Influence in Health Promotion Groups

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ACADEMIC DISSERTATION
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ABSTRACT

This study examines group members' interaction in groups that aim for health promotion. The objective of the study is to gain an understanding of how the health promotion groups work and through what kind of interaction process group members may influence each other. Using conversation analysis and discursive psychology, I analyse the practices in, and through which, group members participate and take a stance in discussion in three types of health promotion groups: health education lessons for adolescents, health counselling groups for adults at high risk of type 2 diabetes, and health and wellbeing counselling groups for women entrepreneurs.

The focus is on four interactional practices of participation and stance-taking by group members: asking questions, producing explicitly self-reflective turns of talk, responding to each other's self-disclosures, and telling comparative time-framed experiences in response to other group members' telling of experiences. This study shows how, through these practices, the *management of experience* unfolds. Experiences are a conjunction of a web of activities: group members invite each other to tell their experiences, connect their experiences to the details of the health promotion intervention, comment on the experiences the other group members have told, compare their own experiences to the experiences of the other group members and show that the experiences are shared.

The management of experience constitutes a focus of attention around which the group work evolves. The results of this study add to the body of research that shows the significance of talking about experiences with regard to managing the relationships of the participants and addressing institutional tasks. Furthermore, this study shows that the management of experience is a specific context for stance-taking and a potential platform for social influence.

The main contribution of this study is to show how, through stance-taking, the health promotion group members both take into account and establish contextually relevant moral, values and ideals. The practices of participation enable and produce stance-taking, resulting in group members endorsing and challenging each other's views. Through that process, the group brings about mutual social support and reflection. Thus, this study provides a description of group processes through which

the group members potentially identify goals and means of behaviour change and consider them as personally relevant. I argue that stance-taking is a critical moment in interaction through which significant activities with regard to mechanisms of conformity emerge. The prerequisite for them to emerge is that the participation framework enables discussion between group members.

TIIVISTELMÄ

Tässä tutkimuksessa tarkastellaan ryhmäläisten välistä vuorovaikutusta terveyden edistämiseen tähtäävissä ohjatuissa ryhmissä. Tutkimuksen tavoitteena on selvittää miten nämä ryhmät toimivat ja minkälaisen vuorovaikutusprosessin myötä ne vaikuttavat jäseniinsä. Keskustelunanalyysin ja diskursiivisen psykologian avulla analysoin osallistumisen ja asennoitumisen osoittamisen käytänteitä kolmessa erityyppisessä ryhmäkontekstissa: yläkoululaisten terveystiedon oppitunneilla, 2-tyypin diabetesriskissä olevien aikuisten elintapaohjausryhmissä, ja naisyrittäjien terveys- ja hyvinvointiryhmissä.

Tutkimuksen kohteena on neljä vuorovaikutuskäytännettä, jotka ovat ryhmäläisten toiminnassa keskeisiä: kysymysten kysyminen, itsereflektoivien puheenvuorojen esittäminen, toisten ryhmäläisten paljastuspuheenvuoroihin vastaaminen, ja vertailevien, ajallisesti paikannettujen kokemusten kertominen toisten ryhmäläisten kokemuksista kertomiseen vastatessa. Tässä tutkimuksessa näytän, miten *kokemusten käsitteleminen* muotoutuu näiden vuorovaikutuskäytäntöjen kautta. Kokemukset ovat solmukohta keskeisille ryhmän työskentelytavoille: ryhmäläiset kutsuvat toisiaan kertomaan kokemuksistaan, kytkevät kokemuksiaan kyseisen terveyden edistämiseen tähtäävän intervention yksityiskohtiin, kommentoivat toistensa kertomia kokemuksia, vertaavat omia kokemuksiaan toisten ryhmäläisten kertomiin kokemuksiin, ja osoittavat jakavansa toistensa kanssa samanlaisia kokemuksia.

Kokemusten käsittely muodostaa kiintopisteen jonka ympärille ryhmässä tapahtuva työskentely muotoutuu. Tutkimuksen tulokset kartuttavat tietoa kokemuksista kertomisen merkityksestä vuorovaikutustilanteen osapuolten välisen suhteen hallinnan ja vuorovaikutustilanteen tavoitteiden käsittelyn kannalta. Lisäksi tutkimus osoittaa, että kokemusten käsittely on erityislaatuinen asennoitumisen osoittamisen konteksti ja sosiaalisen vaikutuksen mahdollistava vuorovaikutustilanne.

Tämän tutkimuksen tärkein kontribuutio on kuvata miten terveyden edistämiseen tähtäävien ryhmien jäsenet, asennoitumisen osoittamisen kautta, sekä ottavat huomioon että luovat ja vahvistavat kontekstuaalisesti relevanttia moraalia, arvoja ja ideaaleja. Osallistumisen käytännöt mahdollistavat ja tuottavat asennoitumisen

osoittamista, johtaen siihen että ryhmäläiset vahvistavat ja haastavat toistensa näkökantoja. Tämän prosessin kautta ryhmä tuottaa keskinäistä sosiaalista tukea ja reflektointia. Tämä tutkimus tuottaa kuvauksen ryhmäprosesseista joiden kautta ryhmän jäsenet tunnistavat mahdollisia elintapakäyttäytymisen muutoksen kannalta olennaisia tavoitteita ja keinoja sekä pohtivat millä tavalla ne voivat olla relevantteja heille itselleen. Tutkimuksen perusteella väitän, että asennoitumisen osoittaminen on kriittinen hetki vuorovaikutuksessa jonka kautta syntyy konformisuuden eli mukautumisen mekanismien kannalta olennaisia toimintatapoja. Niiden syntymisen edellytys on, että osallistumiskehys mahdollistaa ryhmän jäsenten välisen keskustelun.

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TRANSCRIPTION SYMBOLS

[word]	Onset and offset of overlapping talk
=	Contiguous utterances: second is latched immediately onto the first
(0.2)	Timed interval within or between utterances, measured in seconds and tenths of seconds
(.)	Interval of less than 0.2 seconds
wo:rd	Extension of the sound or syllable
.	Falling intonation
,	Continuing intonation
?	Rising intonation
-	Abrupt cut-off
↑ ↓	Rising/falling pitch
word	Emphasis
WORD	Louder volume
°word°	Quieter volume
>word<	Faster-paced talk than the surrounding talk
<word>	Slower-paced talk than the surrounding talk
#word#	Creaky voice
£word£	Smiley voice
@word@	Animated voice
hh	Audible aspiration
.hh	Audible inhalation
w(h)ord	Laughter
hah heh huh	Laughter
(word) ( )	Transcriber doubt
((word))	Transcriber's comments
→	Feature of interest

ORIGINAL PUBLICATIONS

Publication I Logren Aija, Ruusuvuori Johanna, and Laitinen Jaana. (2017). Group members' questions shape participation in health counselling and health education. *Patient Education and Counseling* 100 (10), 1828-1841.

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1 INTRODUCTION

Health promotion is commonly conducted in groups, aiming for improvement of participants' health and wellbeing. Group members are targets of various activities, but they also shape the group activities through their own actions, resulting in group processes such as the emergence of group roles, cohesion and social influence. The ideal is an actively participating, reflecting group member who offers and receives social support, and gains empowerment and agency, eventually resulting in beneficial changes in health behaviour, health and wellbeing (Fielding, 2013; Førland et al., 2016; Laverack, 2012; Lucas & Lloyd, 2005); but how is that ideal accomplished in and through the group processes? To work on individual and private matters, such as ones' health and wellbeing, with a peer group and a group leader is a specific kind of social process that unfolds in, and through, social interaction.

In this study, I take a micro-level perspective on social interaction and apply conversation analysis and discursive psychology to examine the interaction of group members in three kinds of health promotion groups: health education lessons for adolescents, health counselling groups for adults at high risk of type 2 diabetes, and health and wellbeing counselling groups for women entrepreneurs. Focusing on interaction between group members, I analyse the practices in, and through which, group members participate and take a stance in discussions, and thus examine how the groups work and how group members may influence each other.

Considering the central position of talk-based work in health promotion groups, it is crucial to explore how group members take part in discussions, provide topics for discussion, and share their views and beliefs. Fasulo and Pino (2016) note that therapeutic and educational interventions are predominantly carried out through talk, which makes professionals dependent on clients' activity. If the clients do not engage in the intended talking activities and, thus, provide descriptions of their experiences and problems, the professionals fall short of material on which to work with their clients (Fasulo & Pino, 2016; Pino, 2016b). Without group members' active participation, health promotion discussions cannot reach their full potential and may remain as mere delivery of advice and information. Hence, the group leaders face a challenge regarding how to enable and support group members' active

participation. Nevertheless, by focusing the analysis of interaction primarily on the actions of the professional (for example Miller & Silverman, 1995; Pino 2016a; Tiitinen et al., 2018b), the understanding of the participatory roles and the actions of the group members is limited to responsive ones, and the agentive, independent role of the group members, and moreover, their interaction with each other, remain unexplored. So far, little is known of the ways in which health promotion group members share their own experiences, thoughts and concerns; how they bring up things they do not understand or approve of; and how they reflect upon their understandings and discoveries; in short, how they participate and take a stance.

While being separate theoretical concepts, participation and stance-taking are intertwined in the reality of the encounters: when group members participate in group discussions, they also take a stance on the discussed topics. By *participation*, I refer to the practices through which group members organise their activities in the group. In this study, the focus is on how group members steer discussions and how they engage in discussions with each other. (Goodwin, 1984, 2007; Goodwin & Goodwin, 2004.) *Stance-taking* refers to the practices through which group members display their views and beliefs, and address those displayed by the other group members (Goodwin & Goodwin, 1992; Goodwin, 1998; Haddington, 2004; Wu, 2004; Du Bois, 2007; Du Bois & Kärkkäinen, 2012).

This study contributes to the knowledge of interaction in health promotion groups by describing the ways in which group members participate in discussions and take a stance on the topics of talk. The focus is on four interactional practices: asking questions, producing explicitly self-reflective turns of talk, responding to each other's self-disclosures, and telling comparative time-framed experiences in response to other group members' telling of experiences. Through these practices, *the management of experience* unfolds. Experiences are a conjunction of a web of activities: group members invite each other to tell their experiences, connect their experiences to the details of the health promotion intervention, comment on the experiences the other group members have told, compare their own experiences to the experiences of the other group members and show that the experiences are shared. The management of experience constitutes a focus of attention around which the group work evolves. It is a specific context for stance-taking and a potential platform for social influence.

I argue that stance-taking is a critical moment in interaction, through which discussions, significant with regard to the institutional aims, emerge; but only if participation framework enables group members to steer the discussion and to engage in it with each other. I discuss how group roles are negotiated, how cohesion

is managed in interaction, and how mechanisms of conformity unfold in group discussions. Hence, this study shows how group processes, actualised in interaction, contribute to achieving the institutional aims and ideals. The results add to the body of research that shows the significance of talking about experiences with regard to managing the relationships of the participants and addressing institutional tasks.

In the following, I introduce the activity contexts this study deals with: health promotion, health education and counselling; and discuss their key features and institutional aims. Thereafter, I discuss the central features of group dynamics in the context of health promotion groups and elaborate on the focus of this study. Chapter 2 presents the theoretical foundation of this study: the ethnomethodological literature on participation and stance-taking. In Chapter 3, I formulate the research questions. In Chapter 4, I describe the methodology. In chapter 5, I describe the data and the research process. In chapter 6, I summarise the results of the articles. In chapter 7, I discuss the results with regard to the social processes of group work in this institutional context, and to the ideals and aims of health promotion. Finally, I conclude the limitations of this study and present ideas for future research.

1.1 The context of the study: pursuing health promotion through health education and counselling

Perhaps the most widely accepted definition of health promotion is the one provided by the World Health Organization (WHO): 'the process of enabling people to increase control over, and to improve, their health' (WHO, 1986). Health promotion is a general concept that covers several types of activities (Bartholomew, 2011; Laverack, 2012); however, there are differing views of what kinds of activities are included in health promotion, with some scholars thinking that health promotion and health education are separate activities (Snelling, 2014). In this study, health education is understood to be nested within health promotion; that is, health education is one of the activities through which health promotion is pursued. The objectives of health promotion and health education are parallel: to support people in achieving their optimal health (Bartholomew, 2011; Laverack, 2012; O'Donnell, 2002; Poland et al., 2000; Snelling, 2014). Another institutional context, which I consider overlapping with health promotion, is counselling. Counselling is an umbrella term for a variety of activities where the aim is to help people to deal with their problems, focusing on their strengths and assets (Leong, 2008; Vehviläinen, 2003, 2014). Thus, as an activity, counselling shares parallel objectives to health

education and health promotion, even though it is often also used for other types of purposes, such as to discuss educational and vocational challenges and psychological problems (see Figure 1). In the following, I describe the main objectives of health promotion, and the key features of the two activities through which health promotion is pursued and which are in focus in this study: health education and health counselling.

Figure 1. The relationship of health promotion, health education and counselling

In general, *health promotion* focuses on the primary and secondary prevention of illness. Health promotion activities aim, firstly, to prevent illness, injury or disease and, secondly, to identify and treat them promptly (Snelling, 2014; Laverack, 2012; Salazar et al., 2015). These objectives can be pursued both on individual and on community levels. On the individual level, the primary objective is to support people's own activity, involvement, responsibility and power considering their own health (Laverack, 2012; Poland et al., 2000; Snelling, 2014). This is achieved through primary outcomes such as changes in social capital, capacity, empowerment and cognitive determinants of behaviour (such as attitudes, beliefs and knowledge), which result in distal outcomes in health and wellbeing (Stephens, 2008; Valente, 2002). On the community level, health promotion activities either aim to improve the environment (for example by promoting work safety or access to health care in the community) or to influence the individuals' health behaviour via the community (for example by advocating a smoke-free culture in the community) (Fertman, 2015; Laverack, 2012; Parcel et al., 2000; Poland et al., 2000; Polanyi et al., 2000).

Health education is a way to implement health promotion by utilising different types of learning experiences aimed at individuals and communities (Snelling 2014, 10).

The objective is 'to facilitate an informed, empowered and motivated population capable of making health-driven lifestyle choices' (Fielding, 2013, 517). Health education can, firstly, refer to a subject of study in schools that is regulated by the curriculum (Chow et al., 2017; Leahy, 2014; Pickett et al., 2017). In Finland, health education is taught as a part of other subjects in primary school and as an independent subject in secondary and upper secondary school and in vocational school. Secondly, health education can refer to interventions aimed at different populations and carried out in various contexts; for example, the different health promotion activities that are carried out in schools (Freeman et al, 2016; Marks, 2012; Weare, 2015). These include activities such as campaigns in the school cafeteria and interventions implemented by health professionals in collaboration with the school staff. Health education can also be aimed at other population groups than school children and students (Engelund et al., 2014; Fielding, 2013; Førland, Silèn et al., 2016); for example, through interventions organised in health centres, recreation centres or workplaces. In all these approaches, health education consists of learning programmes and resources that aim to influence attitudes and increase knowledge about health issues, in order to enable people to adopt lifestyles and habits that will improve their health (Dictionary of Epidemiology, 2014; Dictionary of Nursing, 2014; Concise Medical Dictionary, 2015).

In contrast to education, *counselling* focuses on facilitation, not direct guidance (Concise Medical Dictionary, 2015). Typical situations that utilise counselling for health promotion are those relating to chronic illnesses or health behaviour change. The aim is to enable the clients to elaborate on their situation and, through guided work, find their own solutions to their problems, instead of providing them directions. However, some educational elements may be included in counselling. For example, in health counselling that aims to support clients in behaviour change or coping with an illness, counsellors may also give instructions for self-care or self-monitoring (Leong, 2008: xxv–xxvi; Vehviläinen, 2014; Visser and Herbert, 1996; Concise Medical Dictionary, 2015; A Dictionary of Social Work and Social Care, 2013).

There are various counselling traditions and techniques, which mostly rely on applying psychological and behaviour change theories to clients' current situations, and aim to facilitate the clients to work through their problems and eventually, gain more control over them. Even though psychological understanding is considered to be the foundation of professional counselling, counselling is distinguished from therapy. Therapeutic approaches are based on an understanding of the dynamics of the psyche: they often take under explicit consideration the relationship between the

therapist and the client and are able to deal with pathologies of the psyche. In counselling, the therapeutic relationship is not explicitly dealt with, and a prerequisite for counselling is that the client is capable of autonomous, reflective work. However, both approaches aim to promote agency, explore the client's strengths and assets, and provide means for the client to explore their own situation for possible solutions (Geiger, 2018; Leong, 2008, xxv–xxvi; Vehviläinen, 2014, 51-52; Visser & Herbert, 1996).

In practice, health promotion activities may incorporate elements from different approaches. Whether pursued through educational means or through counselling, the key task in health promotion is the empowerment of the participants. A common strategy for achieving this task is to organise group activities such as health education groups and health counselling groups, and those are in focus in this study.

1.2 The ideals of health promotion and the engagement of participants

This study takes the standpoint that health and wellbeing are socially constructed phenomena and health behaviour is relational: behaviours have different meanings and values in different social contexts and relationships (Stephens, 2007, 5-7). For example, people are ready to accept certain types of risks in their lives even if they know their health behaviour may have negative consequences for their health (Lucas & Lloyd, 2005). The process of forming such values is a social one and, in this study, I examine how it may unfold in interaction in health promotion groups. Laverack (2012) raises a question about the role of the professional in this process and distinguishes between top-down and bottom-up processes in health promotion activities: if the health promotion activities unfold from the top down, the participants are expected to adopt goals and to comply with norms that have been defined by the professionals. Lucas and Lloyd (2005) argue that, too often, health promotion activities confine themselves to influencing only through pursuing change in knowledge, beliefs and attitudes. Hence, the culturally and socially mediated aspects of health and health behaviour are neglected and therefore not utilised to their full potential (Lucas & Lloyd, 2005, 104, 143-144). Furthermore, the opportunities for social support that the group could provide (such as emotional support, informational support and companionship) remain untapped (Verheijden et al., 2005; Cohen & Syme, 1985; Shumaker & Brownell, 1984; Vaux, 1988). Hence Laverack (2012, 14) advocates a bottom-up process, in which the professionals

support participants to identify 'issues that are important and relevant to their lives, and to enable them to develop strategies to resolve these issues'.

Another challenge for health promotion is then how to bridge the potential gap between the perspectives of the professionals and the clients. Professionals may have well-grounded understanding of what kind of issues would be critical in order to improve clients' health, but clients themselves may not consider them relevant (Engelund et al., 2014; Fielding, 2013; Førland et al., 2016; Laverack, 2012; Lucas & Lloyd, 2005; Marks, 2012). Professionals may assume that clients are able to understand and act upon their delivered initiatives, recommendations and messages, but clients may instead have difficulties in recognising and responding to them (Engelund et al., 2014; Førland et al., 2016). To overcome this challenge, the promotion of *health literacy* is considered to be a critical step (Fielding, 2013; Freeman et al., 2016; WHO, 1984, 1986).

Health literacy consists of competencies that the individual needs in order to be able to assess issues concerning health and make decisions accordingly. The competencies include being able to access health information, to understand and evaluate it, and finally, to apply it to practical situations (Fielding, 2013; Førland et al., 2016). The core components of health literacy are: 1) theoretical knowledge, 2) practical knowledge, 3) critical thinking, 4) self-awareness and 5) citizenship skills. These skills have a hierarchical order: each one is constructed on the foundation provided by the previous skills. To promote these different skill levels calls for different types of health promotion activities and resources. Delivering information is sufficient to achieve the first level, theoretical knowledge, but to acquire the fourth level, self-awareness, more advanced activities are needed to support an individual to learn the means of self-regulation and self-reflection. (Paakkari & Paakkari, 2012; Boud et al., 1996; Dewey, 1933; Mezirow, 1990, 1998.)

Given these points, in its ideal form, health promotion enables and supports the active participation of clients, provides resources for their own reflection and reasoning, offers opportunities for social support and, thus, facilitates the empowerment and increased agency of the participants in relation to their own health. Previous studies on therapeutic contexts have recognised and explored the important role of the professional as the source of influence (Corrigan et al., 1980; Dorn, 1984; Leary & Miller, 1986; Heppner & Claiborn, 1989; Anderson & Levitt, 2015; Kang et al., 2017), but the role of the group members have received less attention. In this study, I examine how the above-mentioned ideals can be actualised in group activities and what kind of asset the group members may be with regard to pursuing the aims of the health promotion intervention. Previous literature on

interaction in group activities for health promotion is based mostly on clinical experience (for example, Geiger, 2018; Holt et al., 2013; Jacobs et al., 2009; Shulman, 2011; Yalom, 1995) rather than empirical research (see however Fasulo et al., 2016; Wiggins, 2009; Tiitinen et al., 2018a & 2018b, on health counselling groups; and Leahy, 2014, for ethnography of health education). Therefore, little is known of the actual practices of interaction in, and through which, group discussions unfold in health promotion activities. In this study, I observe naturally-occurring interaction, and analyse with ethnomethodological interaction analysis (Garfinkel, 1967; Heritage, 1984; Drew & Heritage, 1992; Edwards & Potter, 1992; Wiggins, 2017) how and through what kind of practices health promotion groups work, and how the group members may influence each other.

1.3 Group dynamics in health promotion

Delivering health promotion in group settings is a common practice, partly because of groups' assumed cost-effectiveness compared to dyadic encounters (Paul-Ebhohimhen & Avenell, 2009), and partly because of their supposed influence via group processes such as social support and social comparison (Borek & Abraham, 2018). However, group activities have various characteristics that separate them from dyadic encounters. Groups are, of course, not entities themselves, but groups consist of their members, who may face different kinds of expectations, restrictions and opportunities with regard to their conduct in the group activities. Furthermore, relationships between group members form a complex web that the participants need to establish and take into account in their conduct, whereas, in dyadic encounters, there is only one relationship to establish and maintain. In this study, I examine newly formed groups of adults, and pre-existing groups of adults or adolescents. All these aspects: the group members' age, status and previous relationships with each other, may have potential consequences to the social norms and group interaction that evolve during the group process.

Previous research on health promotion in groups, focusing mostly on the experiences of group leaders and participants, has recognised the complexity of group work, thus indicating a need to understand the group processes specific to such contexts (Hughes et al., 2017; Boström et al., 2013). In the conceptual model by Borek and Abraham (2018), the functioning of health promotion groups is explained as a result of intertwining processes of group development, group dynamics, and social and personal change processes. Among those processes, group dynamics are considered to be crucial, because they 'provide the context for

interaction between members and social change processes that can initiate and consolidate personal development and change' (ibid.). In this study, I take the perspective that group dynamics are not only a context for interaction, but are formed and managed in interaction. Furthermore, social change processes, such as the formation of social values and ideals, unfold in interaction between group members.

Group dynamics is a research field as well as a concept that refers to the characteristics and processes of groups, such as how group norms and roles are formed, what kind of sources of cohesion bond the group members together, and through what kind of mechanisms the group has social influence among its members. These phenomena are intertwined: the forming of norms and roles in groups is also crucial regarding social influence, from the perspective of how norms and roles regulate an individual's behaviour, and the feedback individuals receive on their behaviour from the group (Forsyth, 2014, 17-20; Biddle, 1986). Furthermore, one of the integral consequences of cohesion is social influence, whether it unfolds through, for example, pressure or the avoidance of disagreement (Forsyth, 2014, 133-136).

Understanding the process in which group norms, roles and the activities associated to particular roles are negotiated in health promotion groups would provide insight into how group settings support joint discussion between group members and, furthermore, what kind of joint group work they produce. Descriptions of the management of cohesion in health promotion groups, and the ways in which health promotion group members may influence each other, would help in understanding what kind of resource groups may be with regard to the aims of health promotion and through what kinds of mechanisms they may function. This study elaborates on these phenomena by scrutinising participation and stance-taking in health promotion groups and discusses the ways in which 1) the group roles are negotiated, 2) cohesion is managed and 3) how mechanisms of influence may unfold in practice.

1.3.1 Group roles

The question how groups work can be approached from theoretical perspectives that address group roles and the actions that are associated to the roles. Theories deal, firstly, with what kinds of actions group members perform within particular group roles and, secondly, what kinds of expectations group roles set for the people

who perform the particular roles. In functional role theories, roles have been categorised as follows: 1) roles that focus on achieving the task of the group, 2) roles that focus on social relationships within the group and 3) roles that focus on the needs of an individual (and hence, arguably, disrupt the group). Each category includes several roles, such as 'coordinator', 'evaluator' and 'information-seeker' in the category of task roles; 'encourager', 'commentator' and 'expediter' in the category of relationship roles; or 'blocker', 'dominator' and 'self-confessor' in the category of individual roles. (Forsyth, 2014, 177-178; Biddle, 1986; Benne & Sheats, 1948; Bales, 1950.) The reasons why participants in a group take particular roles have been explained as a consequence of their personalities and their previous experience of being participants in groups (Benne & Sheats, 1948; Biddle, 1986; Forsyth, 2014, 177; Turner, 2001, 233-234).

Interactionist theories of group roles offer another explanation and claim that roles are negotiated in group interaction. Group members' understanding of common group roles and associated actions is the basis for this process, but the more detailed negotiation of role-taking and expected actions for specific roles takes place in and through social interaction (Turner, 2001, 234-235; Stryker & Serpe, 1982). Thus, the roles are shaped within the ongoing activities and dependent on the context, instead of being stable and static and, moreover, not dependent on the personality of the individual. This is the perspective on roles and associated actions that I take in this study.

1.3.2 Cohesion

Another important aspect regarding to how groups work, is what makes a number of people a group. The concept of cohesion depicts the unity of the group and the ties that bind its members together. Sources of cohesion have been distinguished as follows: 1) task cohesion: the commitment to pursue the shared tasks; 2) structural cohesion: the norms and roles that regulate the group work; 3) social cohesion: the attraction among the group members; 4) emotional cohesion: the emotional intensity of the group; and 5) collective cohesion: shared identification with the group. (Evans & Jarvis 1980; Hogg 1993, Schiefer & van der Noll 2017.) While there is comprehensive research that describes the above-mentioned sources of cohesion, there is less knowledge of the process in, and through which, cohesion is formed and managed in interaction in institutional groups. Hendry et al. (2015) demonstrate how participants of a learning group construct group cohesion with self-deprecating

humour and thus show their orientation to the group norms, and argue that group cohesion should be treated as a social accomplishment rather than a factor to be measured. In their study of interaction in therapeutic groups, Lepper and Mergenthaler (2005) argue that cohesion is formed and managed by the group members by linking the topics of talk together. However, their conclusion is based on the resemblance of linguistic features in sequential turns. Other linguistic ways of achieving the linking of topics, and further, other interactional ways of managing cohesion have remained unexplored. In this study, they are in focus.

1.3.3 Social influence

In addition to describing how the groups work, in this study I also examine the mechanisms of the influence that the group members may have on each other. Until recently, the actual social actions through which social influence takes place have received little attention in the field of research on social influence. A simple, theoretical distinction of the mechanisms through which social influence occurs is that people either obey, comply with, or conform to the actions of other people (Cialdini & Goldstein, 2004; Turner, 1991; Kelman, 1958). Obedience means that people follow an order, even if it contradicts their own will and moral. In the context of health education and health counselling a situation hardly exists where any of the participants would force others to do something—indeed that would be strongly against the empowering and agency-promoting ideals of health education and counselling. The second type of social influence, compliance, means that people choose to follow a request (Cialdini & Goldstein, 2004), an order, instruction or advice – or behave in public in a similar way to other people — in a particular situation, but without it resulting in lasting changes in their behaviour, attitudes or values (Wood, 2000). In health promotion, interventions targeted at a population level and community level may function through this type of social influence. For example, declaring a workplace 'smoke-free' or increasing the choice of healthy options in a school cafeteria, may influence the behaviour of individuals in that particular context (which is beneficial to their health), but not outside that setting. The third type, conformity, describes a process by which an individual's cognitive structures change, often also resulting in lasting changes in their behaviour (Kelman, 1958). This is the type of social influence that is pursued in health education and health counselling and, thus, is in focus for the rest of this chapter.

Conformity develops through two processes: internalisation and identification. Internalisation means that a person accepts the views and beliefs of a particular group. Identification describes the process in which a person wants to be associated with a particular group and, hence, adopts its attitudes and behaviours (Kelman, 1958). Conformity stems from two basic psychological needs: to be right and to be liked (Deutsch & Gerard, 1955). Cialdini and Goldstein (2004) elaborate further on the notion of these basic needs: people are motivated to form accurate perceptions and actions, to develop and maintain meaningful social relationships, and to maintain a positive self-concept. These motivations are most likely interrelated (see David & Turner, 2001) although, theoretically, they are sometimes treated separately.

Mechanisms of conformity are divided into informational influence and normative influence (Deutsch & Gerard, 1955) and further, referent informational influence (Turner 1982, 1991). Informational influence means that people seek validation from other people of their perceptions and attitudes and accept information they receive from other people as 'evidence about reality' (Deutsch & Gerard, 1955). Normative influence means that people adapt to the expectations of others in order to gain approval and to avoid social sanctions (Deutsch & Gerard, 1955). The third notion, referent informational influence (Turner et al., 1982) describes conformity through self-categorisation: people define themselves as belonging to particular social groups and categories, and associate particular behaviours to these categories. Hence, people conform to the characteristics of a social category that is meaningful to them, not to the norms or information themselves (Turner. 1982, 31-32).

The ways in which the above-mentioned mechanisms of influence unfold in social encounters are often implicit, indirect and even non-conscious (Koudenburg et al., 2017; Koudenburg, 2018; Cialdini & Goldstein, 2004) and, hence difficult to grasp. An emerging trend in research on social influence examines the actual interaction processes in naturally-occurring face-to-face encounters and technologically-mediated discussions, and describes the patterns of interaction that shape the views and beliefs, and the behaviour of the individual (Price et al., 2006; Hepburn & Potter, 2011; Hollander, 2015; Hollander & Maynard, 2017; Pino, 2017; Humă et al., 2018). Participants take a stance in discussions and compare their views and beliefs with those of others. Price et al. (2006) note that social influence arises, not just through normative pressure and informational persuasion but, most importantly, through comparison, agreement and disagreement. Arguments that emerge in group discussions are the foundation of social influence (Price et al., 2006).

Therefore, it is essential to analyse the discussions themselves in order to fully understand the mechanisms through which social influence ensues.

1.4 The focus of the study

In the previous sections, I have discussed the subject of health promotion in groups from two angles: the institutional aims and ideals of health promotion, and the group processes that might contribute to achieving these aims and ideals. These approaches raise some central notions that I take as focal points for this study. Firstly, if the institutional objectives of an encounter rely on active participation, that is, participants taking turns in discussion instead of staying silent, it is crucial to analyse just that: who gets to talk, and in what ways (Svinhufvud, 2015; Heinemann, 2009; Mondada, 2013; Gibson, 2003). Secondly, a general premise of this study is that group processes emerge through discussions between the group members. Therefore, my point of interest is the ways in which group members engage in discussions with each other, not only with the group leader. Thirdly, to understand the social process through which issues promoted in health promotion activities may become valuable and meaningful for participants, it is necessary to examine the ways in which participants display and address views and beliefs; that is, take a stance in discussions (Du Bois, 2007; Haddington, 2004, 116; Du Bois & Kärkkäinen, 2012; Ochs, 1996). Hence, in this study, I examine the complex relationship of the institutional aims and ideals and the group processes by analysing two observable phenomena in social interaction: participation and stance-taking.

1.4.1 The relationship of social influence and interaction

In this study, I bring together rather different and distinct theoretical approaches. Group dynamics is a central research field in social psychology, but it is usually approached from a cognitive social psychological perspective, treating it first and foremost as an individual, cognitive process. Ethnomethodology, on the other hand, remains far from the mainstream social psychology, and approaches social processes as jointly accomplished actions. There have been previous attempts to examine and re-define social influence from an ethnomethodological perspective (Price et al., 2006; Hepburn & Potter, 2011; Hollander, 2015; Hollander & Maynard, 2017; Pino, 2017; Humă et al., 2018), and the present study joins them. My attempt is to explore

and describe the link between social influence and interaction, and to interpret the familiar concepts of group dynamics in the light of ethnomethodological analysis that is grounded on empirical observations on real data of naturally-occurring interaction.

My key assumption is that interaction is a vessel and a prerequisite for social influence: if people do not interact with each other in one way or another, there can be no social influence. Analysing *participation* is then the first step towards describing what kind of interaction could result in social influence: how do these interlocutors, in this particular context, interact together? And more precisely, how do they collaboratively organise their activities in this context, in relation to each other (Goodwin, 1984, 2007). In analysing how do the interlocutors participate, I focus on how they steer interaction, and how they engage in discussions with each other.

Participation is a prerequisite for social influence to be possible, but not all participation is equally 'influential'. To describe what kind of steering and engaging could make social influence possible, the concept of *stance* is needed. If social influence stems from the basic need of 'to be right and to be liked' (Deutsch & Gerard, 1955), then we, as participants in social encounters, seek constant confirmation if our interlocutors view the world as we do. Stance-taking is the interactional practice in, and through which this confirmation may be accomplished. By stance-taking, we display our views on 'what is right and what is liked', that is, our knowledge and affect on different issues and topics, and furthermore, manage our relationships with the others. With stance-taking, we share our views to each other and negotiate on where do we stand in relation to each other: do we view the world similarly or not. Stance-taking thus contributes to confirming, firstly, 'who do we like', and secondly, 'are we liked', in terms of who we share similar or different views of the world with. However, stance-taking is not limited to just who agrees of affiliates with who, and who does not. As Du Bois argues (2007, 173), when you take a stance, 'you own it'. This means that in taking a particular stance, the stance-taker is accountable of it, and it creates moral attributes: is your stance acceptable?

Therefore, in addition to describing practices of participation, it is necessary to examine what kinds of ground - that is, their stance - participants base their claims on, and further, how do the interlocutors address these claims. Hence, in this study, I ask, how group members in health promotion groups *steer* interaction, *engage* in discussions with each other, how they *display* their views and beliefs, and how they *address* those displayed by the others (Goodwin, 1984, 1998, 2007; Goodwin & Goodwin, 1992, 2004: Du Bois, 2007; Du Bois & Kärkkäinen, 2012; Haddington, 2004; Wu, 2004). My theoretical assumption is that accountability and morality are

the links between interaction and social influence. I presume that in social interaction, participation and stance-taking enable and produce specific activities that have a potential to elicit social influence. In this study, my aim is to examine and describe how they may do so. In the following chapters, I present previous ethnomethodological literature on the abovementioned concepts and discuss on my analytic perspectives on them.

2 PARTICIPATION AND STANCE-TAKING

In this study, I approach the complex dynamics of group processes and the institutional aims of health promotion groups from an ethnomethodological perspective. To examine how particular social activities are managed in interaction is the core of ethnomethodological research. It focuses on the actions and the reasoning that people do in ordinary situations and seeks to understand how people produce order in their shared activities. One of its fundamental claims is that people strive to make the rationale for their activities evident to other participants. They achieve this by relying on sense-making that they presume is available to and recognised by the others (Garfinkel, 1967, 31-34).

