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Naturalistic comparative study on Patient-centred approach

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ACADEMIC DISSERTATION
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To my family

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ABSTRACT

The psychiatric interview aims to evaluate multifaceted mental problems of patients based on descriptive, symptom-oriented diagnostic categories (codified in DSM/ICD). The psychiatric diagnostic classification alone does not allow for planning for the patient the necessary individual psychosocial treatment and rehabilitation. Nonetheless, in public healthcare, client-/patient-centredness - i.e., an approach based on the individual needs of the patient - should be the guiding legal and ethical principle. This dissertation is an attempt to investigate and advance the psychiatric assessment procedure and interview from a patient-centred perspective. This randomised controlled pilot study investigated and compared the usual clinical psychiatric diagnostic assessment – Assessment as Usual (AAU group) and a so-called, case formulation-based assessment process. The Dialogical sequence analysis (DSA) was implemented as a case formulation method. From the very first encounter, DSA, as a method, facilitates comprehending of the patients' adverse, habitual action patterns (so-called obstacles to agency), which may affect and maintain symptoms and mental problems. Its purpose is to complement the psychiatric diagnostic assessment process. The analytical unit of DSA is the speaker's stance towards the referential object, i.e., the content s/he is talking about, and towards the recipient to whom s/he is talking to. All these convey reciprocal relationship which is one of the key guiding concepts of DSA-based case formulation. In the study, 40 patients were randomised into two study groups (AAU group, $N = 40$; DSA group, $N = 40$). At baseline, the groups did not differ in terms of perceived well-being, mental symptoms, functioning or risk behaviour. The research data was also collected by audio-recording the interviews of the first visits of all patients in the DSA group and five randomly selected patients in the AAU group. At the last assessment visits, the patient, and the clinicians (each separately) assessed the quality of the working relationship using a self-reported questionnaire (Working Alliance Inventory, WAI). The duration and number of assessment visits and the number of clinicians who had participated in the assessment phase for all patient, were also measured. The research material was analysed by quantitative as well as qualitative methods. Ten audio-recorded interviews of the first sessions were examined using the Conversational Analysis (CA) as a qualitative method. The study

revealed that in the DSA group the patient's and the clinician's appraisals were convergent concerning the treatment goal (*rho* = .63), tasks (*rho* = .66), bond (*rho* = .56); nonetheless, in the AAU group, only the treatment bond displayed a moderate convergence (*rho* = .36) between appraisals. The assessment period was shorter ($p < 0.001$) and the number of visits were fewer ($p = 0.002$) in the DSA group than in the AAU group. The analysis of interviews focused on the topical content of the utterances: whether they concerned medical matters or the patients' subjective experience. In the DSA-based interviews, the patients described their negative subjective experiences significantly more frequently than in the AAU interviews ($p = 0.016$). Regardless, whether the clinician's question was a closed-ended question focused on symptoms, or an open-ended question that focused on the patient's experiences reported, in both groups, the patients also tended to disclose their experiences. Because in the DSA group clinicians focused on the patient's experiences, the patients also produced more talk about subjective experiences than in the AAU group. Moreover, CA revealed that after the clinicians' symptomatically and factually oriented questions, the patients presented that their "self-disclosure" about subjective experiences is legitimated. In presenting so, the patients, in their utterances, highlighted the intensity and urgency of the experience telling, thus momentarily taking space and control in the interview. The analysis revealed that the clinicians' and the patients' goals and orientations were occasionally divergent and even clashing. These qualitative results call for the further need to clarify the meaning and function of patient-centredness with larger research material in the future. The conclusion of the study is that the DSA-based assessment may refine and complement the diagnostic assessment procedure, advancing a common view - shared understanding - of the patient's individual treatment plan tending to be patient-centred. By implementing DSA-based case formulation, the treatment could start earlier than in the standard assessment process. In the future, more studies should be carried out with larger sample sizes to investigate the impact of the treatment on outcome measures and the cost-effectiveness of DSA-based case formulation in a larger clinical field.

TIIVISTELMÄ

Psykiatrisen haastattelun tarkoituksena on arvioida potilaiden moniulotteisia mielenterveyden häiriöitä kuvailevien, oirekeskeisten diagnostisten kategorioiden avulla (kiteytettynä ICD ja DSM -luokituksissa). Pelkästään psykiatrisen diagnostinen luokittelun avulla potilaalle ei pystytä suunnittelemaan tarvittavaa yksilöllistä psykososiaalista hoitoa ja kuntoutusta. Kuitenkin julkisessa terveydenhuollossa asiakas-/potilaskeskeisyyden – eli potilaan yksilöllisistä tarpeista lähtevän tarkastelutavan - tulisi olla ohjaava oikeudellinen ja eettinen periaate. Tämä väitöskirja on yritys tarkastella ja kehittää psykiatrista arviointia ja haastattelua potilaskeskeisestä näkökulmasta. Tässä satunnaistetussa kontrolloidussa pilottitutkimuksessa verrattiin tavanomaista psykiatrista arviointihaastattelua (assessment as usual, AAU) ja niin sanottua tapausjäsennysmenetelmään perustuvaa arviointia. Tapausjäsennysmenetelmänä käytettiin dialogista sekvenssianalyysiä (DSA). DSA on menetelmä, jolla pyritään jo ensimmäisillä tapaamisilla tunnistamaan potilaan haitallisia, toistuvia toimintamalleja (toimijuuden esteitä), jotka voivat ylläpitää oireita. Sen tarkoitus on täydentää psykiatrista diagnostista arviointia. DSA:n analyysiyksikkö on puhujan suhde puheen viittauskohteeseen, eli siihen asiaan, josta hän puhuu ja kuulijaan, kenelle hän puhuu. DSA-tapausjäsennyksessä yhtenä keskeisenä ajatuksena on se, että nämä kaikki ovat vastavuoroisessa suhteessa toisiinsa. Tutkimuksessa kumpaankin tutkittavaan ryhmään arpoutui 40 potilasta (AAU-ryhmä, $N=40$; DSA-ryhmä, $N=40$). Lähtötilanteessa ryhmät eivät eronneet toisistaan koetun hyvinvoinnin, psyykkisten oireiden, toimintakyvyn ja riskikäyttäytymisen suhteen. Tutkimusaineisto kerättiin siten, että DSA-ryhmässä kaikkien potilaiden ensikäynnit ääninauhoitettiin, ja AAU-ryhmässä viiden satunnaisesti valitun potilaan. Arviokäyntien loputtua potilas ja työntekijä (kumpikin erikseen) arvioivat yhteistyösuhteen laatua itsetäytettävällä kyselyllä (Working Alliance Inventory, WAI). Myös arviokäyntien kesto ja lukumäärä laskettiin, samoin kuin se, kuinka monta työntekijää kunkin potilaan arviokäynteihin oli osallistunut. Tutkimusaineistoa analysoitiin sekä kvantitatiivisin että kvalitatiivisin menetelmin. Kymmenen ääninauhoitettua ensikäynnin istuntoa tutkittiin keskustelunanalyysi - menetelmää (KA) käyttäen. Tutkimuksessa kävi ilmi, että DSA-ryhmässä potilaan ja työntekijän käsitykset olivat yhteneväiset hoidon tavoitteesta (*rho* = .63), tehtävistä

(*rho* = .66) ja sitoutuneisuudesta (*rho* = .56), kun taas AAU-ryhmässä vain hoitoon sitoutuneisuudessa oli kohtalainen yhteneväisyys (*rho* = .36). Arviointijakso oli myös lyhyempi (*p* <0,001) ja käyntien määrä oli vähäisempi (*p* = 0,002) DSA-ryhmässä kuin AAU-ryhmässä. Haastattelujen analyysi keskittyi ilmaisujen sisältöön: käsittelivätkö ne lääketieteellisiä asioita vai potilaiden subjektiivista kokemusta. DSA-ryhmässä potilaat pystyivät kuvaamaan negatiivisia, subjektiivisia kokemuksiaan huomattavasti useammin kuin AAU-ryhmässä (*p* = 0,016). Riippumatta siitä, oliko työntekijän tekemä kysymys oireisiin keskittyvä suljettu kysymys, vai avoin kysymys, jolla keskityttiin potilaan kertomiin kokemuksiin, niin molemmissa ryhmissä potilailla oli pyrkimys puhua myös kokemuksistaan. Koska DSA-ryhmässä työntekijät keskittyivät potilaiden kokemuksiin, niin potilaat myös tuottivat enemmän puhetta kokemuksistaan kuin AAU-ryhmässä. Lisäksi KA paljasti, että kliinikoiden oirekeskeisesti ja faktuaalisesti suuntautuneiden kysymysten jälkeen potilaat osoittivat, että subjektiivisista kokemuksista "avautuminen" on oikeutettua. Tällöin potilaat puheessaan korostivat kokemuksen voimakkuutta ja tärkeyttä, ottaen näin hetkellisesti tilaa ja kontrollia haastattelussa. Analyysi osoitti, että kokemuksesta avautumisen hetkillä kliinikoiden ja potilaiden tavoitteet ja pyrkimykset olivat toisinaan eriäviä ja keskenään ristiriitaisia. Nämä kvalitatiiviset tulokset osoittavat tarvetta potilaskeskeisyyden merkityksen ja toiminnan selventämiselle suuremmilla aineistoilla tulevaisuudessa. Tutkimuksen johtopäätös on se, että DSA-tapausjäsennys voi tarkentaa ja täydentää diagnostista arviointimenettelyä, ja edistää potilaan ja työntekijän yhteneväistä käsitystä - jaettua ymmärrystä - hoitosuunnitelmasta yksilöllisesti pyrkien potilaskeskeisyyteen. DSA-tapausjäsennyksen avulla on myös mahdollista aloittaa hoito nopeammin kuin tavanomaisen psykiatrisen arvioprosessin jälkeen. Tulevaisuudessa tarvitaan lisää tutkimuksia suuremmilla aineistoilla, jotta voidaan selvittää DSA-pohjaisen tapausjäsennyksen mahdollista vaikuttavuutta hoidon lopputuloksiin ja arvioida kustannustehokkuutta.

CONTENT

ABBREVIATIONS

AAU	Assessment as usual
APA	American Psychiatric Association
BPS	Biopsychosocial model
CA	Conversation analysis
CCRT	Core Conflictual Relationship Theme
CFI	Cultural formulation interview
CORE-OM	Clinical Outcomes in Routine Evaluation-Outcome Measure
DSA	Dialogical sequence analysis
DSM	Diagnostic and Statistical Manual of Mental Disorders
E	Experience telling
EASE	Examination of anomalous self-experience
ECF	Extreme case formulation
EMIC	Explanatory model interview catalogue
EQ	Experience-oriented question
ET	Experience-oriented next turn
ICD	International Statistical Classification of Diseases and Related Health Problems
KA	Keskusteluanalyysi
MMPI	Minnesota Multiphasic Personality Inventory
MQ	Medically oriented question
MT	Medically oriented next turn
OCF	Outline for Cultural Formulation
PID	Person-centred Integrative Diagnosis
RDoC	Research Domain Criteria
SASB	Structural Assessment of Social Behavior
U.S.	United States (of America)
WAI	Working Alliance Inventory
WHO	World Health Organization
ZPD	Zone of proximal development

ORIGINAL PUBLICATIONS

Publication I   Savander, E. É., Pänkäläinen, M., Leiman, M., & Hintikka, J. Implementation of Dialogical Sequence Analysis as a Case Formulation for the Assessment of Patients at a Community Mental Health Centre: Randomized Controlled Pilot Study. *European Journal of Mental Health*, 2019a;14: 209-229.

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AUTHOR'S CONTRIBUTION

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The author has contributed to the design and implementation of the randomised controlled trial, data collection and interpretation of results. She has participated in implementing the research intervention. She has written up the first draft of the manuscript, was responsible for revising it and was the corresponding author of the article.

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The author has contributed to designing the study and collecting the data. She has worked on the qualitative data analysis and outlined the argument of the paper. She has written up the first draft of the manuscript, was responsible for revising it and was the corresponding author of the article.

Publication III:

The author has contributed to designing the study and collecting the data. She has worked on the qualitative data analysis and outlined the argument of the paper. She has written up the first draft of the manuscript, was responsible for revising it and was the corresponding author of the article.

1   INTRODUCTION

"[T]he word always wants to be heard" - Mikael Bakhtin

The need for this dissertation emerged from several years of clinical work and experience in public mental healthcare. The psychiatric assessment interview is a core event in which a psychiatrist/clinician evaluates the patient's mental problems using descriptive, symptom-oriented diagnostic categories such as the Psychiatric Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD). Based on this s/he generates an appropriate treatment plan for the patient. The purpose of the assessment interview is to help the patients' suffering and to promote health, as in any medical encounter from the first moment. Despite having been repeatedly revised since the 1950s, a weakness of psychiatric classification remains – one that is generally experienced in clinical work: the diagnosis alone is insufficient to define the necessary psychosocial treatment and rehabilitation with sufficient individual attention or enough detail. Regardless of the shortcomings, diagnoses contribute significantly to the patients' lives and help understand their own complex mental experiences. Furthermore, diagnoses have an essential role in insurance benefits and legal processes.

As is generally known, patient- or person-centredness is a crucial legal and ethical principle of public healthcare. This approach increases the ability of patients to care for their own health and social relationships through their activities, choices, and decisions, supported by professional responsiveness to their needs, hopes and expectations (Byrne & Long, 1976; Laine & Davidoff, 1996; Mead & Bower, 2000). While psychiatry appears inherently person-centred, multifaceted clinical and institutional impacts may weaken this approach. A few studies have explored this principle in psychiatry, for example through Person-centred integrative diagnosis (PID), which is designed to comprehensively advance the psychiatric assessment of

patients (Mezzich & Salloum, 2007; Mezzich et al., 2016b). Many researchers have debated the problem of the validity of diagnostic classification. Nick Craddock and Laurence Mynors-Wallis (2014, p. 93), among others, stated that psychiatric diagnosis is necessary and important, but maintained that "diagnosis alone is insufficient in conceptualising psychopathology in any individual patient. Diagnosis should be part of a formulation that brings together aetiology, severity and functioning and should lead to a management plan". There have also been suggestions to systematically complement the current diagnostic classifications with alternative approaches promoting the individual therapeutic management of patients and prediction of the outcome (Maj, 2018). There appears to be tension between the orientation of patient- or person-centredness and the descriptive and symptom-oriented psychiatric diagnostic classification, which primarily emerges in the clinical work between the clinician and the patient.

The patient-centred strategy involves three crucial components: communication, partnership, and health promotion (Constand et al., 2014). These components appear in all medical fields, especially in psychiatry and psychotherapy. Their assessment tools are more limited than those in somatic fields of medicine. The core event in psychiatry is the social interaction between the patient and the professional. The clinical interaction is usually a dyadic or triadic, mutual, and continuously changing process, and it is therefore challenging to conceptualise and operationalise through exact methodology. In social sciences, psychology, anthropology and linguistics, researcher interest has increasingly turned towards investigations of medical interactions. Among others, Stefan Priebe and colleagues (2011; also Thompson & McCabe, 2016) reviewed research on 'naturally occurring' communication and identified guiding principles that clinicians should apply in order to communicate well in psychiatry, conveying patient- or person-centeredness and establishing a good therapeutic relationship. A large body of research in psychotherapy has demonstrated that the therapeutic relationship is a highly relevant, "demonstrably effective" component of a good treatment outcome, regardless of the problems of clients and the theoretical approaches of psychotherapies (Norcross & Lambert, 2018; Norcross & Wampold, 2011; Wampold & Imel, 2015).

It is notable that in psychotherapy, there is a relatively long tradition of using psychological case formulations that focus on "the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioural problems" (Eells, 1997, p. 1; 2013). A case formulation arranges the complex information on patients, which then helps in transferring the mental disorder diagnosis to the treatment plan and comprehending the problematic events and

experiences of patients from their perspective. The effectiveness of case formulations is understudied: a few controlled studies in psychotherapy have demonstrated superior or at least equal outcomes compared with standard treatment (Schulte et al., 1992; Ghaderi, 2006; Johansson et al., 2012). In current psychiatric research, case formulations have received little attention in the diagnostic assessment process. Irosh Fernando and colleagues (2012) and Fernando and Martin Cohen (2014) have suggested an individual pattern-based formulation methodology based on different renowned theoretical psychological models of psychiatric psychopathology for developing individual treatment.

This doctoral study examined the diagnostic assessment interviews and process in a public psychiatric outpatient clinic in Finland, where the author and her colleagues implemented a particular case formulation method, namely Dialogical sequence analysis (DSA; Leiman, 1997; 2012), to complement the psychiatric assessment interview and process. The DSA is a microanalytical method for analysing utterances of talk. It allows clinicians to identify regularities and habitual action patterns in the freely flowing talk of patients and assists the self-perception of the patients through immediate feedback. Focusing on the guiding concepts of DSA allows for increased comprehension of the adverse, habitual action patterns of patients, or so-called obstacles to agency, which may maintain and affect their symptoms and problems.

After two years of training, the author with her colleagues designed a randomised controlled pilot study to investigate and compare the usually applied psychiatric diagnostic assessment process with a new DSA-based assessment process in the Psychiatric Department of Päijät-Häme Central Hospital in Lahti, Finland. The research data were gathered and investigated quantitatively and analysed qualitatively by employing the conversation analytic method for audio-recorded and transcribed interviews.

In this dissertation, the research is viewed from two different, yet reconcilable methodological approaches. In the first, it is demonstrated in quantitative detail whether the DSA-based assessment process and the standard assessment process differ in terms of collaboration, especially in terms of patient and professional congruence, concerning the goals and tasks of assessment. From the qualitative perspective, the conversation analytic method is used to present whether the organisation of naturally occurring patient–clinician interaction differs between two types of assessment interviews as the patients talk about problematic subjective experiences. Moreover, it is demonstrated how patients can reveal their subjective

experiences and concerns after the clinician's medically oriented inquiries and what types of conversational practices they use.

Finally, the meaning and the possible implications of the integrated results for psychiatric diagnostic assessment are discussed from a clinical perspective. There is a clinically significant question, whether the focus of the treatment plan is on the symptoms or addressing obstacles to individual agency.

2 REVIEW OF LITERATURE

According to the complex nature of mental disorders, this dissertation concerns studies from different fields of sciences that have contributed to our understanding of the psychiatric assessment interview. Next, the literature is reviewed and attempted to maintain a clinical perspective primarily.

2.1 Mental illness and progress of diagnostic classification

2.1.1 A brief history of mental illness

Since ancient times, mental illnesses have been distinguished from normal behaviour, and the human tendency to seek explanations and specific causes for illnesses has resulted in numerous and varied descriptions of mental conditions over the centuries. Physicians in classical times recognized melancholia, mania, delirium, and hysteria. Hippocrates believed that emotional and cognitive functions derived from the brain, whereas Galen presumed that mental illnesses result from imbalances of body fluids or humours. For hundreds of years in the Dark Ages of the mediaeval period, humans projected causes and explanations of mental illnesses to souls and diabolical forces based on religious tenets instead of physical or bodily conditions (Andreasen & Black, 2001).

In the Renaissance, attitudes towards medicine started to change. Doctors and artists began to discover and observe human anatomy and question the role of religious dogmatism in medicine. After the French Revolution and the era of the Enlightenment, significant changes occurred in attitudes toward mental illnesses. Philippe Pinel (1745–1826) was the 'father' of modern psychiatry, who symbolically removed the chains of mentally ill patients. He applied a classification of mental illnesses and introduced his new approach as 'moral' treatment. For the first time, mental illness was endowed with psychological meanings, and psychiatry started to

move both forwards and towards humanistic sciences (Andreasen & Black, 2001; Foucault & Dreyfus, 1987).

In the late 19th century, Emil Kraepelin (1856–1926), a German psychiatrist, created the first systematic nosology of mental disorders in his textbook *Psychiatrie: Ein Lehrbuch fur Studirende und Aerzte* (1896/in English Kraepelin & Dredendorf, 1915). Shepherd (1995, p. 176) stated that in Kraepelin's work, "the combined study of symptoms and outcome had come centre stage, and psychological speculation was virtually jettisoned." The role of psychosocial causes and the subjective experiences of patients were minimized. Unlike Pinel's psychosocial orientation in psychiatry, Kraepelin searched for the causes of mental disorders in the brain. He taught that an accurate clinical description of symptoms with the onset and longitudinal course of illness might connect to the pathogenesis of mental illnesses. By searching for 'natural disease entities' ('natürliche Krankheitseinheiten') of mental illnesses, he gave an impetus to further biological and neuroscientific psychiatric research. Deriving from differently impaired cognitive brain functions, he distinguished dementia praecox and manic-depressive psychosis. Kraepelin's systematic nosology had a determinative and significant role in the further development of clinical work and research in psychiatry (Shepherd, 1995; Andreasen & Black, 2001; Sadock at al., 2015; Kendler & Parnas 2015).

At the same time, unlike Kraepelin, the Austrian neurologist Sigmund Freud (1856–1939) had become interested in the psychic mechanism of mental illnesses and published his significant seminal work on psychoanalysis. He defined the different types of neuroses and their underlying mechanisms with precipitating traumatic events in early life or the causative role of sexuality or 'libido'. Freud's nosology about hysteria and neuroses was used in psychiatry until the late 20th century (Breuer & Freud, 1893; Freud & Draft, 1894; Andreasen & Black, 2001; Sadock et al., 2015).

In these times, the Swiss psychiatrist Eugen Bleuler (1857–1939), in his influential work on mental illnesses, attempted to link brain research and the psychoanalytical method. In his approach to psychopathology, he equally emphasised the impact of objective and measurable data, as well as subjective phenomena. He first named Kraepelin's dementia praecox as belonging to the 'group of schizophrenias', thereby referring to their heterogeneous character (Sadock et al., 2015; Kendler & Parnas 2015).

Among others, the German-Swiss psychiatrist and philosopher Karl Jaspers (1883–1969) criticized Kraepelin's nosology because it poorly supported the 'natural disease entities' of mental illnesses that medical science ideally searches for. He

claimed that it is unrealistic to find a direct relationship between the brain and mental illnesses because of the many factors affecting their aetiology. In Jaspers' opinion, Kraepelin ignored the patient's psychological process in his work (Kendler & Engstrom, 2018). In his influential book *General Psychopathology,* Jaspers (1946/1963) presented a methodological approach to define and understand the subject of psychiatry. Jaspers suggested that the psychopathology of patients is to be considered as a comprehensive whole rather than the sum of particular or single symptoms. He indicated two approaches in examining psychopathology: first, understanding the patient's psychic event or 'subjective' experience in an empathic way, and second, finding a logical explanation from repeated experiences and regularities conveying 'objective' psychological causality (Jaspers, 1968; Sadock at al., 2015; Kendler & Parnas, 2015).

Following the time of Pinel, these renowned psychiatrists and a few of their colleagues investigated psychopathology with a variety of different approaches. They all, however, viewed it from a biological framework.

After the Second World War, starting from the 1950s, the Hungarian-American psychiatrist Thomas Szasz (1920–2012) doubted the biological nature of mental illnesses in his renowned critical work *The Myth of Mental Illness* (1960). He questioned whether there is, in fact, such a thing as mental illness, and stated that deviated or disturbed behaviours or thinking that does not fit ethically or legally with mainstream society should not be interpreted as signs and symptoms of real illnesses. He criticized pharmacological and involuntary treatment as medical actions to correct one's 'problems in living'.

At the same time, the French philosopher Michel Foucault (1924–1984) claimed that mental illness is a result of the interaction between an individual and the culture of society. He judged that the medical 'gaze' of doctors views a sick person through reductive biomedical orientation without context and claimed that medical science had limited the philosophical conception of a human being as a whole entity (Foucault & Dreyfus, 1987 (orig. 1955)).

The Canadian sociologist Erving Goffman (1922–1982) stated in a similar vein that psychiatry interprets deviated behaviours or 'situational improprieties' as mental symptoms that reside in the social interaction order, thereby distinguishing them from a biomedical origin. In this way, the medical and pharmacological interventions of psychiatry serve as social and ethical control (Goffman, 1971). His other considerable works, *The presentation of self of everyday life* (1978), the work on face-to-face *interactional order* and his critical debate about the situation of mental illnesses in

society that gave an impetus to germinate interactional studies in the social sciences (Goffman, 1983).

These social and ethical approaches to psychiatry – the so-called anti-psychiatry movement – started widespread critical debates about mental illnesses. These took place not only in psychiatric sciences but also in other scientific fields, and they had an impact in advancing interactional studies in medical institutions. Opposing the social and ethical critics, the 'neo-Kraepelinian' movement began to restore the image of psychiatric institutions in the 1970s. Under the leadership of Eli Robins, Samuel Guze and George Winokur, an American group of researchers intended to reaffirm the biomedical approach to mental disorders. By rejecting the prevailing psychoanalytic approach, they emphasized the focus on biology and the role of quantifiable methods in scientific research on psychiatry (Decker, 2007).

In 1952, the discovery of the antipsychotic effect of chlorpromazine had a significant impact on the treatment of severe mental illnesses. This gave an impetus for the further development of pharmacotherapy in psychiatry (Shorter, 2005). Moreover, from the 1960s, new technology provided possibilities for the development of modern neurosciences, psychopharmacology, and research on the biological causes of mental illnesses.

Nonetheless, by attempting to compensate for the power of biomedicine and to integrate different approaches in medicine, George Engel (1980) suggested the biopsychosocial (BPS) model for understanding and treating medical and mental disorders (Sadock at al., 2015). In the BPS model, Engel approached health and the development of disease from three aspects: biological, psychological, and social. He claimed that all aspects are equally significant to the patient's overall condition. Since 2002, this model has formed the basic principle of the World Health Organization. Nonetheless, the use of the BPS model has been subject to debate on its advantages and disadvantages.

John Sadler and Yosaf Hulgus (1992) stated that even when scientific research is guided in a multidisciplinary way, the BPS model does not provide enough pragmatic and ethical support for the clinician's decision regarding the problems of an individual patient. On the one hand, the authors stated that it has contributed to a better understanding of health, mental health, and the patient as a whole human being (Wade & Halligan, 2017). On the other hand, this model has also been criticized in psychiatry because of the lack of a coherent philosophical theory and concept. Moreover, the limitations of the model are the interpretation of equality on three levels, the lack of a guide to prioritisation, its eclecticism, and the failure to honour the patient's subjective experiences (Bartz, 1999; Ghaemi, 2009; 2013;

Benning, 2015). Regardless of the benevolent approach of the BPS model, it did not appropriately organize scientific research or clinical practice; moreover, it does not help to determine the boundaries between health and disease (Pilgrim, 2015).

Ultimately, a large number of scientists have set out to search for the aetiology and the pathogenesis of mental disorders in the diverse field of science. During recent decades and mainly in the 21st century, numerous studies have advanced our understanding of shared genetic susceptibility, neurodevelopment, adult brain neuroplasticity, the adaptability of neuronal connections, biomarkers, low-grade inflammation, and its connection with stressful social and environmental factors, which all interact in mental health and disorders. Regardless of increased knowledge and understanding of the mechanisms of mental disorders, the specific aetiology, genetics, biomarkers and mechanisms that distinguish mental health and mental disorders are still incompletely defined (Brown et al., 1996; Kendler, 1996; Kandel, 1998; Berrettini, 2000; Swillen et al., 2000; Weinberger & McClure, 2002;; Allen et al., 2008; Stefansson et al., 2008; Garland & Howard, 2009; Avramopoulos et al., 2015; Genetics of Personality Consortium et al., 2015; Clark et al., 2017; Horwitz, 2017; Shadrina et al., 2018; Zwicker et al., 2018; Borsboom et al., 2019; Smoller et al., 2019; Rantala et al., 2021).

As can be seen through history, mental illness has been approached in various ways, conveying its multifaceted nature. At present, the patient's mental disorder and its meaning are determined through clinical diagnostic work. The diagnosis of a mental disorder is outlined, on the one hand, from the patient's narrative about their subjective experiences, symptoms, and behaviours within their lifeworld. On the other hand, it is interpreted through the prevailing diagnostic classification employed by clinicians.

Next, the short history of diagnostic classifications and their impact on clinical work are reviewed.

2.1.2   The era of ICD and DSM

Ideally, in medicine, the essential purpose of diagnostic classification is to distinguish disease entities, including their aetiology, pathophysiology, and prognosis. In the case of mental disorders, the fields of aetiology and pathophysiology still lack exact

knowledge. During history, the contemporary conceptions of mental illnesses have affected diagnostic classifications, including their validity and reliability.

Since the 1950s, psychiatry has been coordinated by official diagnostic classification. Its purpose is to define and outline mental disorders and distinguish them from mental health conditions. During the last half century, in Finland as well as in other countries, an official diagnostic manual for clinical practice and research has been used in psychiatry.

In the early years, diagnostic classifications predominantly provided descriptive clinical narrations of different mental disorders without any list of items or symptoms. This so-called prototype-based approach was intended to outline patient characteristics, behaviours and complaints in terms of patient functioning (Clark, 2017; Vanheule, 2017). Because of dissatisfaction with contemporary classifications in different countries, both versions were revised. In collaboration between numerous experts, ICD-7 and ICD-8 in Europe and DSM-II in America were created in the 1970s (Andreasen & Black, 2001; Zimmerman & Spitzer, 2005; Lönnqvist et al., 2001).

Having investigated the *reliability* of psychiatric diagnostic classification, Joseph Fleiss, Robert Spitzer and their colleagues (1972) claimed it to be poor in the studies of the 1950s and 1960s. In the context of psychiatry, reliability means the ability of two psychiatrists to agree on the diagnosis of a patient's mental condition. They claimed that traditions in comprehending mental disorders are too divergent, thereby weakening reliability. The *validity* of psychiatric diagnostic classification measurably defines what it is intended to define. To advance the validity of the current psychiatric diagnostic classification, Eli Robins and Samuel Guze (1970), as well as John Feighner and his colleagues (1972), suggested five so-called *Washington University criteria*: 1) a clinical description, 2) delimitation from other disorders, 3) biological and psychological tests, 4) follow-up studies to define the prognosis, and 5) family studies to define the genetic risks. Consequently, these works have contributed to subsequent changes in diagnostic classifications and research.

In the 1980s, to advance the reliability and the validity of diagnostic classification, WHO and the APA started to revise the contemporary ICD and DSM versions. In 1980 DSM-III offered determinative changes in the diagnostic classification, and provided also the first definition of mental disorders: "In order for a mental or psychiatric condition to be considered a psychiatric disorder, it must either regularly cause subjective distress or regularly be associated with generalized impairment in social effectiveness or functioning" (Zimmerman & Spitzer, 2005). The new version used a multiaxial evaluation system and diagnostic criteria, and dropped the term

'neurosis', which referred to an aetiological explanation from a psychodynamic perspective (Frances, 1993). Due to these modifications, the reliability now appeared to be better to some extent than in the previous versions of diagnostic classifications. Nonetheless, these specified criteria were non-theoretical in terms of aetiology and were grounded in clinical expert consensus (Andreasen & Black, 2001; Zimmerman & Spitzer, 2005).

In 1987, the Finnish psychiatric profession took into use ICD-9 with the shared part of classifications of mental disorders of DSM-III-R (Lönnqvist et al., 2001). Through extensive debates in the clinical and research field of psychiatry, DSM-IV was used from 1994 (in Finland from 1997 in teaching and research). Similarly, the ICD version was renewed as ICD-10 in 1992 and it has been officially used in Finland since 1996. In this version, the fifth chapter classified the prototypical descriptions of categories and guidelines for mental disorders. Similarly to DSM before it, the authors stated that "These descriptions and guidelines carry no theoretical implications, and they do not pretend to be comprehensive statements about the current state of knowledge of the disorders. They are simply a set of symptoms and comments that have been agreed, by a large number of advisors and consultants in many different countries" (WHO, 1992, p. 2). In this way, clinicians are warned of shortcomings of the classification. The definition of mental disorders changed in both new versions, with a specification concerning clinical significance being emphasized. The definition of WHO (1992) was a "clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions." (WHO, 1992, p. 5). The definition of a mental disorder provided by APA (1994) was similar.

Over the years, ICD and DSM have constantly converged and both seek signs and symptoms descriptively. However, DSM searches certain homogeneous diagnostic categories according to the criteria of the research culture, whereas the ICD is more pragmatic and less rigid or determinative in these categories, thereby allowing more heterogeneous patient groups within them (Craddock & Mynors-Wallis, 2014; Clark et al., 2017).

In Finland, both an ICD-10 version for clinics with prototypical descriptions of mental disorders and another version for research with particular criteria were created and applied congruently (Komulainen et al., 2012; Korkeila, 2019).

Some forty years ago, the emergence of DSM-III ultimately meant a change in the clinical field and in research. Many authors have concerned that over and above the set of symptoms and behaviours gathered in diagnosis, the patient's contextual subjective experiences have received less attention or have been neglected, thereby

adversely affecting the validity of psychiatric diagnostic classification and the individual treatment and empirical research (van Praag, 1992; Parnas & Zahavi, 2002; Andreasen, 2007; Fuchs, 2010; Parnas et al., 2012; Nordgaard et al., 2013; Vanheule, 2017).

Furthermore, Eero Riikonen and Antti Mattila (1994) also discussed the impact of the categorization of psychiatric diagnostic classification, which interprets the patient's non-objective life experiences, meanings, and values as an objective symptom category, or leaves them without attention. The authors emphasized that the objective and non-objective parts of mental illness phenomena are inseparable.

Surrounded by high expectations and debates, the APA (2013) published DSM-5 in 2013. This version grouped mental disorders into broader clusters and renewed the categories to some extent. However, the changes were less than was expected (Regier et al., 2013; Korkeila, 2019). The criticism of this version, among others, has concerned a few particular diagnoses (for example, normal grief) and criteria (for example, attention-deficit disorder for adults). Furthermore, through a lowered threshold of the criteria, the concept of disorder includes more mental disorders than before (Maj, 2013; Wakefield, 2013).

Since 2009, in the Research Domain Criteria (RDoC) project, the National Institute of Mental Health has intended to advance the nosology and research into mental disorders, grounding it in a dimensional approach to psychopathology and the brain–behaviour relationship. It approaches the possibly subsequent determination of mental disorders through specific psychological constructs and processes and searches for relationships between genetics and neuroscientific results. Although the RDoC project provides integrative dimensional approaches, there are concerns that it also neglects the meaning of the conscious subjective experience, socio-cultural background, and life contexts of patients in which their mental problems and symptoms are embedded (Cuthbert & Insel, 2013; Hietala, 2015; Kozak & Cuthbert, 2016; Clark et al, 2017; Korkeila, 2019; Wakefield, 2014; Parnas, 2014; Vanheule, 2017).

In 2018, WHO published a pre-final version of ICD-11(WHO, 2018). Currently, this new diagnostic classification is under the scrutinizing process of worldwide field study in terms of its strengths and limitations. There was an intention to harmonise the approaches of DSM-5 and ICD-11; however, they still diverge to some extent in the structure and classes of disorders (Clark et al., 2017; Korkeila, 2019). ICD-11 offers a partial attempt to integrate the dimensional approach in defining personality disorders.

In Finland, ICD-10 is still in official use in the clinical field, whereas DSM-5 is mainly used in research. In the future, the psychiatric profession will assess the suitability of ICD-11 in clinical work.

2.1.3 Advantages and disadvantages of the current categorical diagnostic classifications

Almost everywhere in the world, ICD-10 and DSM-5 are the current official diagnostic classifications in clinical work and scientific research. Regardless of the revisions, both are still grounded in observable signs and symptoms and their descriptions, with specific criteria through clinical evaluation. During their use, the advantages and disadvantages have been strongly debated, as has been described above.

The main *advantage* is that diagnostic classification reduces and simplifies our evaluation of complex mental conditions and creates order and structure in various signs and sets of symptoms differentiating mental health and mental disorders. The categorical diagnostic classifications have improved the reliability of diagnoses. For example, the kappa statistic was 0.8 or higher in DSM-IV (Andreasen & Black, 2001).

It is commonly assumed and accepted that the diagnostic classification provides a basis for the development and research of evidence-based treatments. Moreover, by summarizing information, the diagnosis helps clinicians to communicate relatively easily about the mental conditions of patients. Diagnoses contribute significantly to the allocation of resources to mental health organisations. Moreover, diagnoses contribute significantly to the patients' lives and help to comprehend their own complex mental experiences. Furthermore, diagnoses have an essential role in insurance benefits and legal processes (Andreasen & Black, 2001; Lönnqvist et al., 2001). The impact of diagnostic classification is widely and deeply entrenched in different institutions and practice (Poland, 2014).

The main *disadvantage* is the uncertain validity of the diagnosis of mental disorders. Diagnostic classification based on provisional consensus is carried out by a group of experts and describes and defines an average patient's mental condition, thereby not determining the patient's mental condition individually enough.

The diagnosis could arbitrarily guide the evaluation of the clinician while other ways are overlooked. A mental problem in a patient could meet three or more categories of disorders, and this comorbidity could make clinical inference and the

management of treatment rather difficult in many cases. Moreover, the diagnosis could be misinterpreted or abused, and the psychiatric diagnosis may continue to cause stigmatization, affecting the lives, social relationships and everyday functioning of patients and their families (Markowitz, 1998; Andreasen & Black, 2001; Lönnqvist et al., 2001; Lauber et al., 2004; Aromaa et al., 2011; Clark et al., 2017).

By conveying advantages and disadvantages, the impact of diagnostic classification is widely and deeply entrenched in different institutions, societies and in the patients' lives. As noted above, the psychiatric diagnosis is an essential tool, but it is rather impersonal in itself, thus it does not advance the patient's treatment plan individually enough.

2.2 Patient-centred approaches

For a long time in history, medicine was paternalistic, positioning the doctor to make decisions for patients instead of involving them. In the 1950s, the psychiatrist and psychoanalyst Michael Balint (1957) trained general practitioners to focus on the attitudes of patients towards their illness. He taught that patients have to be taken into account as *whole human beings* within their social context. By investigating the doctor–patient relationship, Balint emphasized that the responses of doctors have a significant effect on the disclosure by patients of various "unorganised" medical states. He proposed the term *mutual investment company*, meaning that "both patient and doctor grow together into a better knowledge of each other." He continued that "this mutual influencing is not a simple process, developing either in an entirely good or entirely bad direction" (Balint, 1957, p. 249). Balint's classic work gave an impetus to the further development of the patient-centred approach in medicine.

At almost the same time, in psychotherapy, Carl Rogers (1961) characterised a *helping relationship* in which the therapist focuses on the facilitation of the client's personal development and necessary changing process. His approach was named *client-centred* psychotherapy.

Rogers asserted that therapists need to be aware of what they experience in the relationship with a client and congruent with themselves, their own feelings, and reactions. Only in this way would therapists be able to accept and understand the

problems of their clients. He considered that therapists should present an 'unconditional positive regard' and provide empathic understanding in their communication with clients who seek help for significant problems. He suggested using this type of approach not only in psychotherapy but also in teaching, in partnership or the family, in communication and in the solution of international conflicts.

Rogers presented the inevitable role of subjective experiences on the part of both the therapist and the client in promoting the therapeutic relationship in psychotherapeutic work. Moreover, he also noted the problematic dilemma of scientific objectivity and the role of subjectivity in the therapeutic process. He maintained that "I enter the relationship not as a scientist, not as a physician who can accurately diagnose and cure, but as a person, entering into personal relationship. Insofar as I see him only as an object, the client will tend to become only an object" (Rogers, 1961, p. 257). Here, Rogers disclosed the problem of an objectivated attitude of the therapist in psychotherapy. He compared it to the usual scientific or medical attitude of physicians, who observe the symptoms from an 'out there' approach and distances themselves from the subject/patient, thereby weakening their self-initiated activity and personal development. Rogers had a marked impact on the further development of psychotherapy practice and his research provided a foundation for advancing patient-centred approaches in medicine.

Along the lines of Rogers, Patrick Byrne and Barrie Long (1976) conducted a pioneering empirical study on the communication and behaviour of primary care doctors. They audio-recorded 2500 visits and differentiated basic styles of doctor–patient interaction. Based on the particular knowledge of the participants, they distinguished two styles of interaction in the medical interviews. The doctor-centred style is guided by medical specific knowledge, while the patient-centred style is focused on the patient's experience and knowledge.

As mentioned previously, the roots of the patient-centred approach have been generated from psychotherapy. This approach has been employed and investigated in general and family medicine to compensate for the dominant biomedical approach, as well as doctor-centredness or paternalism (Stewart, 1984; Levenstein et al., 1986; Brown et al., 1986; Henbest & Stewart, 1989; 1990; Coulter, 1999).

In his classical critical study *The Discourse of Medicine*, Elliot G. Mishler (1984) highlighted the roles of the 'voice of the lifeworld' and the 'voice of medicine' in medical interviews. He revealed the dominance of the 'voice of medicine', as the doctor controls the topical content and the interview, thereby regulating and

silencing the patient's 'voice of the lifeworld', such as their personal and contextual experiences.

Ian R. McWhinney has defined the patient-centred approach in another way: "the physician tries to enter the patient's world, to see the illness 'through the patient's eyes' " (1985 p. 35). Other researchers have clarified patient-centred care, which is responsive to and congruent with the patient's values, needs and preferences (Laine & Davidoff, 1996). To advance the clinical method of patient-centred care, four interactive components have been differentiated: 1) exploring the patient's health, disease and the illness *experience* (feelings, ideas, function, expectations); 2) understanding the patient as a *whole person* (history, personal development, social and cultural context); 3) finding *common ground* in problems, goals and tasks of treatment; and 4) enhancing the clinician-patient *relationship* (empathy, hope, self-awareness, transferences) (Stewart, 2001; Stewart et al., 2013).

Nicola Mead and Peter Bower presented five conceptual domains to approach patient-centredness in medical care: 1) the biopsychosocial perspective; 2) "patient-as-a-person"; 3) "doctor-as-a-person"; 4) sharing power and responsibility; and 5) the therapeutic alliance (Mead & Bower, 2000, p. 1087).

In the literature concerning patient-centredness, there is overlap between the terms client-centred and person-centred approach (Adams & Grieder, 2004). In their comparative analysis, Hughes and colleagues (2008) reviewed different types of centredness in health care and social care. They did not find thematic differences at the conceptual level; however, they emphasized the important contribution of 'interrelationships' between clients and professionals. The types of centredness are determined by different practices and institutional contexts. These approaches encourage the professional to shift their narrow biomedical perspective to a broader humanistic view. By maintaining the professional's ethical and knowledgeable responsibility for the patient's treatment, patient- or person-centredness focuses on the patient's health problems in sociocultural contextual details through their perspectives and experiences. The professional not only prescribes treatment for the patient's health problem, as in the traditional biomedical approach, but engages the patient to view the problem and seeks to picture the patient's experiences, goals, perspective, and knowledge.

