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

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Highlights

- Patients’ opportunities to reveal their subjective experiences were investigated.
- Dialogical sequence analysis DSA and usual psychiatric AAU interviews were compared.
- Clinicians facilitated the patients’ subjective experiences significantly more in DSA.
- In AAU, the patients needed to make an extra effort to reveal subjective experiences.
- Working on patients’ subjective experiences may promote individual care planning.

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.

Keywords
dialogical sequence analysis, psychiatric assessment, conversation analysis, subjective experience, working alliance, patient–clinician interaction, individualized treatment plan

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). In total, the AAU interviews lasted 280 minutes and the DSA interviews lasted 283 minutes. 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. Figure 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 Figure 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.

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.

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

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 your perspective’; lines 1–2) involves an invitation to talk about subjective experience. In line with this, 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 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 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.

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

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 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 Figure 1 above, i.e. comprising both transitions. The comparison is presented in Figure 2 below. We found significant differences \((p<0.001)\) between the DSA and AAU cases in all four subgroups.

Figure 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 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 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 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.
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Declarations of interest

None.

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.

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References


Appendix

Transcription Symbols (Jefferson 2004)

T: Speaker identification: therapist (T),
occupational therapist (OT), client (C)
→ Line containing phenomenon discussed in text
[ ] Overlapping talk
= No space between turns
(0.0) A pause of less than 0.2 seconds
*word o* Pause: silence measured in seconds and tenths of a second
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
Figure 1  Experience descriptions and their sequential environment.
Figure 2  Distribution of the four trajectories of interaction across the AAU and DSA groups.
case DSA 98/8

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)),

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 ollu 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.

((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,

26 PA: meiän äitille .hhhh

 Extract 1
case AAU 05/5

1 DO: njoellisek sii niin et tää ehhä sii niin keskikussa jo niin se
   would you think that maybe the most di- difficult
   depression was over already (...) in June

3 FA: [.hhh oli oli
   actually it was already in May.

5 DO: [.joo.]
   [.hhh it was

6 FA: loppupuu eli mä sitte nhm (0.8) .hh (0.9) sain sit
towards the end of it so then I nhm (0.8) hh (0.9) got
some other things to do in my life(h) or(h) something
like (that s - (.) eh,

9 DO: [.joo.]
   [.yes.]

10 FA: et se ei ollu niinko kauheen pitkä se masennusjakso
   that it wasn’t that long that depressive episode
   last (.) spring and I think that it also clearly resulted
   so (.) my supervisor who (really) was quite (.).hh
   from (.) that I really was quite (.).hh
   [
   
13 FA: [.kknee (.0).hh esimesi sessi jaa se ei (.)
   [and he didn’t (.)

14 DO: [.nii just.]
   [right.

15 FA: mä en (.). mä tiedän et mä en oo ainoo joks
   I know (.). I know that I’m not the only one who
   feels that way that (.). I talked with several people
   [.joo.]
   [.yes.]

18 FA: [.hás joo pin siel syöopaikalla ja monet sano mulle et
   there at that workplace and many people said to me that
   [.kkseen sii keskitt tota syöoppa@.hhh niin oli van et pakko
   [.hhh if I was just I have to

19 FA: [.joo oh no not that way the way.]
   [.hhh at that point but then eventually it did

21 FA: [.joo.
   [.hhh end that employment exactly because of that].hhhh
case DSA98\$ continuation of Extract 1

24 DA: mut en mä siitässä pu- (0.8) puhunu.
25 DO: mm-mm,
(0.8)
26 FA: meiän äitille . hhhh
to cuiir mother . hhhh

27 DO: [et puhunut kaalleikä,
you didn’t tell anyone,

28 DA: e:::m,

29 DO: mm keulus[sakas ei ketonskaa hhh
mm at schoooel ar at home hhh

30 FA: [c- c - en mä tiil cih en mä helunnu vaiveta man
[a- a- so I no: noh I didn’t want to bother

31 assiills [. hhh
anyones with my staff [. hhh

32 DO: [mhhh

Extract 3
case AAU 05/5 continuation of Extract 2

18 FA: I was just at that point but then eventually my employment
there at that workplace and many people said to me that
@miten sii kestä tätä syytypää .hnh @m@ oli va@ et pakt@
@how can you bear that guy@ .hnhh @I was just I have to
20 kestä siinä vaiheessa mus sitte lopulta se kylä se
jatk@ at that point but then eventually my employment
sitte loppu se työpientä olen takia jyuikin [.hnhh
was terminated exactly because of that [.hnhh

22 DO: [koska sä
[when did you
käviti viimesen kerran siel mm ee- tota (. ) tapaamas
then go to mm exam (. ) meet that psychiatrist for the last time
24 tätä psykiatrii sii (. (lääkärineman nimi)).
in that (.a name of the medical clinic)).

_extract_4
Table 1. Distribution of subjective experience sequences across the interviews.

<table>
<thead>
<tr>
<th>Case ID</th>
<th>DSA 02</th>
<th>DSA 84</th>
<th>DSA 98</th>
<th>DSA 121</th>
<th>DSA 128</th>
<th>DSA mean per interview</th>
<th>AAU 05</th>
<th>AAU 71</th>
<th>AAU 108</th>
<th>AAU 111</th>
<th>AAU 126</th>
<th>AAU mean per interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>18</td>
<td>13</td>
<td>11</td>
<td>15</td>
<td>14</td>
<td>14.2</td>
<td>11</td>
<td>9</td>
<td>6</td>
<td>12</td>
<td>10</td>
<td>9.6</td>
</tr>
</tbody>
</table>
Table 2. The emergence of patients’ negative subjective experience descriptions from the clinicians’ questions in two different type of diagnostic assessment interviews.

<table>
<thead>
<tr>
<th></th>
<th>DSA</th>
<th>AAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQ - E</td>
<td>51 (71.8%)</td>
<td>23 (47.9%)</td>
</tr>
<tr>
<td>MQ - E</td>
<td>20 (28.2%)</td>
<td>25 (52.1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>71 (100%)</td>
<td>48 (100%)</td>
</tr>
</tbody>
</table>
Table 3. Consequences of the patients’ descriptions of negative subjective experiences in two different types of diagnostic assessment interview.

<table>
<thead>
<tr>
<th></th>
<th>DSA</th>
<th>AAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>E - ET</td>
<td>64 (90.1%)</td>
<td>19 (39.5%)</td>
</tr>
<tr>
<td>E - MT</td>
<td>7 (9.9%)</td>
<td>29 (60.5%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>71 (100%)</td>
<td>48 (100%)</td>
</tr>
</tbody>
</table>