Group members' interaction in the context of health promotion has been studied in few previous ethnomethodological studies. These studies describe the ways in which group members orient to the potential, and perhaps contradictory, expectations of them as participants. The expectations concern their possibilities to manage the discussions, their responsibilities with regard to their health, and their relationships with the other participants. Tiitinen et al. (2018b) describe how the structure of the counselling discussions may limit the possibilities of the participants to comment on each other's experiences. Furthermore, Tiitinen et al. (2018a) explore a potential dilemma of group participation: group members tell stories that create joint understanding with other group members, offering peer support, but with the same stories, they misalign with the institutional agenda, avoiding reflection upon their own behaviour. Another study that examines group discussions in the context of health promotion, by Fasulo et al. (2016), focuses on a specific type of question asked by group members in diabetes self-management groups; namely 'what about x?' Their analysis shows that this type of question functions as a request for information, leaving it to the group leader to choose how to address it. According to Fasulo et al., this may indicate an orientation to requesting information as not being appropriate in the current context (Fasulo et al., 2016). Wiggins (2009) shows that members of a weight management group orient to blame, that is, the stigma of weight problems and the moral accountability for their activities, and resist blame either by denying having carried out the activities in question or locating the blame outside their control. Wiggins argues that this causes challenges for group leaders in

managing this resistance in supportive ways and, furthermore, in how socio-cultural issues affecting weight and health can be addressed in group discussions (Wiggins, 2009). With regard to the focus of the present study, group dynamics, these studies indicate that group settings may, firstly, set restrictions for the group members in terms of how they can steer and engage in discussions. Secondly, group members seem to actively manage their relationships with the other participants in terms of how they display and address the rationale of their own activities or those of the other participants.

Because the ethnomethodological literature concerning group interaction in health promotion is limited to the above-mentioned studies, in this chapter I also draw on research on interaction in counselling and group activities in other but resembling contexts. In the following sections, I review earlier ethnomethodological literature from two perspectives. Firstly, I explain how the concept of *participation* is understood in ethnomethodology and present research on how interlocutors participate in institutional multi-party encounters. Secondly, I present literature on *stance-taking*.

2.1 Participation in institutional multi-party interaction

Participation means the ways in which participants of an encounter collaboratively organise themselves – their body and talk – in relation to each other through the encounter (Goodwin, 1984, 2007). People rely on various resources, such as gaze, body posture and gestures, as well as nuanced features of talk, to display to each other their current focus of attention and their intents for next actions. The purpose of these practices is to coordinate involvement in shared activities, since they inform others about how they are expected to join in the activities. (Goodwin & Goodwin, 2004.) Participation refers not just to the actions of a speaker, but also to the positions and actions available for other participants, who may adopt or be entitled to various roles. According to Goffman (1981, 10-11), the roles of participants can be distinguished to ratified and unratified participants, and addressed and unaddressed hearers. Speakers orient to these roles in their talk, but hearers also actively position themselves as recipients or non-recipients (Goodwin & Goodwin, 2004). In multi-party interaction, these different roles, and the constant shifting between them, are more complex and, thus, more consequential than in dyadic interaction (Gibson, 2003 & 2010). Theoretically, any kind of active or passive

presence in an encounter is 'participation', but my attempt is to examine the group members' active role in interaction.

I use the concept of *participation framework* to describe the different combinations of actions that speakers and hearers use to organise their activities in a particular situation, and also their expectations of what kind of participation is appropriate in that situation. A certain participation framework offers certain participatory roles, actions and responsibilities to participants, but also yields restrictions. Thus, it has consequences with regard to how the encounter unfolds: who initiates the topics of talk and what kind of input is expected from others. (Goffman, 1981, 137, 153-155; Goodwin & Goodwin, 2004, 238-239.) Goodwin (2007) argues that people are generally expected to be willing and able to sustain a participation framework that is relevant in the current situation. Aligning or misaligning their actions towards other participants in accordance with the current participation framework generates a moral stance – a signal of whether the participant can be trusted to act appropriately so that the current tasks can be accomplished (Goodwin, 2007). Hence, participant frameworks reflect and produce morality: an obligation to be, and to display being, a competent member, both regarding the current activity and the community as a whole. This notion has been supported by empirical evidence that participants display their orientation to current participation frameworks and treat breaching them as problematic – even when they themselves breach the framework (for example Arminen, 1998; Halonen, 2002; MacMartin & LeBaron, 2006; Mondada, 2013; Svinhufvud, 2015; Goodwin, 2007).

Research on participation in institutional interaction offers detailed descriptions of the ways in which participants organise their collaborative activities. Additionally, this kind of research takes a critical look at these practices of interaction and asks what kind of participation they enable and offer to the participants. The analysis can focus on how the current participation framework enables participation, and how it engages or disengages group members in discussion and thus in collaborative social processing (see for example Arminen, 1998; Svinhufvud, 2015; Nielsen, 2012; see also Heath et al., 2005). Thus, who gets to talk, how often and in what ways are focal questions in research on institutional interaction (Gibson, 2003). The findings can provide insight into the characteristics of particular institutional settings: the ways in which participants 'talk the institutions to being', and the participatory roles the participants orient to in their actions. In other words, by focusing on the specific practices in which the institutional work is organised in collaboration with the participants, research on participation is able to describe how the institutions work.

There are few studies that describe how health promotion groups work. Participation in institutional multi-party interaction has been studied in various settings, notably in education (Gardner, 2015; Koole & Berenst, 2008; Oliver & Cromdal, 2016; Paoletti & Fele, 2004; Svinhufvud, 2015; Lee, 2017; Liang, 2016; Lerner, 1995; Herrle, 2015; Tholander, 2007; Nguyen, 2007; Markaki & Filliettaz, 2017; also McDermott, 1976/1977 and Mehan, 1979). Another strand of research has focused on groups of professionals working together, such as in meetings and collaborative decision-making (Nissi & Lehtinen, 2016; Ford, 2010; Gibson, 2005; Koole et al., 2017; Wasson, 2016), and teamwork in safety-critical settings (Depperman, 2014; Korkiakangas, 2016; Nevile, 2007 & 2009). Participation in the multi-party interaction of professionals with their clients has been studied, firstly, in situations where a client participates in an encounter with a group of professionals (Keel & Schoeb, 2017; Heinemann, 2009) and, secondly, in situations where a group of peers is guided by one or more professionals. These situations include rehabilitation (Halonen, 2002, 2006 & 2008; Pino, 2014 2016a&b, 2017, 2018; MacMartin & LeBaron, 2006), political meetings and workshops (Mondada, 2011, 2015; Nielsen 2012), guided visits (Mondada, 2017), therapy and counselling[1] for families, couples or groups (Muntigl, 2013; Miller & Silverman, 1995; Peräkylä, 1995; Valkeapää et al. in press), health and work ability counselling (Tiitinen et al., 2018a, 2018b) and weight or diabetes management groups (Wiggins, 2009; Fasulo et al., 2016). A comparable setting is Alcoholics Anonymous (AA) meetings (Arminen, 1988), even though they are usually peer-led, rather than led by a professional. Nevertheless, they, as well as the above-mentioned wide body of research, show how a participation framework is, firstly, a collaborative achievement of the participants, and secondly, a central element with regard to how the institutional aims in a particular institutional setting are pursued and achieved. However, even though a broad range of studies have examined participation in other types of institutional setting, little knowledge exists regarding participation in health promotion groups.

Research on interaction in a group of peers that is led by a professional has focused mainly on the actions of the group leader and, therefore, empirical knowledge of the participation of group members is confined to being responsive to leader's actions. Previous research has examined practices such as group leaders' verbal directives (Raevaara, 2017), practices that professionals use to solicit talk from

[1] While previous literature exists regarding counselling interaction, the research has focused mostly on dyadic settings (for example Sarangi, 2009; Poskiparta et al., 2001; Poskiparta et al., 1995; Vehviläinen, 2001, 2003, 2009); thus, the group context has received less attention.

the participants (Netz, 2016; Pino, 2016b & 2014; Miller & Silverman, 1995; Tiitinen et al., 2018b; Valkeapää et al., 2018), how facilitators select and announce next speakers (Mondada, 2013; Mondada et al., 2017) and the ways in which group facilitators formulate or interpret participants' turns (Mondada, 2015; Halonen, 2001). This focus reflects the common way of organising participation in institutional encounters: the professional takes responsibility for the agenda and progress of the encounter (see for example Land et al., 2017; Collins et al., 2007). Such research has revealed successful practices that professionals use to encourage group members to contribute to group work (Nielsen, 2012; Pino, 2014 & 2016b; Tiitinen et al., 2018b) and to enable and ensure equal participation of members in a large group (Mondada et al., 2017; Mondada, 2013). Furthermore, the research has shown how well-intentioned professional practices may actually hinder group participation and the progress of the encounter. These include practices such as designedly incomplete utterances that aim to facilitate responses, but eventually lead to monologues rather than discussion (Netz, 2016), and forming an opposition with one client to manage resistance of another (Muntigl, 2013). Due to the analytic focus on group leader's actions, there is less knowledge on the actions of the group members, and therefore, little insight on what kind of active roles group members may take in group encounters.

A few studies focus on group members' initiating actions and show how group members steer the discussion with their initiating actions. Fasulo et al. (2016) describe a specific type of group members' questions as a way in which group members solicit information on topics that they consider to be relevant to themselves. Keel and Schoeb (2017) argue that, in interaction with a group of professionals, clients produce initiatives when the progress of the institutional activity is compromised, either because of a disagreement between the professionals or due to their difficulties in moving towards formulating a goal. Halonen (2002, 99) shows that members of a rehabilitation group break in to each other's talk when the actions of the speaker threaten the meaningfulness of the therapeutic discussion. According to these studies, group members' initiating actions are located in positions within the interaction that are particularly important for the progress of the encounter or the achievement of the institutional aims. In the present study, one point of interest is the ways in which health promotion group members may steer the discussions, whether with their initiating actions or with other types or actions, and how these actions may be linked to the institutional aims.

Another perspective on group members' participation is to examine the ways in which they engage in discussions with each other. Participation framework sets

limitations to whether it is possible and expected for participants to comment on each other's turns of talk or not, and how this is done. Group members can create and maintain topical cohesion by referring to previous turns and incorporating particular elements from earlier turns as part of their own telling (see Goodwin, 2013; Halonen, 2008; also Lepper & Mergenthaler, 2005). They can achieve this even when the structure of the interaction limits group members to directly comment on previous turns. For example, in rehabilitation and AA meetings, in which each of the participants presents a monologue, they can refer to earlier turns with named references to specific speakers (Halonen, 2008; Arminen, 1998). In addition, group members can invite other group members to engage in mutual discussions – either by asking questions, or by inviting them to ask questions (Halonen, 2002, 88-99). Since one of the premises in the present study is that social influence emerges through discussions with group members, the possibilities and interactional practices for group members to engage in discussion with each other are in focus in the analysis.

The analytic perspective of participation adopted in this study describes how health promotion group members can steer discussions and engage in them, and thus, provides insight into how health promotion groups work. There remains another point of interest: when group members participate in discussions, they may display their views and beliefs, and address those displayed by the other participants. In other words, when participating in discussions, group members take a stance on the topics they discuss. This perspective is addressed in the next section.

2.2 Stance-taking in social interaction

Stance-taking is a more pervasive concept than, for example, evaluation or assessment, and it refers to an intersubjective, dialogical and contingent activity that is accomplished in collaboration with the participants of the interaction (Goodwin & Goodwin, 1992; Ochs, 1996; Goodwin, 1998; Haddington, 2004; Wu, 2004; Du Bois & Kärkkäinen, 2012; Du Bois, 2007). Goodwin (2007) argues, that there are at least five kinds of stance: instrumental, epistemic, co-operative, moral and affective stance. In the present study, I follow Wu's (2004, 3) description of stance as "a speaker's indication of how he or she knows about, is commenting on, or is taking an affective or other position toward the person or matter being addressed", and I define stance as a combination of epistemic, affective and moral positioning of the speaker in relation to a particular object, in a particular context. Stance is thus not to

be understood as a revelation of subjective attitudes through interactional resources, but a social action (Haddington, 2004; Edwards & Potter, 2005; Potter, 1996). Stance-taking is a collaborative interactional achievement that is both sensitive to its context and renewing the context and, further, visible for the participants in the details of interaction and, thus, observable for analysis (Wu, 2004, 3-19; Du Bois & Kärkkäinen, 2012). As a concept, stance-taking captures the interactional work participants do to address and manage the multiple stances that may simultaneously be 'talked into being' in their talk (Goodwin, 2007, 2013; Haddington, 2004).

Research on stance-taking has generated considerable empirical evidence on the ways in which participants accomplish stance-taking in interaction. Wu (2004) has summarised the key features that previous research has focused on as: 1) lexical choice, that is, the choice of words; 2) syntactic design, which means the various possibilities, such as word order, for designing a turn; 3) prosodic manifestation, that is, features such as rhythm and pitch; and 4) sequential positioning. The latter is the most crucial one and refers to a specific location in the flow of interaction where stance-taking is occasioned (Wu, 2004). In a more recent summary, Du Bois and Kärkkäinen (2012) notice a growing interest in multimodal resources such as body posture, gaze and facial expressions, and the use of physical objects in stance-taking. However, they too emphasise the importance of sequentiality in the recognition and interpretation of stance. Any feature of interaction itself is not sufficient alone to act as a specific stance marker; instead, features of interaction gain their meaning in relation to their context. (Du Bois & Kärkkäinen, 2012.)

The sequential positioning of interactional resources, such as choice of words, laughter or facial expressions, has an influence on how they are interpreted as specific stance markers in that specific situation and context. Participants give subtle cues and monitor each other's cues as to what kind of a stance is expected in that particular context, and they can quickly adjust their stance according to other participants' actions. (Goodwin, 1992; Peräkylä & Ruusuvuori, 2012; Ruusuvuori & Peräkylä, 2009; Kaukomaa et al., 2015; Couper-Kuhlen, 2012.) Thus, stance-taking unfolds sequentially, and it is created in collaboration.

In this study, I draw on Du Bois' (2007) theoretical framework on stance-taking, 'the stance triangle', which emphasises the consequentiality of stance-taking with regard to social relationships. Du Bois describes stance as a triplex act in which 'the stancetaker 1) evaluates an object, 2) positions a subject (usually the self), and 3) aligns with other subjects' (Du Bois, 2007, 163). Positioning refers to the ways in which speakers choose and display their position along an affective or epistemic scale in relation to the stance object (Du Bois, 2017, 143, 152-157, 163). 'Alignment'

describes the 'matching' participants do in designing their evaluations in relation to the evaluations of others (Du Bois, 2007, 144, 150, 159-163). Furthermore, alignment refers to participants monitoring and modulating their individual positioning in relation to that of other participants (Du Bois & Kärkkäinen, 2012). Of course, the positioning of a stance in relation to others' is not always perfectly aligned. Instead, participants may take contradictory stances in their discussion. In that case, their positioning is not aligned, but divergent or ambiguous in relation to the positioning of others (Du Bois, 2007, 162). Nevertheless, alignment is a crucial feature of stance-taking that participants need to address in their interaction, and misalignment makes them accountable (Bergmann, 1998). In this study, I use 'alignment' to describe the positioning of stances in general, in a similar way to Du Bois (2007), and 'affiliation' in the context of affective stances (cf. Stivers, 2008[2]).

Being an inherently intersubjective social action, stance-taking is argued to also evoke more far-reaching social consequences (Du Bois, 2007; Ochs, 1996). Stance-taking is not just displaying or reflecting views and beliefs, and the social values potentially attached to them: it also generates and renews the social values (Du Bois, 2007, 173-174; Haddington, 2004, 116; Ochs, 1996). Furthermore, Du Bois (2007) notes the responsibility of the stance-taker: 'if you take it, you own it' (Du Bois, 2007, 173). This means that, because taking a particular stance evokes social values and simultaneously places the speaker in a particular kind of position in relation to others, it also creates consequences in terms of social relationships—who agrees with or opposes whom—and in terms of what kind of moral attributes and inferences of the speaker's stake, interest or epistemic entitlement other people may make according to speaker's stance-taking (Du Bois, 2007, 173; also Potter, 1992, 110, 121-125).

With regard to the focus of the present study, social influence, the above-mentioned aspects—the formation of social values, the alignment with others and the management of epistemics and moral attributes—are central. They are specifically connected to the mechanisms of conformity, and therefore stance-taking is a fruitful analytic perspective into how social influence may unfold in health promotion group interaction. I approach stance-taking by analysing the ways in which health promotion group members display and address views and beliefs. In the following chapter, I formulate the research questions.

[2] Stivers (2008) uses 'alignment' to describe the structural features of utterances in relation to the ongoing action, and 'affiliation' to describe the similarity of stances in relation to the preceding turn.

3 RESEARCH QUESTIONS

The general objective of this study is to gain understanding of how the health promotion groups work and through what kind of interaction process group members may influence each other. Mutual discussion with peers is assumed to be the crucial feature contributing to the positive effect of health promotion in groups (Stephens, 2008; 7; Valente, 2002) and is therefore in focus in this study. The research objective is addressed by examining two observable phenomena in social interaction: participation and stance-taking.

Participation is approached by studying who gets to talk, and in what ways, in health promotion groups. What kinds of independent and initiative roles are available for group members? How do group members steer the discussions, and how do they engage in discussions with each other, rather than only with the group leader? Stance-taking is approached by studying what group members do when they participate in group discussions: how they display and address views and beliefs and what they accomplish in doing so.

Each of the four articles analyses a specific pattern of interaction and addresses a more elaborated research question. The analytic focus and the research questions of the four articles were formulated from an emic, data-driven perspective, and the process is explained in detail in the next chapter. In this section, I list the research questions and the analysed interactional phenomena of the four articles.

The first analysed pattern of interaction, the most frequent initiating action of group members in the data, is group members' questions to the group leader and to other group members. The first research question, addressed in Article 1, is: *how do group members' questions shape participation in health counselling and health education groups, and what kind of functions they may have?*

The second analysed pattern of interaction is turns of talk in which group members take a verbalised stance towards their own actions and behaviour; that is, group members' explicitly self-reflective talk. The second research question, addressed in Article 2, is: *what is achieved in interaction when group members produce explicit self-reflective turns, that is, when they 'talk into being' their stance towards their own actions and behaviours and make it available for other participants: what kind of social purposes or consequences may this serve?*

The third analysed pattern of interaction is episodes wherein group members reveal their own experiences and the others subsequently comment on them; specifically, group members' responses to each other's self-disclosures and comparative time-framed experience telling[3] in response to another group member's experience telling. The third research question, addressed in Articles 3 and 4, is: *how do group members take a stance on the discussed subjects while also managing their relationships, through alignment, with each other? What may be accomplished in and through a) responses to self-disclosures and b) comparative time-framed experience telling in response to experience telling?*

[3] Comparative time-framed experience telling involves segments of talk in which the speaker talks about their own experiences at certain moments or periods in their lives (usually a point in the past and the present) and compares them.

4 ANALYTIC PERSPECTIVES

The point of departure for this study, in examining interaction in health promotion groups, is ethnomethodology. Ethnomethodology has its roots in sociology, rather than psychology, and its aim is to understand how people's collaboration with each other is possible. The core questions are how people make sense of what is going on and what others are doing, how people reach intersubjective understanding, and how people coordinate their joint activities. (Garfinkel, 1967; Heritage, 1984). Therefore, I consider ethnomethodology to be at the very core of social psychological interests of knowledge and thus a suitable approach for this study, wherein the objective is to find out how health promotion groups work and how group members may influence each other.

In this study, I regard both conversation analysis (CA) and discursive psychology (DP) as methodological applications of ethnomethodological theory, even though I am aware that this is not beyond dispute. In the early days of discursive psychology, ethnomethodology was considered just one of its theoretical roots (Edwards & Potter, 1992). Later, the contribution of ethnomethodology has significantly increased, and it is now a key aspect of discursive psychology (Wiggins, 2017). Both of these methodological approaches, CA and DP, analyse naturally-occurring interaction as a socially and collaboratively achieved action and understand it as both context-dependent and context-shaping. Furthermore, they both take an emic perspective on interaction and analyse the participants' practices as the participants themselves interpret them, instead of categorising them according to classifications predefined by the researcher (cf. Austin, 1962; Searle, 1969). Together, they offer a rich analytic view, on the one hand, on the structural organisation of health promotion group interaction, and on the hand, on the ways on which social actions are produced and managed in that context.

Both CA and DP are interested in the ordinary, everyday interactions of people, but have also been applied to the study of institutional settings. The orders of everyday conversation form the structure of institutional interaction, but they are adjusted according to the specific institutional tasks and roles in question. They are utilised and adapted by the participants in order to assign institutionally relevant participatory roles, accomplish institutional functions and serve the institutional aims

(Hutchby & Wooffit, 1998; Peräkylä et al., 2005; Drew, 2003). Interactional practices are thus the foundation for institutionally relevant frameworks and procedures (Heritage, 1997, 163-164), which may result in asymmetries in terms of participation, agency and control over the encounter (Ruusuvuori, 2000; Peräkylä, 2002; Gibson, 2000). Institutions do not define the interaction per se, but they are 'talked into being' in interaction and, thus, are a collaborative achievement of the participants (see Drew & Heritage, 1992; Antaki, 2011; and Chevalier & Moore, 2015, for edited collections of studies). In this study, CA and DP provide descriptions of how the institutional functions of health promotion discussions may be achieved in collaboration with the group participants and further, how they may serve the institutional aims.

In the following sections, I describe the analytic foundations of this study. Firstly, I elaborate on the question of morality from an ethnomethodological perspective. Then I introduce the methodological approaches I apply in this study: conversation analysis and discursive psychology.

4.1 Ethnomethodological perspective on morality

Morality is a central concept within research on social influence, but it has usually been approached as an inherent, psychological and cognitive phenomenon. Earlier literature suggests that social relationships have an important role in shaping moral judgements, but traditionally studies have focused more on the individual factors, such as power, that may have an effect on the judgements. Recently there has been a growing interest in exploring what kinds of social process, such as different types of argumentation, may have an effect on moral judgements, but without much analytic focus on the argumentation process itself. (Lees & Gino, 2017; Simpson et al., 2016; McGraw & Bloomfield, 1987; & Cummins, 2013; Kelly et al., 2017.) Ethnomethodology offers another perspective to morality as a context-dependent and context-shaping social phenomenon, and studies the actual social processes as they unfold in interaction.

The ground-breaking idea in ethnomethodology is that people *orient to* normative practices (instead of obeying them) and that understanding of those practices is based on peoples' common sense understanding and reasoning of what is expected in each situation. The practices and expectations emerge in local interaction, instead of being determinants or precursors of the interaction in the situation in question, and become visible especially when they are breached. (Garfinkel, 1967, 7-13, 76-79, 100-103.) Furthermore, as Garfinkel (1967, 41-49, 51-53) convincingly showed,

breaching of the norms is possible (instead of norms being an external determinant of peoples' conduct) and, when breaching happens, people seek explanations and orient to each other as accountable for it. Morality is thus intrinsically present in social interaction, but it is always interpreted in relation to the context, instead of being an inherent feature of an individual or a set of external, pre-defined norms and rules. Hence, ethnomethodological understanding of morality provides an original theoretical perspective on how social influence may unfold in interaction.

In interaction, participants orient to the contextually relevant morality in two ways: the morality concerning their actions in the interaction itself (for example how they participate in discussions), and the morality concerning their conduct in general (for example their health behaviour) (Bergmann, 1998; Stivers et al., 2011; Edwards & Potter, 1992, 165-170). In ethnomethodological theory, the fundamental claim is that people treat each other as *accountable* for their actions and activities. Consequently, people provide different kinds of explanations, justifications, excuses – that is, *accounts* – to show the intelligibility, sensibility and responsibility of their actions and activities. (Garfinkel, 1967, 1-2, 7-10; Robinson, 2016.) As theoretical concepts, accountability and accounts are often considered to cover both of the abovementioned layers of morality, but Robinson (2016, 16) suggests distinguishing 1) the accountability of actions *in interaction* and 2) the accountability of conduct *outside* the encounter, and scrutinising them separately.

The first layer, the accountability *in interaction*, reflects two different aims: *accountability of* actions, and *accounting for* the actions. This means that, in interaction, participants firstly strive to make their actions account-able, that is, definite and sensible and, therefore, recognisable and understandable to the other participants. Secondly, they strive to show responsibility concerning the relevance rules that participants orient to as constraining and forming their actions, that is, to show that they recognize, understand and adhere to these rules. (Robinson, 2016; Garfinkel, 1967, 1-2.) These two aims are crucial to participation and maintaining the relationships of the participants. They contribute to the formation of the roles and conditions that participants take into account when operating in the encounter. Therefore, they are a key issue regarding the question of *how the groups work*.

The second layer of morality concerns the accountability of *conduct outside the encounter* (in the context of health promotion, issues such as participants' health, health behaviour and their activities in pursuing behaviour change). This type of accountability can be defined as the actions that the participants perform to attribute responsibility and motives for their own conduct to themselves or to other agents, such as other people or circumstances. (Wiggins & Potter, 2008, 78; Edwards, 2007;

Edwards & Potter, 1992, 165-170 & 1993.) These practices contribute to producing ideals and values concerning conduct; that is, shared understanding of what kind of things the participants consider to be valuable, possible or achievable (Du Bois, 2007). This type of accountability presumably plays a central role regarding the question of *through what kind of interaction process group members may influence each other.*

4.2 Conversation analysis and discursive psychology

Conversation analysis (CA) focuses on talk in interaction as it unfolds turn by turn, in and through the adjoining utterances of the participants (Sacks, 1984; Schegloff, 2007; Heritage, 1984). As observed by the pioneers of CA, the continuous, fluent flow of conversation is a collaborative achievement of the participants. Sacks, Schegloff and Jefferson (1974) provided meticulous evidence of how even the most mundane discussions are systematically organised and structured in terms of turn-taking, sequentiality and repair, and participants both take these orders into account and utilise them in participating in discussions (Sacks & Schegloff, 1973; Schegloff et al., 1977).

Turn-taking organisation is a particularly powerful feature of interaction that offers and restricts possibilities of participation. Turn-taking is constantly negotiated in each possible *transition relevant place* (TRP); that is, whenever a *turn constructional unit* (TCU) is produced. The question for the participants of the conversation at this point is: will the first speaker continue or will there follow a speaker change, and further, in the case of more than two participants, who will be selected (and by whom) to be the next speaker. The rules under which this negotiation unfolds are hierarchically organised and locally managed in the sense that they are adapted to the particular context and the positions of the participants in that local context. (Sacks et al., 1974.) In an institutional encounter, turn-taking can be organised freely, strictly structured, or anything in between. For example, it can resemble mundane interaction where participants can select each other or self-select themselves as the next speaker. Then again, turn-taking can follow different types of explicit structures; for example, pre-selecting a number of speakers to produce consecutive monologues with a fixed time limit, each taking their turn. Different ways of organising turn-taking serve different institutional purposes. (Mondada et al., 2017; Mondada, 2017; Svinhufvud, 2015; Arminen, 1998; Halonen 2002)

Another important notion about TCUs is that their meaning or purpose is not inherent, but each TCU has potential for action and the participants make sense of

the actions in the flow of the conversation. The core of CA is the sequentiality of interaction, indicating that 'the action' that a TCU performs is dependent on its sequential position and further, that specific actions restrict the choice of possible next actions. A particular first turn – for example, asking a question – makes a particular second turn – answering – relevant. (Schegloff, 2007, 7-12.) These relevancies are constantly observed by participants in conversation and their understanding of the ongoing turn of talk is then put forward in their own upcoming turn of talk: 'an answer' produced to a question shows the respondent's understanding of the previous turn as 'a question' (Heritage, 1984, 242, 260; Schegloff, 2007, 3-7). Moreover, any problems in accomplishing mutual understanding of the ongoing action, whether the problems arise from difficulty in talking, hearing or understanding, are repaired through organised and systematic practices (Schegloff et al., 1977; Schegloff, 1992). Thus, as an analytic method, CA takes into consideration the minute practices and procedures in, and through which, people 'get things done' in collaboration with each other. Using the analytic tools of CA, I describe how group members' turns are located within ongoing sequences of action, what sorts of action make them relevant and what kinds of interactional consequences or functions subsequently ensue.

Discursive psychology (DP) is a theoretical and analytical approach that has roots both in ethnomethodology and CA, as well as in post-structuralist and social constructionist perspectives (Wiggins, 2017, 16-27; Edwards & Potter, 1992). The core principles of DP have been synthesised as follows: discourse is 1) simultaneously constructed and constructive, 2) situated within a social context and 3) action-oriented (Wiggins, 2017, 8-15). These principles mean that participants of an interactional encounter use cultural resources such as words and grammar, prosody, embodied resources, and further, expressions and phrases that are culturally available and established, to construct discursive practices. These practices, then, construct 'versions of the world' (Wiggins, 2017, 10) that the interlocutors are able to interpret and that have implications and potential consequences for the context of the interaction. The context of the interaction can be understood, firstly, as the immediate context of turn-taking and sequence and, secondly, as the wider interactional context in which the discourse takes place. Furthermore, the aforementioned 'versions of the world' form a rhetorical framework within which the discourse is situated and interpreted by the participants, who 'talk into being' their understanding of what they talk about (and what kind of issues can be talked about) in relation to the specific context. Hence the participants' actions both shape the context and orient to the context that sets constraints to possible actions.

(Wiggins, 2017, 12-14.) Moreover, discursive psychology is able to dismantle how psychological concepts, such as identities or attitudes, are made relevant in interaction and what kind of implications they may have in practice in the local context (Edwards, 2007). Participants 'talk into being' 'what is at stake'; that is, their orientation to the responsibility and accountability regarding the specific issues they talk about.

I apply discursive psychology to examine what kind of social actions are accomplished when the participants, firstly, take a verbalised stance towards their own behaviour and, secondly, when they compare their own experience to the experiences of others. The analytic tools of DP build on the foundation established in CA and focus on several types of discursive devices. The discursive devices enable the description and interpretation of how social actions are produced and managed in discussions. With regard to this study, some of the central discursive devices are assessments and second assessments which invoke the stance of the speaker and also their knowledge or experience regarding the object of assessment; hedging, that marks the talk as tentative or conditional and thus works to manage accountability; and consensus and corroboration, that is, implications that there are other people who can agree with or support the presented claims (Wiggins, 2017, 149, 152, 160). Moreover, in this study, I examine the more complex discursive devices, such as the use of narrative structure and the agent-subject distinction that, on the one hand, support the credibility of the speaker and, on the other, manage the agency and thus the accountability of the speakers themselves or the people who are talked about. Discursive devices that orient to emotion, namely, displays of affective stance and references to categories of emotions, make relevant and address psychological conceptions, and invoke notions of what kind of conduct is considered to be, for example, rational, normal or unavoidable in particular situations. (Edwards, 2007; Wiggins, 2017, 165-172.) Thus, the discursive devices that are in focus of the analysis in this study enable an examination of how the participants produce the particular 'versions of the world' and orient to psychological notions as relevant in the current context through their actions (Wiggins, 2017, 10, 37).

In this study, I incorporate the two analytic perspectives described above, CA and DP, to enable a more elaborate scrutiny of health promotion group interaction than either of the approaches would afford alone. CA focuses on the social organisation of interaction, describing how people make their actions intelligible to each other and, thus, are able to accomplish joint projects. Hence, the primary focus of CA is the action, while the content of discussions is regarded as largely indifferent. (Sacks, 1984.) CA is thus useful for providing answers to the research questions concerning

how the group members participate and take a stance in group discussions. However, the action-centred approach of CA may leave unattended some aspects that may be especially consequential and meaningful regarding the specific context that is in focus in this study; namely, health promotion. Health and health behaviour are highly charged, delicate subjects to address in interaction that may make the participants particularly accountable for their conduct. Furthermore, the context of health promotion may set expectations of successful change, learning, or meaningful insight for the participants to accomplish. As Haddington (2004) argues, when analysing stance-taking, it is necessary to address also the stance object, that is, the discussed issue; and the wider interactional context in which the stance-taking takes place. The participants 'take into account what they talk about, who their co-interactant is and whom or what this co-interactant represents' (Haddington, 2004, 116.) Therefore, it is essential to analyse the entitlements and responsibilities concerning the topics of talk that the participants visibly orientate to and construct in their talk. Discursive psychology offers analytical tools for this kind of analysis.

5 THE DATA AND ANALYTIC PROCESS

5.1 Data and research ethics

In this study, I analyse three datasets of video recordings from three types of health promotion interventions that aimed for individual health behaviour change. The first dataset was gathered by myself during a health education intervention that was developed and implemented by the UKK Institute[4] in Finland. The two other datasets were drawn from a corpus collected by the Finnish Institute of Occupational Health (FIOH). This study started as an independent project, but was later incorporated into two research projects, Counselling[5] and Promo@Work[6], which both aimed to locate and describe interactional practices in group counselling.

I use a different sample of the datasets for each article, partly due to the research questions that were addressed in the articles and partly because the third dataset was not available until later in the research process. Table 1 provides an overview of the data.

[4] UKK Institute—a Finnish centre for health promotion research

[5] Counselling—group interaction and technology-mediated counselling as part of individually tailored healthcare (2014, in partnership with the Finnish Institute of Occupational Health, funded by the Juho Vainio Foundation) (Nevanperä et al., 2015).

[6] Promo@Work—evidence-based health promotion at work (2016-2019, in partnership with the Finnish Institute of Occupational Health, University of Oulu and University of Cologne, funded by the Strategic Research Council (SRC) at the Academy of Finland) (Laitinen et al., forthcoming).

Table 1. Overview of the data

Name of the intervention, the organiser of the intervention and the timescale of data capture	Kasit liikkeelle!/Kids Out! (UKK) 2012	Elvira-counselling (FIOH) 2007-2010	Naiset työssä/Women at Work (FIOH) 2015-2016
Aims of the intervention	To increase physical activity and reduce sedentary behaviour.	To increase skills for losing 5 kg of weight, to follow a diet of high nutritional quality, to improve cognitive eating restraint, and to increase physical activity.	To promote work ability and health, to increase physical activity and nutritional quality, and to support stress management and recovery from work.
Context of the intervention	Health education lessons for adolescents (face to face)	Health counselling for people at risk of type 2 diabetes (face to face)	Health and work ability counselling for women entrepreneurs (via Skype)
Duration of each group session	45 minutes	90 minutes	90 minutes
Total duration of the data (h)	4½ hours	46 hours	27 hours
Number of captured sessions for each group	2	1–6	3–5
Total amount of the sessions	6	23	18
Number of groups and participants	3 groups, 14–21 group members and one leader per group. Total 54 group members and 2 leaders.	6 groups, 4–8 group members and one leader per group. Total 38 group members and 4 leaders.	4 groups, 3–6 members and two leaders per group. Total 20 group members and 4 leaders.
Analysed interactional practice	Group members' questions (Article 1)	Group members' questions (Article 1), explicit self-reflective talk (Article 2), responses to self-disclosures (Article 3), comparative time-framed experience telling (Article 4)	Comparative time-framed experience telling (Article 4)

The first dataset consists of video and audio recordings of health education lessons for adolescents in Finnish upper secondary school, and was used in Article 1. The data was gathered in 2012 during an intervention that was developed in a Kasit

liikkeelle!/Kids Out![7] project run by the UKK Institute. The project developed and evaluated material for health education in upper secondary schools in Finland. The intervention was implemented in several schools and was delivered by teachers. The video recordings were not part of the original Kids Out! project, but were carried out for the purpose of my dissertation. The aims of the intervention were to increase physical activity and reduce sedentary time, especially screen time (that is, the time students spend using digital appliances). The intervention was implemented through various resources and materials: a teacher's manual for talking activities with the class, a SoftGIS mapping application, a YouTube video, posters, and leaflets for students and their families. The intervention was implemented in three consecutive health education lessons over a period of two or three weeks. During the first lesson, the students carried out an individual written assignment utilising the mapping application. During the second and third lessons, they engaged in various activities with their teacher and completed homework between the lessons. The teachers had free choice regarding how they used the resources and how they facilitated the activities in practice.