Sara Swenson and colleagues (2004) suggested the implementation of 'flexible approaches' and demonstrated that 69% of adult patients prefer patient-centred communication, while 30% prefer the traditional biomedical style of communication; thus, doctors need to understand the *relationship* of patients with their problems and their expectations regarding the present medical encounter.

In recent decades, in the field of oncology, researchers have investigated the patient-centred approach and communication, intending to promote the conceptual framework and methodology. These studies have emphasized the collaborative and shared role of both participants in a medical encounter, not only in oncological but in all clinical encounters (Epstein et al., 2005; 2007; 2009; Street et al., 2009; Shields et al., 2009; Mack et al., 2009).

Communication is an essential element in this process for improving patient adherence to the treatment, facilitating shared decision making and supporting self-management, also improving health outcome (Stewart, 1995; Robinson et al., 2008). Marissa Constand and colleagues (2014) reviewed different patient-centred strategies from 25 studies and observed three common elements of this framework: 1) communication, 2) partnership and 3) health promotion.

In Finland, this principle, by which the patients actively participate in their treatment, was generally recommended to advance the effectiveness of health care organization (Teperi at al., 2009). Moreover, according to the Finnish Health Care Act (2010), the purpose of the act is, inter alia, to "promote *client orientation* in the provision of health care services" [italics added], which obliges clinicians to consider the patient's perspective, needs and preferences. Furthermore, the Act on the Status and Rights of Patients (785/1992, as amended) strengthens the autonomy of patients and advances their involvement in their care.

 Moreover, there is an interpretation debate in health care concerning whether a person seeking help for a health problem is in the role of a *patient* or *client* (Saarni, 2018). In clinical work, especially in specialist care such as psychiatric outpatient clinic, the term *patient* is used. However, at the management level of healthcare organisations, the term *client* is usually used. This corresponds with the term *consumer,* meaning that the person chooses, buys and uses the service.

Nowadays, patients receive health information from various channels of social and other media, making their own knowledge broader than a few decades ago. The vague and complex health problems of patients clearly challenge health professionals to achieve patient satisfaction. Instead, it is advisable to promote and build a mutual understanding or common ground for the targets and tasks of the treatment. Accordingly, the core of this debate is that although health professionals strive for patient satisfaction, this does not in itself guarantee an improvement in health problems or the promotion of health and the effectiveness of the healthcare system. Nonetheless, the change in terms in recent decades might convey a tendency for equalization in the interaction occurring in this medical institutional encounter (Ruusuvuori, 2000; 2013).

Regardless of heuristic research on patient-centredness, a clear consensual model is still lacking. There are so many socio-cultural and interpersonal variables affecting the unique patient's health and treatment decisions in a medical encounter that evaluating the effectiveness of patient-centred care appears challenging. Next, studies on patient- or person-centredness are reviewed in different fields of health care.

2.2.1   Studies applying a patient- or person-centred approach

In different fields of medicine, predominantly in primary healthcare, there have been various studies applying a patient-centred or person-centred approach. In the literature, the two definitions overlap; however, the term person-centredness is mainly used with chronic medical and mental illnesses.

There are observational studies and meta-analyses of randomized control trials, as well as systematic reviews on patient-centred interventions and their effect on outcomes. These trials have applied the framework of patient-centred interventions based on the clinicians' communication skills, shared decision making and empathic responses when pursuing a partnership with the patient; however, they lack a consensual concept, as mentioned previously. These studies have aimed at evaluating the *effectiveness* of patient-centred communication or interventions through different types of outcome measure.

Extensive studies in primary care have demonstrated that patient-centred communication and interventions positively impact on *patient satisfaction* and self-management and reduce referrals and diagnostic tests (Stewart et al., 2000; Little et al., 2001; Rathert et al., 2013; McMillan et al., 2013).

In the United States, ten community mental health centres randomized patients into two groups investigating the effect of person-centred planning and collaborative documentation (Stanhope et al., 2013). The professionals were trained to identify the client's life goals and integrate them into the patients' health behaviour and treatment. The researchers compared 177 clients (intervention group) and 190 clients (control group with standard treatment) with various mental disorders. The results demonstrated significantly increased *medication adherence* and better *treatment engagement* in the intervention group using person-centred planning than in the control group.

In their meta-analysis, Peter Coxeter and colleagues (2015) found that patient-centred intervention conveying shared decision making resulted in reduced *inappropriate medication* prescriptions (antibiotics for acute respiratory infections).

Another systematic review revealed that clinicians with patient-centred skills reduced the number of inappropriate prescriptions of benzodiazepine and z-drugs by reducing or stopping their use (Mokhar et al., 2018).

Furthermore, many studies and meta-analyses investigating patient-centred interventions have found an effect on outcomes, with *health improvements* in patients having depression, alcohol addiction and cardio-metabolic syndrome (Jani et al., 2012; Barrio & Gual, 2016; Zhang et al., 2016), as well as a reduction in the patient symptom burden and agitation with dementia (Little et al., 2001; Conn et al., 2016; Kim & Park, 2017). Some studies have found a modest improvement in *quality of life* as a patient-centred outcome (Conn et al., 2016; Kim & Park, 2017). Nonetheless, in another large study in the United Kingdom, there was no evident effect on quality of life or the illness burden in patients with multiple chronic conditions (Salisbury et al., 2018).

Moreover, Lars-Eric Olsson and colleagues (2013) also found mixed outcome results in their research. They systematically reviewed person-centred care as an intervention, selecting 11 controlled trials in a variety of contexts. In eight studies, the outcomes of the person-centred interventions were successful regarding *partnership* in medical encounters. They noted that there is not enough evidence for the values and efficacy of person-centred care due to methodological difficulties in conceptualizing and operationalizing the interaction between patients and health professionals.

As demonstrated, these studies applying the patient- or person-centred approach have been grounded in communication between at least two participants, which does not bend easily to the arrangement of randomised controlled trials as the 'gold standard'. This might to some extent explain the slightly positive, modest or mixed results that have been reported.

In Finland, some studies also investigated patient–doctor interviews concerning the patient-centred perspective. In a large Finnish interaction study with 100 video-recorded medical consultations in primary health care, Anssi Peräkylä (1998; 2002a) demonstrated through conversation analysis that doctors provide a reasoned account for the diagnosis. Thus, instead of seeking old-fashioned unconditional authority, doctors convey a patient-centred development of the medical interaction.

In another recent Finnish study, Harry Köhler (2019) analysed doctor–patient interviews and reported that the interaction might strengthen or weaken the patient's agency, depending on whether the doctor focuses on the health problem only or also considers the patient's contextual lifeworld issues. By using two specific questions concerning the lifeworld issue, the doctor can reduce the need for recurrent visits and improve the caring effect of the interaction. Thus, by considering both the medical problem and its meaning within the patient's lifeworld, the doctor enables patients to be actively involved in their own treatment, which can impact on the effectiveness of the treatment.

In another Finnish study, Ritva Vatjus (2014) analysed the relationship-centred approach in the doctor–patient encounter in education on general practice. The semi-structured interviews of doctors were evaluated through qualitative analysis of the transcribed texts and questionnaires. It was found that the essential core of the doctor–patient relationship in diagnosing and deciding on treatment is that the doctors pay attention to the concerns, experiences, thoughts, feelings, and meanings of the patients, as well as their own medical expertise, being aware of their own preferences and attitudes.

The studies mentioned above derived from multiple fields of medicine and involved heterogeneous intervention models, which considered the perspectives, values, needs and experiences of patients more than in usual treatments. Only a few studies in mental healthcare or among patients with mental disorders have investigated person-centred interventions. Inherently, in mental healthcare and psychiatry, the different psychotherapies represent so-called person-centred short-term or long-term interventions. Nonetheless, a review of the relevance of psychotherapies is outside of the scope of this dissertation.

To summarise, regardless of the slightly positive, modest or mixed results of extensive studies, the patient-centred approach, extending to person/client-centredness, is an ethical, value-based orientation and recommended all over the world, conveying the tendency for equalization of the medical institution (WHO, 2015; Kattelus & Sariola, 2021).

Nonetheless, Mark Arnold and colleagues (2020) recently presented an ethical critique of person-centred healthcare. The authors warned against overinterpreting its utility and efficiency, as well as extreme assumptions regarding preference-driven healthcare and consumerism considering the economics and politics of healthcare organisations. Despite their debate, Arnold and colleagues stated that a manifestation of the humanism and bioethics of healthcare is conveyed by taking the patient's lived experience and preferences seriously.

Defining the conceptual framework and finding optimal methods for investigating the process and effectiveness of the patient-centred approach is multifaceted and challenging. Nonetheless, it is a value-based ethical approach that includes the possibility for improving the effectiveness of health care. The physician always remains a responsible medical expert, a) in the context of, b) backed up by, and c) framed by the practices of health organisations.

The patient, however, is always expert regarding his/her unique experiences. In patient-centred interaction, it is only through collaboration that common ground and an optimal care plan that can strengthen the patient's self-management, agency and quality of life is achieved.

Patients with mental health problems are more helpless, also vulnerable and their mental problems are more vague, multifaceted and complex than patients with somatic problems. Therefore, such patients need particular ethical attention from mental health professionals, as also stated in the Madrid Declaration (World Psychiatric Association, 1996; Pylkkänen, 1999). Next, the person-centredness is reviewed in psychiatry.

2.2.2 Person-centredness in psychiatry or mental healthcare

The psychodynamic and biomedical traditions co-existed for most of the 20th century, following the fundamental work in psychoanalysis and psychiatry by Freud and several other contemporary scientists and psychiatrists. The psychodynamic approach was somewhat dominant, as was the European and American approach to diagnostic assessments and treatment.

Among others, a well-known American psychiatrist, Nancy Andreasen (2001), discussed the differences between these traditions in her work. She maintained that the biomedical tradition focuses on the determination and recognition of symptoms and behavioural features as a disorder. However, the psychodynamic model tries to understand the 'why', i.e., what type of psychological process or background underlies the complains, symptoms and maladaptive behaviours of patients, while conveying in itself the possibilities of psychotherapeutic treatment (see also: Sadock at al., 2015).

The person-centred approach in the psychiatric assessment tends to, as it were, remind the psychodynamic model of what Michael Balint (1957) drew his principles

of the patient-centred approach from. On the one hand, while modern psychiatry employs not only biomedical practices but also accepts humanistic and psychological visions in medical and mental disorders (such as Engel's BPS model), psychiatry should be or is inherently person-centred. On the other hand, disregarding the disadvantages of diagnostic classification and the contingent dominance of the biomedical approach may contribute to a weakening of person-centredness in the field.

Since the latter part of the 20th century, through advancements in psychopharmacology, neurosciences and genetics, psychiatry gradually moved towards the biomedical model. According to these positive changes and developments and other critical movements in society, asylums were closed and the hospitalisation of psychiatric patients was reduced all over the world. However, the need for outpatient community mental health services clearly increased (see also section 2.1.1). For example, in the 1970s in the United States, a large study was conducted on the expectations of patients/applicants ($N = 611$) and relatives ($N = 433$) concerning the type of treatment and service utilization (Honstra et al., 1972). The researchers found that patients and relatives expected relief from symptoms and secondarily a change in addictive behaviours (drugs, alcohol). Moreover, the patients only expected a minimal commitment to mental health services. Nonetheless, 51% of them were hospitalized, even though only 11.9% requested this. The researchers discussed the need to develop the quality of outpatient treatments. The results revealed divergent orientations and expectations of treatment between patients/relatives and clinicians, reported as 'worlds apart', mirroring the persistent contemporary hospital-centred treatment culture in mental healthcare.

Respectively, there were attempts to contemporize the outpatient mental services, which were supported by studies at walk-in psychiatric outpatient clinics in the United States. In their studies, Sherman Eisenthal and Aaron Lazare (1976a; 1976b; 1977; Eisenthal et al., 1979) sought the perspectives of patients after the psychiatric interview process by applying a negotiated or *customer approach* compared with the diagnostic approach. They reported that when the clinician helped the patients put their concerns and requests into words, the co-construction of a positive relationship was possible. Correspondingly, treatment adherence also increased in the diverse patient population. Although the customer approach represented a local treatment culture, it had an impact on further research in this field.

Yrjö Alanen and colleagues received international attention following their study, which employed *need-adapted* assessment and treatment for patients with

schizophrenia. This assessment method is deeply rooted in Finnish family and psychodynamic psychotherapy (Alanen et al., 1991; Alanen, 2007; 2009). In this Finnish treatment model, the authors emphasized the therapeutic flexible attitudes of clinicians towards patients as unique individuals with unique mental problems, also considering their family from the beginning of the treatment process.

Based on a former model, Jaakko Seikkula (2003; also Olson et al., 2014) and his team gradually developed the *open dialogue* model in Finland for the patient's (or person's) psychotic experiences. It is primarily a psychotherapeutically oriented, network-based and community-based approach in which the patient and the staff, and possibly also the relatives, work together on an equal dialogical level. They approach the symptoms or disorders as a mental crisis or meaningful reaction belonging to human existence embedded in the patient's intersubjective relationship and socio-cultural context (examined further in section 2.2.2.1).

Originally, in the United Sates, when considering not only the assessment process but the whole treatment in mental healthcare, the so-called *recovery-oriented approach* was developed, deriving from the service user movement and activist organisations in the country (Deegan, 1988; Davidson & Strauss, 1992; Resnick et al., 2005; Korkeila, 2017; Nordling, 2018). This approach offers a new perspective, transferring a patient from the role of someone to be merely treated by others to someone emphasizing their own opportunity and agency, and influencing their own recovery. By applying elements of positive psychology, the recovery-orientation framework highlights the person's resources, participation, values, hope, empowerment and positive health experience, regardless of the limitations of symptoms or disabilities.

Larry Davidson and colleagues (2009) compared evidence-based practice with recovery-oriented practice. They argued that there is a need to shift the emphasis from symptom reduction to personal growth, which challenges researchers to search for appropriate indicators for measuring self-efficacy and self-agency. Larry Davidson and colleagues reported the need for both practices in patients with mental illnesses. By advancing a respectful and collaborative relationship and applying evidence-based interventions, mental healthcare can help patients to manage distress or disabilities and enhance their functioning and achievement of personal life goals.

Jan Hummelvoll, Bengt Karlsson and Marit Borg (2015) integrated recovery and *person-centred* approaches as an evolving and purposed ideology for mental health professionals and organisations. The person-centred approach was implemented in numerous countries. Brendan McCormack and colleagues (2015) overviewed this

approach, stating that there are diverse strategies in different countries and clarification is needed on how they are operationalised in everyday clinical situations.

In recent decades, patient-centredness has also been comprehended as person-centredness, mostly for treating chronic medical conditions and mental illnesses in healthcare (Adams & Grieder, 2004; Mezzich et al., 2016a). Any illness experience, whether chronic or acute, affects personhood and social identity. However, mental illnesses can influence the identity of patients more than somatic illnesses, and the *meanings* of pathological mental experiences are more determinative for them. Guilherme Messas and colleagues (2017) argued that a psychopathological diagnosis always includes two simultaneous and convertible levels. These are primarily recognition of the nature of the pathological experience, and secondly of its meaning for the unique person who experiences it. The authors stated that understanding of the dialectical relationship between both levels is the essence of person-centred mental healthcare.

Moreover, severe mental illnesses can restrict a person's rights and autonomy, also affecting their social identity. Every country has *legislation* for patients with severe mental disorders concerning their autonomy and self-determination. In Finland, the Mental Health Act (2001), stipulated by the Finnish mental health services, determines the medical reasons and conditions for ordering the involuntary treatment of a mentally ill patient. An important section (22b) is the following: "A patient must be cared for, as far as possible, *in mutual understanding* with the patient. A care plan must be drawn up in the context of giving treatment" [italics added]. This order emphasizes that the attending physician must try to consider the wishes and will of the patient, regardless of whether the physician decides on involuntary treatment.

As discussed earlier, the legislation and ethical declarations aim for client- or person-centredness in all medical fields. Occasionally, there may be conflicts between the personal rights and public good, which challenge mental healthcare and the clinician's decisions in psychiatric encounters. In the implementation of person-centred care situations, this conflict emphasizes the *clinicians' attitude* as a key element in balancing between the rights of the patients and the best treatment for them. Although the person-centred approach attends to the needs, values, and preferences of patients, it can also result in better satisfaction and well-being for clinicians, which is a significant factor in collaboratively planning good treatment outcomes (Boardman & Dave, 2020). The competence of providers in delivering person-centred care is trainable and maintainable; furthermore, it significantly improves with practice (Stanhope et al., 2021).

In Finland, and variably in other countries, various professionals work together as a *multidisciplinary team* in community mental healthcare. Psychiatrists/physicians, psychiatric nurses, psychologists, social workers and sometimes occupational or physiotherapists shape a network with the patient and relatives to collaboratively improve the patient's mental problems. In multidisciplinary teamwork, the person-centredness (patient-centredness or client-orientedness), grounding in the significant role of communication, facilitates a mutual understanding of the targets and tasks to achieve a good treatment outcome (Maddock et al., 2015; Mönkkönen et al., 2019; Happell et al., 2019). In multidisciplinary teamwork, the person-centred approach highlights the significance of the assessment process in which the patient's personhood or social identity can be protected and integrated.

Studies on the *patients' perspective* have found that patients with mental illness seek understanding, an explanation and help for their problems. Furthermore, they expect to develop a good relationship with the clinician and to be listened to, and they want to participate in treatment decisions (Björkman et al., 1995; Noble et al., 2001; Johansson & Eklund, 2003; Bilderbeck, 2014; see also section 2.3.2). The results support the relevance and need for patient- or person-centredness in psychiatric assessment and treatment.

Next, various person-centred tools are reviewed that can individually complement the psychiatric diagnostic evaluation.

2.2.2.1   Person-centred tools in psychiatric assessment

There have been some attempts to complement the diagnostic classification with various theory-driven psychotherapeutic approaches that consider the psychopathology of patients from various perspectives. These methods make it possible to achieve detailed explanations as to why people have certain symptoms and why they behave maladaptively in their sociocultural context. Based on the different renowned psychotherapeutic theories (for example, psychodynamic, interpersonal, cognitive, and dialectical behavioural theories), Fernando and colleagues (2012) suggested using pattern-based psychiatric formulations to gain a broader understanding of the clinical problems of patients. According to their suggestion, these methods are trainable in psychiatric medical education. By complementing the individuality of the psychiatric diagnostic assessments, these pattern-based formulations from different psychotherapeutic theories support the person-centred approach in clinical work.

Leon Eisenberg (1977, p. 11) discussed the relationship and the discrepancy between illness and disease and stated that "illnesses are *experiences* of disvalued changes in states of being and in social function; diseases, in the scientific paradigm of modern medicine, are *abnormalities* in the *structure* and *function* of body organs and systems" [italics in the original]. Laurence Kirmayer, Juan Mezzich and Werdie Van Staden (2016) also reviewed the crucial meaning of the patient's health and illness experiences and values in psychiatry based on the person-centred approach. In the case of psychiatry, the term disease corresponds with the term *mental disorder*. The authors reviewed that the process of assessing the patient's health and illness experiences is fundamentally intersubjective and co-constructed in medical or psychiatric encounters. According to this interactive process, patients bring their mental problems – which may also be physiologically embodied – as well as their contextualised lifeworld experiences to the clinicians, who interpret them based on their medical expertise, clinical experience, ethical values and institutional responsibilities. Carrying on with their own orientation, both participants interactively influence and shape the health and illness experiences.

Considering the health experiences of patients, there are some person-centred semi-structured interviews that I present in more detail in the following.

Firstly, Arthur Kleinman (1978), an American psychiatrist and anthropologist, presented a method derived from cross-cultural and anthropological research, namely illness 'explanatory models'. There is a family of semi-structured tools, the so-called Explanatory Model Interview Catalogue (EMIC), with a long tradition of advancing the evaluation of the patient's experienced or perceived causes of illness in different ethnicities and cultures (Weiss et al., 1995; Weiss, 1997).

Due to the length of the EMIC, there was a need to develop the Short Explanatory Model Interview for field studies in different cultures to be used in further quantitative or qualitative analyses (Lloyd et al., 1998; McCabe & Priebe, 2004a, 2004b).

Mitchell G. Weiss and Daryl Somma (2007) discussed the advantages of illness explanatory frameworks conveying empathy and facilitating engagement with the treatment in the clinic and research on cultural psychiatry. Nonetheless, they also criticized the static nature of the model and its neglect of the effect that the details of the social context may have.

Rooted in these traditions, the diagnostic classification of DSM-IV presented the Outline for Cultural Formulation (OCF) as a semi-structured interview, which was also translated into Finnish (APA, 1994; Bäärnhielm et al., 2010). Based on worldwide interest in training programmes and outpatient service implementations

of OCF, for example in Sweden (Scarpinati Rosso et al., 2012) and in the Netherlands (Rohlof et al., 2009), DSM-5 supplied the Cultural Formulation Interview (CFI), claiming better operationalization than the former DSM-IV. By implementing the CFI, clinicians define the patients' mental problems and experiences in detail from different socio-cultural contexts and perspectives in varied religions and ethnicities, clarifying the diagnostic assessment process (Lewis-Fernandez, 1996; Lewis-Fernandez et al., 2014; 2016). There are four key domains: 1) the cultural identity of the individual; 2) the cultural explanation for the illness, 3) cultural factors related to the psychosocial environment and levels of functioning and 4) cultural elements of the relationship between the individual and the clinician. These domains guide the semi-structured CFI, defining a culturally accurate diagnosis and individual treatment plan. The field trial (318 patients and 75 clinicians) demonstrated that the CFI is a useful, feasible and an acceptable tool to complement and clarify the diagnostic assessment with more individuality (Lewis-Fernandez et al., 2017). Although the CFI is a time-consuming tool and lacks systematic research on the treatment outcome, researchers have presented its clinical utility in diagnostic evaluation and individual treatment planning with patients from different cultures. The CFI was broadly implemented in various countries to be utilized in medical training programmes and clinical communication, reducing misdiagnosis and discrimination between ethnicities and facilitating the patients' engagement with mental health services (Aggarwal et al., 2015; 2020; Jarvis et al., 2020).

Furthermore, there has been yet another attempt to improve person-centredness in medical or psychiatric assessment. Mezzich and colleagues (2010; 2016b) described the so-called Person-centred integrative diagnosis (PID), which brings together medical science and humanism, considering the person as a 'whole human being'. They suggested examining both domains of the health condition, ill health and positive health, investigating through the health status, the experiences and different contributors to the state of health (intrinsic/extrinsic; biological, psychological and social). They recommended using the PID for patients with multimorbidity and with psychiatric disorders. In a detailed guidebook, the authors discuss this comprehensive diagnosis, considering both illness and well-being, maintaining that it may promote health and partnership in care. However, its implementation is time consuming and it still lacks conceptual validity (Mezzich et al., 2016b).

In Denmark, Josef Parnas and colleagues (2005; also Davidson, 2009; Raballo et al., 2012; Koren et al., 2016) developed a phenomenologically oriented person-centred interview for evaluating and advancing the early detection of a patient's

vulnerability to psychosis in schizophrenia spectrum disorders. The so-called Examination of Anomalous Self-Experience (EASE) is a reliable, comprehensible and internally consistent clinical tool that focuses on the problems and disorders of self-awareness, exploring the patient's responses and narrative of subjective experiences in a semi-structured interview (Møller et al., 2011; Norgaard & Parnas, 2012). Moreover, there are many types of self-report scales and questionnaires. However, this dissertation focuses on naturally occurring interaction in the psychiatric assessment encounter, thus, do not review them.

Unlike the former semi-structured interviews, Jaakko Seikkula and his team (2003; also Olson et al., 2014) in Finland developed the Open Dialogue model for the patient's (or person's) psychotic experiences. It is primarily a psychotherapeutically oriented, network-based and community-based approach in which the patient and the staff, and possibly also the relatives, work together on an equal dialogical level. They approach the symptoms or disorders as a mental crisis or meaningful reaction belonging to human existence embedded in the patient's intersubjective relationship and socio-cultural context. This holistic and person-centred approach involves seven structural and twelve therapeutic principles, constituting the fidelity criteria for guiding the practice.

Recently, Tomi Bergström himself (2020) and with co-authors (2018) reported their register-based cohort study outcomes from the west Lapland catchment area following their investigations of the medical records of patients with first-episode psychosis during 1992–2015. They compared the mortality and the need for treatment in two groups of patients: those who were treated with the network-based Open Dialogue model and those treated using standard community-based psychiatric treatment interventions. The authors found apparent differences in the situation of the patients, but not in mortality. After 19 years, more than half of the patients in community mental services with first-episode psychosis receiving standard treatment were still in treatment, over 80% took antipsychotics and over 60% lived on a disability pension. In contrast, only about 30% of patients treated with network-based Open Dialogue were still in contact with mental services and lived on a disability pension. Although the results convey real-life effectiveness, the authors suggested a need for randomized controlled trials to demonstrate the significance of this approach.

To summarise, the above-mentioned person-centred approaches and assessment tools may facilitate recognition of the patient's lived experiences, needs, values and preferences, which also impact on the treatment process. The Cultural Formulation Interview has been implemented in training programmes and contingently in

outpatient services in different countries. Moreover, the Open Dialogue model has been applied in the clinical field in various countries. Nonetheless, the other semi-structured interviews are only occasionally used and more often in research.

In the following section, the current recommendations for the psychiatric interview are presented and discussed its functioning from the clinical perspective of community mental healthcare.

2.3 Psychiatric assessment interview and related interactional studies

2.3.1 Psychiatric interview as clinically recommended

In the psychiatric interview, mental problems experienced by the patient interact with the clinician's expertise. This encounter has fundamental significance for the evaluation and treatment of mental disorders. Depending on the severity of illness, urgency, risk management and the circumstances of the encounter (for example, outpatient clinics or hospital), the purpose of the interview is basically determined by current criteria-based diagnostic classification (ICD/DSM). Occasionally, because of the tendency towards multidisciplinary teamwork, the interviewer is not always a physician, and other significant persons may provide important information about the patient's condition in the encounter.

Regarding the latest edition of the educational textbook *Synopsis of Psychiatry* (Sadock et al., 2015), the psychiatric interview or assessment process is recommended to provide a multidimensional and biopsychosocial framework of mental disorders, as well as information on the prognosis and person-centred treatment plan.

The authors reviewed the *general principles* and described the process and techniques of the interview. These principles should influence the clinician's attitude toward the patient's mental problem, contributing to the assessment process and interviewing techniques. The principles are reminiscent of the above-mentioned patient- or person-centred approaches. However, there are some specific attributions in this context. At the beginning of the interview, the clinician should seek the patient's agreement to participate in the process, regardless of whether the patient participates voluntarily or involuntarily in the encounter. Based on ethical and legal

orders, privacy, confidentiality, respect, and consideration also are emphasized. These should contribute to an empathic approach and the development of rapport, which is defined as "the *harmonious responsiveness* of the physician to the patient and the patient to the physician" (Sadock et al., 2015, p. 193 [italics added]).

As in other fields of medicine, the core principle is that the patient–physician relationship is one in which the patient is of prime importance and there should be an attempt to strengthen the *therapeutic alliance* through mutual understanding. Although the psychodynamic model of mental disorders has nowadays received less attention, one of these general principles still notes the role of conscious or unconscious processes. The therapeutic relationship should be advanced by recognizing the role of *transference* and *countertransference* in the encounter. For a long time, the psychodynamic model has helped clinicians to observe and recognise the behaviours of patients and provide the appropriate type of psychosocial treatment in psychiatry. This model advances understanding of the patient's and the clinician's own emotional experiences in a stressed situation and conceptualizes the defence and coping mechanisms (Andreasen & Black, 2001; Lönnqvist et al., 2001; Othmer et al., 2005; Sadock et al., 2015; MacKinnon et al., 2016).

Despite the recommendations for observation of defence mechanisms, the clinical employment of these mechanisms is very limited because of the need for psychotherapeutic education and frequent supervision.

The core principle of the interview is *person-centredness,* and not the traditional disorder-centredness, as Sadock and colleagues (2015) recommended. Respectively, the central theme of the interview is the unique experience of patients concerning their personal early life history, as well as the present situation concerning social, psychological, spiritual, and biological/genetic variables. Moreover, in the interview situation, there needs to be comfort and physical safety with an appropriate amount of time or number of sessions to build a person-centred treatment plan.

Depending on the urgency and severity of the mental illness, the elements of the initial psychiatric interview vary in quantity, quality and time. Based on educational literature, these elements are described in Table 1 (Andreasen & Black, 2001; Lönnqvist et al., 2001; Othmer et al., 2005; Sadock et al., 2015). The data gathered from the interview indicate that the clinician oriented toward the symptoms and diagnostic categories at the same time. There are four main diagnostic groups: mood, anxiety, psychosis, and other conditions, which direct the clinician's orientation towards a more specific provisional diagnosis.

The initial clinical psychiatric interview is traditionally unstructured, conveying the unique nature of the patient's mental problem. Depending on the patient's

medical and psychiatric condition, if necessary, there is the possibility to use and complement the evaluation process with different structured diagnostic interviews or rating scales in the follow-up assessment sessions. Moreover, laboratory tests and neuroimaging methods for excluding nonpsychiatric causes may be needed.

The educational literature also discusses the *technique of the interview*. Firstly, *facilitating interventions* are mentioned and recommended. These are open-ended questions, reinforcement, reflection, summarizing, education, reassurance, encouragement, acknowledgement of emotion, humour and silence. Moreover, *expanding interventions* are described as clarifications, associations, leading, probing, transitions and redirecting. These interview techniques, combined with appropriate attendance to nonverbal communication, promote information gathering and should positively affect the therapeutic relationship. Nonetheless, *obstructive interventions* are also mentioned. These can hamper the progress of the interview and the cooperation with the patient. They include close-ended questions, 'why' questions, judgmental questions or statements, premature advice or interpretation, as noted in an educational textbook (Sadock et al., 2015).

Furthermore, Roger MacKinnon and colleagues (2016) discussed the clinical psychiatric interview in detail. They argued that the distinction between diagnostic and therapeutic interviews is artificial. Moreover, they emphasized that when the interview only targets diagnostic evaluation, the patients may feel that they are a "specimen of pathology" being explored or examined, thereby impeding them from disclosing their mental problems (MacKinnon et al., 2016 pp. 23). The authors approached a successful interview from a therapeutic perspective and emphasised the relevance of shared understanding between the physician and the patient.

Giovanni Stanghellini (2004) has criticised the epistemological problem of the psychiatric interview. He pointed out that the mental status is based on the patient's subjective narrative about their experiences from a first-person perspective. Thus, the trend to avoid subjectivity leads to the overestimation of objectivity in diagnostical interpretation. Moreover, the professionals as an interviewers assume that patients can aptly express their problems in words, although this could be incomplete and individual. In psychiatric interview, information is gathered from the first-person perspective into existing categories in the third-person perspective (viewing behaviours as 'shells' with observed content), requiring a process of change. The interviewer is a subjective person and, regardless of their expertise, could misunderstand and misinterpret the patient's meaning and the relevance of the narrative. Ultimately, these barriers can transform the authentic mental experience in this interviewing interaction. Stanghellini (2004) suggested that the professionals

need to be aware of the disadvantages of the diagnostic process and take an 'observer participant' role, with empathetic skills as tools for understanding and evaluating the mental problems that characterise an effective therapist.

To summarise, these general principles, recommendations for the interview process and techniques are self-evidently important in teaching and specialist education. However, in real-life clinical practice, regardless of the best medical knowledge and ethical attitude or orientation, the wide variety of inherently interfering factors, barriers and data in natural dynamic interaction inevitably affects the process and the outcome of the assessment interview.

Next, studies are reviewed that have investigated the perspective and expectations of patients regarding the psychiatric encounter and mental healthcare.

Table 1.   Elements of the psychiatric interview

1	Identifying the data on the patient and the referral
2	Reason for the interview and chief complaint
3	Presently experienced illness or mental condition
4	Psychiatric history
5	Substance abuse, addiction
6	Medical history
7	Family and developmental history
8	Educational and occupational history
9	Marital and social history, habits
10	Mental status examination
11	Physical examination
12	Short summary of the interview
13	Provisional diagnosis
14	Treatment plan

2.3.2   Studies on the patient's perspective in psychiatry

Studies on psychiatric assessment and care have investigated the patient's perspectives and needs by reflecting the general principles of person-centredness in the psychiatric encounter. There have been studies on the expectations of patients concerning the therapeutic relationship or outcome, to some extent conveying the divergent orientations of participants in the psychiatric encounter.

In Sweden, Lars Hansson and colleagues (1993, also Björkman et al., 1995) analysed the quality of inpatient ($N = 78$) and outpatient ($N = 94$) psychiatric care from the perspective of patients using an open patient interview and content analysis. In both studies, the results revealed that the patients expect and value empathetic qualities in the staff in terms of listening, understanding and showing respect. These studies emphasized the importance of the *staff–patient relationship,* co-influence and appropriate information giving from the patient's perspective.

Furthermore, in another qualitative study, Håkan Johansson and Mona Eklund (2003) performed an open-ended in-depth interview with seven out-patients and nine in-patients having heterogeneous mental disorders. They reviewed the experiences of the patients concerning psychiatric care and the meaning of it. Their results revealed that the most important factor is the 'helping alliance', which was also identified as the quality of the *therapeutic relationship* in psychotherapy.

Moreover, in their qualitative study, Amy Bilderbeck and colleagues (2014) investigated the psychiatric assessment interview in patients with mood instability. Data were gathered by interviewing 28 patients who participated in a psychiatric diagnostic assessment in secondary care. The patients noted the importance of explaining their problems and symptoms and the *value of a good relationship* with the clinician. Moreover, they wanted to be listened to and involved in the clinical decision. The needs of the patients were not consistently met by the clinician, and the received diagnosis (bipolar disorder or borderline personality) elicited negative as well as positive responses, depending on the *personal meaning and understanding* of the diagnosis, prognosis and treatment, and the effect of stigma. The authors concluded that clinicians should be aware of and recognize the experiences of patients concerning the diagnostic assessment, promoting the therapeutic relationship between them.

In a very recent study that also concerned the patient–clinician relationship in community mental health teams, Richard Laugharne and co-authors (2020) investigated the opinions and expectations of patients ($N = 132$) regarding

sociocultural and behavioural features of psychiatrists using a questionnaire with ten items. They found that the patients valued their *psychiatrist's communicative skills* in conveying dedication to personal treatment, competence and politeness.

Furthermore, Camilla Gudde and colleagues (2013) demonstrated that patients ($N = 19$) with major mental disorders in mental crisis seek clear understanding, open dialogue and reflection from a well-known clinician in an early phase. Although there is a high threshold for contact, it still indicates that the patient intends to *participate actively* in the encounter, challenging the traditional view of the mental health system.

Eva Maassen and colleagues (2016) also investigated the relevance of the patient–clinician relationship, interviewing patients with bipolar disorder ($N = 35$) and ADHD ($N = 30$) regarding their view of the conceptualisation of patient-centred care. The results indicate that, firstly, the patients expect a caring attitude from mental health professionals, showing that they listen without judgment. Secondly, the patients acknowledge the personal connection in the relationship with the professional. Thirdly, the patients expect the operation and response of the organization to flexible to their changing needs due to the fluctuating nature of mental disorders. Fourthly, the patients emphasized that professionals should consider their strengths and not only their deficits and disorders. Finally, although the patients respect and expect professional expertise, they expect their own *'expertise' of life experiences* to be taken seriously and considered individually.

A few decades ago, in a remarkable systematic review, Lorraine Noble and colleagues (2001) estimated whether the patient's *expectations of improvement* relate to the treatment outcomes and made comparisons with earlier systematic work before 1980. After 1980, the majority of the 21 reviewed studies indicated that the patient's expectations of improvement were linked to the clinical outcome; nonetheless, it was a complex relationship. Moreover, the authors found some evidence that *incongruence* between the patient's expectations and the provided treatment interventions yielded a *lower clinical outcome*.

Furthermore, referring to *insufficient collaboration*, Selma Gaily-Luoma (2020) recently reviewed the international literature on experiences of the services provided to them among patients who had attempted suicide. The patients wished for warm and non-judgmental responses, as well as an appreciative attitude in the interaction with professionals. Moreover, they wished for more collaboration with professionals and more information about their treatment process. The patients found contact with a professional highly helpful when the professional made them *feel valued* and they were *met with empathy*, which appeared as a key aspect of their recovery.

Moreover, in the United Kingdom, Samuel Thomson and Gilian Doody (2010) investigated preferences and suggestions for visits in 103 patient–psychiatrist pairs before their outpatient consultation. They investigated the correlation between the preferences of the patients and psychiatrists for six key components. These were: 1) good communication and rapport, 2) talking about the patient's wants, 3) equalization of power and encouraging the patient to become involved, 4) asking about the mental state, 5) helping the patient and the patient's family to understand the symptoms and diagnosis and 6) talking about the harmful situation of the patient or others. According to results, there was no statistically significant correlation for these components, indicating *different priorities and orientations* for the two participants.

In another study, Eline Jochems and colleagues (2016) investigated the perspectives on treatment motivation among clinicians ($N = 57$) and patients with severe mental illnesses ($N = 294$) using questionnaires based on three different motivation theories. The clinicians assessed the patients' motivation or readiness for change as poor or moderate. The authors discussed the impact on the therapeutic relationship of the *different perceptions* of the clinicians and patients regarding treatment motivation.

Moreover, Lisa Wood and colleagues (2019) explored perspectives on psychiatric care priorities among 12 in-patients with psychosis and 12 health professionals. They conducted a thematic analysis of semi-structured interviews with all the participants. This indicated a *gap between the perspectives of the patients and professionals*, thereby revealing that the needs of the patients were unmet in terms of their social marginalisation, distress, and trauma, as well as their need for more collaborative treatment, including spirituality.

As described earlier, many countries have tended to promote more collaborative patient- or person-centred healthcare; nonetheless, in the Mediterranean context, Concepción Martinez-Martinez and colleagues presented a paternalistic approach to mental healthcare (2020). According to their study in Spain, patients with mental disorder still experience *stigmatization, malpractice, overmedication, and abuse of power* from professionals. They also noted that the patients wanted to actively participate in their treatment decisions and be heard by professionals; thus, there is a need to promote therapeutic relationships and treatment adherence.

To summarise, these studies demonstrate the perspectives, preferences and experiences of psychiatric assessment and care among patients in clinical contexts, thereby referring to the significance of the therapeutic relationship as the primary rather than the only meticulous diagnostic evaluation. These studies have to various

extents indicated a mismatch and tension between the perspectives or priorities of patients and clinicians.

In the following section, communication studies are reviewed in psychiatry. The scope of studies involving interviews is restricted mainly to conversation analysis in clinical encounters.

2.3.3   Communication research in psychiatry

The patient-centred or person-centred approach, as described above, is grounded in a collaborative and communicative process. Although the patient and the clinician attempt to achieve common ground and mutual understanding concerning the health problems and treatment intervention, they nonetheless have divergent personal and institutional/medical knowledge and orientations. A disparate selection of qualitative methods is currently being used in psychiatric communication studies. Because patient–clinician communication is reviewed here from the perspective of both sides, studies are focused on interviews that have been audio- or video-recorded in real-life clinical contexts and mostly investigated using conversation analysis (CA; see section 4.6.).

Studies on psychiatric interviews rely, for the most part, on the findings of research of usual medical interviews. In each medical interview, the *role of questions* is determinative and powerful (Boyd & Heritage, 2006; Heritage & Clayman, 2010; Deppermann & Spranz-Fogasy, 2011).

According to Mishler's classical work (1984; see also section 2.2), in a routine medical interview, the basic unit is composed of a three-part sequence: 1) the doctor's question, 2) the patient's response and 3) the doctor's assessment, attending to or ignoring something from the response. As Mishler encapsulates, "All roads lead back to the physician's question" (Mishler, 1984, p. 112). Thus, the exchange of information in the medical interaction is regulated. Mishler discussed the concept of voices carrying frameworks of meaning. As he wrote: "Two are distinguished, the 'voice of medicine' and the 'voice of the lifeworld', representing, respectively, the technical-scientific assumption of medicine and the natural attitude of everyday life" (Mishler, 1984, p. 14). He presented and reviewed the dominance of the 'voice of medicine', which silences and regulates the 'voices of the lifeworld'. Regarding the striving for coherence, they interrupt each other, causing 'troubles' in the sequential

progression of the interview: gaps, hesitation and self-repairs in the next speaker's turns.

In their study, Christine Barry and colleagues (2001) adapted Mishler's conception of the binarity of 'voices' in general medicine consultations. They found that when the 'medical voices' met each other, or when 'lifeworld voices' worked together, the outcome was better measured by patient-centred indicators. The outcome was weak in cases where the clinician transferred the patient's lifeworld topic towards the 'voice of medicine'.

The medical or psychiatric interview as an institutional social interaction is *asymmetrical* in various ways. The physician is an expert in medicine or psychiatry and the patient is an expert in their lived experiences. The interactional order and tension between them are created by the different knowledge and orientations/priorities of the patient and the clinician. Moreover, roles and identities are conveyed and shaped by their verbal and non-verbal features of talk as a continuous reciprocal process (Heath, 1984; Ruusuvuori, 2000; Heritage et al., 2007; Li et al., 2007; Drew & Sorjonen, 2011).

During a psychiatric evaluation of the patient's mental problems and experiences, the clinician's tool is communication itself. In psychiatry, there are not as many technical instruments as in the somatic fields of medicine. The psychiatric encounter or consultation as studied at the micro-level by qualitative methods enlightens how the clinician and the patient deal with and manage their interaction.

In an early German study, Jörg Bergmann (1992) explored audio-recorded psychiatric intake interviews using conversation analysis. He described the indirect resources of psychiatrists to cautiously elicit discrete information about mental problems from the patients before their voluntary or involuntary hospitalization. Using indirect mitigated resources, the psychiatrists elicit some information – received or observed – without a direct question ("*you're not doing so well*"), inviting or 'fishing' for the patient's answer concerning a delicate topic. By presenting the findings of his study, Bergmann also discussed the profession's 'veiled morality', maintaining that the psychiatric profession deals with mental illnesses from the medical approach as well as according to peoples' improper behaviour from the *moral approach* of society.

In the United Kingdom, Rosemary McCabe and co-authors (2002) investigated routine consultations from the perspective of the engagement of patients with schizophrenia or schizoaffective disorders in two outpatient clinics. They found that the patients actively tried to talk about their psychotic experiences or symptoms. Nonetheless, the clinicians evaded the patients' account with another question, or

hesitated, smiled and laughed, showing that they were reluctant to engage with the patients' concerns or experiences. The authors concluded that this "noticeable interactional tension" might hamper the patients' commitment to their care (McCabe et al., 2002, p. 1148).

In another study (McCabe et al., 2013), 138 consultations with patients having schizophrenia or schizoaffective disorders were audio-visually recorded and 118 cases were followed up. A standard coding system (informed by conversation analysis) was employed on the interviews to define the conversational repairs. The interviews were assessed in relation to the patients' treatment adherence six months later. Conversational repairs mean that the patients solicit a clarification of the clinician's talk and the clarification is provided for them. In the results, the researchers found that the number of repairs was associated with better treatment adherence six months later ($p = 0.02$). Encouraging the patients to request clarifications from the clinicians created possibilities to improve the quality of the interaction, involving a shared understanding in the psychiatric consultations.

Based on former results, the same researchers (McCabe et al., 2016) designed a cluster randomized controlled trial in which 21 psychiatrists participated and were randomized. In the intervention group, the psychiatrists were trained in communication that focused on improving shared understanding with patients having schizophrenia or schizoaffective disorder ($N = 97$; 5 months later, $N = 64$). The psychiatrists with training in communication used significantly more conversational self-repairs (as an indicator of shared understanding) than the clinicians without training ($p < 0.011$). The psychiatrists with training evaluated the therapeutic relationship more positively ($p = 0.022$), as did the patients who met with a trained psychiatrist ($p=0.043$). McCabe and Healey (2018) discussed the role and meaning of the clinician's self-repairs in communication with psychotic patients. They reported that *conversational repairs* reduce misunderstanding and may make that the patients feel understood rather than merely assessed. The authors suggested that repairs of talk indicate the clinician's sensitivity toward the patient and might be a key mechanism for building shared understanding and better engagement in therapeutic communication.

Moreover, Ziółkowska (2012) analysed the questions of doctors in psychiatric diagnostic interviews. By approaching the impact of questions based on the linguistic concept of nominalisation, she demonstrated that the doctors objectified the patients' lived experiences of measurable symptoms or behaviour as *nominal phrases* (for example, '*thoughts about death*' or '*will to act*') in their questions, without an agent and context, being standard diagnostic manual language. Consequently, the patients

presented their own actions and subjective experiences in their responses in the same objectified way, losing their agency and the meaning of their life context.

In another study, Laura Thompson and colleagues (2016) (also Thompson & McCabe, 2016) focused on the role of questions and management of the therapeutic relationship in psychiatric interviews and investigated 138 outpatient consultations by classifying the psychiatrist questions with a coding protocol. The psychiatrists regularly used four question types: polar questions (yes/no), Wh-questions, declarative questions and tag questions. The authors found that using more declarative questions (for example: '*So you feel a bit anxious*'), which conveyed empathetic understanding towards the patient's experiences and considered their emotions, was associated with a slightly better therapeutic alliance. A declarative question might parallel a formulation (a term used in psychotherapy), due to its focus on the emotional or psychological meaning of the patient's concerns or experiences. Moreover, the researchers found that *declarative formulations* advance a topic transition in an empathetic way closely with the patient's experience and promote the progress of the interview. The authors discussed and suggested refinements to the traditional recommendations for interview techniques, and they suggested the use of declarative questions to advance the patient-centred approach and therapeutic relationship in psychiatric interaction.

Furthermore, a study by same research group investigated the function of the clinician's *question on suicidal thoughts* (McCabe et al., 2017). From 319 video-recorded interviews, the researchers identified 77 visits in secondary mental health care. Their results indicated that the clinicians tend to ask about suicidal ideas using negatively phrased closed questions, with 75% of questions being of this type ('*No thoughts of harming yourself?*'), and only 25% of questions were phrased positively ('*Do you feel life is not worth living?*'). A comparison between the patients' answers after both types of questions showed that there were significantly more negative answers ($p = 0.016$) after negatively phrased questions. The results have important clinical implications in the evaluation and prevention of suicidality.

Among others, there have been studies investigating how clinicians deal with the patient's *emotional cues* and *concerns* in psychiatric interviews. The researchers (Del Piccolo et al., 2012) analysed interviews with 16 doctors (having at least three years of experience working in mental healthcare) and 104 patients with various mental health problems. The interviews were audio-recorded and analysed using a coding system of emotional cues and concerns. By cues, the authors referred to hints that have no reference to symptoms through the patient's own words and expression, for example "*My world is collapsing*" or "*I have gloomy thoughts*". The measured concerns

often referred to psychiatric symptoms, for example *"I have panic attacks".* In their results, the authors noted that the clinicians were rarely engaged explicitly with the patients' spontaneous emotional cues or presented empathetic responses. Female clinicians dealt with emotional cues and concerns more frequently than male clinicians. Considering the process of gathering diagnostic information, the clinicians usually provided more space for concerns (also including symptoms) that the patients elicited by themselves.

Moreover, Anette Davidsen and Christina Fosgerau (2014) investigated the responses of psychiatrists and general practitioners to patients' *emotional disclosures* in depression. They compared 13 video-recorded consultations with general practitioners and 17 consultations with psychiatrists, using the conversation analytic method. According to the findings, the psychiatrists responded to the emotional exposure of the patients with rational argumentations or by changing the subject, as well as with symptom clarification or interpretation of emotions. The general practitioners responded differently; they showed an emotional attunement without reflection or used formulations. They also reflected the patient's emotions with their life circumstances. The authors discussed how the general practitioners considered the emotional disclosures of the patients from the contextual approach of a depressed condition, but the psychiatrists mirrored them from the biomedical approach of depression as a disease.

Concerning the person-centred approach in psychiatric encounters, some studies on the *shared decision-making* process in treatment decision making shall be mentioned. Claudia Goss and colleagues (2008) investigated this issue with 80 audio-recorded outpatient psychiatric interviews. While testing the reliability and internal consistency of the OPTION scale, they found that the psychiatrists' attempts to involve the patients in the therapeutic decisions were poor. Moreover, Alan Quirk and colleagues (2012) explored shared decision making in the context of the decision over antipsychotic treatment in 91 psychiatric consultations by using conversation analysis. They found three different main actions in the decision-making process. At one end, they found escalation and resistance, indicating that one of the participants fell into the subordinate position. In the middle, the psychiatrist steered the patient towards cooperation, directing the decision regarding antipsychotic treatment. At the other end, the psychiatrist allowed the patient to decide openly and freely by using little or no pressure. In this data set, pressured or escalated extreme decision-making was rare, and directed or open decisions were found most frequently. The authors also discussed the challenges for the psychiatric profession in communication in voluntary or involuntary clinical contexts.

In another study, Beth Angell and Galina Bolden (2015) analysed 36 audio-recorded interactions between psychiatrists and patients with severe mental illnesses. By employing the conversation analytic method, they investigated the way in which psychiatrists present their *recommendation for changes in medications* and how patients treat these accounts. The authors found two types of recommendations. There were "client-attentive accounts" in which the psychiatrist shaped the account according to the patient's needs and concerns by using the patient's own words and by taking a therapeutic stance. The other type was "authority-based accounts" in which the psychiatrists used their professional expertise, describing the further prognosis of the patient's mental illness or emphasizing the patient's condition as medically symptomatic (Angell & Bolden, 2015, p. 44). This type of recommendation created more asymmetrical relationships between the participants than the other type, attending to the client's account. The results indicated occasional distance between the ideal approach of a shared decision-making process and the current praxis of psychiatry, projecting the still multifaceted professional challenges to promote person-centred health services.

Using the former data set, Bolden and Angell elaborated on the complexity of *shared decision-making regarding treatment recommendations*, presenting a pattern in which the clinician orients and attempts to get the patient to engage and give "full informed consent" to shape the medication recommendation (Bolden & Angell, 2017, p. 151). Also, Bolden and colleagues (2019) advanced understanding of the *patient's request for medication changes* in their analysis. According to their findings, patients may present with physical problems, medication problems or they may openly solicit medication changes. In some responses, the clinicians offered a solution to the patient's request; in other responses, they accepted or rejected the solicitation. Moreover, the authors noted that the patients usually respected the clinicians' medical authority and described them as trustworthy persons in their experience.

Furthermore, in a Japanese outpatient psychiatric clinic, Kushida and colleagues (2016) used CA to investigate patient *participation in decision-making* about treatment in 85 consultations. They found that patients take the initiative, explicitly requesting a candidate treatment when they believe it is appropriate. However, when patients were not sure about this treatment appropriateness, they merely displayed interest without explicit request. In another Japanese study, Kushida and Yamakawa (2018) also examined psychiatric consultations and described the way that clinicians *steered the patient's talk away from the persistent complaints*. They showed that the clinicians navigated between respecting the patients' knowledge about their symptoms and the risk of providing inappropriate medication.

Moreover, in a study including 49 consultations, the same researchers (Kushida & Yamakawa, 2020) used CA to investigate the patients' practices in *resisting the treatment recommendation*. On the one hand, the patients showed *passive resistance* with minimal agency by withholding acceptance (for example: gap of silence or unmarked acknowledgement) that invited the psychiatrist to offer further explanation for adjusting the medication. Occasionally, the passive resistance of patients became *active resistance* after the clinician's explanation. With active resistance, the patients presented questions or revealed the reason for their resistance. Additionally, when the clinician prematurely presented a recommendation regarding a candidate treatment, the patients took an interactional space and showed a need to describe additional problems or concerns using their agency. The researchers observed that the patients do not explicitly resist the psychiatrists' treatment recommendations and respect their authority; however, they navigate by using their agency in the mentioned ways, inviting the psychiatrist to consider their preferences and concerns.

According to these studies, by examining the recurrent practices of patients and clinicians in this clinical interaction, there are possibilities to enhance knowledge and awareness about their divergent orientations, which helps to advance their participation in the collaborative decision-making process in a person-centred way.

There have also been studies comparing *interviews and interaction styles* in different clinical contexts. Tony Hak and Fijgje de Boer (1995) described three different types of interviews in different interactional contexts, investigating the professional's receiving formulations as a response to the patient's account. In a medical interview, they found an "interrogative style" without the professional's responsive formulation. In a psychiatric interview, they observed an "exploratively oriented style" in which the clinician used formulations to check and clarify the psychotic patient's fragmented talk about lived experiences, transforming them into a diagnostic evaluation. In the third type of interview, taking place in psychotherapy, the clinician – contrary to the first two types of interviews – used formulations that considered the gist of the patient's talk and worked on it collaboratively with the patient (Hak & de Boer, 1995, p. 341).

In another study, Justyna Ziółkowska (2009) investigated 15 psychiatric interviews with patients having depressive illness and argued that *the clinicians' questions influenced the patients' positions* toward themselves. By using discourse analysis to investigate the recorded and transcribed interviews, the author presented three different positions achieved by the patients. These positions were 1) "observing assessor", in which the patients put the experience or problem outside themselves; 2) "informing witness", in which the clinicians invited the patients to verify their

problems, and 3) "experiencing narrator", in which the clinicians invoked the patients to talk about the ways in which they themselves had experienced the problem (Ziółkowska, 2009, p. 1621). The first two positions dominated in the data. Ziółkowska noted that during these positions, the clinicians predominantly invited factual knowledge, while the patients' lived experiences received less attention. By focusing on factual knowledge and symptoms, the reliability of the medical/psychiatric diagnostic assessment process and the 'objectivation' of the mental problem is supported. However, the therapeutic contact with a patient suffering from mental experiences becomes secondary.

Within the Finnish Helsinki Psychotherapy Study (Knekt & Lindfors, 2004), researchers investigated *follow-up diagnostic interviews* concerning the mental condition of patients or changes in it using conversation analysis (Vehviläinen et al., 2007). These interviews were not clinical interviews but were required and recorded for the protocol of the original study. The authors discussed the function of the research interviewer's third-position receiving response to the patient's experience telling. By analysing audio-recorded and transcribed interviews, the authors revealed different conversational practices in the interviewer's responses (repetition, extension, formulation and follow-up questions) that shaped and steered the meaning of the patient's telling, together yielding a description of the patient's mental condition.

In the *field of psychotherapy*, many interactional studies have focused on the responsive actions of therapists or the practices by which they attempt to understand and access the subjective or interpersonal knowledge and experiences of patients regarding their mental problems (Antaki et al., 2005a; Peräkylä, 2011; 2019; Weiste & Peräkylä, 2013; Weiste et al., 2016). For example, a conversation analytical study concerning cognitive-constructivist psychotherapy demonstrated that therapists employed *recognition* and *validation* of their clients' emotion, followed by an interpretation of their experiences (Voutilanen et al., 2010).

Elina Weiste and Anssi Peräkylä (2013) observed four different types of *formulations* in cognitive psychotherapy and in psychoanalysis. In both therapies, rephrasing and highlighting formulations were common. However, the exaggerating formulations found in cognitive psychotherapy, and relocating formulations found in psychoanalysis, may reflect their theoretical background. Recently, based on empirical interactional research, Peräkylä (2019) reviewed the interactional process of transformation of the client's experience and the function of the therapist formulations or responses in psychotherapy.

Generally, any psychotherapy is targeted at the understanding and transformation of the subjective problematic experience of clients, thereby yielding more adaptive

behavioural patterns and promoting mental health. As seen above, the psychiatric interview may also become an interactional transformative process and it may impact on the patient's interpretation of their mental subjective experiences and agency through the clinician's positions and the types of questions and responses (see also above, Stanghellini, 2004). By appropriately attuning questions and responses to the patient's account of mental experiences, the clinician should be able to balance between the gathering of diagnostic information and building of the therapeutic relationship.

To summarize, these studies on psychiatric interviews with naturally occurring interactions have demonstrated the impact of the clinician's questions and responses to the patient's emotional accounts or shared decision-making accounts in real-life clinical contexts. Although the psychiatric interview primarily targets a diagnostic assessment, it should nevertheless attempt to advance the therapeutic relationship in a person-centred way, as has been recommended. Regarding the empirical studies presented, the diagnostic and biomedical orientation is somewhat dominant, leaving less attention to the therapeutic relationship or person-centredness. The atheoretical diagnostic classification gives a framework and algorithm to interpret various types of data on the subjective concerns and experiences of patients in making a diagnosis. As known from clinical work, there is much more personal information with sociocultural contextual details over and above the diagnostic data presented by the patient and required by the clinician. Nonetheless, diagnostic classification does not provide a conceptual or theoretical model of organization or use for advancing the therapeutic alliance. The psychiatric interview, including the targets and orientation of clinicians, as well as embedded styles of questioning and responding, may impact on how patients interpret their mental problems and subjective experiences. This may shape the interactional interpretation and transformation process in the same way as was shown in the psychotherapeutic interaction.

As discussed above regarding the general principles of the psychiatric interview, the clinician should advance the therapeutic alliance with "*harmonious responsiveness"* (Sadock et al., 2015, p. 193 [italics added]) towards the patient. This is a major and responsible challenge in the clinical psychiatric diagnostic evaluation. Nonetheless, an abundant body of studies indicates that the *therapeutic alliance* as a therapeutic relationship between a therapist and a client has a central impact on the outcome of the psychotherapeutic process. Norcross (2010, p. 113) defined "the client-therapist relationship as the feelings and attitudes that therapist and client have toward one another and how these are expressed" (see also Wampold & Imel, 2015). The psychiatric profession should take more advantage of psychotherapeutic techniques

and models in the diagnostic assessment process, not just in the treatment process. As MacKinnon and others (2016) argued, the distinction between diagnostic and therapeutic interviews is artificial. As shown above, the orientation of professionals and interactional contexts can steer interaction towards diagnostic information gathering, or they can help to achieve a therapeutic relationship in a person-centred way. Do the psychiatric assessment offer opportunities to build both simultaneously? Based on the findings, this dissertation is an attempt to answer this question.

Next, the role and function of psychological case formulations are reviewed that have relevance in the traditions of different theory-driven psychotherapies. The psychological case formulation has a potential to advance person-centred psychiatric assessment.

2.4   Case formulation in psychotherapy

Since the end of the 20th century, the dominance of the biomedical approach in medicine and psychiatry and the activity of the pharmaceutical industry has put pressure on psychotherapies to prove their value and effectiveness. Attempting to promote the appreciation and effectiveness of psychotherapies, Jacqueline Persons (1991) suggested that *case formulation* contributes collaboratively to disclosing the patient's unique psychological action patterns for assessment and treatment in cognitive-behavioural psychotherapy.

An American professor of clinical psychology, Tracy Eells (1997; 2015), has comprehensively studied the model of case formulation. He defined it to be "essentially a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems" (Eells, 1997, p. 1). Case formulations help to convey the mental disorder diagnosis to the treatment plan and understand the problematic experiences of patients in their context in an empathetic way by organizing the complex patient information. Case formulation as an assessment tool includes elements such as the patient's preferences, experiences, collaboration, the therapist's empathetic attitude and appropriate responsiveness, also having elements of the therapeutic alliance in any helping encounter.

Since the 1990s, Eells, along with other researchers, has broadly reviewed multiple theory-driven case formulation methods. The best known of these range, for example, from the traditional psychoanalytic approach (Messer, 1997) to well-

known case formulation approaches such as the Core Conflictual Relationship Theme (CCRT) method (Luborsky, 1994; 1997), configurational analysis (Horowitz, 1994; Horowitz & Eells, 1997), the Structural Assessment of Social Behaviour (SASB) method (Benjamin, 1974; Henry, 1997), cognitive-behavioural case formulation (Persons & Tompkins, 1997), the Plan Formulation Method (Curtis et al. 1994; Curtis & Silberschatz, 1997) and case formulation in cognitive analytic therapy (Ryle 1995; Ryle & Bennett, 1997).

Eells presented the *integrative model* of case formulation, consisting of "four sequential subcomponents: Create Problem List, Diagnose, Develop Explanatory Hypothesis and Plan Treatment" (Eells, 2015, p. 72). By following the client's story and continuously monitoring the progress, the order of the model and process remains flexible. He stated that the model of case formulation is compatible with the diagnosis of mental disorders, placing the diagnosis back into the patient's life context.

Another research group in the United Kingdom has applied psychological formulations in psychotherapy (Johnston & Dallos, 2014). The group approached the framework of psychological formulations from different theory-driven theories: psychodynamic, cognitive-behavioural, systemic and integrative. The researchers also elaborated an integrating formulation and emphasized that the formulation does not need to be broad and include all the client's contexts and internal as well as external factors, but it should focus on the "central integrating factor" as the client's "personal meaning" (Johnston & Dallos, 2014, p. 186). They characterized the *integrative formulation* as a collaborative dynamic process centred on "the co-construction of therapeutic relationship" (Johnston & Dallos, 2014, p. 214).

A few studies in psychotherapy research have investigated the effectiveness of case formulation in randomized controlled trials, providing some evidence that case formulation-based treatment is superior or at least equivalent to the standard treatments (Schulte et al., 1992; Ghaderi, 2006; Johansson et al., 2012; Allen et al., 2016).

Moreover, an un-controlled trial in cognitive-behavioural psychotherapy research has shown the utility of the case formulation-based approach (Persons et al., 2006). In interpersonal reconstructive therapy, Critchfield et al. (2015) studied 93 adult inpatients with complex and comorbid presentations and suggested that case formulation is highly reliable and unique to individuals.

Furthermore, a case-specific process-outcome study by George Silbertschatz (2017) investigated the responsiveness of therapists through the above-mentioned Plan Formulation method, which defines the patient's problems and conflicts.

Accordingly, the authors concluded that the *therapist's consistent response* to the patient's plan (unconscious pattern) is a powerful predictor of the treatment outcome. Furthermore, the patient's experience of the therapy was positive.

Although the case formulation method has been understudied, there is some clinical and empirical experience and a number of single case studies (Iwata et al., 1994; Haynes &Williams, 2003; and many others not reported here) suggesting a need for further investigation, concept development and research methods for evidence-based practices.

Eells (2013) reported that the DSM diagnostic system is necessary and useful, but he has also suggested that outcome results of randomized controlled trials along with systematic case studies be complemented to understand the treatment process individually and contextually.

Outside of psychotherapy, there have only been a few studies on psychiatric staff views or the *clinicians' perspective about using psychological formulations* in mental healthcare in the United Kingdom (Summers, 2006; Berry et al., 2009). After staff training in psychological formulation, the staff perception of the degree of control over the patients' mental problems and themselves was increased. Additionally, there was an increase in the number of staff observations that the patients were more optimistic about treatment, they were coping better, and their blame was reduced. The staff experienced that they understood the patients' mental problems more easily and they reported more confidence in their work.

Moreover, Roxanna Mohtashemi and colleagues (2016), also in the United Kingdom, interviewed 12 psychiatrists in different mental health services to ascertain how they understand psychological formulations, how they use them and whether they value the process of formulation in multidisciplinary teamwork. Their results indicated that the main focus of these psychiatrists was on the diagnosis and medication. However, the psychological formulation was understood as a heuristic device enhancing an understanding of where the patient's mental problems came from and why. The psychiatrists acknowledged that formulation carried out collaboratively with the psychologist provides consistent language to communicate with the staff and patients. Nonetheless, they disclosed that contextual barriers to the formulation – time, resources, professional rivalry and pressure to use the medical model – facilitate or limit the process, leading to a disjointed manner of working.

To summarise, case formulation advances patients' individual assessment of their subjective experiences and activities in their life context, while also giving promising results for the outcomes of psychotherapy. The case formulation method includes

elements such as the patient's meanings, preferences, experiences, collaboration, the therapist's empathetic attitude and appropriate responsiveness, while simultaneously applying them to the goal and task of the treatment plan. Accordingly, all elements interplay with the therapeutic relationship or working alliance, which is the primary "demonstrably effective" component in a successful psychotherapeutic process (Norcross & Lambert, 2018 p. 311; Zilcha-Mano, 2017). There are several different theory-driven case formulations in the clinical field of psychotherapy and empirical research. Nonetheless, they tend to move towards an integrative framework, emphasizing the effective role of the therapeutic alliance. In employing case formulation methods, clinicians require comprehensive psychotherapeutic education and experience.

Next, a case formulation method based on Dialogical sequence analysis (DSA) is reviewed, which has been implemented in the clinical trial presented in this dissertation.

2.5 Dialogical sequence analysis as a case formulation method

2.5.1 Background of Dialogical sequence analysis

The DSA is a micro-analytical method for studying communicative utterances, which originally developed in the supervision process of cognitive analytic therapy (Ryle, 1995). In this psychotherapy model, the therapist and the client co-construct during the initial sessions a case formulation of the client's repetitive action patterns, provoking and maintaining their psychological problems.

In the 1990s, Mikael Leiman, a professor of clinical psychology, elaborated the method to examine the client's freely flowing utterances and expressions, also conceptualizing its basic analytical unit (Leiman, 1997; 2004a; 2011; 2012). The DSA concept rests on the theory of activity, introduced by Lev Vygotsky (1978), and the *theory of utterance,* outlined by Mikhail Bakhtin (1984; 1986).

According to the *activity theory*, all psychic or mental actions are object directed and mediated. Instrumental actions are mediated by tools, while communication and

mental actions are sign mediated. Mental activity is mediated by words and nonverbal signs and engendered from social interaction.

An utterance is a part of speech, being an object-directed act. Bakhtin stated that the speaker positions him/herself simultaneously towards the referential object and the recipient, adopting a so-called *semantic position* (Figure 1). The semantic position or the speaker's *stance towards the referential object* is the analytical unit of DSA, conveying a reciprocal relationship with the content and recipient. By constructing sentences containing words with their prosody, gestures and nonverbal signs, the speakers express their stance towards an object or recipient, including networks of personal meanings and values. Bakhtin's term *semantic* means that the stance involves a network of signs that marks the speaker's utterance. In the speaker's talk, referential objects with their stance are constantly changing and evolving.
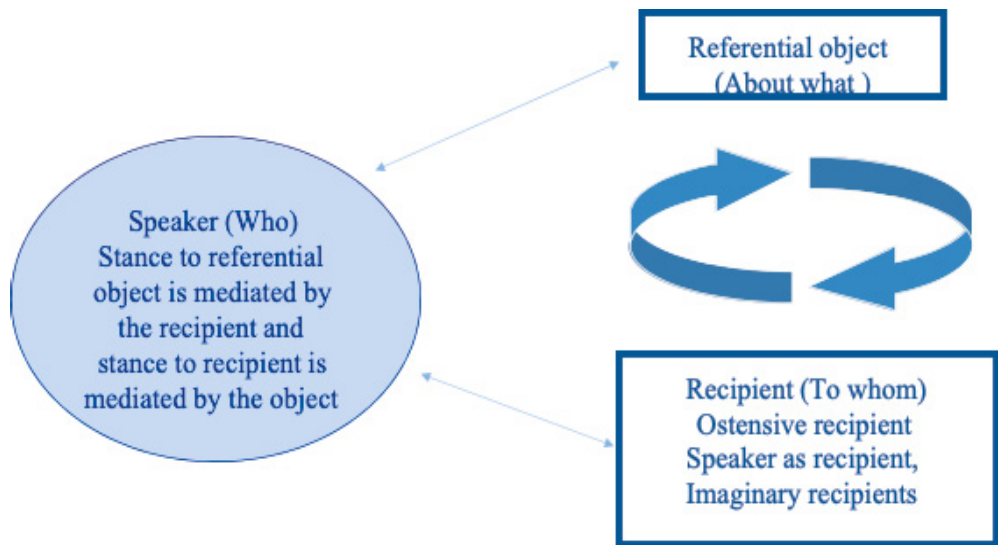
Figure 1. The double positioning in utterances (Savander et al.,2019a)

The micro-analytic method of DSA is used to track these changing micro-phenomena from video-recorded or transcribed psychotherapeutic sessions or other interactions, and to identify the client's recurring semantic positions in the sequence of utterances. In a clinical psychotherapeutic encounter or context of supervision, DSA also allows a clinician to identify *regularities and habitual action patterns* in a patient's freely flowing talk and to assist the patient in making self-observations by providing immediate feedback or short formulations.

2.5.2 Studies with Dialogical sequence analysis

There have been numerous studies on DSA in psychotherapy research that have analysed and conceptualised the process and change during psychotherapy or other counselling encounters. By analysing transcribed recorded therapeutic sessions, authors have focused on the client's self-observation and the change process in the client's maladaptive action patterns (Makkonen, 2003; Kivikkokangas & Leiman, 2018a; 2018b; Kivikkokangas et al., 2020). Studies have frequently shown that the client's problematic pattern, becoming later the main focus of the therapy, is manifested in the client's first utterances at the very beginning of the first session (Leiman & Stiles, 2001; Stiles et al., 2006; Gersh et al., 2018; Kivikkokangas et al., 2020). These findings are relevant in employing DSA-based case formulations in psychotherapy and in clinical work.

Moreover, in a theory-building case study analysed by DSA, Soile Tikkanen and colleagues (2011; 2013; 2014) demonstrated that the clinician's empathetic response helped a mother to shape empathetic and self-reflective stances towards her 4-year-old daughter, who suffered from neurological contact and communication problems. Later on, a recurring problematic pattern of a conflicting dilemma between the mother and the pre-school staff was also eased with the help of DSA formulation. Accordingly, achieving a *self-reflective position* with oneself precedes the formation of an *empathetically responsive* relationship with others.

Using DSA in an educational group counselling, the study revealed the students' problematic action patterns regarding their agency and simultaneously promoted their ability for self-observation (Koivuluhta & Puhakka, 2013).

Moreover, DSA as a method helped to identify self-reflection by teachers in a peer group that intended to support their well-being at work. The results demonstrated that the peer group supported the self-understanding of the teachers,

promoted self-reflection and indicated realistic professional work options (Kaunisto et al., 2013).

In an IT enterprise, the DSA method provided possibilities to investigate worker self-observation and positioning towards obstacles to their agency in group counselling. In particular, the participants' views about each other's meaning of their work evolved (Vanhalakka-Ruoho & Ruponen, 2013).

In order to guide the University of Eastern Finland, the strategy of DSA was widely applied in a social and educational project - *'Toimijuuden tuki: dialoginen ohjaus'* (Koivuluhta & Kauppila, 2015).

There have been studies supporting the developmental paradigm of the DSA concept that have helped clients to achieve a self-reflective position with themselves. Anna Zonzi and colleagues (2014) demonstrated in their theory-building case study that the client's ability to self-observe and to 'play' within the *zone of proximal development* (ZPD; Vygotsky, 1978) *depends on the referential object* or the *content* that the client is talking about. In a single case study, Elon Gersh and colleagues (2018) investigated the therapy sessions of a 22-year-old patient with borderline personality disorder. By using the DSA method, the authors determined that the content of sessions had a mediating role on the quality of the *therapeutic alliance.*

In his doctoral study Harri Valkonen (2018) investigated the psychotherapy process of three patients with borderline personality disorder by using DSA. He noted that the ability of the patients to self-observe is variable and depends on the referential object of interaction and the clinician's responsive work, which assists the self-understanding of the patients and promotes their agency.

By using the conceptual tools of DSA, these studies indicate that the self-observation ability of patients is not a permanent feature or trait, but rather a *dynamic* reciprocal process also dependent on the *clinician's stance* and *appropriate response* to the content or referential object of the patient's account.

In DSA training, Professor Leiman emphasizes the tools and concepts of case formulation as well as the components of the assessment and therapeutic process from the very beginning of any helping encounter.

Anyone in need of help is under pressure and afraid of feelings of shame, humiliation and loss of face. Consumed by their possible feelings of helplessness or hopelessness, they may engage in self-protective actions. The client's behaviour and communication may already reveal maladaptive activity patterns in the initial encounter.

By applying DSA case formulation, it is possible to help a professional attend to a client's or patient's needs and perspective, to reveal their recurring problematic

action patterns as obstacles to their agency, and to promote the therapeutic relationship in a helping encounter. The detailed DSA-based assessment process is shown in section 4.3.1.

2.6   Summary of the review

As briefly presented earlier, explanations for mental illnesses have been approached in various ways during thousands of years of human history. From the time of Pinel, mental illness was endowed with psychological meanings, and modern psychiatry began to germinate. The first systematic nosology of mental disorders, created by Kraepelin, gave an impetus to further biological and neuroscientific psychiatric research. The psychological approach and psychoanalysis, created by Freud, co-existed side by side with a biomedical approach in the 20th century.

However, after the Second World War, widespread critical debates in society about mental illnesses and the psychiatric profession began, advancing not only psychiatric sciences but also the fields of sociology and anthropology, and activating interactional research in medical institutions. Social and ethical critics launched the so-called *neo-Kraepelinian* movement to restore the image of the psychiatric institution in the 1970s. By reaffirming the biomedical approach to mental disorders, the role of quantitative scientific research and the role of psychopharmacology and the pharmaco-industry were increased. Grounding in significant scientific developments, as well as critical debates of the psychiatric institution, several asylums were closed and outpatient mental healthcare became widespread.

During recent decades, many scientists have searched for aetiological and pathogenetic factors underlying mental disorders. An abundance of studies has advanced our understanding of shared genetic susceptibility, neurodevelopment, neuroplasticity, the adaptability of neuronal connections, biomarkers, and their connection with environmental and social factors, which all interact in mental health and disorders. Regardless of the highly increased knowledge in understanding the specific aetiology and mechanisms of mental disorders that create the distinction between mental health and mental disorders, their concepts still lack complete specification.

By implying and emphasizing contemporary conceptions of mental illnesses, the psychiatric diagnostic classifications have been revised since the 1950s. Without

specific aetiology and pathophysiology of mental illnesses, the validity and reliability of diagnostic classification have varied in the past. Initially, diagnostic classifications provided a prototype-based approach intended to outline the patient characteristics, behaviour and complaints in terms of patient functioning.

To advance the reliability and validity of diagnostic classification, WHO and the APA started to revise the contemporary ICD and DSM versions. In 1980, DSM-III offered determinative changes in diagnostic classification, as well as producing the first definition of mental disorders. Over the decades, the successors of DSM and ICD have constantly converged, and both seek a descriptive set of symptoms and behaviours according to criteria and categories. Purposing measurable homogeneous categories, the existing classifications reduce and simplify mental phenomena, leaving less attention on the patient's subjective health experiences with their detailed sociocultural contexts.

Diagnosis has essential advantages in communication and in the comprehension of mental phenomena. Moreover, it contributes to the allocation of resources to mental health organizations, and it has a relevant role in patients' life and insurance benefits and legal processes. The role of diagnosis is thus deeply entrenched in different institutions and practice.

The main disadvantage of the diagnostic classification is the uncertain validity of the diagnosis, thus hindering the patient's mental condition from being defined individually enough. Moreover, the problem of comorbidity could make clinical decision-making and treatment management very difficult in some cases.

As described earlier, medicine was paternalistic and doctor-centred for a long time, placing doctors as the decision makers for their patients rather than involving the patients themselves. Gradually, through the development of medical and other sciences, as well as the socio-cultural progression of societies, especially concerning the tendency towards equalization, the patient- or person-centred approach pushed forward. According to the patient-centred approach, the clinicians aim to understand patients as whole persons, considering their health experiences, and intend to find common ground in problems, goals and tasks of treatment, thereby promoting the patient–clinician relationship.

In different fields of medicine, predominantly in primary healthcare, many studies have presented slightly positive or mixed results on the effectiveness of interventions based on the patient- or person-centred approach. This value-based, ethical approach is recommended all over the world, conveying the tendency towards equalization of the interaction between patients and professionals in the medical institution.

Patients with mental health problems are more helpless and vulnerable, and their mental problems are vaguer and more complex than patients in the somatic field of medicine, thereby needing special ethical and legal attention. In the best case, current psychiatry employs not only biomedical aspects, but accepts humanistic and psychosocial aspects for mental disorders and treatment, and it should be or is inherently *patient- or person-centred*.

On the other hand, disregarding the disadvantages of diagnostic classification and the contingent dominance of the biomedical approach may contribute to the weakening of patient- or person-centredness in the field. Studies have revealed that patients with mental illnesses seek understanding, an explanation and help for their problems. They also expect a good relationship with the clinician, want to be listened to and want to participate in treatment decisions, thereby disclosing a need for patient-centredness in psychiatric practice. As mentioned in section 2.2.2.1, there are some semi-structured interviews and pattern-based psychiatric formulations, which complement the standard diagnostic assessments in a patient- or person-centred way. However, they are in contingent clinical use and more aimed at empirical research.

As presented in detail, current psychiatric educational textbooks recommend the ideal *psychiatric diagnostic interview* with general principles of *person-centredness* and the relevance of the *therapeutic alliance*. In real-life clinical practice, there are many inherently interfering factors and information in the naturally occurring interaction that inevitably affect the process and the outcome of the assessment interview. In clinical environments, empirical studies have shown a mismatch and tension to variably occur between the perspectives or orientations of patients and clinicians.

In psychiatry, the clinician's essential tool is *communication* itself, not having so many other technical instruments as in the somatic fields of medicine. *Interactional studies* on the psychiatric interview have demonstrated the impact of the clinician's questions and responses to the patient's emotional accounts or shared decision-making accounts in real-life clinical contexts. The context of institutions (medical, psychiatric or psychotherapeutic and others) also impacts on the professional's responsiveness, shaping the patient's position or orientation toward themselves. These interactional practices might convey the therapeutic alliance. The psychiatric interview, including the clinician's targets and orientation, embedding styles of questions and responses in the given conversational environment, can influence the patient's interpretation of their own mental subjective experiences and can modify it.

According to the long tradition of psychotherapy research, the *case formulation* method has been suggested and employed with increasing effectiveness in different psychotherapies. Case formulation helps to organise the complex patient information and to convey the diagnosis of a mental disorder to an individual treatment plan. The model of case formulation is compatible with the psychiatric diagnosis, thus placing the diagnosis back in the patient's life context. Elements of case formulations interplay with the *therapeutic alliance*, which has been presented as the demonstrably effective core component of a successful psychotherapy process, and as mentioned above, one of the general principles of the psychiatric interview.

In section 2.5, *Dialogical sequence analysis* was introduced. DSA is a microanalytical method for investigating recorded and transcribed interviews and for observing a participant's recurrent maladaptive action patterns during a helping clinical encounter. Studies on DSA have noted that the client's problematic action pattern, later becoming the main focus of psychotherapy, is already manifested at the very beginning of the first session in the client's first utterances. Applying DSA as a case formulation may offer an opportunity for professionals to consider the perspective of clients or patients and to address their recurrent problematic action patterns as obstacles to their agency.

3   AIMS OF THE STUDY

The author and her colleagues were educated in DSA-based case formulation during 2013–2015. They designed a randomized controlled pilot trial in the psychiatric outpatient clinic of Päijät-Häme Central Hospital. The aim of the naturalistic project was to investigate and compare the standard psychiatric assessment process and the alternative assessment process basing on DSA-based case formulation. There was intention to examine how DSA-based case formulation works in the psychiatric assessment process. Furthermore, five randomly selected standard interviews (AAU, assessment as usual) and all DSA-based assessment interviews were audio-recorded and transcribed for qualitative analysis concerning the clinicians' and the patients' interactional practices during interviews.

The specific aims of the three studies were as follows:

1) To study whether DSA-based case formulation and the standard approach differ in terms of collaboration, especially including patient and clinician congruence concerning the goals and tasks of the assessment (Study I).
2) To investigate the possible differences in resources and time use between the individualized assessment with DSA-based case formulation and the standard psychiatric assessment process (Study I).
3) To compare the patient–clinician interaction in AAU interviews and DSA interviews and examine whether there are measurable differences in the interactional environment for revealing accounts of the patients' subjective problematic experiences (Study II).
4) To examine whether the sequential organisation of the interaction around the patient's talk about subjective problematic experiences differs between the two assessment styles of interviews, and to analyse how the clinicians offer or do not offer the patients possibilities to disclose their subjective problematic experiences, and how this is dealt with (Study II).
5) To analyse the interactional practices and possibilities of patients to disclose and legitimate their self-disclosures of negative subjective experiences in response to the factual or medical questions from the clinicians (Study III).

4 MATERIALS AND METHODS

4.1 Study design

This naturalistic comparative study conducted between January 2015 and March 2017 in the Unit for Psychiatric Assessments of the Community Mental Health Centre of Päijät-Häme Central Hospital. This trial firstly includes a single-blind randomised controlled study and two qualitative studies of psychiatric interviews. Ten audio-recorded psychiatric interviews were analysed by CA, yielding qualitative data for the second and third studies. The trial was retrospectively registered at the Clinical Trials Registry with an International Standard Randomised Controlled Trials Number (ISRCTN15831929, 2018) in June 2018.

4.2 Study population (I, II, III)

4.2.1 Study I

This research included 138 patients who came with a referral to the unit for psychiatric assessment and were assessed for eligibility. The referrals were received from primary, student and occupational healthcare units or from private practices. The study's *inclusion criteria* were: 1) the patient had to be 18–65 years of age; 2) the patient had to be able to understand the study's purpose and provide written, informed consent; 3) the patients' native language had to be Finnish. The *exclusion criteria* applied to patients 1) whose referral proposed any psychotic or neuropsychiatric symptoms or disorders such as attention deficit disorders and autism, or any cognitive disabilities, and 2) whose referral suggested an urgent or emergency assessment (within seven days).

    All patients were randomized and they were diverse in terms of mental symptoms, severity of distress, background, limits of functioning, socioeconomic status, marital status, occupation, and education. Of the 138 recruited patients, 40 (35%) declined

to participate. Six (13%) subjects in the DSA group, and 12 (23%) subjects in the AAU group discontinued the study. In this regard, there was no significant difference between the groups ($p = 0.20$). There was no difference in the discontinuation rate between men (5/28, 18%) and women (13/70, 19%; $p = 0.93$). The mean age of patients who participated in the study was 37.9 (SD 12.6) years, whereas for those who discontinued the study, the mean age was 33.1 (SD 12.1) years ($p = 0.14$). There were 26/40 (65%) women in the DSA group and 32/40 (80%) women in the AAU group ($p = 0.13$). The mean age of the study subjects was 37.4 (SD 12.0) years and 38.2 (SD 13.2) years, ($p = 0.80$) respectively. In Study I, data were analysed from 40 patients in the DSA group and 40 patients in the AAU group.

4.2.2   Study II and Study III

In Study II, five randomly selected interviews from the AAU group were matched with five DSA interviews in terms of seven criteria. These interviews were audio-recorded and transcribed for further analysis. The AAU interviews lasted 280 minutes and the DSA interviews lasted 283 minutes.

For Study III, the data of ten interviews were further investigated. During the research process, 45 question–answer sequences from interviews were selected and presented qualitatively.

4.3   Assessment Groups

Here, the DSA-based assessment style (DSA group) is presented. Then, the style of standard assessment (AAU group) is described that usually conducted in community mental healthcare in Finland. The differences between the clinicians' strategies in DSA-based and AAU assessments are outlined in Table 2.

Table 2.   Differences between the professionals' strategies (Savander et al.,2019a)

Differences between the professionals' strategies in AAU and the DSA-based assessment.[1]

	AAU	DSA
1. Focus	Mainly focusing on the patient's symptoms as categorized by psychiatric knowledge	Mainly focusing on the patient's internal and interpersonal subjective experiences, events, and attitudes
2. Observation	Observing signs and behaviors that selectively confirm the set of symptoms	Observing signs and behaviors that refer to subjective experiences
3. Communication practices	Using more closed questions, alongside structured scales and questionnaires	Using more open questions, follow-up questions, and reflections
4. Inference	Mainly deductive thinking	Mainly inductive thinking at the first part of interview
5. Attitude	Professional's attitude is interested and neutral. Spontaneous, yet restricted empathy may facilitate the gathering of diagnostic information.	The professional is purposefully trying to empathize with the patient's perspective to gather individually meaningful information and increase awareness of the patient's problem.
6. Objective	Intention to form an explanation of problems based on diagnostic categories	Intention to form an individual formulation of the patient's problems, their psychosocial causes, and action patterns associated with them, thereby complementing the diagnostic process

1   DSA: DSA-based case formulation assessment; AAU: Assessment as usual

4.3.1   Assessment based on Dialogical sequence analysis - DSA group

In 2013–2015, three psychiatrists and three psychologists were trained in DSA case formulation in the secondary psychiatric outpatient clinic in Lahti. Although the DSA training was not completed, the research started in January 2015.

The first visit of the assessment phase was conducted by a psychiatrist–psychologist pair. The visit was divided into two parts. From the beginning, the clinicians approached and focused on the patient's current problem (symptom/s, event, interpersonal conflict, problematic behaviour, problematic personal experience, etc.) by applying the trained conceptual tools of DSA in the first part of the interview (see also section 2.5.1). By constructing sentences containing words with their prosody, gestures and nonverbal signs, the patients express their stance towards a referential object and the clinician, including networks of personal meanings and values. By *eschewing presuppositions*, the clinician intent to focus on the problematic experience disclosed by the patient. This is followed by an elaboration through the conceptual tools and strategies of DSA. There is the intention that the clinicians might avoid a premature drift to improper conclusions and increase their understanding of the patient's perspective. Moreover, a trustful connection between the clinician and the patient from the beginning was emphasised in DSA strategies also, impacting how the interaction proceeds. There is essential to build a trustful relationship using the therapeutic components that Rogers (1961) has suggested (see also section 2.2): 1) the professional's congruence with themselves or genuineness; 2) an 'unconditional positive regard' without prejudice and judgement; and 3) empathetic understanding of the patient's perspective.