The data was gathered in one of the schools that participated in the intervention. Two teachers, specialised in health education, volunteered with their classes. One teacher had one group of students and the other had two groups. There were 14–21 students in each group, aged 14–15 years. I captured lessons 2 and 3 for each class, resulting in six captured lessons. The length of each lesson was 45 minutes, totalling 4½ hours of data. I was present during the lessons and captured them with one video camera fixed on a tripod and one hand-held video camera, and used an additional audio recording device. The cameras were directed mostly towards the students, so the teacher and objects at the front of the class, such as the blackboard and projector screen, were rarely visible.

The ethical committee for the Tampere region approved the data collection (document number 7/2012, 29.8.2012). The city's chief education officer and the school principal gave their permission to recruit teachers and students for the study. Participation in the study was voluntary. The teachers, the students and their parents or guardians gave their written, informed consent to either be video recorded or only audio recorded (and thus seated in the class so that they were not visible to the cameras). Before the start of the recruitment, I established an ethical principle stating that, if any student in the class was not willing (or whose parents or guardians did not give permission) to be recorded in any way (not even audio-recorded), I could

[7] Jussila et al., 2015.

not collect data in that class: the student's right to participate in the lesson overruled the researcher's interest in collecting data. This scenario was realised in a class in another school that was recruited for the study and the class was therefore withdrawn from the study. Before the start of each lesson, I made sure that all students understood that they were being recorded and that they understood that they had a right to decline to participate in the study. None of the students withdrew from the study at this point.

The second dataset comprised a sample of video recordings that were collected as part of the Elvira-counselling[8] study in 2007–2008 conducted by the Finnish Institute of Occupational Health. The data was obtained from FIOH for use in this dissertation and was used for Articles 1, 2, 3 and 4. The data consisted of video recordings of health counselling for adults at risk of type two diabetes. The aims of the intervention were to increase skills for losing five kilograms of weight, permanently, in the following year: to follow a diet high in fibre, moderate in unsaturated fats and low in saturated fats; to improve cognitive eating restraint; and to exercise regularly for at least four hours per week. The intervention was developed and delivered by the Finnish Institute of Occupational Health. The group leaders (who were registered nutritionists) were part of the development team. The resources used in the intervention included a group counsellor's manual, written assignments, written information for the group members, pictures and checklists. The resources were used during the group sessions and also independently, at home, by the group members between the sessions. At the start of the intervention, group members had a blood test and received individual feedback of their test results from the counsellor. Some of the group members were diagnosed with type 2 diabetes during the intervention due to these tests and were referred for appropriate healthcare while they also continued to participate in the group counselling sessions.

The participants were recruited by nurses in basic healthcare and occupational healthcare during the nurses' regular appointments. Nurses recommended that their clients participate in the study if the clients had a high risk of type 2 diabetes. Informed consent was obtained from all participants. The collection and use of the data was approved by the coordinating ethics committee of the hospital district of Helsinki and Uusimaa (document number 50/E0/2007).

The sample of video recordings I used for this dissertation consisted of 23 group sessions, totalling 46 hours of data. There were six groups, with four to eight group members in each group, totalling 38 group members. Each group was led by one

[8] Laitinen et al., 2010.

registered nutritionist, and there were, altogether, four leaders. Each group met six times. The first four sessions took place fortnightly and one or two follow-up meetings took place within six to eighteen months after the beginning of the intervention.

The third dataset consisted of a sample of video-recordings of health counselling that was collected during a Naiset työssä/Women at Work[9] health promotion intervention conducted in 2015–2016 by the Finnish Institute of Occupational Health. The data was obtained from FIOH for use in this dissertation and was used in Article 4.

The intervention was developed and implemented by Finnish Institute of Occupational Health. The aims of the intervention were to promote peer support among the participants and to promote the health and work ability of women entrepreneurs, support stress management and coping skills, and improve recovery, sleep, physical activity and healthier nutrition. Participants were recruited by sending invitations through entrepreneurial organisations, social insurance institutions for entrepreneurs, and the media. Informed consent was obtained from all participants. The collection and use of the data was approved by the ethics committee of the Finnish Institute of Occupational Health.

The group sessions were carried out via Skype (except for two groups in the sample which met face-to-face for their first counselling session). Resources for the intervention included a counsellor's manual, written assignments to be completed during the group sessions and at home between the sessions, and books about weight control and depression that were delivered to the group members. Features of Skype were utilised so that the group could share content on the screen and work on shared documents. Groups were led by a nutritionist and a work psychologist. In the data sample, there were four groups, 20 participants, and three to six group members in each group. Each group met five times: approximately once a month for four months and once for a follow-up. The sample consisted of 18 sessions in total (two face-to-face and 16 via Skype), totalling 27 hours of data.

All participants in the three interventions received verbal and written information about the research projects and the video recordings. Regarding the second and third datasets, participation in the intervention was voluntary, but the participants' consent to be video recorded was a prerequisite, i.e. it was not possible to participate in the counselling without being video-recorded. However, refusal or withdrawal from the

[9] Turpeinen et al. (forthcoming).

study did not affect the care or services otherwise received, since the intervention was auxiliary to normal care.

While handling the data and reporting the results of the study, it was necessary to secure the anonymity of all the participants, including the group leaders. The topics of talk could be sensitive, and people might disclose information about their health; in addition, some of the group members might not want people to know they had participated in such intervention. The data was transcribed, and all names were changed into pseudonyms. In addition, some personal details were anonymised in the published articles. I have permission to use the video recordings of the first dataset for teaching and training purposes. The video recordings of the second and third datasets are not allowed to be shown outside the research group.

I own the first dataset and will archive it. The owner of the second and third datasets is FIOH. I have their permission to use the data in this study. I will return the data to FIOH after the completion of this study and destroy all copies I have made of the video recordings.

5.2 Analytic process

The aim of the preliminary analysis was to identify recurrent patterns of interaction that would contribute to the research questions defined in Chapter 3. Three of such patterns of interaction are: 1) the most frequent initiating actions the group members produced in the data, that is, group members' questions to the group leader and to other group members; 2) turns of talk in which group members take a verbalised stance towards their own actions and behaviour, that is, groups members' explicitly self-reflective talk; and 3) episodes where one group member reveals their experiences and the others subsequently comment on them, that is, a) group members' responses to each other's self-disclosures and b) comparative time-framed experience telling in response to other group member's experience telling.

The article numbers represent the order in which they were written and published; however, the process of analysis was overlapping. Working with each article has provided ideas and observations for the subsequent articles. During most of the study, I only had access to the first and second datasets. The third dataset was obtained later.

At the start of the analytic process, I watched all the videos and made notes on the overall structure of the group meetings and of interesting parts of discussion that caught my attention. Most of the data was transcribed verbatim by research assistants

and transcribing service providers; the rest I transcribed myself. Parts of the data that were the focus of the analysis, I transcribed following CA conventions whereby details of talk, such as overlaps, gaps, intonation and laughter, are taken into account (Jefferson, 2004).

The first observation in the very first phases of the analysis was the frequency and significance of the group leaders' actions: the group leaders take care to follow the agenda in both the health education data and the health counselling data. I made a rough classification of the group leaders' actions using samples of the first and second datasets and discovered that there were dozens of group leaders' questions and instructions per session.

The second observation was the tendency of organising the group work into 'rounds'. In the counselling groups, it was typical that when a group leader asked a question or gave an instruction for an assignment, each group member responded in the order they were seated, one at a time, until everyone had responded (although sometimes the rounds were not complete). In the health education lessons, there was a parallel pattern whereby the round of responses was initiated by the teacher, again with a question or an instruction for an assignment. The students volunteered to answer by raising their hand, and the teacher allocated response turns to several students, one at a time, until no more students volunteered, or the teacher proceeded to the next topic. I gathered a collection of 647 group leaders' questions from the first and second datasets and analysed them, showing that the well-known Initiation-Response-Feedback -pattern (Sinclair & Coulthard, 1975; Koole, 2015) was used in both environments: health education and health counselling.

My interest was drawn to the occasions on which these patterns were somehow altered, and I tried to determine what the group members did in addition to responding to questions initiated by the group leader. I noticed a recurrent activity that clearly differed from the prevalent, leader-driven pattern of interaction; namely, group members asking questions. This was observable in both the health education and health counselling data. I gathered a collection of 247 group members' questions from the first and second datasets, and using CA, analysed how group members shaped participation and steered the discussions with their questions. The results were published in Article 1.

During the analysis I conducted for the first article, I noticed a recurrent feature of turn design in the group members' talk in the health counselling data: often, the group members designed their turns so that they emphasised the observing, evaluating or interpreting position of themselves with regard to their own behaviour; that is, they took an explicit stance towards it. Interestingly, this type of turn design

did not occur in the health education data. I gathered a collection of these types of turns, which I called 'explicit self-reflective talk', from the second dataset, resulting in 104 clips. They were analysed with CA and DP to find out what kind of social purposes or consequences they might serve, and the results were published in Article 2.

During the analysis I conducted for these two articles, my attention was drawn to the ways in which group members sometimes produced candidate understandings of the previous group member's talk. I gathered a small collection of these and analysed them. I found that they often took place in response to some kind of reporting of events by the previous speaker. In those reports, I found a phenomenon that is well known in psychological literature and is also described in earlier CA studies; namely, self-disclosure (see for example Jourard, 1971; Vinogradov & Yalom, 1990; Antaki et al., 2005; Leudar et al., 2006). Eventually, I gathered a collection of 37 clips of self-disclosures and their responses and analysed them with CA. Again, there were no such turns in the health education data, so all the clips were taken from the second dataset. The analysis focused on how the speakers take a stance and manage their relationship with other group members, and the results were published in Article 3.

Throughout the analytic process, especially when analysing the self-reflective turns, I now and then noticed segments wherein group members compared separate moments or phases in their life. These segments were quite rare in the data and, over time, I found 41 instances of them in the second dataset. In the preliminary analysis, I found that they were either initiative or were located in response to the group leaders' initiative or other group members' experience telling. The first two locations were the most frequent, and the analysis of those clips repeated what I had already described in Article 2 and did not bring further insight to that analysis. However, the latter, more infrequent location—in response to other group members experience telling—seemed interesting. When the third dataset became available to me in 2017, I gathered a collection of 12 clips of such segments in total, from the second and third datasets. They were analysed with DP, focusing on the management of stance and alignment, and the results were published in Article 4.

6 RESULTS

The results show how group members' active participation and stance-taking unfold through asking questions (Articles 1 and 3), through producing interpretations of the discussed issues (Articles 1, 2, 3 and 4) and through the telling of experiences (Articles 2, 3 and 4). In the following sections, I present the results of each of the articles and a synthesis.

6.1 Shaping group participation

The first article examined the most frequent initiating action of group members in health education and health counselling groups: the questions that the group members ask from the leader and from the other group members. The analysis shows that, in the predominantly leader-driven context of health promotion, group members' questions were a pivot point in interaction, since they shifted the participatory roles of the speaker, the respondent and the listener.

The group members' questions were produced in three sequential locations: initiating a new sequence, following the group leader's talk, and following another group member's talk. The questions had three functions, depending on their sequential location and turn allocation. Firstly, questions that initiated a new sequence either requested counselling, that is, information or advice; or challenged a particular topic, such as counselling materials. In addition, when they were allocated to another group member, they were 'doing counselling'; that is, accomplished similar activities as a group leader could do. Secondly, questions that were located after information or advice either challenged it or requested counselling. Thirdly, questions that followed another member's disclosure either challenged it or 'did counselling'.

Questions could place the group leader in the role of the listener, while the group members occupied the roles of the speaker and the respondent. The group members' questions were often answered by other group members, even in cases when the questions requested counselling; that is, asked for information and advice. Hence, in answering the question, the group members could take the role of an expert.

Furthermore, the group members could temporarily adopt a similar role as the counsellor with their questions when 'doing counselling' in discussion with other members. As a result of the group members' questions and the role shifts they induced, the discussion was shifted from leader-driven to member-driven, from dyadic to multi-party or vice versa, and from a discussion between members to a discussion involving the leader or vice versa.

The group members' questions were usually considered to be legitimate actions. Most of the time, the shifts in participatory roles and topics of talk that were induced by the questions were accepted, and the questions were treated as relevant actions, even when they were challenging the previous talk or the counselling materials. In cases where the questions were treated as breaching, the participants (including also the group members, not only the leader) worked to sustain the current participatory roles and activities. I could not identify any topics or actions that the questions performed that would categorically be treated as deviations. Instead, the participants interpreted whether the actions and topics initiated by the questions were appropriate in that particular, immediate context. It is notable that group members' questions were more common in the health counselling data than in the health education data, and they were also more easily treated as deviation in the health education data. This may reflect what kind of participation is generally expected of teenage students in class, compared to adult members of a counselling group. Nevertheless, in both contexts, the questions operated similarly.

The group members' questions steered the discussion by topicalising issues that seemed relevant to the group members. The questions that challenged previous talk, by calling into question some of its aspects, introduced a new critical perspective to the topic in discussion. Even though questions were usually orienting towards the institutional task, it is noteworthy that they could also endorse views or suggest solutions that were not in line with the institutional aims. Nevertheless, since they made the group members' views and understanding available for the other participants, they served as a starting point for the group leader to work on further with the group.

The results suggest that, in their talk, the group members orient to rationality and responsibility regarding health and lifestyle. This was achieved through questions displaying the existing knowledge of the participants. The questions that requested counselling were often designed so that they asked for confirmation of some knowledge that the speaker claimed to already possess. Furthermore, some of the questions that adopted the group leader's actions displayed existing knowledge and positive orientation towards the institutional aims of the counselling. They could

establish an orientation towards striving for behaviour change and suggest habits that had been promoted in the counselling. However, this was not always the case. It was also possible that the questions could pose a challenge to counselling materials or to a speaker who had been expressing interest towards the aims of counselling, thereby calling into question their relevance and perhaps endorsing a stance that would contradict the institutional aims. The observable features that enabled such questions to be recognised as challenging also showed the speakers' orientation towards the institutional ideals as something towards which they might be expected to adopt a positive stance.

6.2 Providing interpretations of the discussed topics

The second article focused on self-reflective talk; that is, turns of talk in which the group members take an observing, evaluating or interpreting position towards their own actions and experiences. The analysis focused on what kind of interactional work group members do when they take a verbalised stance towards their behaviour and experiences and mark them as targets of cognitive processing. It showed how, through self-reflective talk, group members produced interpretations of the discussed topics by connecting details of counselling with their own experiences.

The analysis of the sequential location showed that self-reflective talk was often produced in response to the group leaders' initiatives and assignments but was not exclusively dependent on them. Instead, self-reflective talk was also found in initiating positions and in response to other group members' talk. With self-reflective talk, the group members displayed awareness of the institutional aims and the expected behaviour with regard to healthy lifestyle. It was also a way for the participants to display being willing and able to participate, and to display understanding of, and alignment with, the issues promoted in counselling. In this way, they produced contextually relevant morality, both regarding their actions in interaction and their conduct outside the encounter, while they also managed to discuss and elaborate on delicate topics. In addition, they steered discussion from the abstract to the practical level by relating the group members' own experiences to the advocated guidelines and, in some cases, they subtly challenged them.

Self-reflective talk was often designed with features of talk that offered experiences to be shared by the other participants, such as laughter and humour and, most prominently, turn designs that fade out the subject or offer the turn to be completed by other participants. Consequently, the group members often responded

to self-reflective talk in a way that displayed recognition and sharing of the described experiences. Self-reflective talk enabled the discussion of delicate issues and made it possible to participate in constructing a mutual understanding of what group members considered problematic behaviour and what kind of actions a health behaviour change would require in their current situation in life.

6.3 Addressing personal experiences

The third article analysed segments of talk in which a group member produced a self-disclosure and the other group members responded to it. Self-disclosures were understood as revelations of personal experiences and thoughts, presented as voluntary telling. The analysis in Article 3 shows that they were designed with detailed descriptions of specific elements of experience that served as evidence for the claims and assumptions that were raised through the self-disclosure. The group members responded to each other's self-disclosures with responses that displayed different levels of recognition and sharing of the experience that was described in the initial self-disclosure, or that offered a different perspective on the discussed issues.

In the analysis, attention was paid to the ways in which group members displayed their stance and epistemic access in relation to the discussed topics and simultaneously managed their relationships with each other. In the responses that displayed sharing or recognising the experience, the speakers stated that they had had a similar experience, told about a similar experience and carefully matched the details of their talk to the details of the previous speaker's talk, or completed the previous self-disclosing turn. In doing so, they displayed, or at least implied, epistemic access to similar experiences, thus aligning with the first speaker's stance and endorsing their view. On the other hand, the group members could change the perspective with responses that foregrounded some aspects of the experience or challenged the presented claims. Firstly, this was achieved implicitly through assessments and questions, which constituted an interpretation of the previous turn, but refrained from displaying recognition or sharing of the experience. Secondly, explicit disaffiliation was achieved either by self-disclosing one's own experience, which differed from the first speaker's perspective, or by presenting differing claims as general knowledge. The disaffiliative self-disclosure in response to the other group member's self-disclosure displayed that the speaker had had a similar experience to the first one. Nevertheless, at the same time, the responses challenged the

assumptions made in terms of the experience; for example, what kind of circumstances in life would be regarded as obstacles to a healthy lifestyle.

The interesting aspect in the data was that, since both sharing an experience and disaffiliating with it could be done by presenting a second self-disclosure, the respondents thus exposed themselves in a similar way to that of the one who had presented the initial self-disclosure. Hence, these response types make the speakers' own conduct susceptible to be challenged. By contrast, responding to the initial self-disclosure with the other types of response enabled group members to participate in discussions without revealing private details of experience.

Through self-disclosures and the responses to them, the participants 'talked into being' the ideals of health counselling and healthy lifestyles: they made explicit what kind of activities were considered eligible and attainable. The responses endorsed or challenged the claims that were made and the stance that was taken in the initial self-disclosure, and linked the personal, individual experience to general axioms such as conceptions regarding health.

6.4 Managing the dilemma of the uniqueness and comparability of experiences

The fourth article focused on episodes in which the speakers responded to the other group members' experience telling by telling their own experiences at certain moments or periods in their lives, most often a point in the past and the present, and comparing them. In doing so, the speakers told a story of a successful change process which they had encountered in their life. In Article 4, this practice was defined as 'comparative time-framed experience telling'. It was shown that, with comparative time-framed experience telling, the participants managed the dilemma of the uniqueness and comparability of individual experiences. With comparative time-framed experience telling, the group members either reinforced and encouraged the previous speaker's positive stance or challenged their negative stance towards the discussed subject.

Comparative time-framed experience telling were located in response to turns in which the first speaker took either 1) a positive stance or 2) a negative stance towards a particular, accomplished or suggested, change in behaviour. In the first category, comparative time-framed experience telling aligned with the positive stance taken by the previous speaker and either a) reinforced the first speaker's description of accomplishing a change in their own behaviour or b) acknowledged the first

speaker's problem implication and encouraged their plans for a solution, often including a 'word of warning'. In the second category, comparative time-framed experience telling misaligned with the negative stance taken and produced a counterclaim that challenged the negative stance and the presented claims.

Comparative time-framed experience telling displayed that the speaker had independent access to a comparable experience to that of the previous speaker, by describing the details of the experience. In addition, they backed up epistemic independence in relation to the claims made on the grounds of the experience by making explicit the basis of the speaker's reasoning. Further, comparative time-framed experience telling differentiated the speaker's own position from the others' and showed respect for the difference of the other's experience. They simultaneously produced and reflected the similarity and difference of the experiences, hence explicating the possibility of change, and positioned the speaker in a favourable light as successful and experienced, and thus entitled to interpret and even redefine the experience of others. Furthermore, they offered a resource for the group members to show affiliation, while still managing to disagree. In health promotion group discussions, they operated to question and reconstruct arguments and shared understanding of the discussed issues. They aligned with the institutional aims of improving health and wellbeing and, with them, the participants took a positive stance towards the change process and the suggested solutions.

6.5 Synthesis of the results

6.5.1 Summary

In this study I have analysed interaction in institutional health promotion groups from two perspectives: how the group members participate and how they take a stance towards the topics of discussion. The analysis of participation, that is, how group members organise their activities in the group, focused on two main aspects: how the group members *steer* discussions and how they *engage* in discussions with each other. The analysis of stance-taking focused on how the group members *display* their views and beliefs concerning the topic of discussion, and further, how they *address* those displayed by the other group members. In the following, I summarise the results in relation to each of these four themes (see Table 2).

Table 2. The summary of the results of the analysis

	Steer	***Engage***	***Display***	***Address***
Questions	Shift participatory roles, activities and topics. Introduce a critical perspective.	Shift participatory roles and thus shift discussion to member-driven, and to involving other members. Request and 'do' counselling. Challenge.	Make existing knowledge and understanding available for others. Introduce critical perspectives. Challenge.	Challenge the views of the other speaker. Explore the views and claims of the other speaker.
Self-reflective talk	Introduce delicate topics. Introduce critical perspectives.	Offer experiences to be shared.	Produce interpretations of discussed topics by connecting details to own experiences. Display orientation to institutional task.	May allow comparison of experiences.
Responses to self-disclosures	Introduce or foreground new, potentially critical, perspectives. May have different consequences for participatory roles.	Endorse views. Provide interpretations. Challenge assumptions. Link individual experiences to more general axioms.	Display epistemic access in various ways. Allow the handling of different levels of privacy vs. exposure.	Offer recognition, sharing, and endorsement. Offer a different perspective. Challenge.
Comparative time-framed experience telling	Introduce critical perspectives. Construct and reconstruct arguments.	Allow comparison of experiences and individual change processes with respect.	Display independent access and epistemic independence Display being successful and experienced.	Reinforce and encourage. Provide evidence for and against claims. Challenge.

Group members *steered* discussions by asking questions, and through self-reflective talk, responses to self-disclosures and comparative time-framed experience telling. These actions invited others to participate and served as ways to topicalise issues relevant to the speakers. Questions were the most frequent of the four practices in the analysed data. They were also the strongest way to steer discussion: questions make relevant an answer and, hence, they are not easy to bypass, even when treated as deviations. Questions induced a shift in participatory roles and activities, and topicalised new or revisited topics for discussion. Questions, as well as the three other analysed interactional practices, were a way for group members to introduce critical perspectives, either concerning the counselling materials or claims that were presented by other group members. Furthermore, self-reflective talk was a way to

topicalise delicate issues; responses to self-disclosures enabled the introduction or foregrounding of new perspectives; and comparative time-framed experience telling steered the discussion towards constructing and reconstructing arguments. The different types of responses to self-disclosures may also have consequences regarding participatory roles, because they evoke different types of relevancies regarding the next action.

The analysis of the four interactional practices described the ways in which group members *engaged* in discussions with each other. Because questions shifted participatory roles, they shifted the discussion from leader-driven to member-driven and, further, to involving the other group members in the discussion. With questions, the group members both requested counselling and adopted a position that resembled the counsellor's position in their discussions with other group members. Moreover, the group members challenged each other with their questions. Self-reflective talk offered individual experiences to be shared. Responses to self-disclosures linked individual experiences to more general axioms, and furthermore, they endorsed views, provided interpretations, and challenged assumptions. Comparative time-framed experience telling enabled a comparison of experiences and individual change processes while simultaneously showing respect for individual differences.

Group members *displayed* their views and beliefs through the four analysed practices. Questions made the speaker's existing knowledge and understanding available for the others and were occasionally a way to challenge the discussed topics. Self-reflective talk was a way to produce interpretations of the discussed topics by connecting details to group members' own experiences. In addition, with self-reflective talk, speakers displayed their orientation to the institutional tasks. With their responses to self-disclosures, speakers displayed epistemic access in various ways, which enabled different levels of privacy and exposure to be handled. Comparative time-framed experience telling displayed independent access and epistemic independence regarding the discussed issues and was a way to show being successful and experienced.

Finally, the group members *addressed* the views and beliefs that were displayed by the other group members through these four analysed practices. Questions explored, and sometimes challenged, the views and claims of the other speaker. Self-reflective talk potentially allowed for comparison of experiences. With their responses to self-disclosures, the group members offered recognition and sharing of experiences and, thus, endorsement for the views of the other. Alternatively, they offered a different perspective, thus challenging the views of the other. In addition, with comparative

time-framed experience telling, group members reinforced and encouraged, or challenged, each other's views by providing personal evidence for and against claims. In doing so, they managed their relationships by showing respect for individual differences.

6.5.2 The management of experience

I synthesise the results of this study into a framework that I call *the management of experience*. I argue that the telling of experiences constitutes a centre of attention around which the group work takes shape.

Figure 2. The management of experience

Figure 2 illustrates the five activities that are accomplished through the analysed practices and that are central to the management of experience. The group members invite each other to tell of their experiences and to elaborate on them. The tellers connect their experiences to the details of the counselling. The experiences and the claims that are based on the experiences are commented upon, also in a critical

manner. The experiences are compared, and their similarities or differences, including the change in experience over time, are addressed. Finally, the experiences are offered and shown to be shared. In the following, final section, I discuss the significance of the findings.

7 DISCUSSION

I argue that the management of experience is a central mode of operation through which the groups work and a potential platform for social influence. The contribution of this study is to re-define and interpret social psychological concepts of group dynamics from an ethnomethodological perspective, and provide a description of group processes in, and through which, the group members endorse and challenge each other, resulting in social support and reflection. These processes potentially support the group members in identifying goals and means for behaviour change and consider them relevant for themselves.

The results contribute to three gaps in knowledge regarding interaction in health promotion groups. Firstly, previous research has focused mostly on the group leaders' actions, leaving aside the initiative and potentially independent role of the group members in participating in the discussions. Secondly, the ways in which the members of health promotion groups bring their own perspectives to the mutual discussion has been addressed in only a few earlier studies. Therefore, the core of talk-based health promotion work – group members bringing up materials, such as their views, beliefs and concerns, to work on together and with the group leader – has been largely unexplored. Thirdly, the interaction between the group members in health promotion groups has rarely been studied, even though it may have significant consequences for how the planned activities of the health promotion intervention unfold and, thus, whether the activities eventually support the institutional aims of the health promotion group in question.

In the following, I discuss the results from the two overarching perspectives of this study: how the groups work and through what kind of interaction process the group members may influence each other. Thereafter, I outline how the ideal of an actively participating, reflecting group member, who offers and receives social support, was actualised in the analysed groups, and suggest some practical implications. Finally, I discuss the limitations of the study and its contribution to social psychology, and present ideas for future research.

7.1 Groups work through the management of experiences

The most common way for group members to participate in group discussions in the data was to follow the group leaders' instructions and to respond to their initiatives. Thus, a prominent role of the group members in discussions was a responsive one. This is not surprising in the light of previous studies that have examined parallel types of group settings and have scrutinised the various ways in which group leaders take responsibility for organising and leading the group activities (Netz, 2016; Pino, 2016b; Tiitinen et al., 2018b; Mondada, 2013; Mondada et al., 2017; Mondada, 2015; Halonen, 2001). The contribution of this study is to describe the nevertheless existing possibilities for group members to take the initiative and independent participatory roles, to bring up their perspectives and to engage in discussions with each other.

This study shows that group members' initiating actions allow for revisiting an earlier topic or bringing forward a specific aspect that has not been prominent in earlier discussion. Furthermore, with initiating actions, the group members manage to bring up alternative perspectives or request clarification of the presented claims. Through their questions, interpretations and telling of experience, group members show their orientation towards the institutional task at hand and, further, engage in discussions by aligning their stance in relation to the stance of others. It has been suggested in earlier literature that group members' initiating actions take place in locations that are significant with regard to the progress of the encounter or the achievement of the institutional aims (Fasulo et al., 2016; Keel & Schoeb, 2017; Halonen, 2002). In the data of this study, the analysed practises usually aligned with the institutional aims with regard to both their topics and actions. The group members showed orientation both to the tasks of the group and to their relationships as members of the group, and accordingly oriented towards task roles and relationship roles (Forsyth, 2014; Benne & Sheats, 1948; Bales, 1950). In other words, the group members adopted such participatory roles they considered relevant in the current interactional context, in relation to the more general task roles and relationship roles, with regard to the intervention and its aims. The task roles and relationship roles and the associated actions were negotiated over and over again in the course of the encounter, and the relevant actions were interpreted in relation to the immediate context.

The speaker roles and participatory roles that the group members took (and that can be interpreted as the relevant role-related actions regarding the group roles), may at times contradict the actual aims of the group. In practice, this means that, in

following a leader-driven participatory framework and adopting a responsive role, the group members accomplish such task-oriented, role-related actions, that are relevant in that immediate context (for example, to participate in a specific assignment or activity), but from a wider perspective, these actions may not support the overall tasks of the group. As Fasulo and Pino (2016) have noted, group work is dependent on the contribution of the group members. If the available participatory roles for the group members are limited to responsive ones, then also the group members' input to group work remains sparse. Hence, the group cannot reach its full working potential.

Moreover, at times, the task roles and relationship roles may be in opposition to each other. The relevant role-related actions with regard to the task roles may pose a threat to the relationships between the participants. Challenging another group member's views, and the disagreements or even the mere argumentation that takes place in group discussions inevitably venture the relationships. This study describes the ways in which the group members do interactional work to maintain their relationships with each other. I suggest that the group members' orientation to addressing and managing the relationships interrelates to cohesion. It seems that, in the analysed health promotion groups, cohesion was formed primarily with regard to the social relationships of the participants. According to earlier literature, one important source of cohesion that strengthens the ties between the group members is the joint task that the group members pursue together (Evans & Jarvis, 1980; Evans & Dion, 1991; Hogg, 1993). Nevertheless, in the health promotion groups analysed in this study, the institutional task of the groups, achieving a healthier lifestyle, is not genuinely a joint task: it is not dependent of the collective effort of all participants. One member may achieve the task, but another may not, and their success is not related to, or dependent on, each other (compared to, for example, a team at work or in sports). Hence, the task itself is not the primary source of cohesion in these groups, but cohesion is dependent on the relationships between the group members. Therefore, addressing and managing the relationships is of particular importance in these groups. This study has shown the ways in which the negotiation of social relationships occurs through joint stance-taking.

The conclusion of this study is that the central mode of operation through which the groups work is the management of experience (see section 6.5.2 for more detailed description). Earlier research on the telling of experiences in various institutional contexts (Kuroshima & Iwata, 2016; Weiste et al., 2015; Lehtinen, 2006; Arminen, 1998; Pollner & Stein, 1996; Voutilainen et al., 2010; Ruusuvuori, 2005) has pointed out the importance of sharing experiences with regard to, on the one hand, managing

the relationships of the participants and, on the other, addressing institutional tasks such as constructing an institutionally relevant identity or establishing a shared understanding of the working problem. For example, in rehabilitation, a recurring pattern of interaction for group members is to display and offer their experiences as relatable and shareable by others (for example Pino, 2017; Halonen, 2002 & 2008; Arminen, 1998 & 2004; Fasulo, 1997). Furthermore, the telling of experiences has been shown to provide evidence for an argument, strengthening the teller's credibility (Heritage, 2011; Kääntä & Lehtinen, 2016; Andersen, 2017). This study adds to that body of knowledge by illustrating the web of activities to which the telling of experiences is a conjunction: inviting, connecting, commenting, comparing, and sharing experiences.

Group work thus evolves around the management of experience. The analytic perspective on participation taken in this study has shown how this becomes possible in interaction: the mutual working of the group members on their experiences is dependent on whether the participation framework enables it. The group setting itself sets some intrinsic challenges that require interactional work from the participants. In dyadic interaction, the speaker roles are quite straightforward: when one person speaks, it inevitably makes the other one the expected listener and the relevant next respondent. In multi-party interaction, the roles are more complex: there can be many options regarding who can be treated as the next relevant speaker and who can take the role of the listener on the side. Furthermore, several people can take, and sometimes compete for, the same role (Sacks, Schegloff & Jefferson, 1974). Hence, the participants in the group need to negotiate and form the participation framework as a basis which they can work from. Previous studies on participation in institutional groups have described the ways in which group leaders invite group members to participate in discussions and allocate turns (for example Tiitinen et al., 2018b; Pino, 2016b & 2014; Valkeapää et al., 2018). In this study, I have shown how group members themselves shift the participatory roles and steer the discussions and, in so doing, evoke opportunities for mutual discussion between the group members on topics that they consider to be relevant.

7.2 Group members influence each other through stance-taking

This study has described the central processes in health promotion group interaction that are significant regarding the mechanisms of social influence; namely, the ways in which group members endorse and challenge each other's views. By emphasising

the joint process of stance-taking, the results illustrate the indirect and implicit negotiations that take place in social interaction, which have received less attention in the previous research and theory regarding social influence. Findings contribute to the gap in knowledge concerning the mechanisms of conformity in the process of interaction.

The results show that, in health promotion groups, the management of experience is a specific context in which stance-taking takes place. Previous research on stance-taking has shown how stance-taking is a joint achievement of the participants focusing on, for example, assessment sequences, reported speech and question-answer –sequences (for example Goodwin & Goodwin, 1992; Clift, 2000; Niemelä, 2005; Haddington, 2006; Keisanen, 2006; Tainio & Laine, 2015). This study has analysed stance-taking in the array of activities that unfold around the management of experience and, thus, widens the body of knowledge on the joint process of stance-taking. The results support the theoretical framework on stance, 'the stance-triangle', developed by Du Bois (2007). The framework illustrates the three dimensions of stance-taking: the evaluation of the stance object, the positioning of the individual participants in relation to the stance object, and the alignment of the positionings of the participants (ibid.). This study shows in detail the various ways in which the participants produce the similarity and difference of their stance and, in so doing, produce the convergent or divergent alignment of their positionings in relation to each other.

The contribution of this study is to show how, through stance-taking, the group both takes into account and establishes contextually relevant moral, values and ideals. The practices of participation enable and produce stance-taking, resulting in group members endorsing and challenging each other's views. Figure 3 is a synthesis of the findings and illustrates the centrality of stance-taking in the process through which the group members influence each other. Through that process, the group produces mutual social support and reflection.

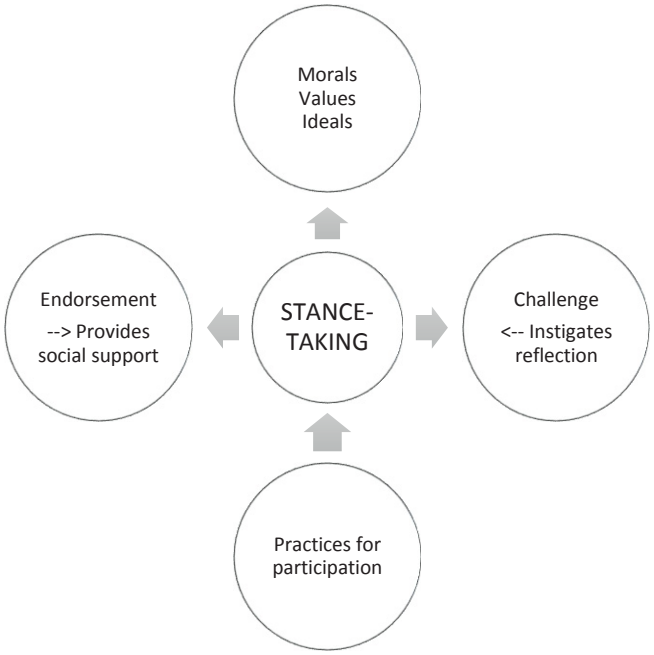

Figure 3. Stance-taking as a central feature in the process of social influence.