As included also in DSA strategies, the clinician provides a short formulation or feedback, which is a description derived from the patient's previous narrative, with the focus remaining on the referential object or the stance towards it. The clinician's short formulations help the patient to organize their observation about themselves, showing how reasonable these formulations are in their subsequent response. The patient's way of approaching the formulations expresses the direction in which self-understanding can be deepened and what can be talked about. This is called working in the patient's *zone of proximal development*, introduced by Vygotsky (1978). The concept helps the clinician to understand the patient's ability for *self-observation*: what can be talked about and what still needs to be kept silent, i.e., the patient's space for moving in their self-observation, determines the direction of the conversation. Moving forward in this way, the interview gradually reveals the patient's protective

activities, risk positions and unbearable positions. These concepts serve as tools for listening to patients' accounts of their experiences and recognising their functions in their mental actions.

By using DSA strategies in this interview, it is gradually possible to condense a preliminary case formulation, pointing out repetitive maladaptive action patterns, and discuss together with the patient how such patterns impede their agency. The patient's way of responding to the DSA-based case formulation shows its personal validity and relevance to them.

At the first part of the visit, the clinicians worked on the patient's problematic experience and tried to outline a preliminary hypothesis about repetitive maladaptive action patterns using DSA tools and strategies.

After the first part, there was a 10–15-minute break. During the break, the clinicians negotiated and preliminarily formulated a working hypothesis about the patient's recurrent problematic action patterns that might maintain the patient's symptoms and distress.

In the second part of the visit, the clinicians evaluated the patient's possible risk behaviour, suicidal thoughts, self-harm or thoughts of harming others. Furthermore, they assessed possible psychotic symptoms or other diagnostically significant or observable symptoms. At the same time, the clinicians estimated the patient's need for other clinical intervention concerning laboratory tests or medications and statements about social security benefits. Finally, they offered the patient a tentative formulation of the problem presented, which the patient could reflect on, aiming to further shape the treatment plan collaboratively. They discussed the prefatory working diagnosis and the content of the later assessment visits.

According to the patient's further needs for assessment, one or both of the clinicians conducted the following assessment visits. It was possible to use diagnostic questionnaires or rating scales as needed. The goal was to comprehend in detail the patients' significant life events, problems, distress, symptoms and social relationships through their narrative. Furthermore, by using DSA concepts and strategies, the clinicians observed the patient's stance towards the addressed topic or object.

In the last assessment visit – the treatment-planning session – the clinicians and the patient aimed at enlightening the recurrent internal and external activity patterns that seemed to provoke and conserve the patient's current problems. Grounded in this co-constructed formulation, they adumbrated the targets and tasks for the treatment plan. The intent was to clarify a diagnosis with an individual case formulation and define the immediate as well as the long-term objectives. Among other information, the treatment plan, along with the DSA-based case formulation,

was written in the patient's records. After the assessment phase, one of the clinicians conducted the treatment based on the treatment plan and schedule. Examples of recorded diagnoses with DSA-case formulation are mentioned here:

"F33.1 Recurrent depressive disorder, current episode moderate.
The patient's central problem is a mood decline associated with anxiety. This combination seems to be related to strong and paralyzing feelings of guilt and shame, to which she responds with a lack of initiative and avoidance. This pattern of behaviour may protect the patient from intolerable failure, because he is very self-critical and a perfectionist, having a tendency to compete with others.

F33.1 Recurrent depressive disorder, current episode moderate; F40.1 Social phobia.
In addition to symptoms of depression and anxiety, the patient suffers from social phobia. It seems that behind these is a complex of excessive demandingness, self-criticism, and judgmental stance toward self. The patient easily feels guilty and in such situations, she thinks that she does not deserve help. Her basic assumption is that she will fail and, hence, she does not dare to try, which strengthens her assumption of failure. She has begun to avoid social situations and at times she tends isolate herself."

(this text has been modified to not identify the patients; Publication I, pp 218-19)

4.3.2   Assessment as usual - AAU group

The AAU assessment team included seven physicians (psychiatrists and residents), five psychologists and nine psychiatric nurses who worked and rotated irregularly in the Evaluation Team of the Community Mental Health Care Centre in Lahti, Finland. The clinician pair was chosen from this group, as usual. The patient's clinical evaluation and evaluation of the need for treatment were performed in terms of the present descriptive and symptom-oriented, diagnostic assessment guidelines of public mental healthcare, recommended by educational textbooks as was mentioned in section 2.3.1. It was possible to use diagnostic questionnaires or rating scales as needed. The clinicians estimated the patient's need for other clinical intervention

concerning laboratory tests or medications and statements about social security benefits. The number of assessment visits was not dictated.

A physician conducted the first visit together with a psychologist or a nurse. Thereafter, one of the clinicians continued the assessment of the patient's clinical condition according to the usual symptom-oriented guidelines in the subsequent assessment visits. At the end of the assessment phase in the treatment planning visit, both clinicians recommended the treatment targets and tasks and negotiated with the patient about them. If the duration of treatment was evaluated to last longer than six months, the patient's treatment was guided to the Care Team within the same mental healthcare centre.

4.4   Measurements

In this study, the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) was used at baseline and the Working Alliance Inventory (WAI) at the end of the assessment phase. Furthermore, the number and durations of visits and the lengths of individual assessment periods, as well as the numbers of clinicians involved in the assessment process were recorded.

4.4.1   Clinical Outcomes in Routine Evaluation-Outcome Measure

The CORE-OM is a standardized self-report measure for primarily indicating the changes in the client's mental health during a psychotherapeutic process. Chris Evans and colleagues (2002; 2006; also, Connell et al., 2007) developed and researched its psychometric properties in the British population. The researchers stated that CORE-OM provides the core pattern of mental health problems as the "lowest common denominator" for evaluating the clinical effectiveness of psychotherapies (Evans, 2002, p. 59). The copyright is maintained by CORE Information Management Systems. The Finnish version of the CORE-OM has been validated at the University of Eastern Finland (Juntunen et al., 2015; Honkalampi et al., 2017). The study showed, in the same manner as in the British study, that the CORE-OM is a usable, internally consistent and reliable measure of the

psychological effect of psychological interventions. The researchers reported that CORE-OM is a useful tool to evaluate the changes in the patient's mental health/distress and to complement clinical evaluation. Moreover, it is a useful tool for evaluating the effectiveness of psychosocial interventions in Finnish mental health care. This 34-item self-report instrument provides a means to evaluate four domains of mental health or distress: subjective well-being (CORE-W, 4 items), psychic symptoms (CORE-P, 12 items), life functioning (CORE-F, 12 items) and risk behaviour (CORE-R, 6 items). In Study I, CORE-OM was used at baseline to provide a general evaluation of the cohort patients' mental condition.

4.4.2   Working Alliance Inventory

The Working Alliance Inventory (WAI) was primarily introduced for self-assessment of the therapeutic alliance in psychotherapy (Horvath & Greenberg, 1989). The concept of the therapeutic alliance postulated by Bordin (1979) includes three components: agreement on goals, agreement on tasks and the development of a therapeutic bond. There are versions for the patient (WAI-P) as well as the therapist (WAI-T), mirroring the reciprocal process in therapy. Both scales incorporate 36 items measuring three domains of alliance, concerning agreement on the goals of therapy (Goal Scale), consensus on the efficacy of the tasks employed in treatment (Task Scale) and the therapeutic bond (Bond Scale). This scale has been extensively used in evaluating the therapeutic relationship, including collaboration and goal consensus, and patient–therapist congruence in psychotherapy and in counselling (Horvath et al., 2011; Tryon & Winograd 2011; Marmarosh & Kivlighan, 2012). The Finnish version was used in the Helsinki Psychotherapy Project (Heinonen et al., 2014). The Finnish version of the WAI (long form) was applied at the end of the assessment phase.

4.5   Quantitative methods and statistical analyses

In Study I, the Student's *t*-test or the Mann–Whitney *U*-test was employed, depending on the distribution when comparing continuous variables between the groups. Because of the skewed distributions, Spearman's rank-order correlation

coefficients (*rho*) were calculated to compare the WAI scores between the groups. To compare the correlation coefficients, *rho* values were first transformed into *Z* scores. Thereafter, *Z* statistics were used to assess the statistical significance of differences in correlation coefficients. A *p*-value of <0.05 indicated statistical significance.

In Study II, examples of each trajectory selected by CA were first described. Thereafter, the statistical results concerning their distribution in the two assessment interview approaches were calculated. The chi-squared test was used for the statistical analysis.

4.6   Qualitative method

4.6.1   Background of Conversation analysis

Conversation analysis (CA) is a qualitative micro-analytic method that examines *naturally occurring interaction* in everyday and institutional interactions from audio or video-recorded data. CA is used to search for structures and regularities at the fine-grained level of conversation and to examine the speakers' practices or resources while orientating to and constructing the social relations and situations (Tainio, 1997; Peräkylä et al., 2002b; 2004; Sidnell & Stivers, 2013; Stevanovic & Lindholm, 2016).

The tradition of interaction research is rooted in the 1960s. An American sociologist and ethnomethodologist, Harold Garfinkel observed cultural norms and practical reasonings of mundane social communication with the ethnomethodological approach. He claimed that all utterances in a conversation are indexical, including their symbolic meaning that is impacted by contextual interpretations (Garfinkel, 1967; Tainio, 1997). Inspired by these ethnomethodological ideologies, an American sociologist, Harvey Sacks audio-recorded telephone calls of the Suicide Prevention Centre in Los Angeles in the early 1960s. Sacks, with his colleagues Emmanuel Schegloff and Gail Jefferson, created the preliminary basis and theories of conversation analysis. They investigated audio-tape recordings and transcribed conversations, observing and examining the naturally occurring interaction as sequentially organized social activity at the turn-by-turn micro-level (Sacks et al., 1974; Tainio, 1997; Maynard, 2013).

As briefly presented in section 2.1.1, Erving Goffman's heuristic work also contributed to understand and interpret the structure and function of conversation in different social situations (Goffman, 1971; 1978). The theoretical background of CA is based also in Goffman's basic idea that social interaction is an autonomous system – an *institution* – with its tasks, permanency and rules (Goffman, 1983; Heritage, 2009). The first and most basic principle of CA is that talk in itself is an *action*. More specifically, talk is naturally occurring organized activity between at least two participants, manifesting in the form of a *turn-taking system* (Sacks et al., 1974; Tainio, 1997; Peräkylä, 2004; Schegloff, 2007). Talk, including verbal and non-verbal features of language, is a speaker's action, occurring turn-by-turn in conversation. In everyday interaction, an action can take the form of, for example, a question, an answer, an invitation, diagnosis telling, physical examination, interpretation, prescription and so on. By taking the next turn, the second speaker orients themselves to the preceding turn of the first speaker, thereby performing an action that is shaped by the preceding turn (for example, after a question comes an answer). Such turns are called *adjacency pairs*. The core focus of CA is the place where the change in a turn is performed, namely the *transition relevance place*, displaying whether the preceding turn is completed and the next turn is invited. In interaction, these turns or actions are *sequentially organized,* containing in themselves implicative expectations and prepositions towards the conversational partner (Tainio, 1997; Peräkylä, 2004; Schegloff, 2007). However, deviations may occur in the organization of interaction, and the normative structure of adjacency pairs may be re-established by *repairs* (for example by requiring clarification) or it may be *extended* in different ways.

In addition to the adjacency pair structure, another frequently performed structure is the *third-position turn*. The third-position utterance shows how a person performing, for example, a question (the first part) treats the response to the question (the second part). The third position contains an interpretation of what the questioner regards as relevant in the answer, and by their response gives further direction to the subsequent turns in talk (Peräkylä, 2010; 2011; Schegloff, 2007). For example, Publication II presents the ways in which clinicians deal with the responses of patients towards subjective experience telling, ranging from acknowledgements to closings and topic elaborations to changing the topic, thereby directing the following talk. These actions, or turns, also convey the speaker's *stance* toward the other's action, performing in nonverbal as well as verbal features the practices of talk (Kiesling, 2011).

Another central principle in CA is that through sequential organization of talk, speakers build their *intersubjective reality* moment-by-moment and turn-by-turn. As Schegloff has stated in his seminal work: "Next turns are understood by coparticipants to display their speaker's understanding of the just-prior turn and to embody an action responsive to the just-prior turn so understood" (2007, p. 15). In stating this, Schegloff refers to the connectedness of turns, conveying possibilities of *intersubjective understanding* maintained by repairing the possible misunderstandings between speakers in any social context (Heritage & Atkinson, 1984; Heritage, 2009; Peräkylä, 2004; 2019). These principles guide the analyst to view what occurs in the conversation in a contingent situation. CA researchers investigate and describe what participants are doing and performing, what kinds of practices they are using, and what they are orienting towards, using naturally occurring conversational data.

While CA is rooted in naturally occurring mundane conversation, a large body of studies have also observed and described *institutional interaction* in contexts such as education, medicine, psychotherapy and family, among others. In many forms of institutional interaction, the participants follow the same rules of turn-taking as they do in mundane conversations. However, there are specific elements guiding and making the conversation institutional rather than mundane. These interactional elements are: 1) the participants have a specific goal orientation, making relevant their roles and identities in the institutional situation; 2) constraints, making certain actions allowable or not allowable; 3) specific procedures and inferential frameworks in specific institutional contexts. According to their expertise, professionals possess the appropriate knowledge or information – or *epistemics* – that other parties as recipients may not have, creating varying asymmetrical social relations in institutional contexts (Peräkylä, 1997; Heritage & Maynard, 2006; Heritage & Clayman, 2010; Drew & Sorjonen, 2011; Weiste et al., 2016). Recently, CA researcher Paul Drew argued that participants' orientation toward epistemics in social interaction is omnipresent; thus "participants monitor on a moment-by-moment and turn-by-turn basis, and orient to, their relative states of knowledge – to epistemics" (Drew 2018).

Anssi Peräkylä and Sanna Vehviläinen (2003) discussed the role of CA in different institutional contexts and the role of *stocks of interactional knowledge* in institutional interaction. Stocks of knowledge are understood as organized knowledge, such as theories, models or textbook recommendations, which are described in more or less detail and penetrate to a higher or lower degree into the praxis of the institution. CA offers possibilities to reveal and specify the way of praxis and contingent gap between theories and practice. For example, Johanna Ruusuvuori (2000) investigated doctors' opening questions in medical consultations. The recommendation of

patient-centred medicine is to ask 'open-ended' questions ('what' questions) and to avoid 'closed' yes–no questions. Conversation analytical research, however, demonstrated that both question types were used in a successful way. Rather than the grammatical design of the question, the context and the goal orientation of the visit determined the function and consequences of the opening question. Peräkylä and Vehviläinen (2003) noted that CA provides fine-grained pictures of professional knowledge of interaction and offers possibilities for professionals to revise, correct and specify their assumptions and recommendations.

4.6.2   The conversation analytical research process

Next, the conversation analytical research process is described as configured by CA literature (Tainio, 1997; Peräkylä et al., 2002b, 2004; Sidnell & Stivers, 2013; Stevanovic & Lindholm, 2016). The research process starts by *choosing the field* of investigation where conversations naturally occur, such as everyday conversation among friends or a medical consultation. There is always a requirement to negotiate with and to acquire the permission of participants and/or the institutional organization. Occasionally, there are possibilities to define the *focus of research* in advance, for example, the treatment negotiation phase in a medical consultation or an invitation to a celebration in a mundane phone-call conversation. Moreover, it is useful to attain ethnographic understanding of the norms and procedures of the sociocultural environment in the research field, especially in institutional research.

Next, *audio or video-recording* of the interaction is a basic prerequisite for gathering the data for analysis. The technical quality of the recordings is essential. The number of recordings varies between studies. There should be enough recordings to indicate the full variation of the phenomena of interest. The CA notation helps to transform a recorded interaction into an analysable written form. The basic CA notation was originally developed by Gail Jefferson (2004), containing a variety of symbols to indicate vocal and physically embodied phenomena. Developed versions of the Jeffersonian transcription style are used for *transcribing* the recorded data. There are fine-graded symbols indicating, for example, gaps, overlaps, inbreath, outbreath, prosodic features such as volume and pitch, accented sound, places of intonation, and so on (see also Appendix, Publication II). Transcribing is rather slow and precise work but helps the transcriber to develop a deeper understanding of the details of interaction. Although in recent years computer programs have been developed to

advance the process, manual transcriptions are likely to remain more detailed and thorough.

The next step is the "unmotivated exploration" of data (Peräkylä, 2004, p. 170), during which the researcher observes and repeatedly listens to a part of the data without a specific aim or focus. This process is inductive, meaning it is data-oriented without an exact hypothesis. However, previous CA research literature and contextual knowledge can give general direction to the analysis. This phase of analysis is rather laborious to employ alone. Thus, working in pairs or in a group will promote the uncovering of the organization of interactional phenomena found in the data. The process of systematic data observation is supported by *data sessions*, where a small group of researchers explore and listen repeatedly to a small segment of data together, using their intuition and methodological expertise concerning the targeted conversational phenomena. In concrete terms, the researcher examines a selected action or turn (a specific word, particles, specific syntax or perspective, stance, prosody, verbal or non-verbal timing, gaze, gestures, postures, etc.). Next, the researcher asks what this action is; what precedes it and what is it followed by; what is it like; how is it organized? The researcher observes whether there is repair organization or other relevant deviations or signs in turn-taking places. Moreover, s/he examines how the participants reveal their own experience and how they interpret the other's action. During this explorative work, the researcher *identifies phenomena* from the data that s/he finds challenging or somehow interesting. For example, in Study III, this phenomenon is the way of action that the patient uses in making the account of subjective experiences as a self-disclosure after the clinician's medically orientated inquires. In order to identify a genuinely new phenomenon, it is relevant to know, and compare it with, previous interactional research (Peräkylä, 2004).

After identifying the instance of interest, the researcher tracks through all recorded data and creates a *collection of instances* case by case. In Study III, 45 question–answer sequences were analysed. In general, there are 10–200 instances in a collection. *Determining the variation* within the collection is performed in the same way as described above. Thus, the researcher asks where this phenomenon or action comes from, what follows it, in what way is it performed and what it produces. By searching for regularities in the variations of the phenomenon and its environment, it is possible to create subgroups of collections. For example, in the Study III collection, four different subgroups of different trajectories were found, ranging from medical question to the patient's self-disclosure of subjective experience telling. Generally, the *regularities* in findings may indicate the *orientation* and *social relations* of

the participants. It is common for researchers to present in their publications the variation of subgroups by prototypes of instances, as well as deviant instances (Peräkylä, 2004).

The *quantification* of data in CA research is increasing, giving a general view of the frequency of instances selected qualitatively (Robinson, 2007). The viability in quantification depends on the sample size of the qualitative instances selected. For example, in his seminal work, Anssi Peräkylä (1998; 2002a) established doctors' practices concerning telling of the diagnosis to the patients from 100 recorded doctor–patient consultations in Finnish primary healthcare. Seventy-one diagnostic statements were collected and three different ways of presenting the diagnosis were found among them. The data were first analysed qualitatively and thereafter quantitatively. The statistical analysis presented a strong association ($p = 0.001$) for the third diagnostic approach: when the doctor verbally explained the evidence for the diagnosis, the patients started to talk about the diagnosis more actively than in the other two approaches, when doctors did not explain the evidence. By orienting to explicate the diagnosis verbally, the doctor can facilitate the patient's participation in the consultation. In Study II, quantification was used to compare the account of the sequences of patients' subjective experience telling in two different styles of interviews.

4.7 Study procedures

4.7.1 Study I

In this single-blind randomised controlled trial, the patients were randomised into two groups. According to power analysis, for a 10–15% increase in the total WAI score to be statistically significant ($\alpha = 0.05$, power 80%), we would need 40 study subjects in both groups. The purpose was achieved with 40 participants for both groups. If the referral was accepted and was it decided to start the assessment phase, the randomization was performed immediately.

In both groups, the study protocol was similar. In the first visit, the clinicians provided information about the study, offered a written statement, and requested the patient's consent to participate in the study. Furthermore, in the AAU group,

five randomly selected patients gave written consent for the first interview to be audio recorded. In the DSA group, each first interview was audio-recorded with the patient's written consent, and occasionally some following visits were also recorded with the patient's agreement. In both groups, each patient was asked to complete the CORE-OM form during the first visit. Subsequently, in the treatment-planning visit – the last assessment visit – the patients in both study groups were asked to fulfil a WAI-P scale and to put it in an envelope, hiding the results from the clinicians. The clinicians filled in the WAI-T scale together after the patient's departure. Based on the study protocol, after each assessment visit, the clinicians in both study groups fulfilled an assessment form with details such as the participants, time, medication and questionnaires used.

4.7.2   Study II

As mentioned above, the interviews of five randomly selected patients were audio-recorded in the AAU group. In the DSA group, each first interview was audio-recorded, and occasionally some following visits were also recorded with the patient's agreement. For the matching process, the author described a set of 45 patients (5 random AAU cases and 40 DSA cases) in terms of seven clinical criteria, employing the audio-recorded interviews and the patients' medical records as sources of information. The seven clinical criteria were: 1) gender, 2) age, 3) educational level, 4) psychiatric treatment history, 5) substance abuse history, 6) ability to self-reflect and 7) ability to verbalize experiences.

Based on these matching criteria, two researchers (a professor of clinical psychology and supervisor of this dissertation, and the author) matched five DSA cases to five AAU cases, forming five pairs through consensus negotiation. In Study II, qualitative as well as quantitative results were employed. The author primarily worked on interview data, but she received support from other co-researchers as well as in data sessions.

The sequential organization and progression of the interactions was examined and three-part sequences were identified. Considering the *content* of the talk, turns approaching medical or experiential domains were determined. These domains approached Mishler's (1984) binarity of 'voice of medicine' and 'voice of the lifeworld'. The middle turn of three-part sequences was the patient's telling about her/his negative subjective experiences (E) approaching 'the voice of the lifeworld'.

According to the E turn, the patient tells in negative terms a personal attitude, feeling, experience or life event. Thereafter, the author analysed how these E turns emerged and where they led. In the interviews, the information elicitation phases were focused on, thereby excluding the clinicians' opening question and advice on treatment recommendation or educative statements. Accordingly, the key phenomenon as the patient's negative subjective experience telling – E turn – emerged as an answer to the clinician's question. Regarding the binary approach, on the one hand there were medically oriented questions (MQ), and on the other, experience-oriented questions (EQ). MQs refer to interrogative turns about symptoms or factual knowledge, as well as inferential statements (making relevant the patient's previous account) without concerning the patient's subjective experience, meanings, or feelings. EQs refer to interrogative turns or inferential statements concerning the patient's negative subjective experience, feelings, attitude, meanings, or life events. As responses to the patient's experience telling were distinguished, on the one hand, the medically oriented next turn (MT) related to symptom-oriented or factual knowledge, and on the other, the experience-oriented next turn (ET) referring to the patient's presented experience. As these responses were coded, minimal response tokens were excluded – for example, '*mm*' (Gardner, 2001). Based on these identifications of turns, three-part sequences were selected in which the participants' orientation oscillated between medical or experience-oriented domains (Figure 3). In the middle, the focus of three-part sequences was the E turn, which preceded EQ or MQ, and was followed by ET or MT.

By repeatedly listening to and tracking the ten interviews, first, 124 three-part segments were selected. Initially, the author selected and coded them. In order to achieve reliable coding, a second coder, knowledgeable in CA, read the coding instruction from definitions, then randomly selected 20% of segments. Thereafter, the rationale behind the coding was negotiated between the second coder and the author. Based on their discussion, five segments were excluded due to the clinician's turn being an educative statement or the patient's turn being factual and non-experiential (in study terms), as well as the clinician using opening questions. Furthermore, they disagreed about six other coded segments. Having developed a shared coding system through negotiation, the second coder examined the remaining 80% of the extracts independently, coding each of them into four categories: EEE, EEM, MEE and MEM (Figure 3). Eventually, agreement was achieved for 93 of the 119 extracts, and the remaining 26 were coded during consensus negotiation. The 119 extracts were divided into four categories. In this study, the prototypes of extracts were analysed by CA and presented that showed the way that the patient's

subjective experience telling emerged (EQ/MQ-E), and the consequences of the patient's subjective experience telling (E-MT/ET). Additionally, the account and frequency of these pairs and three-part sequences were compared between two different styles of interviews.

4.7.3   Study III

In Study III, investigation of the data of Study II was deepened by CA. Here, the focus of the analysis was specific question–answer sequences involving the clinician's medically oriented questions, followed by the patient's response with self-disclosure of negative subjective experiences.

The preliminary analysis was conducted by the author based on the previous work in Study II. Altogether, 45 question–answer (MQ-E) pairs were recognized. Employing CA with an expert researcher (the supervisor of the dissertation), four trajectories were discovered in and through which the transition from medical to experiential focus could occur. Forty question–answer sequences could be grouped in one of the four trajectories. However, five were excluded due to not fitting into any group. After this process, the author analysed all the sequences in each group. The most prototypical sequences were selected from each group and these were subjected to in-depth conversation analysis.

4.8   Ethical considerations

An evaluation of ethical standards and permission to conduct the study were obtained from the Ethics Committee of Tampere University Hospital (R 14094) in 2014. Moreover, the permission to complete the clinical study was received from the board of Päijät-Häme Central Hospital in 2014 (PHSOTEY Dnro 52/2014). Written informed consent was required and obtained from all cohort participants.

5   RESULTS

5.1   Differences in the CORE and WAI measurements (Study I)

As mentioned earlier, each patient was asked to complete the CORE-OM questionnaire at baseline in Study I, which examined their basic general mental health condition using self-report. There were no significant differences in patients' self-reported mental health conditions between the DSA and the AAU groups (see Table 3). At the end of the assessment phase, there were slightly higher values for the patients' and clinicians' total and subscale WAI scores in the DSA group than in the AAU group. Nonetheless, the differences were not statistically significant (see Table 4).

In the DSA group, there was a significant correlation between the patients and the clinicians in the Total WAI score (rho = .62) and the score in all subscales (treatment Goal rho = .63; treatment Task rho = .66; therapeutic Bond rho = .56). In the AAU group, there was a significant, yet weaker correlation only in the WAI therapeutic Bond subscale (rho = .36) (see Figure 2).

Between the DSA and the AAU groups, the correlation coefficients differed borderline significantly in the Total working alliance score ($p = 0.05$) and were statistically significant in treatment Goal ($p = 0.03$) and Task ($p = 0.03$) subscales. There was no correlation between study groups in the therapeutic Bond subscale scores ($p = 0.13$).

Moreover, the findings demonstrated that the duration of the assessment periods was shorter ($p < 0.001$) and the number of visits was fewer ($p = 0.002$) in the DSA group than in AAU group, with the differences being statistically significant (see Table 5.

Table 3.   Baseline CORE-OM scores in the DSA and AAU groups (Savander et al., 2019a)

	DSA group (n = 40) Mean (SD)	AAU group (n = 41) Mean (SD)	Mann–Whitney U test p-value
CORE-W	2.04 (0.79)	2.30 (0.80)	0.127
CORE-P	2.15 (0.89)	2.30 (0.76)	0.616
CORE-F	1.66 (0.78)	1.89 (0.57	0.155
CORE-R	0.30 (0.44)	0.39 (0.43)	0.245
CORE-TOTAL	1.64 (0.69)	1.82 (0.57)	0.234
CORE-TOTAL WITHOUT R	1.92 (0.79)	2.12 (0.64)	0.264

Notes: DSA = Assessment based on dialogical sequence analysis; AAU = Assessment as usual; CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure; CORE-W: subscale of subjective well-being; CORE-P = subscale of psychic symptoms; CORE-F = subscale of life functioning; CORE-R = subscale of risk behavior

Table 4.   WAI total and subscale scores (Savander et al., 2019a)

WAI total and subscale scores compiled by professionals (WAI-T) and patients (WAI-P) at the end of the assessment period in the DSA and AAU groups

Scales	DSA group Mean (SD)	AAU group Mean (SD)	Mann–Whitney U test p-value
WAI-T total	209.1 (27.6)	200.9 (32.9)	0.90
WAI-T Task	67.6 (6.8)	65.3 (12.0)	0.90
WAI-T Bond	75.4 (18.8)	71.1 (9.0)	0.92
WAI-T Goal	66.1 (7.9)	64.1 (13.7)	0.94
WAI-P total	199.1 (27.0)	195.0 (29.9)	0.43
WAI-P Task	65.9 (9.0)	64.6 (10.1)	0.46
WAI-P Bond	67.6 (10.3)	65.0 (11.5)	0.28
WAI-P Goal	66.1 (9.3)	65.3 (9.8)	0.62

Notes: WAI-T = Working Alliance Inventory form for Therapist; WAI-P = Working Alliance Inventory form for Patient; DSA = Assessment based on dialogical sequence analysis; AAU = Assessment as usual

Table 5.　　　Characteristics of the assessment periods (Savander et al., 2019a)

Characteristics of the assessment periods in the DSA and AAU groups.

	DSA	AAU	Student's *t*-test *	
	Mean (SD)	Mean (SD)	*t*	*p*-value
Duration of assessment period (days)	58.9 (39.2)	90.1 (35.2)	3.74	<0.001
Number of visits (n)	4.3 (2.0)	5.9 (2.4)	3.24	0.002
Total duration of visits (minutes)	290.1 (121.1)	355.7 (253.8)	1.48	0.14
Total time used by professionals (minutes)	448.5 (155.6)	460.0 (254.5)	0.24	0.81

Notes: DSA = Assessment based on dialogical sequence analysis; AAU = Assessment as usual
*: df = 79

Figure bar chart content:

Congruence of patient and professional perspective on working alliance

	DSA group	AAU group
Treatment goal	0.63**	0.23
Treatment task	0.66**	0.27
Therapeutic bond	0.56**	0.36*
Total Working Alliance score	0.62**	0.27

Axis: 0,00 0,10 0,20 0,30 0,40 0,50 0,60 0,70 0,80

■ DSA group　■ AAU group
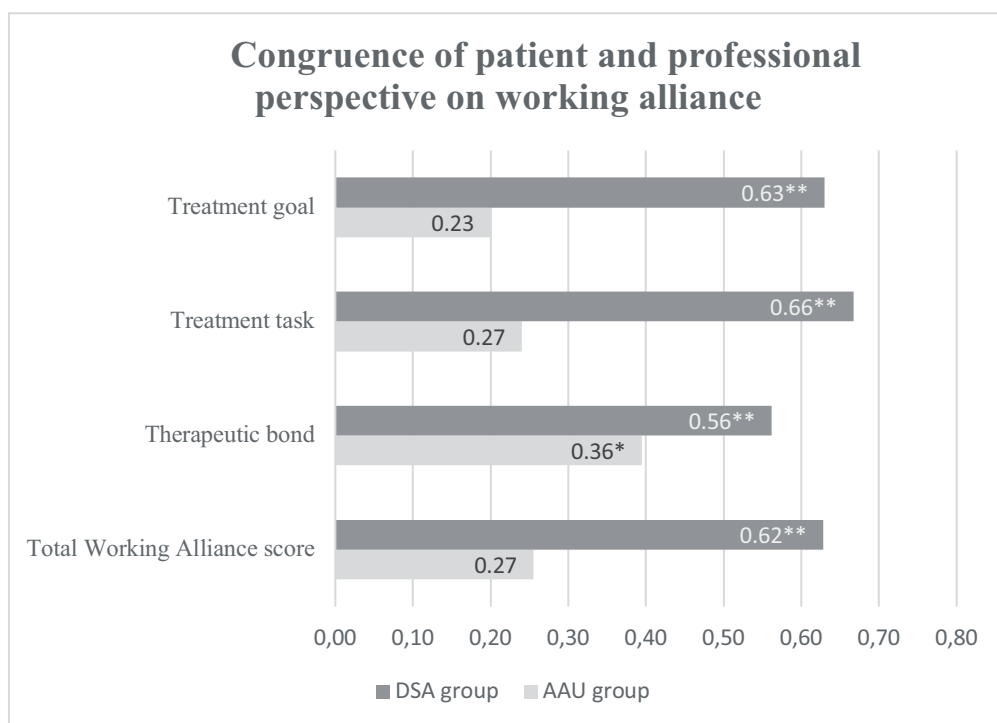
* p<.05 ** p<.01

Figure 2.　Correlations of patient and professional perspectives (Savander et al., 2019a)

5.2   Comparing styles of interviews (Study II)

In comparing the interviews, the findings revealed that in the five DSA interviews, the patients described their negative subjective experiences as their response – the E-turn – to the clinicians' question 71 times, while the respective figure in the AAU interviews was 48 times. The mean number of E-turns was 14.2 (SD 2.8) in the DSA interviews and 9.6 (SD 2.3) in the AAU interviews, the difference between the two study groups being significant ($p = 0.016$).

5.2.1   Emergence of the patients' descriptions of negative subjective experiences

The interactional environments where the patients' descriptions of negative subjective experiences (E) *emerged,* were analysed. The results showed the most representative extracts for two different types of trajectories. One type of action contained an experienced-oriented question (EQ) preparing the ground for the patient experience-oriented telling. The other type of action started with a medically oriented question (MQ), which called forth, foremost, a medical or factual answer. The patient promptly provided a medical answer, thereafter shifting the topic to the experiential domain, going beyond the medical agenda of the clinician's question. The distributions of these question–answer sequences were compared between the five DSA-based interviews and the five AAU interviews. There were significant differences between the two styles of interviews ($p < 0.001$). In the DSA-based interviews, the clinician provided an EQ for the patient's E-turn in most cases (71.8%), whereas in the AAU interviews, in more than half (52.1%) of the cases, the clinicians oriented themselves to the medical domain by an MQ, preceded by the patient's account of subjective experience. Based on these findings, it appears that in the DSA-based interview, patient was readily able to provide an account of their problematic subjective experience, whereas in the AAU interview, in most cases, the patients had to put effort into revealing their subjective experiences.

5.2.2 Consequences of the patients' descriptions of negative subjective experiences

The *consequences* of the patients' disclosure of negative subjective experiences (E) in the interactional environment were analysed. These were the clinician's specific responses or next turns, oriented to medical (MT) or experiential (ET) domains. In ETs where the focus of the experiential domain was maintained, this was performed by a follow-up question or formulation. Furthermore, in MTs where the focus shifted the topic to the medical domain, this was performed by a new medically oriented question or a follow-up question concerning the medical aspects or implications of the patient's prior account of the experience. In the DSA-based interviews, the clinician continued the experiential focus of the patient's subjective experience telling in 90.1% of cases. However, in the AAU interviews, the clinicians maintained the experiential realm significantly less, in 39.5% of cases. There was a tendency to shift the topic to the medically oriented diagnostic realm in 60.5% of cases.

5.2.3 Three-turn trajectories of interaction

In comparing the three-turn trajectories of the interaction, the findings indicated that in the DSA-based interviews, the patient's account of subjective experience was surrounded with the clinician's experience-oriented question and experience-oriented response in 67.6% of cases. In contrast to this, in the AAU interviews, the patient's account of subjective experience was most frequently surrounded by the clinician's medically oriented questions and next turns in 37.5% of cases (see Figure 3 and 4). These results demonstrate that the strategy of the DSA-based interview offers a favourable environment for the patient's disclosure of subjective problematic experience. On the contrary, the AAU interview does not facilitate such telling; thus, the patient needs to do the interactional work of going *against the grain* in disclosing their subjective experiences.

Figure 3. Experience descriptions and their sequential environment. (Savander et al., 2019b: https://doi.org/10.1016/j.pec.2019.02.021)
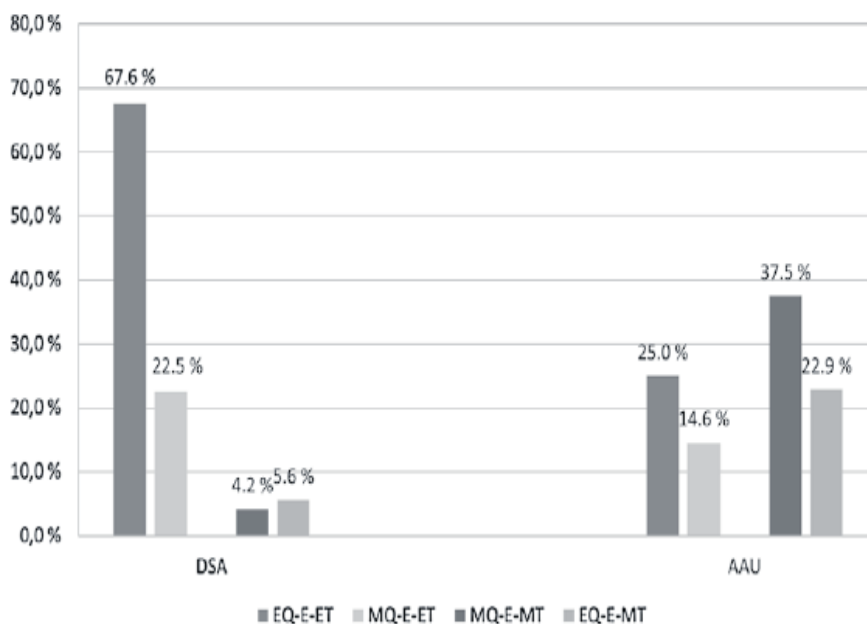
Figure 4. Distribution of the four trajectories of interaction across the AAU and DSA groups. (Savander et al., 2019b: https://doi.org/10.1016/j.pec.2019.02.021)

5.3 The patients' practices to disclose personal experiences (Study III)

Study III was conducted using data gathered in Study II. This study investigated in more detail one key phenomenon: sequences where the patients go 'against the grain' in disclosing their negative subjective experiences after the clinician's factually or medically oriented questions. As conversation analysis focuses on participants' actions, the key phenomenon became the patient's self-disclosures of subjective negative experience. The concept of self-disclosure derived from the work of Sidney Jourard (1971, p. 19), who stated that: "Self-disclosure is the act of making yourself manifest, showing yourself so others can perceive you." Charles Antaki and colleagues (2005b) viewed self-disclosure as a *social action* and described it by three specific features. First, it is performed voluntarily. Second, it is highly emphasized and newsworthy, for example, by extreme case formulation (ECF) (Pomerantz, 1986). Third, self-disclosure represents personal information about an intimate experience over and above of momentary expectation of co-participants. The 40 sequences from the data of the previous study were formed by the clinician's medically oriented questions and the patient's response, including usually a required answer with a self-disclosure of subjective negative experience. Four different interactional trajectories, forming four groups, were discovered through the analysis of the 40 sequences. As a 'baseline', Extract 1 presented a typical medical, psychiatric question–answer sequence. Thus, it may facilitate comparisons of the subsequent four different types of trajectories. Here, the clinician asked a paradigmatic question about the lack of appetite as a possible symptom of depression. After the patient's answer, the clinician offered a minimal response token, thus encouraging the patient to extend his answer. The patient gave more information about his appetite and the clinician's acknowledgement closed the sequence, offering space for the next medically oriented question (Extract 1).

As shown in literature (Mishler, 1984; Boyd & Heritage, 2006; Deppermann & Spranz-Fogasy, 2011), in the question–answer structure, the questioner generally reserves control of the topic and action. Occasionally, the results showed that the clinician's questions that gather diagnostic information may also convey a dual function and leave some possibilities to the patient to disclose more information about themselves. Next, the four different trajectories are presented in which the

patients' conversational control gradually increased from the first to the fourth type of trajectory.

```
Extract 1


1  DO:    mite onks sulla nyt ruokahaluu vai pitääkö sillee pakottaa
          how about do you have apetite now or do you have to like force

2         ittesä syömää nytte,
          yourself to eat now,

3         (0.6)

4  PA:    nyt on taas ruokahaluu (0.2) mut tos (0.8) kuukaus sit
          now I have some appetite again (0.2) but about (0.8) a month

5         takaperi ni (0.4) ei oikee (1.0) (h)ollu näl[kä tai
          ago (0.4) I really (1.0) (h)didn't feel hun[gry or

6  DO:                                                [joo?
                                                      [yeah?

7  PA:    mitää ei maistunu,
          I didn't crave for anything,

8         (1.0)

9  PA:    kyl mä silti söin pieniä määriä.
          surely I still ate some little bits.

10        (0.2)

11 DO:    joo?
          yeah?

12        (4.0)

13 DO:    miten sä yleisesti ottain pystyt keskittymään asioihin,
          how are you in general able to concentrate on things,
```

Extract 1 (see also transcription symbols in: Savander et al., 2021)

5.3.1 Self-disclosure of personal experience after medical answer and its acknowledgement

In the first group of the results, the patient performed self-disclosure of subjective experience after the clinician's acknowledgement. In these cases, an acknowledgement - for example: *'yeah'* or *'okey'* - may accomplish sequence-closing or project a move to the next question, also facilitating the progression of the talk (Schegloff, 2007). This group included 15 extracts. In the first extract of the group, the clinician's yes–no question about suicidal thoughts as a paradigmatic agenda question showed a dual function, touching upon not only symptoms but also personal experience- "*so have your thoughts over the last months been life feels so difficult that you wouldn't want to live anymore*"(Publication III, p. 5). However, in the other prototypical extract in this group, the clinician's yes–no question – "*would there be any other like more racy phase like throughout life that you would've had*" (Publication III, p. 7)- about a manic episode stays in the medical domain. In both prototypical examples, the clinician acknowledged the patient's initial answer to the question, and thereafter, the patient could move on toward their self-disclosure of personal experience. Compared to the paradigmatic 'baseline' Extract 1, where the clinician took the next turn with a new question after the acknowledgement, in this group, the patient took the turn of the self-disclosure of subjective experience. In both examples, after the clinician's acknowledgement, the patient took momentary control of the interaction and used emphasizing interactional practices, such as a rising pitch, rhetorical question, complaining tone, creaky voice, extreme case formulation - "*probably throughout my life*" (ECF: diverse grammatical forms represented semantically to convey extreme meanings). The patient also performed intense emotions, storytelling, repeated key descriptors - '*I was raging*' - with a louder volume (Publication III, p.6; Ainsworth‑Vaughn, 1994; Ogden, 2003; 2010; Pomerantz, 1986; Heritage & Clayman, 2010). Moreover, in the other example, the patient's self-disclosure is also self-corrective, suggesting an alternative explanation for a manic episode as the problem of lifelong anxiety – "*nn or like with that kind of tch anxiety I have been fighting with indeed fighting also during my student life already or like probably throughout my life*" (Publication III, p.7). The patients legitimated their personal account voluntarily, over and above the expectation of a medically oriented question by displaying highly coloured and emphasized practices.