I argue that stance-taking is a critical moment in interaction through which significant activities, with regard to the mechanisms of conformity, emerge. The prerequisite for them to emerge is that the participation framework enables discussions between group members. The vast body of previous research on social influence has distinguished the mechanisms of conformity: 1) informational influence, that is, the validation of perceptions and attitudes; 2) normative influence, that is, the expectations and social sanctions concerning conduct; and 3) referent informational influence, that is, conformity through self-categorisation and identification with particular characteristics of a category) (Deutsch & Gerard, 1955; Turner, 1982, 1991). In the analysis I have described the ways in which these mechanisms unfold in my data, and the findings are in line with the notion of Price et al. (2006) that agreement, disagreement and comparison are the points of departure for social influence. The contribution of this study is to show in detail the practices in, and through which, the process of joint stance-taking is managed by the participants and, consequently, through which the mechanisms of conformity take shape; namely, asking questions, providing interpretations and telling of experiences.

While most of the informational influence in the analysed groups was provided by the group leaders – and they are indeed requested to do so, as shown in Article 1

– the group members also validate and challenge each other's perceptions. Firstly, the group members answer some of the other members' questions that seek information. Secondly, the group members validate each other's perceptions by displaying that they share a similar experience and further, a similar stance. Thirdly, by asking questions and responding to each other's telling with a disagreeing response, the group members challenge the stance and the grounds of reasoning of their peers, thus offering new perspectives. This can be done also with responses that describe the details of their own experience that are different from the experiences told by the other group member – and, again, emphasise the difference of the stances.

The practices of displaying the similarity and differences of experiences and the associated stances are also integral to the formation of normative influence in my data. Normalising the experience of an individual and showing that the others share a similar experience and an associated stance is a key feature in the emergence of local group norms. Furthermore, the telling of experiences elaborates the process of change which the tellers personally can witness, both in terms of a change in their behaviour and a change in their stance. Thus, it provides examples of success and positive role models regarding the process of change. However, the group members can also support and endorse the views that emphasise the negative aspects of the change process by aligning with the negative stance.

Furthermore, the process of joint stance-taking forms a foundation for referent informational influence. By aligning their stance with the stance of their peers, the group members participate in creating shared ideals concerning what kind of activities are possible, necessary, desirable, reasonable or useful with regard to the institutional goal: a healthy lifestyle. As a result of these interactional practices, a 'prototype' of a health promotion group member emerges, to which group members can assimilate through self-categorisation and can identify themselves with the characteristics of the 'prototype'.

Hence, in this study I have formed a re-defined perception of social influence: it is not so much unidirectional influence from a person to another, but a joint process, in which negotiations of morality are central. This study shows that practices of participation and stance-taking reflect and produce morality: what it means to be a rational and responsible agent regarding health and health behaviour (see also Edwards, 2007). Morality is an interactional achievement and the results show that the group members orient to displaying rationality and responsibility with regard to their own health and lifestyle. Similarly, as Wiggins (2009) has shown, health promotion group members orient to being accountable for their health behaviour

and their health-related knowledge and conduct (or lack of them), and strive to show their rationality concerning their conduct (see also Barnes & Moss, 2007; Webb, 2009). This study points out how the group members 'talk into being' the values and ideals attached to a healthy lifestyle and to the process of health behaviour change. Through subtle means, the group members show that they are capable of understanding the risks of unhealthy lifestyles and their need to change their behaviour. Furthermore, the group members show that they are willing and able to carry out the recommended health-related activities even, and especially, when they have not actually undertaken any of those activities yet. In their talk, group members take into account both the management and reproduction of values that may be attached to topics of health and healthy living. In sum, the analysed practices of participation and stance-taking invoke ideals of what kind of health-related outcomes and activities the participants consider useful, desirable and available – and to whom, and under what terms, they are considered to be so. These may also have unwanted consequences regarding the aims of the intervention, which I will discuss next.

7.3 The institutional ideals and aims actualise in group interaction

This study has concentrated on interaction in group interventions for health promotion and asked how health promotion activities enable and support the participation of the group members, the emergence of reflection and social support in the group and, thus, the clients' empowerment to take responsibility for their own health. In this section, I discuss the results in relation to these institutional ideals. Thereafter, I present some practical implications.

This study has shown what kind of patterns of interaction group members' active participation consist of: namely, group members ask questions, provide interpretations of discussed issues and tell of their experiences. These patterns of interaction make group members' views and experiences available for the group, providing material for the group members to reflect upon, and give social support. Furthermore, they make the group members' views explicit to the leader, who can then adjust the topics and activities of the intervention to better suit the needs of the participants. Nevertheless, the prominent leader-driven participatory framework that is based on a group leader's recurring questions offers the group members an easy, passive role. Hence, to take an active role may require additional interactional work

from the group members (See Peräkylä & Silverman, 1991; Peräkylä & Ruusuvuori, 2007).

Reflection is a complex phenomenon that interactional practices may support or constrain. Following the theories of reflective processing (Boud et al., 1996; Dewey, 1933; Mezirow, 1990, 1998), I connect the practices of participation to the three phases of reflective processing: returning to an experience, attending to feelings, and re-evaluation. Group members compare and evaluate their own behaviour and volunteer stories about their experiences. In so doing, they connect details of their own life with issues discussed in health promotion. Hence, these practices offer a starting point for returning to experience, because they open discussion on particular topics and display to others how the speakers consider them to be relevant in their own life. The second phase of reflective processing, attending to feelings, may be accomplished through the management of experience when the participants comment on and compare the experiences, and show that the experiences are shared. Finally, the management of experience, through elaboration and comparison, may result in the re-evaluation of the experiences.

The functions of social support: emotional support, informational support and companionship, can as well be achieved in discussions between the group members. The key feature in offering emotional support is empathy (Cohen & Syme, 1985; Shumaker & Brownell, 1984; Vaux, 1988). The recurrent practices for showing empathy in health promotion groups involve telling of similar experiences and producing subtler displays of sharing a similar experience, which show understanding of the described experience and acceptance of it through normalisation. Telling of personal experiences (whether initially or in response to another group member's telling) is a display of trust and it creates and reinforces intimacy between the participants. To show that the experiences and problems of an individual are familiar to other participants, and that they have found ways to overcome them, offers encouragement. As the results show, participants could imitate the actions of the group leader and thus 'do counselling'. By asking questions, they could give advice or provide suggestions to the other participants. By describing their own activities, they offered guidance by modelling positive behaviour and tying the topics of the counselling to aspects of their own lives. Thus, asking questions and responding to other group members' turns provided informational support that helps in problem solving. The third function of social support, companionship, was achieved by showing that problems were recognised and shared: the participants faced similar challenges and struggled together to find solutions. One feature of talk that emphasised this was the use of a 'zero-person': a specific Finnish linguistic

construction that was used recurrently throughout the data. It offers the described activities to be shared by omitting the subject (Laitinen, 2006; VISK § 1347-1365). In addition to this, companionship was offered in more explicit ways by stating and evidencing the similarity of experiences.

The results of this study have described the group processes that play a role in achieving the institutional aims and ideals of the health promotion groups. Thus some practical implications can be suggested. The management of experiences is a resource that is generally not available for the group leader in a similar way as it is for the group members. Being able to recognise the patterns of interaction described above helps group leaders to understand the social process that may contribute to different health-related issues becoming valuable and meaningful for people. Consequently, it helps group leaders to organise their own activities in such ways that they do not unintentionally restrict the management of experience by the group members. Nevertheless, in the data, it was clear that sometimes the group members endorsed views and suggestions that were not in line with the institutional goals, and reinforced perceptions and ideals that may be harmful with regard to achieving the institutional tasks of a healthier lifestyle. Observing the occurrence of active participation, and determining the valence of the stance that the group members take in relation to the institutional goals, helps group leaders to decide when to provide space for member-driven discussion, and when it is necessary to intervene and redirect the discussion by providing a professional's view. In practice, this means letting the group members talk, unless it is necessary to correct a misunderstanding or challenge a perception they have formed.

Health promotion comprises of complex and multifaceted tasks, and leading a health promotion group requires complex skills and interactional competence: leaders are required to be attentive, approving and empathetic, but also firm and able to instruct and confront clients without being overwhelming or unsupportive. Furthermore, it is advocated that health promotion activities should be carried out in such ways that generate participation and mutual discussion, support reflection among the participants and engage with their personal experiences. (Jensen, McAuliffe et al., 2015; Gable & Herrmann, 2015; Maruniakova et al., 2017; Vallis, 2013; Førland et al., 2016.) Because talk is the most important tool of health promotion, interaction skills are crucial in the training of professionals. Training programmes have utilised simulations and standardised patients (Schwartz et al., 2015; Holt et al., 2013), and fabricated examples that are based on clinical experience, to demonstrate practices (Geiger, 2018), but their validity in capturing the real-life interactional phenomena has been questioned (Stokoe, 2013). Instead, observation

and systematic analysis of authentic interaction provides detailed descriptions of professional practices, evidence of best practices (Fasulo & Pino, 2016; Kiyimba & O'Reilly, 2016; Bray, 2013), and adds a new dimension to the understanding of professional practices (Peräkylä & Vehviläinen, 2003). This study has provided an evidence-based description of the interactional practices that can support the goals of health promotion interventions.

7.4 Limitations of the study and ideas for future research

This study has observed group members' discussions in naturally-occurring interaction and analysed them as a phenomenon in its own right. The core principle of both CA and DP is that the analysis has to be grounded in the data: the analyst's interpretations have to be based on observations from the data, which show how the participants themselves orient to, and make sense of, the actions in interaction. This principle has guided my work throughout the study, but I acknowledge that there have been some challenges along the analytic process. The essential procedure for ensuring that the findings are genuinely grounded in the data is the 'next-turn proof procedure'. It means that, in order for a researcher to be able to claim that a specific action, such as a challenge, can be interpreted as such, it is necessary to prove that the participants indeed treat it as such. (Peräkylä, 2011.) In most cases throughout the analysis, this has been possible. However there were some instances where the participants' interpretations of the specific ongoing actions were rather vague or hard to determine. Due to the multi-party nature and the rapid progress of the agenda of the groups, the discussion could swiftly veer in other directions and, therefore, the actions in analytic focus did not always receive a response that could be claimed as strong 'next turn proof'. Nonetheless, I have strived to produce a transparent description of the findings in the articles, which enables the readers to evaluate the analytic interpretations.

Another possible limitation is that, since the analysed data are from three specific Finnish interventions, it could be argued that the results are not generalisable to any other setting. This analysis provides no evidence of how common the analysed practices are in general in the field of health promotion, or if some of them are more culture-specific than others. For example, in some contexts or cultures, it might be considered inappropriate to challenge someone's private experience in the way that has been described in this study. Furthermore, it is not self-evident that all professionals who plan and execute health promotion activities share the ideal of

health promotion as an empowering process. Instead, they might engage more with the information delivery and solution orientation ethos of their work. This may well be the reason why some group leaders in the data adhered to practices that retained the group leaders' control over discussion, instead of adopting practices that enable member participation, and thus, may explain the relatively low frequency of some of the analysed practices. Nevertheless, it has been possible to observe group members' active participation and stance-taking, and thus show that these practices are possible in these types of context. Furthermore, through careful analysis of the details of talk, this study has shown how these practices are made available by the participants themselves (see Peräkylä, 2011). Therefore, the results add up to the cumulative formation of knowledge about patterns of interaction in institutional health promotion groups and can be discussed with regard to other, parallel settings.

Out of this study, some ideas for future research arise. Firstly, the conceptual framework I have synthesised out of the results of this study, the management of experience, could be examined in relation to the longitudinal process of group work. The presupposition for group work is that the group evolves during the intervention process, both in terms of its formation as a group and in terms of the actual aims of the group intervention. Longitudinal analysis of the data could reveal trajectories of interaction which may lead, on the one hand, to the emergence of active participation of the group members that supports the aims of the intervention. On the other hand, it could reveal trajectories of interactions that may lead to group members withdrawing from active participation, or participating in such ways that eventually hinder the aims of the intervention. It is likely that group leaders' actions and the type of group activities and assignments play a role in the formation of these trajectories. Hence, further research could provide new insights into how group leaders can manage group discussions and enable them to reach their full potential.

Secondly, there is little knowledge on the management of cohesion in health promotion groups. Lepper and Mergenthaler (2005) have attempted to operationalise it via topic coherence: the features of interaction through which speakers tie the topics of their turns to the previous speakers' turns are suggested to be one way that has impact on group cohesion. This study has described how speakers connect their talk, via stance-taking, with the other group members' talk. Thus, this study provides means for operationalising the management of cohesion and could thus open up directions for studying cohesion in real-life settings.

Thirdly, as I have suggested earlier, managing conflict is an integral part of the management of cohesion. The ways in which group members managed conflict in this data seemed to be working quite well: no overt conflict occurred and

disagreements were settled easily, due to the ways in which participants displayed that they took into account and respected differing views. Nevertheless, the group leader may play an important role in managing conflict, and that could be examined further. Conflict and its management are interesting topics for further research, both in terms of ethnomethodological research on interaction and social psychology in general.

Finally, the management of experience could be approached from a more general viewpoint, not limited to the institutional context of the interaction, with an attempt to form a more profound theory on what experience is, and how it is managed in interaction: how knowledge and affect are intertwined in the management of experience.

Throughout its history, social psychology has had a special interest in social influence; that is, the impact people have on each other. In research on social influence, there is a long tradition of experimental research, whether in the field, in settings that simulate real life encounters or in laboratory, such as the classical studies (Asch, 1952; Sherif, 1936; Milgram, 1963; and Haney, Banks & Zimbardo, 1973, being the most famous) and several more recent experimental studies (for example Nolan et al., 2008; Lowery et al., 2001; Salganik et al., 2006). While the vast body of research on social influence has affirmed that peoples' perceptions, attitudes and behaviours are indeed strongly shaped by other people, it has rarely been able to describe the subtle processes through which that influence takes place. Social influence is not simply an input-output issue—not even in a laboratory as, for example, the analysis of the original recordings that were made in the Milgram experiments shows: people do interactional work to negotiate, to validate and to resist the demands (Hollander, 2015; Hollander & Maynard, 2016). In this study I have provided an illustration of the interactional work group members do in negotiating, validating and resisting the institutional aims of the health promotion intervention they participate in and, hence, influence each other.

The abovementioned aspects are, of course, the constitutive point of departure in ethnomethodology. This study joins an emerging trend of research (Price et al., 2006; Hepburn & Potter, 2011; Hollander, 2015; Hollander & Maynard, 2016; Pino, 2017; Humă, 2018) that introduces the possibilities that ethnomethodology offers for basic research on the central themes of social psychology; namely, group dynamics and social influence.

REFERENCES

Andersen, E. M. (2017). Typing yourself accountable: Objectifying subjective experiences in an online health forum. *Linguistik Online*, vol. 87, no. 8.

Anderson, R. S., & Levitt, D. H. (2015). Gender self- confidence and social influence: Impact on working alliance. *Journal of Counseling & Development*, *93*(3), 280-288.

Antaki, C. ed., (2011). *Applied conversation analysis: Intervention and change in institutional talk*. Basingstoke: Palgrave Macmillan.

Antaki, C., Barnes, R., & Leudar, I. (2005). Self-disclosure as a situated interactional practice. *British Journal of Social Psychology,* 44(2). 181-199.

Arminen, I. (1998). Organization of participation in the meetings of Alcoholics Anonymous. *Issues in Applied Linguistics*, vol. 9, no. 2, pp. 59-98.

Arminen, I. (1998). Sharing experiences: Doing therapy with the help of mutual references in the meetings of Alcoholics Anonymous. *The Sociological Quarterly*, *39*(3), 491-515.

Arminen, I. (2004). Second stories: The salience of interpersonal communication for mutual help in Alcoholics Anonymous. *Journal of Pragmatics*, 36(2), 319-347.

Asch, S. E. (1952). Group forces in the modification and distortion of judgments. In S. E. Asch, *Social Psychology* (450-501). Englewood Cliffs, NJ, US: Prentice-Hall Inc. http://dx.doi.org/10.1037/10025-016

Austin, J. L. (1962). *How to do things with words: The William James lectures delivered at Harvard University in 1955*. London: Oxford University Press.

Bales, R. F. (1950). *Interaction process analysis; a method for the study of small groups*. Oxford, England: Addison-Wesley.

Barnes, R. & Moss, D. (2007). Communicating a feeling: the social organization of `private thoughts'. *Discourse Studies*, 9(2), 123–148. https://doi.org/10.1177/1461445607075339

Barnes, S. (2011). Claiming mutual stance: On the use of 'that's right' by a person with aphasia. *Research on Language and Social Interaction*, vol. 44, 359-384.

Benne, K. D. & Sheats, P. (1948). Functional roles of group members. *Journal of Social Issues*, 4(2), 41-49. http://dx.doi.org/10.1111/j.1540-4560.1948.tb01783.x

Biddle, B. J. (1986). Recent Developments in Role Theory. *Annual Review of Sociology, 1986* 12:1, 67-92

Borek, A. J. & Abraham, C. (2018). How do Small Groups Promote Behaviour Change? An Integrative Conceptual Review of Explanatory Mechanisms. *Applied Psychology, Health and Wellbeing*, 10 1, 30-61.

Boström, E., Isaksson, U., Lundman, B., Graneheim, U. H., & Hörnsten, Å. (2014). Interaction between diabetes specialist nurses and patients during group sessions about self-management in type 2 diabetes. *Patient Education and Counseling*, Volume 94, Issue 2, 2014, 187-192, ISSN 0738-3991, https://doi.org/10.1016/j.pec.2013.10.010. (http://www.sciencedirect.com/science/article/pii/S0738399113004515)

Boud, D., Keogh, R. and Walker, D. (1996). Promoting reflection in learning: a model. In: R. Edwards, A. Hanson, & P. Raggatt. (Eds), *Boundaries of Adult Learning* (32–56). New York: Routledge.

Bray, D. R. (2013). Advancing a nutrition counseling session: Using video modules to enhance critical counseling skills. *Journal of the Academy of Nutrition and Dietetics*, 113(9), A49. doi:10.1016/j.jand.2013.06.169

Chevalier, F. H. G. & Moore, J. (Eds.), (2015). *Producing and Managing Restricted Activities: Avoidance and withholding in institutional interaction*. Amsterdam/Philadelphia: John Benjamins.

Chow, R. et al. (2017). Does Physical and Health Education Classes Improve Physical Fitness? *International Journal on Disability and Human Development,* 16.2 (2017), 171-8.

Cialdini, R. B. & Goldstein, N. J. (2004). Social Influence: Compliance and Conformity. *Annual Review of Psychology, 2004* 55:1, 591-621

Clift, R. (2000). Stance-taking in reported speech. *Essex Research Reports in Linguistics* 32, University of Essex.

Clift, R. (2006). Indexing stance: Reported speech as an interactional evidential. *Journal of Sociolinguistics*, vol. 10, no. 5, 569-595.

Cohen, S. E. & Syme, S. L. (1985). *Social support and health*. San Diego, CA, US: Academic Press.

Collins, S., Britten, N., Ruusuvuori, J. & Thompson, A. (Eds.), (2007). *Patient participation in health care consultations: Qualitative perspectives*. New York, McGraw Hill.

Collins, S., Britten, N., Ruusuvuori, J., & Thompson, A. (2007). Understanding the process of patient participation. In: *Patient participation in health care consultations: Qualitative perspectives*, New York, McGraw Hill, 3-21.

Corrigan, J. D., Dell, D. M., Lewis, K. N., & Schmidt, L. D. (1980). Counseling as a social influence process: A review. *Journal of Counseling Psychology*, *27*(4), 395.

Counselling (n.d.). In A. M. Colman (Ed.) (2015b). *A Dictionary of Psychology* (4th ed.). London: Oxford University Press.

Counselling (n.d.). In E. A. Martin & T. A. McFerran (Eds.) (2014). *A Dictionary of Nursing* (6th ed.). London: Oxford University Press.

Counselling (n.d.). In E. Martin (2015a), *Concise Medical Dictionary* (9th ed.). London: Oxford University Press.

Counselling (n.d.). In J. Harris & V. White (2013). *A Dictionary of Social Work and Social Care* 1st ed. London: Oxford University Press.

Couper-Kuhlen, E. (2012). Exploring affiliation in the reception of conversational complaint stories. In M-L. Sorjonen & A. Peräkylä (Eds.), *Emotion in Interaction* (113–146). London: Oxford University Press.

David, B., & Turner, J. C. (2001). Majority and minority influence: A single process self-categorization analysis. In C. K. W. De Dreu & N. K. De Vries (Eds.), *Group consensus and minority influence: Implications for innovation* (91-121). Malden: Blackwell Publishing.

Deppermann, A. (2014). Multimodal Participation in Simultaneous Joint Projects: Interpersonal and Intrapersonal Coordination in Paramedic Emergency Drills. In P. Haddington, T. Keisanen, L. Mondada, & M. Nevile (Eds.), *Multiactivity in Social Interaction: Beyond Multitasking* (247–282). Amsterdam: John Benjamins.

Deutsch, M. & Gerard, H. B. (1955). A study of normative and informational social influences upon individual judgment (PDF). *Journal of Abnormal and Social Psychology*. 51 (3), 629–636. doi: 10.1037/h0046408. PMID 13286010.

Dewey, J. (1933). *How We Think: A Restatement of the Relation of Reflective Thinking to the Educative Process*. Lexington: DC Heath and Company.

Dorn, F. J. (1984). The social influence model: A social psychological approach to counseling. *The Personnel and Guidance Journal*, *62*(6), 342-345.

Drew, P. & Heritage, J. (1992). Analysing talk at work: an introduction. In P. Drew, & J. Heritage (Eds.), *Talk at work: interaction in institutional settings* (3-65). Cambridge: Cambridge University Press.

Drew, P. & Heritage, J. (Eds.). (1992). *Talk at work: Interaction in institutional settings*. Cambridge: Cambridge University Press.

Drew, P. (2003). Comparative analysis of talk-in-interaction in different institutional settings: A sketch. In P. Glenn, C. D. LeBaron, & J. Mandelbaum (Eds.), *Studies in Language and Social Interaction: In honor of Robert Hopper* (293-308). Mahwah, NJ, Lawrence Erlbaum.

Du Bois, J. W. (2007). The stance triangle. In R. Englebretson (Ed.), *Stancetaking in discourse: Subjectivity, evaluation, interaction*, (139-182). Amsterdam: John Benjamins.

Du Bois, J.W. & Kärkkäinen, E. (2012). Taking a stance on emotion: affect, sequence, and intersubjectivity in dialogic interaction. *Text* & *Talk*, 32(4): 433-451.

E. Clayman, S. E. & Heritage, J. (2014). Benefactors and beneficiaries: Benefactive status and stance in the management of offers and requests. In P. Drew & E. Couper-Kuhlen, (Eds.), *Requesting in Social Interaction* (55-86). Amsterdam: John Benjamins Publishing Company, no. 26.

Edwards, D. & Potter, J. (1992), *Discursive Psychology*. London: Sage.

Edwards, D. & Potter, J. (1993). Language and Causation: A Discourse Analytical Approach to Description and Attribution. *Psychological Review*, vol. 100, no. 1, 23-41.

Edwards, D. & Potter, J. (2005). Discursive psychology, mental states and descriptions. In H. Molder & J. Potter (Eds.), *Talk and Cognition: Discourse, Mind and Social Interaction* (pp. 241-259). Cambridge University Press, Cambridge.

Edwards, D. & Potter, J. (2005.) Discursive psychology, mental states and descriptions. In H. Molder, H. & J. Potter (Eds.), *Conversation and Cognition* (241-259). New York: Cambridge University Press.

Edwards, D. (2007). Managing subjectivity in talk. In A. Hepburn and S. Wiggins (Eds.), *Discursive Research in Practice: New Approaches to Psychology and Interaction* (31–49). Cambridge: Cambridge University Press.

Engelund, G., Møller Hansen, U., & Willaing, I. (2014). 'The Health Education Juggler': Development of a Model Describing Educator Roles in Participatory, Group-Based Patient Education. *Health Education,* 114.5 (2014), 398.

Evans, N. J. & Jarvis, P. A. (1980). Group Cohesion: A Review and Reevaluation. *Small Group Behavior*, 11(4), 359–370. https://doi.org/10.1177/104649648001100401

Fasulo, A. & Pino, M. (2016). Sharing Knowledge and Shaping Identities in Healthcare Interactions. *Patient Education and Counseling,* 99.6 (2016), 875-7.

Fasulo, A. (1997). Other voices, other minds: The use of reported speech in group therapy talk". In L. Resnick, R. Saljo, C. Pontecorvo, & B. Burge, (Eds.), *Discourse, tools and reasoning: Essays on Situated Cognition* (203-223). Berlin: Springer-Verlag.

Fasulo, A., Zinken, J., & Zinken, K. (2016). Asking 'what about' questions in chronic illness self-management meetings. *Patient Education and Counseling*, 99 (2016), 917–925.

Fertman, C. I. (2015). *Workplace Health Promotion Programs: Planning, Implementation, and Evaluation*. 1st ed. San Francisco, California: Jossey-Bass.

Fielding, J. E. (2013). Health Education 2.0: The Next Generation of Health Education Practice. *Health Education* & *Behavior,* 40.5 (2013), 513-9.

Ford, C. E. (2010). Questioning in meetings: Participation and positioning. In A. F. Freed & S. Ehrlich, (Eds.), *Why do you ask: The function of questions in institutional discourse* (211-234). Oxford: Oxford University Press.

Førland, G. et al. (2016). Searching and Dealing, Confirmation and Feeling–Participants' Approaches to Learning in a Health Education Setting. *Health Education Journal,* 76.3, 326-36.

Forsyth, D. R. (2000). The social psychology of groups and group psychotherapy: One view of the next century. *Group,* 24, 147-155.

Forsyth, D. R. (2014). *Group Dynamics* (6th, international ed.). Belmont, CA: Wadsworth Cengage Learning

Freeman, R., et al. (2016). School-Based Health Education Programmes, Health-Learning Capacity and Child Oral Health–related Quality of Life. *Health Education Journal,* 75.6 (2016), 698-711.

Gable, J. & Herrmann, T. (2015). *Counselling Skills for Dietitians* (3rd ed.). West Sussex, England: Wiley Blackwell.

Gardner, R. (2001). *When listeners talk: Response tokens and listener stance.* Amsterdam: John Benjamins.

Gardner, R. (2015). Summons turns: The business of securing a turn in busy classrooms. In *International Perspectives on ELT Classroom Interaction* (pp. 28-48). Palgrave Macmillan, London.

Geiger, P. (2018). *Intentional Intervention in Counseling and Therapy: Goals and Process in Client Engagement*. New York: Routledge.

Gibson, D. R. (2000). Seizing the Moment: The Problem of Conversational Agency. *Sociological Theory*, vol. 18, no. 3, 368-382.

Gibson, D. R. (2003). Participation Shifts: Order and Differentiation in Group Conversation. *Social Forces,* 81.4 (2003), 1335-80.

Gibson, D. R. (2005). Taking Turns and Talking Ties: Networks and Conversational Interaction. *American Journal of Sociology*, vol. 110, no. 6, 1561–1597.

Gibson, D. R. (2010). Marking the Turn: Obligation, Engagement, and Alienation in Group Discussions. *Social Psychology Quarterly*, vol. 73, no. 2, 132-151.

Glenn, P. (2010). A Mediator's Dilemma: Acknowledging or Disregarding Stance Displays. *Negotiation Journal*, vol. 26, no. 2, 155–162.

Goffman, E. (1981*). Forms of Talk.* Oxford: Basil Blackwell.

Goodwin, C. & Goodwin, M. H. (1992). Assessments and the construction of context. In A. Duranti & C. Goodwin (Eds.), *Rethinking context: Language as an interactive phenomenon*, 147–190. Cambridge: Cambridge University Press.

Goodwin, C. & Goodwin, M. H. (2004). Participation. In A. Duranti (Ed.), *A Companion to Linguistic Anthropology* (222–244). Oxford: Blackwell.

Goodwin, C. (1984). Notes on story structure and the organization of participation. In J. M. Atkinson & J. Heritage (Eds.), *Structures of social action: Studies in Conversation Analysis* (225–246). London: Cambridge University Press.

Goodwin, C. (1986). Audience Diversity, Participation and Interpretation. *Text*, vol. 6, no. 3, 283–316.

Goodwin, C. (2007). Participation, Stance, and Affect in the Organization of Activities. *Discourse and Society*, vol. 18, no. 1, 53–73.

Goodwin, C. (2013). The co-operative, transformative organization of human action and knowledge. *Journal of Pragmatics*, Elsevier B.V., vol. 46, no. 1, 8–23.

Goodwin, M. H. (1998). Games of Stance: Conflict and Footing in Hopscotch. In S. M. Hoyle & C. T. Adger, (Eds.), *Kids' Talk: Strategic Language Use in Later Childhood* (23–46). New York: Oxford University Press.

Goodwin, M. H. (2006). *The Hidden Life of Girls: Games of Stance, Status, and Exclusio*n. Malden, MA: Blackwell, 344.

Goodwin, M. H., Cekaite, A., Goodwin, C., & Tulbert, E. (2012). Emotion as stance. In A. Peräkylä & M. L. Sorjonen, (Eds.), *Emotion in Interaction* (16-41). New York, Oxford University Press.

Haddington, P. (2004). Stance taking in news interviews. *SKY Journal of Linguistics*, vol. 17, 101-142.

Haddington, P. (2006). The organization of gaze and assessments as resources for stance taking. *Text* & *Talk*, vol. 26, no. 3, 281–328.

Hakulinen, A. & Sorjonen, M. L. (2011). Ways of agreeing with negative stance taking. In T. Stivers, L. Mondada, & J. Steensig, (Eds.), *The Morality of Knowledge in Conversation (*235-256). Cambridge: Cambridge University Press.

Halonen, M. (2001). *Terapeutti elämäkerran tulkitsijana myllyhoidon ryhmäterapiassa*. [Therapist as the interpreter of life stories in Minnesota model group therapy.] In J. Ruusuvuori, M. Haakana & L. Raevaara (Eds.), *Institutionaalinen vuorovaikutus. Keskustelunanalyyttisia tutkimuksia* [*Institutional interaction: Studies in conversation analysis*], (62–81). Helsinki: Finnish Literature Society.

Halonen, M. (2002). Kertominen terapian välineenä. Tutkimus vuorovaikutuksesta myllyhoidon ryhmäterapiassa. [Telling as a device for therapy. Study on interaction in 'Minnesota' group therapy for addiction.] Suomalaisen Kirjallisuuden Seura, Helsinki.

Halonen, M. (2006). Life stories used as evidence for the diagnosis of addiction in group therapy. *Discourse* & *Society*, vol. 17, 283-298.

Halonen, M. (2008). Person reference as a device for constructing experiences as typical in group therapy. In A. Peräkylä, C. Antaki, S. Vehviläinen, & I. Leudar (Eds.), *Conversation Analysis and Psychotherapy*, (139–151). Cambridge: Cambridge University Press.

Haney, C., Banks, C., & Zimbardo, P. (1973). Study of prisoners and guards in a simulated prison. *Naval Research Reviews*, 26(9), 1-17.

Health Education (n.d.). In E. Martin & T. McFerran (Eds.), (2014). *A Dictionary of Nursing*. Oxford, UK: Oxford University Press. Retrieved 8 Feb. 2019, from http://www.oxfordreference.com/view/10.1093/acref/9780199666379.001.0001/acref-9780199666379-e-3893.

Health Education (n.d.). In E. Martin (Ed.), (2015). *Concise Medical Dictionary*. Oxford, UK: Oxford University Press. Retrieved 8 Feb. 2019, from http://www.oxfordreference.com/view/10.1093/acref/9780199687817.001.0001/acref-9780199687817-e-4363.

Health Education (n.d.). In M. Porta (Ed.), (2014). *A Dictionary of Epidemiology*. Oxford, UK: Oxford University Press. Retrieved 8 Feb. 2019, from http://www.oxfordreference.com/view/10.1093/acref/9780199976720.001.0001/acref-9780199976720-e-896.

Heath, C., vom Lehn, D., & Osborne, J. (2005). Interaction and interactives: Collaboration and participation with computer-based exhibits. *Public Understanding of Science*, vol. 14, no. 1, 91-101.

Heinemann, T. (2009). Participation and exclusion in third party complaints. *Journal of Pragmatics*, vol. 21, no. 12, 2435-2451.

Hendry, G., Wiggins, S., & Anderson, T. (2015). "That's me being stupid": Using discursive psychology to analyse self-deprecating humour as a means of constructing group cohesion in PBL. *Global Research Community: Collaboration and Developments*, 70.

Hennoste, T., Rääbis, A., & Laanesoo, K. (2017). Polar questions, social actions and epistemic stance. *STUF - Language Typology and Universals*, vol. 70, no. 3.

Hepburn, A. & Potter, J. (2011). Threats: Power, family mealtimes, and social influence. *British Journal of Social Psychology*, vol. 50, no. 1, 99-120.

Heppner, P. P., & Claiborn, C. D. (1989). Social influence research in counseling: A review and critique. *Journal of counseling psychology*, *36*(3), 365.

Heritage, J (1984). *Garfinkel and Ethnomethodology*. Cambridge: Polity Press.

Heritage, J. (1997). Conversation analysis and institutional talk: analysing data. In D. Silverman, (Ed.). *Qualitative research: Theory, method and practice* (161-82).London: Sage Publications.

Heritage, J. (2011). Territories of knowledge, territories of experience: empathic moments in interaction. In T. Stivers, L. Mondada, & J. Steensig. *The morality of Knowledge in Conversation* (159-183) Cambridge University Press.

Herrle, M. (2015). Availability stances in classroom openings. In *Aufmerksamkeit* (pp. 265-283). Springer VS, Wiesbaden.

Hogg, M. A. (1993). Group cohesiveness: A critical review and some new directions. *European Review of Social Psychology*, 4(1), 85-111.

Hollander, M. M. & Maynard, D. W. (2017). Do Unto Others . . . ? Methodological Advance and Self- Versus Other-Attentive Resistance in Milgram's 'Obedience' Experiments, *Social Psychology Quarterly*, vol. 79, no. 4, 355-375.

Hollander, M. M. (2015). The repertoire of resistance: Non-compliance with directives in Milgram's 'obedience' experiments. *British Journal of Social Psychology*, vol. 54, no. 3, 425–444.

Holt, R. L., Tofil, N. M., Hurst, C., Youngblood, A. Q., Peterson, D. T., Zinkan, J. L., White, M. L., Clemons, J. L., & Robin, N.H. (2013). Utilizing high-fidelity crucial conversation simulation in genetic counseling training. *American Journal of Medical Genetics, Part A*, 161(6), 1273-1277.

Hughes, S., Lewis, S., Willis, K., Rogers, A., Wyke, S., & Smith, L. (2017). The experience of facilitators and participants of long term condition self-management group programmes: A qualitative synthesis. *Patient Education and Counseling*, Volume 100, Issue 12, 2017, Pages 2244-2254, ISSN 0738-3991, https://doi.org/10.1016/j.pec.2017.06.035. (http://www.sciencedirect.com/science/article/pii/S073839911730383X)

Humă, B., Stokoe, E., & Sikveland, R. O. (2019). Persuasive Conduct: Alignment and Resistance in Prospecting "Cold" Calls. *Journal of Language and Social Psychology*, *38*(1), 33-60.