In this group, the patients' self-disclosures occurred after their answers to the medically oriented question and the clinician's acknowledgements. Thus, the patients could move toward their self-disclosure of subjective experience relatively directly and fluently.

5.3.2   Shift without prior acknowledgement of the answer

In the second group, the patients answered the medical question and shifted to their self-disclosure *without* the clinicians' acknowledgement of the answer. In this group, 11 extracts were found in which the patients, in some way, took more control in the conversation than in the first group. In the prototypical extract of the group, the clinician asked a yes–no question about the magnitude of the patient's '*anger*' as a symptomatic inquiry (Extract 4). Here, at the beginning, the patient overlapped the question, implying that the answer arises from his/her own perspective (Jefferson, 1984a; Schegloff, 2000; 2001). Moreover, the patient gave minimal confirmation and elaboration that recycled the key term '*increased*' from the question, thereby adumbrating an independently expressed account where the patient would break away from the terms of the question (Lee, 2013; Heritage & Raymond, 2012; Enfield et al., 2019). After that, the patient brings in the self-disclosure about a problem with the '*uncle*'. The patient indicated the intensity of this problem by using ECFs, '*actually a re:ally big problem in my life h*', and an idiomatic depiction of the uncle's reaction, '*goes bananas*', then emphasized with another ECF as '*he is totally, (0.2) insane*'. Here, the patient's self-disclosure also represents a complaint about the uncle's behaviour in which ECF is also typically presented (Pomerantz, 1986; Heinemann & Traverso, 2009; Ruusuvuori & Lindfors, 2009).

In this second group, by shifting to self-disclosure of problematic personal experience without the clinician's confirmation/acknowledgement, the patient momentarily took more control over the interaction than in the previous group. In both groups, by performing certain emphasizing practices in their answers, the patients legitimated the self-disclosures of personal experiences.

Extract 4

```
1   PS:    onks semmonen kiukustuminel lisääntyny: (.)
           has this kind of anger increa:sed (.)

2          tai [herkkyys,
           or [propensity,

3   PA:        [on: se on nyt lähiaikoin lisääntyny
               [it ha:s it has now recently increased

4          varsinki että se on ollus sillee että .hh (0.2)
           especially that it has been so that .hh (0.2)

5          no sit toi mun setä ↑on oikeestaan to:si iso
           well so then that uncle of ours ↑is actualy a re:ally big

6          ongelma mun elämäs. h
           problem in my life. h

7          (.)

8   DO:    [mm,

9   PA:    [mä vaan toivon et tän asian sais sillee et se
           [I just hope that this thing could be sorted out so that he

10         lähtis nyt eläkkeelle itekkhi.
           would now retire himself.

11         (.)

12         .h siit on enemmä haittaa tua ku hyätyy,
           .h he does more harm than good,

13         (.)

14  DO:    mm-m j[oo,
           mm-m y[eah,

15  PA:          [sit ku silles sanoo jotain ni se ottaa
                 [then when you say something to him he

16         herneen nenään siitä ja,
           goes bananas about it and,

17         (.)

18  DO:    .h[hh

19  PA:    [se< k:iukuttele[e °muaa::° se on ihan (0.2)
           [he< throws t:antrums [°at me::° he is totally (0.2)

20  DO:                    [khh.

21  PA:    älytön (.) ei sitä voik kukaan käsittää ellei
           insane (.) no one can understand it unless

22         kukaan nää.
           one can see.
```

Extract 4 (see also transcription symbols in: Savander et al., 2021)

5.3.3　Shift to self-disclosure within the patients' extended response

In the third group, the patients gave more complex extended answers to the medically oriented questions than in preceding groups. Nine extracts were discovered in which the patients answered medical questions and continued to self-disclosure of subjective experience without a clear border between the initial required answer and the self-disclosure.

In the representative example of the group, a kind of transition occurred, which the well-known conversation analyst Gail Jefferson called a 'stepwise transition' (1984b). In this example, the clinician's question *'how do you sleep'* showed a dual function, combining a yes–no question that restricted the answer and a Wh-question that opened up space for choosing the direction of the answer. Thereafter, the clinician continued with an agenda yes–no question *'do you have sleeping problems °currently°.'* at present. This medically oriented complex question makes it relevant for the patient to provide a medically oriented answer and self-disclosure about subjective experience. In this example, the patient transferred her/his topic from the present sleeping problem (*no*) to the next step, in which s/he vividly talked about sleeping difficulties in the past, emphasizing them with an ECF, thereby starting to reveal the self-disclosure of personal experience. In the third step, the patient moved on towards the topic about *'ear acupuncture'*, and thereafter finalized the self-disclosure, including her/his persistent complaint about not having been offered psychotherapy. During the patient's answer to the medical question and the self-disclosure of personal experience (where there is also a complaint), the clinician took a passive recipient position with silent minimal responses *'mm'* (Gardner, 2001), facilitating in part the patient's move toward the final phase of the self-disclosure.

In this group, the patients produced an extended answer to the medically oriented questions. In their responses, the medical answer and the self-disclosure of personal experience were intertwined more than in the previous groups. Moreover, in their self-disclosures, the patients emphasized interactional practices to highlight the emotional intensity of the matter and took more space and control over the interaction than in the previous groups.

5.3.4 Shifts with the patient's evasive response

In the former three groups, the patients first answered the clinician's medically oriented questions with medical answers, and after that, in one way or another, they moved onto the self-disclosure of personal experience. In the fourth group, involving only five cases, instead of answering the medical question, the patients moved directly to self-disclosure of subjective experience. However, they provided a medical or factual answer during or after their utterance of self-disclosure.

In the representative extract of the group, a typical trajectory was described in detailed. Here, the clinician used a Wh-question: '*How has your free-time been going so far*', inviting an evaluative answer and leaving it up to the patient to decide a direction for the answer. The patient started the answer with a '*well*' preface adumbrating the indirectness of the answer, negotiating, and implying their own perspective (Heritage, 2015; Vepsäläinen, 2019). The patient's self-disclosure is a complaint story about the uncle's disturbing behaviour. The patient portrayed the story with emotionally emphasizing practices: ECF, colloquial expressions of negative feeling and a complaining tone. Moreover, the patient had overridden the clinician's efforts to present follow-up questions twice. After the clinician's last follow-up question about calming means, the patient answered directly: '*wait for Saturday evening to get the sauna f- drink beer h,*'. In this case, by disclosing the complaint story about the uncle's behaviour, the patient openly controlled the interaction more than was seen in the previous groups.

5.3.5 Summary of the results of Study III

Based on these four different trajectories, the patients used various means to accomplish the self-disclosures of subjective negative experiences. The patients' *conversational control* (Drew & Heritage, 1992; Ruusuvuori, 2000) gradually increased from the first to the fourth group. In the first trajectory, after the patient's answer to the medical question, the patient 'waited' for the clinician's acknowledgement and thereafter moved on to self-disclosure of personal experience. This shift was relatively fluent and collaborative. In the second trajectory, the patient also gave a medically expected answer, then directly moved towards the self-disclosure of subjective experience without the clinician's confirmation/acknowledgement, showing more conversational control than in the first trajectory. In the third

trajectory, the patient provided an extended account in which the required medical account and the self-disclosed experiential account were intertwined without a clear border. The patient took more conversational control and space than in the former trajectories. The fourth trajectory was rare: here, the patient, after the medical question, rushed to the self-disclosure of personal experience without offering a required medical account, showing an urgent need to reveal their personal report.

Moreover, the patients performed their self-disclosures of personal experiences with various interactional practices, highlighting the urgency of their account. The means for depicting the need and urgency of telling included expressive (and sometimes rude) words and idioms, ECFs, a loud voice, dramatization through stories, a complaining tone, rhetorical questions, and overriding the clinicians' efforts to take a turn.

In these actions of the psychiatric assessment interview, the patient took the conversational space and control from the clinician's diagnostic inquiry, momentarily going 'against the grain' of conversation, in other words, they must use effort to produce their account.

6 DISCUSSION

6.1 Main findings

According to the five aims of the studies (section 3), the main findings are presented in the same order.

1) Regarding the randomized pilot study, the collaboration between the clinician(s) and the patient was compared in two different assessment procedures, the AAU and a new assessment method applying DSA-based case formulation. The study aimed to identify the patients' needs and expectations regarding psychiatric treatment. Using the WAI-P and WAI-T as the main indicators, the appraisals of the patient and the clinician(s) were compared at end of the assessment period. The comparison revealed a marked correlation in the DSA group, indicating clear *convergence of the working alliance* between the appraisals of the patient and the clinician(s) concerning the treatment Goal, Tasks, Bond and Total scores. Slightly better WAI appraisals were observed on the part of the patient and clinician(s) in the DSA group than in the AAU group, but the differences were not statistically significant. In the AAU group, in the treatment Bond subscale of WAI, a moderate correlation was detected between the appraisals of the patient and the clinician(s), but not in the other subscales and not for the Total scores. Consequently, by implementing DSA-based case formulation in the psychiatric assessment phase, it is possible to achieve better congruence – *shared understanding* – between the appraisals of the patient and the clinician(s) regarding the treatment plan (Study I).

2) In the randomized controlled pilot study, some differences were found in resources and time-use between the DSA and AAU groups. The number of visits was fewer and the assessment period was shorter in the DSA group than in the AAU group. Respectively, the DSA-based assessment proved to

be more *convenient* for the patient, and the treatment could start earlier than in the standard psychiatric assessment process (Study I).

3) In comparing the interviews in Study II, the findings indicated that in the DSA-based interviews, the patients could describe their negative subjective experiences significantly more frequently than in the AAU interviews (Study II).

4) In the DSA-based interviews, the clinician provided experience-oriented questions for the patient's account of subjective experience in most cases, whereas in more than half of the cases in the AAU interviews, the clinicians oriented themselves to the medical domain that preceded the patient's account of subjective experience. Similarly, in most of the cases in the DSA interviews, the clinician continued the experiential focus in their receiving next turn to the patient's account of subjective experience. In contrast, in the AAU interviews, the clinician usually shifted the topic towards a medical or factual inquiry. Based on these findings, the DSA-based interview offered the patient *favourable interactional circumstances* to provide their account about a problematic subjective experience. In contrast, in most cases, the AAU interview does not advance such talk about problematic experiences, and the patients must put effort into revealing their subjective experiences (Study II).

5) In Study III, the previously gathered data from ten psychiatric interviews was qualitatively analysed in further detail using CA. Investigation of the four different conversational trajectories that were discovered, revealed that the patients performed and legitimated self-disclosures of subjective negative experiences with various interactional practices, highlighting the *need and urgency* of their account. The conversational control of the patients gradually increased from the first to the fourth group. The patients legitimated their self-disclosures of personal experiences with various interactional practices. The means for depicting the urgency of telling included expressive words and idioms, ECFs, a loud voice, dramatization through stories, a complaining tone, rhetorical questions and overriding the clinicians' efforts to take a turn. The patient took the *conversational space and control* from the clinician's project of diagnostic inquiry, going momentarily 'against the grain', in other words, they must use effort to produce their account and accomplishing their own divergent interactional project (Study III).

6.2   Discussion of the results

6.2.1   DSA-based case formulation and patient-centredness in the psychiatric assessment

As noted earlier, the psychiatric diagnosis is an essential tool in the assessment of mental disorders, but it is not sufficiently individual. As presented in the literature review, several publications and the current psychiatric educational textbooks recommended the ideal psychiatric diagnostic interview with the general principle of *patient- or person-centredness*, emphasizing the role of the *therapeutic alliance*. By implementing the DSA-based case formulation in psychiatric assessment interviews, the author and her colleagues designed this clinical pilot study to investigate and possibly advance legal and ethical patient-centredness in this institutional context.

In Study I, the working alliance was the key indicator for investigating the patient's and the clinician's viewpoints regarding the agreement on treatment goals, tasks, and the development of a therapeutic bond (Bordin, 1979). By comparing the standard psychiatric assessment period with the DSA-based assessment period at the group level, the findings demonstrated a marked correlation in the DSA group (*rho* = 0.62; see Figure 2). This correlation indicates *convergence* between the patient's and the clinicians' viewpoints, or interpersonal *congruence of the working alliance*. Sinclair (2013) noted that the degree of alliance congruence implies the level of convergence between the patient's and the clinician's views concerning the working alliance, including the three elements determined by Bordin (1979): treatment targets, tasks and the bond.

As far as known there have been no previous studies examining the congruence of the working alliance between the patient and the clinician(s) in a psychiatric assessment. Nonetheless, researchers in the field of psychotherapy have largely investigated the role of the alliance in the therapeutic relationship. Several studies have demonstrated that among others, the alliance, goal consensus, collaboration, empathy, positive regard and affirmation are "demonstrably effective" elements of the therapeutic relationship. The therapeutic relationship has an evidence-based effect on the treatment outcome regardless of the theoretical background or type of

psychotherapy (Norcross, 2010; Norcross & Wampold, 2011; Tryon & Winograd, 2011; Wampold & Imel, 2015; Zilcha-Mano, 2017; Norcross & Lambert, 2018).

In their meta-analysis, Georgina Tryon and colleagues (2007) investigated the congruence of client and counsellor alliance ratings in 53 studies presenting different forms of counselling and psychotherapy. They observed that the working alliance ratings of clients and therapists were only moderately correlated (mean $r = 0.36$). In the AAU group, the convergence of WAI lies in the lower range of their meta-analysis results (Tryon et al., 2007).

Recently, Volker Tschuschke and colleagues (2020) investigated the impact of patients' and therapists' views on convergence of the treatment alliance and the treatment outcome. Their naturalistic study revealed that a converging alliance between participants during the therapy process highly correlated with the treatment outcome and suggested that it primarily depends on the therapist's professional competency whether s/he empathizes appropriately with the patient's expression.

Similarly, according to the work of Del Re and colleagues on previous psychotherapy research, the therapist's impact is relevant in the alliance–outcome relationship (Del Re et al., 2021). Moreover, in their meta-analysis, Libby Igra and colleagues (2020) recently investigated the perspective of clients with schizophrenia spectrum disorders, personality disorders and substance abuse disorders and their therapists on the therapeutic alliance. According to the findings, the client's diagnosis – even severe mental disorder – did not affect the therapeutic alliance between the participants. However, they found that the type of alliance instrument could moderately modify the therapeutic alliance outcomes. Based on the reviewed research, it appears that the therapeutic alliance is a significant and independent phenomenon in the therapeutic encounter, regardless of the type of psychotherapies and possibly even the diagnosis.

However, in Study I, the convergence of the working alliance was only investigated at the end of the assessment period, which is the starting point for the treatment plan. Furthermore, the psychiatric assessment's purpose is more diagnostic than a psychotherapeutic evaluation. Nonetheless, any visit for a mental health problem, purposing diagnosis or not, always has therapeutic relevance from the first moments of the encounter.

Using a coherent set of high-level concepts (section 2.5 and 4.3.1), the DSA-based assessment procedure guided the clinicians' perception of the patients' significant life events, personal meanings and interpersonal experiences in their life contexts. Moreover, this flexible method may expand the patients' self-observation and understanding of their unique problems, behaviours and attitudes. This

individualized interview strategy invites, or prompts the patient to collaborate in recognizing their recurrent maladaptive patterns of thoughts and actions and invites them to modify or relate to them in a more functional way.

A possible explanation for the differences in the congruence of the working alliance is that the DSA-based case formulation primarily dealt with the patient's subjective problematic experiences within their life context, conveying recurrent patterns of thought and actions. During this process, the patient's account reveals the crucial symptoms, and the clinician can eventually clarify the necessary diagnostic issues, risk behaviour and other relevant considerations (laboratory tests, medication, statements of social security). In the standard AAU assessment process, mostly focusing on the generalized diagnostic categories, the patient's account of personal events and experiences in their life context tent to receive less attention.

At this point, the work of Stephen Finn and Mary Tonsager (1997) on psychological assessment is worth mentioning. They presented the shortcomings of the psychological assessment procedure when using a traditional information gathering model targeting neutral 'objectivity'. This assessment to some extent parallels the usual psychiatric assessment, which gathers information in terms of already existing categories or sets of symptoms. The authors introduced the Therapeutic Assessment Model to enable a comprehensive psychological assessment that is complementary to the information gathering model. By collaboratively employing personalized test feedback, further advancing the client's 'self-discovery', this model still maintains the reliability and validity of the psychological assessment process. For example, the MMPI-2 (Minnesota Multiphasic Personality Inventory) examines personality features and psychopathology (Finn & Tonsager, 1992; 2002; Finn & Martin, 2013).

John Poston and William Hanson (2010) demonstrated in their meta-analysis (17 studies) that the psychological assessment with therapeutic applications could serve as an effective brief therapeutic intervention. In a similar way, by using specific feedback strategies, the DSA concepts can organize and clarify the patient's life events and experiences for a case formulation over and above a diagnosis, while considering their needs, values and preferences. Thus, DSA-based psychiatric assessment may also work as a brief therapeutic intervention; moreover, it promotes the co-construction of the individual treatment plan.

The second goal of Study I was to investigate whether there were any differences in the employee or time resources used between the two assessment processes. The number of visits was fewer and the assessment period was shorter in the DSA group than in the AAU group. DSA-based assessment proved to be more *convenient* for the

patient, and the treatment could start earlier than in the standard psychiatric assessment process.

However, there were no significant differences in employee resources, because the clinicians intentionally worked more often in pairs (during the study, the DSA training was still ongoing), and they took a break within the first visit to use their expertise and negotiate a preliminary case formulation.

Previously, among others, Person-centred integrative diagnosis (PID) (see section 2.2.2, Mezzich, 2010, 2016b) presented as time-consuming evaluation. In contrast, the DSA-based assessment in this study is shorter than the standard assessment process. The possible explanation is that this method organizes the information revealed by the patient in a different way for the diagnosis and for a coherent case formulation.

At the beginning of an encounter, DSA-based assessment challenges clinicians' general tendency to maintain control and their authority in the institutional interaction, requiring them to leave their presuppositions about the patient's medical condition and to attend, empathize and/or affiliate with the patient's lifeworld experiences. Nonetheless, it may also be more appropriate for the clinician, because achieving a mutual understanding helps their clinical work. It reduced the clinician's emotional distress comparing with situation when the interactional tension between the participants is salient.

Based on these findings, it is possible to assert that DSA-based case formulation can refine an individual diagnostic assessment by advancing a shared understanding of the treatment plan in a patient-centred way. Ultimately, it improves the quality of the psychiatric assessment process and shortens the time spend on it while using the same amount of resources. DSA-based case formulation is teachable and learnable, similarly to the categories of the diagnostic classification. Moreover, it can help in targeting an appropriate individual psychiatric evidence-based intervention.

6.2.2   Patient-centred actions in naturally occurring psychiatric interviews

As reviewed in section 2.1.3, regarding the current categorical diagnostic classification, the subjective experiences of patients with their lifeworld context have received less attention in psychiatric assessment. In Study II, the comparison of two different kinds of interviews revealed that patients have more opportunities to

disclose their personal experiences in DSA-based interviews than in the standard interviews. Moreover, it was found that patients must momentarily use effort to reveal their subjective experiences within the medical realm, because the clinicians do not invite nor topicalize them.

The result is positive in terms of the value-based and ethical principle of patient-centredness in the DSA-based interviews. However, as realized in the clinical work, psychiatric patients do not always want to, or are not always able to talk about their personal, intimate experiences, because they may feel vulnerable, anxious, shy and/or helpless. Nonetheless, as reviewed in section 2.3.2, they still expect the clinician to consider their needs and perspectives; this encourages them to occasionally reveal their lifeworld experiences.

Furthermore, Laura Thompson and colleagues (2016) investigated the effect of so-prefaced declarative questions (for example: '*So, you feel a bit anxious*') in psychiatric consultations, showing close attendance and empathy with the patient's experiences. Their findings indicated that the frequency of these declarative questions is slightly positively correlated with the treatment alliance and adherence. Moreover, the researchers observed that declarative formulations may advance a topic transition in an empathetic way nearly with the patient's experience and promote the progress of the interview.

As presented in the results of Study II, the clinician can facilitate or restrict the opportunities of patients to disclose their personal experiences by orienting their inquiries medically or to the patient's experiences. Moreover, they guided the direction of topical expression by subsequent turns that were medically oriented or experience oriented. Earlier interactional studies in psychiatry have demonstrated that the response of the professional to the patient's subjective experiential or emotional account tends to be neutral, poor or medically oriented (Hak & Boer, 1995; Goss et al., 2008; Davidsen & Fosgareu, 2014). It needs to be borne in mind that in the usual and DSA-based interviews examined, the medical and experiential realms oscillate back and forth, and occasionally they are highly intertwined. By using the tools of DSA-based assessment, there are possibilities to advance the clinicians' skills to attend to the patients' needs, values and preferences in a patient-centred way.

The subjective experience of patients is not only important for themselves, but also relevant in evaluating the *clinical significance* of the mental problem – or set of signs and symptoms – and in creating the individual treatment plan. In the best case, the clinicians also give the patient some opportunities to reveal personal experiences and listen actively and empathically in standard interviews. However, there are no

relevant concepts to organize the experiential data. Thus, the categorical diagnostical evaluation dominates in clinical reasoning.

In a recent qualitative study, Hanna-Mari Hilden, Lotta Hautamäki and Jyrki Korkeila (2021) interviewed 13 physicians (10 psychiatrists and 3 residents in psychiatry) about their clinical experiences concerning shared decision making in Finnish mental healthcare. They presented three different alternating standpoints of discourses from which the clinicians approached the patients' treatment decisions. These were the medical standpoint, the psychodynamic standpoint and a patient-centred approach. The authors reported that in all discourses, the evidence-based guidelines were emphasized in diagnostic and treatment decisions within various limited resources of organizations, not having helped to strengthen the patient's agency appropriately. Thus, the ideal shared decision-making is not easy to reach.

Nonetheless, the DSA method can help clinicians face the challenges in achieving mutual understanding about a treatment plan. In attending to the lifeworld experiences of patients in the DSA method, patients may be able to organize their thinking and observations about themselves, showing and validating how reasonable the clinician's responses and formulations are.

The way by which patients approaching the clinician's formulations expresses the direction to which their self-understanding can be deepened and what can be talked about. This is referred to as movement in a patient's or client's *zone of proximal development* (ZPD), as introduced by Vygotsky (1978). This concept may help to understand and advance the ability of patients' self-observation or self-reflection, concerning their recurrent maladaptive activities or descriptive symptoms and diagnostic categories. Negotiating these themes together with patients point at the ways in which their individual agency could be freer and more functional.

In Study III, in-depth qualitative conversation analysis was conducted on the interview sequences. The key phenomenon was the response of patients as they disclosed their subjective negative experiences after the clinician's medically oriented questions. The data from the two different types of interviews were combined. The clinician's medical questions invoked a description of the life and circumstances of the patient concerning specific symptoms or other features of the patient's medical status. In their answers, the patients might 'go against the grain' of conversation with self-disclosures of subjective experience, legitimating the matters under discussion as their 'investment' by specific practices of emphasising (Edwards, 2000; Whitehead, 2015).

As mentioned in the results (section 5.3), the patients performed their self-disclosures of subjective experiences during four different trajectories, using gradually increasing effort, interactional space and control to reveal them. In this conversational action of self-disclosure, the patients utilized various interactional practices, highlighting the *need and urgency* of their account. The means for depicting the urgency of telling included expressive (occasionally rude) words and idioms, ECFs, a loud voice, dramatization of stories, a complaining tone, rhetorical questions and occasionally overriding the clinicians' attempts to take a turn. In these actions of the psychiatric assessment interview, the patient took the conversational control from the clinician's diagnostic inquiry, momentarily going 'against the grain' in other words, they must use effort to produce their account. These actions support the relevance of patient-centredness of the psychiatric interviews.

Nonetheless, as observed and recognised in clinical work and research, patients with different clinical mental conditions or disorders, for example severe depression or social phobia, may be shy, helpless, anxious and withdrawn (Vanheule & Hauser, 2008). They may feel shame or fear of stigmatization, thereby not being able to disclose their personal, intimate experiences 'against the grain'. Thus, they may expect encouragement and empathetic understanding from the clinician (Muntigl, 2016). While our data occasionally revealed even rude expressions, they remained relevant; thus, the data may indicate maladaptive behavioural features of the psychopathology of patients or their ordinary agency in the interaction.

Based on interactional research, Schegloff (2007) reported that the orientation of participants generally persists over the sequences of a conversation. Levinson (2013, p. 127) elaborated and described such orientation by stating that "actions often form a part of a larger project inheriting part of their import from the larger whole." Accordingly, in the institutional context of this study, the clinician's questions expressed their orientation of gathering medically relevant diagnostic information, selecting them from wider experiential realm of the patients. Furthermore, in this study, the patient's interactional project displayed a need to share and complain during the self-disclosure of personal life experience. According to the four different trajectories, the patient's control of the interaction momentarily increased. Thus, a 'clash' of interactional projects for a moment was observable. As mentioned earlier in the review (section 2.3.2), this 'clash' mediates a mismatch and tension between the perspectives or priorities of patients and clinicians (McCabe, 2002). These differing projects are unaware of each other's; however, they can negotiate with each other; still, the patients must utilise emphasising practices to disclose them. Based on research literature, it is possible to note that when the projects of patients are

designed to share and complain about their problematic life experiences, they seek an empathetic understanding or affiliation (Jaspers, 1968; Voutilainen et al., 2010; Peräkylä, 2011; Heritage, 2011; Sorjonen & Peräkylä, 2012; Weiste & Peräkylä, 2013; Muntigl, 2016; Weiste et al., 2016). Nonetheless, in the case of psychiatric interviews, the clinicians rarely engage or present empathetic responses to the patients' emotional cues or expressions (McCabe et al., 2002; Del Piccolo et al., 2012; Davidsen & Fosgareu, 2014). Still, the patient's conversational project also has a diagnostic function, correcting, for example, diagnostic argument, as occurred in the prototypical example in section 5.3.1. One patient complained about lifelong *'anxiety'* instead of hypomanic symptoms, and another patient revealed possible maladaptive behavioural features associated with *distress* about the *'uncle'* in section 5.3.2. and 5.3.4.

While the way in which the clinician receives the patient's self-disclosure was not analysed in Study III, preliminary findings on these actions, named medically- or experience-oriented next turns, was presented in Study II. More frequently in DSA-based interviews than in AAU interviews, the clinicians produced formulations or follow-up questions, giving an opportunity to the patients to elaborate their account of the subjective experience. The DSA-based assessment interviews were more favourable for these 'third' actions than were the standard interviews. Study II revealed that the clinicians moved toward the medically oriented subsequent turns more frequently in the standard assessment interview than in DSA-based interviews. The clinician's medically oriented subsequent turns were formatted as formulations or questions concerning medical or factual topics or ancillary topics.

These voluntarily expressed and emphasized, personal and intimate 'bonus' accounts, meaning the self-disclosures of subjective experience by patients, can help in searching for the clinically *difficult to reach border* between mental health and mental disorder. Additionally, by displaying appropriate empathetic responses after a self-disclosure of personal experience, the clinician may promote the patient's ability for self-observation and offer the possibility to advance the patient's agency. Moreover, the clinician may eschew a *medicalization* of the patient's mental condition (Louhiala & Hemilä, 2005; Tikkinen, 2017; Raivio, 2020; Reito & Tikkinen, 2020). Furthermore, self-disclosures can provide relevant information for the diagnostic evaluation and contribute a case formulation to promote an individual treatment plan in a patient-centred way.

6.3   Discussion of methods

This research project was possibly the first to investigate the working alliance between patients and clinicians in the diagnostic assessment procedure. Moreover, this project increased the number of rare interactional studies that have analysed the naturally occurring interaction in psychiatric assessment interviews, comparing two different approaches. This clinical trial located in the public mental healthcare system, thereby possessing ecological validity. By maintaining a natural clinical context and relatively wide inclusion criteria, there was an attempt to approach realistic and lifelike arrangements of the psychiatric assessment procedure.

As the 'gold standard', randomised controlled trials are used widely in investigating the effectiveness of pharmacological and other medical treatments. For example, drugs and technical medical treatment methods can work as independent outcome variables; however, psychotherapeutic interventions depending on the participants' interaction and responsiveness to each other, are not independent variables, in the same way, indicating challenges in correlation analyses and outcome interpretations on the effectiveness of different psychotherapies (Stiles, 1994; Leiman, 2004b). This RCT pilot study in the natural environments of psychiatric assessment interviews is reminiscent same challenges as in psychotherapy research.

The natural clinical environments conveyed the *benefits* as well the limitations of the research project. The samples were randomly chosen from those who sought help and treatment voluntarily instead of deliberate recruitment. The researchers wanted to maintain the natural clinical process; hence, randomization was performed with knowledge and information of the patients' referrals arrived in the community mental health centre. The written informed consent was required and obtained for all patients at the first visit. When the patient rejected their participation in the study, the diagnostic assessment process was conducted in a usual way, whether the clinicians worked in AAU-group or DSA-group.

The DSA group and the AAU group were recruited from the same socio-demographically heterogeneous population, although this was not analysed in detail. At baseline, using a self-report questionnaire, no differences were recorded in the total or subscales scores of CORE-OM. Accordingly, the groups and the results appear to be comparable.

Based on the research literature on CA, it is clearly a very suitable method for analysing medical or psychiatric interviews. Talking is the core activity that co-

constructs the evaluation, explanation, information exchange, empathetic understanding and treatment recommendation between the participants in naturally occurring interactions. The interactional practices of the participants show their relation to social actions and each other (Sacks et al., 1974; Heritage, 2009; Ruusuvuori, 2000; Heritage & Clayman, 2010; Peräkylä & Vehviläinen, 2003; Peräkylä, 2016). The *validity* of CA as a qualitative research method is based on fine-grained testing and the way that the veracity of the analytical claims mirrors the reality of the selected environment. In CA studies, the data can demonstrate the validity of the researcher's analytical claims. Due to the sequential structure of interaction, the next speaker almost invariably shows their understanding of the prior speaker's turn. The next speaker's interpretation of the prior speaker's turn thus shown is also the primary instance of validation of the conversation analytical researcher's interpretations regarding the meaning of utterances (see Sacks et al., 1974). Moreover, the transparency of the research process and other researchers' control supports the validity of an analytical claim based on CA. Participating in data sessions together with experienced CA researchers and reflecting on personal preconceptions clarifies the research process and the outcomes of the study. Additionally, using statistical techniques supports the generalizability of the research findings (Peräkylä, 2016).

Nonetheless, these studies also have *limitations*. In the randomized controlled pilot study, the sample size was relatively small, and the statistical power of the results was thus limited. As known, a correlation indicates common variability in one outcome variable. However, it shows a probability of dependence between two variables, and it is not an indication of the evidential causality. Because of the naturalistic environments of the research project, many of the uncontrolled variables may affect the outcome.

Furthermore, the self-assessment tool, the Working Alliance Inventory (WAI-P, WAI-T), was originally validated for assessing a dyadic process of counselling or psychotherapy. In Study I, the target of the psychiatric assessment was different from the target of psychotherapy, although both have a therapeutic impact. Furthermore, at the time of the treatment planning visits when the WAI had been completed, there were more than two participants (two clinicians and the patient), which might influence the appraisal of the WAI. In the DSA group, the number of visits was less than that in the AAU group, and the final visit was thus earlier. Accordingly, the WAI questionaries were completed earlier than in the AAU group, which may have affected the results. Nonetheless, previous studies in psychotherapy research have assessed the working alliance and convergence in the early phase, between sessions

one and five (Horvath & Bedi, 2002; Flückiger et al., 2012; Marmarosh & Kivlighan, 2012). Thus, the mean number of visits in Study I was comparable with previous studies in psychotherapy research.

Additionally, in Study I, there were some differences between the two groups in the educational backgrounds of the clinicians. The DSA group included psychiatrists and psychologists, but in the AAU group, there were also psychiatric residents and nurses conducting the study protocol. All the professionals had several years of clinical experience. Nevertheless, the differing expertise of the clinicians might have impacted on the findings to some extent.

Moreover, application of the DSA method requires two years of training (nowadays one year) and supervision. At the time when the study protocol began, the professionals of the DSA group were still learning the strategy of the DSA-based interview, while the professionals in AAU group continued their ordinary work. Moreover, the professionals in the DSA group participated in supervision 16 times a year, while those in the AAU group participated in supervision ten times a year. It needs to be borne in mind that these differences partly affect the outcome as the Hawthorne Effect (Chiesa & Hobbs, 2008). Furthermore, the author was one of the six researchers contributing to the DSA-based assessment intervention that can implicate unintentional bias that can influence the results. The enthusiasm of the researchers towards DSA training can also affect the results. However, it was not possible to examine or rule out these variables in more detail.

It should be noted that training on the DSA strategy is arranged annually for professionals who have encountered people with various mental and social problems. Nevertheless, the implementation of the DSA method is limited.

Furthermore, there were some limitations in Studies II and III. These studies investigated only ten naturally occurring psychiatric interviews; thus, the small sample size – regardless of the careful matching procedures and interrater process – may have biased the results. Coding the interview data with Mishler's (1984) binary distinction between medical and experiential realms is a simplification. However, it was necessary for the analysis and for the quantification of the naturally occurring data. During any moment of talk, both realms are in some way intertwined, and this might momentarily affect the different actions of the participants or their interactional projects.

Furthermore, the variety of mental disorders among the patients might have affected and limited the significance of the results to some extent. Additionally, these analysed sequences do not display all the details of the whole assessment interviews,

although they mediate relevant knowledge about the participants' interactional projects and orientation.

6.4 Suggestions for further investigation

In the future, more studies should be carried out with larger sample sizes to investigate the outcomes of the evaluation and treatment, as well as the cost-effectiveness of this case formulation in the larger clinical field. From the recorded interviews, the medical and experiential realms demand a more detailed articulation of conversation analysis, investigating interviews in wholeness. Further findings may advance the evaluation of the diagnostic work and the patient-clinician relationship. Moreover, from the gathered data, the subsequent action of clinicians after the self-disclosures of personal experience by patients will also be a relevant task to investigate in more detail, which may provide additional clinical benefits. It would be important to investigate the effect of different mental disorders on the interaction in naturally occurring psychiatric interviews and to investigate whether there are any repetitive or typical interaction features in specific mental disorders or characteristics that might be utilized in the diagnostic evaluative procedure.

7 CONCLUSIONS

Overall, it can be viewed that the complexity of mental disorders has pros and cons. It may mean 'richness', offering multifaceted approaches and research opportunities for their evaluation and treatment. However, it can also be a source of insecurity or tolerance of uncertainty. The diagnostic classification is an inevitable means to comprehend and treat the complex nature of mental illnesses. Nonetheless, the current categorical psychiatric diagnostic classifications describe and define an average patient's mental illness and provide evidence-based treatment methods for an average patient. Individual variation is abundant within the diagnostic categories, and a single patient may have multiple diagnoses.

This naturalistic comparative study attempted to investigate and possibly advance the psychiatric assessment from an individual and *patient-centred* perspective. Preliminarily, by implementing DSA-based case formulation in the psychiatric assessment, there are possibilities to achieve better congruence of the working alliance – a *shared understanding* – between the patient's and the clinicians' appraisal on the treatment goal, tasks and commitment. Furthermore, the DSA-based assessment period was *shorter* as well as *more convenient* for the patient than the standard assessment. In the future, more studies should be carried out with larger sample sizes to investigate the impact on outcome measures of the treatment and the cost-effectiveness of DSA-based case formulation in a larger clinical field.

While the psychiatric interview as an institutional interaction is asymmetric and clinicians remain experts of their profession in one regard, patients are 'experts' of their lifeworld experiences in another regard. The narrative of the patient always involves their *lifeworld experiences* with cultural and social backgrounds and contexts. The mental health experiences of patients are more than a diagnostic category, and this dissertation has aimed to demonstrate some part of its clinical relevance. In the naturally occurring interviews, it was observed that patients have a *need and urgency* to disclose their subjective problematic experience voluntarily as a surplus account, over and above the medical inquires. Thus, there might be divergent orientations that appear momentarily in the conversation as an interactional 'clash' or at least interactional tension. These actions may mirror the desire of patients to share their concerns and seek acceptance and understanding for them, and this may call for a

further clarification of patient-centredness in a larger and more detailed set of psychiatric interviews.

As discussed above, it is possible to state that the DSA-based interview offered the patients *favourable interactional circumstances* to provide an account of their problematic lifeworld experiences. In contrast, in most cases, the standard interview does not advance such a narrative in the same way, and the patients must momentarily put effort into revealing their subjective experiences.

The DSA concept can provide opportunities for patients to manage and organize their lifeworld experiences, including their needs, values and perspectives, and it offers tools for clinicians advancing the patient-centred approach in the psychiatric assessment. However, further studies are warranted in order to understand the strategies of patient-centredness and the DSA-based case formulation process in psychiatric interviews.

DSA-based assessment may refine and complement the diagnostic assessment procedure, advancing shared understanding of the individual treatment plan, which would promote patient-centredness in this institutional context. Over and above the diagnosis, it may provide a consistent case formulation as a 'common denominator' to communicate between multidisciplinary staff and the patient in any mental healthcare. Respectively, it may facilitate the targeting of appropriate individual psychiatric evidence-based intervention. The diagnostic assessment may lose its purpose without appropriate investment in the therapeutic relationship, which is an inevitable factor to individually advance the patient's recovery and agency. The DSA-based assessment offers opportunities to co-construct a therapeutic relationship as well as to complement the diagnostic evaluation simultaneously; furthermore, it put a diagnosis back to the patients' lifeworld context.

Furthermore, the DSA concept is a highly ethical and human tool for approaching mental illness in the context of a helping encounter. Archiater Risto Pelkonen noted that the doctor–patient interaction always includes two levels. On the knowledge-based medical level, interaction is always asymmetrical. However, on the other predominantly humanistic level, there should be interactional symmetry between two equal human beings (Kattelus & Sariola, 2021). As long as the psychiatrist's main examination tools are conversation and observation, the patient's knowledge about subjective lifeworld experiences represents the ground for clinical diagnostic work. Inherently, the medical and humanistic level are more intertwined in psychiatry than in other fields of medicine. Regarding the multifaceted nature of mental disorders, the relevance of the humanistic level of psychiatric interaction is or should be self-evident (Messas et al., 2017). Recently, Amos Pasternack and

colleagues (2020) viewed the relevance of humanities and arts to medical education in Finland, because the heart of medical sciences is not just natural science, but rather *human beings* themselves as the healers and receivers of help.

By clarifying and conceptualising the patient-centredness in psychiatry in the same way as psychiatrist and psychoanalyst Michael Balint (1957) introduced this approach – orientation to the patient as a 'whole human being' – to general medicine in his time, the psychiatric profession could be a flag bearer of humanism in today's medical sciences. In general, psychiatry suffers from a shortage of professionals; thus, by increasing the opportunities for approaching the multifaceted mental phenomena and their treatment, it may improve the image of the field and increase the attractiveness of the psychiatric profession.

7.1   Clinical research implications

By implementing DSA-based case formulation, clinicians can refine and complement the psychiatric diagnostic evaluation in a patient-centred way, promoting the co-construction of an individual treatment plan. Some patients are open to bringing their lifeworld experiences to the interview; however, some patients need encouragement in revealing their personal experiences and perspectives. DSA-based interactional strategies can help clinicians to recognize and understand the problematic lifeworld experiences and maladaptive action patterns of patients, also may advance their self-observation and individual agency. Moreover, DSA-based case formulation may facilitate the individual targeting of appropriate psychiatric evidence-based intervention.

Finally, at the end of the Introduction (section 1.) was a clinically significant question: whether the focus of the treatment plan is on the symptoms or addressing obstacles to individual agency. Grounding on the integrated results, the answer suggests that clinicians need to be aware of and acknowledge the relevance of both. Nevertheless, clinicians should focus on issues that they can clarify and elaborate *mutually* with the patient in the psychiatric encounter.

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PUBLICATIONS

PUBLICATION
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Implementation of Dialogical Sequence Analysis as a Case Formulation for the Assessment of Patients at a Community Mental Health Centre: Randomized Controlled Pilot

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IMPLEMENTATION OF DIALOGICAL SEQUENCE ANALYSIS AS A CASE FORMULATION FOR THE ASSESSMENT OF PATIENTS AT A COMMUNITY MENTAL HEALTH CENTRE**

Randomized Controlled Pilot Study

Background: We implemented a case formulation method, which is based on dialogical sequence analysis (DSA) in a community mental health center. The aim was to achieve better congruence and collaboration between the patient and professionals concerning the tasks and goals of the assessments. Here we report a randomized clinical study in which we compare DSA-based and standard psychiatric assessments.

Methods: In this randomised clinical study, we compared DSA-based and standard psychiatric assessments. There were 40 outpatients in both, the DSA and the assessment as usual (AAU) groups. We recorded the lengths of individual assessment periods, the number and durations of visits, and the numbers of clinicians who were involved in the various phases of assessment. The Working Alliance Inventory was completed by the patients (WAI-P) and the clinicians (WAI-T) during the treatment planning (i.e. final) visit.

Results: In our results, the total WAI-P and WAI-T scores and all WAI subscale scores correlated significantly in the DSA group (Spearman's rho = 0.562–.667, $p < 0.01$). In the AAU group, the only significant – albeit weaker – correlation was found in the WAI Bond subscale (rho = 0.369, $p < 0.05$). Compared to the AAU group, assessment periods were shorter and the number of visits were fewer in the DSA group.

Conclusion: Our findings are clinically notable. They show that the patient-centred, DSA-based case formulation complements psychiatric assessment in a collaborative way and results in a better joint understanding regarding the patient's problems and needs in a shorter time period than the standard assessment.

1. Background

In addition to causing suffering to patients and their families, mental disorders place a burden on societies around the world. In the ageing West, they are the major cause of work disability among both middle-aged and younger people (JÄRVISALO et al. 2005). There is an urgent need to develop appropriate, accurate, and pragmatic methods of psychiatric assessment to enhance individualised and patient-focused treatment.

As is generally known, the aetiology and the pathophysiology of psychiatric illnesses are still mostly unidentified; thus, the diagnostics of mental disorders are mainly determined (e.g. ICD-11 and DSM-5) by symptoms and as syndromes (World Health Organization 2018; American Psychiatric Association 2013). Interacting with the social context and cultural background, the symptoms are manifested through the patient's problematic behavioural, emotional, and cognitive functions. As ANDREASEN and BLACK (2001, 23) note, 'Diagnosis helps to simplify our thinking and reduce the complexity of the clinical phenomena in psychiatry'. Moreover, CRADDOCK and MYNORS-WALLIS (2014) state that psychiatric diagnosis is necessary and important, but the 'diagnosis alone is insufficient in conceptualising psychopathology in any individual patient. Diagnosis should be part of a formulation that brings together aetiology, severity, and functioning and should lead to a management plan' (93). MEZZICH and SALLOUM (2007), MEZZICH and colleagues (2016) have constructed the model of Person-centered Integrative Diagnosis (PID) to advance the patients' psychiatric evaluation comprehensively. In a quite recent editorial, MAJ (2018) suggested that the current diagnostic classifications would be complemented systematically with alternative approaches promoting the patients' individual therapeutic management and prediction of outcome.