Jacknick, C. M., Avni, S. (2017). Shalom, bitches: Epistemic stance and identity work in an anonymous online forum. *Discourse, Context & Media*, Elsevier BV, vol. 15, 54–64.

Jacobs E., Masson R. L., Harvill R. L. (2009). *Group Counseling: Strategies and Skills*. Thomson Higher Education, Brooks/Cole, Belmont.

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. Lerner, (Ed.), *Conversation Analysis: Studies from the First Generation* (13-31). Amsterdam: Benjamins. DOI: 10.1075/pbns.125.02jef

Jensen, M. J., McAuliffe, G. J., & Seay, R. (2015). Developmental level as a predictor of counseling skills. *Journal of Counselor Preparation and Supervision*, 7(1) doi:10.7729/71.1065

Jourard, S. M. (1971). *The Transparent Self*, 2nd, revised edn. New York: Van Nostrand Reinhold.

Jussila A. M., Vasankari T., Paronen O., Sievänen H., Tokola K., Vähä-Ypyä H., Broberg A., & Aittasalo M. (2015). KIDS OUT! Protocol of a brief school-based intervention to promote physical activity and to reduce screen time in a sub-cohort of Finnish eighth graders. *BMC Public Health,* 2015, 15, 634.

Kääntä, L. & Lehtinen, E. (2016). Patterns of experience talk and argumentation in digital peer learning discussions. *Language@Internet*, vol. 13, no. 2.

Kang, S. H., Krum, D. M., Khooshabeh, P., Phan, T., Chang, C. Y., Amir, O., & Lin, R. (2017). Social influence of humor in virtual human counselor's self-disclosure. *Computer Animation and Virtual Worlds*, *28*(3-4), e1763.

Kaukomaa, T., Ruusuvuori, J., & Peräkylä, A. (2015). How Listeners Use Facial Expression to Shift the Emotional Stance of the Speaker's Utterance. *Research on Language and Social Interaction*, vol. 48, no. 3, 319-341.

Kay, B. L. (2011). *Planning Health Promotion Programs: An Intervention Mapping Approach*. 3rd ed. San Francisco (Calif): Jossey-Bass.

Keel, S. & Schoeb, V. (2017). Patient participation in action: patients' interactional initiatives during interdisciplinary goal-setting meetings in a rehabilitation clinic. *Text* & *Talk*, vol. 37, no. 2, 213-242.

Keisanen, T. (2006). Patterns of stance taking: Negative yes/no interrogatives and tag questions in American English conversation. Oulu: Oulu University Press.

Kelly, M., Ngo, L., Chituc, V., Huettel, S., & Sinnott-Armstrong, W. (2017). Moral conformity in online interactions: rational justifications increase influence of peer opinions on moral judgments. *Social Influence*, *12*(2-3), 57-68.

Kelman, H. (1958). Compliance, identification, and internalization: Three processes of attitude change. *Journal of Conflict Resolution*, 2 (1): 51–60. doi:10.1177/002200275800200106.

Kim, M. S. (2014). Reported thought as a stance-taking device in Korean conversation. *Discourse Processes*, vol. 51, no. 3, 230–263.

Kiyimba, N., & O'Reilly, M. (2016). The value of using discourse and conversation analysis as evidence to inform practice in counselling and therapeutic interactions. In *The Palgrave Handbook of Adult Mental Health* (pp. 520-539). Palgrave Macmillan, London.

Koole, T. (2015). Classroom interaction. In K. Tracy, C. Ilie, T. Sandel (Eds.), *International Encyclopedia of Language and Social Interaction*. Oxford: Wiley-Blackwell.

Koole, T., & Berenst, J. (2008). Pupil participation in plenary interaction. In J. Deen, M. Hajer, M. & T. Koole, (Eds.), *Interaction in two multicultural mathematics classrooms: Mechanisms of Inclusion and Exclusion*. (107-139). Amsterdam: Aksant Academic Publishers, (NWO-reeks Sociale Cohesie; no. 15).

Koole, T., & van Burgsteden, L., Harms, P., van Diemen, C. C., & van Langen, I. M. (2017). Participation in interdisciplinary meetings on genetic diagnostics (NGS). *European Journal of Human Genetics*, vol. 25, no. 10, 1099-1105.

Korkiakangas, T. (2017). Mobilising a team for the WHO Surgical Safety Checklist: a qualitative video study. *BMJ Qual Saf*, *26*(3), 177-188.

Koudenburg, N. (2018). Regulating Shared Reality with Micro-Dynamics in the Form of Conversation. *Current Opinion in Psychology*, 23, 47-51. https://doi.org/(...)j.copsyc.2017.12.002

Koudenburg, N., Postmes, T., & Gordijn, E. (2017). Beyond Content of Conversation: The Role of Conversational Form in the Emergence and Regulation of Social Structure. *Personality and Social Psychology Review*, 21(1), 50-71. https://doi.org/10.1177/1088868315626022

Kundu, P., & Cummins, D. D. (2013). Morality and conformity: The Asch paradigm applied to moral decisions. *Social Influence*, *8*(4), 268-279.

Kuroshima, S., & Iwata, N. (2016). On Displaying Empathy: Dilemma, Category, and Experience. *Research on Language and Social Interaction*, 49:2, 92-110, DOI: 10.1080/08351813.2016.1164395convrsat

Laitinen, J., Korkiakangas, E., Alahuhta, M., Keinänen-Kiukaanniemi, S., Rajala, U., Timonen, O., Jokelainen, T., Keränen, A. M., Remes, J., Ruokonen, A., Hedberg, P., Taanila, A., Husman, P., & Olkkonen, S. (2010). Feasibility of videoconferencing in lifestyle group counselling. *Int J Circumpolar Health,* 5 (2010) 500–11.

Laitinen, L. (2006). Zero person in Finnish. A grammatical resource for construing human evidence. In M-L. Helasvuo & L. Campbell (Eds.), *Grammar from the Human Perspective. Case, space and person in Finnish,* 173-208. Amsterdam: John Benjamins.

Land, V., R. Parry, & J. Seymour (2017). Communication Practices that Encourage and Constrain Shared Decision Making in Health-Care Encounters: Systematic Review of Conversation Analytic Research. *Health Expectations*, 10.1111/hex.12557

Laurier, E. (2017). The uses of stance in media production: A study in embodied sociolinguistics. *Journal of Sociolinguistics*, Wiley-Blackwell, vol. 21, no. 1, 112–137.

Laverack, G. (2012). *Health Promotion Practice: Power and Empowerment*. 1st ed. Los Angeles: SAGE, 2012.

Leahy, D. (2014). Assembling a Health[Y] Subject: Risky and Shameful Pedagogies in Health Education. *Critical Public Health,* 24.2 (2014), 171-81.

Leary, M. R., & Miller, R. S. (1986). The Social Influence Model in Counseling and Psychotherapy. In *Social Psychology and Dysfunctional Behavior* (pp. 147-163). Springer, New York, NY.

Lee, J. (2017). Multimodal turn allocation in ESL peer group discussions. *Social Semiotics*, vol. 27, no. 5, 671-692.

Lees, J., & Gino, F. (2017). Is the moral domain unique? A social influence perspective for the study of moral cognition. *Social and Personality Psychology Compass*, *11*(8), e12327.

Lehtinen, E. (2006). Achieving similarity: Describing experience in Seventh-Day Adventist Bible study. *Text*, vol. 25, 341-371.

Leong, F. L. (2008). *Encyclopedia of Counseling, Volume 1: Changes and challenges for counseling in the 21st century*. Los Angeles, Calif: SAGE Publications, Inc.

Lerner, G. H. (1993). Collectivities in action: Establishing the relevance of conjoined participation in conversation. *Text*, vol. 13, no. 2, 213–245.

Lerner, G.H. (1995). Turn design and the organization of participation in instructional activities. *Discourse Processes*, vol. 19, 111-131.

Leudar, I., Antaki, C., & Barnes, R. (2006). When psychotherapists disclose personal information about themselves to clients. *Communication* & *Medicine,* 3(1), 27-41.

Liang, M.-Y. (2016). Achieving Multimodal Cohesion during Intercultural Conversations. *International Journal of Society, Culture* & *Language*, vol. 4, no. 2, 55-70.

Local, J., Walker, G. (2008). Stance and affect in conversation: On the interplay of sequential and phonetic resources. *Text* & *Talk*, vol. 28, no. 6, 723–747.

Lowery, B. S., Hardin, C. D., & Sinclair, S. (2001). Social influence effects on automatic racial prejudice. *Journal of personality and social psychology*, 81(5), 842.

Lucas, K. & Lloyd, B. B. (2005). *Health Promotion: Evidence and Experience*. 1st ed. Thousand Oaks, Calif; London: SAGE.

MacMartin, C. & LeBaron, C. D. (2006). Multiple Involvements within Group Interaction: A Video-Based Study of Sex Offender Therapy. *Research on Language and Social Interaction,* 39.1 (2006), 41-80.

Markaki, V. & Filliettaz, L. (2017). Shaping Participation in Vocational Training Interactions: The Case of Schisming. In S. P. Doehler, A. Bangerter, G. de Weck, L. Filliettaz, E. González-Martínez, & C. Petitjean, (Eds.), *Interactional Competences in Institutional Settings: From School to the Workplace,* (89-116). Palgrave Macmillan, Cham.

Marks, R. (2012). *Health Literacy and School-Based Health Education*. Bingley [England]: Emerald.

Maruniakova, L., Rihacek, T., & Roubal, J. (2017). How beginning counselors learn: The interaction of personal and professional experiences in counselors with an experiential orientation. *Counselling Psychology Quarterly*, 30(1), 48-66. doi:10.1080/09515070.2016.1148013

Mayes, P. (2015). Becoming an 'autonomous writer': Epistemic stance displays and membership categorization in the writing conference. *Discourse Studies*, vol. 17, no. 6, 752–769.

McDermott, R. (1977). Social Relations as Contexts for Learning in School. *Harvard Educational Review*, July 1977, Vol. 47, No. 2, 198-213. https://doi.org/10.17763/haer.47.2.c9umx75267433434

McGraw, K. M., & Bloomfield, J. (1987). Social influence on group moral decisions: The interactive effects of moral reasoning and sex role orientation. *Journal of Personality and Social Psychology*, *53*(6), 1080.

Mead, G. H. (1934). *Mind, Self, and Society from the Standpoint of a Social Behaviorist*. Chicago: University of Chicago Press.

Melander, H. (2012). Knowing how to play the game of jump rope: Participation and stancetaking in a material environment. *Journal of Pragmatics*, vol. 44, no. 11, 1434–1456.

Mezirow, J. (1990). How critical reflection triggers transformative learning. In: J. Mezirow et al. (Eds), *Fostering Critical Reflection in Adulthood,* (1–20). San Francisco: Jossey Bass.

Mezirow, J. (1998). On critical reflection. *Adult Education Quarterly* 48(3), 185–198.

Milgram, S. (1963). Behavioral study of obedience. *Journal of Abnormal and Social Psychology*, 67, 371–378.

Miller, G., Silverman, D. (1995). Troubles Talk and Counselling Discourse: A Comparative Study. *Sociological Quarterly*, vol. 36, no. 4, 725–747.

Mondada, L. (2011). The interactional production of multiple spatialities within a participatory democracy meeting. *Social Semiotics*, vol. 21, no. 2, 289–316.

Mondada, L. (2013). Embodied and Spatial Resources for Turn-Taking in Institutional Multi-Party Interactions: Participatory Democracy Debates. *Journal of Pragmatics,* 46.1 (2013), 39-68.

Mondada, L. (2017). Walking and talking together: Questions/answers and mobile participation in guided visits. *Social Science Information*, SAGE Publications, vol. 56, no. 2, 220–253.

Mondada, L., Svensson, H., van Schepen, N. (2017). A table-based turn-taking system and its political consequences. *Journal of Language and Politics*, vol. 16, no. 1, 83-109.

Mondada, M. (2015). The facilitator's task of formulating citizens' proposals in political meetings: Orchestrating multiple embodied orientations to recipients. *Gesprächsforschung - Online-Zeitschrift zur verbalen Interaktion*, vol. 16, 1-62.

Muntigl, P. (2013). Resistance in couples counselling: Sequences of talk that disrupt progressivity and promote disaffiliation. *Journal of Pragmatics*, vol. 49, no. 1, 18–37.

Netz, H. (2016). Designedly Incomplete Utterances and student participation. *Linguistics and Education*, vol. 33, 56-73.

Nevanperä, N., Keränen, A. M., Ukkola, O., & Laitinen, J. (2015). Effects of group counseling transmitted through videoconferencing on changes in eating behaviors. *Journal of nutrition education and behavior*, *47*(6), 555-559.

Nevile, M. (2007). Seeing the point: attention and participation in the airline cockpit. In *Interacting Bodies. Online Proceedings of the 2nd International Conference of the International Society for Gesture Studies. Lyon: ENS LSH and ICAR Research Lab, http://gesture-lyon2005. enslsh. fr/article. php3*.

Nevile, M. (2009). You are well clear of friendlies: Diagnostic error and cooperative work in an Iraq war friendly fire incident. *Computer Supported Cooperative Work* (CSCW), vol. 18, no. 2-3, 147-173.

Nguyen, H.T. (2007). Rapport building in language instruction: A microanalysis of the multiple resources in teacher talk. *Language and Education*, vol. 21, no. 4, 284-303.

Nielsen, M.F. (2012) Using Artifacts in Brainstorming Sessions to Secure Participation and Decouple Sequentiality. *Discourse Studies,* 14.1 (2012), 87-109.

Niemelä, M. (2005). Voiced directed reported speech in conversational storytelling: Sequential patterns of stance taking. *SKY Journal of Linguistics*, vol. 18, 197-221.

Nissi, R., Lehtinen, E. (2016). Negotiation of expertise and multifunctionality: PowerPoint presentations as interactional activity types in workplace meetings. *Language & Communication*, vol. 48, 1-17.

Nolan, J. M., Schultz, P. W., Cialdini, R. B., Goldstein, N. J., & Griskevicius, V. (2008). Normative social influence is underdetected. *Personality and social psychology bulletin*, 34(7), 913-923.

O'Donnell, M. P. (2002). *Health promotion at the workplace* (3rd ed.). Albany, NY: Delmar.

Ochs, E. (1996). Linguistic resources for socializing humanity. In J. J. Gumperz & S. C. Levinson (Eds.), Rethinking linguistic relativity (407– 437). Cambridge: Cambridge University Press.

Paakkari, O. & Paakkari, L. (2012). Future Directions: How to Organize Classroom Practices to Support the Development of Holistic Health Literacy. In: R. Marks, *Health Literacy and School-Based Health Education*. Bingley [England]: Emerald Group Publishing Limited.

Paoletti, I. & Fele, G. (2004). Order and disorder in the classroom. *Pragmatics*, vol. 14, 69-85.

Parcel, G. S., Kelder, S. H., & Basen-Engquist K. (2000). The School as a Setting for Health Promotion. In: B. D. Poland, W. G. Lawrence, & I. Rootman. *Settings for Health Promotion: Linking Theory and Pra*ctice (86-120). Thousand Oaks, Calif: Sage Publications.

Parton, K. (2014). Epistemic stance in orchestral interaction. *Social Semiotics*, vol. 24, no. 4, 402–419.

Paul-Ebhohimhen, V., & Avenell, A. (2009). A systematic review of the effectiveness of group versus individual treatments for adult obesity. *Obesity Facts*, 2, 17–24. https://doi.org/10.1159/000186144.

Peräkylä, A. & Ruusuvuori, J. (2012). Facial expression and interactional regulation of emotion. In A. Peräkylä & M-L. Sorjonen, (Eds.), *Emotion in Interaction* (64-91). Oxford: Oxford University Press.

Peräkylä, A. (1995). *AIDS Counselling: Institutional interaction and clinical practice*. Cambridge: Cambridge University Press.

Peräkylä, A. (2002). Agency and authority: Extended responses to diagnostic statements in primary care encounters. *Research on Language* & *Social Interaction*, vol. 35, no. 2, 219-247.

Peräkylä, A. (2011). Validity in research on naturally occurring social interaction. *Qualitative Research*, 365, 382.

Peräkylä, A., & Silverman, D. (1991). Reinterpreting speech-exchange systems: Communication formats in AIDS counselling. *Sociology* 4, (1991) 627–51.

Peräkylä, A., & Vehviläinen, S. (2003). Conversation analysis and the professional stocks of interactional knowledge. *Discourse & Society*, *14*(6), 727-750.

Peräkylä, A., Ruusuvuori, A., & Vehviläinen, S. (2005). Introduction: Professional theories and institutional interaction. *Communication* & *Medicine*, vol. 2, no. 2, 105-109.

Pickett, K. et al. (2017). Teaching Health Education. *Health Education,* 117.3 (2017): 323.

Piirainen-Marsh, A., & Koskela, H. (2000). Collective Participation as a Resource in Multiparty Multicultural Broadcast Interactions. *Issues in Applied Linguistics* 11.2 (2000): 243. Web.

Pino, M. (2014). Epistemic struggles in addiction Therapeutic Community meetings. In A. Zuczkowski, R. Bongelli, I. Riccioni, & C. Canestrari, C. (Eds.), *Communicating Certainty and Uncertainty in Medical, Supportive and Scientific Contexts* (201-221). Amsterdam: John Benjamins Publishing Company.

Pino, M. (2016a). Delivering criticism through anecdotes in interaction. *Discourse Studies*, vol. 18, no. 6, 695-715.

Pino, M. (2016b). Knowledge displays: Soliciting clients to fill knowledge gaps and to reconcile knowledge discrepancies in therapeutic interaction. *Patient Education and Counseling*, vol. 99, 897–904.

Pino, M. (2017). I-Challenges: Influencing Others' Perspectives by Mentioning Personal Experiences in Therapeutic Community Group Meetings. *Social Psychology Quarterly*, vol. 80, no. 3, 217–242

Pino, M. (2017). I-Challenges: Influencing Others' Perspectives by Mentioning Personal Experiences in Therapeutic Community Group Meetings. *Social Psychology Quarterly*, vol. 80, no. 3, 217–242.

Pino, M. (2018). Invoking the Complainer's Past Transgressions: A Practice for Undermining Complaints in Therapeutic Community Meetings. *Research on Language and Social Interaction*, vol. 51, no. 2, 194-211.

Poland, B.D., Green, L.W., & Rootman, I. (2000). *Settings for Health Promotion: Linking Theory and Practice*. Thousand Oaks, Calif: Sage Publications.

Polanyi, M. F. D., Frank, J. W., Shannon, H. S., Sullivan, T. J., & Lavis, J. N. (2000). Promoting the determinants of good health in the workplace. In B. D. Poland, W. G. Lawrence, & I. Rootman. *Settings for Health Promotion: Linking Theory and Practice* (138-160). Thousand Oaks, Calif: Sage Publications.

Pollner, M., & Stein, J. (1996). Narrative mapping of social worlds: The voice of experience in Alcoholics Anonymous. *Symbolic Interaction*, *19*(3), 203-223.
Poskiparta, M., Kettunen, T., & Liimatainen, L. (1998). Reflective Questions in Health Counseling. *Qualitative Health Research*, 8 (1998), 682–93.
Poskiparta, M., Liimatainen, L., Kettunen, T., & Karhila, P. (2001). From Nurse-Centered Health Counseling to Empowermental Health Counseling. *Patient Educ Couns,* 45 (2001), 69–79.
Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction.* London: Sage.
Price, V., Nir, L., & Cappella, J. N. (2006). Normative and informational influences in online political discussions. *Communication Theory*, 16(1), 47-74.
Raevaara, L. (2017). Adjusting the design of directives to the activity environment. In L. Raevaara, M-L. Sorjonen, & E. Couper-Kuhlen (Eds., *Imperative Turns at Talk: The design of directives in action* (381–410). Amsterdam: John Benjamins Publishing Company.
Robinson, J.D. (2016). Accountability in Social Interaction' In J. D. Robinson (Ed), *Accountability in social interaction*. Oxford: Oxford University Press. p.xx-xx
Ruusuvuori, J. (2000). *Control in the medical consultation: Practices of giving and receiving the reason for the visit in primary health care*. Tampere: Tampere University Press.
Ruusuvuori, J. (2005). "Empathy" and "sympathy" in action: Attending to patients' troubles in Finnish homeopathic and general practice consultations. *Social Psychology Quarterly,* 68(3), 204–222.
Ruusuvuori, J., & Peräkylä, A. (2009). Facial and verbal expressions in assessing stories and topics. *Research on Language* & *Social Interaction*, vol. 42, no. 4, 377 — 394.
Sacks, H. (1984). Notes on methodology. In J. M. Atkinson & J. Heritage (Eds.) *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press. 21-27.
Sacks, H., & Schegloff, E. A. (1973). Opening up closings. *Semiotica*, vol. 8, no. 4, 289–327.
Sacks, H., Schegloff, E.A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language*, vol. 50, no. 4, 696–735.
Salazar, L. F., Crosby, R. A., & DiClemente, R. J. (2015). *Research methods in health promotion*. John Wiley & Sons.
Salganik, M. J., Dodds, P. S., & Watts, D. J. (2006). Experimental study of inequality and unpredictability in an artificial cultural market. *Science*, 311(5762), 854-856.
Sarangi, S. (2009). The Spatial and Temporal Dimensions of Reflective Questions in Genetic Counselling. In A. F. Freed and S. Ehrlich, (Eds.), *Why Do You Ask? The Function of Questions in Institutional Discourse,* (235–55) Oxford: Oxford University Press.
Schegloff, E. A. (2007). *Sequence organization in interaction: A primer in conversation analysis I* (Vol. 1). Cambridge: Cambridge University Press.
Schegloff, E. A., Jefferson, G., & Sacks, H. (1977). The preference for self-correction in the organization of repair in conversation. *Language*, 53(2), 361-382.
Schegloff, E.A. (1992). Repair After Next Turn: The Last Structurally Provided Defense of Intersubjectivity in Conversation. *American Journal of Sociology*, vol. 97, no. 5, 1295–1345.
Schiefer, D., & van der Noll, J. (2017). The essentials of social cohesion: A literature review. *Social Indicators Research*, 132(2), 579-603.
Schwartz, V. S., Rothpletz-Puglia, P., Denmark, R., & Byham-Gray, L. (2015). Comparison of standardized patients and real patients as an experiential teaching strategy in a

nutrition counseling course for dietetic students. *Patient Education and Counseling*, 98(2), 168-173.
Searle, J. R., & Searle, J. R. (1969). *Speech acts: An essay in the philosophy of language* (Vol. 626). Cambridge: Cambridge University Press.
Sherif, M. (1936). *The Psychology of Social Norms*. Oxford, England: Harper.
Shulman, L. (2011). *Dynamics and Skills of Group Counselling*. Brooks/Cole, Cengage Learning, Belmont.
Shumaker, S. A., & Brownell, A. (1984). Toward a theory of social support: Closing conceptual gaps. *Journal of Social Issues*, 40(4), 11-36.
Simpson, J. A., Farrell, A. K., & Marshall, E. (2016). A relational perspective of social influence on moral issues. In *The Social Psychology of Morality* (pp. 113-125). Routledge.
Sinclair, J. McH., & Coulthard, R. M. (1975). *Towards an analysis of discourse: The English used by teachers and pupils*. London: Oxford University Press.
Snelling, A. (2014). *Introduction to Health Promotion*. 1st ed. San Francisco, California: Jossey-Bass.
St John, O., & Cromdal, J. (2016). Crafting Instructions Collaboratively: Student Questions and Dual Addressivity in Classroom Task Instructions. *Discourse Processes*, 53.4 (2016): 252-79.
Steensig, J., Mondada, L., & Stivers, T. (Eds.), (2011). *The morality of knowledge in conversation*, Cambridge: Cambridge University Press.
Stephens, C. (2008). *Health Promotion: A Psychosocial Approach*. Maidenhead: Open University Press.
Stevanovic, M., & Peräkylä, A., (2014). Three orders in the organization of human action: On the interface between knowledge, power, and emotion in interaction and social relations. *Language in Society*, vol. 43, no. 2, 185–207.
Stivers, T. (2008). Stance, alignment and affiliation during storytelling: when nodding is a token of affiliation. *Research on Language and Social Interaction*, vol. 41, no. 1, 31–57.
Stivers, T. (2019). How We Manage Social Relationships through Answers to Questions: The Case of Interjections. *Discourse Processes*, 56:3, 191-209, DOI: 10.1080/0163853X.2018.1441214
Stokoe, E. (2013). The (in)authenticity of simulated talk: comparing role-played and actual interaction and the implications for communication training. *Research on Language and Social Interaction*, vol. 46, no. 2, 165–185
Stricker, G. & Fisher, M. (1990). *Self-disclosure in the Therapeutic Relationship*. New York: Plenum.
Strong, T., & Zeman, D. (2010). Dialogic Considerations of Confrontation as a Counseling Activity: An Examination of Allen Ivey's Use of Confronting as a Microskill*,* 88 (2010) 332–9.
Stryker, S., & Serpe, R. T. (1982). Commitment, identity salience, and role behavior: Theory and research example. In *Personality, roles, and social behavior* (pp. 199-218). Springer, New York, NY.
Svahn, J., & Evaldsson, A. C. (2013). Talking moral stances into being: the interactional management of moral reasoning in Aggression Replacement Training (ART) classroom sessions. *Text* & *Talk*, vol. 33, no. 6, 793–815.
Svinhufvud, K. (2015). Participation in the Master's Thesis Seminar. Exploring the Lack of Discussion. *Learning, Culture and Social Interaction*, 5, Supplement C, 66-83

Tainio, L., & Laine, A. (2015). Emotion work and affective stance in the mathematics classroom: the case of IRE sequences in Finnish classroom interaction. *Educational Studies in Mathematics*, *89*(1), 67-87.

Tholander, M. (2007). Students' Participation and Non-Participation as a Situated Accomplishment. *Childhood*, vol. 14, no. 4, 449-466.

Tiitinen, S., Weiste, E., Ruusuvuori, J., & Laitinen, J. (2018b). Ryhmänohjauksen vuorovaikutusmekanismit vertaistuen kokemusten taustalla. [Interactional mechanisms explaining the experiences of peer support in group counseling] *Psykologia* 53 (05-06), 345–363.

Tiitinen, S., Weiste, E., Vehviläinen, S., Ruusuvuori, J., Lusa, S., & Laitinen, J. (2018). Reflektoinnin välttämistä ja vertaistukea: tarinoiden tehtävät palo-ja pelastusalan lähijohtajien ryhmäohjauksessa. *Aikuiskasvatus 38 (2018): 3*.

Turner, J. C. (1982). Towards a cognitive redefinition of the social group. In H. Tajfel (Ed.), *Social Identity and Intergroup Relations* (14–40). Cambridge, UK: Cambridge University Press.

Turner, J. C. (1991). *Social influence*. Pacific Grove, CA: Brooks/Cole.

Turner, J. C., Wetherell, M. S., & Hogg, M. A. (1989). Referent informational influence and group polarization. *British Journal of Social Psychology*, 28(2), 135-147.

Turner, R. H. (2001). *Role theory. In Handbook of sociological theory*. Boston, MA: Springer, 233-254

Turpeinen M., Nevanperä N., Turunen J., Weiste E., Salmi A., & Laitinen J. (Forthcoming). Associations between work ability, health promotion and business performance among female microentrepreneurs.

Valente, T.W. (2002). *Evaluating Health Promotion Programs*. New York: Oxford University Press.

Vallis, M. (2013). Behaviour change counselling-how do I know if I am doing it well? The development of the behaviour change counselling scale (BCCS). *Canadian Journal of Diabetes*, 37(1), 18-26. doi:10.1016/j.jcjd.2013.01.005

Vaux, A. (1988). *Social support: Theory, research, and intervention*. New York, NY, England: Praeger Publishers.

Vehviläinen S. (2001). Evaluative advice in educational counseling: the use of disagreement in the "stepwise entry" to advice. *Research on Language and Social Interaction,* 34:3:371-398.

Vehviläinen S. (2003). Avoiding providing solutions: orienting to the ideal of student's self-directedness in counselling interaction. *Discourse Studies,* 5:3:389-414.

Vehviläinen S. (2009). Student-initiated advice in academic supervision. *Research on Language and Social Interaction*, 42:2:143-190.

Vehviläinen, S. (2014). Ohjaustyön opas. Yhteistyössä kohti toimijuutta. [Guidebook for counselling. In co-operating towards agency.] Helsinki: Gaudeamus.

Verheijden, M. W., Bakx, J. C., van Weel, C., Koelen, M. A., & van Staveren, W. A. (2005). Role of social support in lifestyle-focused weight management interventions. *European Journal of Clinical Nutrition*, (2005) 59, Suppl 1, S179–S186.

Vinogradov, S., & Yalom, I. D. (1990). Self-disclosure in group psychotherapy. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the Therapeutic Relationship* (191-204). New York: Plenum.

VISK = Hakulinen, A., Vilkuna, M., Korhonen, R., Koivisto, V., Heinonen, T.R., & Alho, I. (2004). *Iso suomen kielioppi*. Helsinki: Suomalaisen Kirjallisuuden Seura.

Verkkoversio, 1.11.2018. [*Great Finnish Grammar*. Online version.] Available: http://scripta.kotus.fi/visk URN:ISBN:978-952-5446-35-7
Visser, A. & Herbert, C. (1996). Counseling in Healthcare. *Patient Education and Counseling*, 28 (1996), 233-234.
Voutilainen, L., Henttonen, P., Kahri, M., Kivioja, M., Ravaja, N., Sams, M., & Peräkylä, A. (2014). Affective stance, ambivalence, and psychophysiological responses during conversational storytelling. *Journal of Pragmatics*, Elsevier B.V., vol. 68, 1–24.
Voutilainen, L., Peräkylä, A., & Ruusuvuori. J. (2010). Recognition and interpretation: Responding to emotional experience in psychotherapy. *Research on Language and Social Interaction* 43(1). 85–107.
Wasson, C. (2016). Integrating conversation analysis and issue framing to illuminate collaborative decision-making activities. *Discourse* & *Communication*, vol. 10, no. 4, 378-411.
Weare, K. (2015). *What works in promoting social and emotional well-being and responding to mental health problems in schools*. London: National Children's Bureau.
Webb, H. (2009). 'I've put weight on cos I've bin inactive, cos I've 'ad me knee done': Moral work in the obesity clinic. *Sociology of Health* & *Illness*, 31, 854–871. doi:10.1111/j.1467-9566.2009.01188.x
Weiste, E., Voutilainen, L., & Peräkylä, A. (2015). Epistemic asymmetries in psychotherapy interaction: therapists' practices for displaying access to clients' inner experiences. *Sociology of Health* & *Illness*, vol. 38, no. 4, pp. 645–661.
Widdicombe, S. (2017). The delicate business of identity. *Discourse Studies*, vol. 19, no. 4, 460 - 478.
Wiggins, S. (2009). Managing blame in NHS weight management treatment: Psychologizing weight and 'obesity'. *Journal of Community* & *Applied Social Psychology*, 19(5), 374-387.
Wiggins, S. (2017). *Discursive psychology: Theory, method and applications*. Sage: London.
Wiggins, S., & Potter, J. (2008). Discursive psychology. In: *Sage Handbook of Qualitative Research in Psychology*. London: Sage, 73-90. ISBN 9781412907811
Wood, W. (2000). Attitude Change: Persuasion and Social Influence. *Annual Review of Psychology 2000*, 51:1, 539-570
World Health Organization. (1984). *Discussion document on the concept and principles of health promotion*. Copenhagen: European Office of the World Health Organization.
World Health Organization. (1986). Ottawa charter for health promotion. *Health Promotion*, 1(4), i-v
Wu, R. J. R. (2004). Stance in talk: A conversation analysis of Mandarin final particles. Amsterdam/Philadelphia: John Benjamins.
Yalom, I. D. (1995). *The Theory and Practice of Group Psychotherapy*, 4th edn. New York: Basic Books.

PUBLICATIONS

PUBLICATION I

Group members' questions shape participation in health counselling and health education

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Group members' questions shape participation in health counselling and health education

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Abstract

Objective: This study examines how group members' questions shape member participation in health counselling and health education groups.
Methods: The study applies conversation analytic principles as a method. The data consist of video-recorded health education lessons in secondary school and health counselling sessions for adults with a high risk of Type 2 diabetes.
Results: Group members' questions accomplish a temporary change in participatory roles. They are used to 1) request counselling, 2) do counselling or 3) challenge previous talk. They are usually treated as relevant and legitimate actions by the participants, but are occasionally interpreted as transitions outside the current action or topic.
Conclusion: Group members' questions result in a shift from leader-driven to member-driven discussion. Thus they constitute a pivot point for detecting changes in participation in group interventions.
Practice Implications: Observing the occurrence of group members' questions helps group leaders to adjust their own actions accordingly and thus facilitate or guide group participation. Comparison of the type and frequency of members' questions is a way to detect different trajectories for delivering group interventions and can thus be used to develop methods for process evaluation of interventions.

Keywords
applied conversation analysis, client initiation, group counselling, group discussion, health education, interaction, multiparty interaction, participant-centred communication, participation, questions

Group members' questions shape participation in health counselling and health education

1. Introduction

Participation, empowerment and agency are key processes that support successful health promotion [1,2,3,4,5]. Health outcomes are better achieved when service recipients have a sense of autonomy and control in pursuing the goals of health-promoting activities [5,6,7].

Street et al. [1] suggest that health outcomes are achieved through proximal outcomes in interaction, such as an increase in knowledge, shared understanding of the problem, social support, and stronger therapeutic alliance [1]. These proximal outcomes are realised through participation in interaction. In order to understand what promotes participation and what kind of participation is beneficial for reaching the proximal outcomes, we need research on the dynamics of interaction.

In this study we examine members' possibilities to participate in two group contexts of health promotion: health counselling for adults at risk of Type 2 diabetes, and health education in secondary school. Both environments share an institutional task wherein the leader – either a teacher or a counsellor – encourages the group towards a common goal of healthier behaviour through actions such as giving information and advice and prompting participants to reflect on whether they are currently leading a healthy lifestyle. Our focus is on the ways group participation is realised in the two environments.

Health counselling and health education are commonly conducted in group settings. Interaction in health counselling has mainly been studied in dyadic settings [however, see 8,9], and these studies have mainly concentrated on counsellors' actions – questioning, advice-giving and confrontation [10,11,12,13,14]. Less is known about clients' actions and counselling processes in group settings. Interaction in health education has not been studied, as research on classroom interaction has focused on the teaching of languages and theoretical subjects [15,16,17] . Both health education and health counselling attempt to influence individuals' attitudes and behaviour. Thus it is essential to gain information on clients' and students' possibilities to participate in efforts to achieve the institutional goals.

In institutional contexts, participants orient to the structures and norms of interaction that offer different kinds of opportunities for participation depending on their social role. Whether the situation is dyadic or multiparty, a recurrent feature is that the discussion is primarily driven by the professional [18,19,20]. This is easily observable in classroom interaction, where teachers regulate next-speaker selection, ask known-information questions and evaluate the answers they receive [21,22,23,24]. Leader-driven practice entails the regulation of participation in order to accomplish the institutional task at hand.

Members' initiatives are one key point for analysis of whether and how group members take an active role in group participation. Asking a question is a powerful device for steering the direction of conversation. It makes an answer relevant and thus cannot easily be bypassed. With a question, a participant can initiate both a new topic of talk and a new line of action, and reshape the participatory roles of the encounter [25,26,27,8,28].