As is known, the descriptive and symptom-oriented psychiatric diagnostics have *proven reliability*, but their validity is much more uncertain (ANDREASEN & BLACK 2001). One of the weaknesses of current psychiatric diagnostics is that they do not provide a definitive direction for appropriate, individualised psychosocial treatments or define the appropriate rehabilitation methods reliably, because they permit a large variation in any diagnostic category. However, in the era of evidence-based medicine, diagnosis provides the basis for treatment. The goal of usual psychiatric assessment practices is a symptom-based descriptive diagnosis upon which plans for treatment and rehabilitation and several other decisions are based.

By searching the advantages and disadvantages of diagnostic assessment work, a recent British study found that people who seek psychiatric assessment wish to receive an explanation for their symptoms and problems (BILDERBECK et al. 2014). They expect a good interpersonal relationship with their clinician(s), want to be acknowledged and listened to, and seek to be involved in and informed about clinical decisions. Furthermore, receiving a psychiatric diagnosis evokes both positive and negative responses among patients relating to stigma, personal understanding and responsibility, prognosis, and treatment. By presenting the individual needs of patients, the researchers also negotiate the limitations of the diagnostic system (BILDERBECK et al. 2014).

For a long time, medicine in general – and psychiatry, as a part of its tradition – has been a paternalistic, physician-centred institution. In recent decades, healthcare has advanced gradually towards a patient-centred approach (LAINE & DAVIDOFF 1996; MEAD & BOWER 2000). CONSTAND and colleagues (2014) have detected three common features of the patient-centred approach, namely communication, partnership, and health promotion. Communication was the most consistently emphasised phenomenon. Patient-centred approaches are based on the assumption that the patients can care for their own health and social relationships through their actions, choices, and decisions. These approaches take place in the interaction between the patient and the clinician, during which the clinician tries to focus on the patient's experiences, needs, hopes, and expectations. Psychiatric assessment tools are more limited compared to those in the somatic fields of medicine. One of the psychiatrist's tools is the interaction with the patient, which is usually a dyadic, mutual, and constantly changing process, and this interaction is challenging to conceptualise and operationalise using scientific methodology. MEAD and BOWER (2000) have considered and recommended some conceptual dimensions for the measurement of patient-centeredness, including the therapeutic alliance. In psychotherapy research, the working alliance has repeatedly been shown to be an effective part of a good treatment outcome (NORCROSS & WAMPOLD 2011). The working alliance concept incorporates three components: agreement on goals, agreement on tasks, and the development of a therapeutic bond (BORDIN 1979). The working alliance is operationalised through a variety of measures, and these instruments can be used to measure the important aspect of the quality of the clinician-patient relationship and the degree of mutual understanding in terms of the goals and tasks of treatment in the clinical condition (HORVATH & GREENBERG 1989). The degree of alliance congruence indicates the level of convergence between the patient's and the clinician's viewpoints of the three components of the working alliance (SINCLAIR 2013). TRYON, BLACKWELL and HAMMEL (2007) have conducted a meta-analysis of the studies on client and therapist congruence. They found a moderate positive mean correlation (*mean r* = .36) between the therapists' and the clients' alliance ratings. MARMAROSH and KIVLIGHAN (2012) have explored the working alliance agreement between the client and the counsellor in two studies. They found that higher alliance convergence was associated with the smoothness – but not with the depth – of the

therapy session. Furthermore, more symptom change at the end of the treatment was associated with higher alliance agreement at the beginning of the treatment.

1.1. Case formulation as patient-centred care

In psychotherapy research, PERSONS (1991) introduced the idea of an individually conceptualised therapeutic case formulation to improve the therapeutic relationship. In the 1990s, EELLS outlined a working definition for psychotherapy case formulation: it is a 'hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioural problems' (1997, 1). Since then, various case formulation methods have been developed (EELLS 1997; JOHNSTONE & DALLOS 2014). There is some evidence that when a psychotherapy assessment is based on a case formulation, the treatment outcome is superior – or at least equal – to standard treatment (SCHULTE et al. 1992; GHADERI 2006; ALLEN et al. 2016). Outside the field of psychotherapy, case formulation is a rare approach for assessing patients within general psychiatry. For example, FERNANDO and colleagues (2012) have suggested an individual psychiatric pattern-based formulation methodology, based on the renowned theoretical models of psychiatric psychopathology, for the development of trainees' and students' skills to complement the diagnostic work and advance the treatments more individually.

1.2. The current study

Based on our clinical experience with the usual psychiatric assessments together with the above-mentioned considerations, we conducted a randomised clinical trial in a community mental health centre in Finland. The Finnish mental health services are stipulated by *Mielenterveyslaki 1116/1990* [Mental Health Act] (1990). Prevention of mental health disorders, early diagnosis, and treatment are organized by municipal primary social and health services. The professionals are general practitioners, psychiatric nurses (3rd degree education), psychologists, and they have possibilities to provide a psychiatric consultation in the primary outpatient care. More severe and problematic mental health disorders, assessments, and treatments are arranged via specialised psychiatric outpatient clinics and hospital care. At this level, the professionals are also psychiatric nurses, psychologists, and physicians (psychiatrists or residents). Our study was conducted in the environments of specialized psychiatric outpatient clinics.

We implemented a case formulation method to complement the psychiatric assessment process. Dialogical sequence analysis (DSA) is a microanalytical method for analysing utterances (LEIMAN 1997; 2012). Its concept is based on Mikhail BAKHTIN's (1984) theory of utterance, which states that utterances, simultaneously, convey the speaker's position to the referential content and the recipient. DSA focuses on this twofold dynamic of content and participant in any communicative situation (*Figure 1*).
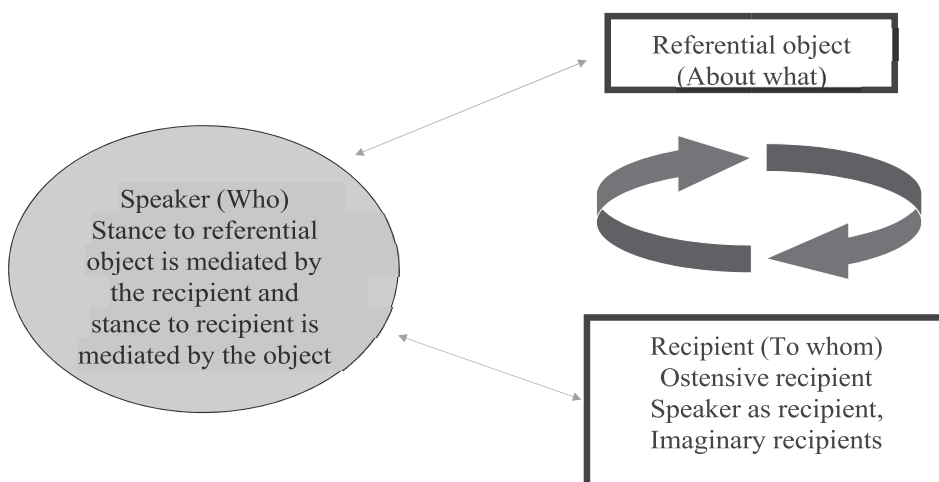
Figure 1
The double positioning in utterances

The unit of analysis is the *stance to the referential object*, bearing in mind that the speaker's stance is determined by the reciprocal relationship between the referential object and the recipient. As a simple illustration of analysis, a published excerpt of a client utterance in a counselling session (COOPER 2004) will be presented here. The referential object is in boldface and the stance in italics.

> *Counsellor:* So you're saying you *hate* that **feeling of tiredness**, but tell me more about what goes on for you when you feel it.
> *Client:* I just get this sense that **everything** is *completely pointless*. Like, why should I bother getting up, why should I go to work, what's the point of it all. It's *just* **another** *pointless* **day**: fixing printers, cleaning computer screens, reading the news on the internet. . . **It all** seems *totally futile*. I may just as well stay in bed. (COOPER 2004, 70)

The client describes vividly the personal meaning of 'tiredness' that the counsellor referred to in his request. It is worth noticing that the counsellor's turn also contains an expression of stance, i.e., hating the feeling of tiredness. The client has presumably introduced the topic before this excerpt.

The client continues his response by elaborating the hating of 'felt tiredness'.

> And I *just hate* **feeling like that**, because **it's** so *bloody stupid* and **it's** such a *bloody luxury to be able* **to say that**. . . what about all those people with one arm or who have got Aids in Africa who are so much worse off than me. **It's** so *self-indulgent*. (COOPER 2004, 70)

The client addresses the negative, dismissing stance to his everyday life, which he introduced in the first part. He now adopts a highly judgmental and critical attitude to the sense of complete futility by which he characterized his days. Both feeling it and saying it are condemned and labelled as self-indulgent.

The second part of the utterance may be regarded as a response to the first part. Clients hear what they are saying, and when answering the counsellor's request, the client adopts a conscious stance to what he has just expressed. This is an illustration of how the recipient may shape the content of the utterance, remembering that in clinical interaction, the client is one of the recipients. The stance to a referential object is affected by the anticipated response of the recipient. In this illustration, the client adopts a judgmental attitude to his personal experience, but this attitude may partly be affected by the client's assumption that the counsellor, too, will adopt a moral position toward his 'self-indulgence'.

BAKHTIN (1984) termed this double positioning *semantic position.* This implies that the stance toward an object involves networks of personal meanings and values that are manifested in the words used, the prosodic aspects of speech, the ways by which the sentences are compiled, and the nonverbal signs accompanying their utterances.

In DSA, identifying recurring semantic positions in the sequence of utterances helps generate hypotheses about habitual action patterns and their relationships within multiple domains, such as in intimate relationships or in one's relationship with oneself. By identifying a person's individual configuration of semantic positions, DSA is a useful tool in clinical case formulation. It allows the clinician to identify regularities in the patient's freely flowing talk and provides immediate feedback to assist the patient's self-observation. Appropriate and well-timed feedback has a powerfully validating effect on the patient, who experiences a sense of being heard.

More recently, DSA has also been applied in psychotherapy research. DSA, as a microanalytic method, has been used to detect clients' recurring problematic positions in early sessions (LEIMAN & STILES 2001); in-session development using the assimilation model (STILES et al. 2006; TIKKANEN et al. 2013; ZONZI et al. 2014), as well as alliance ruptures, and their repair in brief psychotherapy (GERSH et al. 2018).

1.3. Objectives

In this study, our aims were: 1) to determine how the DSA-based case formulation and the standard approach differed in terms of collaboration, especially in terms of patient and professional congruence concerning the goals and tasks of assessment; and 2) to examine whether there were any differences in the time and resources needed between the individualised and patient-focused assessment and the standard psychiatric assessment processes.

2. Methods

2.1. Study registration

The study was conducted between January 2015 and March 2017 at the Unit for Psychiatric Assessments at the Community Mental Health Centre, which is a part of Päijät-Häme Central Hospital in Lahti, Finland. The trial was registered retrospectively at the Clinical Trials Registry with the International Standard Randomised Controlled Trials Number (ISRCTN15831929) in June 2018.

2.2. Study population

There were 138 eligible patients who came in with a referral to our unit for a psychiatric assessment (*Figure 2*). The referrals were sent from primary, occupational, or student healthcare units, or from private practice. The study's inclusion criteria were as follows. First, the patient had to be 18–65 years of age. Second, the patient had to be able to understand the study's purpose and give written, informed consent.

We excluded subjects whose referral suggested any psychotic or neuropsychiatric disorders, such as attention deficit disorders and autism, or any cognitive disabilities. Secondly, patients were excluded if they had a referral for an emergency or urgent assessment (i.e. within seven days). Thirdly, the patient's native language had to be Finnish.

All randomised patients were diverse in terms of background, mental symptoms, severity of distress, limits of functioning, socioeconomic status, occupation, education, and marital status. Of the 138 recruited patients, 40 (35%) declined to participate. Six (13%) subjects in the DSA group and 12 (23%) in the AAU group discontinued the study, and in this respect, there is no significant difference between the groups ($p = 0.20$). No difference was found in the discontinuation rate between men (5/28, 18%) and women (13/70, 19%; $p = 0.93$). The mean age of those who participated in the study was 37.9 (SD = 12.6) years; the average age of those who discontinued was 33.1 (SD = 12.1) years ($p = 0.14$). There were 26/40 (65%) women in the DSA group and 32/40 (80%) women in the AAU group ($p = 0.13$). The mean ages of the study subjects were 37.4 (SD = 12.0) years and 38.2 (13.2) years, respectively ($p = 0.80$).
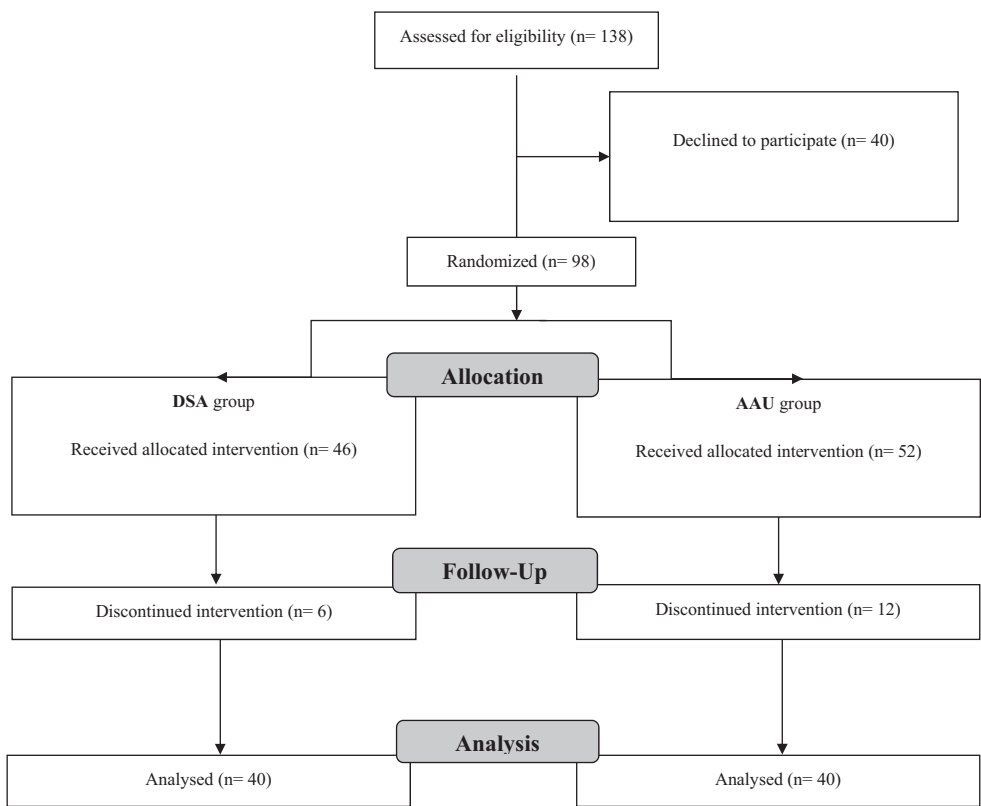
Figure 2
Patient flow in the randomised controlled trial

Note: DSA: Assessment based on dialogical sequence analysis; AAU: Assessment as usual

2.3. Study interventions

2.3.1. Assessments based on Dialogical Sequence Analysis (DSA group)

In the DSA group, the assessments were performed by three psychiatrists and three psychologists who participated in a two-year DSA training programme between September 2013 and May 2015. The DSA training was not yet completed when the project began in January 2015.

In the DSA group, the patient's first visit was conducted by a psychiatrist-psychologist pair. The visit was divided into two parts. In the first part, the clinicians focused on the patient's presenting problem. The conceptual tools of DSA-based case formulation were used when conducting the clinical interview and the evaluation of the patient's current problem.

After the initial interview, there was a 10–15-minute break, during which the clinicians discussed and formulated a working hypothesis about the patient's repetitive problematic action patterns that possibly maintained the patient's predicament and symptoms.

In the second part of the first visit, the clinicians estimated the patient's risk behaviour, possible self-harm, and psychotic symptoms. Similarly, they evaluated the patient's need for other necessary clinical interventions, such as laboratory tests or medications, and wrote statements to allow the patient to receive social security benefits. At the end of the first visit, the clinicians offered the patient a tentative formulation of the current problem, which the patient could then reflect on in order to collaborate in shaping the treatment plan. The clinicians and the patient then discussed the content of the following assessment visits and the preliminary diagnosis.

Depending on the patient's needs, the psychologist, the psychiatrist, or both conducted the following assessment visits. The purpose was to understand accurately the patients' important life events, problems, symptoms, and relationships with significant others through their accounts and reports. Additionally, by paying close attention to their gestures, facial expressions, speech prosody, postures, and behaviours, the clinicians observed the patient's stance on the addressed topic.

In the final assessment visit, which was the treatment-planning session, the clinicians and the patient aimed at clarifying the repetitive external and internal activity patterns that seemed to provoke and maintain the patient's presenting problems. Based on this joint formulation, they outlined the treatment targets and tasks. Additionally, the intent was to specify a diagnosis and identify the immediate and long-term objectives as well as the relevant patient-specific outcome indicators. The treatment plan, along with case formulation, was written in the patient's records. After the assessment phase, one of the clinicians continued the treatment according to the treatment plan and schedule.

2.3.2. Assessments as usual (AAU group)

In the AAU group, the assessment team was chosen from a group of seven doctors (psychiatrists and residents), nine psychiatric nurses, and five psychologists who worked and rotated irregularly at the Evaluation Team of the Community Mental Health Care Centre, Lahti. In the AAU group, the patient's clinical assessment and need for treatment were based on the current symptom-oriented and descriptive diagnostic evaluation guidelines of public mental healthcare. The number of assessment visits was not specified. A doctor with a nurse or a psychologist conducted the first visit. During the following assessment visits, one of the clinicians continued the evaluation of the patient's clinical condition based on the usual symptom-oriented guidelines. In the treatment-planning visit, both clinicians presented and shaped the treatment tasks and targets, and agreed on the subsequent treatment placement with the patient. If the duration of the treatment was estimated to last longer than six months, the patient's treatment was transferred to another Care Team within the same Mental Health Care Centre.

The clinicians' interview strategies were methodologically different in the AAU and DSA group. These different aspects are summarised in *Table 1*.

Table 1
Differences between the professionals' strategies in AAU and the DSA-based assessment

		AAU	*DSA*
1.	Focus	Mainly focusing on the patient's symptoms as categorized by psychiatric knowledge	Mainly focusing on the patient's internal and interpersonal subjective experiences, events, and attitudes
2.	Observation	Observing signs and behaviors that selectively confirm the set of symptoms	Observing signs and behaviors that refer to subjective experiences
3.	Communication practices	Using more closed questions, alongside structured scales and questionnaires	Using more open questions, follow-up questions, and reflections
4.	Inference	Mainly deductive thinking	Mainly inductive thinking in the first part of interview
5.	Attitude	Professional's attitude is interested and neutral. Spontaneous, yet restricted empathy may facilitate the gathering of diagnostic information.	The professional is purposefully trying to empathize with the patient's perspective to gather individually meaningful information and increase awareness of the patient's problem.
6.	Objective	Intention to form an explanation of problems based on diagnostic categories	Intention to form an individual formulation of the patient's problems, their psychosocial causes, and action patterns associated with them, thereby complementing the diagnostic process

Note: DSA: DSA-based case formulation assessment; AAU: Assessment as usual

Here, we present a few examples of DSA-based case formulation from the patients' records (the text has been modified to not identify the patients). Three diagnoses with the DSA-based case formulations:

F32.1 Moderate Depressive Episode (prolonged).
> *The patient is seeking psychiatric help for the first time in her life. Her traumatic background has shaped her attitude toward herself and to others. She sacrifices herself, she would like to repair issues, and she tries to avoid unbearable feelings from her past. On the other hand, she can be very demanding and critical, then her tone may become quite offensive to others, getting her into trouble at work. She recognizes that her feelings may stem from her traumatic past, but she is not able to change or control them. She has difficulties in limiting what she can give to others and she feels unable to ask for help.*

F33.1 Recurrent depressive disorder, current episode moderate.
> *The patient's central problem is a mood decline associated with anxiety. This combination seems to be related to strong and paralyzing feelings of guilt and shame, to which she responds with a lack of initiative and avoidance. This pattern of behaviour may protect the patient from intolerable failure, because he is very self-critical and a perfectionist, having a tendency to compete with others.*

F33.1 Recurrent depressive disorder, current episode moderate; F40.1 Social phobia.
> *In addition to symptoms of depression and anxiety, the patient suffers from social phobia. It seems that behind these is a complex of excessive demandingness, self-criticism, and judgmental stance toward self. The patient easily feels guilty and in such situations, she thinks that she does not deserve help. Her basic assumption is that she will fail and, hence, she does not dare to try, which strengthens her assumption of failure. She has begun to avoid social situations and at times she tends isolate herself.*

2.4. Measures

The Working Alliance Inventory (WAI) was originally developed for the self-assessment of the therapeutic alliance in psychotherapy (Horvath & Greenberg 1989). Both patient (WAI-P) and therapist (WAI-T) scales consist of 36 items measuring three domains of alliance, namely agreement on the goals of therapy (Goal Scale), consensus on the efficacy of the tasks undertaken in treatment (Task Scale), and the therapeutic bond (Bond scale), as originally postulated by Bordin (1979). WAI has been widely used to assess therapeutic collaboration and patient-therapist congruence in counselling and psychotherapy (Horvath et al. 2011; Tryon & Winograd 2011; Marmarosh & Kivlighan 2012). In this study, we applied the Finnish version of the Long Form WAI, which was used in the Helsinki Psychotherapy Project (Heinonen et al. 2014). The 36-item is scored with a 7-point Likert scale as follows: 1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Sometimes; 5 = Often; 6 = Very Often; 7 = Always. The higher score means better alliance. Next, we present some examples from both inventories (http://wai.profhorvath.com). From the WAI-P (WAI-C, in English version) inventory, questions in the Task scale are: '*4. What I was doing in therapy gave me new ways of looking at my problem*'; or in the Bond scale: '*28. My relationship with 'my clinician' was very important to me*'; or in the Goal scale: '*25. As a result of the therapy I became clearer as to how I might be able to change*'. Furthermore, from the WAI-T inventory, the analogue questions in the Task scale are: '*4. My client and I both feel confident about the usefulness of our current activity in therapy*'; or in the Bond scale: '*28. Our relationship is important to "my patient"*' and in the Goal scale: '*25. As a result of these sessions, "my patient" is clearer as to how she/he might be able to change*'. The internal consistency of WAI-P and WAI-T subscales

together was measured by calculating Cronbach's alphas (a). They were 0.911 in the Task subscales, 0.633 in the Bond subscales and 0.915 in the Goal subscales.

The Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) was used as the baseline (Evans et al. 2002) which was completed during the first visit. This 34-item self-report instrument was developed to evaluate four domains: subjective well-being (CORE-W, 4 items), psychic symptoms (CORE-P, 12 items), life functioning (CORE-F, 12 items), and risk behaviour (CORE-R, 6 items). The Finnish version of the CORE-OM was approved by the Core System Trust in 2011. A validation study of the Finnish version has been conducted at the University of Eastern Finland (Juntunen et al. 2015). The 34-item is scored with a 5-point scale as follows: 0 = Not at all; 1 = Only occasionally; 2 = Sometimes; 3 = Often; 4 = Most or all the time (http://www.coreims.co.uk). Next, we show the following examples of each subscale domain, hereby from CORE-W: '*17 I have felt overwhelmed by my problems*' or from CORE-P: '*11 Tension and anxiety have prevented me doing important things*' or from CORE-F: '*10 Talking to people has felt too much for me*' and from CORE-R: '*24 I have thought it would be better if I were dead*'. The higher scores mean the patient's worse condition. The scale reliability of the CORE-OM subscales was estimated in Cronbach's alpha (a) coefficient, as they were 0.748 in the CORE-W domain, 0.906 in the CORE-P domain, 0.854 in the CORE-F domain, 0.667 in the CORE-R domain and 0.944 in the CORE-Total.

In addition, we recorded the lengths of individual assessment periods, the number and durations of visits, and the numbers of clinicians who were involved in the various phases of assessment.

2.5. Procedure

An evaluation of the ethical standards and permission to conduct the study was obtained from the Ethics Committee of Tampere University Hospital.

This was a single-blind randomised controlled trial. The patients were randomised into two groups. We calculated that to get a 10–15 percent increase in the total WAI score to be statistically significant (a = 0.05, power 80%), we would need 40 study subjects in both groups. Thus, the aim was to obtain 40 participating subjects for both groups. The randomisation was carried out immediately when the patient's referral was accepted and the assessment phase started. The study protocol was similar in both groups. At the first visit, the clinicians informed the patient about the research protocol, provided a written statement, and requested the patient's consent to participate in the study. In addition, five randomly selected patients in the AAU group gave their written consent for the first visit to be audiotaped. In the DSA group, every first visit was audiotaped with the patient's consent. If the patient agreed, some later visits were also recorded.

During the first visit, every patient in both study groups was asked to complete the CORE-OM form. Furthermore, in the treatment-planning (i.e. final) visit, patients in both groups were asked to complete a WAI-P scale and to put it in an envelope,

making the results of this assessment unknown to the clinicians. After the patient's departure, the clinicians completed a WAI-T scale together. The clinicians in both groups completed an assessment form after every assessment visit.

2.6. Statistical analyses

Depending on the distribution, we used Student's *t*-test or the Mann-Whitney *U* test to compare continuous variables between the groups. To compare the WAI scores between the groups, Spearman's rank-order correlation coefficients (rho) were calculated because of the skewed distributions. The correlation coefficients were compared by first transforming rho values into Z scores and then Z statistics was used to evaluate the statistical significance of differences in correlation coefficients. A *p* value < 0.05 was used to indicate statistical significance.

3. Results

3.1. Differences in the CORE and WAI measurements

No differences were found in total and subscale CORE-OM scores between the DSA and AAU groups at study entry (*Table 2*). No significant differences were found in the patients' and assessors' total and subscale WAI scores between the DSA and AAU groups at the end of the assessment periods. However, the DSA group score was slightly and consistently higher (*Table 3*). The total score and all subscale WAI scores separately rated by clinicians and patients correlated significantly in the DSA group, whereas in the AAU group the only significant – albeit weaker – correlation was found in the WAI Bond subscale (*Figure 3*). In addition, the assessment periods were shorter and the visits were fewer in the DSA group compared to the AAU group (*Table 4*).

Table 2
Baseline CORE-OM scores in the DSA and AAU groups

	DSA group (n = 40)	AAU group (n = 40)	Mann–Whitney U test
	Mean (SD)	Mean (SD)	*p*-value
CORE-W	2.04 (0.79)	2.30 (0.80)	0.127
CORE-P	2.15 (0.89)	2.30 (0.76)	0.616
CORE-F	1.66 (0.78)	1.89 (0.57)	0.155
CORE-R	0.30 (0.44)	0.39 (0.43)	0.245
CORE-TOTAL	1.64 (0.69)	1.82 (0.57)	0.234
CORE-TOTAL WITHOUT R	1.92 (0.79)	2.12 (0.64)	0.264

Notes: DSA = Assessment based on dialogical sequence analysis; AAU = Assessment as usual; CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure; CORE-W: subscale of subjective well-being; CORE-P = subscale of psychic symptoms; CORE-F = subscale of life functioning; CORE-R = subscale of risk behavior

Table 3
WAI total and subscale scores compiled by professionals (WAI-T) and patients (WAI-P)
at the end of the assessment period in the DSA and AAU groups

Scales	DSA group Mean (SD)	AAU group Mean (SD)	Mann–Whitney U test p-value
WAI-T total	209.1 (27.6)	200.9 (32.9)	0.90
WAI-T Task	67.6 (6.8)	65.3 (12.0)	0.90
WAI-T Bond	75.4 (18.8)	71.1 (9.0)	0.92
WAI-T Goal	66.1 (7.9)	64.1 (13.7)	0.94
WAI-P total	199.1 (27.0)	195.0 (29.9)	0.43
WAI-P Task	65.9 (9.0)	64.6 (10.1)	0.46
WAI-P Bond	67.6 (10.3)	65.0 (11.5)	0.28
WAI-P Goal	66.1 (9.3)	65.3 (9.8)	0.62

Notes: WAI-T = Working Alliance Inventory form for Therapist; WAI-P = Working Alliance Inventory form for Patient; DSA = Assessment based on dialogical sequence analysis; AAU = Assessment as usual

Table 4
Characteristics of the assessment periods in the DSA and AAU groups

	DSA Mean (SD)	AAU Mean (SD)	Student's t-test[*] t	p-value
Duration of assessment period (days)	58.9 (39.2)	90.1 (35.2)	3.74	<0.001
Number of visits (n)	4.3 (2.0)	5.9 (2.4)	3.24	0.002
Total duration of visits (minutes)	290.1 (121.1)	355.7 (253.8)	1.48	0.14
Total time used by professionals (minutes)	448.5 (155.6)	460.0 (254.5)	0.24	0.81

Notes: DSA = Assessment based on dialogical sequence analysis; AAU = Assessment as usual
[*]: df = 79

Figure 3
Correlations of patient and professional perspectives in this study

*: p < 0.05 **: p<.01; DSA: DSA-based case formulation assessment group; AAU: Assessment as Usual group

The correlation coefficients differed between the DSA and AAU groups statistically significantly in treatment goal (p = 0.03) and task (p = 0.03) subscales and borderlined significantly in the Total Working Alliance score (p = 0.05). No difference was found in the therapeutic bond subscale (p = 0.13).

4. Discussion

In this study, we compared the usual psychiatric assessment with the new assessment method of using a DSA-based case formulation. We wanted to determine how each method addresses the patient's needs and expectations concerning his/her treatment. To assess the joint understanding of goals and tasks, we used the correlation of the patient and clinician WAI scores as our main indicator.

We found no previous studies that examined the congruence of the working alliance between the patient and the clinician(s) in the psychiatric assessment phase.

Our comparison showed that there was a remarkable convergence between patients' and clinicians' appraisals of the alliance when psychiatric assessments were conducted using the DSA-based case formulation. By contrast, the findings from the AAU group indicate a moderate mutual understanding of tasks and goals, corresponding with the congruence estimations in the research literature. Moreover, the assessment periods were shorter and the visits were fewer in the DSA group than in the AAU group, suggesting that the DSA-based assessments were more convenient

for the patients. The evaluations of the working alliance by both the patients and clinicians were slightly – but consistently – better in the DSA group than in the AAU group. Nevertheless, no statistically significant differences were found due to the weak statistical power of our study (*Table 3*).

TRYON and colleagues (2007) examined the congruence of client and counsellor alliance ratings in their meta-analysis of 53 studies representing different modes of counselling and psychotherapy. They found that client and therapist working alliance ratings were only moderately correlated (*mean r* = 0.36). The congruence of the AAU group lies in the lower range of the findings of TRYON and colleagues (2007). By contrast, in our study, the correlation between client and therapist ratings in the DSA group (*rho* = 0.63) was exceptionally high compared to the meta-analysis. This finding suggests that the psychiatrists and psychologists in the DSA group could generate a formulation of the patients' predicament that was accessible to both themselves and the patient, and it could be shared.

In the DSA-based case formulation assessment, the clinicians derived the treatment plan from a use of a coherent set of high-level concepts that guided their perception of the patient's important interpersonal experiences, attitudes, behaviour, and personal meanings of life events. This permitted a flexible method of accommodating the patients' unique way of making sense of their problems and personal attitudes. This interview strategy invited the patient to collaborate in recognising repetitive patterns of thoughts and actions and to find alternative ways of relating to these issues. An individualised case formulation strategy is diametrically opposed to the standard diagnostic approach that aims at subsuming the patient's personal action patterns and attitudes under a general descriptive label (*Table 1*). A possible explanation for the variance in congruence between the DSA and AAU groups may lie in this difference: it is difficult to derive individualised treatment plans based on generalised diagnostic categories.

The working alliance concept makes the therapeutic relationship measurable (NORCROSS & WAMPLOD 2011); it can also be used to address the quality of the clinician-patient relationship in the diagnostic assessment phase. While the therapeutic relationship and the assessment cooperation serve different purposes, both forms of institutional interactions can be therapeutic from the beginning of the very first contact. Based on our results of the first research goal, we found that the DSA-based case formulation resulted in a greater joint understanding of the patient's problems and needs compared to the standard assessment process.

Our second goal was to determine whether there were any differences in the time and/or employee resources used between the DSA-based and usual assessment processes. Using the DSA method, the assessment phase was shorter and fewer visits were required, making it likely more patient-friendly than the standard approach. Nevertheless, there were no statistically significant differences in the total duration of visits and total time used by professionals. Both assessment protocols demanded the same amount of employee resources. In the DSA group, the clinicians worked deliberately in pairs more often, and they took a break for discussion during the first

visit so that they could both contribute their expert views to the case formulation. Thus, the assessment with the DSA-based case formulation could complement and modify the usual assessment accurately and address the patients' needs and expectations in a shorter period than the standard assessment. Essentially, we can improve the quality while using the same resources.

As mentioned above, healthcare has been advancing gradually toward the patient-centred approach (LAINE & DAVIDOFF 1996; MEAD & BOWER 2000). Our findings confirm the value of such a patient-centred orientation in the psychiatric assessment phase.

4.1. Limitations and strengths

Our intention was to build a naturalistic setting, which may entail many uncontrolled variables that could affect the outcome. Correlation is an indication of common variability in one outcome variables, but it is not in itself sufficient evidence for causality. The sample size was small and the statistical power for showing differences between the groups was limited.

In addition, we used the Working Alliance Inventory, which has been validated for the evaluation of the psychotherapy context and dyadic processes. We used this scale in psychiatric assessment situations that sometimes involved more than two participants, and the setting was sometimes more varied than in standard psychotherapeutic contexts.

The WAI scales were completed during the treatment-planning visit, which was the final assessment visit. Our findings showed shorter assessment periods and fewer visits in the DSA group than in the AAU group. Consequently, the working alliance was measured at different time points. This may have affected the working alliance ratings. In psychotherapy research, most studies evaluated working alliance and convergence in the early phase of psychotherapy or counselling, between sessions one and five (HORVATH & BEDI 2002; FLÜCKIGER et al. 2012; MARMAROSH & KIVLIGHAN 2012). The mean numbers of visits in our study groups are comparable with those studies. However, our study's comparability with those studies is limited concerning our different diagnostic assessment context.

There were some differences in the educational backgrounds of the clinicians between the groups. All clinicians in the DSA group were psychiatrists and psychologists. In the AAU group, there were also residents and nurses. Nevertheless, all of them had several years of clinical experience. During the study project, the AAU group received supervision ten times a year while the DSA was supervised 16 times a year. The effects of these differences on the results cannot be ruled out.

The clinical skill of conducting the dialogue with the DSA method demands two years of training and supervision. When the study began, the members of the DSA group were still learning the new interview strategy, while the members of the AAU group continued their ordinary work. It may be the case that the differences in outcome were partly affected by this Hawthorne Effect (CHIESA & HOBBS 2008), but it

was not possible to estimate whether it had any effect on the results. In the future, more studies should be done with bigger sample sizes in order to determine the results in the larger clinical field. The two-year DSA training is taught by the author of the concept and theory, Emeritus Professor Mikael Leiman. However, while he teaches the new trainers all the time, the clinical implementation of the DSA case formulation is still limited.

Notwithstanding these limitations, our study has some unique strengths. It possesses ecological validity; it was a clinical trial located in a public mental health care clinic. We tried to maintain the natural context and keep the inclusion criteria as wide as possible. We chose the samples randomly from public healthcare patients who sought help and treatment. Both groups were recruited from the same socio-demographically heterogeneous population. However, possible socio-economic differences between the groups were not analysed. No differences were found in total and subscale CORE-OM scores between the DSA and AAU groups at study entry. Therefore, the groups seem to be clinically comparable.

4.2. Conclusion

The present clinical pilot study was the first to apply the DSA-based case formulation in psychiatric assessment. Our findings of a higher mean level of convergence between the patient's and professional's viewpoints of the working alliance suggests that the DSA-based case formulation can help to improve psychiatric assessment and move towards an individual- and patient-centred approach within a shorter period of time. A shared view of the problem and the treatment plan may strengthen the patient's vulnerable agency and influence the efficacy of the treatment. This novel method may also improve the patient-centeredness and the validity of the psychiatric assessment for the individual patient.

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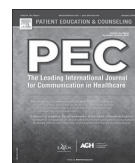# PUBLICATION
II

Offering patients opportunities to reveal their subjective experiences in psychiatric assessment interviews

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Offering patients opportunities to reveal their subjective experiences in psychiatric assessment interviews

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ABSTRACT

Objective: With the intention of understanding the dynamics of psychiatric interviews, we investigated the usual (DSM/ICD-based) psychiatric assessment process and an alternative assessment process based on a case formulation method. We compared the two different approaches in terms of the clinicians' practices for offering patients opportunities to reveal their subjective experiences.
Methods: Using qualitative and quantitative applications of conversation analysis, we compared patient–clinician interaction in five usual psychiatric assessments (AAU) with five assessment interviews based on dialogical sequence analysis (DSA).
Results: The frequency of conversational sequences where the patient described his/her problematic experiences was higher in the DSA interviews than in the AAU interviews. In DSA, the clinicians typically facilitated the patient's subjective experience talk by experience-focused questions and formulations, whereas in AAU, such talk typically occurred in environments where the clinicians' questions and formulations focused on non-experiential, medical matters.
Conclusion: Interaction in DSA was organized to provide for the patient's experience-focused talk, whereas in AAU, the patient needed to go against the conversational grain to produce such talk.
Practice implications: By facilitating patients' opportunities to uncover subjective experiences, it is possible to promote their individualized care planning in psychiatry.

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1. Introduction

In psychiatry, a clinician's biomedical understanding of a patient's condition can be incongruent with the patient's subjective experience. Mishler [1] distinguished between 'the voice of medicine' and 'the voice of the lifeworld' in the medical encounter, representing respectively, the technical-scientific assumptions of medicine and the natural attitude of everyday life. He pointed out a conflict between these voices, as the voice of medicine silences and regulates the voice of the lifeworld through, for instance, question and answer sequences.

Despite the general understanding regarding the importance of the patient's subjective experience and lifeworld, there is little empirical research on the ways in which clinicians accommodate – or fail to accommodate – the patient's experience in psychiatric consultations. McCabe et al. [2] investigated the ways in which psychiatrists responded to psychotic patients' accounts of delusional thoughts. Clinicians' counter-questions, smiles, and laughter conveyed their reluctance to address these topics. Recently, McCabe et al. [3] investigated the ways in which patients' possible suicidal thoughts are addressed in psychiatric consultations, showing that the predominant grammatical structure of questions about suicide ideation discouraged patients from admitting such thoughts. On a more positive note, Thompson et al. [4,5], suggested that a particular design in psychiatrists' questions – so-prefaced declarative questions, such as *'so, you feel a*

bit anxious' – serves as a display of empathy and a close attendance to the patient's experience. Furthermore, Thompson et al. [4] found that the more frequent use of declarative questions was positively correlated with the clinician–patient alliance and treatment adherence.

In sum, earlier research suggests that the clinician's interactional practices can either facilitate or restrain the clients' talk about subjective experiences. Research has revealed the interactional functions of specific practices (such as the grammatical structure of questions) in this. On the other hand, studies have yet to offer more global views of the clinician's conduct in facilitating or curbing the clients' talk about their subjective experience. This is what we aim to do in the study at hand.

We compared two psychiatric interview protocols regarding the ways in which clinicians offer opportunities for patients to reveal their subjective experiences. The two interview protocols are the usual psychiatric assessment process (AUU; assessment as usual) and an alternative assessment process based on the case formulation method (DSA; dialogical sequence analysis). The usual psychiatric assessment process is organized around eliciting information about the patient's symptoms and illness history with the aim of defining a diagnosis according to the DSM/ICD categories [6,7]. Assessment based on case formulation, by contrast, is not driven by diagnostic categories alone. Case formulation is a 'hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioural problems' [8]. We studied a particular variant of case formulation called Dialogical Sequence Analysis, the aim of which is to produce an individualized evaluation of recurring action patterns maintaining the patient's problems and deficiencies of agency; this complements the diagnostic work [9–16]. These two approaches were investigated in a clinical randomized controlled trial at a community mental health centre in Finland [17].

1.1. Objectives

We compared patient–clinician interaction in AAU consultations and DSA consultations, focusing on sequences where the patients talk about their subjective problematic experiences. We examined how the patients are provided with or obtain the opportunity to direct their talk to subjective problematic experiences, and how the clinicians respond to and deal with these descriptions. We sought to discover whether the organisation of interaction is different between the two assessment methods when it comes to talk about problematic subjective experiences.

2. Methods

2.1. Participants and data

The data were selected from a dataset that was collected in a randomized clinical study at a community mental health centre in Finland. The Ethics Committee of Tampere University Hospital accepted the study. In this larger study, 80 patients were randomized into two equal groups. Patients with psychotic or neuropsychiatric disorders and patients who needed urgent evaluation within seven days were excluded [17]. In the DSA group, all the participants' first visits were audio-recorded; in the AAU group, five randomly selected patients' first visits were recorded.

The data for the study reported here were obtained by matching the five randomly selected AAU cases from the larger study, with five corresponding DSA cases. These ten interviews were transcribed using conversation analysis (CA) notation [18] (see

Appendix A). In total, the AAU interviews lasted 280 min and the DSA interviews lasted 283 min. Each interview involved two clinicians (a physician with a psychologist or a nurse) and the patient. Overall, the data include ten patients, three psychiatrists, three psychiatric residents, three psychologists and three nurses. The clinicians working on the DSA cases received special training for the method.

The patients' symptoms and diagnoses varied. The patients included four female and six male adults.

2.2. Interview strategy with the DSA case formulation

According to clinical theories and instructions, in the DSA approach the clinician should follow and validate individual and interpersonal experiences, events, and attitudes. Questions and reflections are used to access the patient's perspective and derive individually meaningful information to promote the patient's awareness of his/her problems [9,11,12]. Towards the end of the session, the clinician clarifies the symptoms and complements the preliminary diagnosis with an individual case formulation.

2.3. Interview strategy as usual (AAU)

In the standard psychiatric interview, the clinicians focus on the patient's communication and behaviours that indicate symptoms of mental disorders encapsulated in the DSM/ICD categories [6,7,19]. Questions and structured questionnaires are used to identify symptoms. The intention is to provide an account of the patient's problems based on diagnostic categories.