Students' initiative actions have been examined in academic counselling and classroom interaction, particularly from the perspective of how questions are treated as requests for advice, thus working for the institutional task [29,30], or as attempts to challenge the advice or institutional agenda [31,32,33]. In classroom interaction, students can initiate topics and actions and display knowledge through questions. These initiations may, however, be treated as initiating a shift from the current institutional activity, and thus as transgressions [34,29,32].

In dyadic counselling, clients' questions can generate departures from counsellor-driven activities: by asking a question, a client is able to temporarily reverse the roles of questioner-answerer and speaker-listener. This can be accomplished either by the counsellor offering "question time" to the client or by the client initiating a question voluntarily. Offering "question time" sustains the counsellor's primacy and control over the discussion, and voluntary questions are suggested to be more significant breaches of the counsellor-driven procedure. [35] In group counselling interaction, "what about" types of question have been shown to function as seeking information or instruction [8]. So far there is no further research on other types of question or questions addressed to other group members.

In this article we explore patterns of group participation in the contexts of health education and health counselling. Our aim is to find out how group members' questions operate in shaping participation [36,20]. We show how with questions members can 1) request counselling, 2) engage in activities that resemble the leader's activities and thus "do counselling" for the other members, and 3) challenge what has been stated in the previous turns or counselling materials. Our focus on group interaction enables us to observe the dynamics of interaction between group members and its potential benefits with regard to the institutional task of supporting behaviour change.

2. Material and methods

2.1 Data and participants

The data consist of audiovisual recordings of three hours of health education lessons in secondary school (three groups, one lesson each) and 18 hours of health counselling sessions for adults with a high risk of Type 2 diabetes (six groups, one to three sessions each). The health education data were gathered from an intervention that aimed to increase physical activity and reduce sedentary behaviour in adolescents. Health education teachers delivered the intervention to groups of 14–21 students aged 14–15 years old over the course of three lessons [37]. The health counselling data were gathered from an intervention that aimed to increase physical activity, eating control and nutritional quality for adults. Groups of six to nine participants, led by nutritionists, met six times [38]. Informed consent was obtained from all participants, and the data were anonymised and transcribed. The study was approved by the ethics committee of the Tampere region and the Coordinating Ethics Committee of the Hospital District of Helsinki and Uusimaa (document number 50/E0/2007).

2.2 Method

In the preliminary phase of the analysis, we gathered all question-answer sequences in the data (n=977), and compared the number of group leaders'[1] and members' questions in each session. We focused on members' questions (n=330), and excluded 83 questions that were oriented to the organisation of an ongoing assignment such as "Whose turn it is now?" or questions such as "What is in that picture?" Hence a detailed analysis was carried out of 247 members' question sequences that addressed the themes of the counselling interventions. The method applied was conversation analysis, a systematic method for analysing patterns of interaction based on ethnomethodological theory [39,40,41,19,42]. We analysed the sequential location of the question within the conversation and its allocation, that is, to whom the speaker was directing the question and who (if not the whole group) was thus being treated as the primary respondent [25]. Other aspects analysed were the design of the turns, the topical focus of the questions, who responded to the question, and the kinds of action embodied in the answer. We also paid attention to what happened after the response.

[1] "Leader" and "member" are used to refer to participants in both environments. They include the teacher and counsellor, and the students and clients, respectively.

3. Results

In general, both environments were leader-driven: leaders followed the intervention agenda, initiated and instructed on assignments, delivered information, and took general responsibility for the timing and content of sessions. Asking questions was a salient counselling activity, and teachers and counsellors used similar question types: 1) questions that asked members to recall facts: "What are the benefits of physical activity?", 2) questions that invited members to reflect: "What do you think about…?", or 3) survey questions: "How many of you live near here?" In the health counselling groups, it was common for clients to answer the counsellor's questions in "rounds", one client at a time, in the order in which they were seated around the table, whereas in health education lessons, the students volunteered to answer questions that were allocated to the whole group. In both environments, leaders also allocated some of the questions to specific respondents.

A well-known pattern of interaction – the IRE/F structure – was common in both environments. The IRE/F structure unfolds as *initiation* from the leader, *response* from the member, and *evaluation* or *feedback* from the leader [43,44]. Table 1 shows examples of IRE/F in both contexts.

Initiation is observable in both data excerpts: the group leaders ask a question (lines A3–6 and B1–2) and allocate the next speaker (A8, B4–5]. A *response* is given by the student and the client (A9–11, B6–10, B12–13). Thereafter, the leaders give *feedback:* the teacher gives a formulation of the answer as feedback to the student (A12–13); the counsellor highlights some details of Maija's answer by writing them on the flip chart (B11) and then verbally evaluates a part of the answer as *important* (B14–15). The IRE/F structure illustrates a leader-driven practice where group leaders control the flow of discussion through allocated questions and by highlighting the institutionally relevant parts of the answers through evaluations and formulations.

Leaders' questions were frequent in both environments. *Members' questions* were considerably more frequent in health counselling sessions than in health education lessons (Figures 1 and 2). However, there were notable differences in the number of members' questions between different health counselling groups, and between sessions of the same group (Figure 3). The question topics varied from whether some specific food was recommended to enquiries about group members' personal lives.

Table 1

A) HE2/II: IRE/F in health education

A1 T: mut jos AJATELLAAN ettei käydäkään
but if THINK+PASS that+not go+not
but if WE THINK that we won't go

A2 o:hjatussa, liikunnassa?
instructed, sport?
to o:rganized, sports?

A3 (.) niin, (1.0) miten sä silloin
(.) so, (1.0) how you then
(.) **so, (1.0) how could you then**

A4 voisit semmosilla pienillä
could some+with small+with
with some little

A5 jutuilla lisätä sitä sun
things+with increase that your
things increase your

A6 arkiliikkumistasi.
everyday+moving.
everyday physical activity.

A7 (2.2)

A8 T: ää Jelena.

A9 J: no ↑jos nyt kävelee kouluun
well ↑if now 0+walks school+to
well ↑if one walks to school

A10 tai harrastukseen
or hobby+to
or to hobbies

A11 tai kaupunkiin tai jotain.
or town+to or something.
or into town or something.

A12 T: eli ↑LISÄÄT
so ↑INCREASE+you
so ↑YOU INCREASE

A13 ↑SITÄ ↑KÄVELYN määrää.
↑THAT ↑WALKING amount.
↑**THE ↑AMOUNT of walking.**

B) HC7/I: IRE/F in health counselling

B1 C: no, entäs sitte tuo viimenen
well, what then that last
well,how about that last one then

B2 mitäs sanotte, mitä hyö.tyä?
what say+you+PLUR, what bene.fit?
what do you say, what bene.fits?

B3 (2.2)
((Counsellor writes on the flip chart))

B4 C: mennäänkö toisinpäin taas että
go+we+O other+way again so
do we go the other way again so

B5 Maija alottaa siitä.=
Maija starts there+from.=
Maija will start there.=

B6 M: =mm mulla täälä on että
=mm I here have that
=mm I've got here that

B7 hyvä ↑kunto
good ↑stamina
good ↑stamina

B8 ja >tietenki< terveys
and >of+course< health
and >of course< health

B9 ynnä muut asiat,
plus other things,
and other things,

B10 (täs niin on) hyötyjä?
(here then are) benefits?
(here so they) are benefits?

B11 (1.2)
((Counsellor writes on the flip chart))

B12 M: virkeämpi niinku tö:issä
alert+more like work+at
One would be more alert at wo:rk

B13 ois sitten kanssa.
0+be+would then also.
then also.

B14 C: joo tuo on tärkee näkökohta
yeah that is important aspect
yeah that is an important aspect

B15 tuo virkeys.
that alertness.
that alertness.

B16 M: **mhm**

B17 (0.2)

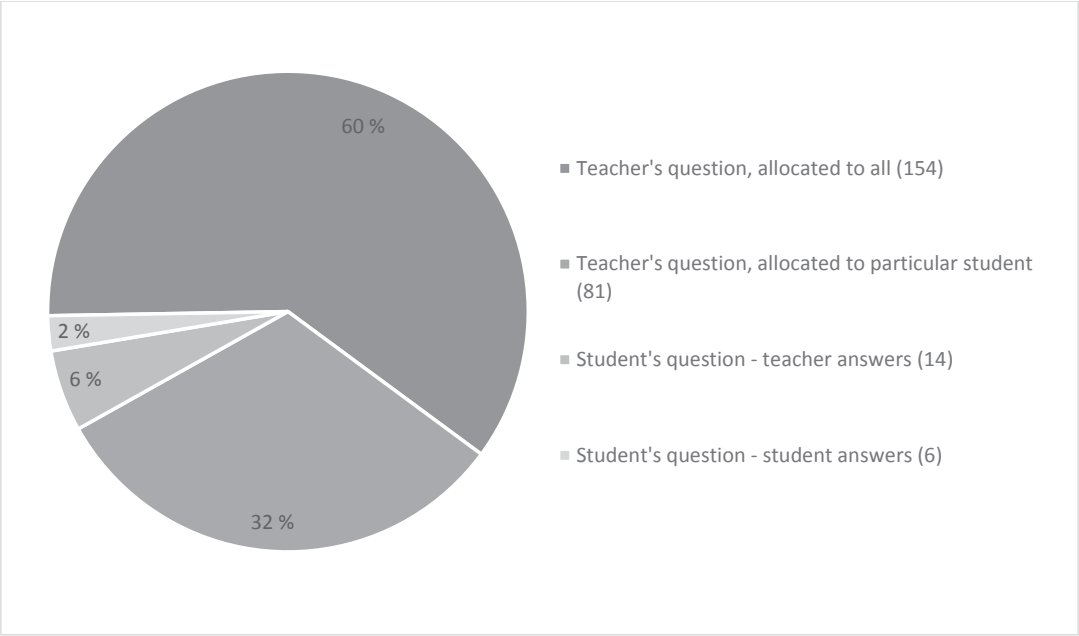

Figure 1. Number and percentage of teachers' questions and students' questions in three health education lessons.

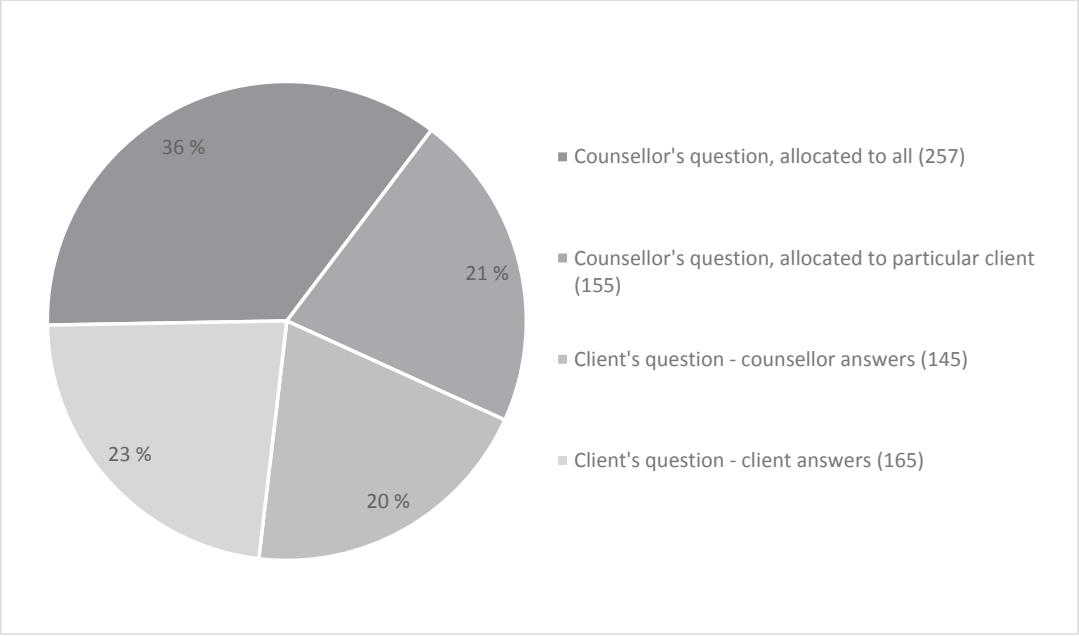

Figure 2. Number and percentage of counsellors' questions and clients' questions in 12 health counselling sessions.

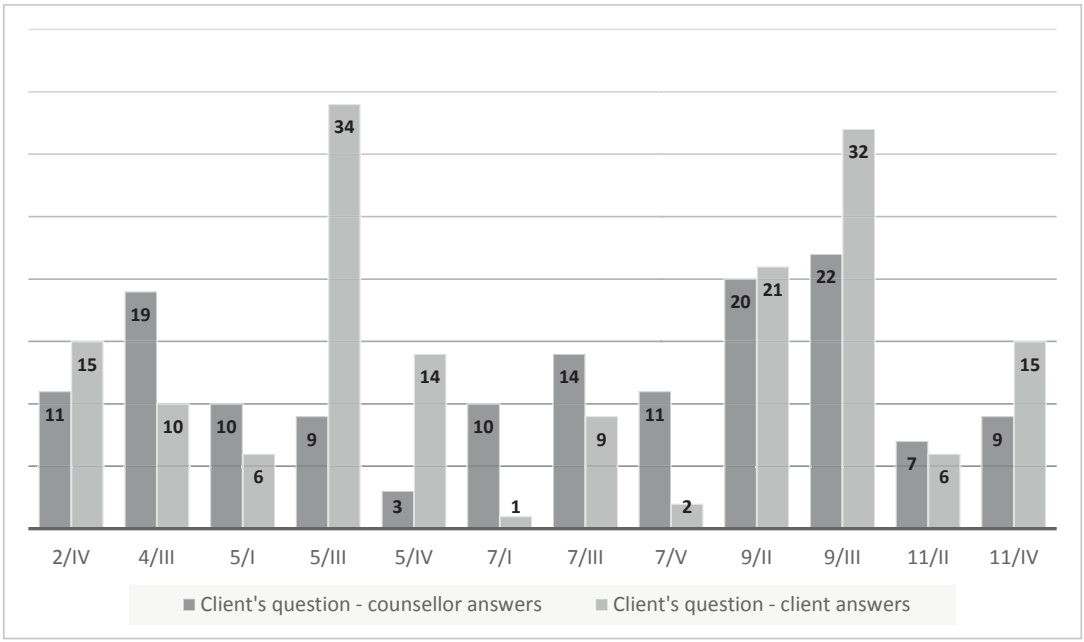

Figure 3. Comparison of the number of clients' questions in 12 health counselling sessions. The Arabic numeral identifies the group, the Roman numeral identifies the session.

Drawing upon the analysis of sequential location, turn allocation, turn design and topical focus, and of actions embodied in the responses to the questions, we found three types of function which members' questions served: requesting counselling, doing counselling and challenging a particular topic. While members' questions were significantly more frequent in health counselling than in health education, all three types of function were found in both data sets.

Table 2. Sequential location and function of members' questions, and distribution of responses between leaders and members in health counselling and health education

	Requesting counselling		**Doing counselling**		**Challenging**	
Sequential location	Leader	Member	Leader	Member	Leader	Member
Initiative	37	11	0	25	4	7
After information or advice	30	8	0	2	15	0
After another member's disclosure	3	3	0	41	0	22
Within own disclosure	2	1	0	0	0	0
	72	23	0	68	19	29

Table 2 illustrates the relation of the sequential location of members' questions to the function of the question, and the distribution of first responses between the leader and the members. First, questions that initiated a new sequence were either requests for counselling or challenges to a particular topic. In addition, they were doing counselling when they were allocated to another member. Second, questions that were located after information or advice were challenging it or requesting counselling. Third, questions that followed another member's disclosure were challenging it or doing counselling. In the following, we describe how questions generate shifts in participatory roles, and how this offers possibilities for member-driven discussion. There were also

32 questions that were interpreted as transitions outside the current action or topic. These are not included in Table 2 and will be addressed in section 3.4.

3.1 Member's question is a request for counselling

Ninety-five members' questions (Table 2) functioned as requests for advice or information about the counselling topics (for example, nutritional recommendations), or for confirmation of some knowledge the speaker claimed to already possess. They mainly followed information or advice, or initiated a new sequence. The latter were direct questions referring to a topic that had been previously discussed or was assumed to be known by the participants. The questions positioned either the leader or another member as a respondent, and thus accomplished a temporary change in the leader-driven trajectory of discussion. By answering the question and providing the requested information, the respondent accepted the offered position as the expert.

Table 3. HC5/I: Member's question is a request for counselling

```
1 Counsellor: >meillähän   se<   kahen viikon kuluttua ois   sitte se,
              >we+have+CLI that< two   weeks  after    would then  that,
              >we'll have< in two weeks then that,

2             (0.2)

3 Merja:      °.tjoo°
              °.tyeah°

4 Counsellor: seuraava,
              next,

5             (.)

6 Maria:      mm

7 Counsellor: tapaaminenh? (.) .hh (.)
              meetingh?    (.) .hh (.)

8             ja  nyt mullois      oikeestaan sit  ↑teille nää,
              and now I+have+would actually   then ↑you+to these
              and actually now I would have these ↑for you,

9             (0.6)

10 Counsellor: [askelmit-         ]
               [pedomet-          ]

11 Sonja:      [oliko  muute      ]ajatus et   joka  kerta on se   punnitus
               [was+Q  by+the+way ]idea   that every time  is that weighing
               [by the way was the]idea that we would weigh ourselves every time

12             vai sitte  [lopuksi.]
               or  then   [end+at.]
               or then at [the end.]

13 Counsellor:            [.hh     ] =se on lopuksi.
                          [.hh     ] =it is end+at.
                          [.hh     ] =it is at the end.

14 Sonja:      =aha.

15 Counsellor: =joo  et   se on ihan tää  ensimmäinen kerta ja  [sitte.]
               =yeah that it is just this first       time  and [then. ]
               =yeah then it is just this first time and            [then. ]
```

```
16 Sonja:                                                    [joo.
                                                             [yes.

17 Merja:                                                    [pitääkö
                                                             [do+must+Q
                                                             [do we need to

18              meiän töissä  ottaa [(välissä) (   )
                us    work+at take  [(between) (   )
                weigh ourselves at  [work (in between) (   )

19 Maria:                           [pitää.
                                    [must.
                                    [yes we do.

20 Sonja:                           [(hyvä lisäys)  (   ) he he he [he .hh
                                    [(good addition)(   ) he he he [he .hh

21 Paula:                                                      [onko tossa nyt
                                                               [is+Q there now
                                                               [is there any

22              mitää suositusta     kuinka paljo askelia pitäs  ↑tulla?
                any   recommendation how    much  steps   should ↑come?
                any recommendation for how many steps one should ↑take

23              (0.2)

24 Counsellor: .hh (.) no   sehä   on se   to#ta se#, (.)
               .hh (.) well it+CLI is that er#m  that#, (.)
               .hh (.) well it is that er#m, that#, (.)

25              mm #ee ö ee# m, >sanotaanko et   jos me aatellaan se<
                mm #ee ö ee# m, >let's+say  that if  we think     that<
                mm #ee ö ee# m, >let's say that if we think of it as<

26              terveysliikuntaa.      niin ni sehän  on:, se on,
                health+activity+about. then so it+CLI is:, it is,
                exercise for health. so then it is:, it is,

27              se on kymmenentuhatta askelta.
                it is ten+thousand steps.
                it is ten thousand steps.

28              on se   niinku semmonen  terveysliikunnan.
                is that like   that+kind health+activity+of.
                that is the (recommendation) to exercise for health.

29              kaheksan tuhatta  >joissaki lähteissä<     joissaki kymmenen tuhatta.
                eight    thousand >some+in  references+in< some+in  ten thousand.
                eight thousand >in some references< ten thousand in some.
```

In Table 3 there are two member's questions that request counselling. The first (11–12), by Sonja, is marked as a breach of the current activity with the words "by the way". It returns to a topic that was discussed earlier: weighing the participants. The question offers a choice of two possibilities, of which the counsellor confirms (13) the second. This evokes a follow-up question from Merja to other group members, who are her co-workers, on whether they should weigh themselves in their workplace (17–18). Paula asks yet another question (21–22), taking up a new topic concerning the pedometers that the counsellor is simultaneously handing out to the members (27–29). Paula asks about the proper number of steps to be taken. By asking for recommendations she explicitly marks the nutritionist as the knowledgeable person. Further, by asking for information, Paula orients to the institutional task at hand, showing interest in the goal of the group.

Sonja's and Paula's questions show how, by asking a question, participants can initiate a topic and position the group leader as a respondent while maintaining the leader's position as an expert. Sonja asks the first question as the counsellor is commencing a new activity, and manages to temporarily return to a preceding topic. Paula's question steers the discussion back from a multiparty discussion between group members to a dialogue between a group member and the counsellor. The questions initiate shifts in participatory roles and topics, and the participants treat them as relevant and accept the offered roles.

Table 4. HE2/II: Member's question is a request for counselling

1 Teacher:	mitäs muuta.	
	what+s else.	
	anything else.	
2	**(0.6)**	
3 Teacher:	äsken oli paljon käsiä ylhäällä.=Asko.	
	a+moment+ago were lot+of hands up. =Asko.	
	there were a lot of hands up a moment ago.=Asko	
4 Asko:	niin että rasittaakse silmiä jos kattoo tähän	
	so that strains+it eyes if 0+looks here+at	
	so does it strain eyes if one looks into this	
5	valolamppuun (mikä) [( )( )	
	light+lamp+at (which)[( )( )	
	light bulb (which [( )( )	
6 Jake:	[kyllä rasittaa.	
	[yes strains.	
	[yes it does.	
7	>tää on niin pieni<, pi- pimee [huone?	
	>this is such+a small<, da- dark [room?	
	>this is such a small<, da- dark [room?	
8 Teacher:		[↑no,
		[↑well,
9	↑tämmöset ↑vilkkuvat (0.8)	
	↑**these** ↑**blinking (0.8)**	
10	hä- vilkkuvat valothan kyllä vähän voi rasittaa että,	
	di- blinking lights+CLI indeed a+little can strain so,	
	di- blinking lights can indeed cause some strain so,	
11	ei toi oo oikeen, hyvä silmille pi[temmän päälle.	
	no that is really, good eyes+for lo[nger on+top.	
	it's not really, good for the eyes [in the long run.	
12 Jake:		[tää on noin pimeä huone nytten.
		[this is so dark room now.
		[this is such a dark room now.
13 Teacher:	niin. (0.8)	
	yes. (0.8)	

In Table 4, the teacher has asked what kind of harm is caused by extensive screen time, and one student has already answered that it is harmful to the eyes (data not shown). The teacher solicits more responses and allocates the turn to Asko (3). Instead of responding to the teacher's question, Asko asks a question about whether the classroom projector lamp is harmful to the eyes (4–5). Thus the question disaligns from the line of activity suggested by the teacher and returns to a previously discussed topic. While the participatory roles in the current IRE/F framework position the students as respondents, by asking a question Asko shifts the role of respondent to the teacher

while sustaining the teacher's role as an expert. Although the question is allocated to the teacher, another student, Jake, answers it first (6–7), volunteering his existing knowledge. Thereafter the teacher responds by giving information. It is noteworthy that the teacher brings up a different explanation from Jake's, emphasising the blinking of the lights rather than the darkness of the room as the reason for the strain on the eyes. As Jake repeats his own explanation of the problem (12), the teacher confirms this too. By answering the question and delivering the requested information the teacher accepts the offered participatory role as a respondent. By giving a different explanation for the strain from Jake's, and by confirming Jake's comment on the darkness of the room (13), she also makes a move to regain her position as the expert.

These examples illustrate how group members request counselling by asking questions concerning the topic that is currently being or has earlier been talked about. In both examples, the questions were somewhat disaligning from the current activity suggested by the leader. However, both showed an orientation towards the institutional task. By requesting counselling, the members offered the expert position either to the leader or to the other participants. In this way they managed to steer the direction (both topic and activity) of the counselling discussion.

3.2 Member's question is doing counselling

Sixty-eight of the members' questions (Table 2) requested information about the respondent's personal situation or actions, offered advice or new perspectives, or invited the respondents to evaluate some topic of talk. With these questions the members were adopting tasks that were usually performed by the leader. They were mostly located after another member's disclosure or initiated a new sequence. They were usually designed with an explicit turn allocation or a contextual reference that implied turn allocation to a specific respondent or to a group of respondents. They were always answered by one or more group members, never by the leader. The questions changed the leader-driven trajectory of discussion so that the leader was set aside as a listener. Table 5 is a case in point from the health counselling data.

The episode is launched with a written assignment and the leader's instruction to members to assess their own habits and potential need for improvement. The counsellor-driven initiation of an assignment is observable in lines 1–5, 7 and 12. The first member's question (16) is located after group member Maria's disclosure. This would be a relevant place for the counsellor to give feedback (as illustrated in Table 1), provide information or advice, or ask a follow-up question. Instead, another member, Sonja, asks a question.

Table 5. HC5/III: Member's question to other member is "doing counselling"

1	Leader:	on hyvä kattoo niitä missä menee ↓hyvin (.) it+is good to+check those where goes+it well **It is good to check those that go ↓well (.)**
2		ja sitte toinen oli se että millaisessa tilanteessa on parannettavaa and then another was it that what+kind+in stuation+in is improvement+need **and then another was that in what kind of situation we could do better**
3		ja (.) .mt millaiset tilanteet koette tuota (.) erityisen niinku and what+kind+of stuations experience+you like especially like **and (.) .tch what kind of situations you feel like** (.) **especially like**
4		riskialttiina ni (.) syömisen hallinnan suhteen. risky like eating+of control+of in+terms+of **risky as (.) in terms of eating control.**
5	Ella:	**mm**
6		(1.2)

7 Leader: mitä teille, tuliko teille?
what you+for, got+Q you+for
What did you, did you?

8 (1.4)

9 Maria: mun, mun näitä positiivisia asioita on se et et mun ei m- öö,
my, my these positive things is the+thing that that I not
my,one of these positive things of mine is the thing that that I don't m-

10 tarvii enää paneutua siihen aamupalaan et mä syön säännöllisen,
need+to anymore focus that+on breakfast that I eat regular
umm, need to focus on that breakfast that I eat a regular,

11 ja [terveellisen
and [healthy
and [healthy

12 Leader: [joo=
[Yeah=

13 Maria: =aamupalan, (.) ja mä syön lounaan säännöllisesti että mun ongelma on
breakfast and I eat lunch regularly so my problem is
=breakfast, (.) and I eat lunch regularly so my problem is

14 sitte se pitkä iltapäivä ja se kotisyö[pöttely illalla.
then that long afternoon and that home+bi[ngeing night+at
then that long afternoon and that binge[ing at home at night.

15 Sonja: [mm,

16 Sonja: oot sää [keksiny nyt siihen jonku, mm,
have you[figured now that+for something,
→ **Have you[figured out something for that now, mm,**

17 Maria: [siihen
[that+for
[**for that**

18 (.)

19 Maria: no se hedelmien m- määrä ja niitten, niitten käyttö et mä syön,
well that fruit+of amount and their, their use that I eat
well that amount of fruit and their, their use is that I eat,

20 ehkä pari omenaa tai appelsiinia kun mä tuun töistä
maybe a+couple+of apples or oranges when I come work+from
maybe a couple of apples or oranges when I come from work

21 XXX: **mm**

22 Maria: ja istun vähän aikaa alas ja luen lehteä tai muuta että et sit vasta,
and sit short while down and read magazine or other that that then not+until
and sit down for a while and read a magazine or something so not until then,

23 (.)

24 Leader: ↑joo. ((nyökkää))
↑**Yeah. ((nods))**

25 Maria: ottaa [jonku
take+0 [some
one takes[some

26 Paula: **[mm [mm**

```
27 Maria:                  [voileivän ja kun siellä on  jo     se   kylläsyyden tunne
                           [sandwich and when there is already that fullness+of sense
                           [sandwich and when there is that sense of fullness already

28            olemassa nii kyl   se kantaa sitte yllättävän pitkäl[le.
              existing so indeed it carries then suprisingly      [far
              so it indeed supports you surprisingly              [well then.

29 Sonja:                                                         [laitakko   nää
                                                                  [cook+you+do you
→                                                                 [Do you cook

30          lämpimän ruuan vielä kotona sit[te.
            warm    meal   even  home+at th[en
→            a warm meal even at home    th[en.

31 Maria:                                  [e:n (.) hyvin harvoin. [hyvin harvoin.
                                           [no      very rarely    [very rarely
                                           [n:o (.) very rarely.   [very rarely.

32 Sonja:                                                          [.hh joo
                                                                   [.hh yeah

33 Maria:     ku ei meit oo  kun kaks aikuista [oikeesti
              as not we  are but two  adults   [really
              as we are only two adults        [really.

34 Sonja:                                      [nii
                                               [yeah

35 Maria:     mutta tuota? .hh (.) voishan   sitä aatella et   se vois  olla joku, (.)
              but   erm       could+0+indeed it   think   that it could be   some
              but erm? .hh (.) you could really think that it could be some,  (.)

36            kevyt, kasviskeitto tai [jotain
              light  vegetable+soup or[something
              light, vegetable soup or[something
```

The question (16) is oriented to the institutional task of achieving change. It suggests that Maria has been actively involved in contemplating possible solutions to her problem. In her answer, Maria describes how she has tried to solve her problem (starting at line 19); the leader subsequently acknowledges Maria's answer (24). As Maria's disclosure continues, Sonja asks another question (29–30), that offers one possible solution – a preferred habit – and can thus be interpreted as advice. Maria accounts why she is not doing as suggested (31,33) – a typical way of rejecting advice – and continues by suggesting another solution (35–36). It is noteworthy that although Maria resists Sonja's advice, her own solution is also in line with the institutional task. The leader gives minimal acknowledgements and lets the members' discussion continue.

As illustrated in this example, this kind of members' question was located where the leader's follow-up questions, evaluations or advice could have taken place. They were designed similarly to the ways in which the leader's questions were designed and aligned with the institutional task. Thus the members adopted the role of counsellor, asking about personal solutions and giving advice in the form of a question. As such they were "doing counselling", resulting in member-driven participation.

3.3 Member's question is challenging the previous talk

Forty-eight questions (Table 2) called into question some aspect of the previous talk or of the materials used in the intervention. They were mostly located after another member's disclosure or information or advice, and they were allocated either to one or more group members or to the

leader. They were often designed with a clitic –kO[2] or the word “eikö” (isn’t), which indicate doubt by requesting confirmation while implying that the opposite is anticipated [45,46,47].

Table 6 illustrates a challenging question to a group member. The question (21) refers to the meal the group members (who are colleagues) have had for lunch.

Table 6. HC5/IV: Member’s question to other member is challenging what has been said

```
1 Paula:    ja  tännää mun piti,   työkaverin  piti   sanoa että
            and today  I   had+to, work+friend had+to say   that
            and today I had to, my colleague had to say that,

2           nyt ei  Paula ennää   ota [lissää.
            now not Paula anymore take[more.
            now Paula won’t take more [any more.

3 Sonja:                              [↑niinkö?
                                      [↑really?

4 Paula:    .joo
            .yeah

5 Sonja:    >pitikö     p- mennä< puu[ttumaan     siihen.]
            >0+had+to+Q i- go<    int[ervene      it+to. ]
            >did one have i- to<  int[ervene to it.      ]

6 Paula:                          [mää on  =>me ollaan<] tehty semmonen
                                  [I   have=>we have<  ] made  that+kind+of
                                  [I have  =>we have<  ] made that kind of a

7           sopimus että, mä en  voi ennää  [↑ottaa ↑lissää?            ]
            deal    that  I  not can anymore[↑take  ↑more?              ]
            deal that, I can’t take         [↑more ↑anymore?            ]

8 XXX:                                      [ah  ah    ah ah            ]

9 Ella:                                     [>muttako<     ei  se   ruoka]
                                            [>but+because< not that food ]
                                            [>but that< food wasn’t      ]

10          [kyllä  nii ihan  hirveen,
            [really so  quite beastly,
            [really so beastly,

11 XXX:     [ah ah ah ah ah ah

12 Paula:   muttako     mää en     kykene     siihen   ite    niin nyt sitte
            but+because I   not+am cabable+be that+for myself so   now then
            but ’cos I can’t handle it myself so now then

13          Pirjo #saa:# Pirjo sano nyt Paulalla,[loppu ruokailu?
            Pirjo  can   Pirjo said now Paula    [stops lunch?
            Pirjo #can:# Pirjo said that now the [lunch is over for Paula?

14 Merja:                                        [heh heh eh eh eh ah hah hah hah hah

15 Paula:   eh [heh heh heh hehe

16 Ella:       [hmheh heh heh

17 Merja:   £voi ett[ä? hir::vittävää£        ]
            £oh  dea[r? aw::full£             ]
            £oh  dea[r? tha::t is awfull£     ]
```

[2] For example: “*PitääkÖ* juoda maitoa?” – ”*Does one need to* drink milk?”; “*LaihtuukO* tällä?” – “*Does one lose weight* with this (diet)?”

18 Paula: [£ku lautanen vietiin] ↑pois?£ heh
[£when plate taken+was] ↑away?£ heh
[£when the plate was taken] ↑away?£ heh

19 Merja: **heh heh heh**

20 Sonja: [(tää on tosi kätevä tää)
[(this is really handy this)

21 Ella: → [↑>olikse muka< niin hyvvää.=minusta [se ei ( )
[↑>was+Q+it as+if so good. =in+my+opinion[it no ( )
[↑>was it really< that good. =I think [it wasn't ( )

22 Paula: [e:i se [ollu mutta]
[n:o it [was+not but]
[n:o it [wasn't but]

23 Merja: [se oli maut]onta
[it was tast]eless

24 Ella: **[eh hehe ↑heeh he]**

25 Paula: [£kuhan sitä syö] [vaikkei o hyvvääkää£.]
[£as+long+as that 0+eats] [even+if+not is good+either]
[£one will eat it] [even if it's not good£.]

26 Maria: [ei se hyvvää.]
[no it good.]
[no it wasn't good.]

27 =[munki teki mieli mutta en ottanu lissää.]
=[me+too did crave but I+not took more.]
=[I craved it too but I didn't take more.]

28 Merja: [nii. =mä teen näin just että saako ottaa lissää] ↓mautonta ↓ruokaa.
[yeah. =I do like+that exactly that can 0+take more] ↓tasteless ↓food.
[yeah.?=I do exactly like that can one take more of that] ↓tasteless ↓food.

29 Paula: **mhäh ha ↑haah hah**

30 Merja: **[mm eh heh he**

31 Ella: [minusta se ei kyllä maistunu.
[in+my+opinion it not really tasted
[I think it didn't really taste.

32 Merja: ei maistunu [↑millekkää.]
not tasted [↑anything.]
it didn't taste [like ↑anything.]

33 Paula: [ei se maistunu mutta]ko [sitähän voi
[no it tasted+not but+be]cause[it+CLI can
[no it didn't but] [one can well

34 Sonja: [(mitä se oli sitte)
[(what it was then)

35 Paula: syyä silti
eat anyway
eat it anyway

36 Maria: [( )

37 Ella: [kinkkukiusausta
[ham casserole

```
38 Paula:    ja (rivakasti) heh heh heh
             and (double-quick)heh heh heh

39 Maria:    heh hehheh heh
```

At the beginning of the episode, Paula reveals that she has made a deal with her colleague to stop her from bingeing. At lines 9–10 Ella initiates a challenging remark about whether the food was really that delicious, but this remark does not get a response. With a question (21) Ella manages to topicalise the tastelessness of the meal in question. The topic is known to the participants including Ella herself, so this question is not asking for information about the food. The participants interpret Ella's enquiry about the taste of the meal as a critique of overeating even when the food is not delicious, and this generates multiparty discussion among members. Paula responds with a confirmation and an account (22,25), and Merja and Maria also join the conversation with their responses (23,26). Furthermore, the clients continue (27,28,33,35) and ridicule the habit of overeating.

Table 7 is an example of a challenging question to the group counsellor. The question (6) is located after counsellor's information about vegetables. It picks one item from the list of beneficial food items, and by requesting confirmation that this item is not fattening, it challenges the counsellor's previous turn.

Table 7. HC11/II: Member's question to group counsellor is challenging what has been said

```
1            (1.0)

2 Counsellor: eli näitä niinku, jossakin muodossa joka päivä
              so  these like,   some+in  form+in  every day
              so these like, in some form every day

3             ois hyvä olla (    )(.)
              would good be (    ) (.)
              it would be good to have (   )(.)

4             ↑banaania mandariiniä, omenaa. (1.0)
              ↑banana mandarin, apple. (1.0)

5             tomaattia kurkkua, porkkanaa.
              tomato cucumber, carrot.

6 Mikko:      eikö  banaani liho:ta.
              not+Q banana  fatten.
              isn't banana fa:ttening.

7             (1.2)

8 Counsellor: ei se [sen
              no it [its


9 Marko:            [elä       nyt heti         tyrmää    [k(h)u (    )hah hah hah
                    [don't+you now immediatelly knock+out [wh(h)en (    ) hah hah hah
                    [don't throw it out right away        [wh(h)en (    ) hah hah hah

10 Counsellor:                                            [heh heh heh

11 Counsellor: s[e:,
                i[:t,

12 Mikko:       [sitä kuulee  kaiken[laista.
                [     0+hears all+ki[nds+of+things.
                [one hears all kinds[of things
```

```
13 Counsellor:                    [se on,
                                  [it is,

15 Harri:       mm

16 Counsellor: ↑semmonen,    hirveen vahvassa, (.) oleva    usko.
               ↑the+kind+of, terribly strongly (.) existing belief.
               ↑like a, belief that is (.) terribly strong.

17             (0.2)

18 Counsellor: mutta siis, (0.6)
               but   like, (0.6)

19             #ei#  ↑siinä   banaanissa oo sen enempää energiaa ku   on
               #not# ↑that+in banana+in  is any more    energy   than is
               #no# ↑there is no more energy in a banana than there is

20             (0.2) on tuota marjoissa tai (.)
               (0.2) is erm berries+in or (.)
               (0.2) is erm in berries or (.)

21             tai niinku omenassakaa et se se on ehkä vähän tiiviimpää että,
               or like apple+in+either that it it is maybe little denser that,
               or like in apple either that it it is maybe a little denser that.
```

The participants treat the question as challenging: there is a significant gap after the question (7) and another client explicitly describes the turn as “throwing out” (9). However, the counsellor treats it as a relevant question, and answers it. Furthermore, the counsellor provides an interpretation of the question (16) and evidence for the answer (19–21). Thus, while retaining her expert position and resisting the perspective indicated in the question that bananas might be fattening, the counsellor also accepts the position of respondent (as with the types of question that request counselling). Thus the counsellor acknowledges the topic of the question as relevant and the action of challenging as legitimate.

While the challenging questions cast doubt on a particular topic of talk, in both examples they were aligning with the institutional task with regard to healthier lifestyles. In the first example, the question did not induce a shift in participatory roles: the discussion was already member-driven. Nevertheless, it sustained the member-driven discussion while introducing a new perspective, and generated multiparty discussion. In the second example, the question induced a temporary shift towards member-centred discussion, similarly as questions that requested counselling from the leader.

3.4 Member’s question is treated as deviation

In general, participants treated members’ questions as relevant actions in which members of a group counselling intervention could legitimately engage. This was observable in how the members accepted the changes in participatory roles. However, in 32 cases participants did not treat the question as a relevant action and sought to sustain their current participatory roles.

In the next excerpt from the health education lesson (Table 8), the teacher offers “question time” [35] to a student. Therefore there is an opportunity to shift towards member-driven discussion, for example by asking for information from the teacher. However, instead of answering the question, the teacher immediately blocks it with a counter-question, thus treating it as a disruption.

Table 8. HE1/II: Student's question to teacher is treated as disruption

1 Teacher:	mikä Elias oli se sun kysymys mitä sä äsken kysyit. what Elias was that your question that you just asked **What Elias was that question of yours that you just asked.**
2 **Elias:**	että onks sun (mielestä jos) pelaa kakstoista tuntia putkeen, that is+q in+your (opinion if) 0+plays twelwe hours in+a+row, **That is it (in your opinion if) you play twelve hours in a row,**
3	(.) joskus. sometimes. **(.)sometimes.**
4 Teacher:	[mitä luulisit.] [what think+would+you.] **[What would you think.]**
5 Boy:	[(pelaa) video]pelei [0+plays video]games [**plays video]games**
6	(0.4)
7 Elias:	hä huh **Huh**
8 Teacher:	mitä luu[lisit. what thi[nk+would+you **What would [you think.**
9 Boy:	[pleikka kolmosen [(ohjeessa)lukee [Playstation three+of [manual+in says+it **[In Playstation 3 [manual it says**
10 Teacher:	[onko hyvä. [is+Q good **[Is it good.**
11 Boy:	että saattaa saada kouristuksen ja jotkut kuvat that 0+might get a seizure and some pictures **that one might get a seizure and some pictures**
12 Teacher:	ei [tietenkään. no [of+course+not. **Of [course not.**
13 Boy:	[jotkut kuviot voi vaikuttaa (että tulee) jotain kouristuksia [some patterns may affect (so+that 0+gets) some seizures **[Some patterns may have an effect (so that one gets)some seizures,**
14	pitää pitää tunnissa vartti taukoa. 0+must take hour+in quarter break **one must take a quarter break in an hour.**
15	(0.6)
16 Teacher:	hei, nyt katse tänne näin, elikkä, täälä on tytöt, ja pojat. hey, now gaze here+to like+this, so, here are girls and boys. **Hey, now all eyes on here, so, here are girls, and boys.**

```
17              ensimmäinen,(0.2) ensimmäinen (.) diagrammi, (.) on, (0.6)
                First             first           chart          is
                The first, (0.2) the first,(.) chart, (.) is, (0.6)

18              teevee deeveedee
                TV, DVD
```

It is uncertain whether the question (2) is intended as heckling or is rather a real issue the boys want to discuss. The teacher seems to interpret the question as heckling and responds to it with a counter-question, using a rather annoyed tone of voice (4). We can see how Elias answers the question with an open-class repair initiation – "huh" (7) – thus treating the counter-question as unexpected.

The teacher treats Elias's answer as if it indicates a problem with hearing (8), and repeats her counter-question. Next, another student joins in with information that could be interpreted as an account of Elias's question (9,11,13–14). The teacher ignores his turn and states that the answer is obvious, implying that the question was inappropriate (12). The teacher then moves on (16–18), reinforcing her treatment of the question as inappropriate and a disruption, even though she had initially offered "question time" to the student.

In the 32 cases of the data, the leader or the members treated the questions as transitions away from the current action or as topically inappropriate. We could not identify any topic or sequential location as categorically "non-relevant". Thus we suggest that the participants monitor whether the questions align with the institutional task and agenda, and make their interpretations depending on local contingencies.

4. Discussion and Conclusion

4.1 Discussion

In many respects, group members' questions operate similarly in both health counselling and health education. First, they have similar sequential locations. Second, they have similar functions: 1) requesting counselling, 2) doing counselling, 3) challenging. Third, they induce a shift in participatory roles.

In light of the current analysis, members' questions can be seen to support behaviour change in various ways [1]:

1) Requests for counselling ask for advice and information on specific topics, thus increasing knowledge of the issues that are relevant for the participants. This helps leaders to adjust the counselling to better serve the needs of the participants, which strengthens the therapeutic alliance.

2) Doing counselling may induce an increase in knowledge, but it is noteworthy that other group members may give advice or feedback to each other that is not accurate regarding the institutional goals.

3) Challenging questions may lead to discussions where the leader can correct misunderstandings or false presuppositions. This can result in an increase in knowledge. When the leader treats challenging questions as legitimate actions, thereby showing respect for the views of the participants, this may lead to a stronger therapeutic alliance.

Regardless of the function of the question, members' questions make members' views and experiences available to the group, providing material for the members to reflect upon, recognise and use to give social support.

4.2 Conclusion

Members' questions shape the participatory roles in health education and group counselling to allow member-driven interaction. Questions are used to topicalise issues relevant to the members and thus constitute a way to steer the direction of the discussion. Members' questions can steer the discussion from dyadic discussion with the leader, to dyadic or multiparty discussion among the group members, and back again. Thus group members' questions constitute a pivot point in participation.

Requesting counselling and challenging the issues that are dealt with in the counselling discussions are activities that are possible in dyadic counselling, and they have been recognised in previous research [30,31,35]. The group context makes more complex participation available. For group members, asking a question provides a legitimate way to influence the dynamics of counselling interaction. For group leaders, members' questions afford an observation point from which to monitor, facilitate or restrict member participation in the counselling session.

4.3 Practice implications

Observing the occurrence of group members' questions helps group counsellors and health educators to adjust their own actions accordingly and thus facilitate or guide group participation. Comparison of the type and frequency of members' questions is a way to detect different trajectories for delivering group interventions, and can thus be used to develop methods for process evaluation of interventions.

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All authors confirm all personal identifiers have been removed or disguised so the persons described are not identifiable and cannot be identified through the details of the story.

Appendix: Transcription symbols

[word]	*Brackets*: Onset and offset of overlapping talk
=	*Equals sign*: Contiguous utterances: second is latched immediately onto the first
(0.2)	Timed interval within or between utterances, measured in seconds and tenths of seconds
(.)	Interval of less than 0.2 seconds
wo:rd	*Colon*: Extension of the sound or syllable
.	*Full stop*: Falling intonation
,	*Comma*: Continuing intonation
?	*Question mark*: Rising intonation
-	*Dash*: Abrupt cut-off
↑↓	*Upward/downward pointing arrows*: Rising/falling pitch
word	*Underlining*: Emphasis
WORD	*Capital letters*: Louder volume
°word°	*Degree signs*: Quieter volume
>word<	Faster-paced talk than the surrounding talk
<word>	Slower-paced talk than the surrounding talk
#word#	Creaky voice
£word£	Smiley voice
@word@	Animated voice
hh	Audible aspiration
.hh	Audible inhalation
w(h)ord	Laughter
hah heh huh	Laughter
(word) ( )	Transcriber doubt
((word))	*Text in parentheses*: Transcriber's comments
→	*Arrow*: Feature of interest

References

[1] R.L. Street, G. Makoul, N.K. Arora, R.M. Epstein, How does communication heal? Pathways linking clinician–patient communication to health outcomes, Patient Educ Couns 74 (2009) 295 – 301.
[2] N. Wallerstein, What is the evidence on effectiveness of empowerment to improve health? Health Evidence Network report, WHO Regional Office for Europe, Copenhagen, 2006, http://www.euro.who.int/Document/E88086.pdf
[3] S. Brandstetter, J. Rüter, J. Curbach, J. Loss, A systematic review on empowerment for healthy nutrition in health promotion. Public health nutrition 18 (2015), 3146-54.
[4] M. Sharma, Theoretical foundations of health education and health promotion, Jones & Bartlett Publishers, 2016.
[5] R.M. Ryan, E.L. Deci, Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being, Am Psychol 1 (2000) 68–78.
[6] A. Bandura, Self-Efficacy: The Exercise of Control. Freeman, New York 1997.
[7] A. Bandura, 'Health promotion by social cognitive means', Health Education & Behavior 31 (2004) 143–64.
[8] A. Fasulo, J. Zinken, K. Zinken, Asking 'what about' questions in chronic illness self-management meetings, Patient Educ Couns 99 (2016) 917–25.
[9] S. Wiggins, Managing blame in NHS weight management treatment: Psychologizing weight and 'obesity', Journal of Community & Applied Social Psychology 19 (2009) 374–87.
[10] S. Sarangi, "The Spatial and Temporal Dimensions of Reflective Questions in Genetic Counselling", In Why Do You Ask? The Function of Questions in Institutional Discourse (Alice F. Freed, Susan Ehrlich, eds.), Oxford, Oxford University Press, (2009) pp. 235–55.
[11] T. Strong, D. Zeman, Dialogic Considerations of Confrontation as a Counseling Activity: An Examination of Allen Ivey's Use of Confronting as a Microskill, Journal of Counseling and Development 88 (2010) 332–9.
[12] M. Poskiparta, L. Liimatainen, T. Kettunen, P. Karhila, From Nurse-Centered Health Counseling to Empowermental Health Counseling, Patient Educ Couns 45 (2001) 69–79.
[13] M. Poskiparta, T. Kettunen, L. Liimatainen, "Reflective Questions in Health Counseling", *Qualitative Health Research*, 8 (1998) 682–93.
[14] Gale Miller, David Silverman, (1995), Troubles Talk and Counselling Discourse: A Comparative Study, Sociological Quarterly, 36 (1995) 725–47.
[15] T. Koschmann, J. Mori, "It's Understandable Enough, Right?" The Natural Accountability of a Mathematics Lesson, Mind, Culture & Activity, 23 (2016) 65–91.
[16] F. Rusk, M. Pörn, F. Sahlström, (2016), The management of dynamic epistemic relationships regarding second language knowledge in second language education: Epistemic discrepancies and epistemic (im)balance, Classroom Discourse 7 (2016) 184-205.
[17] V. Heller, Meanings at hand: Coordinating semiotic resources in explaining mathematical terms in classroom discourse, Classroom Discourse
[18] P. Drew, J. Heritage, Talk at work: Interaction in institutional settings, Cambridge University Press, Cambridge 1992.
[19] S. Hester, D. J. Francis, "Is institutional talk a phenomenon? Reflections on ethnomethodology and applied conversation analysis", in: A. McHoul, M. Rapley (Eds.), How to Analyse Talk in Institutional Settings: A Casebook of Methods London, Continuum, 2001, pp. 206-17
[20] P. Drew, 2003. "Comparative analysis of talk-in-interaction in different institutional settings: A sketch". In: Studies in language and social interaction: In honor of Robert Hopper, Edited by: Glenn, P., LeBaron, C. D. and Mandelbaum, Mahwah, NJ: Erlbaum, pp. 293-308.
[21] A. McHoul, The organization of turns at formal talk in the classroom, Language in Society 7 (1978) 183–213.
[22] H. Mehan, 'What time is it, Denise?' Asking known information questions in classroom discourse, Theory into Practice 18 (1978) 285–94.
[23] G. H. Lerner, Turn design and the organization of participation in instructional activities, Discourse Processes 19 (1995) 111-31.
[24] R. Jones, J. Thornborrow, (2004), Floors, Talk and the Organization of Classroom Activities, Language in Society 33 (2004) 399-423.

[25] H. Sacks, E.A. Schegloff, G. Jefferson, A simplest systematics for the organization of turn-taking for conversation, Language 4 (1974) 696–735.
[26] E.A. Schegloff, On some questions and ambiguities in conversation, in: J.M. Atkinson, J. Heritage (Eds.), Structures of Social Action: Studies in Conversation Analysis, Cambridge University Press, Cambridge, 1984, pp. 28–52.
[27] C.E. Ford, Questioning in meetings: Participation and positioning, in: A. F. Freed, S. Ehrlich (Eds.), Why Do You Ask: The Function of Questions in Institutional Discourse, Oxford University Press, Oxford, 2009, pp. 211–34.
[28] S. Ehrlich, A.F. Freed, The function of questions in institutional discourse: An introduction, in: A.F. Freed, S. Ehrlich (Eds.), Why Do You Ask? The Function of Questions in Institutional Discourse, Oxford University Press, Oxford (2009), pp. 3–19.
[29] O. St. John, J. Cromdal, Crafting instructions collaboratively: Student questions and dual addressivity in classroom task instructions, Discourse Processes 4 (2016) 252–79.
[30] S. Vehviläinen, Student-initiated advice in academic supervision, Research on Language and Social Interaction 2 (2009) 143–90.
[31] S. Vehviläinen, Problems in the research problem: Criticism and resistance in academic supervision encounters, Scandinavian Journal of Educational Research 2 (2009) 185–201.
[32] M.S. Solem, Displaying knowledge through interrogatives in student-initiated sequences, Classroom Discourse 1 (2016) 18–35.
[33] S. Garton, Speaking out of turn? Taking the initiative in teacher-fronted classroom interaction, Classroom Discourse 1 (2012) 29–45.
[34] H.Z. Waring, E. Reddington, N. Tadic, Responding artfully to student-initiated departures in the adult ESL classroom, Linguistics and Education 33 (2016) 28-39.
[35] A. Peräkylä, D. Silverman, Reinterpreting speech-exchange systems: Communication formats in AIDS counselling, Sociology 4 (1991) 627–51.
[36] S. Speer Hypothetical Questions: A Comparative Analysis and Implications for “Applied” vs. “Basic” Conversation Analysis, Research on Language and Social Interaction 45 (2012).
[37] A.M. Jussila, T. Vasankari, O. Paronen, H. Sievänen, K. Tokola, H. Vähä-Ypyä, A. Broberg, M. Aittasalo, KIDS OUT! Protocol of a brief school-based intervention to promote physical activity and to reduce screen time in a sub-cohort of Finnish eighth graders, BMC Public Health 15 (2015) 1-9.
[38] J. Laitinen, E. Korkiakangas, M. Alahuhta, S. Keinänen-Kiukaanniemi, U. Rajala, O. Timonen, T. Jokelainen, A.-M. Keränen, J. Remes, A. Ruokonen, P. Hedberg, A. Taanila, P. Husman, S. Olkkonen, Feasibility of videoconferencing in lifestyle group counselling, Int J Circumpolar Health 5 (2010) 500–11.
[39] J. Heritage, Garfinkel and Ethnomethodology, Polity Press, London, 1984.
[40] C. Antaki, Six Kinds of Applied Conversation Analysis, in: C. Antaki (Ed.), Applied Conversation Analysis. Intervention and Change in Institutional Talk, Palgrave Macmillan, Basingstoke, 2005 pp.1-14.
[41] C. E. Ford, "Conversation analysis and turn taking", in: C. A. Chapelle (Ed.), The Encyclopedia of Applied Linguistics, Oxford, U.K., Wiley-Blackwell, 2013, pp. 1121-7.
[42] P. ten Have, "Applied conversation analysis", in: A.McHoul, M. Rapley (Eds.), How to Analyse Talk in Institutional Settings: A Casebook of Methods, London, Continuum, 2001, pp. 3-11.
[43] J.McH. Sinclair, R.M. Coulthard, Towards an analysis of discourse: The English used by teachers and pupils, Oxford University Press, London, 1975.
[44] T. Koole, Classroom interaction, in: K. Tracy, C. Ilie, T. Sandel (Eds.), International Encyclopedia of Language and Social Interaction, Wiley-Blackwell, Oxford, 2015.
[45] A. Hakulinen, M. Vilkuna, R. Korhonen, V. Koivisto, T.R. Heinonen, I. Alho, (Eds.), Iso suomen kielioppi [Great Finnish grammar], Suomalaisen Kirjallisuuden Seuran toimituksia 950. Helsinki: Suomalaisen Kirjallisuuden Seura, 2004.
[46] L. Raevaara, Kysyminen toimintana. Kysymys-vastaus-vieruspareista arkikeskustelussa [Asking as an action. Of question-answer –sequences in everyday conversations], University of Helsinki, Helsinki, 1993.
[47] V. Yli-Vakkuri, Suomen kieliopillisten muotojen toissijainen käyttö [Secondary use of the grammatical forms of Finnish language], TYSYKLJ 28, University of Turku, Turku, 1986.

[48] D. Maynard, J. Freese, Good news, bad news, and affect: Practical and temporal “emotion work” in everyday life, in: A. Peräkylä, M.-L. Sorjonen (Eds.), Emotion in Interaction, Oxford University Press, Oxford, 2012, pp. 92–112.

PUBLICATION II

Self-reflective talk in group counselling

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'Self-reflective talk in group counselling'

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Abstract

Reflective processing is a joint social action that develops in interaction. Using conversation analysis and discursive psychology, this article focuses on self-reflective turns of talk in group counselling for adults at risk of Type 2 diabetes. We show how reflective processing unfolds in patterns of interaction, wherein group members take an observing, evaluating or interpreting position towards their own actions and experiences. Self-reflective talk is neither exclusively dependent on counsellors' actions nor limited to the niches the counselling programme structure offers. Self-reflective talk is one method of generating joint reflective processing. Such talk makes a topic available for discussion by connecting details of counselling with individuals' experiences and enabling sharing. Self-reflective talk thus serves as a way for group members to participate in constructing a lifestyle problem, to invite or provide sharing of experiences and to display their orientation to the institutional task at hand.

Keywords

Cognition, conversation analysis, counselling, discursive psychology, ethnomethodology, group counselling, group discussion, group interaction, health behaviour change, health counselling, interaction process, reflection, self-reflection

Autobiographical note

Aija Logren (M.Soc.Sc) is a social psychologist and doctoral student at the University of Tampere. Her research focuses on group interaction in counselling situations and on socially shared cognition.

Johanna Ruusuvuori (Professor of Social Psychology at the University of Tampere) has vast experience in analysing interaction in various contexts of health care. She has published widely on practices equivalent or close to counselling, empathy and participation in health care consultations, and qualitative methods.

Jaana Laitinen (Adjunct Professor in Nutrition and in Public Health, Director) specializes in intervention studies aiming to promote healthy lifestyles and work ability. Additionally, she has studied the development of unhealthy behaviours in an epidemiological prospective study of Northern Finland 1966 and 1986 cohort studies.

Self-reflective talk in group counselling

Introduction

Pursuing a reflective process is the gist of counselling methods in health counselling. Observing and evaluating one's own behaviour and getting feedback are connected to self-efficacy, self-regulation and motivation (Bandura, 1997, 2004). These processes can be promoted through various behaviour change techniques implemented in counselling (Michie et al., 2011, 2014a). However, there is little knowledge on what kind of action *self-reflective talk* is, and what is accomplished with it in counselling discussions.

In previous research, the terms *reflection* and *self-reflection* have both been used to describe the individual's reflective actions. In this article we use *self-reflection*, as here the focus is persons who are talking about their own actions. We analyse turns of talk where clients take an observing, evaluating or interpreting position towards their own actions and experiences. These turns of talk are defined as *explicit self-reflection*; that is, a social display of cognitive processing (Vehviläinen and Lindfors, 2005). Our aim is to contribute to a conceptual understanding of what self-reflective talk is and its role in discussions of behaviour change.

Reflective cognitive processing is a prerequisite for changing behaviour: critical thinking leads to revised action (Baumeister et al. 2007). As a theoretical concept, *reflection* has been widely discussed in the field of education. It has been described as a method for problem-solving by linking previous experiences to a chain of ideas and aiming for a conclusion (Dewey, 1933), and as an intellectual and affective response to an experience leading to a revised understanding (Boud et al., 1996). As a learning process, it is argued that reflection involves a critique of the

presuppositions on which our beliefs have been built, thus reassessing, interpreting and validating the foundations of our perspectives, actions and choices (Mezirow, 1990). Our interest is the ways in which this processing is talked into being and made available for participants in the interaction studied (Edwards and Potter 2005).

Reflection as a social action is interpretable in three ways. First, as an activity of the counsellor, reflection is understood as practices that counsellors use to mirror, dismantle and conceptualize their clients' talk (Brownlee et al., 2009; Miller and Rollnick, 2012; Zoffmann et al., 2008). Second, as an activity of the client, it consists of practices such as autonomous clarifications and reassessments of one's own statements (Zoffmann et al., 2008), or disagreements and explanations (Zapata-Rivera and Greer, 2003). Third, reflection can be understood as joint action of both the counsellor and the client. In this latter interpretation, it is argued that the client is actively engaged in reflective activities (Strong, 2006) and might verify or challenge the counsellor's conceptualizations (Williams and Auburn, 2015). Yet even as a joint action, reflection is assumed to depend on the initiatives and actions of the counsellor. Research has focused on practices through which counsellors invite their clients to recollect and interpret their experiences (Strong, 2006; Tomm, 1987; Williams and Auburn, 2015). The question has been how counsellors, therapists or other professionals prompt or encourage clients' reflection; for example, by using open-ended questions, future-oriented or hypothetical questions and different follow-ups (Antaki, 2013; Poskiparta et al., 1998), or by using cues such as video or pictures (Raingruber, 2003; Booth and Booth, 2003). Less attention has been paid to clients' self-reflective talk: how the turns of talk are designed and what kind of interactional functions they may serve.

In this article, we study reflection as a joint social action that develops in interaction between counsellors and clients in group counselling for adults at risk of Type 2 diabetes. Our focus is on sequences of conversation in which clients produce self-reflective turns of talk; we analyse the interactive processes that lead to and follow these sequences.

Promoting change through reflective processing

Counselling aims to support people in their life challenges in such ways that promote their agency, strengths and assets. Counselling is utilized in issues such as psychological problems, vocational challenges and chronic illnesses, and approaches vary between numerous counselling traditions. Health counselling addresses topics such as coping with an illness or motivating clients towards behaviour change. It is distinguished from health education, although some educational elements – such as instructions for self-care or self-monitoring – may be merged into counselling (Leong, 2008: xxv–xxvi; Vehviläinen, 2014; Visser and Herbert, 1996).

Health counselling programmes utilize behaviour-change techniques, such as self-monitoring a particular behaviour and analysing the factors that influence that behaviour. Clients are encouraged to adopt a revised identity, self-image or perspective through reframing or reattribution (Michie et al., 2011, 2014a). Techniques are based on theories about behaviour change, such as the health belief model (Rosenstock et al., 1988), the theory of planned behaviour (Ajzen, 1985) or social cognitive theory (Bandura, 2001). It is assumed that the observation, recognition and evaluation of actions leads individuals to become aware of the need for change, and thus increases their motivation to implement new behaviour (Glanz et al., 2008; Michie et al., 2014b). Reflective processing can be identified as a common denominator in various strategies to pursue behaviour change.

Methods to promote reflection range from instruments such as diaries, journals and applications to conversational practices such as cue questions and stimulated recall (see, for example, Coulson and Harvey, 2013; Donaghy and Morss, 2000; Prilla et al., 2012; York et al., 2016). These methods have been developed within adult education (Boud et al., 1996; Mezirow, 1998; Samuels and Betts, 2007; Waring Hansun, 2014), the reflective practice of health professions (Mann et al., 2009) and medical education (Sandars, 2009). The development of methods has drawn upon interview, observational and textual data, together with theoretical knowledge about the cognitive factors that benefit individual change.

Previous conversation analytic research on counselling has addressed various environments, such as academic supervision and student counselling (Hazel and Mortensen, 2014; Svinhufvud, 2016; Vehviläinen 2003), genetic counselling (Lehtinen, 2013; Sarangi, 2009) and HIV counselling (Miller and Silverman, 1995; Silverman, 1997). Tele-mediated interaction, such as email and telephone counselling, has been examined (Lamerichs and Stommel, 2016; Woods et al., 2015). Studies have centred mainly on professionals' actions and their consequences in interaction, especially counsellors' strategies to give advice while striving to encourage clients' integrity (Butler et al., 2010; Emmison et al., 2011; Poskiparta et al., 2001; Vehviläinen, 2001). Clients have different possibilities for participation in counselling interaction. On one hand, they have an opportunity to (for example) elicit more information by asking questions (Fasulo et al., 2016; Vehviläinen 2009); on the other, their participation has been found to be very limited (Poskiparta et al., 2001). In general, clients' actions in counselling interaction have been afforded less attention in previous research.

Poskiparta et al. (1998) have described a pattern in which a certain order of topics concerning patients' thoughts and feelings arguably represents reflective questioning. Antaki

(2013) has examined professionals' practices to encourage reflection among adults with intellectual disabilities, paying attention to the asymmetry of knowledge in favour of the professionals. Veen and de la Croix (2016) have studied the tutor's role in the context of medical training in which the main task was group reflection on patient cases. Like Antaki (2013), they pay attention to the somewhat asymmetrical relationship between the tutor and the other participants in controlling the transition from talking about an experience to reflecting upon it. In another line of inquiry, Vehviläinen and Lindfors (2005) have described the ways in which clients construct their self-reflective talk to give evidence of positive development. Like Vehviläinen and Lindfors (2005), we analyse clients' ways of displaying self-reflection and further, the trajectories wherein they are produced.

Strong (2005) argues that joint understanding and reflection are achieved in the cooperation between counsellor and client (also Strong et al., 2006), but notes that the practices participants use in reflecting have not been addressed (Strong, 2006). We take clients' self-reflective talk as a starting point to examine what is accomplished with turns designed to display reflective processing to other participants. In addition, our research addresses the specific characteristics of multiparty interaction. Group settings enable interaction not only between client and counsellor but also between clients, which presumably has an important impact on how the counselling discussions unfold. There is little knowledge of this aspect, as most previous research on counselling interaction has focused on dyadic settings (although see Lepper and Mergenthaler, 2005; Pino, 2016; Wiggins, 2009).

Data and method

This article draws upon a qualitative analysis of video data from group counselling for Finnish adults with a high risk of Type 2 diabetes. Nutritionists counsel groups of five to eight participants towards an institutional task of eating control and exercise, using actions such as giving information and advice and prompting the participants to reflect upon their current situations with regard to healthy lifestyles. The particular counselling method used in the intervention is based on a constructivist theory of learning (see, for example, Fosnot, 2013), and the materials and assignments are designed to support reflection (Laitinen et al., 2010). All participants have given their written informed consent for the study and the ethical committees of the relevant university hospitals have approved the study [Nr. 50/E0/2007].

The data consist of seven counselling sessions of 90 minutes each with four groups (one to three sessions per group). The data were drawn from a larger corpus comprising six groups and 22 sessions: altogether 33 hours of counselling, recorded using three cameras. The data were anonymized and transcribed according to conversation analytic conventions (Atkinson and Heritage, 1984). Transcription symbols are presented in the Appendix.

We combine conversation analysis (CA), which focuses on the structures of conversation (Hutchby and Wooffit, 1998) and discursive psychology (DP), which addresses how psychological themes are managed within conversation (Edwards and Potter, 2005). These methods of analysis explore turns of talk as actions that are made relevant and intelligible in the ongoing context. Rather than being expressions of mental states, self-reflective turns can therefore be analysed for the kind of interactional work they do. The analytic tools of CA and DP enable us to find out what is achieved in interaction when participants talk *as if* they were reporting cognitive processing. This approach highlights the social organization of reflective processing instead of taking for

granted the individual cognitive process displayed. Thus, we study how notions of individual cognitive processing are made available for other participants in the situation studied.

Vehviläinen and Lindfors (2005) state that, with self-reflective turns, speakers position themselves as observing, evaluating or interpreting their own behaviour. Following this definition, and drawing upon a preliminary analysis of the data, we defined explicit self-reflective turns as utterances in which speakers report their own behaviour and experiences and *mark them as a target of reflection* in at least one of three ways:

1. The speakers describe their own action using verbs such as *to notice*, *to remember* or *to pay attention to*, making explicit that their behaviour is a target of certain cognitive observational actions (Vehviläinen and Lindfors, 2005.) They may say, for example: *I have noticed that my stamina is much worse than it used to be*.
2. The speakers evaluate their own behaviour by:
    a) describing some aspect of it as a problem: *I suppose it is there that problem of mine that I have too big portions*,
    b) using positive or negative evaluations to assess their own behaviour, or
    c) using a pattern that starts with a report or a positive evaluation of something, continues with *but/then* and finishes with a negative evaluation of another thing (or vice versa): *Even though I do eat salad, so then I eat some meat and potatoes with it, way too much.*
3. The speakers present a causal interpretation concerning their own behaviour. For example, they report a certain behaviour followed by a negative consequence: *I don't sleep more than that – then I am tired in the afternoon.*

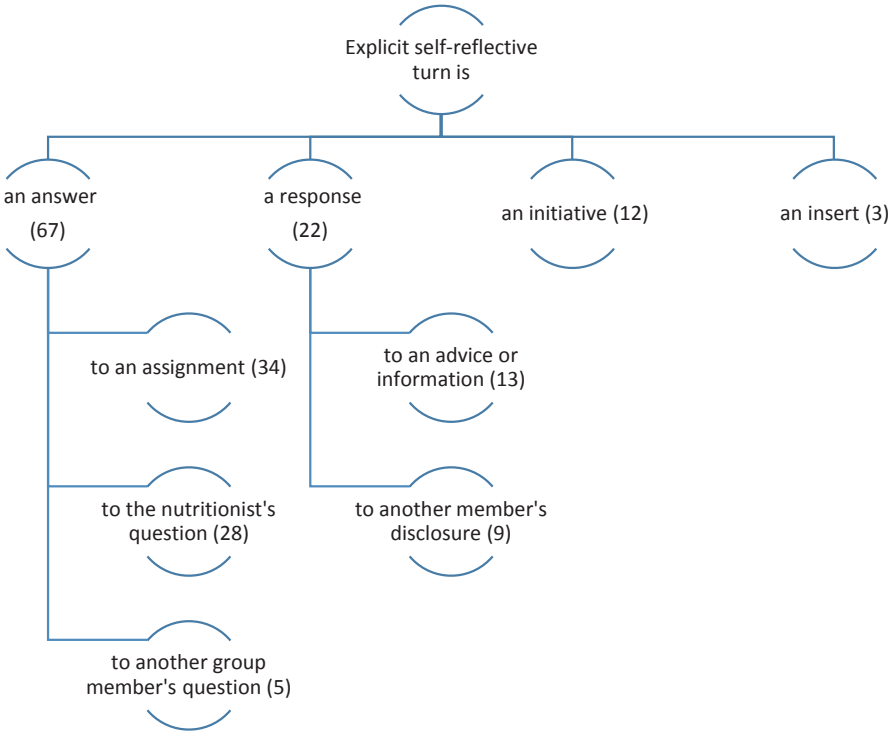
These types of self-reflective turns can be differentiated from mere reports of one's own experiences concerning healthy or unhealthy behaviour, such as *I eat maybe a couple of apples or oranges when I come home from work and sit down for a while and read a magazine or something.* Although such reports might imply awareness of one's own past actions, we excluded them from the collection because they show no clear signs of speakers *taking a position* of observing, evaluating or interpreting their own actions. Here, we focus on what we call *explicit self-reflective turns*, in which speakers explicitly treat their own actions as a target of cognitive processing and hence topicalize them in a specific way.

We identified 104 explicit self-reflective turns. These were not evenly located among different encounters in our data, and often, there was more than one self-reflective turn in a single episode. In the following analysis, we examine the local interactional context of self-reflective talk and the kind of interactional work it does.

Trajectories of self-reflective talk in group counseling

Most self-reflective turns were answers to a nutritionist's question or other prompt (n=67). In these cases, a missing answer would be accountable. The second most common location was following the nutritionist's advice or information or another member's disclosure (n=22). In these cases, a response is possible but not essential. In 12 cases, the self-reflective turn was made as an initiative that commenced a new action sequence, although it could be topically linked to previous turns (Schegloff, 2007). In three cases, the self-reflective turn was an insert: a remark (often explanatory) located within some other action, such as a response or a storytelling. Figure 1 shows where the 104 explicit self-reflective turns were located in the data.