2.4. Procedure

In order to match patients in the two assessment conditions, the first author described a set of 45 patients (5 random AAU cases and 40 DSA cases) according to seven clinical criteria, using the patients' medical records and the audio-recorded interviews as the source of information. The criteria included (1) gender, (2) age, (3) educational level, (4) psychiatric treatment history, (5) substance abuse history, (6) ability to self-reflect, and (7) ability to verbalize experiences. Thereafter, two authors (Savander, who is an experienced psychiatrist, and Leiman, who is a professor of clinical psychology) chose five pairs of AAU and DSA cases that matched in terms of these criteria through consensus negotiation.

While the selection of the data (the matching of the AAU and DSA interviews) was based on clinical judgement, the actual data analysis was mostly based on conversation analysis (CA). CA is a method for the investigation of sequential actions in social encounters [20,21]. As has been increasingly done in recent studies [22], we used conversation analysis as a resource for coding interactions, and hence, our key results are quantitative as well as qualitative. While CA helped us to identify the three-part sequences that the study focussed on, we also considered the "content" of the talk in differentiating turns focussing on medical or experiential domain.

The focus of our data analysis was on sequences with turns in which the patient described his/her negative subjective experiences using 'the voice of lifeworld' (below, abbreviation E). In such turns, the patient describes in negative terms a personal feeling, attitude, experience, or life event. Our way of understanding 'subjective experience' was thus based on the content of the talk (what the participants referred to). We were more inclusive than, for example, Hayano [23] or Wiggins and Potter [24], who differentiated subjective and objective linguistic constructions on the basis of grammatical form. Furthermore, we wanted to focus on *negative* experiences only because they – rather than positive experiences – are primarily relevant for help seeking behaviour.

We wanted to see how these utterances emerge and where they lead.

Our analysis focuses on the information elicitation phases of the interview, and we excluded the discussions on treatment and the clinicians' advice or educative statements. This means that we focused exclusively on descriptions of subjective experience that emerged as answers to the clinicians' questions. Questions have a strong constraining function regarding the topic and action of the next turn [25], and hence, they potentially show the ways in which the clinicians facilitate – or do not facilitate –the patients' talk about their negative subjective experiences. Thus, there were medically oriented questions (MQ); these were interrogative turns about factual knowledge or symptoms, or inferential statements (making relevant the patient's confirmation or elaboration) regarding what had transpired in the interview thus far, without reference to the patient's own experience, feelings, or meanings. By contrast, an experience-oriented question (EQ) was an interrogative or an inferential statement related to the patient's negative experience, life events, feelings, attitudes or meanings.

As for the uptake of the patients' descriptions of their experiences, we distinguished between medically oriented next turns (MT) – responses related to psychiatric factual knowledge or symptoms – and experience oriented next turns (ET) – responses that refer to the patient's experience. In coding these responsive turns, we did not include minimal response tokens [26] in either category.

Thus, we ended up having sequences of talk where the participants' focus of attention oscillated between the 'medical' and 'experiential' domains. In the 'middle' of these sequences, there is the patient's description of his/her problematic subjective experience. That experience description is preceded and followed by the clinician's turns that focus either on subjective experience or on medical matters. Fig. 1 depicts the focal sequences.

In the ten interviews, we found 124 segments where, preceded by the clinician's questions, the patient's turns referred to negative subjective experiences. These sequences were initially identified and coded by the first author, who is an experienced clinician with a knowledge of CA. The reliability of the coding was assessed by introducing another coder. The second coder (the fifth author, who is knowledgeable of CA and also psychiatric interviewing) first read the coding instructions devised by the first author and then coded a randomly selected 20% of these segments and discussed the rationale behind the coding with the first author. Following this discussion, five extracts were excluded because the clinician asked opening questions, the clinician's turn was an educative statement, or the patient's turn was factual and not experiential. Additionally, the two coders disagreed about six other extracts. Agreement about these cases was achieved through negotiation, whereby a shared coding culture was developed. After this training period, the second coder investigated the remaining 80% of the extracts independently, coding each of them into one of the four categories as shown in Fig. 1 above. Agreement on 93 of the 119 extracts was achieved. For the remaining 26 cases, the codes were applied based on a consensus negotiation.
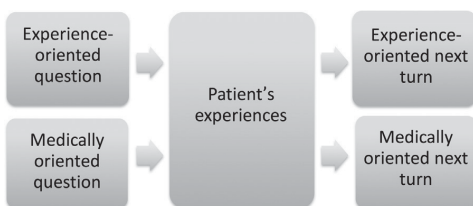

Fig. 1. Experience descriptions and their sequential environment.

Below, we first present examples of each trajectory, and thereafter, present the statistical results regarding their distribution in the two assessment interview approaches. The chi-squared test was used for the statistical analysis.

3. Results

In the five DSA interviews, the patients responded to clinicians questions with descriptions of their negative subjective experience altogether 71 times, while in the five AAU interviews, such sequences occurred 48 times. The distribution of such turns across individual interviews is presented in Table 1 below. The average number of experience turns was 14.2 (SD 2.8) in the DSA interviews and 9.6 (SD 2.3) in the AAU interviews. This means there was a significant difference ($p = 0.016$) between the two groups.

3.1. Emergence of patients' descriptions of negative subjective experiences

The patient's description of negative subjective experiences is prompted either by an experience-oriented question (EQ) or a medically oriented question (MQ). In the former case, the question prepares the ground for the patient's description of subjective experiences, whereas in the latter case, the patient departs from the topical domain of the question. We will first show an example of the description of a subjective experience emerging from the clinician's experience-oriented questions (EQ). Such questions may take up something that the patient has told in the previous turn, or the clinician may open a new topic.

In Extract 1 below, the patient (PA) is a 34-year-old woman with anxiety, depressive symptoms, and aggressive behaviour. It transpires in the interview that she has for a long time struggled with non-adaptive efforts to control her behaviour. In the history-taking phase of the interview, the psychologist (PS) asks a question about a period in her childhood (lines 1–2).

Asking an unspecified question about a life phase and focusing on the patient's standpoint ('from yo- your perspective'; lines 1–2) involves an invitation to talk about subjective experience. In line with this, in line 3, the patient reveals her adverse experiences in her peer group (lines 3–23) and her inability to seek help (lines 24–26).

While a clinician's experience-oriented questions create a favourable environment for the patient's description of his/her subjective experience, medically oriented questions are different. Such questions, by and large, make medically oriented answers relevant. It is possible, however, for the patient to depart from the question's topical relevancies. In a number of cases, the patients produced their descriptions of subjective experiences as responses to medically oriented questions. Typically, the patient responded briefly to the factual medical question, and thereafter continued with a narrative of experience that was relevant to the question. Extract 2 illustrates this mode of response to a medically oriented question. The patient (PA) is a 33-year-old woman with an affective disorder. Prior to the extract, she had been telling about her difficulties during a depressive episode in her past.

The doctor's (DO) medically oriented question is a polar interrogative, inviting a yes/no response, regarding the time of the end of the patient's depressive episode (lines 1–2). The question is part of the standard medical agenda, as the tracking of mood episodes is a key task in diagnosing bipolar disorder. In lines 3–4, the patient responds with factual information, correcting the clinician's suggestion. The doctor receives the information in line 5. However, the patient continues her factual answer in line 6, offering further specification for the time of the end of the depression ('towards the end of it' [i.e. May]). This incremental continuation is further expanded without any gap, by the patient who begins a narrative description of the circumstances that

Table 1

Distribution of subjective experience sequences across the interviews.

Case ID	DSA 02	DSA 84	DSA 98	DSA 121	DSA 128	*DSA mean per interview*	AAU 05	AAU 71	AAU 108	AAU 111	AAU 126	*AAU mean per interview*
E	18	13	11	15	14	*14.2*	11	9	6	12	10	*9.6*

ID, observation ID of cases; DSA, Dialogical sequence analysis-based assessment; AAU, Assessment as usual; E, Subjective experience description.

```
1   PS:   minkäslainen (1.0) vaihe se oli sitten sun kan-
          what kind of (1.0) period it was then from yo-
2         sun kannalta [ku muutit,
          your perspective [when you moved ((to Finland)),
```
EQ

```
3   PA:                   [no se on ollu semmone vaihe
                          [well it [has been that kind of period
4   PA:   että mua ruvettii heti kiusaamaa (.) oon ollu
          that others started bullying me (.) I've been
5         ulkomaalainen huora ja mä oon venepakolain- siis
          a foreign bitch and I've been one of the boat people- I mean
6         yheksän vuotiaast asti mä oon [niitä kaikkia,
          from the age of nine I've been [all of those,
7   DO:                                 [mm mm mm.
```
E

```
((17 lines removed about patient's talk about in which grades she was bullied))
```

```
24  PA:   mut en mä siitäkää pu- (0.8) puhunu.
          but I didn't tell abou- (0.8) about that either.
25  DO:   mm-m,
          (0.8)
26  PA:   mei[än äitille .hhhh
          to ou[r mother .hhhh
```
E

Extract 1. .

prompted her depression (line 6 onwards). Here, the patient goes beyond the topical agenda of the doctor's question. She suggests that her depression was prompted by the bad supervisor (lines 11–13), and characterizes her own and other people's responses to the supervisor with an animated voice (lines 19–20). The lengthy narrative keeps the patient in the experiential realm; the doctor aligns as the recipient of the narrative (see lines 9, 14, and 17).

Extracts 1 and Extracts 2 above illustrate the two sequential paths that can lead to the patient's description of negative subjective experiences: such a description can emerge either after an experience-oriented question (EQ) or after a medically oriented question (MQ). We can now compare the two types of interviews regarding these sequential routes leading to the patient's description of a problematic subjective experience (Table 2).

The quantitative results show a significant difference ($p < 0.001$) between the two types of assessment process. In the DSA-based assessments, the patient's description of the subjective experience in most (71.8%) cases arises from the clinician's experience-oriented question, whereas in AAU, the patient describes his/her subjective experience more often than not (in 52.1% of cases) after a question where the clinician has elicited medical and/or factual information. We might say that in the DSA-based assessment, the patient's talk about subjective experience takes place in an environment that the clinician has prepared for such talk, whereas in AAU, the patient in most cases must make an effort to create the environment for such talk.

3.2. Consequences of the patients' descriptions of negative subjective experiences

The patient's description of a negative subjective experience is eventually followed by the clinician's response to that description. This next turn can focus on the experiential domain that was attended to by the patient in his/her turn, or it can switch to the medical domain. Usually, the focus on the experiential domain is done by a follow-up question; focusing on the medical domain can take place either through a question that changes the topic or through a follow-up question that focuses on the medical aspects or implications of the patient's prior description of the experience. Below, we will show examples of both trajectories.

In Extract 3 , the patient's description of her subjective experience is taken up by the clinician in her next turn by an experience-oriented response (ET).

In line 27, the clinician takes up the patient's account of not telling about the bullying to her mother, with a generalizing formulation [27,28]. After the patient's confirmation (line 28), the clinician in line 29 extends her formulation further. These formulations stay in the realm of the patient's experience, as they maintain the topical focus on the patient's ways of dealing with the bullying. The clinician's formulations facilitate the patient's further reflection on her choice not to tell others (see lines 30–31).

In the Extract 4 , the clinician's response switches the focus to the medical domain. The extract is a continuation of Extract 2 above. In lines 18–21, the patient is talking about her bad supervisor, whom she considers to be the cause of her depression.

Like in the previous extract, here the patient also seems to make relevant some kind of affiliating response to her complaint, as her description of the circumstances is emotionally dense (reported speech, extreme case formulations and an animated voice in lines 19–20). Furthermore, the reference to the end of the employment (lines 20–21) is like a gloss that makes unpacking [29] relevant, i.e. finding out how and why the employment was terminated. In lines 22–24, the clinician's turn is designed to be a follow-up question (the connection to the prior talk is established by the particle 'sit' / 'then'). However, the clinician does not focus on the experiential and affective contents of the patient's prior turn, nor does he seek

```
 1  DO:   ajattelisiks sä niin että ehkä siin kesäkuussa jo niin se      M
           would you think that maybe the most di- difficult
 2         niiku ha- hankalin (.) ma[sennus oli ohi.                      Q
           depression was over already (.) in [June
 3  PA:                                     [.hhhh  oli  oli
                                            [.hhhh it was
 4         oikeestaa jo toukokuus.
           actually it was already in May.
 5  DO:   #joo.#
           #yes.#
 6  PA:   loppupuol et mä sitte mhm (0.8) .hh (0.9) sain sit              E
           towards the end of it so then I mhm (0.8).hh (0.9) got
 7         jotai muutakit tekemistä mun elämä(h)än t(h)ai siis
           some other things to do in my life(h) or(h) something
 8         nä[:in että e- (.) et,
           like [that  s- (.) so,
 9  DO:      [joo.
              [yes.
10  PA:   et se ei ollu niinku kauheen pitkä se masennusjakso
           that it wasn't that long that depressive episode
11         viime (.) keväänä ja se oli mum mielest nii selkeesti
           last (.) spring and I think that it also clearly resulted
12         myös siitä johtuva (.) et se oli #oikeesti aika# .hhh
           from (.) my supervisor who #really was quite# .hhh
13         @karsee@ se (0.4) .hh esimies siellä [ja se ei (.)
           @hidious@ (0.4)    .hh               [and he didn't (.)
14  DO:                                         [nii just.
                                                [right.
15  PA:   mä en (.) mä tiedän et mä en oo ainoo joka
           I know (.) I know that I'm not the only one who
16         niin kokee et (.) [mä tosi monen muunki
           feels that way that (.)[I talked with several people
17  DO:                     [joo.
                             [yes.
18  PA:   kaa puhuin siel työpaikalla ja monet sano mulle et
           there at that work place and many people said to me that
19         @miten sä kestät tota tyyppiä@ .hhhh @mä oli vaa et pakko
           @how can you bear that guy@ .hhhh @I was just I have to
20         KEStää@ siinä vaiheessa mut sitte lopulta se kyl se
           BEAr@ at that point but then eventually it did
21         sitte loppu se työsuhde sen takia juurikin    [.hhhh
           end that employment exactly because of that[.hhhhh
```

Extract 2. .

Table 2
The emergence of patients' negative subjective experience descriptions from the clinicians' questions in two different type of diagnostic assessment interviews.

	DSA	AAU
EQ - E	51 (71.8%)	23 (47.9%)
MQ - E	20 (28.2%)	25 (52.1%)
TOTAL	71 (100%)	48 (100%)

DSA, Dialogical sequence analysis-based assessment; AAU, Assessment as usual; EQ, Experience-oriented question; MQ, Medical question; E, Subjective experience description.

to unpack the gloss. Rather, he asks when the patient's last psychiatric consultation that the patient had for this depressive episode was. Thereby, the question accomplishes a topic shift, moving the focus back to the timing of medically relevant facts pertaining to the past depressive episode. Thereafter, the talk continues about medications (data not shown).

The quantitative results concerning the clinicians' next turns after the patients' subjective experience descriptions are presented in Table 3 below.

The clinicians' next turns are significantly different ($p<0.001$) in the two types of assessment process. After the patients' descriptions of their subjective experience, in the DSA-based assessments, the clinicians continue to focus on experience in most (90.1%) cases, whereas in assessment as usual (AAU), the clinicians stay in the

patients' experiential mode in only 39.5% of the cases; they tend to transfer the topic towards medical and factual investigation (60.5%).

3.3. Three-turn trajectories of interaction

Above, we investigated the relation between the medical domain and the experiential domain by two sequential transitions. We can now compare the AAU and DSA consultations regarding a longer trajectory of interaction that was outlined in Fig. 1 above, i.e. comprising both transitions. The comparison is presented in Fig. 2 below. We found significant differences ($p<0.001$) between the DSA and AAU cases in all four subgroups.

EQ, Experience-oriented question; ET, Experiential next turn; E, Subjective experience description; MQ, Medical question; MT, Medical next turn; DSA, Dialogical sequence analysis-based assessment; AAU, Assessment as usual

Fig. 2 shows the distribution of four conversational trajectories of oscillation between the medical and experiential domains for the two groups. In the DSA-based interviews, the patient's description of subjective experience was most frequently (in 67.6% of cases) enveloped by the clinician's turns (preceding question and subsequent turn) that were also experience-oriented. In contrast to this, in the AAU interviews, the patient's description of subjective experience was most commonly preceded and followed by the clinician's medically oriented turns (in 37.5% of

```
24 PA:  mut en mä siitäkää pu- (0.8) puhunu.
        but I didn't tell abou- (0.8) about that either.
25 DO:  mm-m,
        (0.8)
26 PA:  mei[än äitille .hhhh
        to ou[r mother .hhhh
```
E

```
27 DO:       [et puhunut kenellekää,
             [you didn't tell anyone,
28 PA:  e:::n,
        no:::,
29 DO:  mmm koulus[sakaa ei kotonakaa hhh
        mmm at sch[ool or at home hhh
30 PA:            [e- e- en mä e:i eih en mä halunnu vaivata mun
                  [n- n- no I no: noh I didn't want to bother
31      asioilla [.hhh
        anyone with my stuff [.hhh
32 DO:                       [mmhh
```
ET

Extract 3. .

```
18 PA:  kaa puhuin siel työpaikalla ja monet sano mulle et
        there at that work place and many people said to me that
19      @miten sä kestät tota tyyppiä@ .hhhh @mä oli vaa et pakko
        @how can you bear that guy@ .hhhh @I was just I have to
20      KEStää@ siinä vaiheessa mut sitte lopulta se kyl se
        BEAr@ at that point but then eventually my employment
21      sitte loppu se työsuhde sen takia juurikin  [.hhhh
        was terminated exactly because of that [.hhhhh
```
E

```
22 DO:                                              [koska sä
                                                    [when did you
23      kävit viimesen kerran sit siel mm ee- tota (.) tapaamas
        then go to mm erm (.) meet that psychiatrist for the last time
24      tätä psykiatrii siäl ((lääkäriaseman nimi)).
        in that ((a name of the medical clinic)).
```
MT

Extract 4. .

cases). The pattern that was most frequent in the DSA sample (EQ-E-ET) was found only in a quarter of the AAU interviews, while the dominant pattern (MQ-E-MT) in the AAU sample was found only in 4.2% of the DSA cases.

The differences between the two types of consultation suggest that the DSA approach creates a favourable environment for the patient's talk about their subjective experiences. While the AAU approach clearly does not prevent such talk, the conversation is often organized so that the patient needs to do the interactional work, as it were, against the grain in talking about his or her subjective experience.

4. Discussion and conclusion

4.1. Discussion

Using qualitative and quantitative applications of conversation analysis, we investigated psychiatric assessment

Table 3
Consequences of the patients' descriptions of negative subjective experiences in two different types of diagnostic assessment interview.

	DSA	AAU
E - ET	64 (90.1%)	19 (39.5%)
E - MT	7 (9.9%)	29 (60.5%)
TOTAL	71 (100%)	48 (100%)

DSA, Dialogical sequence analysis; AAU, Assessment as usual; ET, Experience-oriented next turn; MT, Medical next turn; E, Subjective experience description.

interviews, especially the sequential environments of the patients' turns of talk focusing on subjective problematic experiences. The patient's opportunity to reveal his/her experiences is shaped by the clinician's previous turn. An experience-oriented question, regardless of whether it emerges from the previous topic or constitutes a topic change, offers the patient an opportunity to reveal his/her subjective experience. An account of subjective experience can also be produced after the clinician's medically oriented question. In such cases, the patient typically first provided the factual information invited by the question. After the clinician's acknowledgement of this information, the patients expanded his/her answers, thereby moving towards descriptions of negative subjective experiences
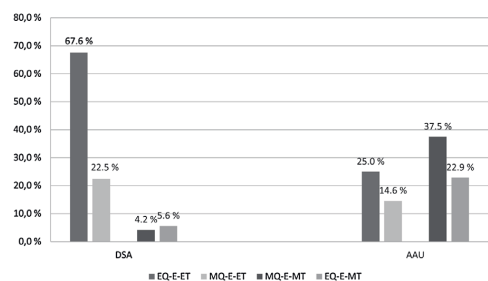

Fig. 2. Distribution of the four trajectories of interaction across the AAU and DSA groups.

that were linked to the topic of the question, but arose from a different, subjective perspective.

The clinician's turns after the patient's descriptions of experience were typically formatted as questions or formulations. The medically oriented questions involved a new medical or factual topic, or an ancillary topic [30] that was associated with a medical aspect of the patient's preceding experience oriented account. When the clinician preserved the experiential focus in his/her next turn, he/she produced formulations of the patient's prior talk or follow-up questions [27,28,31]. Such turns gave the patient a further opportunity elaborate on his/her subjective experience.

In this study, we have implicitly regarded the patients' opportunities to talk about their subjective experience as a positive thing. Earlier research indeed suggests that such opportunities may be positively correlated with a working alliance and adherence to treatment [4]. However, not necessarily all patients want to talk about or not able to verbalise their subjective experiences. The patients' *opportunities* to talk about subjective experience may be important clinically in psychiatry, because an unwillingness or inability to use these opportunities may be informative for the assessment of their problems and the planning of the treatment.

The interactional differences that we have found between the AAU and DSA approaches suggest that the course of the psychiatric consultation is not rigidly fixed by its institutional (medical) frame [32]. There is leeway in the ways in which the interaction between the patient and the clinician can be organized. In Mishler's [1] terms, the dialogue between the voices of the life-world and medicine can be transformed: they can co-exist and both be part of the assessment.

There were some limitations to this study. Our dataset included only ten recorded psychiatric interviews. Despite the statistical significance of our findings and the careful matching of the cases along several relevant patient characteristics, unknown features of both the patient and the study design may have biased the results. Additionally, inspired by Mishler [1], we have applied a binary distinction between medical and experiential domain, because it has enabled us to quantify our observations. However, we are aware that the binary distinction is a simplification: in any moment of talk, the two realms may also be intertwined, and references to them can be incorporated into quite different actions and interactional projects. It will be the task of future work to investigate the articulation of these realms in a more qualitative way in CA.

4.2. Conclusion

In our data, DSA- and AAU-based assessments are different in the ways in which they offer patients opportunities to reveal their subjective experiences. Interaction in DSA is more organized to provide for the patient's experience-focused talk, whereas in AAU, the patient more often needed to go against the grain to produce such talk.

4.3. Practice implications

By facilitating the patient's opportunities to reveal his/her subjective experiences, there is a chance to build a shared understanding of the patient's unique problem and improve individualized care planning in the psychiatric assessment process.

5. Authors' contributions

The contributions of authors to the manuscript are as follows: E È Savander: Designing the study, data collection, qualitative data analysis, outlining the argument of the paper, writing up the first draft of the paper, revising the manuscript. E Weiste: Qualitative data analysis, outlining the argument of the paper, revising the

manuscript. M Leiman: Designing the study, revising the manuscript. *J* Hintikka : Designing the study, quantitative data analysis, revising the manuscript. T Valkeapää : qualitative data analysis, revising the manuscript. E Heinonen : commenting the methodology and analysis, revising the manuscript. Anssi Peräkylä: Qualitative data analysis, outlining the argument of the paper, revising the manuscript, supervising research and writing.

All authors have made substantial contributions and they all have approved the final version to be submitted.

6. Declarations of interest

None.

A

T:	Speaker identification: therapist (T), occupationaltherapist (OT), client (C)
→	Line containing phenomenon discussed in text
[]	Overlapping talk
=	No space between turns
(.)	A pause of less than 0.2 s
(0.0)	Pause: silence measured in seconds and tenths of a second
°word°	Talk lower volume than the surrounding talk
WORD	Talk louder volume than the surrounding talk
hh	An in breath
hh	An out breath
mt,krhm	vocal noises
£word£	Spoken in a smiley voice
@word@	Spoken in an animated voice
#word#	Spoken in a creaky voice
wo(h)rd	Laugh particle inserted within a word
((word))	Transcriber's comments
()	Transcriber could not hear what was said
word	Accented sound or syllable
-	Abrupt cut-off of preceding sound
:	Lengthening of a sound
>word<	Talk faster than the surrounding talk
<word>	Talk slower than the surrounding talk
↑↓	Rise or fall in pitch
?	Final rise intonation
,	Final level intonation
.	Final falling intonation

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PUBLICATION
III

The Patient's Practices Disclosing Subjective Experiences in the Psychiatric Intake interview

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The Patients' Practises Disclosing Subjective Experiences in the Psychiatric Intake Interview

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In psychiatric diagnostic interviews, a clinician's question designed to elicit a specific symptom description is sometimes met with the patient's self-disclosure of their subjective experience. In shifting the topical focus to their subjective experiences, the patients do something more or something other than just answering the question. Using conversation analysis, we examined such sequences in diagnostic interviews in an outpatient clinic in Finland. From 10 audio-recorded diagnostic interviews, we found 45 segments where medical questions were met with patients' self-disclosures. We show four sequential trajectories that enable this shift of topic and action. There are four possible trajectories: (1) the patient first answers the medical question and the clinician acknowledges this answer, whereupon the patient shifts to a self-disclosure of their subjective experience; (2) the patient first gives the medical answer but shifts to self-disclosure without the clinician's acknowledgement of that answer; (3) the patient produces an extensive answer to the medical question and, in the course of producing this, shifts into the self-disclosure; (4) the patient does not offer a medical answer but designs the self-disclosure as if it were the answer to the medical question. We argue that in the shifts to the self-disclosure of their subjective negative experience, the patients take local control of the interaction. These shifts also embody a clash between the interactional projects of the participants. At the end of the paper, we discuss the clinical relevance of our results regarding the patient's agency and the goals of the psychiatric assessment.

Keywords: psychiatric assessment interview, mental disorder, subjective experience, conversation analysis, self-disclosure

INTRODUCTION

In contemporary psychiatry, patient assessment is guided by the classification of mental disorders. In psychiatric interviews, the clinician's goal is to evaluate the patient's problems and provide an evidence-based treatment grounded on symptom-oriented diagnostic ICD-10/DSM-5 categories (1, 2). Since the 1980s—after the emergence of the DSM-III—many researchers have pointed out that the patient's subjective experience is overlooked in the contemporary descriptive classifications. It has been argued that by attempting to define objective signs and symptoms as in the other fields of medicine, psychiatry de-contextualises, simplifies, and reifies mental phenomena. While the symptom-oriented diagnostic categories may have provided for better reliability of diagnoses

[however, see Vanheule (3), who clearly argues against it], the validity of psychiatric diagnoses—something that requires the understanding of the individual psychopathology—has been neglected in clinical work and research (4–11).

Clinician–patient communication is important in psychiatry because social interaction with the patient is the clinician's primary means for understanding, evaluating and eventually diagnosing the patient's mental suffering. Communicative practises in psychiatry have been taken up in studies on shared decision-making, mutual understanding, and patients' expectations (12–17). For example, researchers showed a considerable interactional tension in routine psychiatric consultation with psychotic patients as the patients repeatedly attempt to talk about their psychotic experiences, and the clinicians reject the topic (18). Other studies have demonstrated how minute practises in clinical communication are associated with better understanding and patient adherence. The frequency of patients' requests to psychiatrists to clarify what they say is associated with better treatment adherence (16). Training emphasising the importance of understanding the patients' psychotic experiences, on the other hand, is associated with psychiatrists' increased use of self-initiated clarification as "self-repair" (19) in their talk.

Clinicians' questions are important in all medical interviews (20–22). By asking questions, the clinicians gather information about the patients' history, experiences, and symptoms, yielding diagnoses and treatment recommendations. In psychiatric assessment interviews, the role of questions is particularly significant because the psychiatrist does not have the support of other data gathering instruments such as physical tests.

Ziółkowska (23) analysed the doctor's questions in the psychiatric diagnostic interviews. Through linguistic analysis, she showed that the doctors objectified the patients' experiences, focusing on measurable symptoms or behaviours. This was achieved by the use of "nominal phrases" (such as "*will to act*" or "*thoughts about death*") that presented the patient's experiences without agency and context. The nominal phrases were derived from standard diagnostic manual language.

Consequently, in their responses, the patients represent their own actions and subjective experiences in the same objectified way, losing their agency and meaning of the context. Another study focused on questioning practises that acknowledge the patient's subjective experience. Thompson et al. (24) argued that a particular question design—"so prefaced declarative questions," for example "*So you feel a bit anxious*"—conveys empathy, and they showed that their frequent use is positively correlated to therapeutic alliance and adherence.

In his now classical study *The Discourse of Medicine*, Elliot G. Mishler (20) investigated a routine medical interview as an interplay of two "voices." He stated that the "voice of medicine" has a technical focus, providing the meaning of events without personal and social context. The "voice of the lifeworld" involves a reference to the contextual, personal meaning of events and experiences. Mishler pointed out that the standard sequential structure of the interview, consisting of the doctor's question, the patient's answer, and the doctor's assessment, maintains the doctor's control of the interview and its topical content. When

the patient adds to their answer's surplus content arising from the "voice of the lifeworld," the routine sequential organisation is interrupted, causing troubles such as hesitation, gaps, or self-repair in the doctor's next turn. In the participants' attempts to achieve coherent and shared meanings, the "voice of medicine" dominates and regulates the "voice of the lifeworld."

Barry et al. (25) elaborated on Mishler's conception of "voices" and showed multiple relationships between them. When both the patient and the doctor operated within the voice of medicine (for example, in dealing with a broken leg), and when both of them used the "voice of the lifeworld" (for example when discussing the patient's psychosocial problem), the outcome of the general practise consultation (as measured by indicators of the patient-centred perspective) was better. The outcome was worse, however, when the doctor met the patient's "voice of the lifeworld" by transferring the topic toward the "voice of medicine."

Some studies have explored contextual differences in how clinicians respond to patients' descriptions of their subjective experiences. Comparing general practitioners' and psychiatrists' responses to the patients' emotional disclosures of depression, Davidsen and Fosgerau (26) suggested that general practitioners dealt with the patients' emotions emphatically and took a contextual approach to their problems, while the psychiatrists treated their emotional descriptions as symptoms, using their own biomedical interpretations and explanations. Hak and Boer (27) investigated how professionals receive the patients' accounts in three clinical contexts. They found an "interrogative style" in a medical interview, in which the clinician regularly proceeded to the next question without rephrasing (formulating) the patient's answer. In a psychiatric interview with a psychotic patient, there was an "exploratively oriented style," as the professional used formulations to check and clarify the patient's fragmented lifeworld talk, thereby transforming into the diagnostic assessment. In psychotherapy, in contrast, the clinicians formulated the gist of the patient's talk collaboratively with the patient.

In psychotherapy, the therapists' responsiveness to the patients' accounts of their experiences is at the heart of the clinical task (28–31). By analysing cognitive–constructivist psychotherapy, Voutilainen et al. (29) showed that the therapist combined recognition and interpretation to access the patient's experiences. Through recognition, the therapist validated the patient's emotions, thereby preparing the interpretation of their experiences. Furthermore, by analysing cognitive psychotherapy and psychoanalysis, Weiste and Peräkylä (31) demonstrated that therapists use four types of responsive formulations to gain access into the patients' experiences. They found that rephrasing and highlighting formulations were common in both therapeutic approaches.

Nonetheless, they were relocating formulations only in psychoanalysis and exaggerating formulations only in cognitive psychotherapy. According to this study, it can be said that different therapeutic approaches apply only partially different formulations in therapeutic responses.

Thereafter, Weiste et al. (32) took up what they call the "epistemic relation" between the psychotherapist and

patient, showing how the psychotherapist attempts to maintain the patient's primary right to know about and define their inner experiences. All in all, interactional studies on psychotherapy document how clinicians attend to the patients' subjective experience. Such attentiveness is something that is largely lacking in psychiatric interviews, as the studies cited earlier suggested.

While earlier research has covered some of the ways in which clinicians respond to the clients' accounts of their experiences, as far as we know, no interactional research has been made on how clients manage (or fail to manage) to insert their experience-oriented tellings in the psychiatric interview. This will be the task of the paper at hand. To understand how clients bring forth their experience in the interview, the concept of *"self-disclosure"* as social action is illuminating.

The idea of self-disclosure was introduced in the work of Canadian psychologist Sidney M. Jourard [(33), p. 19], who presented that "self-disclosure is the act of making yourself manifest, showing yourself so others can perceive you." He also stated that self-disclosure is a sign of growing toward a healthy personality and healthy relationships and viewed its function in the treatment process of psychotherapy and psychiatry. Antaki et al. (34), reviewing it from the interactional perspective, argued that "self-disclosure is a social performance which must be brought off in interaction, and has its interactional context and its interactional consequences" [(34), p. 181]. In data of naturally occurring therapeutic conversations, they pointed out three specific features of this interactional performance. First, it is manifested voluntarily when the speaker discloses some topic initiatively by themselves. Second, it is significant because it indicates that the telling is newsworthy, highly emphasised, or coloured, for example by means of "extreme case formulations" (35). Third, the self-disclosure reports personal information of intimate experiences being possibly a "bonus," thus over and above the momentary expectations of the co-interactant. Recently, Logren et al. (36) investigated self-disclosures in group counselling.

Recently, attempting to develop the participants' collaboration and advance patient-centred or individual evaluation in the psychiatric assessment interview, Savander et al. (37) compared two kinds of psychiatric assessment interviews: one supported by psychological case formulation (38, 39) and one following the standard medical approach (40). Clinicians who had received training in psychological case formulation asked questions about the patient's subjective experiences more frequently and topicalized such accounts more actively in the subsequent talk compared to clinicians whose interview style was based on the standard DSM/ICD orientation. Based on a quantitative analysis, this study also suggested that the patients frequently "go against the grain" in telling the clinicians about their subjective experiences. The patients offer their subjective experience accounts despite the fact that the clinicians do not invite or topicalize them.

In the work at hand, we will qualitatively examine one key environment where the patients go against the grain in reporting their subjective experiences. We focus on the patients' answers to clinicians' questions. In the cases that we examine, the clinicians' questions concern medical matters, while the patients include self-disclosures of their subjective experience in their answers.

Objectives

We investigate the patients' possibilities and practises to disclose their negative subjective experiences in response to the clinicians' medical or factual questions. We aim to explicate the interactional practises that the patients use in doing self-disclosures of their negative subjective experiences in this conversational environment.

MATERIALS AND METHODS

Participants and Data

Our data were initially collected for a randomised clinical study in a community mental health centre in Finland (37, 41). The study was accepted by the Ethics Committee of Tampere University Hospital. For that study, we audio-recorded 45 psychiatric intake interviews with patients who were referred to the mental health centre by their primary care or occupational health doctors. For the study at hand, we used 10 intake interviews (altogether 563 min). Five interviews represent the usual standard psychiatric interview (ICD/DSM) practise (Assessment as Usual, AAU group) (40), while the other five involve psychological case formulation based on dialogical sequence analysis (DSA group) (38, 39). While the interviews were not guided by a ready-made question list, the clinicians, especially in the AAU group, asked questions that routinely belong to the psychiatric diagnostic evaluation. The sequences that we examined came from two (often overlapping) phases of the interview: patient history and exploration of their present condition. During the interviews, some of the clinicians made notes on paper. They worked with a computer only at the end of the encounter, for example, when writing prescriptions or other formal statements. As the study at hand focuses on patients' interactional practises (rather than the clinicians' interview style), we did not separate between these two types of interviews but used all the data as one pool. We excluded patients with neuropsychiatric disorders and psychotic disorders and also those who needed acute assessment within 7 days. In each interview, the participants were two clinicians (a physician with a nurse or a psychologist) and the patient. The data from 10 interviews involved three psychiatric residents, three psychiatrists, three psychologists, three nurses, and ten adult patients (four female and six male adults) with various symptoms and diagnoses.

We audio-recorded 40 first visits in the DSA group and five randomly selected first visits from the AAU group. The five AAU interviews lasted 280 min, and the five DSA interviews lasted 283 min. Using the matching method, we chose five DSA interviews that corresponded with the five randomly selected AAU interviews. The matching was based on patient characteristics including (1) gender, (2) age, (3) educational level, (4) psychiatric treatment history, (5) substance abuse history, (6) ability to self-reflect, and (7) ability to verbalise experiences [for more details, see (37)].

For an earlier quantitative study (37), from the recorded interviews ($N = 10$), we collected all patients' utterances in

which they described their negative subjective experience in non-medical terms ($N = 119$). Sometimes, these utterances were preceded by the clinician's questions which focused on experiential (nonmedical) matters and sometimes by questions that focused on medical matters. In this study, we qualitatively examine the sequences where the patient's subjective experience-oriented utterance was preceded by the clinician's medically oriented question. There were 45 such sequences.

Procedure

The data were analysed using conversation analysis (CA). CA is a qualitative method for examining action sequences in social interaction (42). As mentioned above, the actual question–answer sequences that we analysed came from our previous study (37), where they were examined quantitatively. The sequences involved the clinician's medically oriented questions followed by the patient's response focusing on their negative subjective experiences.

The point of departure in our previous and current work has to do with the topical focus of utterances: we differentiated between *medical* and *experiential* domains. This distinction corresponds grossly to Mishler's (20) binarity between the "voice of medicine" and "voice of the lifeworld."

The complexities pertaining to the binarity between medical and experiential domains should be acknowledged. In one sense, everything the patient tells about their symptoms and psychological problems involves subjective experience; otherwise, the patient could either not tell about psychological problems involving subjective experience or would not be able to talk about it. Likewise, all clinicians' questions have to be linked to some aspect of the patient's experience in order for the patient to be able to answer at all. On the other hand, anything that the patient tells about himself/herself can ultimately be understood as medically relevant. Our distinction between medical and experiential domains, however, is more specific. We assume that the clinician's questions are often informed by the standard agenda of psychiatric interview, their aim being to collect information for the diagnosis. Even if such agenda questions have to do with subjectively experienced things such as appetite, sleeping problems, or feeling high, we consider them as questions that belong to the medical domain. On the other hand, the patients can provide the information that was asked for and thereby remain in the medical domain—or alternatively, they can tell something else about their lives, thereby shifting to an experiential realm. Our focus was particularly on the patients' tellings about their negative subjective experiences. In the earlier study where the coding was initially done, we defined the experiential answers as ones that "the patient describes in negative terms a personal feeling, attitude, experience, or life event" [(37), p. 1297].

Thus, in our corpus, medically oriented questions involved interrogatives or inferential statements about symptoms or behaviours characterising the patient's condition or functioning. Such questions did not seek to elucidate the meanings, which the patient attributes to symptoms or behaviours. The patients' responses focusing on subjective experiences involved negatively valenced voluntary descriptions—doing more than just answering the question—of personal experiences, feelings, attitudes, or life events. In terms of action, these answers were understood as self-disclosures. In the qualitative data analysis presented in this paper, self-disclosure as action proved to be the key concept.

The preliminary analysis of the interviews was done by the first author. She identified 45 question–answer sequences that were analysed for this paper. The sequences started with the clinician's question with a medical focus, which was followed by the patient's response which included an account of negative subjective experience. Examining these sequences, the first and fourth authors found four trajectories in and through which the shift from medical to experiential focus could take place. Of the 45 question–answer sequences, 40 could be grouped in one of the four trajectories. The remaining five did not fit in any of the trajectories, and they are not analysed in this paper. In these cases, for example, either the nurse's question was not heard by the patient or the patient's experience was positively and not negatively valued. After the grouping of the sequences, the first author analysed all instances in each group. Based on this analysis, the first and fourth authors selected the clearest and most representative sequences from each group. These were subjected to in-depth conversation analysis performed by the first author and followed by elaboration by the first and fourth authors.

Most of these sequences are presented in this paper.

RESULTS

In all examples, the indirectly identifiable data have been presented without gender and age, and all personal information has been anonymized in the extracts. In our collection, we found four different trajectories in which the focus of the participants' talk shifts from the clinician's medical question to the patient's disclosure of their subjective experience in the following turn. Out of the 45 cases, 40 represented one or the other of these four trajectories. Before we present the trajectories, we will show an example of where the patient does *not* shift the focus of the talk after a medical question, but instead produces an answer that remains in the medical domain. This is the "baseline" trajectory, from which the cases differ from those to be shown later. Consider **Extract 1**.

Extract 1 is a typical instance of a medically oriented psychiatric interview. In lines 1–2, the doctor (DO) asks a yes–no question about appetite. This is a paradigmatic agenda question, as lack of appetite can be a symptom of depression. The patient (PA) describes the symptoms with some pauses in lines 4–10. During PA's turn, DO offers a minimal response token, *"yeah?"* (line 6), thus encouraging PA to continue and extend the response. In lines 11–12, DO acknowledgement and a long pause (4.0) close this sequence and the topic of appetite. Maintaining medical orientation, DO asks another symptom-oriented question in line 13. PA's answer (lines 4–9) involves more than a mere "yes" or "no," which would grammatically be the minimal adequate answer to the question. Yet in her extensions of the answer, PA remains on the topic (appetite) and indeed

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Extract 1

1   DO:   mite onks sulla nyt ruokahaluu vai pitääkö sille pakottaa
           how about do you have apetite now or do you have to like force

2         ittesä syömää nytte,
           yourself to eat now,

3         (0.6)

4   PA:   nyt on taas ruokahaluu (0.2) mut tos (0.8) kuukaus sit
           now I have some appetite again (0.2) but about (0.8) a month

5         takaperi ni (0.4) ei oikee (1.0) (h)ollu näl[kä tai
           ago (0.4) I really (1.0) (h)didn't feel hun[gry or

6   DO:                                              [joo?
                                                     [yeah?

7   PA:   mitää ei maistunu,
           I didn't crave for anything,

8         (1.0)

9   PA:   kyl mä silti söin pieniä määriä.
           surely I still ate some little bits.

10        (0.2)

11  DO:   joo?
           yeah?

12        (4.0)

13  DO:   miten sä yleisesti ottain pystyt keskittymään asioihin,
           how are you in general able to concentrate on things,
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Extract 2

1   DO:   mut käydää vielä mu- muutamia asioita ähh
           but let's go th- through a fe- few more things uhh

2         nyt lä- läpi enne kup (.) tehdään näitä se-
           now before p (.) we make these ple-

3         öh. suunnitelmia mietitään mistä- mistä
           uh. plans let's think about what- what

4         sinä saattasit hyötyä .mthhhhh ni onks
           you might benefit from .tchhhhh so have your

5         viime k:uukausina ollu ajatukset elämä tuntuu
           thoughts over the last mon:ths been life feels

6         nii vaikealta ettet haluais enää e#lää#.
           so difficult that you wouldn't want to l#ive# anymore.

7         (0.3)

8   PA:   e::i.
           no::o.

9   DO:   joo-o?
           ye-ah?

10  PA:   .mthhhh joskus ↑vaa tuntuu niinku (0.5) et
           .tchhhh sometimes it ↑just feels like (0.5) so that

11        niinkus siltä että koska nää sairastelut ja
           like when will this being ill and

12        nää #riittää mun kohal[la,#
           all this #be enough on my pa[rt,#

13  DO:                        [joo?
                                [yeah?

14  PA:   et kun niit ton sillee ollun niin paljon.
           'cos there's been like so much of it.

15  DO:   joo no se on iha ymmärrettävää elikkä onko
           yes well it is quite understandable so is

16        se näin ettet om myöskää suunnitellu viime
           it so that you haven't even planned in last

17        kuukausina itsemurhan teke:mistä.
           months to commit suici:de.

18  PA:   e::n.
           no::o.

19  DO:   joo-o?
           ye-ah?

20        (2.0)
```

gives further information related to it, which hearably serves the question's agenda (information gathering about appetite). The patient does not make self-disclosures of their subjective experience. Contrary to our subsequent cases, here it is mainly the clinician who controls the interview by asking medically oriented questions.

While the question–answer structure generally allocates control of the topic and action to the questioner (20–22), in the trajectories we analysed, the patient takes some control by steering the talk. In some trajectories, the patient's "grasp" of control is more pervasive than in others. Below, we will present the four trajectories in an order related to the patient's control, starting from the weakest control and moving toward the stronger control.

Self-Disclosure of Personal Experience After Medical Answer and Its Acknowledgement

In the first type of trajectory, the clinician's medical question is followed by the patient's answer, which focuses on the medical realm. Thereafter, the doctor acknowledges the patient's answer, and after this acknowledgement, the patient moves on to self-disclosing personal experience. The patient takes topical and action-related control as they make the self-disclosure. The grasp of control is not drastic, however, as the patient first cooperates fully with the clinician's question, offering a topically adequate answer and waiting for the clinician to acknowledge it.

We discovered 15 sequences following this pattern, of which we will introduce two cases. **Extract 2** below is from an interview with a young adult patient whose main symptoms are anxiety and unspecified stomach pain. In the past, PA has suffered from a malignant disease, but the control has been normal for several years. In lines 1–4, DO explicates their plan for the rest

of the interview: DO still wants to cover *some things* before moving on to discussion of treatment (lines 3–4: *"what you might benefit from"*).

In lines 4–6, DO asks about suicidal thoughts. PA gives an answer in the negative (line 8), which DO acknowledges in line 8. After the acknowledgement, PA moves on to self-disclose a negative personal experience (lines 10–14).

A yes–no question about suicide ideation, like the one that DO asks in lines 4–6, is part of the standard and even required agenda in a psychiatric assessment interview (40). DO's orientation to the agenda is indeed manifested in their preface to the question: DO needs to go through a few things before moving on to discuss treatments (lines 1–3). DO's voice quality during the question also appears to convey an orientation to a standard agenda: a matter-of-fact and neutral tone of voice conveys an impression of reading from a questionnaire. Yet, the question is simultaneously one that potentially touches upon a most personal experience in the patient. A "no" answer could project the closing of the

topic, while "yes" would project further questions about suicidal thoughts. This dual characteristic of the question (part of the medical agenda, yet also a touching experience) may prompt how PA answers it. PA gives a simple (yet a bit delayed) answer in the negative in line 8. DO acknowledges this answer in line 9. The interactional work that the token in line does is ambiguous: it could close the sequence, but with its rising intonation, it could also be heard as a "continuer" (43) displaying an expectation of further talk to come. Immediately after the acknowledgement, however, PA moves on to talk about their tiredness with physical illnesses (lines 10–14). Thus, PA expands their initial answer with a self-disclosure of their subjective experience. By their self-disclosure, PA steps away from the possible projection of the question (closing topic after "no," further talk after "yes") and momentarily takes some control of the topic and action. However, PA's self-disclosure (lines 10–12, 14) is linked to DO's question and PA's initial answer: it implicitly conveys a kind of hopelessness that the question was about, even though PA explicitly denied having suicidal thoughts. In their question, DO has left the door half-open in this direction, as it were. The linkage to the question is preserved by PA's word choice: in line 10, PA recycles the word "tuntuu"/"feels" that was in the doctor's question (line 5). DO receives PA's answer with a continuer in line 13, whereafter PA reiterates their account once more in line 14. DO receives PA's self-disclosure with a normalising evaluation (line 15), whereby they decline the possibility of further talk about it. The evaluation is seamlessly followed by a question where DO returns to the question of suicide ideation (lines 15–17). PA once again answers in the negative (line 18), and DO receives the answer in line 19 with a token similar to the one by which she received PA's initial answer in line 9. Now the token is treated by both participants unequivocally as a "sequence closing third" (42) and DO moves on to new topic and activity (line 21).

PA's self-disclosure is designed to convey a strong negative affect. This form of a rhetorical question (44) conveys the action of complaint. The pitch contour at the beginning of the account, especially the rising pitch at the word "just" (line 10) is typical for complaints. Emphasising the words "sometimes" (line 10), "when" (line 11), and "enough" (line 12) also maintains the complaining tone (45). While the creaky voice at the end of line 12 can be associated with a turn transition (46), it also seems to convey sadness in this context. In reiterating their complaint in line 14, PA emphasises the amount or frequency of their illnesses by an "extreme case formulation" (35), "so much." By all these means of affective expression, the patient's self-disclosure is designed to convey the importance and emotional weight of what is being said. PA portrays the reports as a matter of concern and personal importance, thereby legitimising the move to self-disclosure.

For another example of the patient's self-disclosure following a medical answer and the clinician's acknowledgement, consider **Extract 3**. PA has a mood disorder. In the history-taking phase of the psychiatric interview, DO has just explored PA's manic symptoms in their adolescence and recent past. In lines 1–3, DO offers PA a medical (and uncertain) view about the severity of their recent symptoms. Following this, in lines 3–5, DO asks whether PA has had other manic episodes in their life—using the conventional Finnish euphemism "racy" for manic. Mapping

past occurrences of manic episodes is part of history-taking in mood disorders. Grammatically, the question projects a "yes" or "no" answer. Yet, in the context of diagnostic interview, the possible trajectories after different answers would be different: a "yes" would call for further elaboration of the other racy episodes, while a "no" could warrant a move to the next agenda item.

Here (as in **Extract 1**) PA's initial answer (line 6) orients to the yes–no polarity; in this case, the answer is in the negative, with some qualification. DO acknowledges the answer by repeating the negation word "no" in line 8, thereby opening up the possibility for an extension of the answer and giving the space for PA to continue. PA indeed elaborates the answer in lines 9–16, displaying something of her grounds to think that there have not been other "racy" episodes. Through the expansion, the patient orients herself to the medical diagnostic agenda: she provides information about possible specific symptoms in her past. DO receives the patient's elaboration by a string of acknowledgements (lines 15, 17, 19); the final one ("okay" in line 19), through its placement (after a gap following the acknowledgement in line 17) and design (rising intonation), not only closes the prior sequence but also projects a move to the next question or action (47). At this point, PA hurriedly cuts in (line 20) and moves on to extend their account with a self-disclosure of negative personal experience.

PA's answer in lines 6–16 conveyed that in their past, there have not been manic episodes other than those already discussed; however, PA now offers another view of the past, characterising it as one filled with anxiety. The change of direction in PA's account is embodied in the turn beginning "tai että," best translated "or like" (line 20): PA seems to point out that, despite the fact that there were no more manic episodes, there still were mental problems. PA's self-disclosure is expressive, emphasising the key descriptor of the subjective experience, "<anxiety>," by stressing two syllables and slow delivery. PA highlights the effort to endure anxiety by using the word "fighting" (lines 21–22). PA first points out that this fighting against anxiety took place during their student years, but thereafter, they upgrade the temporal characterisation with an extreme case formulation, "probably throughout my life" (line 23). PA continues their expressive emphasised account with a storey about a scene from their childhood; here, the repeated key descriptor, "I was raging" (lines 25, 31, and 32), depicts a particularly intensive negative experience. The louder volume at the final delivery of this descriptor (line 32) seems to embody PA's forceful emotions.

In sum, after the clinician acknowledged the patient's answer to the clinician's factual and medical question, the patient in **Extract 3** self-disclosed a negative subjective experience on their own initiative. The self-disclosure was designed as a self-corrective expansion of the patient's medical answer.

With expressive delivery, verbs depicting intense emotions, extreme case formulation, and storytelling, the patient's self-disclosure conveys the importance and emotional weight of being said. Here, as in **Extract 2**, such practises seem to legitimise the patient's shift to self-disclosure.

In **Extracts 2**, **3**, the patients' self-disclosures occurred after the clinicians' medical questions, the patients' answers, and the clinicians' acknowledgements of the answers. In

```
Extract 3

1    DO:   hypomania vai mania vähä riippuu nyt pi- mitä
           hypomania or mania it depends a bit on sh- what

2          siihen nsit (0.2) ku (.) var- varsinaisesti
           for it (0.2) 'cos (.) act- actually

3          #oli mutta# .hhh onks mitää muut semmost
           #there was but# .hhh would there be any other like

4          vauhdikk#aampaa jaksoo# (0.4) niinku elämän
           more ra#cy phase# (0.4) like throughout

5          [#aikana# et ois,]
           [#life# that you would've had,]

6    PA:   [hffff-fff hm krhm hff mt ei ning ei tällästä.
           [hffff-fff] hm krhm hff tch no like not like this.

7          (0.3)

8    DO:   [°#ei.#°]
           [°#no.#°]

9    PA:   [et] kyl se oli niinku kyl mä
           [so] surely it was like surely I

10   PA:   nyt niinku #u# tunnistan sit#ä< m# tai kum
           like #uh# recognize it now thi#s< m# or when

11         mi mietin sit#ä#< (0.5) nyt sitä kevään
           I think abo#ut it#< (0.5) now about the event

12         tapahtum#aa ni# em .hh emmä kyl muistan.
           during the spr#ing time then# .hh I really don't remember h.

13         niinku noin vauhdi£kast(h)a£ .hhh #jaksoah
           like such a ra£c(h)y£ .hhh #phase h

14         aiemmin [e#ttä pait]si sillon (0.7) sillon
           before [s#o except when (0.7) when

15   DO:          [.hhh °joo.°]
                  [.hhh °yeah.°]

16   PA:   teini-iässä että.
           I was a teenager so.

17   DO:   .joo-o
           .ye-ah

18         (1.7)

19   DO:   .mhhthhh oke:i?=
           .tchhhhh oka:y?=

20   PA:   =nn tai että sellasen niinkum (0.6) mth
           =nn or like with that kind of (0.6) tch

21         <ahdistunneisuuden> kanssa mä oon taistenu
           <anxiety> I've been fighting with

22         kyl (.) taistellu myös opiskeluaikoina ju.
           indeed (.) fighting also during my student times already.

23         tai niinku varmaa läpi elämäni et sillon n
           or like probably thoughout my life so then n

24         tyylii seittemäv #vuotiaana# kum mun piti
           when I was about seven #years old# when I had to

25         opetella @tavaamaa ni@ .hh mä [raivosin
           learn @spelling so@ .hh I was [raging

26   DO:                                 [.hhh

27   PA:   isälle[le] jostain ikkunasta isä #al-#isä
           at my d[ad] from a window dad #dow-# dad

28   DO:         [phh.]

29   PA:   ja muut kaverit oli ulkon#a# (.) ulkona mh
           and other friends were outsi#de# (.) outside mh

30         leikkipuistossa mä muistan sen ku mä huusin
           by the play park and I remember when I was yelling

31         sielt ikkunasta >mä va< sitä raivo rai-
           out the window >I was just< the ra-

32         RAIVOSIN sitä tusk#aa#
           I was RAGING out that pa#in#

           ((narration continues))
```

these environments, the patients' shift to self-disclosure of their subjective experience is relatively fluent and direct. Nonetheless, the patients intensify the meanings of their telling,

thereby seemingly legitimising their self-initiatory accounts of subjective experience.

Shifts Without Prior Acknowledgement of the Answer

In the cases shown above, the patients shifted to self-disclosure of personal experiences after the clinicians had acknowledged their medical answers. Sometimes, however, the patient gives the medical or factual answer but then moves onto their self-disclosure *without* the clinician's acknowledgement of that answer. Thereby, the patients take somewhat more control of the course of the interaction than they do in the cases shown thus far. In our data, there were 11 sequences in this group; below, we will show one of them.

In **Extract 4**, PA has a mood disorder and aggression management problems. Two clinicians are present: DO and a psychologist (PS). Before PS's question, PA complained about some physical symptoms associated with his anger (not shown here). Thereafter, in line 1 of the extract, PS asks a follow-up question on the topic of anger.

PS's question (lines 1–2) seeks to clarify whether PA's anger or propensity for it has increased. Here the anger is a medical symptom expressed as a noun without context, and the clinician asked about its magnitude. The polar question projects a "yes" or "no" answer; a "yes" could particularly make relevant further inquiries or elaboration about the anger. The patient gives an answer in the positive and moves on to extend their turn with a self-disclosure of problematic personal experience (lines 3–22).

PA's turn initiation (line 3) overlaps with the end of PS's question. The overlap may imply that the answer is designed as one that arises from PA's own perspective (48–50). PA first answers with minimal confirmation, "*it ha:s*," whereafter PA redoes and specifies the confirmation in the same prosodic unit by a sentence where PA recycles the verb from the question, "*it has now recently increased especially that it has been so that.*" This two-fold turn-design (minimal confirmation plus elaboration that recycles the key term from the question) may adumbrate an independently articulated and expanded account where PA would break away from the terms of the question (51–53). However, the specification of the confirmation is left incomplete, as PA aborts their sentence construction, breathes in, pauses (line 4), and restarts with a new sentence in line 5. Here, PA self-discloses a personal experience, bringing in a new but related topic—problems with their uncle. Naming a problem (lines 5–6) projects its further unpacking and elaboration (54). PA indicates the intensity of the problem by extreme case formulation: "*actually a re:ally big problem in my life h.*" DO aligns themselves as a recipient of such elaboration by the minimal response particle "*mm*" in line 8.

PA extends the self-disclosure by elaborating the complaints regarding their uncle in lines 9–22. The emotional intensity of their account is encapsulated, for example in the idiomatic depiction of the uncle's unreasonable reactions, 'ottaa herneen nenään," which could possibly be translated as "*goes bananas*," and in characterisation with an extreme case formulation: "*he is*

Extract 4

```
1   PS:    onks semmonen kiukustuminel lisääntyny: (.)
            has this kind of anger increa:sed (.)

2          tai [herkkyys,
            or [propensity,

3   PA:        [on: se on nyt lähiaikoin lisääntyny
                [it ha:s it has now recently increased

4          varsinki että se on ollus sillee että .hh (0.2)
            especially that it has been so that .hh (0.2)

5          no sit toi mun setä ↑on oikeestaan to:si iso
            well so then that uncle of ours ↑is actualy a re:ally big

6          ongelma mun elämäs. h
            problem in my life. h

7          (.)

8   DO:    [mm,

9   PA:    [mä vaan toivon et tän asian sais sillee et se
            [I just hope that this thing could be sorted out so that he

10         lähtis nyt eläkkeelle itekkhi.
            would now retire himself.

11         (.)

12         .h siit on enemmä haittaa tua ku hyätyy,
            .h he does more harm than good,

13         (.)

14  DO:    mm-m j[oo,
            mm-m y[eah,

15  PA:         [sit ku silles sanoo jotain ni se ottaa
                [then when you say something to him he

16         herneen nenään siitä ja,
            goes bananas about it and,

17         (.)

18  DO:    .h[hh

19  PA:    [se< k:iukuttele[e °muaa::° se on ihan (0.2)
            [he< throws t:antrums [°at me::° he is totally (0.2)

20  DO:                    [khh.

21  PA:    älytön (.) ei sitä voik kukaan käsittää ellei
            insane (.) no one can understand it unless

22         kukaan nää.
            one can see.
```

Shifts to Self-Disclosure Within the Patients' Extended Response

In the extracts shown thus far, the clinicians' medical questions were followed first by a medical answer, whereafter the patient shifted to a self-disclosure of personal experience. The clinician's acknowledgement preceded such a shift in the second and third extracts, whereas in the fourth one, the patient made the move without the intervening acknowledgement. We discovered nine sequences following more complex patterns, of which we will introduce one case. In **Extract 5**, shown below, the patient produced an extended answer to the medical question, and here, the medical and experiential realms were intertwined throughout the answer.

The patient concluded by self-disclosing a problematic experience, yet there was not a definite point where the medical answer ended and the self-disclosure began. Rather, the shift toward a self-disclosure of personal experience involves what has been called "stepwise transition" (55).

Extract 5 highlights a middle-aged PA with a recurrent mood disorder and features of personality pathology. The extract is from the history-taking phase of the interview. Prior to the extract, PA had been telling about their tiredness and nervousness. The end of this telling is shown in lines 1–2. DO receives this with a softly uttered *"mm"* (line 3). After a long gap in line 4, DO asks the next question about sleeping difficulties.

DO's question in lines 5–6 seems to have a double function in this context: on the one hand, it shifts to a new standard agenda item (sleeping); on the other hand, it is tied to the previous discussion about tiredness and nervousness, which might lead to sleeping difficulties. This double function is reflected by the structure of the turn, which consists of two parts. The first part involves idiomatic sentence structure combining "yes–no" and "Wh" question features (translated here as *"how do you sleep?"*). With this question, DO invites an evaluation of PA's sleep; this evaluation might be tied to the prior talk about tiredness and nervousness. DO, however, continues with another interrogative sentence, which is more specific and oriented to standard medical agenda: a polar question about *"sleeping problems"* in the present time.

In the extended answer beginning on line 8, PA moves gradually from the factual, medically oriented answer through stepwise topical transitions to self-disclosures of personal experience; they end up with complaints about not having received psychotherapy.

After a 1.0-s gap, PA starts the response in line 8, targeting the latter part of DO's question by hesitantly stating, *"well no:o,"* whereafter PA continues with the qualification, *"I don't have any major ones."* This is followed by beginning a further elaboration, *"so I"* (line 8), which then, after a pause, leads into a narrative in lines 9–14 about having prior sleeping difficulties. In and through the answer, PA moves from the initial answer in the negative, *"well no:o:,"* toward an assertion of problems having been there, and from focus on the present to focus on the past. Furthermore, PA moves from the categorical answer (*"no"*) to a self-initiatory characterisation of the sleeping difficulties that PA has had (in lines 9–14). PA emphasises the severity of their sleeping problems

totally (0.2) insane." DO remains in the recipient's position, as indicated by the response particles in line 14.

In **Extract 4**, the patient first answers minimally to the clinician's medically oriented question. Thereafter, in two "steps," the patient shifts to a self-disclosure of their problematic personal experience. The first step involves redoing (lines 3–4) the initial answer so that it adumbrates the self-directed talk. The second step involves self-interruption and restarting, leading to the self-disclosure where they complain about the uncle. In describing their problems with the uncle, the patient employed expressive and emphasising language, which seemingly legitimised the move into self-disclosure.

By shifting to their self-disclosure of personal experience without waiting for the clinician's confirmation of their initial answer, the patient took more of the local control of interaction than the patients in **Extracts 2**, **3**. Common to all the above extracts, however, were the expressions of intensity of concern that legitimised the shift to a self-disclosure of personal experience.

Extract 5

```
1 PA:     ei tota jos yrittää jotain väkisinkin nii ei
          no well if one tries to force something then

2         siit °oikeen tahot tulla mi[tää.°
          it °really tends to not work [out.°

3 DO:                                [°mm°.

4         (3.2)

5 DO:     .mthhhh no saatko miten nukuttua↓ onks sulla
          .tchhhhh well how do you sleep↓ do you have

6         uniongelmia °täl hetkel.°
          sleeping problems °currently.°

7         (1.0)

8 PA:     no e:i ei mulla nyt suurempia että mulla<
          well no:o I don't have any major ones so I<

9         (0.2) mulla oli jossai vaiheessa aikamoine:
          (0.2) had at some point quite a:

10        sillon (0.2) kesällä aikamoisia
          back in (0.2) the summer quite big

11        (.) uniongelmiaki että mä saatoin sitte
          (.) sleeping problems too so I might have

12        (0.6) valvoa miettiä asioita (0.2) aika
          (0.6) stayed awake thinking about things (0.2) quite

13        pikkutunnillej ja sit sieltä sit alkaa
          until the small hours and thereafter start to

14        nukkumaam °mutta.°
          sleep °but.°

15        (1.5)

16 PA:    vähän tossa nyt oli sitte tuola yksityisklinikan
          I was just recently there at the private clinic

17        puolel mä sain tommosta (0.5) tommosta:.
          side I received that kind of (0.5) that kind o:f.

18        (1.0)

19        akupunktio (.) korva-akupunktiojuttua ni se
          acupuncture (.) ear acupuncture thing so that

20        vähäns siel ni se nyt ei oikee muuhun auttanuk
          a bit so it didn't really help otherwise

21        ku (1.0) auttanus ↑sittek kut tuoho (0.5) vähän
          than (1.0) otherwise ↑than in this (0.5) it helped

22        siihen unee autto semmonen [kolme viikon jakso.
          a bit with the sleep that [three weeks time period.

23 DO:                               [mm.

24 DO:    hm.

25        (3.0)

26 PA:    ja vähän se oli terapiaa tai °>muutaki
          and there was a bit of therapy or °>some other things

27        semmosta<° (0.5) °jotain° (.) em mää nyt ko
          like that<° (0.5) °something° (.) I'm not really as

28        (.) mä en ymmärrä ku mä en oikein koskaan saanus
          (.) I don't understand since I didn't ever really get

29        sitä niim mitä se .hhhh vähän kyselin
          what it .hhhh of course I was asking a bit

30        tietysti mitä siel nyt terapia olis [että.
          about what the therapy there would be like [so.

31 DO:                                        [°mm°.

32        (2.2)

33 DO:    .hhhhh miten pystyt asioihin keskittymään.
          .hhhhh how are you able to focus on things.
```

by characterising them as *"quite big"* (lines 9–10) and pointing out that PA stayed awake *"until the small hours"* (line 13). In this self-initiatory elaboration of their answer, the patient still orients themselves to the agenda of the question, providing information about the sleeping problems. Yet, by describing the details of the problems (thinking about things until the small hours), the patient also makes a move toward the self-disclosure of personal experience.

In line 14, PA's turn seemingly trails off. PA ends the utterance with the connector *"but"* which might also project further talk, possibly disjunctive talk. DO seems to be alive for the possibility of further talk and remains silent, and after a gap, PA resumes their account in line 16. Now PA tells about ear acupuncture therapy in a private clinic, which helped with the sleeplessness *"a bit"* (lines 19–20).

While acknowledging this help, however, PA points out that the acupuncture did not help *"otherwise"* (line 21). DO acknowledges PA's telling by minimal *"mm"* tokens in lines 23 and 24. After a silence of 3.0 s (line 25), PA produces yet another extension of the account, moving hesitantly on to something that is hearable as a complaint for not having received *"therapy"* at this other private clinic (lines 26–30). (Elsewhere in the interview, it becomes clear that PA complains persistently about not having been offered psychotherapy.) In lines 29–30, PA talks about asking for therapy. PA's report trails off at the end of line 30 with the final conjunction, *"että. / so.,"* which may leave some tacit meaning of the previous topic in the air, while still completing the turn (56). In line 31, DO acknowledges PA's account by *"mm,"* and after a gap, DO continues the medical agenda about another medical symptom without taking up or topicalizing PA's extended account.

In **Extract 5**, the clinician's complex question opened up a space for both factual, agenda-oriented information about sleeping problems, and for more contextual talk about them. The patient starts their response with a factual, medically oriented answer (line 8). Then, the patient gradually transfers the topic from the sleeping difficulties toward the last theme about the therapy in three moves, which together constituted a stepwise topical transition (55). In terms of action, PA gradually shifts from answering to self-disclosing a personal experience. During the patient's telling, the clinician positioned themselves as a passive recipient by producing quiet *"mm"* tokens (57) and remaining silent at transition relevance places. The clinician's passivity facilitates the patient's moves toward self-disclosure.

In the first transition (lines 8–10), the patient moved from claiming that they have no "major" sleep problems to accounting for their past difficulties with sleep.

In the second transition (lines 17–19), the patient moved on to talk about the ear acupuncture treatment, characterising it as having helped only *"a bit"* with the sleeping problems. Finally, in the third topical transition (lines 25–30), the patient leaves behind issues directly linked to sleep and delivers a complaining self-disclosure about not having received *"therapy,"* which is coached by the report of having asked for it at the other private clinic. Thus, the patient has moved from the medical question step by step into the self-disclosure of their negative personal experience.

In **Extract 5**, shown above, and in the others of this group of trajectories, the patients produced extended answers to the medical questions, and in these answers, the medical and experiential topics were usually intertwined. Likewise, two actions—answering and self-disclosure—were overlapping. In most of these cases (as in **Extract 5**), the clinicians' questions had two facets, as it were: while they made relevant medical and factual answers, they also left the door open to descriptions of the patients' experiences. The patients then could respond to both facets of the questions. In most cases, the clinicians remained passive and receptive, which facilitated the patients' moves toward self-disclosures of problematic experiences. In their self-disclosures, the patients highlighted by turn design the emotional intensity of the matters that they spoke about. They also took control of the conversational space more than in the extracts shown earlier.

Shifts With the Patient's Evasive Response

In all cases shown thus far, the patients first responded to the clinicians' medical question with a medical answer, and then, in one way or another, they moved onto a self-disclosure of a personal experience. There were, however, a relatively small number of cases—only five—in which the patient did not offer a medical answer at the beginning of their turn but instead started straightaway with a self-disclosure. Only later on during their utterances, the patients may have provided a factual or medical answer. **Extract 6** below is one case from this group. Through an initial question reflecting the psychiatric interview agenda, the clinician seeks information about the patient's free-time activities. The patient responded with a complaint storey about their uncle, linking that to the question but without producing a recognisable proper answer.

PA is the same adult as in **Extract 4**. This sequence is taken from a later moment in the interview. Before the extract below, the participants were talking about the patient's work-related stress. In lines 1–8, PS and PA talk about how many hours per day PA is able to work. In the omitted data (lines 9–16), PA tells about the compulsive nature of the work.

After having dealt with PA's work situation, PS asks a question in line 17 about PA's free time. Mapping out the patient's global functioning, the question about free time is a standard agenda item in the evaluation of the clinical significance of mental problems (40). Here, the question is also anchored in its local context. It follows the discussion about PA's reduced working hours (due to their health): PS now invites PA to tell increased free time. Grammatically, this question is different from the ones shown in the prior extract; as a "Wh" question (and not a yes–no question), it leaves it up to PA to decide the direction of the answer. Yet the design of the question (*"How has your free time been going?"*) invites an evaluative answer, conveying that the free time has been going well, or not so well.

Rather than offering a general evaluation of their free time, however, PA responds by telling a complaining storey about their uncle, whom PA depicts as somebody that spoils Saturdays. The storey about the uncle spoiling the Saturdays conveys an evaluative perspective of free time (made relevant by the question): Saturdays spoiled by the uncle are part of the free

```
Extract 6

1  PS:   joo (.) paljo suunnillee nyt monta tuntii oot
         yeah (.) how much roughly now how many hours

2        ja[ksanu?
         have [you been able to?

3  PA:      [(--) .hh nemmä oo kyl .phh varmaa neljäh (.)
             [(--) .hh I haven't really .phh probably four h (.)

4        ehkä,
         perhaps,

5        (.)

6  DO:   m joo,
         m yeah,

7        (.)

8  PA:   vähä vaihtelevasti (.) neljäst kuutee tunt[ii,
         a bit varying (.) from four to six hou[rs,

         ((8 lines omitted))

17 PS:   mites se vapaa-aika nyt on sit menny (0.2) .mhh
         how has your free-time been going so far (0.2) .mhh

18 PA:   no (1.0) siis sanotaako tällee ku mun setä soittaa
         well (1.0) so let's say in this way when my uncle calls

19       lauantain mua alkaa vituttaa mul on päivä
         on Saturday I get pissed off my day is

20       pilal pelkästää et mä nään et se soittaa,
         ruined only from seeing that he's calling,

21       (0.2)

22 PS:   mitä sä sit teet.
         what do you do then.

23       (1.0)

24 PA:   en tiiä yritän rauhottaa itteni jollai tyylillä.
         I don't know I try to calm myself down in some way.

25       (.)

26 PS:   ymm (.) (m)[i-
         ymm (.) (wh)[a-

27 PA:             [mielellää ei vastais sille ees
                    [I'd rather not answer him even

28       puhelimee mut- (.) vaik sil ei oo mitää
         on the phone but- (.) even though he doesn't have any

29       työasiaa (.) .hh ni silti se puhuu mulle sitte ku mä
         work-related issue (.) .hh he still talks to me then when I

30       vastaa se alkaa et tää olis taas ollu työ[juttu
         answer he starts (saying) that would have been again [a work thing

31 DO:                                            [hhh

32 PA:   tos ja tos [paskaa jauhaa.
         this and that [talks bullshit.

33 DO:              [mm,

34 PS:   .hh minkälaisii [kei-
         .hh what kind of [mea-

35 PA:                   [sellast syyllistämist ja tälläst
                          [this kind of blaming and stuff like that

36       kokoaja.
         all the time.

37 PS:   =ymm (.) ymm .hh millasii keinoi sit siihe itse
         =ymm (.) ymm .hh what means do you have then

38       rauhotteluu sulla nyt on mitä=millä sä yrität rauhottaa ittees,
         to calm yourself now what=how do you try to calm yourself,

39 PA:   .hhh ↓no ei kai sitä mitää oottelet lauantai
         .hhh ↓well not much I guess just wait for Saturday

40       iltaan pääsee saunaa ja r- juomaa kaljaah,
         evening to get to the sauna and f- drink beer h,
```

time. Yet, action-wise, the storey involves the self-disclosure of a subjective experience. PA starts the turn with a *"no / well"* preface, which may implicate the indirectness of the response to

come and a need to negotiate the topic of the question, implying the speaker's own perspective (58, 59). After the preface and a 1.0-s pause, PA frames the answer with a particular phrase, "*so let's say in this way*," adumbrating an answer that is not a direct response to the question but is nevertheless tied to it. After this, PA moves directly onto a self-disclosure of a personal experience, a complaint storey about the uncle who disturbs and irritates the patient with phone calls. In line 19, PA depicts the irritation by using the colloquial expression, "*alkaa vituttaa / I get pissed off*," and characterises the consequences of the phone call using the self-pitying expression, "*my day is ruined.*"

PS aligns themselves as a recipient with a follow-up question about PA's behaviour in response to the uncle's disruptive phone call (line 22). Somewhat hesitantly, PA tells about trying to calm themselves down (line 24). In line 26, PS acknowledges PA's answer and begins something that appears as a further question about the matter. PA, however, continues the answer (describing their response to the phone calls) in lines 27–28. In line 28, PA returns the focus on the uncle and his inappropriate behaviour. The emotional tenor of the account is intensified in line 24, as PA depicts the uncle's talk as "*paskaa / bullshit.*"

In line 34, PS starts a question once more but again aborts it as PA continues telling about the uncle's bad behaviour toward PA, completing it with an extreme case formulation ("*all the time.*"). Only after two acknowledgement tokens in lines 37–38, PS returns to the aborted question (line 34) and asks to specify a means of calming themselves down. PA names the sauna and beer as the means for that.

In **Extract 6**, shown above, the patient answers the clinician's question with a self-disclosure in the form of a complaint storey. With a particular preface (line 18), the patient framed the self-disclosure as an answer to the clinician's question. The clinician was an active recipient asking follow-up questions, yet the patient ignored the psychologist's efforts to ask questions twice (lines 27 and 35), instead continuing the storey. In this storey, the patient portrayed the emotional weight and urgency of what they were saying in many ways: by colloquial expressions of extreme negative feelings, extreme case formulation, complaining tone, and also by overriding some of the clinician's efforts to ask follow-up questions.

DISCUSSION

Using conversation analysis, we investigated 10 psychiatric assessment interviews, zooming on sequences where the clinician's medically oriented question was met by the patient's self-disclosure of a problematic personal experience. We analysed the patient's means for redirecting the talk toward the self-disclosure. We found four different trajectories leading from the medical question to the self-disclosure of a problematic experience. In the first trajectory, the patient answers the medical question first, and then the clinician gives an acknowledgement, after which the patient moves on to self-disclose a problematic experience. In this trajectory, the shift to self-disclosure was relatively fluent and collaborative. In the second trajectory, the patient first gives a medical answer, and immediately after

that, without the clinician's acknowledgement, she/he moves on to the self-disclosure. In the third trajectory, the patient responds to the medical question with an extensive telling in which the medical and the experiential worlds were intertwined without a single boundary between them and between the action of answering and the action of self-disclosure. In the fourth trajectory (with the smallest number of cases), the patient's turn after the medical question started off as a self-disclosure of a problematic experience, which also served as the answer.

Earlier conversation analytical research suggests that control is an indispensable aspect of social interaction: each speaker, through their turn at talking, defines and restricts the relevancies of the next turn (60, 61). In institutional contexts, the dynamics of control may be asymmetric so that one participant has more rights to control than the other (62, 63). Yet, for there to be interaction, the control can never be fully one-sided. While much of the interaction in a psychiatric interview is controlled by the clinician, in the cases presented above, the patients themselves took some control of the topic and action. In the first trajectory, the shift toward self-disclosure was relatively fluent and collaborative as the patient moved to self-disclosure only after the clinician had closed the prior action. In the second trajectory, the patient exerted somewhat more interactional control than in the first one, but the patient's move was more unilateral. In the third and fourth trajectories, the patient gained even more control; patient control was strongest when they bypassed the relevancies of the question (fourth trajectory).

It is a "default" pattern in our data that the patient responds to medical questions with medical answers (like in **Extract 1**). So, the presented cases are special: in these cases, the patients indeed shifted from answering the medical question to self-disclosing their subjective experience. In several of these cases, there was certain ambiguity in the clinician's question; being designed for the collection of diagnostically relevant factual information, it nevertheless left the door partially open for patients' broader accounts of their lives and experiences. This was the case in different ways, especially in **Extracts 2**, **5**, **6**. Yet, in all cases, the patients needed to do particular interactional work for the self-disclosures.

In their interactional work for the self-disclosure, the patients emphasised and intensified their descriptions of the negative subjective experiences and justified it by highlighting the intensity of their concern. The telling was thereby framed as a matter of urgency. The means for depicting the intensity of the experience and the urgency of telling included extreme case formulations, expressive (and sometimes rude) words and idioms, a loud voice, complaining tone, dramatisation through storeys, rhetorical questions, and overriding the clinicians' efforts to take a turn.

In our data, we found Extreme Case Formulations (ECFs) in almost all cases where the patients responded to medical questions with their self-disclosure of subjective experience tellings. As described by Pomerantz (35), the ECFs took diverse grammatical forms, all of which contributed semantically to extreme meanings. For Pomerantz (35), complaining was one of the key action environments of ECF [see also (64, 65)]. The patients' actions in our data—broadly, reporting their negative

subjective experiences—were indeed reminiscent of complaining. The clinicians' medical questions give relevancy to a description of a patient's life and circumstances in terms of specific symptoms or other indicators of the client's medical status (22, 23, 47). In their answers, the patients might "push back" with self-disclosures justified by extreme case formulations (34) and with other practises of emphasising the matters under discussion as their "investment" (66, 67).

In all our extracts, we observed something we could call a "clash of interactional projects." Schegloff (42) points out that in interactions, there are orientations that persist over sequences.

Elaborating on Schegloff's idea, Levinson [(68), p. 127] characterised such orientations: "actions often form a part of a larger project inheriting part of their import from the larger whole." Now, the clinicians' questions in the sequences that we investigated can be understood as part of a project of gathering information for diagnosis. These questions, and how the clinicians deal with the patients' answers, serve to delineate the patient's symptoms and behaviours that may be indicative of their (assumed) underlying mental illness. The patients' project in our sequences is observably different: it is to share, and in most cases, to complain about adverse experiences. In the very sequences that we have shown, the two divergent projects meet, and the participants negotiate them. Importantly, Levinson (68) suggests that the projects often remain incomplete, and participants may also remain relatively unaware of each other's projects. As we have shown, the patients pursue their projects of complaining, despite their divergence from the clinicians' project of diagnosing; to do so, they need to resort to the interactional practises that we have shown in this paper.

In light of the idea of interactional projects, we can further ask what the patients might be seeking and possibly achieving by giving self-disclosures of subjective problematic experiences in a psychiatric interview. If the patients' project is to share or complain about adverse experiences, the response that they seek is affiliation and empathetic understanding (29, 30, 32, 69–71). Yet, in some cases, a patient's self-disclosure can also be potentially functional for the clinician's project of gathering information for diagnosis. The self-disclosure can bring out relevant additional details of the patient's mental problems. For example, in **Extract 3**, the patient highlighted their lifelong anxiety rather than just naming another period of manic symptoms (which would have been relevant to the question); this suggests that the clinician's project of diagnosing a possibly bipolar disorder might not actually match with the patient's clinical condition.

In this paper, we have shown the various and variable ways in which patients take partial and momentary control of the conversation in presenting their accounts on negative subjective experiences. Now, in light of what is known about psychiatric disorders, it is possible that patients with different mental disorders have different abilities in exerting control in social interaction. In some cases, personality disorders can be associated with tendencies to control interaction (1, 2, 72). We assume that patients in (hypo)manic states would be equally prone to control the interaction. In contrast, patients with depression might be much less prone to exert interactional control, at least in terms of manifest and active control. The patient in **Extract 2**, who was diagnosed with a mood disorder, gave their account of a subjective experience less forcefully than how the patient in **Extracts 4**, **6** (who has features of personality pathology) tells about the uncle; that patient first waits for the clinician's acknowledgement of the factual answer and only thereafter proceeds with the telling. In our study, these patients found certain means for disclosing their subjective experiences; they were able to do it. However, patients who are vulnerable, anxious, shy, and helpless are possibly less able to reveal their inner subjective experiences. As recognised frequently in clinical work, patients with depression or, for example, with social anxiety may feel shame and fear about stigmatisation. They have difficulties expressing themselves and telling about inner experiences, and therefore, the clinicians should seek ways to encourage them to speak.

In future studies, the possible associations between the type of mental disorder and the ability to control interaction should be examined systematically.

One should bear in mind that in our data, there are numerous cases where the patients do *not* go against the grain by inserting their self-disclosure of subjective experience descriptions in utterances that follow medical questions. It would be a topic of further study to find out what kinds of disorders—possibly severe depression and anxiety disorders—are associated with such passivity of the patients.

In this study, we focused on the patients' way of finding conversational space for the self-disclosure of negative subjective experience accounts. We made only passing observations of another equally important topic: how the doctors in the "third position" take up these accounts. In our earlier study (37), we quantitatively compared two kinds of psychiatric assessment interviews: those supported by a psychological case formulation and the standard symptom-oriented interview. The study showed that the clinician using a case formulation-supported interview took up the patient's account of a negative subjective experience with follow-up questions about the "experiential" topic in 90% of the cases; however, the clinician using standard symptom-oriented interviews took the experience up only in 40% of the cases. Earlier qualitative studies in psychiatry suggest a similar pattern where the clinician's response to the patient's subjective or emotional account tends to be poor, neutral or medically oriented (26, 27, 73).

If the clinician takes up the patient's self-disclosure with follow-up questions, there is a possibility to *understand* (and display the understanding) the patient's experience. The definition of mental disorders in the ICD-10 is a "clinically recognisable set of symptoms or behaviour associated in most cases with *distress* and *with interference with personal functions*" (2). Self-disclosures offer the clinician an opportunity to recognise and understand the patient's symptoms and behaviour associated with distress, searching the clinically significant border between mental health and disorder. With empathetic and understanding responses after the self-disclosures, clinicians might avoid the unnecessary medicalization of the patient's

mental condition. Therefore, a critical task of future studies is to qualitatively investigate the clinicians' responses to the patients' self-disclosure in detail using CA.

Limitations

In our study, the number of patient interviews and the variety of mental disorders affect and limit the significance of our results to some extent. By applying Misher's (20) binary distinction between medical and experiential orientations of the action sequences of interviews, we simplified the process of the assessment interviews. However, in that way we have been able to advance the analyzability of the data in this institutional context. We recognise that the medical and experiential realm of the interviews are more intertwined than the binary distinction represents and than the medical or diagnostic realm generated from the larger experiential realm. Furthermore, these analysed micro-sequences do not cover all details of the whole assessment interviews. However, as recently mentioned, it will be a task to investigate the clinicians' responses to the patients' disclosure of experience-oriented or medical tellings in detail using CA in the future.

CONCLUSION

The patient's narrative always involves the cultural and social background as well as the actual context. The patients are seeking acceptance and understanding for their subjective experiences. In this study, we showed that after the clinicians' symptom-oriented medical questions in the psychiatric interviews, the patients actively "go against the grain" to uncover and justify their self-disclosure of subjective experiences with their social and personal context. Patients in our data found the means to disclose their subjective problematic or distressing experiences, yet they needed to work interactionally, for example by extreme case formulations, to legitimise the topical shift toward self-disclosure of subjective experiences. By being aware of and recognising the patients' relevant needs to disclose their subjective problematic experiences, the clinicians may promote and clarify the patients' diagnostic psychiatric assessment process in a patient-centred way, advancing to find the clinical border between mental health and disorder and collaboratively improving the individual treatment plan.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because the ethics committee does not allow the transfer the audio-recorded data to third parties. Requests to access the datasets should be directed to the corresponding author. Requests to access these datasets should be directed to Enikö Éva Savander, eniko.savander@phhyky.fi.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Ethics Committee of Tampere University Hospital (R 14094). The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

ES: study design, data collection, qualitative data analysis, outlining the argument of the paper, writing the paper's first draft, and manuscript revision. JH: study design, manuscript comments, and revision. MW: qualitative data analysis, translation of extracts, manuscript comments, and revision. AP: qualitative data analysis, outlining the argument of the paper, manuscript revision, research supervision, and writing. All authors have approved the final manuscript.

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APPENDIX

Transcription symbols—adapted from Jefferson (74)

AB:	Speaker identification: doctor (DO), patient (PA), psychologist (PS)
→	Line containing phenomenon discussed in text
[ ]	Overlapping talk or anonymization
=	No space between turns
(.)	A pause of <0.2 s
(1.0)	Pause: silence measured in seconds and tenths of a second
°word °	Talk lower volume than the surrounding talk
WORD	Talk louder volume than the surrounding talk
.hh	An in breath
hh	An out breath
mt, tch, krhm	Vocal noises
£word£	Spoken in a smiley voice
@word@	Spoken in an animated voice
#word#	Spoken in a creaky voice
wo(h)rd	Laugh particle inserted within a word
((word))	Transcriber's comments
( )	Transcriber could not hear what was said
Word	Accented sound or syllable
-	Abrupt cut-off of preceding sound
:	Lengthening of a sound
>word<	Talk faster than the surrounding talk
<word>	Talk slower than the surrounding talk
word<	Sharp tone at the end of a word
↑↓	Rise or fall in pitch
?	Final rise intonation
,	Final level intonation
.	Final falling intonation