Figure 1. Sequential location of explicit self-reflective turns



In the following we analyse more closely the ways in which self-reflective talk unfolds in group counselling and what is achieved with it. First, we describe a typical trajectory where self-reflective talk is initiated by the nutritionist's prompt. In these cases, the self-reflective turns of talk were mostly displays of orientation to the institutional task at hand. Thereafter, we show two cases of self-initiated self-reflective talk, where the same orientation was less prominent. In both types of cases, the self-reflective talk contained features that offered the experience described as shareable with the other participants.

Self-reflective talk following nutritionist's prompt

Excerpt 1 shows an example of a typical trajectory of a self-reflective turn; here, the turn is an answer to a nutritionist's prompt. The excerpt begins with a typical nutritionist's question, *how have you been, for the last two weeks?*, which is allocated to all group members (in the Finnish original transcript, the pronoun *you* is in plural form). In overlap with Anna's deep sigh, Ella selects herself as the first answerer and produces a report of her actions and thoughts during the previous weeks. The self-reflective turns are located at line 4, where Ella evaluates her actions (*not very well*), at lines 7–8, where Ella elaborates her evaluation (*a couple of days was just fine --- then a couple was a little*), and at lines 18–20 (*there one really noticed that…*).

Excerpt 1

1 NUTR: ↑joo mites teillä on menny,(0.2) ↑kaksi [viimistä viikkoa.
↑right how have you been,(0.2)↑for the last[two weeks.

2 ANNA: [.hhh

3 ANNA: phh[hhh

4 EMMA:→ **[ei kovin hyvin** ainakaan (tu-nyt) niinkun täm(h)än
[not very well at least (??-now) like in th(h)e

5 ohje(h)lman puitteissa ↑.heh
fram(h)es of this program ↑.heh

6 (0.8)((Nutritionist nods))

7 EMMA:→ **.hh ↑muutama päivä meni iha hyvin mu- .hh h sitte osa meni**
.hh↑a couple of days was just fine bu-.hh h then a couple was

8 **°vähä(sitte)° .mt (.) oli vähän semmosta**
°a little (then)°.tch (.)there was a little the kind of

9 **(.) kiirettä ja stressiä** nii ei oikee sitte,
(.) hustle and stress so it did not really then,

10 (0.6)

11 EMMA: vaikka seuras kyllä, .h askeleet kirjas ylös
though one kept track yes, .h one wrote down the steps

12 ja unen määrän kirjas ylös ni se oli sitte (.) enempi
and one wrote down the amount of sleep so it was then(.) more

13 semmosta shokkivaikutust(h)a että enkö mää oikeesti n(h)ukkunu
like the kind of shock effec(h)t that did I really not sl(h)eep

14 viime yönä ku kolome tuntia .hh heh hh h .nff mutta että,
more than three hours last night.hh heh hh h.nff but that,

15 eiköhän tämä tästä kesäkuun myötä vähän helepota?
supposedly it will get a little bit easier by june?

16 (1.6)((Nutritionist nods))

17 NUTR: °joo°
°yeah°

18 EMMA:→ **mut siinä kyllä huomas sen nii et se, elämäntilanne**
but there one really noticed that so that it, the situation in

19 **vaikeu- vaikuttaa hirviän paljon siihen syömiseen?**
life makes it hard- has a really huge effect on that eating?

20 **.h ja liikkumiseen.=että,**
.h and physical activity.=so,

21 ANNA: hh[h

22 EMMA: [et ei sit että jos on hirvee stressi päällä
[that one doesn't then so if one is awfully stressed

23 nii ei sitä jaksa ennää ajatella m- mitä (0.4)
then one is too tired to think anymore about w-what(0.4)

24 syö ja sit että, pitäs lähtä lenkille vielä sitte ku on (.)

one eats and then that,one should go for a jog even when one(.)

25 tehny pitkän työpäivän ja (.) väsyttää muutenki kauheesti.
has had a long day at work and (.) is awfully tired anyway.

26 (0.4)

27 NUTR: mm-m

28 EMMA: .nff

29 (0.6)

30 EMMA: °↑mutta ↑että, (0.2) .mt n:yt optimistisesti kesäkuuhun
°↑but ↑that,(0.2).tch n:ow(let's head)optimistically towards june

31 (1.2)

32 NUTR: no hyvä ((nyökyttelee))
well good ((nods))

33 (1.0)

34 ANNA: hh joo vähän sama ku Ellalla että tuota nii, (0.2)
hh yeah a little same as Ella that erm like, (0.2)

The nutritionist's question (line 1) is not specifically tied to the context of lifestyle change and health behaviour, but Emma responds in this frame, negatively evaluating her past week (line 4). Her evaluation acts as a guide to hearers to interpret the following report in a certain way: that she is not satisfied with her actions and is aware of what she should have done (Goodwin and Goodwin, 1992). The nutritionist responds to Emma's negative evaluation with a silent nod, and a more detailed description follows in which Emma evaluates how *a couple of days went fine, but then some went a little* (lines 7–8), hence positioning herself as an observer of her own actions. In the turns of talk that follow her initial self-reflective turns, Emma *gives an account* in which she explains how she has been too busy, stressed and tired to think about one's eating habits or to go jogging – actions that represent the positive lifestyle changes, healthy eating and physical activity promoted in the counselling. Thus, in her answer, *Emma takes into account the presumed expectations* of having already implemented some changes in her lifestyle.

Thereafter, Emma reports having been monitoring her physical activity and sleeping habits with a pedometer and a diary (lines 9–10), thus detailing her actions that have been in accordance with the counselling programme. In this way, she also *shows awareness of the overall goals of the programme*. Emma explains how her interpretation of the suggested actions was not beneficial; she describes having been shocked by discovering she was sleeping very little (lines 11–12). Emma ends her turn with an optimistic projection that the stressful situation will get easier by summer (lines 12–13).

Following the nutritionist's silence, Emma continues with another self-reflective turn (lines 18–20). Her turn is now designed, by using the verb *to notice*, to make explicit a certain behaviour as a target of cognitive processing and also to point out the change of state in it, this discovery is new to her (compared to verbs like *remembering* or *thinking*) (Vehviläinen & Lindfors

2005). It has been argued – at least in primary care appointments (Halkowski, 2006: 88–89) – that "series of noticings" are ways in which a speaker can present herself as "appropriately, but not overly, concerned about her health" (Gill and Roberts, 2013: 582–583).

Emma continues her turn with a formulation of her preceding talk (lines 22-25), concretizing the effects the situation has had on her health behaviour and displays this through citing her own experience. Thus here, *self-reflective talk is used to account for not being successful, while simultaneously showing that Emma has been attentive to the actions recommended in the group*. With the aforementioned activities – accounting for behaviour that can be seen as unhealthy, showing attentiveness to the recommendations of the counselling programme and displaying a change of state from unawareness to awareness – Emma shows orientation to fulfilling the institutional task of striving towards behaviour change, and can thus be seen to produce institutionally relevant morality.

It is also noteworthy, that Emma constructs her last self-reflective turn as shareable with other participants (lines 18-25). It is designed with a "zero-person" construction (here translated with the pronoun 'one'), which offers the described action as one that others may also have experienced and could thus identify with (Laitinen 2006), which may increase the relevance of affiliating with Emma's evaluation. Here, we see how Anna refers to Emma's preceding experiences as somewhat similar to her own, thus treating Emma's experiences shareable.

In the above case, as is usual in self-reflective turns following the nutritionist's prompt, the nutritionist's role in guiding the conversation is prominent. She provides space for continuing the self-reflective talk whereafter she evaluates it and gives the turn to the next participant. In the following examples of initiative self-reflective turns, the nutritionist's role is less substantial.

Initiative self-reflective talk

Twelve of the self-reflective turns in our data were initiative turns commencing a new sequence. These turns were topically related to previous discussions, but nevertheless launched a new action. Excerpts 2 and 3 show examples of this type of self-reflective turns. In these, the orientation to the institutional morality is constructed differently with regard to the ones given as responses to nutritionist's prompts. In Excerpt 2, the nutritionist has used an assignment as a resource and asked Paula – who has previously told that she likes sweet pastries – whether she eats the pastries fast or savours them slowly. Paula has responded that she eats them very quickly; and this has been followed by joking among the group (data not shown), who share some previous knowledge about Paula's craving for sweet pastries. Similarly as in Excerpt 1, Paula continues by giving more details that unravel her original response. However, unlike in Excerpt 1, the self-reflective turn is not an answer to the nutritionist's prompt but rather an initiative. In addition, it provides elaborations rather than accounts of Paula's behaviour; she tells a small story about her secret binge eating on her way home.

Excerpt 2

```
1 MARIA:                    [hyvin ripeästi
                            [very quickly

2 PAULA:     ni(hh)  (hy(hh)vin ripe(hh)ästi)
             ye(hh)  (ve(hh)ry quic(hh)kly)

3 GROUP:    ah hah hah hah hah[hah
```

4 PAULA: [nii ju(hh)st tos(hh)sa matkalla kerroin että

[yeah ju(hh)st on the way here I told that

5 → **mä saatan sit ↑niin säälittävästi tehä että mä meen,**

I might do ↑such a pitiful thing that I go,

6 **(.) Prisma markettiin ja ostan paperipussiin niitä,**

(.) to Prism supermarket and buy in a paperbag those,

7 **(0.4) niitä viinereitä**

(0.4) those Danish pastries

8 (0.2)

9 NUTR: [joo.

[yeah.

10 PAULA: [(semmosii) irtoviinereitä. ostan

[(those) in individual sale. I buy

11 NUTR: [joo

[yeah.

12 PAULA: [vaikka ↑kaks,

[for example ↑two

13 (0.4)

14 ja sitte tuota, @syön ne ↓a:utossa?@
and then erm, @I eat them ↓i:n the car?@

15 (0.6)

16 nopeesti mä ↑hyvä että mä ehin niiku niin,
quickly I ↑just about have time to like that like,

17 (.) oikeesti ↑maistaa,
(.) really ↑taste it,

18 (0.4) ja sitte (.)äkkiä [( )( )
(0.4) and then (.) quickly [( )( )

19 SONJA: [( )( )

20 PAULA: ↑niin,
↑yeah,

21 NUTR: [joo.
[yes.

22 PAULA: [ja sitte tuota, (.)@lähen kottii ja,
[and then er, (.)@I go home and,

23 (.) kei(hh)tän kaha[(hh)vit @
(.) ma(hh)ke some c[(hh)offee@

24 GROUP: [heh heh
25 heh heh heh [heh heh heh

26 PAULA: [@ja ↑otan pullaa.@
[@and ↑I have some bun.@

27 XXX: hah hah

28 PAULA: ja enkä sano kellekää mittää.
and I don't tell anyone anything.

29 (1.0)

30 PAULA:→ **et se on niinku musta niinku kaikista säälit[tävintä**
so that is like in my opinion like the most [pitiful thing

31 GROUP: [heh heh
32 [heh heh heh heh heh heh heh

33 PAULA: **[mitä mää niinku elämässä (teen),**=tai piilottelen niitä,
[that I like do in my (life), =or hide them,

34 (0.2)

35 ↑niinku ↑ihan ↑niinku ↑joku ↑tämmönen?
↑like ↑just ↑like ↑someone ↑like?

36 (0.2)

37 SONJA: alkoho[listi.
alcoho[lic.

38 PAULA: [↑alkoholisti.=
[↑alcoholic.=

39 SONJA: =joo.
=yeah.

40 PAULA: mm.

41 NUTR: sitten joo.
then yeah.

42 PAULA: nii, (.)ku auton niissä, (.) oven taskuista sitte,
so, (.)when, (.) from the compartments in the car doors,

43 (.)hiljasuudessa kerräilen [niitä ( )
(.)in secrecy I collect [them ( )

44 GROUP: [heh heh heh heh heh

45 PAULA: että niinku sen, (.) sen tyyppistä, on se.
so like that, (.) that's the way, it is.

Paula reports an experience of losing control of eating and evaluates it as *pitiful* (lines 5 and 30). By positioning herself *in an observing and evaluating position towards her own actions*, she manages to discuss a very delicate topic while simultaneously *displaying awareness of the questionable nature of her actions*. In Excerpt 1, the orientation to the institutional morality task of striving for healthier eating habits was stemming from presuppositions about what the participants should have been doing, while here, the orientation is shown by describing what they should have not done. Both ways, speakers display an orientation to the institutional task while bringing up potentially problematic topics.

The features of Paula's talk that make her story shareable with others are also somewhat different to those in Excerpt 1. The laugh particles at the beginning of Paula's story frame her behaviour as humorous and offer other group members the possibility of joining in with the laughter, which they do (line 3). Paula continues with a self-reflective turn (lines 5–7); while she does not laugh anymore, as she continues her story she displays a particular stance with prosody. Her voice sounds suppressed, as if she is trying to hold back laughter (line 14); at lines 22–23 and 26, she animates a carefree, even boastful character, marking her comment with laugh particles (line 23). The other group members show their interpretation on Paula's comment as ironic by joint laughter (lines 24–25). Further, at line 35, Paula presents an assessment of her behaviour but leaves the turn unfinished, thus offering space for the others to complete her utterance (Lerner, 1991). Sonja produces the latter part of the turn, *alcoholic* (line 37), thus offering an interpretation and as such, a recognition of a problem, which Paula then approves (line 38).

In Excerpt 3, the participants are playing a board game designed to provide information and positive feedback on healthy habits, and to support reflection on one's own habits. It is Ella's turn to answer a true-or-false question about the risk levels of alcohol consumption. She has read the question aloud and provided an answer, which the nutritionist has approved. Ella's game turn could have ended here, but she has continued to evaluate the threshold amount of units of alcohol (data not shown). The discussion following this eventually leads to an initiative self-reflective turn at lines 3–4 and its redesign at line 12.

Excerpt 3

1 NUTR: nii
yeah

2 ELLA: mikä on [(kai kuitenki) ( )
which is [(supposedly) ( )

3 SONJA: → **[kyllä kait mää luokittelen itteni**
[I do probably qualify myself as a

4 **suurku[luttajaksi**
large-scale con[sumer

5 ELLA: [tarkot[taako (--)
[does it[mean (--)

6 PAULA: [siis herran jumala (.)

[then oh my god (.)

7 [kaikkihan on sitte

[everyone is then

8 ELLA: [yks olut

[one beer

9 NUTR: joo yks öö (.) olut tai lasi viiniä tai yks

yes one öö (.) beer or glass of wine or one

10 neljän sentin paukku

single shot

11 ELLA: mm

12 SONJA:→ **kyllä mää oon suurkuluttaja ihan ilman[mitää**

yes I am large-scale consumer without [any

13 MARIA:→ **[kyllä määki sitte**

[yes then I am too

14 PAULA: [jos sanotaan

[If it is said

15 että joka toinen viikonloppu ottaa (.) ottaa
that every other weekend one has(.) one has a

16 muuta(hh)mat [(o(hh)luet)
coup(hh)le of[(b(hh)eers)

17 SONJA: [oh heh hoh

Sonja categorizes herself potentially as a *large-scale consumer* of alcohol (lines 3–4). This turn is in overlap with the previous turn, where Ella probably starts to assess the risk limit again. Sonja's self-reflective turn is an initiative; while it is topically tied to the ongoing discussion, it is not a response to the previous turns. She does not assess the threshold itself, which Ella has done previously; rather, she evaluates that, in light of the recommended guidelines, she exceeds the risk limit.

Compared to previous excerpts, there are no signs in Sonja's self-reflective turn of orientation to the presuppositions of appropriate participation or preferred health behaviour. Rather, she presents her evaluation surprisingly bluntly, considering the delicacy of the topic. This could be interpreted as a criticism of the evaluation scale of alcohol consumption levels as too strict and thus unreliable. Indeed, this is how Maria and Paula interpret Sonja's talk; they respond by elaborating that the categorization of a *large-scale consumer* also includes themselves – and *everybody* (lines 7 and 13). However, as other members join in and after a discussion of several minutes, the group eventually ends up agreeing on the need to monitor their alcohol consumption (data not shown). In Excerpt 3, Sonja evaluates her own habits in relation to the

guidelines, and in so doing manages to steer the discussion of alcohol consumption from a rather abstract level to a practical level. Self-reflective turn makes possible the discussion to exceed the actual true-or-false question.

The self-reflective turns in Excerpts 2 and 3 were produced not as straightforward and planned consequences of the agenda but rather as by-products of it. Self-reflective talk is thus not exclusively dependent on the initiatives of the counsellor. Counselling activities may provoke members to compare and evaluate their own actions in relation to, for example, recommended guidelines, as in Excerpt 3, or volunteer stories on own experiences, as in Excerpt 2. Self-reflective turns of talk tie pieces of information on the topic of healthy lifestyle – such as risks of bingeing or concepts like *large-scale consumer* – into participants' own experiences.

Summing up the analysis, self-reflective turns can produce institutional morality by displaying awareness of appropriate participation and institutional goals – even if members had not yet made any of the behaviour changes expected of them. We saw how speakers first accounted for presumed expectations concerning either health behaviour or appropriate participation in a current context, and second evidenced their awareness of the need to change their habits and their will or ability to do so. This was achieved with negative evaluations that display stance, detailing actions in relation with the counselling programme and contrasting success with failure and emphasizing change over time.

Participants can use self-reflective turns to invite recognition and sharing of problems or experiences. This was most often achieved by using the zero-person construction and other types of turn design that fade out the subject. These are linguistic resources that allow the telling to be heard as a general phenomenon rather than exclusively one person's experience (Laitinen, 2006). This makes it easier for other participants to respond in a way that they recognize the experience

and perhaps share a similar experience. In addition, designing the turn to be completed by others (Lerner 1991), and laughter and humour enabled the sharing of potentially delicate issues (Jefferson 1984, Haakana 2001). With self-reflective turns, participants related and connected aspects presented in counselling to their own life events in a detailed way. Thereby, they brought up topics and steered the direction of conversation to allow for elaboration of problematic health behaviour and possibilities for change.

Discussion and conclusion

With self-reflective turns, participants display to others that they are observing and interpreting their own actions. In so doing, they can display a positive stance towards group work and its goals and show they are "being willing and able" to participate and to change their health behaviour despite obstacles. Participants can also display knowledge of what they are supposed to be doing to achieve results, and in many cases, of recognition of the need for change, "being aware" of their problems and associated risks. Further, explicit self-reflective talk makes a topic available for discussion, thus offering opportunities to participate in constructing a lifestyle problem and to invite or provide sharing of experiences.

Previous research has analysed reflective talk as an action that is a response to counsellors' actions (Antaki, 2013; Poskiparta et al., 1998; Strong, 2006; Tomm, 1987; Williams and Auburn, 2015). Our analysis has provided further evidence that the activities used in counselling can indeed prompt self-reflective talk. The majority of self-reflective turns in our data were initiated by counsellors' agenda-based questions and assignments. However, drawing upon the analysis, self-reflective turns are not exclusively dependent on counsellors' actions, as they were also found in other sequential contexts.

The relationship between reflective talk and cognitive reflective processes can be called into question. To avoid cognitivism – that is, taking for granted that interaction is explicable by cognitive processes – the analysis should be grounded in how cognitive processing is constructed and oriented to in interaction (Potter, 2006). Our analysis has focused on turns of talk in which the speakers display reflective processing by positioning themselves as observing, evaluating or interpreting their own actions. It has been argued that the question is not whether reflective talk indicates some cognitive processing or whether "thinking" precedes "talking", but rather *what such talk does* (Edwards and Potter, 2005: 256–258). The speakers use self-reflective turns to display cognitive processing, making their reasoning available to other participants in the interaction. Self-reflective talk can therefore be regarded as one element of cognitive processing. However, it is implausible that self-reflective turns would solely constitute the whole reflective process. Theories of reflective processing suggest that it requires not only returning to the experience but also intellectual and critical re-evaluation and re-interpretation (for example, Mezirow, 1990). Since explicit self-reflective turns describe and interpret experiences, they are starting points for chains of ideas. What follows them in the discussion can be valuable with regard to the later phases of reflective processing: re-evaluating experiences and seeking conclusions (Boud et al., 1996; Dewey, 1933). This requires further analysis.

We have not compared explicit self-reflective turns with other types of disclosure, such as reports of one's own actions, which do not include elements of self-reflection. It is possible that these types of action also generate discussion and the sharing of experiences in group counselling interaction. Further research on the differences between sequences that include non-reflective and reflective responses is needed; this might also reveal why nutritionists' prompts do not

always generate self-reflective responses. Analysing and comparing different patterns might provide insights into the development of reflective processing.

It has been suggested that self-reflective talk may be merely an institutionally adequate way to participate (Vehviläinen and Lindfors, 2005). We argue that self-reflective talk may also have other goals. Drawing upon our analysis, self-reflective talk is found not only following the nutritionist's prompts but in five other locations. This would imply that following the institutional agenda is not the only function of self-reflective talk. Secondly, as shown in extract 3, self-reflective talk may also challenge (although covertly) the premises of the institutional task at hand.

Notwithstanding the location or trajectory of self-reflective talk, it brings forward topics that may launch discussion that is beneficial to the institutional goals at hand. In group discussions, a shared understanding is formed of what problematic health behaviour is and how it can be changed. Self-reflective talk in a group situation allows participants to compare one's own experiences with that of others', which accords with the ideas presented on the benefits of social comparison with regard to behaviour change (Bandura 2001). Further, self-reflective talk brings to discussion points of view different from one's own from people in the same situation, which again provides for reframing and reattribution of existing perceptions (Michie 2014b). Self-reflective talk as such provides one key element of reflective processing and thus of behaviour change.

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References

Ajzen, I. (1985) From intentions to actions: a theory of planned behavior. In: Kuhl, J. and Beckman, J. (eds) Action-Control: From Cognition to Behavior. Heidelberg: Springer, pp.11–39.

Antaki, C.(2013) 'Two conversational practices for encouraging adults with intellectual disabilities to reflect on their activities', Journal of Intellectual Disability Research (57)6: 580–588.

Atkinson, J.M. and Heritage, J. (1984) Structures of Social Action. Cambridge: Cambridge University Press.

Bandura, A. (1997) Self-Efficacy: The Exercise of Control. New York: Freeman.

Bandura, A. (2001) 'Social cognitive theory: an agentic perspective', Annual Review of Psychology 52: 1–26.

Bandura, A. (2004) 'Health promotion by social cognitive means', Health Education & Behavior 31: 143–164.

Baumeister, R.F., Vohs, K.D., DeWall, C.N. and Zhang, L. (2007) 'How emotion shapes behavior: feedback, anticipation, and reflection, rather than direct causation', Personality and Social Psychology Review 11: 167–203.

Booth, T. and Booth, W. (2003) 'In the frame: photovoice and mothers with learning difficulties', Disability & Society 18: 431–442.

Boud, D., Keogh, R. and Walker, D. (1996) Promoting reflection in learning: a model. In: Edwards, R., Hanson, A. and Raggatt, P. (eds) Boundaries of Adult Learning. New York: Routledge, pp.32–56.

Brownlee, K., Vis, J.A. and McKenna, A. (2009) 'Review of the reflecting team process: strengths, challenges, and clinical implications', The Family Journal: Counseling and Therapy for Couples and Families 17(2): 139–145.

Butler, C.W., Potter, J., Danby, S., Emmison, M. and Hepburn, A. (2010) 'Advice-implicative interrogatives: building client-centered supports in a children's helpline', Social Psychology Quarterly 73(3): 265–287.

Coulson, D. and Harvey, M. (2013) 'Scaffolding student reflection for experience-based learning: a framework', Teaching in Higher Education 18(4): 401–413.

Dewey, J. (1933) How We Think: A Restatement of the Relation of Reflective Thinking to the Educative Process. Lexington: DC Heath and Company.

Donaghy, M.E. and Morss, K. (2000) 'Guided reflection: a framework to facilitate and assess reflective practice within the discipline of physiotherapy', Physiotherapy Theory and Practice 16(1): 3–14.

Edwards, D. and Potter, J. (2005) Discursive psychology, mental states and descriptions. In: te Molder, H. and Potter, J. (eds) Conversation and Cognition. New York: Cambridge University Press, pp.241-259.

Emmison, M., Butler, C.W. and Danby, S. (2011) 'Script proposals: a device for empowering clients in counselling', Discourse Studies 13(1): 3–26.

Fasulo, A., Zinken, J. and Zinken, K. (2016) 'Asking 'what about' questions in chronic illness self-management meetings', Patient Education and Counselling 99: 917–925.

Fosnot, C.T. (2013) Constructivism: Theory, Perspectives, and Practice. New York: Teachers College Press.

Gill, V.T. and Roberts, F. (2012) Conversation analysis in medicine. In: Sidnell, J. and Stivers, T. (eds) The Handbook of Conversation Analysis. Malden, MA, Wiley-Blackwell, pp.575–592.

Glanz, K., Rimer, B.K. and Viswanath, K. (2008) Health Behavior and Health Education: Theory, Research and Practice. San Francisco: Jossey-Bass.

Goodwin, C. and Goodwin, M.H. (1992) Assessments and the construction of Context. In: Duranti, A. and Goodwin, C. (eds) Rethinking Context: Language as an Interactive Phenomenon. Cambridge: Cambridge University Press, pp.147–190.

Haakana, M. (2001) 'Laughter as a patient's resource: dealing with delicate aspects of medical interaction', Text 21: 187–219.

Halkowski, T. (2006) Realizing the illness: patients' narratives of symptom discovery. In: Heritage, J. and Maynard, D. (eds) Communication in Medical Care: Interaction between Primary Care Physicians and Patients. Cambridge: Cambridge University Press

Hazel, S. and Mortensen, K. (2014) 'Embodying the institution: object manipulation in developing interaction in study counselling meetings', Journal of Pragmatics 65: 10–29.

Hutchby, I. and Wooffitt, R. (1998) Conversation Analysis. Cambridge: Polity Press.

Jefferson, G. (1984) On the organization of laughter in talk about troubles. In: Atkinson, J.M. and Heritage, J. (eds) Structures of Social Action: Studies in Conversation Analysis. Cambridge: Cambridge University Press, pp.346–369.

Laitinen, L. (2006) Zero person in Finnish: a grammatical resource for construing human evidence. In: Helasvuo, M.L. and Campbell, L. (eds) Grammar from the Human Perspective: Case, Space and Person in Finnish. Amsterdam: Benjamins, pp.209–232.

Laitinen, J., Korkiakangas, E., Alahuhta, M. et al. (2010) 'Feasibility of videoconferencing in lifestyle group counselling', International Journal of Circumpolar Health 69(5): 500–511.

Lamerichs, J. and Stommel, W. (2016) 'But how often does this happen?': problem reducing responses by coaches in email counselling. In: Lester, J.N. and O'Reilly, M. (eds) The Palgrave Handbook of Adult Mental Health. Basingstoke, Hampshire: Palgrave Macmillan, pp.287–307.

Lehtinen, E. (2013) 'Hedging, knowledge and interaction: doctors' and clients' talk about medical information and client experiences in genetic counseling', Patient Education and Counseling 92: 31–37.

Leong, F.L. (2008) Encyclopedia of Counseling Volume 1: Changes and Challenges for Counseling in the 21st Century. Los Angeles: SAGE Publications.

Lepper, G. and Mergenthaler, E. (2005) 'Exploring group process', Psychotherapy Research 15(4): 433–444.

Lerner, G.H. (1991) 'On the syntax of sentences-in-progress', Language in Society 20: 441–458.

Mann, K., Gordon, J .and MacLeod, A. (2009) 'Reflection and reflective practice in health professions education: a systematic review', Advances in Health Sciences Education 14: 595–621.

Mezirow, J. (1990) How critical reflection triggers transformative learning. In: Mezirow, J. et al. (eds) Fostering Critical Reflection in Adulthood. San Francisco: Jossey Bass, pp.1–20.

Mezirow, J. (1998) 'On critical reflection', Adult Education Quarterly 48(3): 185–198.

Michie, S., van Stralen, M.M. and West, R. (2011) 'The behaviour change wheel: a new method for characterising and designing behaviour change interventions', Implementation Science 6: 42.

Michie, S., Atkins, L. and West, R. (2014a) The Behaviour Change Wheel: A Guide To Designing Interventions. London: Silverback Publishing.

Michie, S., West, R., Campbell, R. et al. (2014b) ABC of Behaviour Change Theories. London: Silverback Publishing.

Miller, W.R. and Rollnick, S. (2012) Motivational Interviewing: Helping People Change. New York: Guilford Press.

Miller, G. and Silverman, D. (1995) 'Troubles talk and counselling discourse: a comparative study', Sociological Quarterly 36(4): 725–747.

Pino, M. (2016) 'Knowledge displays: soliciting clients to fill knowledge gaps and to reconcile knowledge discrepancies in therapeutic interaction', Patient Education and Counseling 99(6):897-904.

Poskiparta, M., Kettunen, T. and Liimatainen, L. (1998) 'Reflective questions in health counseling', Qualitative Health Research 8(5) 682–693.

Poskiparta, M., Liimatainen, L., Kettunen, T. and Karhila, P. (2001) 'From nurse-centered health counseling to empowermental health counseling', Patient Education and Counseling 45(1): 69–79.

Potter, J. (2006) 'Cognition and conversation', Discourse Studies 8(1): 131–140.

Prilla, M., Degeling, M. and Herrmann, T. (2012) Collaborative reflection at work: supporting informal learning at a healthcare workplace. In: Proceedings of the 17th ACM International Conference on Supporting Group Work (GROUP '12). New York: ACM, pp.55–64.

Raingruber, B. (2003) 'Integrating aesthetics into advanced practice mental health nursing: commercial film as a suggested modality', Issues in Mental Health Nursing (24)5: 467–495.

Rosenstock, I.M., Strecher, V.J. and Becker, M.H. (1988) 'Social learning theory and the health belief model', Health Education & Behavior 15(2): 175–183.

Samuels, M. and Betts, J. (2007) 'Crossing the threshold from description to deconstruction: using self-assessment to deepen reflection', Reflective Practice: International and Multidisciplinary Perspectives 8(2): 269–283.

Sandars, J. (2009) The use of reflection in medical education: AMEE guide no. 44. Medical Teacher 31: 685–695.

Sarangi, S. (2009) The spatial and temporal dimensions of reflective questions in genetic counselling. In: Freed, AF and Ehrlich, S (eds) Why Do You Ask? The Function of Questions in Institutional Discourse. Oxford: Oxford University Press, pp.235–255.

Schegloff, E.A. (2007) Sequence Organization in Interaction: A Primer in Conversation Analysis. Cambridge: Cambridge University Press.

Silverman, D. (1997) Discourses of Counselling: HIV Counselling as Social Interaction. London: SAGE Publications.

Strong, T. (2005) 'Understanding in counselling: a preliminary social constructionist and conversation analytic examination', British Journal of Guidance & Counselling 33(4): 513–533.

Strong, T. (2006) 'Reflections on reflecting as a dialogic accomplishment in counseling', Qualitative Health Research 16(7): 998–1013.

Strong, T., Zeman, D. and Foskett, A. (2006) 'Introducing new discourses into counseling interactions: a microanalytic and retrospective examination', Journal of Constructivist Psychology 19(1): 67–89.

Svinhufvud, K. (2016) 'Nodding and note-taking: multimodal analysis of writing and nodding in student counseling interaction', Language and Dialogue 6(1): 81–109.

Tomm, K. (1987) 'Interventive interviewing: part II: reflexive questioning as a means to enable self-healing', Family Process 26: 167–183.

Veen, M. and de la Croix, A. (2016). 'Collaborative reflection under the microscope: using conversation analysis to study the transition from case presentation to discussion in GP residents' experience sharing sessions', Teaching and Learning in Medicine 28(1): 3–14.

Vehviläinen, S. (2001) ‘Evaluative advice in educational counseling: the use of disagreement in the ‘stepwise entry’ to advice’, Research on Language and Social Interaction 34 (3): 371–398.

Vehviläinen, S. (2003) ‘Avoiding providing solutions: orienting to the ideal of student’s self-directedness in counselling interaction’, Discourse Studies 5(3): 389–414.

Vehviläinen, S. (2009) ‘Student-initiated advice in academic supervision’, Research on Language and Social Interaction 42(2): 143–190.

Vehviläinen, S. (2014) Ohjaustyön opas. Yhteistyössä kohti toimijuutta [Guide for Counselling: Together Towards Agency]. Helsinki: Gaudeamus.

Vehviläinen, S. and Lindfors, O. (2005) ‘‘Varmaan se oma itsetunto on nousussa’: itsereflektio ja kohentunut vointi haastattelupuheessa [‘I guess my self-esteem is going up’: self-reflection and reports of improved condition in interview talk], Aikuiskasvatus 3: 191–202.

Visser, A. and Herbert, C. (1996) ‘Counseling in health care’, Patient Education and Counseling 28: 233–234.

Waring Hansun, Z. (2014) ‘Mentor invitations for reflection in post-observation conferences: some preliminary considerations’, Applied Linguistics Review 5(1): 99–123.

Wiggins, S. (2009) 'Managing blame in NHS weight management treatment: psychologizing weight and 'obesity'', Journal of Community & Applied Social Psychology 19: 374–387.

Williams, L. and Auburn, T. (2015) 'Accessible polyvocality and paired talk: how family therapists talk positive connotation into being', Epub ahead of print. Journal of Family Therapy. DOI: 10.1111/1467-6427.12096.

Woods, C.J., Drew, P. and Leydon, G.M. (2015) 'Closing calls to a cancer helpline: expressions of caller satisfaction', Patient Education and Counseling 98(8): 943–953.

York, C.S., Yamagata-Lynch, L.C. and Smaldino, S.E. (2016) 'Adult reflection in a graduate-level online distance education course', Reflective Practice: International and Multidisciplinary Perspectives 17(1): 40–58.

Zapata-Rivera, J.D. and Greer, J.E. (2003) Analyzing student reflection in the learning game. In Proceedings of Workshop on Learner Modelling for Reflection, Supplementary Proceedings of the 11th International Conference (eds S. Bull, P. Brna and V. Dimitrova). Volume V of AIED2003 Supplemental Proceedings, pp.288–298.

Zoffmann, V., Harder, I. and Kirkevold, M. (2008) 'A person-centered communication and reflection model: sharing decision making in chronic care', Qualitative Health Research 18: 670–685.

Appendix Transcription symbols

[word]	*Brackets*: Onset and offset of overlapping talk
=	*Equals sign*: Contiguous utterances, second is latched immediately to the first
(0.2)	Timed interval within or between utterances, measured in seconds and tenths of seconds
(.)	Interval of less than 0.2 seconds
wo:rd	*Colon*: Extension of the sound or syllable
.	*Period*: Falling intonation
,	*Comma*: Continuing intonation
?	*Question mark*: Rising intonation
-	*Dash*: abrupt cutoff
↑↓	*Upward/downward pointing arrows*: rising/falling pitch
word	*Underlining*: Emphasis
WORD	*Capital letters*: Louder volume
°word°	*Degree signs*: Quieter volume
>word<	Faster-paced talk than the surrounding talk
<word>	Slower-paced talk than the surrounding talk
#word#	Creaky voice
£word£	Smiley voice
@word@	Animated voice
hh	Audible aspiration
.hh	Audible inhalation

w(h)ord	Laughter
hah heh huh	Laughter
(word) ( )	Transcriptionist doubt
((word))	*Text in parentheses*: Transcriber's comments
→	*Arrow*: Feature of interest

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Stories of change: Comparative time-framed experience telling in health promotion group discussions

Aija Logren, Johanna Ruusuvuori, Jaana Laitinen

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